HIV, sexual and reproductive health: Understanding and claiming rights

Skills-building workshop
Basic curriculum

Maria de Bruyn
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Ipas works globally to increase women’s ability to exercise their sexual and reproductive rights and to reduce abortion-related deaths and injuries. We seek to expand the availability, quality and sustainability of abortion and related reproductive health services, as well as to improve the enabling environment. Ipas believes that no woman should have to risk her life or health because she lacks safe reproductive health choices.

The photographs used in this publication are for illustrative purposes only; they do not imply any particular attitudes, behaviors, or actions on the part of any person who appears in the photographs.

NOTE: Feedback on use of this curriculum would be greatly appreciated. What worked and what didn't? How did it contribute to your work? Please contact the author: debruynm@ipas.org


HIVRIGHTS-E09

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INTRODUCTION

Background to the curriculum

Three Millennium Development Goals (MDGs) are directly related to women’s reproductive health: MDG 3 on promoting gender equality and women's empowerment; MDG 5 on improving maternal health; and MDG 6 on combating HIV/AIDS, tuberculosis and malaria. Initially, governments and multilateral organizations, such as UNFPA, tracked progress in meeting the MDGs; nongovernmental organizations (NGOs) did not have much of a role in this regard. Ipas therefore took the lead in developing a monitoring tool with simple benchmarks that NGOs can use to assess progress toward meeting MDGs 3, 5 and 6 in relation to HIV and reproductive health and rights. The tool was tested by 11 partner organizations in Africa, Europe and Latin America in 2005–2006. A key partner in this endeavor was the International Community of Women Living with HIV/AIDS (ICW), who helped test the tool in Botswana, Lesotho, Namibia and Swaziland.

Key findings from that project were that:

- Women living with HIV are rarely involved in policy and program formulation, monitoring or evaluation regarding HIV/AIDS research or interventions in a meaningful way, especially with regard to reproductive-health issues.
- Health-care professionals, policymakers and clients have heard of human rights but often don’t see how rights are directly relevant to their daily work and lives.
- HIV-positive women may be reluctant to report rights violations in the health-care sector for fear of endangering their future treatment and care.
- Discriminatory practices against HIV-positive women in the health-care sector include humiliating treatment, breaches of confidentiality, refusal to provide medications and treatment, putting conditions on treatment, and delaying treatment.

Subsequent conversations between Maria de Bruyn (Ipas) and Jeni Gatsi Mallet (ICW Namibia) identified a need to work with HIV-positive women to enhance their knowledge and advocacy skills regarding sexual and reproductive rights. Development of a training curriculum for participatory workshops evolved from those discussions.

Curriculum development

Ipas drafted an initial curriculum, which was reviewed by Jeni Gatsi and Edwina Pereira of INSA–India. Edwina contributed three additional exercises that would carry a content message while simultaneously “lightening up” the overall “heavy” subject matter. The curriculum was designed to cover basic facts about sexual and reproductive rights, culminating with a focus on identifying examples of discrimination and rights violations experienced by people living with HIV in relation to parenthood and reproductive choice, including abortion care.
The curriculum was piloted and revised through workshop presentations at the following venues:

- The XVI International AIDS Conference (Toronto, 2006) – co-facilitators: Maria de Bruyn, Jeni Gatsi, Edwina Pereira and Tyler Crone (ATHENA Network); the participants from all regions of the world included representatives of governmental ministries, inter-governmental agencies, NGOs and associations of people living with HIV.
- The International Women’s Summit (Nairobi, 2007) – co-facilitators: Maria de Bruyn, Jeni Gatsi, Esther Sheehama (ICW Namibia) and Susan Paxton (APN+); the multinational participants included representatives of NGOs, associations of people living with HIV, and members of YWCA branches from many countries.
- A training–of–trainers workshop for ICW members from Botswana, Kenya, Malawi, Namibia, Swaziland, Tanzania and Uganda and a workshop for students at the University of Namibia in Windhoek, Namibia, in 2007.
- A workshop organized by Ipas Mexico and UNFPA for young people in Mexico.

This version of the curriculum incorporates material that responds to requests for additional information made by participants and facilitators at those workshops.

**Format and objectives**

The purpose of workshops based on this curriculum is to ensure that participants have a basic understanding of sexual and reproductive rights and to enable them to identify rights violations in relation to reproductive health care. As mentioned, the particular focus is on violations related to HIV, but the material has proved to be very useful for a more general audience interested in sexual and reproductive rights. The case studies could be easily supplemented with other examples of rights violations; case study 27 – concerning coerced sterilization of Roma women – provides an example.

The curriculum utilizes presentations, small–group work, case studies, plenary discussions and games as methods of communication. This varied approach provides participants with an opportunity to share their own experiences and expertise in the subject matter, so that mutual sharing and learning occurs (as opposed to a primarily didactic trainer–trainee relationship).

**Two sample time schedules are presented – for a three-hour and a five-hour workshop.**

**Times for individual exercises indicate whether they are for three– or five–hour workshops.**

**Indications are also given on information that can be explored in more detail during a longer workshop.** The first four appendices provide supplemental information that can be discussed during longer workshops; the fifth appendix includes the case studies with answers. The handouts for workshops can be found in an accompanying document.
SAMPLE TIME SCHEDULES

A three–hour workshop
13:45–14:15: Preparations for the workshop (all co–facilitators)
14:30–14:45 Welcome, goals of the workshop and ground rules
14:45–15:00 What are sexual and reproductive rights?
15:00–15:25 What if?
15:25–15:40 Putting a tail on a cat!
15:40–15:50 Human rights conventions and treaty monitoring committees
15:50–16:00 Refreshment break
16:00–16:05 ❖ The choice is yours (if many participants know Roman numerals)
❖ Mrs Mumbly (for participants not familiar with Roman numerals)
16:05–16:25 Mechanisms for claiming rights
16:25–16:35 The T puzzle
16:35–17:15 Applying human rights: case studies
17:15–17:30 Wrap–up and evaluation

A five–hour workshop
7:30–8:00 Preparations for the workshop (all co–facilitators)
8:00–8:20 Welcome, goals of the workshop and ground rules
8:20–8:40 Introduction of facilitators and participants
8:40–9:00 What are sexual and reproductive rights?
9:00–9:30 What if?
9:30–9:45 Putting a tail on a cat!
9:45–10:10 Human rights conventions and treaty monitoring committees
10:10–10:30 Refreshment break
10:30–10:40 ❖ The choice is yours (if many participants know Roman numerals)
❖ Mrs. Mumbly (for participants not familiar with Roman numerals)
10:40–11:15 Mechanisms for claiming rights
11:15–11:30 The T puzzle
11:30–12:30 Applying human rights: case studies
12:30–12:45 Questions participants may still have about reproductive rights
12:45–13:00 Wrap–up and evaluation
Preparations for the workshop (all co-facilitators)

A week in advance
- If you have resources, prepare CD-ROMs with the curriculum and curriculum handouts for participants, as well as other relevant materials.
- Ensure that you have sufficient supplies (flipcharts, markers, photocopied handouts), including as many sets of pieces for the T puzzle game as the number of workshop participants. (Use handout 7 as a model, cutting the pieces along the lines.)

On the day of the workshop: at least 30 minutes before the workshop begins
- Set up a table with the CD-ROMs and other materials that co-facilitators wish to distribute at the end of the workshop (e.g., flyer on relevant networks, Barcelona Bill of Rights in Appendix 4, Maputo Plan of Action).
- Ensure that a sign-in sheet is available.
- Try to have available a bag of sweets (e.g., hard candies) or some pieces of fruit to pass around during the workshop.
- Arrange the space, making five semi-circles of chairs each (without tables). Make sure the open space faces the area with the flipchart and/or projector screen.
- Check that the LCD projector is working and/or flipchart and markers are available.
- Arrange handouts on table in order to be used.
- Make sure each co-facilitator has a pen and paper to take notes during her “assigned time” (discussed during pre-workshop meeting).

Greeting participants
- Direct participants to semi-circles of chairs and encourage “friends” to go to different groups; explain we are saving time by assigning people to small groups right away.
- Ask participants to include their address/e-mail address on the sign-in sheet (printed legibly!) if they want to be in touch with the co-facilitators after the workshop.

Welcome – 15 or 20 minutes

Expected results: Participants understand purpose of workshop and how it will be run.
Materials required: PowerPoint slides or flipcharts with: 1) names of co-facilitators; 2) workshop objectives; 3) ground rules; 4) sequence of exercises

1. Welcome the participants.
   ✤ If it is a three-hour workshop, remark that due to time constraints, there will be no time for each person to introduce her/himself; just ask people to shout out which countries (or cities or institutions) they come from.
2. Introduce co-facilitators and explain how workshop came about.
3. Explain the objectives of the workshop.
4. Briefly explain the ground rules (and ask if anyone wants to add any to those displayed).
5. Briefly show sequence of exercises to be done and mention that a CD-ROM (or print copies of workshop exercises) will be distributed at the end of the workshop.

**Workshop objectives**

1. Participants gain/enhance an understanding of sexual and reproductive rights
2. Participants become aware of different parts of the international human rights system
3. Participants gain an understanding of mechanisms that can be used to claim rights
4. Participants practice applying human rights principles to case studies of rights violations involving women living with HIV

**Ground rules for the workshop**

- Participants do not need to answer questions during the workshop if they feel uncomfortable.
- Facilitators and participants will listen with respect to every person’s opinion even if they don’t agree with him/her.
- One person speaks at a time: don’t interrupt others when they are speaking.
- Speak in ‘I’ statements (I think..., I believe..., I like/dislike..., etc.) rather than ‘you’ statements (You are wrong when you say that...; you shouldn’t think that way, etc.).
- Respect confidentiality – if someone shares something personal don’t repeat it outside the room in a way that can identify him/her.
- Agree to allow the use of ‘sensitive’ or ‘taboo’ words and terms during the workshop; when we talk about sexuality, we may need to use such phrases.
- Come back from small-group work and the refreshment break on time!
- Turn off cell phones! (or if you must be available for urgent matters, put the phone on vibration)

**Introduction of facilitators and participants – 20 minutes for five-hour workshop**
What are sexual and reproductive rights? –15 or 20 minutes

Expected results: Participants gain, or reinforce their, knowledge about sexual and reproductive rights.

Materials required: Flipchart and markers, handout 1 on sexual and reproductive rights

Instructions
1. Explain that the International Planned Parenthood Federation (IPPF) summarized sexual and reproductive rights that can be derived from international human rights conventions. Mention that these rights can be categorized according to whether they are related to reproductive self-determination (protection of the person him– or herself) or to reproductive health care (obligations of health systems).
2. Ask the participants to brainstorm on what the sexual and reproductive rights might be. Write their suggestions on a flipchart.
3. After five minutes, review the participants’ responses and compare them with the IPPF rights (shown on a flipchart or Power Point slide). Ask them to give examples of what each right might involve or examples of ways in which they can be violated.
4. Mention that there are also some other rights that might be involved in cases where sexual and reproductive rights are violated. For example, if someone is put on trial for infecting another person with HIV, their right to due process might be involved. Due process means that legal proceedings must be fair, that the person involved must know about them, and that the person has a right to be heard before a government can take away life, liberty or property.
5. Ask the participants if they have any questions and give them the handout on sexual and reproductive rights.

Rights related to reproductive self-determination
- The right to equality and to be free from all forms of discrimination
- The right to privacy and confidentiality
- The right to freedom of thought
- The right to decide whether or when to have children
- The right to choose whether or not to marry and to found and plan a family
- The right to freedom of assembly and political participation

Rights related to reproductive health care
- The right to life
- The right to information and education
- The right to liberty and security of the person
- The right to health care and health protection
- The right to the benefits of scientific progress
- The right to be free from torture and inhuman treatment
What if? – 25 or 30 minutes

Expected results: Participants reflect on dilemmas that some health-care clients may be facing in relation to HIV/AIDS.

Materials required: Handout 2 with scenarios for participants, pens

Instructions

1. Give the participants in each small group a handout with the scenario shown below.1
   Tell them they will talk about a story that could lead them into a dilemma about how they should help a young woman in a situation that made her vulnerable to HIV infection.

The scenario

Thuy, your niece, and her boyfriend Duc have gone on their third date. At first, Thuy could not believe her good luck. She had only been at the university for two months and she was dating a wonderful guy. He was smart, funny and even good-looking. On their first date, Duc took her for a walk in a beautiful park; on the second date, he took her to a movie. He behaved beautifully and only kissed her. On the third date, he took her to an expensive restaurant; they both drank a lot of beer. He took her to the house of a friend who was not home. He put on some music and asked Thuy if she wanted to dance. She was feeling good so she said yes and their bodies came close during a slow dance. Duc began kissing her and she liked it; he led her to a sofa and continued kissing her; she did not protest. He began pulling off her pants and Thuy now said she wanted to stop, but Duc said he had spent a lot of money on her and she owed him something in return. He also said he wouldn’t see her anymore if she refused him, so Thuy let him have sex with her, even though he didn’t use a condom. Now she is worried about HIV/STIs and a possible pregnancy; she has come to you for advice.

Which one of these actions would you take and why? (It is possible that you might take them all.)

A. Ask her when this happened and if it was less than a week ago, advise her to get emergency contraception?
B. Tell her that this was a case of rape and she should report him to the police.
C. Tell her that he is no good for her and she should stop seeing him; in the meantime she should get tested for HIV and STIs.
D. Do something else?

2. Give the participants five minutes to answer the question as a group, explaining the reasons for their choice.

3. Ask one group to tell the other groups if they had one predominant answer and why (or why they did not have consensus).

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4. Ask the other groups to briefly state their predominant answers and the reasons behind them.
5. Explain to the participants that the purpose of thinking about this scenario is to remind ourselves that often there are no simple cut-and-dried answers to dilemmas; we need to think about the repercussions of our decisions. Also, ask them if they would have answered differently if the young woman was someone closer to them, like their daughter or sister. It is not uncommon for people to make different decisions when they concern a very close family member; we should remember that reproductive health problems related to HIV can affect women whom we know personally. In our advocacy, we should address such issues as if all affected women were our daughters, relatives, friends and neighbors.

**Putting a tail on a cat!² – 15 minutes**

**Expected results:** Participants think about how we blindly follow customs, behaviors and traditions without understanding them; to discuss the power of listening; to discuss how we can change the way we think.

**Materials required:** Flipchart, pens and paper, cloth for blindfolding

**Instructions**

1. Place the cloth for blindfolding on the table or arm of a chair close to the board, in full view of the group.
2. Draw a picture of a cat on a flipchart and tell the group we will now do a short energizing game. Ask each small group to pick a volunteer who will help in completing the drawing.
3. Ask the first volunteer to blindfold him– or herself and to help finish the drawing by putting a tail on the cat. Put a marker in the volunteer’s hand and place him/her in front of the flipchart.
4. Tell the other participants that they must stay in their seats. Encourage the volunteer’s group to shout instructions on how and where to draw the tail (“up”, “down”, “to the left”) and tell the other groups that they can shout different instructions to confuse the person drawing.
5. After the volunteer draws a tail, write the number of the group by the tail and place the cloth back on the table. Invite the second volunteer to come forward and ask her/him to listen to your instructions: “Please come draw a tail on the cat and try to make it even better than the first tail! Your group can help by shouting instructions and the other groups can also tell you where to draw.”

² This exercise was kindly provided by International Services Association, INSA India. Their e-mail: insaind@airtelmail.in; their website: http://www.insa-india.org.in
6. Do not give any other instruction and do not mention the cloth. If the other volunteers ask if they should put on the blindfold, ignore the question and just say: “Please go on and draw a tail on the cat that is better than the first one.” If other volunteers blindfold themselves, keep a blank expression.

7. Repeat the process with all the volunteers.

8. When they are all finished, lead a discussion with the following questions and points: “What did I ask the first volunteer to do?” Wait for the group to answer. Then clarify that the first volunteer was asked to ‘Blindfold him– or herself and draw the tail on the cat’. Then say: “What did I ask the second volunteer to do?” Wait for the group to answer. If participants say ‘Do the same…blindfold and draw...’ etc., give them the exact words repeated, saying, ‘Who’s next. Come draw a tail on the cat and try to make it even better than the first tail’. Wait for their thoughts to sink in. Then ask each of the persons who came to explain why they blindfolded themselves.

9. If none of the other volunteers blindfolded themselves, mention that in many other workshops, everyone or most volunteers blindfolded themselves, even if they were not asked to do this.

10. Discuss the fact that many people just follow the first person’s action without thinking about the instructions given to them. Discuss whether the participants know of people who follow actions blindly in real life, too. How relevant is it to similar situations they face in real life?

11. Finally discuss how to ‘un–blindfold’ their attitudes, so that they can become more original and active in thinking about how to think about their sexual and reproductive rights.

**Human rights conventions and treaty monitoring committees – 10 or 25 minutes**

**Expected results:** Participants understand that human rights are applied through international human rights conventions.

**Materials required:** PowerPoint slide, flipchart, markers, handout 3 on human rights and treaty monitoring committees; for a five–hour workshop: handouts 4 and 5 on human rights commissions, human rights courts, the Human Rights Council and Special Rapporteurs

**Instructions**

1. Ask the participants if they know what a treaty or convention is; if not, explain that it is an international legal instrument through which governments agree to honor certain commitments. Explain that the words convention, treaty, pact and covenant are basically synonyms (mean the same thing). Sometimes the word “charter” is also used instead of convention.
2. Explain that conventions can apply to different areas of life. There are conventions about protecting exotic animals (CITES) and protecting prisoners of war (Geneva Convention).

3. Ask the participants if anyone is familiar with conventions that can apply to the human rights of people living with HIV; if so, ask a volunteer to name some of them and explain what they cover.

4. Mention that there are also “protocols” to some conventions; governments which sign the protocols agree to honor other rights in addition to those specified in the convention. For example, there is a Protocol on the Rights of Women which was added to the African Charter on Human and People’s Rights.

5. Add points that the volunteer did not mention and be sure they know the difference between signing and ratifying a convention. Ratifying a convention means that a government consents to be legally bound by the convention and to enact legislation that will ensure the rights in the treaty are fulfilled nationally. Signing a treaty means a government expresses its willingness to pursue ratification.

6. Ask the participants if anyone can explain the work of treaty monitoring committees and what shadow reports are. In a longer workshop, you can refer to Appendix 1 to give examples of recommendations that treaty monitoring committees have made to some governments regarding sexual and reproductive rights issues.

7. Ask the participants if they have any questions after the explanations are done and give them the handout on human rights.

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**International human rights standards**

- Conventions are the same as treaties, covenants and pacts. Sometimes the word charter is used to designate a convention
- Conventions are formulated by the United Nations General Assembly, the Council of Europe, the African Union and the Organization of American States
- States must sign and then ratify conventions for them to be valid for a country
- States must respect, protect and fulfill rights stipulated in ratified conventions

**Some global human rights treaties**

- International Covenant on Civil and Political Rights
- International Covenant on Economic, Cultural and Social Rights
- The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)
- The Convention on the Rights of the Child (CRC)
- Convention on the Elimination of Racial Discrimination (CERD)
- Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (CAT)
Some regional human rights treaties

- The African Charter on Human and Peoples’ Rights (ACHPR)
- American Convention on Human Rights (Pact of San José)
- The Inter–American Convention on the Prevention, Punishment and Eradication of Violence against Women

Treaty monitoring committees and shadow reports

- There are treaty monitoring committees for various conventions, such as:
  - Human Rights Committee – International Covenant on Civil and Political Rights
  - CEDAW Committee – Convention on the Elimination of All Forms of Discrimination Against Women
  - CESCR Committee – International Covenant on Economic, Social and Cultural Rights
  - Committee on the Rights of the Child – Convention on the Rights of the Child

- States must submit periodic reports on their compliance with conventions to treaty monitoring committees
- Other agencies may submit shadow reports or shadow letters

8. If you are doing a five–hour workshop, explain that there are other international mechanisms for guaranteeing human rights as well. Ask the participants if they can think of what they might be.

9. Use flipcharts or Power Point slides to discuss commissions on human rights, international human rights courts, the Human Rights Council and Universal Periodic Reviews, and Special Rapporteurs.

10. Note that: the Asian region does not currently have regional human rights bodies although the Charter of the Association of Southeast Asian Nations (ASEAN), adopted 20 November 2007, calls for the establishment of an Asian human rights body.
Commissions on human rights

- Commissions on human rights comprise independent experts who are asked to protect and promote rights and interpret human rights instruments such as treaties.
- They formulate principles and rules related to human rights upon which governments may base their legislation.
- They may investigate specific complaints and cases and make recommendations to governments.
- They may make broader recommendations to governments on specific topics. For example, the African Commission has issued resolutions on violence against women and maternal mortality as a human rights violation (Appendix 2).
- They may organize conferences, symposia and other events and publish studies and position papers to disseminate information on human rights.
- Some commissions review periodic reports from governments about how they are fulfilling rights.
- Examples of such commissions:
  - African Commission on Human and People's Rights (African Union)
  - Inter-American Commission on Human Rights (IACHR; Organization of American States)
  - European Commissioner for Human Rights (Council of Europe)

International human rights courts

- International human rights courts are charged with ensuring that governments respect and observe treaties which they have ratified.
- Governments and commissions may submit legal cases to be heard by the courts.
- They may impose penalties on governments that are found to have violated rights (e.g., imposing monetary fines, obligations to implement laws).
- Examples of such courts:
  - African Court on Human and People's Rights, linked to the African Union
  - Inter-American Court on Human Rights, linked to the Organization of American States
  - European Court of Human Rights, linked to the Council of Europe
The Human Rights Council and Universal Periodic Reviews

- The United Nations General Assembly established the Human Rights Council (HRC) in 2006.
- It comprises 47 Member States, elected by the General Assembly; membership is based on regional groups: African Group, (13 seats), Asian Group (13), Eastern European Group (6), Latin American and Caribbean Group (8), and Western European and others (7).
- It meets at least four times per year in Geneva and may issue resolutions that are voted on by HRC members. These are sometimes preceded by statements which Member and Observer States may sign (Appendix 3).
- The HRC reviews the human rights situation of all U.N. Member States through Universal Periodic Reviews (UPRs). States present reports and NGOs can contribute to stakeholder reports on individual countries (the final stakeholder reports are prepared by the Office of the High Commissioner on Human Rights).
- The UPR Working Group issues reports with recommendations and voluntary commitments made by the 16 countries reviewed in each session.

Special Rapporteurs

- A Special Rapporteur is an independent individual expert appointed by the UN Human Rights Council1 or a regional Inter-governmental body to investigate, monitor, advise and report on human rights concerns.
- Thematic Special Rapporteurs address a specific human rights issue, such as trafficking in persons, the right to food, or freedom of expression. Country Special Rapporteurs address the human rights situation in a particular country.
- Special Rapporteurs submit annual reports about their investigations and on specific topics they have chosen (such as access to medicines).
- Examples of Special Rapporteurs:
  - U.N. Special Rapporteur on the Right to Health
  - U.N. Special Rapporteur on Torture and other Cruel, Inhuman or Degrading Treatment or Punishment
  - U.N. Special Rapporteur on Violence against Women, its Causes and Consequences
  - Special Rapporteur on the Rights of Women in Africa
The choice is yours – 5 minutes

Expected results: Participants understand that there could be a number of possibilities for solving a problem and we should not limit ourselves with usual solutions.

Materials required: Flipchart, pens and paper

Instructions
- Ask the participants: “Do you know how to write the Roman numeral for nine?”
- Write the Roman numeral, IX, on the flipchart and asks the participants to write on a piece of paper as well.
- Then ask the participants to change it into six with only one stroke added to it.
- After a couple minutes, ask if some one has solved the puzzle.
- Most of them will not have solved it. If someone has done it, ask the group to appreciate the effort.
- Add the letter “S” before the Roman numeral, IX, on the flipchart so that it becomes SIX.
- Mention that this game shows how we often think along customary lines; doing so may prevent us from having empathy or recognizing when others’ rights are violated.
- Discuss with workshop participants the need to look at situations from various angles and how this can be useful in determining whether a human rights violation has occurred.

Do you know Mrs. Mumbly? – 5 or 10 minutes

Expected results: Participants relax and laugh

Instructions
- Ask the participants to sit or stand in a circle.
- Explain that you are going to say the following sentence to the person next to you: “Pardon me, have you seen Mrs. Mumbly?”
- Say that that person must say, “No, I haven’t but I’ll ask my neighbor.”
- Say that the second person must now ask: “Pardon me, have you seen Mrs. Mumbly?” and so forth.

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3 This exercise was kindly provided by International Services Association, INSA India. Their e-mail: insaind@airtelmail.in; their website: http://www.insa-india.org.in

4 The origin of this exercise is unknown. It is used in curricula of the Alternatives to Violence Project (AVP Basic Manual), http://www.power2u.org/downloads/A-WayHome.pdf; It has also been credited to: Vi Anderson, Andersen Associates Inc., Barrie, Ontario, Canada; http://pointmanmuncie.org/Warm%20Ups%20-%20Icebreakers/Mrs_Mumbly.pdf and can also be found at the Origins website: http://www.originsonline.org/product_info.php?products_id=234&s=resources&ss=classroom
▪ Say that there is one more rule: the person asking for Mrs. Mumbly must say the sentence without showing his/her teeth or laughing. They must try at least three times and if they do not succeed, you go on to the next person.
▪ The facilitator starts, demonstrating how to say the sentence without showing his/her teeth.

Mechanisms for claiming rights – 20 or 35 minutes
Expected results: Participants learn about different mechanisms that can be used to help them claim their sexual and reproductive rights in the health–care sector.
Materials required: Flipchart, marker, PowerPoint slide, handout 6

Instructions
1. Ask the participants to brainstorm ways in which they can ensure that local health–care providers and clients become aware of sexual and reproductive rights.
2. Add ideas that they may not have mentioned such as:
   ▪ Dissemination of the IPPF Charter of Sexual and Reproductive Rights, Barcelona Bill of Rights, local human rights documents
   ▪ Distribution of international professional association statements (for example, from ob–gyn societies such as the International Federation of Gynecologists and Obstetricians (FIGO) or IPPF’s Medical Advisory Panel) to local professional associations, NGOs and associations of people living with HIV
   ▪ Distribution of brochures and flyers about rights
   ▪ Radio programs
   ▪ Billboards and posters
   ▪ Tribunals about rights violations
   ▪ Training seminars and workshops for health professionals and people living with HIV
   ▪ Documenting and publicizing rights violations (publications, websites, media)
   ▪ Breakfast meetings: for example, to brief parliamentarians who need very complete information
   ▪ Group electronic forum e–mails
   ▪ Letters to the editor.
3. Ask the participants to brainstorm ways in which respect for rights and violations of rights can be addressed. Add ideas that they may not have mentioned such as:
   ▪ Creating an action plan with members of a local medical society (ob–gyn society, midwives’ association) to ensure that health facilities respect rights
   ▪ Advocacy and education targeting parliamentarians/policymakers
• Collecting data about health facilities' respect for rights (e.g., using monitoring tools created by NGOs)\(^5\)

• Creating or publicizing a patients bill of rights and getting health authorities to endorse it

• Proposing the establishment of a hospital or professional association ethics committee to which patients can present anonymous complaints

• Creating a complaints form that is available at hospitals or local NGOs where people can report violations of their rights (in writing or with help from a volunteer)

• Reporting violations to a government ethics committee or district health office

• Mediation involving a human rights organization, NGO or association of people living with HIV

• Publicity about the case through the media

• Presentation of the case to a human rights ombudsperson or human rights commission

• Court case

• Presentation of shadow letter or report to treaty monitoring committee or the Human Rights Council

• Public campaigns for reform of laws and/or regulations.

4. Brainstorm **possible obstacles** to implementing rights and brainstorm how they might be overcome.

5. Discuss some examples.

   • Anti-rights advocates very vocal – find an authoritative “champion” (e.g., respected legislator or judge) to provide alternative statements

   • Youth not interested in rights – find an appealing spokesperson (e.g., athlete, musician, singer, actor)

   • Hospital resistant to establishing an ethics committee – obtain support from human rights group or health ministry; get NGOs to circulate petition

   • Media not interested – offer access to persons to be interviewed

   • Inexperience in writing shadow letters – enlist support and technical assistance from national and international NGOs.

The T puzzle\textsuperscript{6} – 10 or 15 minutes

**Expected results:** Participants play a game focused on skills of listening and independent thinking.

**Materials required:** T games for the participants, handout 5

**Instructions**
1. Give each participant a set of the four pieces of T-puzzle.
2. Tell them they will have five minutes to assemble the pieces into a capital letter T. During the exercise keep reaffirming that the T has no uneven edges.
3. Ask those who get the answer not to show it to the others but to raise their hands when they have it.
4. When at least five participants have completed it, or after seven minutes, ask everyone to stop and show them the overhead with the answer.
5. Ask the participants which piece was the trickiest one? Why? Find out their feelings while trying out the puzzle, while failing (frustration?) and finally succeeding.
6. Point out that for many people, the middle piece is hardest. This is sometimes like our work: if we begin a campaign, we have a lot of enthusiasm and when we achieve our objective, we are thrilled. When things are going slowly in between – in the middle – we may get tired, frustrated and lose patience. In some cases, we might be tempted to just give up. So we need to think about persevering and trying different tactics to complete the work we have begun!
7. Give the participants handout 5, which shows the correct way to assemble the puzzle pieces.

Applying human rights: case studies – 40 or 60 minutes

**Expected results:** Participants practice applying human rights standards to case studies in which reproductive rights of HIV-positive women were violated.

**Materials required:** Four or five sets of handouts with case studies (handouts 8–34); PowerPoint slide or handout 1 with list of sexual and reproductive rights

**NOTE:** Choose four or five case studies from the following list before the workshop so that you can prepare the sets of handouts for each small group. Try to include at least one example each involving contraceptives, denial of pregnancy care, denial of abortion care and denial of parental rights, if necessary choosing from a different region than the one you are in. If the participants come from different regions, choose cases from different regions as well.

\textsuperscript{6} Adapted from “The T-puzzle”, an exercise in *Experiencing options* (2003) by International Services Association, INSA India. Their e-mail: insaind@airtelmail.in; their website: http://www.insa-india.org.in
Africa
Case 1. Denial of a caesarean section in Namibia
Case 2. Coercion to use a contraceptive method in Namibia
Case 3. HIV testing without consent and denial of postabortion care in Nigeria
Case 4. Universal precautions in Nigeria
Case 5. Treatment literacy problems in South Africa
Case 6. Repeated rape and pregnancy of HIV-positive woman in South Africa
Case 7. Antiretroviral treatment stolen from women living with HIV in Zambia
Case 8. Criminalization of a woman for unprotected sex in Zimbabwe

Americas
Case 9. Delayed and denied treatment in Chile
Case 10. Coerced sterilization in Chile
Case 11. Denial of delivery care in the Dominican Republic
Case 12. Pressure for sterilization in the Dominican Republic
Case 13. HIV testing without consent in Mexico
Case 14. Death of a transgender woman during custody in the United States
Case 15. Denial of abortion care between 1988–1992 in the United States
Case 16. Denial of adoption due to prospective parent’s HIV status in the United States

Asia
Case 17. Denial of abortion care in India
Case 18. Self-induced abortion in India
Case 19. Death of HIV-positive woman in India

Europe
Case 20. Denial of parental rights in Russia
Case 21. Discriminatory care in Russia
Case 22. Discriminatory obstetric care in Russia
Case 23. Lack of gynecological care for female prisoners in Spain
Case 24. Pressure to have abortions in the Ukraine
Case 25. Denial of pregnancy-related treatment in the Ukraine
Case 26. Discriminatory pregnancy care in the Ukraine
Case 27. Forced sterilization of Roma women in Slovakia

Instructions
1. Tell the participants that they will now be divided into small groups to consider a case study in which an HIV-positive woman’s reproductive rights were violated.
2. Put up the PowerPoint slide with SRH rights for the small groups’ reference during the exercise.
3. Take 10 minutes to read the example case study below aloud. Ask the participants to explain which reproductive rights were violated in this case and make suggestions on what the victim might do.

**Treating abortion complications in Senegal**

In 1999, the president of the international NGO EngenderHealth visited the Kaolack region in Senegal. While there, she stopped at a health center that many women visit when they are ready to give birth because they have been told that delivering there is safer than at home. Unfortunately, the building was in decay, with a collapsing ceiling, no window screens, rusty beds with broken springs and blood-stained mattresses, and a lack of running water. At the back of the delivery room, a woman was screaming while lying on a wooden pallet. Another woman was holding up her legs as she was undergoing a dilatation and curettage procedure without anesthesia or pain relief. Which reproductive rights might have been violated in this case?

**Sexual and reproductive health rights possibly involved**

- The right to privacy and confidentiality: The woman's procedure was being done in full view of anyone who entered the room.
- The right to health care and health protection: In most cases, WHO advises that vacuum aspiration procedures be done rather than D&C for incomplete miscarriages or induced abortions because fewer complications result.
- The right to be free from torture and inhuman treatment: without anesthesia or pain relief, the woman was being given inadequate care; in some cases – though it was unclear if that was happening here – health-care providers who are against abortion and who believe a woman had an induced abortion "punish" her by withholding pain medications.

4. Give members of each small group handouts with the same case. Ask one volunteer to read their case out loud.

5. Ask the participants to spend 20–30 minutes analyzing their cases. They should identify which sexual and reproductive rights were violated, how these were violated, and suggest what course of action the victim might take.

6. After 20–30 minutes, reconvene the small groups into a plenary group and ask for volunteers to read out their cases and present their answers regarding which rights were violated and which actions might be taken to deal with this.

7. Consult your copy of the case with a list of possible rights violations (from Appendix 5) and add any rights that the groups may have missed.

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8. Thank the participants and ask if they have any concluding comments they would like to make. Give them your contact information in case they want more information (e.g., have it ready on a flipchart or have business cards to give them).

Wrap-up and evaluation – 15 minutes

Expected results: Participants give their opinion of the workshop and receive resource materials to use at home.

Materials required: Evaluation forms, CD-ROMs or other materials you have for distribution

Instructions
1. Thank the participants for coming to the workshop and ask if anyone wants to say anything in conclusion.
2. Hand out the evaluation forms and tell participants they can complete these without identifying themselves.
3. Hand out any materials you have for the participants.
APPENDIX 1
Examples of Concluding Observations (Recommendations)
from Treaty Monitoring Committees

Committee on the Rights of the Child, Concluding Observations to Australia, 2005
Paragraph 46(e): “...prohibit the sterilization of children, with or without disabilities, and promote and implement other measures of prevention of unwanted pregnancies, e.g. injection of contraceptives, when appropriate.”

CEDAW Committee, Concluding Observations to Bolivia, 2008
Paragraph 43: “The Committee recommends that the State party integrate a gender perspective into its national health policy in line with general recommendation 24 and improve access to health services to the most vulnerable groups of women, in particular rural and indigenous women. The Committee urges the State party to act without delay and adopt effective measures to resolve the problem of the high rate of maternal mortality by guaranteeing adequate prenatal, childbirth and post-natal care, and ensuring access to health-care facilities and medical assistance provided by trained workers in all parts of the country, particularly in the rural areas. The Committee urges the State party to adopt regulations to implement existing laws on Bolivian women’s right to therapeutic abortion. The Committee also urges the State party to afford women access to high-quality services for the treatment of complications resulting from unsafe abortions with a view to reducing maternal mortality rates.”

Committee against Torture (CAT), Concluding Observations to Chile, 2004
Paragraph 7: “The Committee recommends that the State party should...(m) Eliminate the practice of extracting confessions for prosecution purposes from women seeking emergency medical care as a result of illegal abortion; investigate and review convictions where statements obtained by coercion in such cases have been admitted into evidence, and take remedial measures including nullifying convictions which are not in conformity with the Convention. In accordance with World Health Organization guidelines, the State party should ensure immediate and unconditional treatment of persons seeking emergency medical care;”

Human Rights Committee (CCPR), Concluding Observations to Botswana, 2008
Paragraph 22: “The Committee notes with concern that the State party criminalizes same-sex sexual activities between consenting adults (arts 17 and 26). The State party should repeal these provisions of its criminal law.”
**CESCR Committee, Concluding Observations to France, 2008**
Paragraph 39: “The Committee recommends that the State party adopt specific legislation criminalising acts of domestic violence. The Committee further recommends that the State party increase its efforts to raise awareness of the seriousness of this offence and the mechanisms available to victims of domestic violence, in particular by directing its awareness campaigns to the most vulnerable groups of women, including those coming from non-European countries and those with a low level of education.”

**CESCR Committee, Concluding Observations to Kenya, 2008**
Paragraph 32: “The Committee is concerned about the high maternal, infant and under-five mortality rates, the lack of adequately equipped maternal health care facilities and skilled birth attendance, especially in the North Eastern and Coastal Provinces, and de facto discrimination against poor women, older women and women with HIV/AIDS in access to maternal health care. (art. 12). The Committee recommends that the State party take immediate measures to ensure that (a) all pregnant women, including poor women, older women and women with HIV/AIDS, have affordable access to skilled care free from abuse during pregnancy, delivery, postpartum, postnatal periods, and to care of the newborn, including in remote rural areas; (b) the waiver of maternity fees in public hospitals and health facilities is effectively enforced without compromising the quality of services; (c) immunization campaigns for children are implemented in all provinces; (d) pregnant women with HIV/AIDS are not refused treatment, segregated in separate hospital wards, forced to undergo HIV/AIDS testing, and discriminated or abused by health workers, and that they are informed about and have free access to antiretroviral medication during pregnancy, labour and after birth, including for their children; and (e) a date is set for the entry into force of the HIV/AIDS Prevention and Control Act (2006) as soon as possible.”

Paragraph 33: “The Committee is concerned about the limited access to sexual and reproductive health services and contraceptives, especially in rural and deprived urban areas, as well as about the high number of unsafe clandestine abortions in the State party. (art. 12). The Committee recommends that the State party ensure affordable access for everyone, including adolescents, to comprehensive family planning services, contraceptives and safe abortion services, especially in rural and deprived urban areas, by eliminating formal and informal user fees for public and private family planning services, adequately funding the free distribution of contraceptives, raising public awareness and strengthening school education on sexual and reproductive health, and decriminalizing abortion in certain situations, including rape and incest.”

**CEDAW Committee, Concluding Observations to Namibia, 2007**
Paragraph 25: “The Committee urges the State party to take concrete measures to enhance women’s access to health care, in particular to sexual and reproductive health
services, in accordance with article 12 of the Convention and the Committee’s general recommendation 24 on women and health. It also recommends the adoption of measures to increase knowledge of and access to affordable contraceptive methods, so that women and men can make informed choices about the number and spacing of children, as well as access to safe abortion in accordance with domestic legislation. It further recommends that sex education be widely promoted and targeted at adolescent girls and boys, with special attention paid to the prevention of early pregnancy and the control of sexually transmitted diseases and HIV/AIDS. The Committee also calls upon the State party to ensure that its National Strategic Plan (MTP III) 2004–2009 is effectively implemented and its results monitored and that the socio–economic factors that contribute to HIV infection among women are properly addressed. The Committee urges the State party to improve women’s access to maternal health services, including antenatal, post–natal, obstetric and delivery services. It encourages the State party to take steps to ensure accurate recording of maternal deaths and to obtain assistance for this from the United Nations Children’s Fund (UNICEF), the United Nations Population Fund (UNFPA) and the World Health Organization (WHO).”

**Human Rights Committee (CCPR), Concluding Observations to Nicaragua, 2008**

Paragraph 19: “The Committee notes with concern a growing number of reports alleging systematic persecution and death threats against human rights defenders by individuals, political groupings and bodies connected to the State authorities. It also notes with concern the criminal investigations mounted against defenders of reproductive rights, including the criminal charges pending against the nine women defenders of women’s rights...which occurred at a time when therapeutic abortion was still legally permitted. It is likewise concerned at the de facto restrictions on the exercise by human rights organizations of their right to freedom of assembly (arts. 19 and 22). The Committee recommends that the State party take the necessary action to put a stop to alleged instances of systematic persecution and death threats, particularly against the defenders of women’s rights mentioned above, and ensure that those responsible are duly punished. The State party should guarantee organizations of human rights defenders the right to freedom of expression and association in the conduct of their activities.”

**Committee on the Elimination of Racial Discrimination, Concluding Observations to Pakistan, 2009**

Paragraph 17: “Notwithstanding the measures taken by the State party such as the amendments of the Criminal Law Act 2004 and the Protection of Women Act 2006, the Committee expresses concern about acts of violence against women, especially those of minority background. (art. 5 (b)). In the light of its general recommendation No. 25 (2000) on gender–related dimensions of racial discrimination, the Committee recommends that the State party ensure the effective implementation of the laws aimed at protecting women from violence and provide information on the measures taken and
their results in its next report. It also encourages the State party to adopt the Bill on domestic violence without delay."

**CESCR Committee, Concluding Observations to the Philippines, 2008**

Paragraph 31: “The Committee notes with concern that, under the State party’s legal system, abortion is illegal in all circumstances, even when the woman’s life or health is in danger or pregnancy is the result of rape or incest, and that complications from unsafe, clandestine abortions are among the principal causes of maternal deaths. The Committee is also concerned about the inadequate reproductive health services and information, the low rates of contraceptive use and the difficulties in obtaining access to artificial methods of contraception, which contribute to the high rates of teenage pregnancies and maternal deaths existing in the State party. (article 12)

The Committee draws the attention of the State party to its General Comment No. 14 (2000) on the right to the highest attainable standard of health, and urges the State party to adopt all appropriate measures to protect the sexual and reproductive rights of women and girls, inter alia through measures to reduce maternal and infant mortality and to facilitate access to sexual and reproductive health services, including access to family planning, and information. In particular, the Committee encourages the State party to address, as a matter of priority, the problem of maternal deaths as a result of clandestine abortions, and consider reviewing its legislation criminalising abortion in all circumstances.”
APPENDIX 2
Resolutions from the African Commission on Human and
People’s Rights

RESOLUTION ON VIOLENCE AGAINST WOMEN
Done in Brazzaville, Republic of Congo, 28 November 2007

The African Commission on Human and Peoples' Rights (the African Commission or ACHPR), meeting at its 42nd Ordinary Session held in Brazzaville, Republic of Congo, from 15–28 November 2007;

Recalling its mandate to promote human and peoples' rights and ensure their protection in Africa under the African Charter on Human and Peoples' Rights (the African Charter);

Bearing in mind that the right to a remedy and reparation is notably affirmed by: Article 25 of the Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa; Article 8 of the Universal Declaration of Human Rights; Article 2 of the International Covenant on Civil and Political Rights; Article 39 of the Convention on the Rights of the Child; and Articles 68 and 75 of the Rome Statute of the International Criminal Court;

Deploring all forms of sexual violence against women and girls;

Considering that rape in times of conflicts has been categorised as a crime against humanity and as a war crime in the founding statutes of the International Criminal Tribunal for the former Yugoslavia (Art 5 (g)), of the International Criminal Court (Arts 7 and 8) and of the Special Court for Sierra Leone (Art 2(g)); and considering furthermore that the International Criminal Tribunal for Rwanda has qualified rape in conflict situations as an act of genocide case No. ICTR– 96–4–T (Sept 1998) and the International Criminal Tribunal for the former Yugoslavia classified rape as amongst the most serious crimes of war by defining it as a breach of the Geneva Conventions in case No.IT–94–1–T (May 1997);

Reaffirming its Resolution ACHPR/Res.103 (XXXX) 06 on the Situation of Women in the Democratic Republic of Congo, adopted during its 40th Ordinary Session held in Banjul, The Gambia, on 29 November 2006;

Recalling also the provisions of the Fourth Geneva Convention on the protection of civilians in armed conflicts;


Noting with great concern the prevailing impunity for the perpetrators and accomplices of crimes of sexual violence and emphasising that a culture of impunity encourages the commission of such crimes;

Taking into consideration the legal and practical obstacles existing in many countries and preventing victims of sexual violence in particular in times of conflict, from accessing their rights to truth, justice and reparation, notably the lack of adequate training on sexual violence issues for actors of the judiciary and the lack of information on services and access to justice for victims;

Concerned by the extent of physical and psychological trauma that women and girls victims face as a result of sexual violence and by the necessity for them to receive adequate and accessible health care, including psychological support;

Acknowledging the civil society initiative creating the “Nairobi Declaration of the Right to A Remedy and Reparation for Women and Girls Victims of Sexual Violence”, which provides guiding principles for the implementation of programmes intended to achieve reparation for crimes of sexual violence perpetrated in times of conflicts;

Convinced that participation of women at all stages of creation and implementation of reparation programmes is necessary to ensure efficient programmes and to achieve sustainable peace;

The African Commission on Human and Peoples’ Rights:
1. CONDEMNS all forms of sexual violence against women and girls;
2. URGES States Parties to the African Charter on Human and Peoples’ Rights to:
   - Criminalise all forms of sexual violence, ensure that the perpetrators and accomplices of such crimes are held accountable by the relevant justice system;
   - Ensure that police and military forces, as well as all the members of the judiciary receive adequate training on the principles of international humanitarian law, women’s rights and the children’s rights;
   - Identify the causes and consequences of sexual violence and to take all necessary measures to prevent and eradicate it;
● Develop campaigns to raise public awareness on existing remedies for cases of sexual violence;
● Put in place efficient and accessible reparation programmes that ensure information, rehabilitation and compensation for victims of sexual violence;
● Ensure that victims of sexual violence have access to medical assistance and psychological support; – Ensure participation of women in the elaboration, adoption and implementation of reparation programmes;
● Ratify without reservations and ensure the effective implementation of the Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa and the Convention on the Elimination of All Forms of Discrimination against Women as well as its Optional Protocol;
● Ratify the Protocol to the African Charter on Human and Peoples’ Rights on Establishing an African Court on Human and Peoples’ Rights and make a declaration according to Article 34(6) of this Protocol, and ratify as well the Rome Statute of the International Criminal Court.

RESOLUTION ON MATERNAL MORTALITY
Done in Abuja, Federal Republic of Nigeria, the 24th November 2008


RECALLING that women’s rights and the principle of non discrimination have been recognised and guaranteed in all international human rights instruments, notably the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, the Convention on the Elimination of All Forms of Discrimination Against Women and its Optional Protocol, and all other international and regional conventions and covenants such as the African Charter on Human and Peoples’ Rights relating to the rights of women;

RECALLING that women’s rights to maternal health have been recognised and reaffirmed by the United Nations Plans of Action on Population and Development in 1994 and on Social Development in 1995 and have been enshrined in the Beijing Declaration and Platform for Action in 1995;

RECOGNISING that improving maternal and reproductive health is both a regional and international obligation enshrined in the Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa and the Millennium Development Goals;
**FURTHER RECALLING** the commitments of the Heads of State and Governments in the Solemn Declaration on Gender Equality in Africa adopted during the 3rd Ordinary Session held in Addis Ababa, Ethiopia from 6–8 July 2004;

**NOTING** the commitments of the Heads of State and Governments in the Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases made during the African Summit on HIV/AIDS, Tuberculosis and Other Infectious Diseases in Abuja, Nigeria from 24–27 April 2001 to allocate 15% of their national budgets to health;

**STANDING** by our Declaration on Economic, Social and Cultural Rights in Pretoria during our 36th Session in December 2004 that lack of political will, privatisation of essential services, failure to allocate sufficient resources and brain drain amongst other factors are at the centre of the non-realisation of economic, social and cultural rights in Africa including the right to enjoy the best attainable state of physical and mental health;

**DEEPLY disturbed** that Africa currently has the worst records of maternal deaths in the world accounting for more than two hundred and fifty thousand deaths annually;

**CONCERNED** that most member states of the African Union are not making progress in reducing the maternal mortality rates in their respective countries;

**NOTING with concern** that maternal mortality destroys the very foundation of the African family which according to article 18 of the African Charter on Human and Peoples’ Rights is the "natural unit and basis of the society" and "the custodian of morals and traditional values recognised by the community";

**CONSIDERING** that the Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa makes provision in article 14 for health and reproductive rights and in particular, obliges states to “establish and strengthen existing pre-natal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breast-feeding”;

**APPRECIATING** the great role women play in securing the future of the society and that pregnancy being a natural occurrence, every society should seek to protect the life of the mother and the child from conception, to delivery and beyond;

**CONVINCED** that preventable maternal mortality is a violation of the rights to life, health and dignity of women in Africa;
FIRMLY convinced that only through effective health institutions as well as strategic and sustained funding to the health sector that the problem of maternal mortality will be managed and finally reduced in Africa;

1. DECLARES that preventable maternal mortality in Africa is a violation of women’s right to life, dignity and equality enshrined in the African Charter on Human and Peoples’ Rights and the Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa;

2. CALLS UPON African Governments to individually and collectively address the issue of maternal mortality in accordance with the recommendations attached to this resolution.

RECOMMENDATIONS ON ADDRESSING MATERNAL MORTALITY IN AFRICA
The African Commission on Human and Peoples’ Rights
In accordance with its Resolution on Maternal Mortality in Africa adopted during its 44th Ordinary Session held from 10–24 November 2008 in Abuja, Federal Republic of Nigeria, hereby recommends that States parties to the African Charter on Human and Peoples’ Rights:

1. Meet their obligations under the Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases. In particular, to:
   - Allocate 15% of their national budgets to the health sector in accordance with the Declaration;
   - Ensure that market based economic reforms including privatisation do not take away the responsibility of the state to fulfil the right to health;
   - Ensure that health reforms, policies and programmes should make adequate considerations of the right of poor and rural women to access basic healthcare as enshrined in the Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa;
   - Further ensure that access to ante natal and obstetric services as much as practicable be free, available and accessible;

2. Adopt human right based approaches in the formulation of country programs and strategies to reduce maternal mortality in Africa. In particular to:
   - Ensure participation of women and civil society in the formulation, implementation, monitoring and evaluation of policies and frameworks aimed at addressing maternal mortality;
   - Take all appropriate measures including positive discrimination in providing funds for specific programs and projects to secure maternal health;
   - Provide a well staffed and equipped maternity centres in rural areas;
   - Employ and retain skilled health personnel and birth attendants at rural and semi-urban areas;
   - Train and retain health workers in emergency obstetric care;
o Develop community led emergency transport systems to cushion the effect of delays in getting medical attention;

o Develop adaptive training curriculum for the education of women and girls on rights to reproductive health.

3. Include in their periodic reports under article 62 of the African Charter:
   o The general state of maternal health, including the level of mortality and morbidity and challenges faced in implementing related programs;
   o Policy and institutional measures taken to give effect to the provisions of article 14 of the African Charter on the right to the best attainable state of physical and mental health for women;
   o Budgetary and institutional measures dedicated to securing maternal health;
   o Other programs and activities undertaken to secure maternal health with results;

4. Consider the declaration on the state of maternal health in Africa as a continental emergency and to take appropriate regional actions;

5. To those member states of the African Union that have not already done so, to urgently ratify the Protocol to the Africa Charter on Human and Peoples’ Rights on the Rights of Women in Africa;

6. To member states that have already ratified this protocol to immediately undertake measures for domestication, including the amendment of internal laws to conform with the provisions of the Protocol;

7. To develop programmes aimed at drawing attention to the negative impacts of maternal mortality on women in Africa and future generations of Africans;

8. To civil society organisations in Africa to work in collaboration and develop partnerships to:
   o Conduct research on maternal mortality in respective African countries;
   o Work in collaboration with governmental agencies to develop effective country strategies for securing the right to maternal health;
   o Ensure the participation of communities and women groups in the formulation of programs and activities aimed at reducing maternal mortality;
   o Monitor the implementation of programs aimed at reducing maternal mortality;
   o Advocate for accountability by governments to their respective obligations in reducing maternal mortality and securing the right to maternal health;
   o Advocate for the ratification and domestication by African states of the Protocol to the Africa Charter on Human and Peoples’ Rights on the Rights of Women in Africa without reservations.
APPENDIX 3
Resolution maternal mortality from Member and Observer States of the UN Human Rights Council

PROMOTION AND PROTECTION OF ALL HUMAN RIGHTS, CIVIL, POLITICAL, ECONOMIC, SOCIAL AND CULTURAL RIGHTS, INCLUDING THE RIGHT TO DEVELOPMENT

Co-sponsors before and after tabling:
Andorra, Australia, Austria, Belgium, Bolivia (Plurinational State of), Brazil, Bulgaria, Cameroon, Canada, Chile, Colombia, Congo (Republic of the), Costa Rica, Croatia, Cyprus, Cuba, Czech Republic, Denmark, Dominican Republic, Ecuador, Equatorial Guinea, Estonia, Finland, France, Germany, Greece, Guatemala, Honduras, Hungary, Iceland, Ireland, Israel, Italy, Jordan, Latvia, Liechtenstein, Lithuania, Luxembourg, Maldives, Mali, Malta, Mauritius, Mexico, Monaco, Morocco, Nepal, Netherlands, New Zealand, Nicaragua, Norway, Panama, Peru, Poland, Portugal, Romania, Rwanda, Senegal, Serbia, Singapore, Slovakia, Slovenia, South Africa, Spain, Sri Lanka, Sweden, Switzerland, Thailand, Turkey, Ukraine, United Kingdom of Great Britain and Northern Ireland, United States of America, Uruguay: revised draft resolution

HRC Res. 11/8: Preventable maternal mortality and morbidity and human rights

Reaffirming the Beijing Declaration and Platform for Action, the Programme of Action of the International Conference on Population and Development and their Review Conferences and the targets and commitments regarding the reduction of maternal mortality and universal access to reproductive health, including those contained in the 2000 Millennium Declaration (General Assembly resolution 55/2) and the 2005 World Summit Outcome (General Assembly resolution 60/1),

Reaffirming also the Millennium Development Goals, in particular the Goals on improving maternal health, promoting gender equality and empowering women, reducing child and infant mortality and the development of a global partnership, 8

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8 Millennium Development Goals 5, 3, 4 and 8 respectively
Recalling the obligations of States parties to the Convention on the Elimination of All Forms of Discrimination against Women, the Convention on the Rights of the Child, the Convention on the Rights of Persons with Disabilities, the International Convention on the Elimination of All Forms of Racial Discrimination, the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights and the Convention on the Protection of the Rights of All Migrant Workers and Their Families,

Convinced that increased political will and commitment, cooperation and technical assistance at the international and national levels are urgently required to reduce the unacceptably high global rate of preventable maternal mortality and morbidity,

Recognizing the leading role of the World Health Organization in maternal health and the work under the annual World Health Assembly agenda item on the monitoring of the achievement of the health–related Millennium Development Goals,

Recognizing also that the unacceptably high global rate of preventable maternal mortality and morbidity is a health, development and human rights challenge, and that a human rights analysis of preventable maternal mortality and morbidity and the integration of a human rights perspective in international and national responses to maternal mortality and morbidity could contribute positively to the common goal of reducing this rate, with a view to eliminating preventable maternal mortality and morbidity,

Welcoming the ongoing efforts of the United Nations human rights treaty bodies to highlight the human rights aspects of preventable maternal mortality and morbidity, including those of the Committee on the Elimination of Discrimination against Women, the Human Rights Committee, the Committee on the Rights of the Child, the Committee on Economic, Social and Cultural Rights, and of the special procedures, in particular those described in the report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (A/61/338),

Recognizing that the Council has a constructive role to play in raising awareness of the human rights aspects of the unacceptably high global rate of maternal mortality and morbidity and in supporting, promoting and enhancing existing national and international efforts to reduce this rate,

Welcoming its initiative to hold an interactive dialogue at its eighth regular session on maternal mortality and the human rights of women, on 5 June 2008,

Recognizing that preventable maternal mortality and morbidity affects women and their families in all regions and cultures, and that it is exacerbated by factors such as poverty,
gender inequality, age and multiple forms of discrimination, as well as factors such as lack of access to adequate health facilities and technology, and lack of infrastructure,

1. *Expresses grave concern* at the unacceptably high global rate of preventable maternal mortality and morbidity, noting in this regard that the World Health Organization has assessed that over 1,500 women and girls die every day as a result of preventable complications occurring before, during and after pregnancy and childbirth, and that, globally, maternal mortality is the leading cause of death among women and of girls of reproductive age;

2. *Recognizes* that most instances of maternal mortality and morbidity are preventable, and that preventable maternal mortality and morbidity is a health, development and human rights challenge that also requires the effective promotion and protection of the human rights of women and girls, in particular their rights to life, to be equal in dignity, to education, to be free to seek, receive and impart information, to enjoy the benefits of scientific progress, to freedom from discrimination, and to enjoy the highest attainable standard of physical and mental health, including sexual and reproductive health;

3. *Requests* all States to renew their political commitment to eliminating preventable maternal mortality and morbidity at the local, national, regional and international levels, and to redouble their efforts to ensure the full and effective implementation of their human rights obligations, the Beijing Declaration and Platform for Action, the International Conference for Population Development Programme of Action and their review conferences, and the Millennium Declaration and the Millennium Development Goals, in particular the Goals on improving maternal health and promoting gender equality and empowering women,\(^9\) including through the allocation of necessary domestic resources to health systems;

4. *Also requests* States to give renewed emphasis to maternal mortality and morbidity initiatives in their development partnerships and cooperation arrangements, including through honouring existing commitments and considering new commitments, and the exchange of effective practices and technical assistance to strengthen national capacities, as well as to integrate a human rights perspective into such initiatives, addressing the impact that discrimination against women has on maternal mortality and morbidity;

5. *Encourages* States and other relevant stakeholders, including national human rights institutions and non–governmental organizations, to give increased attention and resources to preventable maternal mortality and morbidity in their engagement with the United Nations human rights system, including with the human rights treaty bodies, the universal periodic review and special procedures;

\(^9\) Millennium Development Goals 5 and 3.
6. **Requests** the Office of the United Nations High Commissioner for Human Rights to prepare a thematic study on preventable maternal mortality and morbidity and human rights, in consultation with States, the World Health Organization, the United Nations Population Fund, the United Nations Children’s Fund and the World Bank, and all other relevant stakeholders, and requests that the study include identification of the human rights dimensions of preventable maternal mortality and morbidity in the existing international legal framework; an overview of initiatives and activities within the United Nations system to address all causes of preventable maternal mortality and morbidity; identification of how the Council can add value to existing initiatives through a human rights analysis, including efforts to achieve the Millennium Development Goal on improving maternal health,\(^{10}\) and recommended options for better addressing the human rights dimension of preventable maternal mortality and morbidity throughout the United Nations system;

7. **Decides** to address the thematic study requested in paragraph 6 above within the programme of work of its fourteenth session, and to consider taking further possible action on preventable maternal mortality and morbidity and human rights at that session, and invites the Office of the High Commissioner, the World Health Organization, the United Nations Population Fund and the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health to participate in an interactive dialogue on the study in the Council.

\(^{10}\) Millennium Development Goal 5.
APPENDIX 4

WOMEN AND HIV/AIDS: THE BARCELONA BILL OF RIGHTS

As we enter the third decade of the global HIV/AIDS pandemic, women, especially the young and the poor, are the most affected. Because gender inequality fuels HIV/AIDS and HIV/AIDS fuels gender inequality, it is imperative that women and girls speak out, set priorities for action and lead the global response to the crisis.

Therefore, women and girls from around the world unite to declare our rights and urge all governments, organizations, agencies, donors, communities and individuals to make our rights a reality.

Women and girls have the right:
- To live with dignity and equality.
- To bodily integrity.
- To health and healthcare, including treatment.
- To safety, security and freedom from fear of physical and sexual violence and abuse throughout their lives.
- To be free from stigma, discrimination, blame and denial.
- To their human rights regardless of sexual orientation.
- To sexual autonomy and sexual pleasure.
- To equity in their families and intimate partnerships.
- To education and information.
- To economic independence.

These fundamental rights shall include, but not be limited to the right:
- To support and care which meets women’s particular needs.
- To access acceptable, affordable and quality comprehensive healthcare including antiretroviral therapies.
- To quality mental healthcare.
- To sexual and reproductive health services, including access to safe abortion without coercion.
- To a broader array of preventive and therapeutic technologies that respond to the needs of all women and girls, regardless of age, HIV status or sexual orientation.
- To access user-friendly and affordable prevention technologies, such as female condoms and microbicides, with skills building training on negotiation and use.
- To HIV testing after informed consent and protection of the confidentiality of status.
- To choose to disclose status in circumstances of safety and security without the threat of violence, discrimination or stigma.
To live one’s sexuality in safety and with pleasure irrespective of age, HIV status or sexual orientation.

To choose to be mothers and have children irrespective of HIV status or sexual orientation.

To safe and healthy motherhood for all, including the safety and health of children.

To choose marriage, form partnerships or divorce, irrespective of HIV status or sexual orientation.

To gender equity in education and lifetime education for all.

To formal and informal sexual education throughout life.

To information, especially about HIV/AIDS, with an emphasis on women and girls’ special vulnerability due to biological differences, gender roles and inequality.

To food security, safe water, shelter and basic sanitation.

To employment, equal pay, recognition of all forms of work including voluntary and non-coerced sex work and compensation for care and support.

To economic independence such as to own and inherit property, and to access financial resources.

To freedom of movement and travel irrespective of HIV status.

To freedom from harmful traditional practices.

To express religious, cultural and social identities.

To associate freely and be leaders within religious, social and cultural institutions.

To lead and participate in all aspects of politics, governance, decision-making, policy development and program implementation.

XIV International AIDS Conference, Barcelona, Spain, July 11, 2002

A global effort initiated by Women at Barcelona and Mujeres Adelante with lead involvement by the International Women’s AIDS Caucus of the International AIDS Society and the International Community of Women Living with HIV/AIDS.
NOTE: The case studies without answers for small-group work can be found in the handouts that belong with this workshop curriculum.

Case 1. Denial of a caesarean section in Namibia

A 29-year-old pregnant woman started attending antenatal care at the Windhoek Central hospital in April 2007. As part of the antenatal care services, she — like all other pregnant women in Namibia — had to undergo an HIV test and she tested positive. The woman went to the nurse in charge for advice on delivery choices, including the possibility of having a caesarean birth to decrease chances of HIV transmission during delivery. The nurse, in front of other patients, started shouting: "Why do you want to go for a caesarean? You just have to go through normal labour cramps, like any other woman. Do you think HIV makes you more special than other people? If you went out there to contract your HIV, so that we can give you special treatment, you are at a wrong place." She had no choice, but to deliver her child through natural birth.

Sexual and reproductive health rights possibly involved
- The right to equality and to be free from all forms of discrimination
- The right to information and education
- The right to health care and health protection
- The right to the benefits of scientific progress
- The right to be free from torture and inhuman treatment
- The right to privacy and confidentiality

Case 2. Coercion to use a contraceptive method in Namibia

In September 2008, an HIV-positive woman of 34 years went to the Okuryangava clinic for postnatal care; once there, she was told that she had to take contraception. Even
after explaining to the nurse that her husband had just passed away, and that, according to her tradition, she was not allowed to have sexual contact with any man for a year, the nurse insisted she use a contraceptive method. The nurse said: “If you don’t want to take this injection, don’t come back here with another AIDS baby.” She gave in and accepted the contraceptive because she was afraid of being denied future care.

Sexual and reproductive health rights possibly involved
- The right to equality and to be free from all forms of discrimination
- The right to freedom of thought
- The right to health care and health protection
- The right to be free from torture and inhuman treatment

Case 3. HIV testing without consent and denial of postabortion care in Nigeria

An auxiliary nurse in Nigeria reported the following case. "I had worked as an auxiliary nurse for over five years in this hospital. I became pregnant and started having boils, the doctor who is also my employer sent me to the lab for tests. By the time I resumed from off duty, I could not locate my folder. On enquiring about my folder, the doctor gave me unsolicited two weeks leave to go and sort out my health problem and a referral letter to the teaching hospital. On getting to the teaching hospital, I was asked to bring my husband; they tested our blood and told us that I was positive and my husband was negative. In shock I went back to my boss to ask him why he did not even warn me on the reason for referral, he ordered me to go and see the hospital secretary who handed me a letter stating that the hospital is terminating my appointment because they cannot afford to put the staff and patients at risk. I could not believe it. With the entire trauma, I lost the pregnancy and the same hospital I was registered with refused to clean my womb telling me they cannot afford to contaminate their theatre."

Sexual and reproductive health rights possibly involved
- The right to equality and to be free from all forms of discrimination
- The right to privacy and confidentiality
- The right to liberty and security of the person
- The right to health care and health protection
- The right to information and education
- The right to the benefits of scientific progress
- The right to be free from torture and inhuman treatment
**Case 4. Universal precautions in Nigeria**


Not only patients are affected by HIV in reproductive health care. Some hospital staff have negative attitudes towards people living with HIV/AIDS due to their own fears of infection. A nurse at a general hospital in Nigeria said: "It is difficult to get the nurses to care about [persons living with HIV/AIDS] with commitment, because they are afraid. They are human beings, too. They do not have the skills necessary for such care. Moreover, gloves, gowns, goggles, and masks necessary for universal precaution are not readily available in most hospitals. At times, there is even no soap or water to wash hands. Our salaries are very poor, we are short-staffed and work under stress that increases the risk of accidents and if we had pinpricks and develop HIV, too; no one will take care of us. ...It is not really our faults. We need training; skills and a good working condition to enable us [to] cope with the challenges of caring for these [HIV-positive people]."

Sexual and reproductive health rights possibly involved for both clients and providers!
- The right to health care and health protection
- The right to be free from torture and inhuman treatment
- The right to the benefits of scientific progress
- The right to information and education

**Case 5. Treatment literacy problems in South Africa**

(From: Maria de Bruyn. 2006. “There’s nothing you could do if your rights were being violated.” *Monitoring Millennium Development Goals in relation to HIV-positive women’s rights*. Chapel Hill, NC, Ipas)

The Gender AIDS Forum in South Africa held focus groups during a research study in which participants discussed discrimination within the health-care sector. In one group, a case was reported in which a woman living with HIV asked her health-care worker for Bactrim® to be used for prophylaxis purposes. The health-care provider responded very angrily to her, asking who had told her about the drug and inquiring why she had bothered to come to the clinic if she knew everything anyway. The focus-group participants reported that nurses tell HIV-positive people that Bactrim® is only given to patients with tuberculosis, not for prophylaxis.

Sexual and reproductive health rights possibly involved
- The right to health care and health protection
- The right to be free from torture and inhuman treatment
- The right to the benefits of scientific progress
The right to information and education
The right to life

**Case 6. Repeated rape and pregnancy of HIV-positive woman in South Africa**

“...Amnesty International was informed by health care workers at a hospital in KwaZulu Natal that they had intervened at a police station to urge them to take steps against the father of a 24-year-old woman who was pregnant for the fourth time as a result of repeated acts of rape he committed against her. The young woman was HIV-infected, ill with TB, had an epilepsy condition and had already given birth to three children by her father. The police response reportedly was to refuse to go to the house and instead to insist that she must travel to the police station to lodge a criminal complaint. In the view of one of the health care workers, the police do not really see it as their responsibility to deal with violence cases unless the family or victim report directly to the police station.”

**Sexual and reproductive health rights possibly involved**
- The right to decide whether or when to have children
- The right to equality and to be free from all forms of discrimination
- The right to health care and health protection
- The right to the benefits of scientific progress
- The right to be free from torture and inhuman treatment
- The right to security of the person
- The right to freedom from violence

**Case 7. Antiretroviral treatment stolen from women living with HIV in Zambia**
(From; Chris Hangombwa, 13 January 2008. *Mumbwa husbands stealing ARVs from wives, says support group*. HDN Key Correspondent Team. Chiang Mai, Health & Development Networks)

Many pregnant women have undergone routine mandatory HIV tests in Mumbwa District, Zambia, and then discovered they were HIV-positive. Some of them have been abused by their husbands upon disclosing the results and many have been forced to seek treatment alone. On World AIDS Day, December 1, 2007, Lophina Ngosa, chair of the Chambulumina support group for people living with HIV, reported that some men started taking their wives’ antiretroviral medications instead of seeking treatment for themselves.

Ngosa said that the trend was discovered when suspicious antiretroviral therapy (ART) clinics asked home-based care providers to investigate the situations of women
with irregular treatment patterns. The care providers found that some husbands were stealing their wives’ medication when their own health started to deteriorate, leaving the women without treatment and putting their unborn or breastfeeding children at risk. The only options open to these women were to take the drugs at the ART clinic or hide them somewhere in their homes. However, these options are difficult as many Mumbwa women live 15–30 km from the nearest clinic, making it impossible to travel there on a regular basis. Some women have reportedly been beaten or harassed by their husbands for hiding or withholding their own treatment.

**Sexual and reproductive health rights possibly involved**
- The right to equality and to be free from all forms of discrimination
- The right to health care and health protection
- The right to the benefits of scientific progress
- The right to life
- The right to be free from torture and inhuman treatment
- The right to security of the person
- The right to freedom from violence

**Case 8. Criminalization of a woman for unprotected sex in Zimbabwe**

In 2007, a 26–year–old HIV–positive woman from a township near Bulawayo was arrested for having unprotected sex. She was charged with “deliberately infecting another person,” even though her lover tested HIV–negative. Before she was sentenced, the court attempted to have the man tested again – even though it was reported that he didn’t want to proceed with the charges. The woman was ultimately sentenced to a suspended term of five years’ imprisonment.

The law under which she was convicted, Section 79 of the Zimbabwe *Criminal Law (Codification and Reform) Act 23* of 2004, not only makes it a crime for a person who knows that s/he has HIV to infect another person; it also makes it a crime for anyone who realizes “that there is a real risk or possibility” that s/he might have HIV, to do “anything” that she “realizes involves a real risk or possibility of infecting another person with HIV.”

Given this wording, people can be charged with this crime even if they do not transmit HIV or, moreover, even if they themselves turn out not to be HIV–positive. The wording of this law can also cover a pregnant woman who knows or fears that she has HIV if she does “anything” that could involve a possibility of infecting the baby (for example, giving birth or breastfeeding). In all cases, the law prescribes punishment of up to 20 years imprisonment.
Sexual and reproductive health rights possibly involved

- The right to equality and to be free from all forms of discrimination
- The right to privacy and confidentiality
- The right to decide whether or when to have children
- The right to choose whether or not to marry and to found and plan a family
- The right to liberty and security of the person
- The right to health care and health protection
- The right to the benefits of scientific progress
- The right to be free from torture and inhuman treatment

Case 9. Delayed and denied treatment in Chile


In Chile, women have experienced discrimination in the health-care sector because health-care providers have delayed or denied treatment. One woman in Santiago said: “A woman died at the Sótero del Río health center, in a waiting room, with pneumonitis. She died because no one helped her, no one cared for her.”

In another case in Santiago, a woman related this incident: “It happens, because I went to the hospital for endoscopy and I had an appointment at 8:00 a.m. I only had the endoscopy at 1:00 p.m. because they did all the other appointments first because they couldn’t be sterilizing the equipment all the time.”

In Antofagasta, a woman had the following experience: “The doctor was there and the girl who makes appointments. She said to him, ‘doctor, here is the lady,’ and he looked at the sheet and said to her, ‘No, tell her I cannot attend to her.’ I went to him and said, ‘Doctor, why won’t you see me?’ No, he said, ‘because I am not the one to see you.’ I looked at him and said: ‘I am a person like any other that you see here.’ No, he said, ‘people with HIV have to be seen by someone else.’

A fourth case in Santiago: “I also had this problem, because they wouldn’t give me a Pap smear at the Renca health office to which I am assigned. I asked why and they said because my doctor should see because she is treating my HIV...and they didn’t help me. Another time, when I had vaginal herpes, I went to be treated, to get something. The gynecologist wouldn’t see me, I don’t understand why.”

Sexual and reproductive health rights possibly involved

- The right to equality and to be free from all forms of discrimination
- The right to health care and health protection
- The right to the benefits of scientific progress
- The right to be free from torture and inhuman treatment
- The right to security of the person
Case 10. Coerced sterilization in Chile

In Chile, women living with HIV have been coerced into sterilization by physicians who refuse to provide other care unless they “agree” to the procedure. A woman from Calama described what happened to her on July 28, 2001: “I was receiving zidovudine intravenously, and this girl came with a folder containing two documents with copies and all and she said: ‘Mrs. Claudia, you must sign this paper.’ ‘But what are these papers?’ ‘One is the authorization for sterilizing you and the other is a paper from the medical service, from the regional hospital here, saying they are not responsible if they leave a scalpel in the abdomen.’ ‘But how is that possible. No one informed me that I have to be sterilized!’ (…) ‘Oh, the doctor said if you don’t sign, they cannot operate on you and if the baby comes out infected, it’s not the hospital’s problem.’ Well, with my back to the wall, I signed; I couldn’t do anything else.”

A second woman’s case in Santiago went as follows: ‘They told me that I had been sterilized when I just came out of anesthesia. I was very sick….and they told me when I had just awakened: ‘listen, I decided to cut your tubes since you have AIDS, you can’t have any more kids.’

In 2009, a 27-year-old woman submitted a case to the Inter-American Commission on Human Rights, an international human rights body, charging that the government failed to protect her from being forcibly sterilized at the Curicó State Hospital immediately after she gave birth. Neither the Ministry of Health nor Chilean courts recognized that her rights were violated.

Sexual and reproductive health rights possibly involved
- The right to decide whether or when to have children
- The right to information and education
- The right to equality and to be free from all forms of discrimination
- The right to health care and health protection

Case 11. Denial of delivery care in the Dominican Republic
Guzmán, a 22-year-old woman in the Dominican Republic, had married a 27-year-old man when she was 15 years old. She had one child from that marriage and believes her husband died of AIDS. She married again but her new spouse often beat her; she could not ask him to use condoms. The physical attacks continued when she became pregnant, with her husband hitting her in the face, back and stomach. She found out that she was HIV-positive during this second pregnancy when physicians at a public hospital tested her without her consent and without counseling her.

They told her she needed to undergo a cesarean section to avoid perinatal transmission, but they then delayed giving her medical attention, refusing to help her until she had dilated 9 cm. She was also mistreated after the delivery: “[Because of my HIV status] I had to clean up myself alone…They didn’t clean my baby. My mother cleaned him…A nurse didn’t want to give me an injection. She told my mother she didn’t want to [because I had HIV].”

María Báez, a 34-year-old woman, went to a public hospital in Santiago when it was time for her to deliver: “Normally, the hospital mistreats you when you arrive with HIV. Even if you are first, they will do your cesarean section last. I had to wait 24 hours after making the appointment for the cesarean. They demanded I give them [surgical] clothing for the doctors. It cost me more than 500 pesos [US$ 29].”

Sexual and reproductive health rights possibly involved
- The right to equality and to be free from all forms of discrimination
- The right to privacy and confidentiality
- The right to information and education
- The right to liberty and security of the person
- The right to health care and health protection
- The right to the benefits of scientific progress
- The right to be free from torture and inhuman treatment

Case 12. Pressure for sterilization in the Dominican Republic

In the Dominican Republic, one public hospital physician told 18-year-old Juana Díaz during an antenatal visit that she was going to be sterilized because of her positive HIV status. Given her official status as a minor, he explained that she needed her mother’s authorization; he did not tell her that she could refuse to be sterilized. Her mother signed the form, but one day before the procedure had been scheduled, a local NGO member told Díaz that she did not have to undergo the sterilization. However, at that time, Díaz feared the possible consequences of a subsequent pregnancy for her health
so she agreed to the procedure; later she regretted her decision when she was told that she would have had other options. Rebeca Pérez, 39 years, had a similar experience in that country: “[The sterilization] was imposed on me: ‘you cannot have more children [because you have HIV].’ I accepted this because I didn’t know, because I was emotional with this pregnancy and HIV. I said yes, sterilize me, but without any awareness.” Pérez, who had been working as a nurse at a public hospital, emphasized that in her experience the program to reduce perinatal transmission of HIV had not improved this situation: “When the perinatal transmission program began…the doctors said, ‘We must sterilize them.’”

**Sexual and reproductive health rights possibly involved**

- The right to equality and to be free from all forms of discrimination
- The right to decide whether or when to have children
- The right to information and education
- The right to liberty and security of the person
- The right to health care and health protection
- The right to the benefits of scientific progress
- The right to be free from torture and inhuman treatment

**Case 13. HIV testing without consent in Mexico**

(From; Deborah Billings. 2008. Case reported in Mexico during a workshop using the curriculum *Gender or sex: who cares?* Chapel Hill, NC, Ipas)

Mayra, a 22–year–old woman, was 15 weeks pregnant. She had recently married 23–year–old Antonio, with whom she had had a relationship since she was 19. During that time, they had had unprotected sex but she had never become pregnant before. Antonio had traveled to the United States three times during his adolescence to work in housing construction.

During her first antenatal care visit, the nurse counseled Mayra and Antonio about the importance of having an HIV test. Antonio resisted, saying it was unnecessary and Mayra agreed with her husband. During subsequent antenatal care visits, the nurses tried to persuade Mayra to have the test, but she never consented given her husband’s strong stand on this.

Mayra’s pregnancy proceeded well and when contractions began, she and Antonion went to the central hospital, about 30 minutes from their home. Before the delivery, the hospital staff took various blood samples, explaining that they were needed for “some tests” to determine whether everything was ok. About 7 hours later, the baby was born with no problems. Mayra planned to breastfeed her newborn baby girl and was waiting for her while the nurses cleaned up. When they brought the baby, a nurse informed Mayra and Antonio that the blood test had shown Mayra to be HIV–positive.
and it would be better to bottle feed the newborn instead of breastfeeding. Mayra and Antonio remained behind in a state of surprise, shock and fear. The nurse returned with the bottle and formula, and said that the doctor would explain more when he had time. They waited for two hours until the physician could come to discuss possible next steps.

**Sexual and reproductive health rights possibly involved**
- The right to equality and to be free from all forms of discrimination
- The right to freedom of thought
- The right to be free from torture and inhuman treatment
- The right to privacy and confidentiality

**Case 14. Death of a transgender woman during custody in the United States**

Victoria Arellano, a 23-year-old transgendered Mexican woman living with HIV died in detention by the U.S. Immigration and Customs Enforcement (ICE) agency on 20 July 2007. She had been detained at the San Pedro Service Processing Center (SPSPC) for eight weeks. According to her cell-mates, her health began to deteriorate when medical staff refused to continue her regular medical prescriptions.

Victoria's condition steadily worsened during the month of July, and she began to vomit blood; blood also appeared in her urine. Her fellow detainees became increasingly concerned for her welfare as she became too weak to sit up. At the medical clinic, Victoria was told only to take an over-the-counter painkiller (Tylenol) and drink large amounts of water. On the night of July 12, 2007, her condition appeared critical to her cell-mates, who were cleaning her and disposing of her bodily fluids. The "leader" of Pod 3 asked for an ICE representative to come to the pod. An ICE Captain responded to this request. He walked over to Victoria's bunk, placed his shoe on her pillow and asked rudely, "What's wrong with you?" The detainees were shocked. "They were treating her like a dog."

The detainees began chanting "Hospital! Hospital!" A nurse came down and said "Oh it's Victoria! There's nothing we can do. She just needs Tylenol and water." Later that night, Victoria was taken to the hospital, but returned the next day. She was very weak and told her cellmates that the medical and security staff had put her in a holding cell and taunted her. Victoria told her cellmates that "it was a nightmare." The following morning she was taken to the hospital again, where she died a week later of meningitis, a condition often associated with advanced AIDS.

On August 9, 2007 an article about Victoria's death appeared in the *Los Angeles Daily Journal.* Three of Victoria's former cellmates were quoted by name in the article. Human Rights Watch attempted to interview these and other of Victoria's former
cellmates only to find that more than 20 of Victoria’s cellmates from Pod 3 had been transferred to other ICE facilities throughout the United States. Human Rights Watch and the ACLU of Southern California demanded that ICE conduct a prompt, comprehensive and transparent investigation of Victoria’s death as well as the sudden transfer of more than 20 of her former cellmates from Pod 3. When Human Rights Watch published a report, ICE had failed to respond to their demand for a formal investigation.

**Sexual and reproductive health rights possibly involved**
- The right to equality and to be free from all forms of discrimination
- The right to privacy and confidentiality
- The right to health care and health protection
- The right to the benefits of scientific progress
- The right to be free from torture and inhuman treatment

**Case 15. Denial of abortion care between 1988–1992 in the United States**

In 1988, researchers in New York City made phone calls to 25 abortion clinics regarding services. After an appointment was made for an abortion, the caller revealed that she was HIV-positive. Upon hearing this, 16 clinics (64%) would not schedule the abortion.

Another group of investigators called all abortion providers advertising in the New York City phone book in 1988, 1990, and 1992. Again, after establishing an initial appointment for an abortion, the caller said she was HIV-positive. In 1988, 14 of 33 abortion providers (42%) refused to provide services when they discovered that the client was HIV-positive. In 1990, they re–surveyed the same providers plus some new ones; 16 of 51 (31%) refused an appointment or increased the fee on hearing that the caller was HIV-positive.

After the 1990 survey, the New York City Commission on Human Rights issued either a letter or a letter and a subpoena to 18 providers that were considered to have discriminated on the basis of the woman’s HIV status. A new survey in 1992 then found that only 2 (4%) of the providers discriminated; one had received a subpoena in 1990 and the second discriminated for the first time.

Statistical analysis indicated that the letter and/or subpoena was significantly associated with a provider’s change in discrimination patterns from 1988 or 1990 to 1992. While other unmeasured historical factors may have resulted in an increased
awareness of HIV on the part of the abortion providers, the results indicated that HIV-related discrimination was potentially mitigated by active intervention.

**Sexual and reproductive health rights possibly involved**
- The right to equality and to be free from all forms of discrimination
- The right to decide whether or when to have children
- The right to health care and health protection
- The right to the benefits of scientific progress

**Case 16. Denial of adoption due to prospective parent’s HIV status in the United States**

In 2005, a serodiscordant couple (known under the pseudonyms John and James Doe) in New York wanted to adopt a second child. One man was HIV-positive and his partner HIV-negative; John was HIV-positive when the Does adopted their first child and remained in good health.

Children of the World, an adoption agency licensed in New Jersey and New York, refused the request. John said: “We love being parents and we can’t even imagine life without children. We just don’t want anyone else to have to go through what we experienced – the rejection and humiliation of being told we would not even be considered for adoption, even though we’ve given our first child such a loving and stable home.”

The couple decided to file a lawsuit against the adoption agency for violating federal and state laws prohibiting discrimination against people with disabilities. “For many thousands of Americans, HIV has become a part of life, a chronic manageable illness, like many others, that people learn to live with while they go about the rest of their lives – growing up, working, parenting – just as others do,” said Erika L. Wood, the Legal Action Center attorney representing the Does. Ms. Wood added: “More and more HIV-positive individuals are receiving early, effective treatment that allows them to live long and productive lives. Their adoption applications should be evaluated individually to see if they are fit to parent, and not rejected outright based on outdated misconceptions about HIV disease. This case could have an enormous impact on a broad cross-section of people living with HIV. Adoption may be the only safe way for many couples with an HIV-positive partner to have children.”
The case was finally settled with a requirement that Children of the World to publish a public apology in the Essex County Star Ledger, implement anti-discrimination policies and training, and compensate the couple for damages.

**Sexual and reproductive health rights possibly involved**
- The right to equality and to be free from all forms of discrimination
- The right to decide whether or when to have children
- The right to choose whether or not to marry and to found and plan a family
- The right to be free from torture and inhuman treatment
- ALSO: the right to access to justice

**Case 17. Denial of abortion care in India**

On September 1, 2006, an HIV-positive woman in India was forced to perform an abortion on herself at a state-run hospital. When 23-year-old Roshni Mulani, mother of a two-year-old child, requested an abortion, doctors and nurses refused to give her care. Finally, doctors instructed her how to terminate her six-month pregnancy, and forced her to leave the hospital afterwards. “The hospital had no sympathy for me as I had to pull out the fetus with my hands and clean myself as health workers guided me from a distance,” she explained. She added: “They read about my HIV status from medical reports ... and threw medicines from a distance.” AIDS activist Ramen Pandey, who let her recuperate in his home, stated: “Many health workers in India still think AIDS can spread by just touching.”

**Sexual and reproductive health rights possibly involved**
- The right to liberty and security of the person
- The right to health care and health protection
- The right to be free from torture and inhuman treatment
- The right to decide whether or when to have children
- The right to the benefits of scientific progress
- The right to information and education
- The right to equality and to be free from all forms of discrimination
- The right to privacy and confidentiality
Case 18. Self-induced abortion in India

An HIV-positive nurse interviewed for an exploratory study on reproductive choice in India wanted to terminate a pregnancy in the hospital where she worked; her abortion would have been permitted by law. However, she reported: “I did it myself. I was not admitted into the hospital... I induced with tablets through the vagina...It is an international tablet. In total I paid about...2000 rupees for that tablet. It was very painful so I took pain-killing tablets also...Our doctor went to England and from there she brought the sample and she sold it to me. I paid and after that I came to know it was a sample.”

Sexual and reproductive health rights possibly involved
- The right to health care and health protection
- The right to be free from torture and inhuman treatment
- The right to decide whether or when to have children
- The right to the benefits of scientific progress
- The right to information and education

Case 19. Death of HIV–positive woman in India
(From: Center for Reproductive Rights. 2007. Center cites rights violations in death of HIV–positive woman following childbirth; http://www.reproductiverights.org/ww_asia_india.html)

Gita Bai, a 30–year–old woman, died on 2 April 2007 when doctors at a public hospital in India refused to assist her during childbirth because she was HIV–positive. Ms Bai was evicted from the M.Y. Hospital while in labor after the doctors learned of her HIV status. She subsequently gave birth in a vehicle on her way out of the hospital. When she attempted to re–enter the hospital after delivering her baby, the guards were ordered to block the doorway, thereby preventing her from receiving life–saving treatment. When she was finally admitted, two days later, she was denied crucial follow–up care, including nevirapine, a drug used to prevent perinatal HIV transmission. After three days of trauma and humiliation, Gita Bai succumbed to the most common causes of maternal death: sepsis and excessive bleeding.

Sexual and reproductive health rights possibly involved
- The right to health care and health protection
- The right to be free from torture and inhuman treatment
- The right to the benefits of scientific progress
- The right to information and education
- The right to security of the person
• The right to be free from discrimination
• The right to life

**Case 20. Denial of parental rights in Russia**

Natasha R., an HIV-positive woman who attended a self-help group in St. Petersburg, Russia, told Human Rights Watch that people living with HIV/AIDS are so frightened of the consequences of other people knowing their HIV status that they do not even tell their families: “*Hiding your status from parents or spouses is not the exception, it is the rule.*” She related the case of a woman in her support group. When her husband found out she was HIV-positive, he kicked her out of the house and filed a case in court to have her parental rights relinquished. He won, and she was barred from seeing the son she had raised for the first eight years of his life. After her husband evicted her, her mother also refused to let her in to the apartment to which she has a legal right of residency. With nowhere to go, she lived the life of a homeless person for several months, sleeping in train stations and in the streets until she managed to find an inexpensive room to rent on the outskirts of town.

**Sexual and reproductive health rights possibly involved**
(Note: this case also shows violations of numerous other rights, such as the right to shelter.)
• The right to equality and to be free from all forms of discrimination
• The right to privacy and confidentiality
• The right to decide whether or when to have children
• The right to liberty and security of the person
• The right to health care and health protection
• The right to be free from torture and inhuman treatment

**Case 21. Discriminatory care in Russia**

“We do not have the means to treat everyone with ARV, so we have established priorities: women [mothers] and children are given top priority,” said Dr. Elena Vinogradova, chief physician at the St. Petersburg AIDS Center in Russia. *First of all, we
have to help the mother as much as we can to give birth to a healthy child, and then we have to extend her life as long as possible so that her child does not end up an orphan. This is the main priority in St. Petersburg.”

However, some of these HIV-positive mothers are active injection drug users, and are thus automatically rejected from receiving long-term anti-retroviral (ARV) treatment after the birth of their children at AIDS centers throughout Russia. “Giving ARV therapy to a drug user is the same as taking money and throwing it into a pit,” said Vinogradova, reflecting the view many doctors in Russia have, that active drug users will not follow the required drug regimen, and therefore the ARV medication will be useless. Vinogradova’s assessment conflicts with that of Dr. Vadim Pokrovsky of the Federal AIDS Center in Moscow, whose research with active drug users has shown that they can comply with ARV treatment protocols as well as anyone else. Pokrovsky’s conclusion is echoed in experiences from many countries, where active drug users complied very well, especially where ARV treatment was coupled with other services they require.

Sexual and reproductive health rights possibly involved

- The right to equality and to be free from all forms of discrimination
- The right to decide whether or when to have children
- The right to liberty and security of the person
- The right to life
- The right to information and education
- The right to health care and health protection
- The right to the benefits of scientific progress
- The right to be free from torture and inhuman treatment

Case 22. Discriminatory obstetric care in Russia


In the Irkutsk region, which has the highest HIV prevalence among Russia’s 89 regions, it is quite common for doctors to urge their HIV-positive patients to terminate their pregnancies. “We’re slowly starting to see the appearance of specialists who are more tolerant and better trained, but among the circle of doctors there is still a very aggressive group,” that is, doctors who behave in an aggressive or hostile manner toward people living with HIV/AIDS, said Dr. Anna Zagainova, head of the Irkutsk Red Cross center, which offers support services for HIV-positive families. The most aggressive of all, according to Zagainova, are gynecologists: their behavior toward HIV-positive women is often rude and verbally abusive. Rather than counseling a pregnant woman who is HIV-positive about her options, they urge her to have an abortion. “Their means of resolving the problem is to try to push a woman [who is HIV-positive] to have
an abortion. If she doesn’t want to, they say things like, ‘Just who do you think you’re going to give birth to, and how long do you expect to live, anyway?’” said Zagainova. “Some of our women who know they are HIV-positive and pregnant just don’t go for prenatal care at all until they are beyond the term to perform a legal abortion.” Since abortion is legal under certain circumstances until the 22nd week of pregnancy, this means that women who wish to avoid the abortion argument are not seeking prenatal care until well into their second trimester.

Sexual and reproductive health rights possibly involved
- The right to equality and to be free from all forms of discrimination
- The right to decide whether or when to have children
- The right to choose whether or not to marry and to found and plan a family
- The right to information and education
- The right to liberty and security of the person
- The right to health care and health protection
- The right to the benefits of scientific progress
- The right to be free from torture and inhuman treatment

Case 23. Lack of gynecological care for female prisoners in Spain

Spain has a prison population of 61,395 persons, including 4,798 women (i.e., 7.8%). Carlos Hernández, an activist who defends the rights of prisoners, also coordinates the Social Platform for Support to Prisoners. He is familiar with the problems faced by female prisoners. In Nanclares Prison, women who need medical care must first go through the men’s prison to reach the sick bay. Once there, they discover that office has no gynecological or obstetric equipment. The women must therefore rely on visiting physicians to bring such equipment if they are to receive proper care.

Sexual and reproductive health rights possibly involved
- The right to equality and to be free from all forms of discrimination
- The right to health care and health protection
- The right to the benefits of scientific progress
- The right to be free from torture and inhuman treatment
- The right to security of the person
- And also: the right to have access to justice
Case 24. Pressure to have abortions in the Ukraine

Staff at AIDS service organizations in Kherson and Odessa, cities of the Ukraine, say that their clients have complained that doctors told them to get abortions. Nina M., a social worker with the All–Ukrainian Network of People Living with HIV/AIDS in Kherson, told about a client she had: “She went to the doctor and took an HIV test, and when the doctor learned the results, he recommended that she get an abortion. He did not give her any information about treatment to prevent mother–to–child transmission. The doctor told the woman that her child would also be born HIV-positive. He didn’t tell her anything about the possibility that the child would not be born with HIV. She came to a consultation with me at the All–Ukrainian Network of People Living with HIV/AIDS and learned that the child could be born healthy. I have heard several stories like this. Maybe doctors know about the chances the child could be born healthy but still say it’s better that HIV-positive women get abortions.” Nataliya, a volunteer with Life Plus in Odessa, said that “doctors very often recommend that HIV-positive women get abortions. I hear this complaint quite frequently from other people.”

Sexual and reproductive health rights possibly involved
- The right to decide whether or when to have children
- The right to equality and to be free from all forms of discrimination
- The right to information and education
- The right to health care and health protection
- The right to the benefits of scientific progress
- The right to be free from torture and inhuman treatment

Case 25. Denial of pregnancy–related treatment in the Ukraine

Inna B., an HIV–positive social worker in Dnipropetrovsk, the Ukraine, charged that the “law stating that HIV–positive people should get free treatment is a joke….“ She said when she was pregnant, a doctor at her local policlinic told her that HIV–positive pregnant mothers and their babies should be provided with medicines free of charge. She said that after hearing this: “I went directly to the city AIDS center. . . I demanded that they give me this medicine. They said, ‘When you need this, we’ll call you.’ I told them, ‘I know that I am entitled to some medicine, but I don’t know what.’ I called every day asking them, ‘Please give me the medicine.’ Finally one doctor said that I could
come in and get it. When I arrived she threw the tablets on the floor and said, ‘sign here.’ She didn’t tell me how to take it. I had to call her again and all she said was, ‘two times per day.’ I waited for two months to get the therapy. I didn’t even know what it was. No one told me that I couldn’t skip a dose.”

When she was seven months pregnant, she sought emergency treatment at a maternity hospital because of a threat of miscarriage: “I came to get some emergency treatment, but the first hospital refused me. I was sent from one birthing hospital to another. No one wanted to take me because I had used drugs and I was HIV-positive. I had to make an agreement with the head doctor and I had to pay. I was in the hospital for two weeks. When I was ready to give birth I came to the central birthing hospital No. 1 at 11 a.m. My water had already broken. They didn’t want to admit me. Several people refused to admit me. It was only when I said, ‘How much?’ that they took me in. I paid 1100 hryvna [US$ 220] and my daughter was born a few minutes later. If I hadn’t paid, I would have given birth in the waiting room.”

Sexual and reproductive health rights possibly involved

▪ The right to information and education
▪ The right to equality and to be free from all forms of discrimination
▪ The right to liberty and security of the person
▪ The right to health care and health protection
▪ The right to be free from torture and inhuman treatment
▪ The right to the benefits of scientific progress

Case 26. Discriminatory pregnancy care in the Ukraine

Katya N., a 28-year-old woman in the Ukraine, found out that she was HIV-positive when she was pregnant. She talked about her experience: “When I came to the obstetrician, only one doctor and the chief of the department knew about my HIV status. After a while, even the cleaner at the hospital knew about it. The cleaner’s daughter was my friend. The cleaner told her daughter not to be friends with me. After that, I lost my friend.” Klara Z., another woman in the Ukraine, had a similar experience when she was pregnant: “The doctor told me that I was HIV-positive and didn’t behave very well. She told everyone. This was a very big shock for me. My friend took me to the doctor and the doctor told my friend and other doctors that I was HIV-positive. My friend then became very cautious and distanced herself from me.”

Sexual and reproductive health rights possibly involved

▪ The right to equality and to be free from all forms of discrimination
- The right to privacy and confidentiality
- The right to liberty and security of the person
- The right to health care and health protection
- The right to be free from torture and inhuman treatment

Case 27. Forced sterilization of Roma women in Slovakia

During a fact-finding mission in 2002, researchers in Slovakia received confirmation of discriminatory health-care practices against women of the Roma ethnic group. For example, Romani women in maternity and gynecological wards were placed in separate rooms from other women; they were often prohibited from using the same toilets and dining facilities as other women. They furthermore received sub-standard medical care or were sometimes denied care at all.

The researchers further discovered that doctors and nurses were giving misleading or threatening information to Romani women in order to coerce them into providing last-minute authorizations for sterilizations that were performed when women were undergoing a cesarean delivery. They did not provide accurate information about the risks of future pregnancies, nor did they discuss different contraceptive options with the women. A few women under the age of 18 were forcibly sterilized without authorization from their legal guardians. Many other women were never told about the sterilization and it sometimes took them years to confirm that they had, indeed, been sterilized.

Seven women who were unable to get pregnant after delivering children via caesarean sections suspected that they may have been sterilized without their consent during their hospital stays, so they and their legal representatives sought access to their medical records on multiple occasions. Hospital staff either turned them away or told them that they would have to copy the voluminous files by hand since there was no justifiable reason to provide photocopies. Attempts to find redress through the Slovak courts failed.

Note for participants at the end of their exercise: the European Court of Human Rights ruled that the women’s rights had been violated, saying that the refusal to provide photocopies of medical records violated the women’s right to private and family life. The court also recognized that information about their reproductive health status was essential to the women’s moral and physical integrity, as well as to their ability to effectively seek redress before the courts.
Sexual and reproductive health rights possibly involved

- The right to equality and to be free from all forms of discrimination
- The right to privacy and confidentiality
- The right to liberty and security of the person
- The right to health care and health protection
- The right to be free from torture and inhuman treatment
- The right to the benefits of scientific progress
- The right to due process