COMPOUNDED INJUSTICE AND CAUTIONARY NOTES FOR "PROGRESS" IN THE SUSTAINABLE DEVELOPMENT ERA: CONSIDERING THE CASE OF STERILIZATION OF WOMEN LIVING WITH HIV

ALICIA ELY YAMIN[1]
COREY PRACHNIAK-RINCÓN[2]

TABLE OF CONTENTS

---

[1] Visiting Professor of Law, Georgetown University Law Center, and Adjunct Lecturer on Law and Global Health, Harvard TH Chan School of Public Health. Yamin also directs the Health and Human Rights Initiative at the O'Neill Institute for National and Global Health Law at Georgetown, and is a Global Fellow, Centre on Law and Social Transformation. Yamin currently serves as a Commissioner on the Lancet-O'Neill Institute Commission on Global Health and the Law and Panelist on the UN Secretary's General's Independent Accountability Panel for the Global Strategy for Women's, Children's, and Adolescents' Health. Previously, she has served on numerous UN expert groups, steering committees and task forces, as well as the Oversight Committee of Kenya's Constitutional Implementation Commission's work on the right to health, and as an Independent Expert to the Colombian Constitutional Court on the Implementation of its 2008 T-760/08 decision calling for restructuring the health system. She regularly leads judicial colloquia and strategic litigation courses for practitioners, advises on specific cases, submits amicus curiae petitions and participates in expert consultations relating to the application of international and constitutional law to health issues. Yamin can be reached at Aey7@law.georgetown.edu.

[2] Director, Massachusetts Commission on Lesbian, Gay, Bisexual, Transgender, Queer and Questioning Youth. While writing this paper, Prachniak-Rincón served as a Sinclair Kennedy Fellow at Harvard University and a Visiting Scientist at Harvard's Women & Health Initiative. Previously, they had been a student researcher with the FXB Center for Health and Human Rights while serving as a Zuckerman Fellow at the Center for Public Leadership. Prachniak-Rincón worked as an attorney and project leader in HIV and LGBTQ rights at Whitman-Walker Health in Washington, D.C., and has worked for several years as a consultant in these fields, including on the largest LGBTQ-focused public health campaign in U.S. history. Prachniak-Rincón can be reached at cprachniak@mail.harvard.edu.

Introduction

The 2030 Agenda (Agenda) and Sustainable Development Goals ("SDGs"), adopted by the United Nations (UN) General Assembly in 2015 as the roadmap for progress in the world through 2030, "seek[s] to realize the human rights of all and to achieve gender equality and the empowerment of all women and girls."[3] Guiding the Agenda's seventeen ambitious goals is the principle that as the globe continues its trajectory of development, no one should be left behind—that the governments of the world shall "ensure that all human beings can fulfill their potential in dignity and equality."[4] The SDGs notably set out an agenda where health goals, including Universal Health Coverage (Target 3.8) and access to sexual and reproductive health care (Target 3.7), are meant to be addressed in combination with goals on gender equality (Goal 5), as well as those relating to "equal access to justice for all" (Target 16.3) and "effective, accountable and transparent institutions" (Target 16.6).[5] Specifically, seeking to address a gap in the previous Millennium Development Goals ("MDGs"), the agenda includes the proportion of "women aged 15–49 who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care" (Target 5.6.1) among the indicators towards the realization of these Goals.[6]

Access to modern contraception has generally increased throughout the world in recent decades, including with respect to long-acting and permanent methods, such as bilateral tubal ligation ("BTL") for women. But unfortu-

[3] G.A. Res. 70/1, Transforming Our World: The 2030 Agenda for Sustainable Development, at 1 (Sept. 25, 2015) [hereinafter SDGs].

[4] *Id.* at 2.

[5] *Id.* at 16–26.

[6] Rep. of the Inter-Agency and Expert Group on Sustainable Development Goal Indicators, at 8, U.N. Doc. E/CN.3/2016/2/Rev.1, annex IV (2016), http://unstats.un.org/sdgs/indicators/Official%20List%20of%20Proposed%20SDG%20Indicators.pdf [https://perma.cc/3E29-JNHC] [hereinafter U.N. SDG Indicators].

nately, availability has not always been coupled with full and informed choice. It is a tragedy that in many parts of the world where women and girls too often lack information about, as well as access to, a variety of contraceptive methods, governments are nonetheless prepared to provide BTL services for women considered unfit to bear children. The situation is perhaps most flagrantly unfair when the women being targeted for sterilization are those living with HIV, for whom society often failed to provide sexual and other basic education, access to economic opportunities that would provide greater education, or sexual and reproductive healthcare services that might have prevented their seroconversion in the first place. These women face a compounded injustice when the same system that failed them then actively limits their reproductive health choices and remaining agency over their lives. This includes, at the most extreme, when these women are coerced or forced to have sterilization procedures performed without full and informed consent. Such use of permanent contraception converts what is otherwise an advance in reproductive choice into a gross violation of fundamental human rights to bodily integrity, health, and more.[7]

The SDGs' target of having "universal access to sexual and reproductive health and reproductive rights," including eliminating unmet need for contraception, includes an indicator tracking the proportion of women making their own informed decisions on reproductive health and the number of countries guaranteeing access to comprehensive reproductive healthcare and information.[8] Nevertheless, controlling fertility to reduce poverty has long been part of national development plans, both tacitly and explicitly.[9] And history demonstrates that, without explicit guarantees, often admirable objectives of increasing contraception access can quickly result in coercive practices, particularly aimed at the most low-income and otherwise vulnerable sections of a society. Such was the case, for example, in Peru in the 1990s, where what was initially lauded as an expansion of modern contraception access was revealed as a systematic campaign by the Fujimori government to coerce poor and overwhelmingly indigenous women to undergo sterilization in the name of "poverty reduction."[10]

---

[7] Juan E. Méndez (Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment), *Rep. of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, ¶ 45, U.N. Doc. A/HRC/31/57 (Jan. 5, 2016) [hereinafter *Rep. of the Special Rapporteur* (2016)].

[8] U.N. SDG Indicators, *supra* note 6, at 8.

[9] *See generally* Population Policies Reconsidered: Health, Empowerment, and Rights (Gita Sen, Adrienne Germain & Lincoln C. Chen eds., 1994) (explaining history of using population policies to advance demographic imperatives and changing paradigm to reproductive rights); Rayma Kumar, Anne-Emanuelle Birn & Peggy McDonough, *Agenda-Setting in Women's Health: Critical Analysis of a Quarter-Century of Paradigm Shifts in International and Global Health*, *in* Handbook on Gender and Health 25, 27 (Jasmine Gideon ed., 2016) (recounting history of fertility control in women's health policies).

[10] *See* Anna-Britt Coe, *From Anti-Natalist to Ultra-Conservative: Restricting Reproductive Choice in Peru*, 12 Reprod. Health Matters 56, 56–59, 61–63 (2004).

In the context of the SDGs, actors such as donors and international institutions may inadvertently contribute to abuses by evaluating a country's progress with seemingly neutral indicators that do not take into account the power dynamics that mark specific health systems and social contexts. It is foreseeable that in the SDG-era, public policymakers and private program planners alike may seek to drive up metrics of contraceptive prevalence rates, met need for contraception, and the like precisely among the most marginal and disadvantaged of populations—from adolescents to people living with HIV.[11] Indeed, the rhetoric of human rights in the SDGs, such as the need to disaggregate data on achievements and to "leave no one behind," could very well incentivize harmful practices that appear in global indicators as a reduction of HIV and an increase in access to contraceptive access among lowest income quintiles. Worse, the monitoring frameworks of the SDGs are unlikely to detect violations of the right to full and informed consent for reproductive care, since these frameworks track crystallized, quantified measures of progress, abstracted from context. Here, we seek to raise a red flag about this possible perversion of the intent of human rights-based development.

In this Article, we argue that meaningfully incorporating human rights and concern for gender equality in the implementation of the SDGs requires more than rhetoric; it demands addressing the accountability gaps in health systems that mistreat and violate the fundamental rights of women most in need of their services and support. First, we explain the two predominant ways in which involuntary sterilization occurs and illustrate how women in society who are already vulnerable can be particularly susceptible to this form of abuse. Second, we describe the ways in which involuntary sterilization infringes on a series of rights under international human rights law. Third, we discuss the importance of understanding intersectional identities with respect to women living with HIV and argue that to address the contextualized power structures that result in involuntary sterilization, policymakers and courts that are charged with protecting rights must understand how life experiences are interwoven. Fourth, we unpack the reasons for involuntary sterilization of women living with HIV, ranging from practical discrimination in health systems, to empirical misinformation and uninformed biases, to normative assumptions about who deserves to be a mother. Finally, although most responsibility for achieving the aspirational goals in the SDGs falls to political organs of government, we argue that courts, as guardians of fundamental normative commitments in society, have the opportunity and responsibility under international and domestic law to identify the ste-

[11] Alicia E. Yamin & Vanessa M. Boulanger, *Why Global Goals and Indicators Matter: The Experience of Sexual and Reproductive Health and Rights in the Millennium Development Goals*, 15 J. Hum. Dev. & Capacities, 218, 221–22 (2014).

reotypes and harms that enable involuntary sterilization and to affirm the dignity of women and their role in society.[12]

I. Context: Understanding How Involuntary Sterilization Occurs

Free and informed consent is especially important in the context of sterilization, which is a permanent and significant occurrence in a person's life. In turn, it is important for governments to understand the circumstances in which sterilization can occur involuntarily, even if not done by literal force, in order for reproductive rights to be protected.

International ethical standards, as well as norms, require full and informed consent for any medical intervention, but particular attention is paid to this issue when there is a high potential for harm in the event of the intervention being non-consensual.[13] Even voluntary sterilization of women carries with it the potential for serious physical and psychological harms, including pain, stomach cramps, nausea, bleeding,[14] and, in rarer cases, injuries involving anaesthesia and "surgical complications such as bowel and vessel injuries, even death."[15] Mortality rates from female sterilization procedures tend to be much higher than for vasectomies in men, on the order of 4 deaths per 100,000 procedures for women compared to only 0.1 death per 100,000 procedures for men.[16]

There are many legal, ethical, and public health proposals for how to define "full and informed consent," a topic of considerable debate even amongst advocates of sexual and reproductive health. While it is beyond the scope of this Article to review all of them, full and informed consent for permanent methods of contraception should, at a minimum, be understood as a person making a decision to undertake a procedure that she understands

---

[12] *See* Rebecca Cook & Simone Cusack, Gender Stereotyping: Transnational Legal Perspectives 2–3 (2011); *see generally* Liiri Oja & Alicia Ely Yamin, "Woman" in the European Human Rights System: How Is the Reproductive Rights Jurisprudence of the European Court of Human Rights Constructing Narratives of Women's Citizenship?, 32 Colum. J. Gender & L. 62 (2016) (discussing how international law has recognized reproductive rights under a human rights law framework).

[13] *See generally Declaration of Helsinki (1964)*, 313 Brit Med. J. 1448 (1996); *see also* I.V. v. Bolivia, Preliminary Objections, Merits, Reparations and Costs, Judgment, Inter-Am. Ct. H.R. (ser. C) No. 329, at 5 (Nov. 30, 2016); Anand Grover (Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health), *Rep. of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, U.N. Doc. A/64/272 (Aug. 10, 2009) [hereinafter Grover, *Rep. of the Special Rapporteur* (2009)].

[14] Salvatore Gizzo et al., *Female Sterilization: Update on Clinical Efficacy, Side Effects, and Contraindications*, 23 Minimally Invasive Therapy 261, 264 (2014).

[15] *Id.* at 266.

[16] Ninaad Awsare et al., *Complications of Vasectomy*, 87 Annals Royal C. Surgeons England 406, 408 (2005).

will result in ending the possibility of her bearing children, free from both verbal and physical coercion, as well as socioeconomic pressure or incentivization.

In order to understand involuntary sterilization and the rights at issue, it is also essential to understand how and when sterilization *without* full and informed consent generally occurs. First, sterilization without full and informed consent can occur when the procedure is performed entirely without a woman's knowledge. Both consensual and non-consensual sterilization procedures often occur around the time of delivery of a child or an emergency obstetric procedure.[17] This is a time of particular risk for BTL to be performed without the woman's knowledge because she has had anesthesia and/or is in pain and because a major medical event is a time of diminished ability to focus on the terms of a legal agreement. For example, Slovakia lost in a case brought by two Romani women in which sterilization was performed completely without their knowledge while they were having Caesarean deliveries. The women had never discussed sterilization with their providers; one woman was misled into signing a consent form after the procedure, while the other was alleged to have been informed orally after the operation.[18] Sadly, this case represents a widespread practice used against Romani women as a disfavored group that was targeted for involuntary sterilization.[19]

Second, sterilization without full and informed consent can occur when a woman is aware that the procedure will be used, but when force, coercion, or nondisclosure of critical information is employed to pressure the individual into having the procedure. For example, women may be encouraged to undergo sterilization without truly understanding that it is a permanent procedure that will prevent them from having children, offered a significant incentive for undergoing the procedure and feel they are financially unable to refuse the offer, or denied a service or benefit that is rightfully theirs until they agree to have the procedure. In India, health workers—trying to meet target numbers for sterilization procedures in order to keep their jobs—have been found to give incomplete information to women about the permanent nature of the procedure, as well as its risks.[20] State entities have also been found to use incentives, including gold coins and even cars, in order to coax

---

[17] *See, e.g.*, Sangreeta Pati & Vanessa Cullins, *Female Sterilization*, 27 FEMALE STERILIZATION: EVIDENCE 859, 860–61 (2000) (finding that half of female sterilization procedures in the U.S. happen following delivery and that many experts believe it is ideal to have such a procedure as soon as possible following delivery).

[18] *See generally* I.G. and Others v. Slovakia, App. No. 15966/04, Eur. Ct. H. R. (2012), https://hudoc.echr.coe.int/eng?i=001-114514 [https://perma.cc/8U83-WW2E].

[19] CTR. FOR REPROD. RIGHTS, BODY AND SOUL: FORCED STERILIZATION AND OTHER ASSAULTS ON ROMA REPRODUCTIVE FREEDOM IN SLOVAKIA 14–15 (2003), https://www.reproductiverights.org/document/body-and-soul-forced-sterilization-and-other-assaults-on-roma-reproductive-freedom [https://perma.cc/FUD7-M4PG].

[20] *India: Target-Driven Sterilization Harming Women*, HUMAN RIGHTS WATCH (July 12, 2012), https://www.hrw.org/news/2012/07/12/india-target-driven-sterilization-harming-women [https://perma.cc/SUE5-D4SZ].

women into undergoing sterilization.[21] The Supreme Court of India recently condemned these practices, noting the necessity of considering "the impact that policies such as the setting of informal targets and the provision of incentives by the Government can have on reproductive freedoms of the most vulnerable groups of society whose economic and social conditions leave them with no meaningful choice in the matter and also render them the easiest targets of coercion."[22] For women living with HIV—who often lack information and autonomy within the healthcare system, and in practice may also face dire financial situations—there is a particular vulnerability to any of these sterilization practices.[23]

The World Health Organization (WHO) has called states' attention to the myriad ways in which vulnerable women can be coerced into undergoing a procedure with lifelong implications without understanding the consequences or having an option to refuse. "In making a decision for or against sterilization," WHO states, "an individual must not be induced by incentives . . . [including from a] health-care provider or public officer."[24] WHO has further observed that "women living with HIV have been coerced to sign consent forms for sterilization procedures, as a condition of receiving antiretroviral and other HIV treatment and prenatal care for a current pregnancy, or other reproductive health services," and that "[p]regnant women have also been asked to sign consent forms in situations of duress, such as during labour and while in severe pain . . . . In these cases, the women have not been given information on the sterilization procedure, its permanent nature, or alternative methods of contraception."[25] In all of these situations, women may or may not have agreed to a sterilization procedure, but because they were not given full information, were offered an incentive if they agreed, or were asked to decide while in labor or otherwise under duress, full and informed consent was not given and the procedure thus violated their rights.

II. Framing Involuntary Sterilization Under International Human Rights Law

The practice of involuntary sterilization must be evaluated under fundamental human rights instruments, such as the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural

---

[21] *Id.*

[22] Writ Petition (Civil) 95/2012, Devika Biswas v. Union of India and Others, ¶ 87 (India) (2016).

[23] *See* World Health Organization, Consolidated Guideline on Sexual and Reproductive Health and Rights of Women Living with HIV, at ix–x, 9 (2017) [hereinafter WHO, Consolidated Guideline].

[24] World Health Organization, Eliminating Forced, Coercive and Otherwise Involuntary Sterilization: An Interagency Statement 9–10 (2014) [hereinafter WHO, Interagency Statement].

[25] *Id.* at 4.

Rights, the Convention on the Elimination of All Forms of Discrimination against Women, and general human rights law.

First, involuntary sterilization of women living with HIV is utterly inconsistent with the Universal Declaration of Human Rights (UDHR)—the founding charter of international human rights.[26] Since the adoption of the UDHR in 1948, the global commitment to and understanding of the requirements for equal dignity and access to health for women has exponentially grown, and binding treaties have clarified the content of the UDHR's obligations.

For instance, the International Covenant on Economic, Social and Cultural Rights (ICESCR) calls for "[t]he widest possible protection and assistance [to] be accorded to the family," and, in particular, to maternal care.[27] ICESCR requires further that "[s]pecial protection should be accorded to mothers during a reasonable period before and after childbirth."[28] Thus, women who are seeking maternal and follow-up care are given special consideration and concern with respect to services such as sterilization. It follows that states striving to meet this obligation ought to prioritize vulnerable women, such as those living with HIV. In sharp contrast to this requirement, states that permit sterilization without full and informed consent of women living with HIV actually target the most vulnerable women at their most critical time of needing medical attention. These states not only fail to provide such women with quality care, but instead provide unwanted, degrading care. States parties to ICESCR also acknowledge the "right of everyone to the enjoyment of the highest attainable standard of physical and mental health," which includes freedom from unwanted, unnecessary, and non-consensual procedures.[29] In this way, ICESCR should inform States parties on the importance of focusing resources on the most critical elements of care for the most vulnerable individuals, rather than allowing (or even directing) those resources to be spent to harm women living with HIV.[30]

Third, the practice of involuntary sterilization violates the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), which proclaims: "State Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning."[31] This right is violated when women living with HIV are targeted for sterilization, not only

---

[26] G.A. Res. 217 (III) A, Universal Declaration of Human Rights, arts. 16, 28 (Dec. 10, 1948).

[27] International Covenant on Economic, Social and Cultural Rights, art. 10, Jan. 3, 1976, 993 U.N.T.S. 3 [hereinafter ICESCR].

[28] *Id.* at art. 10(2).

[29] *Id.* at art. 12.

[30] *See* Grover, *Rep. of the Special Rapporteur* (2009), *supra* note 13, ¶¶ 19, 58–60, 92–101.

[31] Convention on the Elimination of All Forms of Discrimination Against Women, art. 12(1), Dec. 18, 1979, 1249 U.N.T.S. 13 [hereinafter CEDAW].

because it is unlikely that men are similarly being targeted for sterilization, but also because such a practice preys on the unique vulnerabilities of women living with HIV and reinforces the specific stereotypes they face.[32] The principle of gender equality that CEDAW was established to promote cannot be advanced if the state permits or perpetrates practices that fail to recognize the intersectional forms of discrimination that women face. In this case, the state must recognize that the discrimination women living with HIV face in the healthcare system is distinct from that which men living with HIV will face, or that women generally will face. Advancing equal access to healthcare, especially reproductive healthcare, means recognizing that women have other components to their identities that exacerbate the discrimination they face as women generally and require courts to be particularly sensitive to the precarious nature of the rights of the most vulnerable.

CEDAW's prohibition on discrimination requires States parties "[t]o take all appropriate measures . . . to modify or abolish laws, regulations, customs *and practices* which constitute discrimination against women."[33] The breadth of these requirements means that States parties do not satisfy their commitment to equality under CEDAW merely by having an absence of laws that formally discriminate against women. Rather, it requires that governments take responsibility for practices within the healthcare system that represent a failure to deliver on the human rights guaranteed to all.[34] Importantly, CEDAW not only requires action against individual and concrete instances of discrimination, but also requires "the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women."[35] The CEDAW Committee has further elaborated that this requires action against the "prevailing gender relations and the persistence of gender-based stereotypes that affect women" and the underlying "legal and societal structures and institutions."[36] Thus, the powerful stereotypes and discrimination faced by women living with HIV, as described below,

---

[32] *See* Ronli Sifris, *Involuntary Sterilization of HIV-Positive Women: An Example of Intersectional Discrimination*, 37 Hum. Rts. Q. 464, 469–72 (2015).

[33] CEDAW, *supra* note 31, at art. 2(f) (emphasis added).

[34] *See* Comm. on the Elimination of Discrimination Against Women, Views of the Committee on the Elimination of Discrimination Against Women under article 7, paragraph 3, of the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women, Alyne da Silva Pimentel Teixeira v. Brazil, Comm. No. 17/2008, U.N. Doc. CEDAW/C/49/D/17/2008, ¶ 7.6 (July 25, 2011) [hereinafter CEDAW, Views, Alyne de Silva Pimental Teixeira v. Brazil] (noting that States parties' policies, including maternal healthcare delivery, must be action-oriented, result-oriented, and properly funded to be in compliance with the Convention).

[35] CEDAW, *supra* note 31, at art. 5(a).

[36] Comm. on the Elimination of Discrimination Against Women, General Recommendation No. 25, on Article 4, Paragraph 1, of the Convention to Eliminate All Forms of Discrimination Against Women, on Temporary Special Measures, U.N. Doc. A/59/38, ¶ 7, at 79 (2004).

must be named explicitly as violations of CEDAW in and of themselves and eradicated accordingly.

Finally, in addition to these prohibitions on discrimination against women under CEDAW, sterilization that occurs without full and informed consent results in specific violations of international human rights law, including the rights to (a) health, (b) bodily integrity and freedom from degrading and inhuman treatment, (c) found a family and to private life, and (d) dignity. These rights are protected in a variety of international treaties, which different States parties have ratified, as discussed below.

A. Right to Health

The right to health has been enshrined in numerous human rights treaties at international and regional levels, with all countries in the world having ratified at least one. Many of these instruments, together with their interpretations by different authoritative bodies, have called explicitly for protecting the health needs of women, including with respect to family planning and maternal care.[37] In interpreting the right to health under international law, the Committee on Economic, Social and Cultural Rights (CESCR) has stated that it includes both freedoms and entitlements including "effective protection from all forms of violence, torture and discrimination and other human rights violations that negatively impact on the right to sexual and reproductive health."[38]

The realization of the right to health also requires a health system that is both equitable and efficient, including providing access to care and information in culturally and scientifically acceptable ways, on the basis of nondiscrimination and with adequate information. Yet, rather than being a space in which women can claim their full citizenship and evade the discrimination that pervades the rest of society, health systems that engage in the practice of involuntary sterilization perpetuate the degradation these women face in larger society and in so doing violate their human rights.[39]

---

[37] *See, e.g.*, Universal Declaration of Human Rights, *supra* note 26, at art. 25.1; ICESCR, *supra* note 27, at art. 12.2.

[38] Comm. on Econ., Social and Cultural Rights, General Comment No. 22, U.N. Doc. E/C.12/GC/22, ¶ 7 (May 1, 2016).

[39] *See* Alicia E. Yamin & Fiona Lander, *Implementing a Circle of Accountability: A Proposed Framework for Judiciaries and Other Actors in Enforcing Health-Related Rights*, 14 J. HUM. RTS. 312, 321–22 (2015) (outlining state obligations regarding vulnerable populations' access to health care, and explaining how respect or lack thereof of dignity can "redefine who is considered a full human being and equal member of society"); ALICIA ELY YAMIN, POWER, SUFFERING AND THE STRUGGLE FOR DIGNITY: HUMAN RIGHTS FRAMEWORKS FOR HEALTH AND WHY THEY MATTER 104 (2016) ("[T]he importance of health systems derives not merely from the delivery of services but also from the way citizens interact with the health system."); *id.* at 105 ("[The] understanding of what measures should be taken to achieve equality derives from this basic idea of the health system as part of the foundation of our society, which can exacerbate inequalities and exclusion or facilitate the conditions under which all people can live with equal dignity.").

B. Rights to Bodily Integrity and Freedom from Torture and Other Forms of Cruel, Degrading, or Inhuman Treatment

International human rights law recognizes the right of each individual to bodily integrity[40] and, complementarily, prohibits torture and other forms of treatment that are considered cruel, inhuman, or degrading.[41] It is well established in international human rights law that involuntary sterilization constitutes a violation of the right of bodily integrity and the right to be free of inhuman treatment. For example, the UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment has unambiguously declared:

> Forced sterilization is an act of violence and a form of social control, and violates a person's right to be free from torture and ill-treatment. Full, free and informed consent of the patient herself is critical and can never be excused on the basis of medical necessity or emergency when obtaining consent is still possible.[42]

The Special Rapporteur has found that sterilization that does not meet these conditions violates the rights to life and dignity and may amount to inhuman and degrading treatment,[43] regardless of whether it is done by physical force, without full understanding and consent, or with economic coercion.[44]

The Special Rapporteur has further established that "forced contraception" and other reproductive health services performed without full and informed consent "constitute violations of a woman's physical integrity and security of person," in violation of international law.[45] For its part, WHO recently reaffirmed that involuntarily sterilization can represent an "institutional use of violence"[46] and that "the right to life and physical integrity, including freedom from violence,"[47] prohibits using such practices under the guise of reducing rates of HIV.

The European Court of Human Rights ("ECtHR") has also found that involuntary sterilization violates international human rights law. In a series of cases brought by Roma women against Slovakia, the ECtHR held that sterilizations performed without full and informed consent had amounted to inhuman and degrading treatment in violation of the European Convention

---

[40] *See, e.g.*, Universal Declaration of Human Rights, *supra* note 26, at art. 3 (establishing "the right to life, liberty and security of person").

[41] *See, e.g.*, *id.* at art. 5; Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, arts. 2, 16, Dec. 10, 1984, 1465 U.N.T.S. 85 arts. 2, 16.

[42] *Rep. of the Special Rapporteur* (2016), *supra* note 7, ¶ 45.

[43] Radhika Coomaraswamy (Special Rapporteur on Violence against Women, Its Causes and Consequences), *Report of the Special Rapporteur on Violence against Women, Its Causes and Consequences*, ¶¶ 44–45, U.N. Doc. E/CN.4/1999/68/Add.4 (1999).

[44] *Id.* ¶¶ 51–52.

[45] *Id.* ¶ 45.

[46] WHO, Consolidated Guideline, *supra* note 23, at 36.

[47] *Id.* at x.

on Human Rights ("European Convention").[48] The ECtHR decisions are instructive in highlighting the circumstances of involuntary sterilization, and the failure to offer less intrusive interventions. "The sterilisation had not been a life-saving procedure," the ECtHR noted with respect to one case, and "had been carried out without consideration for alternative ways of protecting [the woman] from the alleged risks linked to a possible future pregnancy, such as the various methods of contraception available to her and her husband which would not have left her permanently infertile."[49] Rather, the ECtHR explained that the sterilization procedure had "to be seen in the context of the widespread sterilising of Roma women,"[50] much as the context of sterilization of women living with HIV must be seen in the context of such practices targeted specifically at women with HIV. The ECtHR concluded that "[t]he nature of the procedure as such and the circumstances in which it had been carried out amounted to inhuman and degrading treatment contrary to Article 3 of the [European] Convention," finding in favor of the petitioners.[51]

C. Right to Found a Family and to Private Life

In addition to the immediate indignity of having their bodies violated by an unwanted medical procedure, sterilization without full and informed consent violates the dignity of women for the rest of their lives. While there is a heated debate in political and human rights forums about expanding the notion of the traditional patriarchal family to encompass a diversity of "families,"[52] there is no question that the ability to choose to create a family is among the most well-established of human rights, dating back to when the UDHR recognized the right (of both men and women, equally) to "found a family."[53] Just as increasing opportunities for women beyond family roles is essential for true gender equality, taking away this ability from women also deprives them of a fundamental right.

The ECtHR, in the aforementioned cases brought by Roma women, also found that Slovakia had violated Article 8 of the European Convention, which guarantees "the right to respect for his private and family life."[54] The

---

[48] *See generally* N.B. v. Slovakia, App. No. 29518/10, Eur. Ct. H.R. (2012); V.C. v. Slovakia, App. No. 18968/07, Eur. Ct. H.R. (2012); I.G. and Others v. Slovakia, App. No. 15966/04, Eur. Ct. H. R. (2012), https://hudoc.echr.coe.int/eng?i=001-114514 [https://perma.cc/8U83-WW2E].

[49] V.C. v. Slovakia, App. No. 18968/07, ¶ 89.

[50] *Id.* ¶ 90.

[51] *Id.* ¶ 91.

[52] *See, e.g.*, Human Rights Council, *Protection of the Family: Contribution of the Family to the Realization of the Right to an Adequate Standard of Living for its Members, Particularly Though its Role in Poverty Eradication and Achieving Sustainable Development*, ¶¶ 7–8, 24–27, U.N. Doc. A/HRC/31/37 (2016).

[53] Universal Declaration of Human Rights, *supra* note 26, at art. 16(1).

[54] European Convention on Human Rights art. 8, Nov. 4, 1950, E.T.S. 5.

ECtHR determined, with an eye towards the particular and socially-embedded vulnerabilities of Roma women, that:

> the absence at the relevant time of safeguards giving special consideration to the reproductive health of the applicant as a Roma woman resulted in a failure by the respondent State to comply with its positive obligation to secure to her a sufficient measure of protection enabling her to effectively enjoy her right to respect of her private and family life.[55]

The ECtHR emphasized that the state of Slovakia had a *positive* obligation to guarantee that vulnerable women were not sterilized without their full and informed consent, not merely that the state should abstain from engaging in the practice itself. Article 12 of the European Convention, which guarantees the right of both men and women to form a family, also supports this holding,[56] as does Article 14, which prohibits discrimination on the basis of sex and also "other status,"[57] including possibly HIV status.

D. Right to Dignity

Dignity is the foundation of all human rights, and it is worth noting that the stigmatizing effects of involuntary sterilization go beyond violating just one or two specific human rights. Women who are sterilized without free and full consent are often subjected to social stigma, isolation, and spousal abandonment as a result of their being unable to bear more children. Even the fear of such outcomes can have a significant negative effect on a woman's health, well-being, and ability to live a life of dignity within a given social context. In a tragic irony, many women are economically coerced into undergoing sterilization[58] only to emerge from the procedure to face increased socioeconomic marginalization. Indeed, researchers at the University of Toronto studying the issue of sterilization have found that the ability to have children is essential to many women's opportunities for survival and that "many women, therefore, may not forgo reproductive opportunities where the condition of maintaining marital, de facto, or transactional sexual unions is seen essential to women's economic and physical security."[59]

---

[55] V.C. v. Slovakia, App. No. 18968/07, ¶ 154.

[56] European Convention on Human Rights, *supra* note 54, at art. 12.

[57] *Id.* at art. 14.

[58] *See* Sofia Gruskin, *Negotiating the Relationship of HIV/AIDS to Reproductive Health and Reproductive Rights*, 44 Am. U. L. Rev. 1191, 1193–94 (1995).

[59] Nisha Anand et al., Bridging the Gap: Developing a Human Rights Framework to Address Coerced Sterilization and Abortion 6 (2009). This is true principally because the unfortunate reality in many socioeconomic settings is that women do not have the ability to live and work independently, and instead must enter into a sexual partnership with a man and produce and raise children in order to have access to even modest economic means. This can also be true for many women who are already in relationships and may face abuse or abandonment if their partner discovers that they are unable to bear children, as well as further isolation from their community.

The involuntary sterilization cases brought against Slovakia reflect the impact this practice has on women's dignity.[60] In one such case, the ECtHR found that the petitioner had endured severe "difficulties in her relationship with her partner" and that the woman cited "her infertility as one of the reasons for her divorce in 2009."[61] The ECtHR added that the "sterilisation had resulted in the deterioration of her relationship with the father of her children and impaired her standing in the Roma community."[62] Importantly, the ECtHR also made clear that involuntary sterilization is a violation of the right to dignity, even if the intent of the medical provider was not malicious: "Although the purpose of such treatment is a factor to be [considered], in particular the question of whether it was intended to humiliate or debase the victim, the absence of any such purpose does not inevitably lead to a finding that there has been no violation of Article 3" of the European Convention on Human Rights, which bans degrading treatment.[63] Thus, regardless of the intent of the health care providers or social workers, a woman's right to dignity is violated when she does not provide consent for sterilization procedures.

In short, involuntary sterilization represents not only systemic and intersectional discrimination, but can also be seen as a violation of the right to dignity, the right to health, and the right to be free from torture and other forms of cruel, inhuman or degrading treatment, when the act constituting that treatment—involuntary sterilization—is targeted towards a disfavored group: in this case, women living with HIV. Because the systemic targeting of women in particular further limits their control over forming a family, this form of discrimination also infringes on the right to found a family.

III. Applying the Concept of Intersectional Discrimination to Women Living with HIV

Human beings are not a sum of characteristics, or a string of adjectives; everyone contains within herself a complex narrative in which different dimensions of identity may play a role within specific social contexts. Thus, understanding the full effect of involuntary sterilization of women living with HIV cannot be reduced to a sum of different rights violated or discrimination based upon different axes of identity. An intersectional approach instead allows legal systems to see the complexity of an individual's experience and craft remedies that address the multiple forms of bias and discrimination in their lives.

---

[60] *See generally* N.B. v. Slovakia, App. No. 29518/10, Eur. Ct. H.R. (2012); V.C. v. Slovakia, App. No. 18968/07, Eur. Ct. H.R. (2012); I.G. and Others v. Slovakia, App. No. 15966/04, Eur. Ct. H. R. (2012), https://hudoc.echr.coe.int/eng?i=001-114514 [https://perma.cc/8U83-WW2E].

[61] V.C. v. Slovakia, App. No. 18968/07, ¶ 118.

[62] *Id.* ¶ 134.

[63] *Id.* ¶ 101.

Under human rights law, formal equality requires that laws treat similarly situated people in the same manner; substantive equality, on the other hand, incorporates the understanding that people are different and require different treatment to be able to enjoy their human rights on an equal basis in practice.[64] The concept of intersectional discrimination[65] recognizes this truth about the need for human beings to enjoy more than just formal equality and provides critical context to the concept of substantive equality. Intersectional discrimination considers how different forms of discrimination, such as discrimination against people living with HIV, interact with each other when an individual is part of more than one disadvantaged group.[66] Intersectionality also allows us to move past a categorical approach to gender, in which we see differences only between men and women, and instead take up what Raewyn Connell calls a relational approach, which "understands gender as multidimensional: embracing at the same time economic relations, power relations, affective relations and symbolic relations; and operating simultaneously at intrapersonal, interpersonal, institutional and society-wide levels."[67] In this way, we do not simply attempt to tally the forms of discrimination that both women and people living with HIV face, but instead examine how the particular status of women living with HIV in a given society has impacted their lived experience and exercise of human rights. The Committee on the Elimination of All Forms of Discrimination against Women ("CEDAW Committee") noted this close to two decades ago:

> While biological differences between women and men may lead to differences in health status, there are societal factors which are determinative of the health status of women and men and which can vary among women themselves. For that reason, special attention should be given to the health needs and rights of women belonging to vulnerable and disadvantaged groups.[68]

Indeed, CESCR has noted that women "belonging to particular groups," including people living with HIV, "may be disproportionately affected by intersectional discrimination in the context of sexual and reproductive health. . . . Measures to guarantee non-discrimination and substantive equality should be cognizant of and seek to overcome the often exacerbated impact that intersectional discrimination has on the realization of the right to

---

[64] *See* Comm. on Economic, Social and Cultural Rights, General Comment No. 20, ¶¶ 8–10, U.N. Doc. E/C.12/GC/20 (July 2, 2009).

[65] *See generally* Kimberlé Crenshaw, *Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color*, 43 STAN. L. REV. 1241 (1991) (introducing the theory of intersectionality of race, gender, and other forms of discrimination).

[66] *See id.*

[67] Raewyn Connell, *Gender, Health, and Theory: Conceptualizing the Issue, in Local and World Perspective*, 74 SOC. SCI. & MED. 1675, 1677 (2012).

[68] Comm. on the Elimination of Discrimination Against Women, General Recommendation No. 24: Article 12 of the Convention (Women and Health), ¶ 6, U.N. Doc. A/54/38/Rev.1 (1999) [hereinafter CEDAW Comm., General Recommendation No. 24].

sexual and reproductive health."[69] As both gender and HIV status have a relationship to human sexuality, and, as a result, are frequently connected to biases and stigma, addressing intersectional discrimination faced by women living with HIV requires identifying both the ways in which people living with HIV are stigmatized and marginalized and the ways in which gender presents particular disadvantages to women living with HIV.

While the concept of sex is based in biology—namely, whether someone is identified as "male" or "female" based on the composition of their bodies—gender is a socially and normatively constructed notion, representing all of the assumptions that society makes based on differences in sex.[70] For example, the ability of women to have children is a sex-based distinction; a social expectation that women *should* have children—or should not—is a gender-based distinction. Stereotypes about women's behavior and roles, or the subjugation of women to men, are based on the concept of gender that a given society has constructed, and repeatedly reconstructs, through the interactions that women have in the private sphere with men, with the larger society, and—importantly—with health systems.

Since these gender stereotypes are not natural or immutable in any way, they can also be deconstructed. Indeed, as these harmful stereotypes interfere with the ability of women to pursue their life plans and participate as full members of society, they need to be challenged and replaced for a state to be in full compliance with international human rights law. "Everyone," states the UDHR, "is entitled to a social and international order in which the rights and freedoms set forth in this Declaration can be fully realized."[71]

In this vein, Rebecca Cook and Simone Cusack have argued that "[w]hen societies fail to recognize and eliminate [gender-based] prejudices and their associated stereotypes, that failure exacerbates a climate of impunity with respect to violations of women's rights. The climate of impunity enables prejudices and wrongful gender stereotypes to fester, causing further devaluation of women."[72] But with respect to both the human rights movement and feminist activism in the Western world, Ronli Sifris has noted that the issue of involuntary sterilization, which tends to impact less-privileged women than other aspects of reproductive rights, has been neglected.[73] If the Sustainable Development Agenda,[74] and the UN Secretary General's Global Strategy on Reproductive, Maternal, Newborn, Child, and Adolescent

---

[69] Comm. on Economic, Social and Cultural Rights, *supra* note 38, ¶ 30.

[70] *See, e.g.*, Nancy Krieger, *Genders, Sexes, and Health: What Are the Connections—and Why Does It Matter?*, 32 Int'l J. Epidemiology 652, 652–53 (2003); Pan Am. Health Org., Guidelines for Gender Based Analysis of Health Data for Decision Making 12 (2010).

[71] Universal Declaration of Human Rights, *supra* note 26, at art. 28.

[72] Cook & Cusack, *supra* note 12, at 1.

[73] *See* Sifris, *supra* note 32, at 467, 469.

[74] *See generally* SDGs, *supra* note 3.

Health in the SDGs (the "Secretary-General's Global Strategy")[75] are going to take gender equality and human rights seriously in practice, and not merely in rhetoric, addressing and redressing the harmful stereotypes that underlie involuntary sterilization of the most vulnerable women and girls in society should be incorporated meaningfully into policies, programs, and judicial oversight.

Experience from countries around the globe suggests that, without addressing intersectional discrimination, judicial decisions that find violations in the occurrence of sterilization may provide immediate relief for infringements of bodily integrity but cannot promote transformation of the systemic factors that drive such practices, and therefore cannot guarantee non-repetition.[76] Further, without such an understanding, the political branches of government will invariably fall short of creating the conditions that will transform the lives of women. These transformative strategies are in keeping with Secretary-General's Global Strategy, which emphasizes the need for multi-sector strategies, as well as the centrality of human rights.[77]

IV. Unpacking How and Why Involuntary Sterilization of Women Living with HIV Discriminates

Involuntary sterilization of women living with HIV can be understood as discrimination through three different constructs, which often occur concurrently in any given instance of such sterilization. First, use of BTL for mass sterilization is always inherently discriminatory against women because the medical practice only applies to women. Second, involuntary sterilization is often rooted in biases and misinformation about women living with HIV, especially with respect to their reproductive health. Finally, involuntary sterilization is often marked by normative biases in which—in addition to thinking that women living with HIV cannot make decisions about their reproductive health or safely handle motherhood—these women actually do not *deserve* to freely execute their reproductive rights.

---

[75] *See* U.N. Secretary-General, *The Global Strategy for Women's, Children's and Adolescents' Health (2016–2030)* (2015), http://www.who.int/life-course/partners/global-strategy/ewec-globalstrategyreport-200915.pdf [https://perma.cc/96HT-A7DM] [hereinafter U.N. Secretary-General, *The Global Strategy*].

[76] *See, e.g.*, Mestanza Chavez v. Peru, Petition 12.191, Inter-Am. Comm'n H.R., Report No. 71/03, ¶ 9 (2003); Government of the Republic of Namibia v. LM and Others (2014) SA 49/2012 (Namib.); *see also* Camila Gianella & Alicia Ely Yamin, *Struggle and Resistance: Using International Bodies to Advance Sexual and Reproductive Rights in Peru*, __ Berkeley J. Gender L. & Just. (forthcoming 2018) (discussing ongoing discrimination against low-income, indigenous women in Peru).

[77] *See* U.N. Secretary-General, *The Global Strategy*, *supra* note 75, at 37, 48.

A. Inherent Discrimination Against Women in Use of Bilateral Tubal Ligation

While sterilization in many parts of the world is widely available to both men and women, and can be offered by a health system in a non-discriminatory way, instances of sterilization conducted without full and informed consent on a systemic level have overwhelmingly targeted women. Indeed, a review of the literature reveals that sterilization programs or practices aimed at people living with HIV have been aimed exclusively at women and have not targeted men and case law regarding sterilization of other marginalized groups demonstrates that such campaigns have disproportionately targeted women.[78] It is certainly true that women generally have been the target of coercive sterilization programs; the infamous sterilizations that took place in Peru between 1995 and 1999, for example, almost exclusively targeted women and may have led to up to 200,000 forced sterilizations.[79] Furthermore, many of these women were from rural, indigenous populations.[80] WHO has observed that "women have been disproportionately subjected to forced, coerced, and otherwise involuntary sterilization,"[81] which the institution notes has "been characterized as a form of discrimination and violence against women" under international law.[82]

All involuntary sterilization, in which female forms of sterilization are used exclusively or disproportionately, or in which the promotion of sterilization is aimed primarily at women, inherently discriminates against women. This is because in all of the aforementioned instances only women were targeted for sterilization, and the method of sterilization in question—BTL—is a procedure that can only be conducted on women. Therefore, even without making a normative statement on this practice vis-à-vis the human rights of the women affected, it must be classified as a practice that *per se* discriminates between men and women.

Sterilization without full and informed consent may well represent discrimination by a government whether the state or its agents are directly involved in the planning, financing, and performance of the procedure, or whether it simply fails to establish effective regulation and oversight of private actors operating within the health system.[83] The need for affirmative government intervention to prevent inhuman or degrading treatment that disproportionately affects women has been noted by the UN Special Rapporteur on torture and other cruel, inhuman, or degrading treatment or punishment,

---

[78] *See generally* Sifris, *supra* note 32 (describing forms of intersectional discrimination leading to forced sterilization).

[79] *See* J. Jaime Miranda & Alicia E. Yamin, *Reproductive Health Without Rights in Peru*, 363 LANCET 68, 68 (2004).

[80] *See id.*

[81] WHO, INTERAGENCY STATEMENT, *supra* note 24, at 3.

[82] *Id.* at 1.

[83] *See* CEDAW Comm., General Recommendation No. 24, *supra* note 68, ¶¶ 13–15, 22.

who called upon states to pay particular attention to the needs of women who face intersectional discrimination and marginalization based on their identities.[84]

In international law, gender-based discrimination includes a state's failure to provide adequate reproductive health services needed only by women.[85] The most notable application of this principle was in the landmark case of *Alyne da Silva Pimentel Teixeira v. Brazil*, decided by the CEDAW Committee.[86] In that case, in which a low-income Brazilian woman of African descent died from lack of adequate maternal care, the CEDAW Committee established three key principles of application to the issue of involuntary sterilization: first, it recognized and defined intersectional discrimination facing vulnerable women;[87] second, and most relevant to the immediate discussion, it established the right to maternal health care as an entitlement guaranteed by substantive non-discrimination;[88] and finally, it reaffirmed that the state must regulate non-state actors in order to meet its obligations under international human rights law and, in this case, guarantee that women have adequate healthcare.[89] Ultimately, the CEDAW Committee held the state of Brazil accountable for failing to guarantee a service that only women needed, thus exacerbating existing social inequities along not only gender but also racial and socioeconomic lines. While in that case the failure of the state to protect the rights of women was with respect to an *entitlement*—specifically, the entitlement to maternal health care—reproductive rights also include *freedoms* that only women need, including the freedom to choose to bear children, that a state must protect if it is to ensure non-discrimination. The CEDAW Committee also found that there was "a casual [sic] link between Ms. da Silva Pimentel Teixeira's gender and possible medical errors committed,"[90] noting also that "the lack of appropriate maternal health services has a differential impact on the right to life of women."[91] Since the practice of BTL only happens to women, as a result of their biological reproductive capacity and socially prescribed gender roles, the CEDAW Committee's rationale could similarly be applied to the practice of those methods of sterilization.

The Inter-American Court of Human Rights ("IACtHR") has already adapted the *Alyne* case and applied it to a case regarding women living with HIV. The court, citing the CEDAW Committee's work in *Alyne*, found that the state of Ecuador violated the rights of a woman living with HIV by

---

[84] *See Rep. of the Special Rapporteur* (2016), *supra* note 7, ¶ 9.
[85] *See* CEDAW, General Recommendation No. 24, *supra* note 68, ¶ 11.
[86] *See* CEDAW, Views, Alyne de Silva Pimental Teixeira v. Brazil, *supra* note 34, ¶ 7.6.
[87] *See id.* ¶ 7.7.
[88] *See id.* ¶ 7.6.
[89] *See id.* ¶ 7.5.
[90] *Id.* ¶ 7.3.
[91] *Id.* ¶ 7.6.

failing to have an adequate system to provide her with services.[92] Furthermore, because the woman had been met with discrimination in nearly every facet of her life on the basis of her HIV status and gender, the IACtHR found that Ecuador had failed not only to prevent the individual discriminatory action but also, importantly, to address the underlying social dynamics as required under international law.[93] Importantly, the IACtHR recognized that the petitioner did not just experience isolated incidences of discrimination because she was a woman or because she was a person living with HIV, but rather that there were fundamental dynamics at work throughout the healthcare and educational systems that failed her as a young woman living with HIV.[94] In so doing, the IACtHR denounced the state of Ecuador for allowing these dynamics to persist and suggested that broader systemic change was needed to advance the human rights of the most vulnerable members of that society.

In another case recently decided in the Inter-American System, involuntary sterilization was found to violate the American Convention on Human Rights' prohibition of discrimination. In *I.V. v. Bolivia*—the case of a Peruvian refugee who was sterilized without consent in Bolivia—the Inter-American Commission on Human Rights (IACHR) stated "that many women in the Americas suffer damages to their right to personal integrity in the context of their access to health services and procedures that are exclusively needed by women because of their sex, their biological differences and their reproductive capacities." It further noted the obligation of the State "to take positive steps to ensure the accessibility, availability, acceptability and quality of maternal health services, as a part of its obligations under the principle of equality and non-discrimination."[95] The IACHR went on to assert that "[t]he greater the consequences of the decision to be adopted, the more rigorous the controls for ensuring the patient's free and informed consent," and that this is particularly true "when the surgical patient belongs to a population group that has traditionally been subject to exclusion or discrimination, as is the case of women, and in particular, the realm of sexual and reproductive health."[96]

In turn, when the case was referred by the IACHR to the IACtHR, the IACtHR stated that "[w]hile sterilization is a method used as contraception by both women and men, sterilizations without consent disproportionately impact women exclusively by reason that they are socially assigned the reproductive and family planning functions."[97] The IACtHR suggested that

---

[92] *See* Gonzales Lluy v. Ecuador, Preliminary Objections, Merits, Reparations, and Costs, Judgment, Inter-Am. Ct. H.R. (ser. C) No. 298, ¶¶ 175–191 (Sept. 1, 2015).

[93] *See id.* ¶¶ 226–229.

[94] *See id.*

[95] I.V. v. Bolivia, Case 12.655, Inter-Am. Comm'n H.R., Report No. 72/14, ¶ 100 (2014).

[96] *Id.* ¶ 123.

[97] I.V. v. Bolivia, Preliminary Objections, Merits, Reparations and Costs, Judgment, Inter-Am. Ct. H.R. (ser. C) No. 329, ¶ 243 (Nov. 30, 2016) (translated from text in

part of women's vulnerability to being involuntarily sterilized is biological, noting that "the fact that women are the sex with the biological capability of pregnancy and childbirth exposes them in that the occurrence of sterilizations without consent is frequently during a Caesarean [section]."[98] Thus, because women have unique biological functions, as well as vulnerabilities from their social roles, a sterilization practice or program that is neutral on its face may well have a discriminatory effect because such neutrality does not factor in women's unique needs in reproductive health and their contacts with the health system.

B. Discrimination Based on Bias and Misinformation

Not only does involuntary sterilization amount to substantive discrimination against women because BTL is a practice that targets women in practice within health systems, it also reflects deeply embedded biases about women, and certain types of women in particular, whether from marginalized communities or those living with HIV. Jelke Boesten notes that biases contributed heavily to the mass sterilizations performed in Peru in the 1990s, including sexism that fostered a "structural character of aggressive and even violent behavior towards women in the healthcare system" and "racist attitudes of the local healthcare providers," including the belief that "indigenous women and men were not capable of understanding birth control methods."[99] For the purposes of this article, one key contributing stereotype is the idea that women generally, and women living with HIV in particular, are incapable of making choices in the best interest of their children or potential children. This stereotype is used to justify withholding information about sterilization to women or using coercion to pressure them into undergoing sterilization, resulting in procedures being performed without full and informed consent. "These gender stereotypes," the IACHR said in its recent case on involuntary sterilization, "come from individual and collective preconceptions about women's social roles and capacities," and result "in women being denied certain abilities—such as the capacity to autonomously make decisions concerning their health."[100]

The IACHR, in its ruling against Bolivia, noted that "the persistence of gender stereotypes in health services results in women being denied certain

---

Spanish: "Aunque la esterilización es un método utilizado como anticonceptivo tanto por mujeres como hombres, las esterilizaciones no consentidas afectan de forma desproporcionada a las mujeres exclusivamente por esta condición en razón que se les asigna socialmente la función reproductora y de planificación familiar.").

[98] *Id.* (translated from text in Spanish: "el hecho de que las mujeres son el sexo con la capacidad biológica de embarazo y parto, las expone a que durante una cesárea sea frecuente la ocurrencia de esterilizaciones sin consentimiento.").

[99] Jelke Boesten, *Free Choice or Poverty Alleviation? Population Politics in Peru under Alberto Fujimori*, 82 EUR. REV. LATIN AM. & CARIBBEAN STUD. 3, 13–14 (2007).

[100] I.V. v. Bolivia, Case 12.655, Inter-Am. Comm'n H.R., Report No. 72/14, ¶ 131 (August 15, 2014).

abilities—such as the capacity to autonomously make decisions concerning their health."[101] They pointed to signs that the medical team that performed the surgery on petitioner I.V. had been influenced by gender stereotypes, noting:

> The medical decision to practice sterilization without I.V.'s informed consent reflects a notion that medical personnel are empowered to take better decisions than the woman concerned regarding control over reproduction. Accordingly, the [IACHR] considers that the presence of these kinds of gender stereotypes in the actions of health personnel has a different impact on women than on men and leads to the former being discriminated against in health services and especially in the delivery of sexual and reproductive health care services.[102]

They also noted that the IACHR had previously underscored that permitting gender stereotypes in the health sector was as an obstacle to women's access to maternal health services, which in turn constituted discrimination.[103]

The IACHR also pointed to a 2012 Colombian case about access to contraception which found that the denial of information and informed choice to women perpetuates the cycle in which they are perceived to be incapable of fulfilling this role.[104] The Constitutional Court of Colombia explained that "one of the mechanisms for perpetuating the historical discrimination experienced by women has been, and continues to be, precisely, to deny or hinder the access to accurate and impartial information on this subject with the objective of denying them control over these types of decisions."[105] This brought the court "to conclude that women's right to health has been threatened because, as has been seen, this right includes access to reproductive health information, especially for women."[106] This reflects one of the core principles of the International Conference on Population and Development in Cairo in 1994—which took place two decades before the SDGs were set—which states, "[r]eproductive health-care programmes should provide the widest range of services without any form of coercion," and that all people are entitled to "the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education

---

[101] *Id.*

[102] *Id.* ¶ 162.

[103] *See id.*

[104] *See id.* ¶ 133.

[105] Corte Constitucional [C.C.] [Constitutional Court], agosto 10, 2012, Sentencia T-627-12, Gaceta de la Corte Constitucional [G.C.C.] (¶ 65) (Colom.), http://www.corteconstitucional.gov.co/relatoria/2012/T-627-12.htm [https://perma.cc/93BM-QMK3] (translated in *I.V. v. Bolivia*, *supra*).

[106] *Id.* (translated from text in Spanish: "concluir que se amenazó el derecho a la salud de las mismas debido a que, como se vio, este derecho incluye el acceso a la información sobre salud reproductiva, especialmente en el caso de las mujeres").

and means to do so."[107] Thus, the stereotype that women are incapable or undeserving of making their own reproductive health decisions leads to a parallel denial of information—because if they are not decision-makers, it is unnecessary to provide women with all the relevant information on which to make a decision—and, as a result, denial of effective enjoyment to the right to health.

Similar reasoning had been utilized in Peru in the above-mentioned "systematic government policy to stress sterilization as a means for rapidly altering the reproductive behavior of the population, especially poor, Indian [sic], and rural women."[108] The petitioner, Mamérita Mestanza—who died following the sterilization procedure—had been "subjected to various forms of harassment, including several visits in which health personnel threatened to report her and [her husband] to the police," until she submitted to be sterilized.[109] Importantly, the Peruvian state admitted that ending the practice of involuntary sterilization will require "eliminating any discriminatory approach and respecting women's autonomy," rather than accepting that women's decisions should be made for them.[110]

Gender biases combine with misinformation about HIV to create the toxic conditions that sometimes produce involuntary sterilization: i.e., the belief that these women cannot be trusted to follow medical advice and regimens to safely bear children, or to care for their children in general. This situation has been observed in Kenya, where two cases pending before the High Court at Nairobi implicate this issue.[111] The Kenya National Commission on Human Rights, in investigating abuses against Kenyan women living with HIV, found that the country has a systemic problem of "[f]orced sterilisation of HIV positive women with or without their knowledge," and cited the correlated fact "that widely there was a belief that women living with HIV should never bear children."[112] Another study conducted in Kenya found that only fifty-eight percent of HIV counselors discussed with patients the implications that condom use would have on their ability to conceive children, and that ninety percent of people testing positive were not referred for family planning assistance, reflecting a "perceived inability of HIV patients to comprehend" the risks involved and to make an informed decision

---

[107] U.N. Population Fund, *Programme of Action of the International Conference on Population Development: 20th Anniversary Edition* 13–14 (2014), http://www.unfpa.org/sites/default/files/pub-pdf/programme_of_action_Web%20ENGLISH.pdf [https://perma.cc/4U79-E7AD].

[108] Mestanza Chavez v. Peru, Petition 12.191, Inter-Am. Comm'n H.R., Report No. 71/03, ¶ 9 (2003).

[109] *Id.* ¶ 10.

[110] *Id.* ¶ 14(11).

[111] *See generally* S.W.K. v. Medecins Sans Frontieres (2018) eKLR (H.C.K.) (Kenya); L.A.W. v. Attorney General (2018) eKLR (Kenya).

[112] Kenya Nat'l Comm'n on Human Rights, Realising Sexual and Reproductive Rights in Kenya: A Myth or Reality? 115 (2012), http://www.knchr.org/Portals/0/Reports/Reproductive_health_report.pdf [https://perma.cc/2D9Q-TUJU].

in the best interest of their family.[113] Additionally, the UN Committee on Economic, Social and Cultural Rights, in responding to the Kenyan government's latest report on conditions in the country, found that the law on sexual and reproductive rights is designed not to help women prevent HIV transmission to their children, but rather to punish women whose children are born with HIV.[114] The fact that a mother would be subject to imprisonment if she transmitted HIV to a child further entrenches in law a system of blaming and shaming women for their perceived failures as mothers—and in turn, as women—rather than one that helps them to pursue goals of having and raising healthy children.[115] The CESCR conclusions with respect to Kenya echo a general observation by WHO about women living with HIV around the world: "In some instances, women living with HIV agree to sterilization on the basis of lack of information or misinformation about their reproductive options," which is the result of providers seeking to impose their opinion on women rather than informing them and allowing them to decide.[116]

As noted above, embedded in the stereotype that women living with HIV cannot be trusted to make their own reproductive decisions and care for their own families are misconceptions based on prejudice, not on empirical evidence. WHO has found that motherhood is generally safe for women living with HIV, but that providers are largely biased against these women and misinformed about the facts.[117] For example, one study found that there is only a two percent chance of mother-to-child transmission when the necessary steps are taken to prevent infection; nevertheless, two-thirds of the women interviewed were told by their health care providers that women living with HIV should not bear children, and half were actively discouraged from having children themselves.[118] The stereotype also runs counter to the reality that many women living with HIV want to at least preserve the option of

---

[113] Shalini Bharat & Vaishali Sharma Mahendra, *Meeting the Sexual and Reproductive Health Needs of People Living with HIV: Challenges for Health Care Providers*, 15 Reprod. Health Matters 93, 99 (2007).

[114] *See* Comm. on Economic, Social and Cultural Rights, *Concluding Observations on the Combined Second to Fifth Periodic Reports of Kenya*, ¶ 55, U.N. Doc. E/C.12/KEN/CO/2-5 (April 6, 2016), http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=E%2fC.12%2fKEN%2fCO%2f2-5&Lang=en [https://perma.cc/RJQ4-VV6X].

[115] *See, e.g.*, UNAIDS, *Ending Overly Broad Criminalization of HIV Non-disclosure, Exposure and Transmission: Critical Scientific, Medical and Legal Considerations* 24 (2013), http://files.unaids.org/en/media/unaids/contentassets/documents/document/2013/05/20130530_Guidance_Ending_Criminalisation.pdf [https://perma.cc/AGY2-PSH5]; Anand Grover (Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health), *Rep. of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, ¶¶ 66–71, U.N. Doc. A/HRC/14/20 (Apr. 27, 2010), http://www2.ohchr.org/english/bodies/hrcouncil/docs/14session/A.HRC.14.20.pdf [https://perma.cc/2Y2V-UT5B].

[116] WHO, Interagency Statement, *supra* note 24, at 3.

[117] *Id.* at 3–4.

[118] Ctr. for Reprod. Rights, Dignity Denied: Violations of the Rights of HIV-Positive Women in Chilean Health Facilities 25 (2010).

motherhood. According to Professor Sofia Gruskin, "Research results have indicated that when women are asked if a positive HIV status would impact on their decision to bear children, they have made clear that it would not."[119] The idea of women living with HIV being ineligible for motherhood thus reflects neither scientific data nor the lived experience and expectations of the affected women.[120] And yet, the infantilizing stereotype that women living with HIV cannot be "trusted" to follow medical advice persists even when women have demonstrated adherence to HIV regimens and have sought out assistance in ensuring a safe pregnancy and delivery. WHO has found that providers are often driven by biases, coupled with poor information about HIV transmission, rather than objectively assessing a woman's options and risks and allowing her to make her own informed decision.[121]

C. Reasons for Involuntary Sterilization Rooted in Normative Assumptions

Also reflected in the practice of involuntary sterilization of women living with HIV is a normative assumption that women living with HIV are *undeserving* of making their own decisions about whether or not to have children. This assumption is closely related but distinct from biases and misinformation about women's actual capacities. That is, when women living with HIV are viewed as undeserving of being mothers and/or as having HIV because of sinful sexual transgressions, it is thought that they should not be the ones who make reproductive choices at all. Under this demeaning view, women are reduced to sexual objects and instruments of childbearing. Just as it is someone else who so often decides when they get pregnant and have children—often men—it is similarly acceptable for a social worker or health care provider to decide that they should not have children. When women are not viewed as capable of making responsible choices about fundamental decisions—from sex to childbearing—and are not viewed as deserving agency over their lives, they are dehumanized and stripped of their basic human dignity.

Further, these normative assumptions create and reflect narratives that transform structural political failures into personal moral deficiencies. Women and girls often contract HIV due to "widespread poverty, which induces transactional sex at an early age, including to pay for school fees; gender inequalities in property rights and marriage and divorce rights, which give women little room to protect themselves from unsafe sex; and early marriage to much older men who may well be HIV positive."[122]

---

[119] Gruskin, *supra* note 58, at 1193–94.

[120] *See* Emily Esplen, Women and Girls Living with HIV/AIDS: Overview and Annotated Bibliography 16 (2007).

[121] WHO, Interagency Statement, *supra* note 24, at 3–4.

[122] Norman Daniels, Just Health 301 (2008).

The transfer of responsibility for controlling the spread of HIV from the state to individual women who face impoverishment and disempowerment, and the subsequent classification of involuntary sterilization as justified by these individuals' "sinful transgressive decisions," is the height of cynicism and injustice. It takes one of the few fundamental aspects of human agency that these marginalized women have left—whether or not to have children—and strips them of it. In examining the choice of women living with HIV to be mothers, researchers have found that "in many cultures, an essential dimension of the expectations for a woman's sense of personal satisfaction or self-esteem is the value placed on pregnancy."[123] Thus, lack of control over life plans and stigma are greatly exacerbated when the possibility of motherhood is stripped from these women for being "unworthy."

In short, involuntary sterilization based on programs that rely on BTL inherently discriminates against women because only women are subject to BTL. Many of these programs are rooted in misinformation and biased assumptions about the ability of women living with HIV to follow their regimes and take care of their children. In turn, these practices are also often based upon normative assumptions about women living with HIV being undeserving of having children and families, which reflect social norms that accept shifting responsibility for structural political failures to the most disadvantaged of women.

V. Responsibility of National Tribunals to Condemn Involuntary Sterilization of Women Living with HIV as Intersectional Discrimination

The success of the SDG agenda, and social policies in general, depend upon the political will, capacity, and competence of the executive and legislative branches of government, as well as appropriate international assistance and cooperation. Nevertheless, as the guardians of constitutional and other fundamental normative commitments, undertaken through international law, courts may well find themselves in positions where they are adjudicating cases involving allegations of involuntary sterilization. The UN Secretary-General's Independent Accountability Panel for the Global Strategy (on which one of this Article's authors, Yamin, sits)[124] has specifically stated that independent judiciaries have an important role to play in enhancing accountability for progress and "can lead to actions from the executive and legislature, and mobilization from civil society, that produce transformative changes in the health sector that transcend discrete remedial action and

[123] Gruskin, *supra* note 58, at 1193–94.

[124] Note that all opinions expressed in this article are personal and do not necessarily reflect those of the UN Secretary General's Independent Accountability Panel.

feed back into the circle of learning and improvement."[125] Judicial remedies may take multiple forms including restitution, compensation, satisfaction, and/or guarantees of non-repetition.[126]

The harms noted in the section above violate myriad international and regional legal agreements with respect to human rights, as well as the constitutional and legislative principles of many domestic legal systems. While the examples of cases above show international and regional tribunals ruling against states in instances of involuntary sterilization, human rights are ultimately enjoyed at a national level. These rights should be protected and enforced at a national level as well, especially given the difficulty, requirements, and sheer time delays inherent in accessing supra-national tribunals.

International law binds states to provide citizens "an effective remedy by the competent national tribunals for acts violating the fundamental rights granted him [or her] by the constitution or by law,"[127] and Goal 16 of the SDGs calls for access to justice as an integral part of achieving the whole SDG agenda.[128] Importantly, judicial remedies not only resolve disputes; they also orient social norms, including gender-related norms, and structure institutional practices, including those of the health system.[129] Thus, it is critical that courts do not restrict their analysis to one or two of the surface issues that involuntary sterilization represents, such as the failure of the individual actors involved to follow informed consent policies. Such an approach may be counterproductive in scapegoating frontline health workers. But perhaps even more importantly, it would do little to change the underlying dynamics at work in societies that marginalize and punish women living with HIV. It is critical that courts recognize the intersectional discrimination that women living with HIV face, address the stereotypes they are subjected to, and develop solutions that seek to elevate their place in society and break down the barriers that prevent them from enjoying full citizenship and its accompanying rights.

A decision by the Supreme Court of Namibia regarding the sterilization of women living with HIV illustrates the shortcomings of a superficial approach. In that 2014 case, the court ruled in favor of women living with HIV who had been sterilized without giving full and informed consent because

---

[125] U.N. Secretary-General, Independent Accountability Panel, *Old Challenges, New Hopes: Accountability for the Global Strategy for Women's, Children's and Adolescents' Health* 11 (2016), http://www.iapreport.org/downloads/IAP_Report_September2016.pdf [https://perma.cc/Q5TS-HZ6D] [hereinafter IAP, *Old Challenges*].

[126] Human Rights Council, *Rep. of the Office of the United Nations High Commissioner for Human Rights: Technical Guidance on the Application of a Human-Rights Based Approach to the Implementation of Policies and Programmes to Reduce Preventable Maternal Morbidity and Mortality*, ¶ 76, U.N. Doc. A/HRC/21/22 (July 2, 2012).

[127] Universal Declaration of Human Rights, *supra* note 26, at art. 8.

[128] SDGs, *supra* note 3, at 14.

[129] *See generally* Alicia E. Yamin, *Taking the Right to Health Seriously: Implications for Health Systems, Courts and Achieving Universal Health Coverage*, 39 Hum. Rts. Q. 341 (2017).

they were in labor when the disputed consent was supposedly given.[130] It was clear that providers were employing their own judgment over that of their patients.[131] Having noted that the Constitution's protections of bodily integrity, dignity, and family life required women to make their own decisions about sterilization,[132] the court ruled that "the doctors should not have sterilized the respondents because of the circumstances in which the consent was obtained."[133] However, the court explicitly refused to speak as to the relevance of the women's HIV status, the possibility of discrimination having played a role in the providers' actions, and the protections against such discrimination afforded by the constitution. Instead, these claims were swiftly dismissed, with the court stating that "there was absolutely no evidence on the record to support the respondents' belief, as articulated in their evidence, that there was in place a policy or arrangement to sterilise women of child-bearing age who were HIV positive."[134] In taking this narrow view, and requiring the existence of a formal policy based upon discrimination, the court utterly failed to consider the level of discrimination and bias faced by women living with HIV in practice in Namibia, and the likelihood that such a bias could be at work even absent a formal policy to sterilize women based on their HIV status. Moreover, the court took this approach despite having determined that the accused healthcare providers, with an "attitude smack[ing] of medical paternalism,"[135] "appeared to have formed the opinion that sterilization was the best option available to the respondents, presumably because—as one of the doctors put it . . . BTL would offer a 'final solution.'"[136] Examining the acts committed in a social vacuum, the court chose to place the burden entirely on the plaintiffs to prove both that discrimination had occurred, and that such discrimination explicitly played a role in what the court itself found was a violation of their rights.

In its decision, the Supreme Court of Namibia missed an important opportunity to address the underlying social and gender dynamics that enabled the practice of involuntary sterilization, including the stereotypes about women living with HIV, the discrimination women with HIV face in Namibian society, and the lack of attention given to their dignity within the health system. This omission came at a time in which researchers from Harvard Law School had found that Namibian health facilities segregated women living with HIV, refused care to some women living with HIV during delivery, and regularly denied information on treatments including sterilization.[137] The researchers noted the tendency of providers to be "dismissive of HIV-

[130] *See* Republic of Namibia v. LM, (2014) SA 49/2012, ¶ 109 [SC] (Namib.).
[131] *See id.* ¶ 105.
[132] *See id.* ¶ 3.
[133] *Id.* ¶ 107.
[134] *Id.* ¶ 2.
[135] *Id.* ¶ 104.
[136] *Id.* ¶ 103.
[137] Aziza Ahmed, Mindy J. Roseman & Jennifer Gatsi-Mallet, "At the Hospital There Are No Human Rights": Reproductive and Sexual Rights Violations

positive women's concerns or understanding of their care."[138] They also found "that significant numbers of women living with HIV have been coerced or forced into sterilization procedures by hospital personnel without being properly advised on the medical realities of having children as an HIV-positive woman."[139] And yet even when presented with information such as this on the realities of life as a woman living with HIV by Harvard and other researchers on behalf of the plaintiffs, the Supreme Court of Namibia refused to even consider the question of discrimination without proof of a formal policy that treated these women differently.

In two cases currently pending before it, the High Court in Nairobi, Kenya, has an opportunity to take a different course and create transformative narratives for disempowered women living with HIV. One case involves a woman who had a BTL procedure performed entirely without her knowledge while in the hospital to receive maternal care;[140] the other involves several women who were financially coerced or misled with incomplete information into having BTL procedures performed.[141] Kenya's constitution guarantees the right to healthcare, explicitly including reproductive health,[142] as well as gender equality,[143] and requires the state to "take legislative and other measures . . . designed to redress any disadvantage suffered by individuals or groups."[144] Indeed, the Kenyan judiciary has ample legal leeway to take a comprehensive and intersectional approach to issues of gender-based discrimination and vulnerability, such as involuntary sterilization against women living with HIV.

The 2010 Kenyan Constitution is an iconic social charter filled with transformative aspirations for a society once riven by tribal, class, and gender cleavages. As the High Court itself noted in a 2012 case regarding women who were imprisoned for their failure to pay hospital bills immediately after delivering children: "[T]he people of Kenya gave to themselves a very expansive Bill of Rights, the purpose of which was to ensure the social transformation that they have been yearning for."[145] Applying this concept in the context of reproductive health, the court there explained that Kenya:

> has a constitutional and international law obligation with respect to ensuring that its citizens have access to the highest attainable standard of health, and specifically with respect to women, that they have access to reproductive health care. . . . Despite these obligations placed on the state under national and international law . . . a

---

OF WOMEN LIVING WITH HIV IN NAMIBIA 4–5 (2012), https://repository.library.northeastern.edu/files/neu:332803 [https://perma.cc/Y7HB-RA4T].

[138] *Id.* at 5.

[139] *Id.* at 28.

[140] *See* L.A.W. v. Attorney General (2018) eKLR (H.C.K.) (Kenya).

[141] *See* S.W.K. v. Medecins Sans Frontieres (2018) eKLR (H.C.K.) (Kenya).

[142] CONSTITUTION art. 43(1)(a) (2010) (Kenya).

[143] *Id*. at art. 27(3).

[144] *Id*. at art. 27(6).

[145] Omuya v. the Attorney General & Others, (2012) eKLR, ¶ 68 (H.C.K.) (Kenya).

> large number of women do not benefit from the protection afforded under the Constitution and international law.[146]

The court went on to adopt much of the rationale of the CEDAW Committee in its *Alyne* decision.

The Constitution of Kenya, in establishing a right to health, specifically notes the importance of reproductive health care, declaring: "Every person has the right . . . to the highest attainable standard of health, which includes health care services, including reproductive health care."[147] The constitution also establishes that: "Women and men have the right to equal treatment, including the right to equal opportunities in political, economic, cultural and social spheres."[148] Not only are individuals banned from discriminating directly or indirectly on the basis of sex or health status,[149] but the government is required to "take legislative and other measures . . . designed to redress any disadvantage suffered by individuals or groups."[150] Therefore, the judiciary in Kenya is well positioned to address the involuntary sterilization of women living with HIV in a comprehensive manner, as noted above. If it does issue a decision that recognizes the unique and challenging situation faced by women living with HIV in Kenyan society, and the role that such status plays in the act of sterilization without full and informed consent, the High Court would be setting an example that could then be followed by other courts within the region and beyond when facing similar claims.

The Kenyan High Court, and others in Africa, could also look towards the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (also known as the "Maputo Protocol"), which offers protections against sterilization without full and informed consent. Specifically, the Maputo Protocol requires states to guarantee women "the right to respect as a person,"[151] to "implement appropriate measures to prohibit any exploitation or degradation of women,"[152] and to ensure for each woman "respect for her dignity and protection . . . from all forms of violence."[153] Notably, in requiring states to ensure the right to health for all women, on the basis of non-discrimination, the Maputo Protocol specifically requires states to recognize "the right to decide whether to have children"[154] and "the right to choose any method of contraception."[155] The Maputo Pro-

---

[146] *Id.* ¶¶ 141–42.
[147] Constitution art. 43(1)(a) (2010) (Kenya).
[148] *Id.* at art. 27(3).
[149] *Id.* at art. 27(7).
[150] *Id.* at art. 27(6).
[151] Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa art. 3.2, July 11, 2003, http://www.achpr.org/files/instruments/women-protocol/achpr_instr_proto_women_eng.pdf [https://perma.cc/KBK3-C2WD] [hereinafter Maputo Protocol].
[152] *Id.* at art. 3.3.
[153] *Id.* at art. 3.4.
[154] *Id.* at art. 14.1(b).
[155] *Id.* at art. 14.1(c).

tocol is thus even more specific with respect to access to an array of contraception options, at the choice of the woman.

Further, given the prevalence of private sector involvement in health care in Africa and elsewhere, national tribunals have not only a responsibility to ensure that public sectors do not engage in the sterilization of women living with HIV, but also to ensure that these women are not subjected to such actions by private actors within the health system.[156] Governments have a responsibility to exercise due diligence in ensuring that private actors provide reproductive health services in keeping with fundamental normative commitments as well, as was explicitly recognized in the *Alyne* case described above.[157] In Kenya, the High Court has already recognized that individuals are still entitled to the right to health when interacting with the private sector, noting that the right of people living with HIV "to access essential medicine which they require on a daily basis in order to sustain life is far greater and more critical than the protection of the intellectual property rights" that Kenya had in place.[158] "The right to life, dignity and health," the court said, "must take precedence."[159]

Given the deeply embedded stereotypes that underlie the practice of involuntary sterilization of women living with HIV, and the discrimination these women encounter as a result of intersectional vulnerabilities, changing these practices is not easy. In many instances, dialogue among the branches of government and serious structural changes will be needed to ensure that any legal decision condemning involuntary sterilization has a lasting effect. Nonetheless, courts can and should play a fundamental role in this process by laying out specific steps for governments to take and requiring them to report back on their progress. Naming and subverting these harmful gender stereotypes when they are used to inflict egregious abuses of rights on the most disadvantaged women and girls in society would make a fundamental contribution toward the SDG agenda.

Conclusion

Despite recent rises in conservative nationalism, the world's agreement on the Sustainable Development Agenda—which addresses both gender and wealth inequalities within and between countries around the globe, as well as connections between health and health systems and access to justice—

---

[156] *See, e.g.*, Michael Stevenson, *The Entrenchment of the Public-Private Partnership Paradigm*, *in* Case Studies on Corporations and Global Health Governance: Impacts, Influence and Accountability 119, 124 (Nora Kenworthy, Ross MacKenzie, & Kelley Lee eds., 2016).

[157] CEDAW, Views, Alyne de Silva Pimental Teixeira v. Brazil, *supra* note 34, ¶¶ 7.5–7.8.

[158] P.A.O. v. Attorney General, eKLR (Kenya), ¶ 85 http://kenyalaw.org/Downloads_FreeCases/85611.pdf [https://perma.cc/LJ3U-4LJV].

[159] *Id.*

presents a remarkable opportunity for advancing women's health and rights, among other goals. Yet the world's promises of progress that "leaves no one behind" will reverberate as the height of cynicism and hypocrisy unless effective measures are adopted by policy makers, as well as oversight bodies, to ensure that the poorest and most marginalized women and girls are not casualties of an exclusionary development agenda. There is a very real risk that global targets and indicators, disconnected from the incentives and programs created on the ground, will not only mask the abuses involved in violations of informed consent, but also encourage them by measuring outcomes in contraceptive and HIV prevalence without relation to power dynamics and context. This Article has suggested that nation states and global institutions must ensure that societies and health systems are actually honoring their commitments to the most vulnerable women and girls. This Article has further argued that independent judiciaries have an important role to play in this regard.

When it comes to the prevention and treatment of HIV, much work is needed to ensure that equity for the most vulnerable is realized. For example, methods for HIV prevention have expanded greatly in recent years, but the majority of the world's poorest women have not benefited from these developments. Similarly, improvements in treatment for people living with HIV have hardly been uniformly beneficial. Many women at risk for or living with HIV are still being left behind by their health systems as a result of resource constraints, priority setting, or both. Tragically, with HIV—to a degree that is perhaps unique among the world's infirmities—women who are inflicted are also all too often made to suffer discriminatory treatment and marginalization based on their status not just as persons living with HIV but as *women* living with HIV. And, of course, this marginalization is exacerbated even further by factors such as race, ethnicity, and socioeconomic status.

While some limitations to healthcare expenditures for people living with HIV are no doubt reasonable in making fair decisions on the path to universal health coverage, and governments are not required to provide every possible healthcare intervention to meet the promise of the "highest attainable standard of health,"[160] governments *must* ensure that no additional harm is done to the most vulnerable in society. In the case of sterilization without full and informed consent, governments actually permit precious resources to be expended *not* to improve the lives of women living with HIV but to shame, harm, and punish them for what are structural political failures. The world today, at the beginning of the SDG era, is one of almost unfathomable inequity and one in which medical advances, including with respect to HIV, are progressing rapidly for the world's well-off, but not for impoverished women who lack basic control over their bodies and lives.

[160] ICESCR, *supra* note 27, at art. 12(1).

This Article has argued that the sterilization without full and informed consent of women living with HIV is a manifestation of the intersectional discrimination that they face. Their sex, HIV status, and often a combination of other factors such as race and economic status together make these women vulnerable to coercion at the same time as they make them a likely target of programs aiming to control a disfavored group. The discrimination underlying involuntary sterilization of women living with HIV is inherent discrimination given that the practice of involuntary sterilization inevitably has a distinct and disproportionate effect on women; this discrimination also has as its basis misinformation about women living with HIV, including that they cannot make decisions in their own best interest, as well as normative assumptions that they do not *deserve* to make their own decisions. When sterilization without full and informed consent is perpetuated against these women, many essential human rights—including to health, to be free from torture and other inhuman treatment, to form a family, and to dignity—are violated, as the health system acts to exacerbate exclusion and marginalization in the overall society.

The issue of sterilization without the full and free consent of women living with HIV highlights that neither efforts against HIV nor efforts to promote contraceptive access will succeed in reducing social inequities if they are purely technical or bureaucratic initiatives. Transforming conditions for women to thrive, as called for in the Global Strategy, requires commodities and services. But it also requires a deconstruction of the biases, stereotypes, and stigma associated with these issues, as well as an effort to address the social inequities with which they interact. Only when this is done can the governments of the world hope to live up to the promises made in the Sustainable Development Agenda, and, even more importantly, to the vision set out in the Universal Declaration of Human Rights, in which *everyone* can live in a "social and international order" where all of the rights in the Declaration are enjoyed.[161]

[161] Universal Declaration of Human Rights, *supra* note 26, at art. 28.