

## VI. ACCESS TO HEALTH SERVICES IN RELATION TO SEX AND SEXUALITY

### A. INTRODUCTORY REMARKS<sup>697</sup>

Health services, as well as health systems that organize and ensure the appropriate delivery of health services and goods, are essential for the promotion of sexual health.

The structure and delivery of health care must be seen as contributing to the experience of being a full valued member of one's society.<sup>698</sup> A health and human rights-based approach to health services focuses not only on the technical and clinical quality of services, but also on the design, delivery, and use of these services. In addition to evaluating the impact of health services on the rights to health and life of all persons without discrimination, a rights-based analysis examines how the structure and delivery of sexual health services interacts with other key human rights principles. This includes assessing the legal and policy framework of health services with attention to values of equality, dignity, freedom, and autonomy for all. Such evaluations address the laws and policies determining the distribution, content, accessibility, and delivery of services, as well as accountability for inadequate services. Moreover, a rights-based framework recognizes that untreated or inadequately treated sexual health conditions are themselves often a source of stigma for affected persons and groups.

While the state is ultimately responsible for ensuring the availability, accessibility, acceptability, and quality of health services, the state itself is not the only provider of these services.<sup>699</sup> The state remains responsible, however, to ensure that non-state actors do not discriminate and that non-state actors providing services to marginalized populations are not themselves discriminated against nor face restrictions on their rights to association and expression.

Four key aspects of accessibility for health services have been spelled out in international human rights law and are applicable to services necessary for sexual health: (1) non-discrimination, which in the sexual health context means that health services must be accessible without discrimination, including on the basis of sex, gender, sexual conduct, marital status, or sexual orientation; (2) physical accessibility, which requires health services to be within safe physical reach of all persons, including persons in detention, refugees, and women facing restrictions on movement; (3) economic accessibility, which means that health services are affordable to all, including marginalized populations; and (4) information accessibility, meaning the right to seek, receive, and impart information and ideas concerning sexual health, including the availability of relevant services, even services challenging dominant sexual mores.<sup>700</sup>

Each of these four aspects must be considered in connection with the wide array of health services important to sexual health. The scope of these services includes the prevention and treatment of STIs and HIV/AIDS (including voluntary testing, post-exposure prophylaxis, and access to anti-retroviral therapies); contraception (including condoms and emergency contraception); and abortion services. Laws that erect barriers to access to contraception or safe abortion services deny girls and women their fundamental right to determine if and when sexual activity will become reproductive, thereby reducing their sexual well-being. Laws that fail to provide adequate access to goods and services in the context of sexual assault (such as forensic tests as well as treatment of injuries and STIs) also have a seriously negative impact on the right to (sexual) health as well as on other rights.

In general, an analysis of health service laws must consider not only the necessary scope of the laws, but also the barriers that specific populations and marginalized sub-groups may face. Does the law on its face or in practice exclude unmarried women from, for example, accessing contraception? Does the law provide for information on and distribution of sexual health services in ways that will reach young married women or men who have sex with men? Is the privacy of persons seeking information and services protected explicitly, or does the law subordinate their rights to police registration of HIV status of sex workers, for example? Are there other laws penalizing behaviour, such that a person seeking care would be reluctant to disclose his or her actual sexual practices? Do the services reach populations in prison and non-nationals, including migrants, refugees, and so-called undocumented persons? Are insurance or social welfare schemes supporting access to health services non-discriminatory and adequately accountable to meeting health and rights protections?

697 These introductory remarks have been drawn from general WHO chapeau text elaborated by Alice M. Miller and Carole S. Vance.

698 See UN Millennium Project, Task Force on Child and Maternal Health (2005).

699 General Comment 14, CESCR; see also General Comment 3, CESCR. For further discussion, see International Human Rights Law section, [add place].

700 General Comment 14, CESCR.

HIV status (actual or imputed) can also function as a major barrier to accessing general health services, or conversely, HIV positive status can result in coercive services (for example, mandatory testing). Specific groups, such as persons in sex work or men having sex with men can also be singled out for coercive health services (mandatory health checks and tests). These services are often rationalized as public health measures but fail on both effectiveness and ethical grounds.<sup>701</sup>

Persons under 18 years of age face particular barriers in accessing sexual health services, care, and information. The right for all persons to consent to health services and procedures is fundamental. Generally, the parents or guardians of minors may retain formal powers of consent. However, respect for the principles of the evolving capacity of the child and of his or her best interest suggests that older adolescents should be able to access appropriate and necessary services without recourse to parental involvement or consent. In addition, the right to enjoy confidentiality in regard to sexual health services and care should be respected. Persons under the age of 18 have the right to accurate, comprehensive, and age-appropriate sexual health information, following from their general right to information. This right applies regardless of the nature of the provider (state or non-state actor), and the information may not be restricted on discriminatory grounds (for example, sex, gender, or sexual orientation).

## **A. ABORTION AND CONTRACEPTIVES**

### **1. Introduction**

As noted above, access to contraceptives and to safe and legal abortions is relevant for sexual health in multiple ways. Easily available contraceptives, accessed without discrimination, enable women and men to freely decide if they want sexual activity to result in reproduction, which results in significant advantages for their sexual health. Access to abortions enables women to exercise control over their bodies in the case of unwanted pregnancies. Furthermore, termination of a pregnancy is sometimes necessary to preserve the physical and mental health of the woman, including when the pregnancy was a consequence of rape.

The UN Committee on the Elimination of Discrimination Against Women has stated that “barriers to women’s access to appropriate health care include laws that criminalize medical procedures only needed by women and that punish women who undergo those procedures.”<sup>702</sup> In the context of abortion, this can be translated into an obligation to provide abortion services at a minimum when the health of the pregnant woman is at stake and when pregnancy is the result of rape.<sup>703</sup> It is important to keep in mind, however, that access to abortion is always facilitated best where abortion is available on request, even when the woman’s health is what motivates her to seek the procedure. In those cases, she will not have to endure procedures that may be humiliating and lengthy, such as proving that her health condition is ‘sufficiently serious’ or obtaining a police report or court order that confirms she has suffered sexual violence. She will not have to go through complicated administrative processes to show that her condition falls under relevant provisions; experience shows that even when a woman’s condition is well within the legal framework, provisions that condition her right to the service tend to restrict availability in practice.<sup>704</sup> Furthermore, in countries where there are bars to legal abortion, whether total bans or conditions on availability, the prevalence of illegal and unsafe abortions is much higher than in countries where abortions are legal – which by itself constitutes a serious health risk to women.<sup>705</sup> Thus, the availability of abortion without restriction for a reasonable gestational period has significant advantages from a sexual health point of view.

As will be shown, many countries in Europe have permissive abortion laws, making abortion either available on request during the first trimester or providing broadly defined conditions that justify abortion during that period. There are exceptions, however, and also variations in how states have framed the right to abortion and specific elements of that right.

In regard to contraception, in many countries in the western part of the region access to contraceptives

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701 Systems that impose mandatory testing on certain groups based on their alleged or actual higher risk often drive persons further from care and services. These mandatory tests also violate medical norms in that testing is not provided for the health benefit of those tested, but rather for the good of others (most clearly shown in laws that mandate tests without providing for treatment of tested individuals). See also Chapter 1: Non-discrimination.

702 Committee on the Elimination of Discrimination Against Women, General Comment 24 (women and health), 5 February 1999, at [14].

703 See, for example, the reasoning of the Human Rights Committee in *KL v. Peru*, CCPR/C/85/D/1153/2003, decided on 17 November, 2005. Discussed in the International section of this project.

704 For examples of this, see *Tysiac v. Poland*, below, and *KL v. Peru*, op cit.

705 For clear evidence of this see the facts presented in *Safe Abortion: Technical and Policy Guidance for Health Systems*, WHO 2003, pp. 82–87.

is uncontroversial. In these countries, regulation tends to fall under general policies on health insurance coverage and access to medication, and not specific policies only addressing contraceptives. Condoms and most hormonal contraceptives are easily available without discrimination based on marital status or on other grounds. In many western European nations, contraception is publicly funded under public health insurance schemes. Some countries subsidize the cost of contraception for everyone, while others limit subsidies to women of a given age or income.<sup>706</sup> A few countries explicitly guarantee the right to access family planning methods in constitutional provisions or in statutes. Some courts in the region have addressed issues such as adolescents' access to contraception without parental consent and the conflict between access to contraception and the religious convictions of pharmaceutical providers.

Yet in several countries in the eastern part of the European region access to hormonal contraceptives is limited, primarily for economic reasons. Many states in Central and Eastern Europe lack legal and policy frameworks that protect reproductive rights. This, among other things, allows states to exempt contraceptives from state subsidies and from public health insurance coverage.<sup>707</sup> Therefore many women cannot afford modern family planning methods and thus their right to affordable and good-quality contraceptives is frequently violated.<sup>708</sup>

## 2. Council of Europe

### *Jurisprudence of the European Court of Human Rights*

#### **Abortion**

In *Tysiac v. Poland*,<sup>709</sup> the applicant was a woman who had suffered from myopia (nearsightedness) since she was a child. Upon learning that she was pregnant for the third time, she consulted different doctors to find out whether the pregnancy would have detrimental effects on her health in general and her eyesight in particular. The doctors concluded that the pregnancy and a potential delivery constituted risks to the applicant's eyesight but refused to issue a certificate for the pregnancy to be terminated. Under Polish law, abortion is prohibited except when the pregnant woman's life or health is in danger, the fetus is severely malformed, or the pregnancy was a result of rape. The applicant had her baby, and her eyesight deteriorated drastically. It was determined that she needed constant care and assistance in her daily life. The applicant lodged a criminal complaint in a Polish court against one of the doctors, alleging that his refusal to authorize an abortion caused her to suffer severe bodily harm by way of almost losing her eyesight. The complaint was dismissed.

In her case before the European Court of Human Rights, the applicant submitted that her right to respect for private life and her physical and moral integrity under Article 8 had been violated both substantively – as she had been denied a therapeutic abortion – and procedurally – as Poland had not lived up to its positive obligations to provide her with a comprehensive legal framework to guarantee her rights.

The Court noted that the issue was not whether the Convention guarantees a right to abortion but rather whether Poland met its obligation under the Convention to provide actual access to abortion under the specific provisions of Polish law that allowed the procedure in certain circumstances. The Court reaffirmed that states have certain positive obligations under Article 8. Once the state has decided that therapeutic abortions are legal under certain circumstances, the state must not arrange its legal framework in a way that severely limits access to such abortion in practice. Furthermore, relevant procedures must ensure that women have access to information about their rights under the abortion laws and that decisions on the legality on abortion be made in a timely fashion.

Without determining whether the applicant's health problems were sufficiently serious to qualify her for a therapeutic abortion under Polish law, the Court held that her fear of losing her eyesight was not irrational, and that the procedure leading to the conclusion that she could not terminate her pregnancy had several flaws. The Court concluded that Poland had failed to meet its positive obligation to secure the right to physical integrity arising under Article 8.

706 See Center for Reproductive Rights, "European Standards on Subsidizing Contraceptives" (September 2009). Available at [http://reproductiverights.org/sites/crr.civicaactions.net/files/documents/pub\\_fac\\_slovak\\_european%20standards\\_9%2008\\_WEB.pdf](http://reproductiverights.org/sites/crr.civicaactions.net/files/documents/pub_fac_slovak_european%20standards_9%2008_WEB.pdf). Last visited on 7 July 2011.

707 See Center for Reproductive Rights, "Calculated Injustice. The Slovak Republic's Failure to Ensure Access to Contraceptives" (2011), pp. 14–15 (hereinafter Center for Reproductive Rights 2011). Available at <http://reproductiverights.org/en/resources/publications/books-reports>. Last visited on 7 July 2011.

708 For a demonstration of how access to contraception is perceived as included in the right to sexual and reproductive health, see, for example, the UN Committee on Economic, Social, and Cultural Rights, in its Concluding Observations on Poland, U.N. Doc. E/C.12/1/Add.82 (2002), para 28, and its Concluding Observations on Armenia, U.N. Doc. E/C.12/1/Add.39 (1999), para 15.

709 Application no. 5410/03, decided 20 March 2007.

It is worth noting that the Court did not discuss the adequacy of the Polish law on access to abortion or whether there are rights-problems with a legal approach as restrictive as the Polish law. Nevertheless, the case has a clear impact on the issue of sexual health and rights. What was under examination was whether there was actual access to a therapeutic abortion, as provided for under Polish law and, more specifically, whether the procedure for determining whether such access should be granted complied with guarantees under the Convention. These procedures, the Court held, must provide the pregnant woman with the opportunity to question the examining doctors' conclusion if she is in disagreement with their findings. The procedures must be timely. It is not sufficient to provide mechanisms by which the pregnant woman retroactively can bring disciplinary or criminal proceedings against the medical personnel involved. In short, the right to abortion (a consequence of sexual activity) as prescribed by law must be translated into real access for the health of the woman to be preserved.

### **Domestic aftermath**

In September 2009, a Polish court awarded Ms Tysiac 7.400 euros in damages in her suit against a Catholic magazine that had compared her with a child murderer and had compared abortion to the experiments of Nazi war criminals at Auschwitz. The magazine stated that the judgment of the European Court of Human Rights compensated Ms Tysiac for wanting to kill her child. According to the Polish court in Katowice, southern Poland, Catholics have the right to express their disapproval with abortion, but they do not have the right to vilify individuals. The judge stated that the magazine had shown "contempt, hostility and malice" towards Ms Tysiac.<sup>710</sup>

In *A, B and C v. Ireland*,<sup>711</sup> the restrictive Irish law on abortion was challenged by three women who had traveled to England to terminate their pregnancies on different grounds. The Irish law only allows abortion when the life of the pregnant woman is in danger; not for health and well-being reasons. One of the women had suffered from alcoholism, depression and poverty and considered herself unfit to take care of a baby; the other initially feared an ectopic pregnancy and, while she knew at the time of travelling to England that this was not the case, she was not prepared to become a single parent; and the third suffered from a rare form of cancer and feared that a pregnancy could cause a relapse and thus be life-threatening to her. Applicants A and B complained that the prohibition of abortion for health and well-being reasons violated their right to respect for their private life under Article 8, and applicant C that the Irish failure to implement the legal right to an abortion in the case of a risk to the life of the woman violated the same article.

The Court first discussed the case of the first and second applicants. It acknowledged that the Irish law is out of line with the rest of Europe and, thus, that there was an undisputed consensus among Council of Europe states allowing broader access to abortion than under Irish law. It also noted that the restrictive law had had a negative impact on all three applicants. Nevertheless, by referring to the lack of any legal or scientific agreement in Europe about when life begins, and to the fact that the rights of the pregnant woman and the fetus are inextricably linked, the Court decided that the strong consensus among European states was not sufficient to narrow down the broad margin of appreciation afforded states in abortion matters. In applying the margin of appreciation, the Court noted that the applicants had been able to travel abroad to undergo abortions, and that the Irish law was based on "profound moral values of the Irish people in respect of the life of the unborn." The Court concluded that a fair balance had been struck between the rights of the pregnant women and the rights invoked on behalf of the unborn. Thus the rights of the first two applicants, A and B, had not been violated.

With regard to C, the Court examined the claimed failure of the Irish state to implement the one exception to the prohibition of abortion: the right to abortion in a case where the woman's life is in danger. It noted that no criteria had been laid down to interpret this principle, whether in legislation, case law or otherwise, by which to measure or determine the risk to the pregnant woman's life, meaning that the precise application of the law was uncertain. Since the exception for the right to life of the pregnant woman had been established in case law<sup>712</sup>, but no legal amendments had been made to the criminal provisions prohibiting abortion, these provisions on their face expressed an absolute prohibition. The Court held it for evident that this legal situation constituted a chilling factor for both women and doctors in the medical consultation process. It also found that the possible recourse to the courts to determine if a woman qualified for abortion under Irish law was ineffective and inappropriate. In conclusion, neither the medical consultation nor litigation options constituted effective and accessible procedures allowing the third applicant to determine whether she had a legal right to abortion. Thus, her right to her private life under Article 8 had been violated.

710 According to news reports, see BBC News, 23 September 2009, available at <http://news.bbc.co.uk/2/hi/europe/8271895.stm>. Last visited on 30 March 2010.

711 Application no. 25579/05, decided on 16 December 2010. Grand Chamber judgment.

712 *Attorney General v. X and Others* (1992) 1 IR 1

The A, B and C case is interesting in many ways. The Court's finding that the state has a positive obligation to legislate so that the exception to the prohibition of abortion will become real and not merely theoretical is important, and bears similarities with the outcome in the *Tysiac* case. The conclusions about the first two applicants, however, are confusing, and troubling from a health and rights perspective. The Court usually concludes that a strong consensus around a human rights issue in Europe significantly narrows down the margin of appreciation. Here, it found the opposite. In a strongly worded dissenting opinion, six judges expressed their dissatisfaction with this finding. They noted that the majority of the Court had shifted its focus away from the issue of balancing the right to life of the fetus against the right to health and well-being of the pregnant woman – an issue where most European states have determined that the health and well-being of the woman takes precedence. Instead, the majority of Court had focused on the question of when life begins – an issue where indeed a wide margin of appreciation exists. The dissidents called this disregard for the existence of a European consensus on the basis of moral views “a real and dangerous new departure in the Court's case-law.” Indeed, from a health and rights point of view, it is troubling that the Court failed to acknowledge that the woman's right to health and her right to life are inextricably linked, and that in the abortion context it is sometimes virtually impossible to distinguish one from the other. Therefore, a legal regime as strict as the Irish runs the risk to deny all women abortions, whether they seek them on life or health grounds.

In *R.R. v. Poland*,<sup>713</sup> the Court found for the first time that the denial of abortion-related medical service could amount to degrading treatment under Article 3. The applicant was a woman who, when 18 weeks pregnant, had learnt that her fetus might suffer from a severe genetic abnormality. Abortion is allowed under Polish law in cases of fetal abnormality. However, doctors refused to make a referral for an amniocentesis, which would determine the state of the fetus. The applicant saw several doctors in different parts of the country, all of whom refused to make the relevant referral and some of whom criticized her for considering an abortion. In one hospital she was made to stay for three days while tests unrelated to her concern were conducted. When she finally managed to have an amniocentesis – after reporting to a hospital as an emergency patient, claiming to suffer a miscarriage – she was in her 23rd week of pregnancy. When she received the results of the test two weeks later – confirming that the fetus had Turner syndrome – it was too late to have a legal abortion. She gave birth to a baby with Turner syndrome. She claimed before the European Court of Human Rights that she had suffered degrading treatment under Article 3 and that her right to respect for her private life under Article 8 had been violated.

The Court agreed. It noted that the applicant repeatedly had tried to obtain access to genetic testing and for weeks had been made to believe that she would undergo necessary tests. She was sent to different doctors, several far from her home, and was even hospitalized for no clear purpose. The Court also noted that she was in an extremely vulnerable position, having to “endure weeks of painful uncertainty concerning the health of her foetus, her own and her family's future and the prospect of raising a child suffering from an incurable ailment.” This anguish was further aggravated, according to the Court, by the fact that the diagnostic relevant services were at all times available and that she according to Polish law was entitled to them. All in all, concluding that the applicant had been “shabbily treated by the doctors dealing with her case,” the Court found that her suffering reached the level of degrading treatment, prohibited under Article 3.

In regard to the claim under Article 8, the Court repeated – referring to both *Tysiac* and to *A, B and C* – that once the decision to legally allow abortion in certain situations had been taken, there had to be a coherent framework in place to guarantee the practical access to the relevant health services. In particular, there had to be an adequate legal and procedural framework to guarantee that relevant, full and reliable information on the health of the fetus be made available to the pregnant woman. It reiterated that the Convention is intended to “guarantee not rights that are theoretical and illusory but rights that are practical and effective.” In this case, by failing to provide timely access to prenatal testing as guaranteed under Polish law, the Polish state had breached its positive obligations under Article 8.

The finding that humiliations suffered by a woman when denied abortion-related services may amount to degrading treatment under Article 3 is hugely important from a health and rights point of view. In addition, in its discussion on claimed violations under Article 8, the Court made an important remark. Discussing the right of physicians to refuse certain services on grounds of conscience, the Court stated that States are obliged to “organise the health services system in such a way as to ensure that an effective exercise of the freedom of conscience of health professionals [...] does not prevent patients from obtaining access to services to which they are entitled under the applicable legislation.” As references to a right to so-called conscientious objection in the abortion context are becoming increasingly common in Europe, this statement has great importance for the sexual health and rights of women in the region.

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713 Application no. 27617/04, decided on 26 May 2011.

Finally, it is worth noting that the applicant in the 2004 case *Vo. v. France*<sup>714</sup> requested that the Court hold that Article 2, the right to life, protects the life of the unborn. While the Court declined to do so, it did not hold that the Convention does *not* protect the life of the fetus.

### Contraceptives

In *Pichon and Sajous v. France*,<sup>715</sup> the Court considered the case of two pharmacy owners who on religious grounds refused to provide doctor-prescribed contraceptives to several women. They were subsequently found guilty of violating France's Consumer Code, which stated that it was prohibited to refuse to sell a product or provide a service to a customer for no legitimate reason.

The pharmacists contended that their rights to freedom of thought, conscience, and religion under Article 9 of the Convention had been violated. Thus, the case addressed the well-known issue concerning 'conscience clauses:' the conflict between respect for medical providers' individual religious beliefs and respect for patients' beliefs and health. The Court stated that the protection of freedom of religion in Article 9 "does not always guarantee the right to behave in public in a manner governed by that belief." It noted that the sale of contraceptives was legal and occurred on medical prescription nowhere other than in a pharmacy. Taking these facts into account, "the applicants [could not] give precedence to their religious beliefs and impose them on others as justification for their refusal to sell such products, since they [could] manifest those beliefs in many ways outside the professional sphere." Thus, the application was declared inadmissible.

### 3. European Union

While the European Court of Justice has determined that abortion services are medical activities that qualify as 'services' under the EC Treaty, it has also found that it is not contrary to Community law in a state where abortion is illegal to prohibit the distribution of information about where to obtain this service when the information providers are not directly linked to the overseas clinics.<sup>716</sup> The issue of *access to contraceptives or abortion* as a health and rights issue falls outside of the scope of binding EU law.

### 4. Regional non-binding material

Both the Parliamentary Assembly of the Council of Europe and the European Parliament of the EU have called for the liberalization of abortion. In *Resolution 1607 (2008), Access to safe and legal abortions in Europe*,<sup>717</sup> the Parliamentary Assembly calls on Council of Europe member states to decriminalize abortion within reasonable gestational limits, to guarantee women's effective right to access safe and legal abortions, and to lift restrictions that hinder, *de jure* and *de facto*, access to safe abortions. Its EU counterpart, in the *European Parliament resolution on sexual and reproductive health and rights*,<sup>718</sup> recommends that, "in order to safeguard women's reproductive health and rights, abortion should be made legal, safe and accessible to all," and that member states should refrain from prosecuting women who have undergone illegal abortions. Furthermore, the European Parliament calls upon the member states to provide sexual and reproductive health services that include high quality advice and counselling adapted to the needs of specific groups, such as immigrants. Addressing contraceptives specifically, the Parliament urges governments to strive to provide contraceptives free of charge or at low cost for "underserved groups" such as young people, ethnic minorities, and the socially excluded and to ensure that people living in poverty have better access to contraception and other means to prevent sexually transmitted diseases. The resolution also recommends that member states and candidate countries facilitate access to affordable emergency contraception.

### 5. Domestic legislation and case law

#### *Abortion*

In **Slovenia** the right to reproductive choice is recognized constitutionally. The *Slovenian Constitution* sets forth:

714 Application no. 53924/00, decided on 8 July 2004. This case is not discussed in detail here because it focuses on the potential right to life of the fetus rather than on health service-related issues.

715 Application no. 49853/99, *Admissibility decision*, decided on 2 October 2001.

716 Case C-159/90, *The Society for the Protection of Unborn Children Ireland Ltd. v. Stephen Grogan and others* [1991], ECR I-04685.

717 Adopted on 16 April 2008.

718 2001/2128 (INI), adopted 3 July 2002.

*Article 55 (Freedom of Choice in Childbearing)*

(1) *Everyone shall be free to decide whether to bear children.*

(2) *The state shall guarantee the opportunities for exercising this freedom and shall create such conditions as will enable parents to decide to bear children.*<sup>719</sup>

This right is regulated in a provision in the Slovenian Law of 20 April 1977 on medical measures to implement the right to a free decision regarding the birth of children,<sup>720</sup> which provides that abortion is available on request during the first ten weeks of pregnancy (Art 17). Abortion is free under the country's health care system. After the first ten weeks, abortion is permitted "if the procedure entails a risk to the woman's life, health or future motherhood that is less than the risk to the woman or the child associated with continuation of the pregnancy or childbirth" (Art 18). Slovenia does require parental authorization when the pregnant person is a minor.<sup>721</sup>

In the **Netherlands**, abortion is regulated in the Law on the termination of pregnancy of 1 May 1981 and the Decree of 17 May 1984 laying down provisions for the implementation of the Law on the termination of pregnancy.<sup>722</sup> Abortion is permitted on request of the pregnant woman at virtually any time between implantation and viability, if performed by a physician in a clinic licensed to perform the procedure. Hospitals that carry out abortions after 13 weeks of pregnancy must meet special requirements and must have received special approval (Section 6(2) of the Law, Chapter 4 of the Decree). Termination of a pregnancy when the fetus "may reasonably be assumed to be capable of remaining alive outside the mother's body" is a crime according to the Dutch Penal Code (Section 82a). According to reports, fetal viability is set at 24 weeks, but abortions are rarely performed after 22 weeks.<sup>723</sup> Parental or guardian consent is required for girls under 16 seeking abortion.<sup>724</sup>

Abortions may only be performed by physicians in a licensed hospital or clinic (Section 2 of the Law). A woman seeking an abortion must consult a physician, who is obliged to assess whether the woman has made the decision to terminate her pregnancy freely (Section 5(2)(b) of the Law). After the consultation, the woman has to wait six days before the termination of her pregnancy can be performed (Section 3(1) of the Law). Following the termination of the pregnancy, the law proscribes that the woman and those nearest to her "have access to adequate aftercare, including information regarding methods of preventing unwanted pregnancies" (Section 5(2)(d) of the Law). Furthermore, the clinic where the procedure is performed shall ensure that the privacy of the woman be respected to the extent possible, that she be "treated as a mature person," and that rules are adopted governing the independent hearing of complaints from her (Section 16 of the Decree). Abortion costs are reimbursed by the national health insurance.<sup>725</sup>

In **France**, the Law No. 2001-588 on Voluntary Interruption of Pregnancy and on Contraception<sup>726</sup> regulates abortion. Since 2001, abortion is available during the first twelve weeks if the woman is in a "state of distress" (Art L2212-1). It is the woman herself who determines whether this criterion is fulfilled, such that abortion in practice is available on request during the first trimester. The pregnant woman must consult with a doctor before the procedure, and it is also recommended that she consult with an appropriate family or social counselor (Art L2212-4). If she is a minor, the consultation with a family or social counselor is obligatory. However, interestingly, if the minor wishes to keep the termination of her pregnancy secret from her family, the law permits this if she is accompanied by another adult of her choosing (Art L2212-4 and L2212-7). The law also states that post-abortion counselling on contraceptives should be proposed to minors (Art L2212-7).

At any point after the first twelve weeks, the pregnancy can be interrupted if two physicians confirm that the woman's health is endangered or that the fetus has a serious abnormality (Art L2213-1).

The costs for abortion are 80 percent covered by public health insurance. Women under 18 or living

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719 Official translation.

720 Excerpts available in unofficial translation.

721 Center for Reproductive Rights, "The World's Abortion Laws" (2009), fact sheet available at [http://reproductiverights.org/sites/crr.civicaactions.net/files/pub\\_fac\\_abortionlaws2008.pdf](http://reproductiverights.org/sites/crr.civicaactions.net/files/pub_fac_abortionlaws2008.pdf). Last visited on 20 December 2009.

722 Both available in unofficial translation.

723 International Planned Parenthood Federation, *Abortion Legislation in Europe*, January 2007, p. 45.

724 Ibid.

725 Ibid.

726 Incorporated in the Public Health Code, not available in English translation.

in conditions of poverty can receive a 100 percent reimbursement.<sup>727</sup>

In **Albania**, Law No. 8045 of 7 December 1995 on the interruption of pregnancy<sup>728</sup> came into force in 1995. Article 10 states that “when a woman considers that pregnancy causes psychological and social problems,” abortion on request will be performed up to the end of the twelfth week of pregnancy. Abortion is available until the twenty-second week of pregnancy when the pregnancy is the result of a rape or other sexual crime, or when “other social reasons” are present. If the continuation of the pregnancy and/or childbirth would put the woman’s health or life at risk, or if there is an incurable deformation of the fetus, abortion is available at any time (Art 9). Parental authorization for unmarried girls under 16 is required.

The **German** Constitutional Court held as early as 1975 that while the fetus’s right to life was protected under the German Constitution, abortion had to be permitted where the pregnancy would seriously compromise the fundamental interests of the woman.<sup>729</sup> The Court declared that when the “right to life and bodily inviolability” of the woman was at stake, she could not be expected to sacrifice these for the unborn life. This was the case, for instance, when there was a “danger to her life or the danger of a serious impairment to the condition of her health.” It also held that the legislature was free to legalize the interruption of pregnancy in the case of “other extraordinary burdens for the pregnant woman” of similar seriousness.<sup>730</sup> However, abortion legislation has been the subject of significant controversy and political debate. Termination of pregnancy is unlawful under Section 218 of the Penal Code,<sup>731</sup> subject to certain exemptions, last revised in 1995. Exemption is granted in cases of abortion on request within 12 weeks of conception, subject to the pregnant woman receiving counselling at least three days before the procedure. According to Section 219, the aim of the counselling should be to protect the right to life of the unborn child and encourage the woman to continue with the pregnancy. Termination is lawful up to 12 weeks in the case of rape, and on medical grounds when the life, physical or mental health of the woman is threatened (there is no specified time limit to this exception).<sup>732</sup>

#### *Contraceptives*

**Belgium’s** Constitutional Court, in the 2006 case Merck, Sharp and Dohme BV v. Belgium,<sup>733</sup> examined pharmaceutical pricing statutes and addressed policies for state subsidized drugs. The Court noted that drugs could be added to the list of reimbursed medicines to meet a public health goal, and the reduction of unwanted pregnancies was found to be such a public health goal. Thus, contraceptives, for public health reasons, constitute a type of drug that must be made accessible to the public at an affordable price.

**Portugal’s** constitution explicitly guarantees a right to family planning. The state has a duty to protect the family as provided in Article 67 of the constitution, which includes the following:

*With respect for individual freedom, guaranteeing the right to family planning by promoting the information and access to the methods and means required therefore, and organising such legal and technical arrangements as are needed for motherhood and fatherhood to be consciously planned. (Art 67.2 (d))*<sup>734</sup>

Portugal has implemented this guarantee through Law 120/99,<sup>735</sup> which requires primary and secondary schools to teach students about human sexuality, including AIDS and other sexually transmitted diseases, contraceptive methods, and gender equality. That law also states that condoms will be available at schools through vending machines because of the importance of condoms in preventing AIDS and other STIs.<sup>736</sup> As for adults, Decree 259/2000 requires all hospitals within Portugal’s national health service that provide obstetric or gynecological care to also offer family planning counselling.<sup>737</sup>

727 International Planned Parenthood Federation, *Abortion Legislation in Europe*, January 2007, p. 24.

728 Available in unofficial translation.

729 BverfGE 39, 1 (F.R.G.), decided on 25 February 1975. Unofficial translation to English by Robert E. Jonas & John D. Gorby (1976).

730 *Ibid.*, at 648.

731 Available at <http://www.iuscomp.org/gla/statutes/StGB.htm#218>. Last accessed 3 August 2011.

732 Daniela Reitz and Gerd Richter, “Current Changes in German Abortion Law”, *Cambridge Quarterly of Healthcare Ethics* (2010), 19: pp. 334–343.

733 Constitutional Court, case 150/2006, 11 October 2006. Only available in French.

734 Portuguese Constitution (1976; as amended), Art. 67 s. 2. Official translation.

735 Law 120/1999: Strengthening the Guarantee of Access to Reproductive Health (11 August 1999), Art 2.1. Only available in Portuguese. For more about legal provisions on sexuality education in Portugal, see Chapter 7A: Sexual education and information.

736 *Ibid.* at Art. 3.2.

737 Decree DL 259/2000 (17 October 2000), Art. 6.1.

Furthermore, hospitals must ensure the free distribution of contraception.<sup>738</sup>

In the **United Kingdom**, case law has established that it is lawful for doctors to provide contraceptive advice and treatment to minors without parental consent, provided certain criteria are met. This policy was laid out in *Gillick v. West Norfolk and Wisbech Area Health Authority* in 1985.<sup>739</sup> The criteria specified by the judge – that have come to be known as the Fraser Guidelines – are also considered applicable to abortion.<sup>740</sup> According to these guidelines, it is lawful for doctors to provide contraceptives and other treatment without parental consent if, *inter alia*, the health professional is satisfied that the young person will understand the professional's advice, cannot be persuaded to inform his or her parents, and that it is in his or her best interest to be given contraceptive advice or treatment with or without parental consent.<sup>741</sup>

In 2002, the issue of emergency contraception was brought to the attention of the England and Wales Court of Justice. In *Smeaton v. Secretary of State for Health*,<sup>742</sup> the Society for the Protection of Unborn Children [SPUC] challenged a government decision to reclassify a particular emergency contraceptive (the so-called morning after-pill) as a drug that could be sold without a doctor's prescription. SPUC claimed that the drug in question was an abortifacient, arguing that anything that might prevent a fertilized egg from implanting was equivalent to abortion – even though emergency contraception cannot end a pregnancy if a fertilized egg is already implanted in the womb. Because the provision of emergency contraception did not meet the statutory requirements for legal abortion, SPUC argued, it was criminal.

Taking pains to point out that, “[i]t is no part of my function as I conceive it to determine the point at which life begins,” and that it was not the job of the court to concern itself with religious or moral issues, the judge noted that SPUC's argument, if taken to its logical conclusion, could call into question the lawfulness of all hormonal contraception and intra-uterine devices, both of which had been in popular use in the UK for about 50 years.<sup>743</sup> The Court found that the drug in question was a contraceptive, not a form of abortion, and allowed the government's over-the-counter policy to proceed.

As mentioned, however, there are also troubling trends regarding access to contraceptives in the European region, in particular in its central and eastern parts. For example, in **Slovakia** – an economically prosperous country that is an EU member and part of the Euro zone – hormonal contraceptives are not covered by the obligatory public health insurance scheme, requiring women to pay for these drugs out of pocket.<sup>744</sup> This policy clearly contradicts and undermines the Slovak abortion law, according to which unintended pregnancies should be prevented and which, for this reason, requires that prescription contraceptives be provided free of charge.<sup>745</sup> Similarly, in **Poland**, the number of state-refundable oral contraceptives was recently reduced, which has severely limited their availability in that country.<sup>746</sup> This decision to withdraw funding for modern family planning methods has been criticized by several human rights bodies.<sup>747</sup>

As discussed by the European Court of Human Rights in *Pichon* (above), pharmaceutical providers may object to the sale of contraceptives on religious or moral grounds. In some countries, such

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738 Ibid. at Art 6.3.

739 House of Lords [1985] 3 All ER 402, decided on 17 October 1985.

740 The guidelines are available at [http://itsacr02a.nottscg.gov.uk/apps/pr/diary/memdiary.nsf/0/FB7DEF429A4FCD95802573D90030190C/\\$file/08A\\_Appendix%20to%20Free%20Pregnancy%20Testing%20Service.pdf](http://itsacr02a.nottscg.gov.uk/apps/pr/diary/memdiary.nsf/0/FB7DEF429A4FCD95802573D90030190C/$file/08A_Appendix%20to%20Free%20Pregnancy%20Testing%20Service.pdf). Last visited on 20 December 2009.

741 See also Chapter 7A: Sexual education and information.

742 [2002] EWHC 610 (Admin), decided on 18 April 2002.

743 Paras 54–72.

744 As evident from Act No. 580/2004 Coll. Of Laws on Health Insurance and Amending and Supplementing Act No. 95/2002 Coll. Of Laws on the Insurance Industry, and Amending and Supplementing Certain Acts, *as amended* (2004). The only family planning method covered by public health insurance is surgical sterilization. Information and legal citation from Center for Reproductive Rights 2011, pp. 18–24.

745 Sections 2 and 3, Act No. 73/1986 Coll. On Artificial Termination of Pregnancy as amended by the Act No. 419/1991 Coll. Information and legal citation from Center for Reproductive Rights 2011, p. 20.

746 According to Polish Federation for Women and Family Planning, “Sexual and Reproductive Health and Rights. Independent Report Submitted to the United Nations Human Rights Committee” (2004). Available at [http://federa.org.pl/index.php?option=com\\_content&view=article&id=224&Itemid=141](http://federa.org.pl/index.php?option=com_content&view=article&id=224&Itemid=141). Last visited on 8 July, 2011.

747 See Human Rights Committee, Concluding Observations on Poland, U.N. Doc. CCPR/CO/82/POL (2004), para 9, and Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Mission to Poland, A/HRC/14/20/Add.3 (2010), para 27.

'conscience clauses' have been codified in law. **Poland**, for instance, allows physicians to withhold services contrary to their consciences, but they must document the patient's opportunities to obtain treatment elsewhere.<sup>748</sup> According to commentaries, in practice, that requirement is frequently unfulfilled.<sup>749</sup> This raises sexual health concerns because individual physicians may effectively be able to successfully prevent their patients from accessing desired health care.

## 6. Concluding remarks

Abortion policies still vary across Europe, but since the 1970s there has been a strong trend in the region to liberalize abortion. In a few small European countries, abortion is completely prohibited (Malta, Andorra, and San Marino). Other countries have varying degrees of restrictions with regard to access to service. Some permit abortion only to save the woman's life (Ireland), while others also permit abortion to preserve her physical health (Poland), and her mental health (Spain, Israel). Some countries also permit abortion for socio-economic reasons (United Kingdom, Cyprus, Finland, Iceland).<sup>750</sup> Many countries that have restrictive laws make exceptions for pregnancies that are the result of rape or incest, though it is well-known that in practice it may be difficult to access an abortion in such cases.<sup>751</sup>

However, in most European countries abortion is now available without restriction during the first period of pregnancy. Gestational limits for free access to abortion vary between ten and 24 weeks, and there are also differences with regard to whether parental notification for minors is required.<sup>752</sup> The accessibility of abortion services in practice is also affected by whether abortion falls under national health insurance coverage.

Several courts have struck a balance between the rights of the pregnant woman and the state's interest in protecting potential life, reaching the conclusion that the fundamental protection of the rights of the woman requires that abortion be legal when certain minimum conditions exist.<sup>753</sup> With regard to access to health care and the right to health in relation to abortion, there are early examples, including from Germany. The European Court of Human Rights clarified in *Tysiack* (2007) that states' obligations under the Convention require them to make legal norms that allow for abortion under certain circumstances – albeit restrictively – also available in practice, with due regard and respect to the opinions and feelings of the pregnant woman.

Contraception policies in many countries in the region are permissive and well in line with international standards for access to sexual health care without discrimination. In those countries, public funding for contraceptives tends to be available, which underlines the recognition that access to family planning methods has a clear public health value – as also made explicit by the Belgian Constitutional Court. British case law has established that, under certain circumstances, adolescents should be able to access contraceptives even without parental consent. In other countries, however, including Slovakia, hormonal contraceptives are excluded from public health insurance coverage, and in many Central and Eastern European states there are no state subsidies at all for such drugs. Thus the access in practice to safe and modern family planning methods is clearly limited in these countries, which is problematic from a health and rights point of view and which has been criticized repeatedly by UN human rights bodies. The European Court of Human Rights has hardly addressed issues surrounding access to contraceptives. It has, however, indirectly pointed to the importance of easily accessible

748 According to Joanna Z. Mishtal, "Matters of 'Conscience': The Politics of Reproductive Healthcare in Poland." *Medical Anthropology Quarterly*, v. 23 no. 2 (June 2009), at p. 169, and in Federation for Women and Family Planning et al, "Report to the UN Human Rights Committee in Connection with the 6th Period Review of Poland." (July 2009) [discussing The Act of the medical doctor profession and the dentist profession of 5th of December 1996 – unified text. *Journal of Laws* No 226, item 1943, as amended.] The FWFP's Report translates Article 39 of the Act as: "the doctor may abstain from accomplishing medical services discordant with his/her conscience, (...) nevertheless s/he is obliged to indicate real possibilities of obtaining the service from another doctor, or in another medical institution and justify his/her decision and mention about the refusal in the medical documentation." FWFP, at p. 3.

749 Ibid and in Mishtal at 163–172.

750 See Center for Reproductive Rights, "The World's Abortion Laws" (2009), fact sheet available at [http://reproductiverights.org/sites/crr.civicactions.net/files/pub\\_fac\\_abortionlaws2008.pdf](http://reproductiverights.org/sites/crr.civicactions.net/files/pub_fac_abortionlaws2008.pdf). Last visited on 20 December 2009.

751 See, *inter alia*, the HRC 2004 Concluding Observations to Poland, 2 December 2004 CCPR/CO/82/POL, at para. 8; the CESCR 2006 Concluding Observations to Mexico, 9 June 2006, E/C.12/MEX/CO/4, at para. 25, and the Inter-American Commission for Human Rights case *Paulina Ramirez v. Mexico*, Case 161-02, Friendly Settlement, Report No. 21/07 (2007).

752 Center for Reproductive Rights, "The World's Abortion Laws" (2009), fact sheet available at [http://reproductiverights.org/sites/crr.civicactions.net/files/pub\\_fac\\_abortionlaws2008.pdf](http://reproductiverights.org/sites/crr.civicactions.net/files/pub_fac_abortionlaws2008.pdf). Last visited on 20 December 2009.

753 These include courts in Italy, Germany, Spain, and France. See Amicus Brief prepared by the Center for Constitutional Rights, The Lowenstein International Human Rights Clinic at Yale Law School, Red Alas, and Gómez-Pinzón, Linares, Samper, Suárez, Villamil Abogados S.A. presented before the Colombia Constitutional Court, Case No. D5764, May 2005, available at [http://reproductiverights.org/sites/crr.civicactions.net/files/documents/BriefColombia\\_English\\_0505\\_FINAL.pdf](http://reproductiverights.org/sites/crr.civicactions.net/files/documents/BriefColombia_English_0505_FINAL.pdf). Last visited on 20 December 2009.

family planning methods, when it, in [Pichon](#), dismissed the application that alleged that the obligation to provide such drugs violated the right to freedom of religion. Furthermore, its more explicit recent statement on the need to regulate health professionals' right to conscientious objection, in [R.R. v. Poland](#), may also have bearing on access to contraceptives in the region – even though that decision addressed access to abortion-related services and not contraceptives.

## **B. ACCESS TO STI AND HIV/AIDS SERVICES**

### **1. Introduction**

Access, both financially and logistically, to services and treatment for HIV and other sexually transmitted infections (STIs) has obvious bearings on sexual health, as noted above. Most European nations have publicly funded health insurance schemes, under which HIV/STI prevention and treatment generally fall. Therefore, most residents in European countries have at least formal access to such treatment, to the same extent that they can access other health services. However, there are individuals who fall outside of such schemes, or persons who have difficulty accessing such services in practice. This chapter will highlight two such groups: detainees/prisoners and migrants, whether undocumented or asylum seekers.

The European Court of Human Rights has addressed the accessibility of HIV treatment in prison in a few cases, in particular in former Soviet Republics where HIV prevalence is high, and has highlighted the states' obligation to provide treatment to this group under the right not to suffer inhuman treatment or punishment (Article 3). In several cases and with mixed conclusions, the Court also has addressed the right of HIV positive immigrants to obtain asylum or residence on humanitarian grounds in Europe based on lack of adequate treatment in their home countries.

Domestically, migrants who are either undocumented or whose status has not yet been formalized often fall outside of health insurance schemes. Therefore, in the region there is a particular need to monitor access to HIV/STI services for migrants. Lack of resident status and health insurance, as well as schemes that charge fees based upon insurance status, are among the main factors that deprive migrants of access to HIV/STI treatment. Even when undocumented migrants are formally entitled to treatment, they are often reluctant to contact official health agencies, as doing so increases the likelihood of police investigations, expulsion, or deportation.

Generally, it has been difficult to find legal standards and jurisprudence specifically targeting the right to HIV/STI services in Europe, because these services tend not to be regulated separately, and/or many issues that have bearing on practical access to HIV/STI services tend to be regulated by local policies. Thus, the following will provide a few examples gleaned from the wide array of regulations on (sexual) health care in Europe, only to highlight a few issues that may have a particular impact on sexual health.

### **2. Council of Europe**

#### *Jurisprudence of the European Court of Human Rights*

In several cases, the European Court of Human Rights has examined the right to adequate medical care for HIV positive persons who are held in detention. While in the individual cases, transmission may have taken place as a result of intravenous drug use and not through sexual interactions, these cases are still relevant from a sexual health point of view. HIV/AIDS is often linked (in reality but even more in public perception) to sexual behaviour, and the stigma attached to HIV/AIDS, regardless of mode of transmission, can clearly be traced to its supposed links with sexuality and with groups that are perceived to engage in non-conforming sexual activities.

In [Yakovenko v. Ukraine](#),<sup>754</sup> the applicant was an HIV positive man who had spent about one year in pre-trial detention on suspicion of burglary. He also suffered from tuberculosis. He argued that his ill-treatment while in police custody, the inhuman conditions of detention, and the lack of medical assistance violated Article 3 of the Convention.<sup>755</sup>

With regard to the latter claim, the Court noted that prison authorities did not take any urgent medical measures upon learning that the applicant was HIV positive. He was not brought before an infectious diseases doctor for treatment, nor was he monitored for any other infectious diseases. He was transferred each month to a different prison facility in another town for ten days, and information about his HIV condition appeared not to have been shared with the staff of the other facility. There was no medical

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754 Application no. 15825/06, decided on 25 October 2007.

755 Other cases where the Court examined similar claims are [Khudobin v. Russia](#) (application no. 59696/00, decided on 26 October 2006), and [Aleksanyan v. Russia](#) (application no. 46468/06, decided on 22 December 2008).

practitioner at the staff of the second facility. The applicant did not receive appropriate treatment until he was admitted to a local AIDS center three months after his condition had been discovered.

The Court reaffirmed its earlier case law, stating that inadequate health care while in detention may amount to ill-treatment violating Article 3 of the Convention.<sup>756</sup> In the present case, it concluded that the authorities had failed to provide timely and appropriate medical assistance to the applicant in connection with his HIV and tuberculosis infections. This failure amounted to inhuman and degrading treatment under Article 3.

In *D. v. United Kingdom*,<sup>757</sup> the applicant was a citizen of St. Kitts, who was imprisoned in the United Kingdom for drug possession. While in prison he was found to be HIV positive. After his release, he was to be deported from the UK and returned to St. Kitts. He challenged the decision to deport him, claiming that his forced return would expose him to inhuman and degrading treatment in violation of Article 3 of the Convention because in St. Kitts he would have no access to health care or adequate treatment. He would suffer homelessness, lack of proper diet, and poor sanitation, which would expose him to opportunistic infections. Hospital facilities on the island were also severely limited. These circumstances would dramatically hasten his death.

At the time of the Court's deliberation, the applicant was in advanced stages of AIDS. The Court found that the implementation of the decision to remove him to St. Kitts would amount to inhuman treatment under Article 3. It reached this conclusion even though the deterioration of his health would stem from factors that "cannot engage either directly or indirectly the responsibility of the public authorities of [St. Kitts] or which, taken alone, do not in themselves infringe the standards of [Article 3]." In other words, the Court ascribed responsibility for the man's well-being to the country where he was present – the UK – and found this responsibility so serious that deporting him to St. Kitts would amount to inhuman treatment and infringement of Article 3. However, the Court stressed that it was the exceptional individual circumstances in the case that led it to this conclusion:

*[T]he Court emphasises that aliens who have served their prison sentences and are subject to expulsion cannot in principle claim any entitlement to remain in the territory of a Contracting State in order to continue to benefit from medical, social or other forms of assistance provided by the expelling State during their stay in prison.*

*However, in the very exceptional circumstances of this case and given the compelling humanitarian considerations at stake, it must be concluded that the implementation of the decision to remove the applicant would be a violation of Article 3. (para 54)*

The Court in its later jurisprudence has maintained that there is a very high bar for finding a violation of Article 3 following the expulsion of an HIV infected person to a country where he or she cannot expect the same level of treatment as in the host country. In a number of cases, the Court has assessed claims similar to those of *D.*,<sup>758</sup> but in no other case has it found that the host country would violate Article 3 following forced deportation. The main distinguishing factors from *D. v. United Kingdom* have been that the applicants in the later cases have not been as critically ill as *D.* and that they have not been able to show that no treatment would be available to them upon return to their countries of origin.

#### *European Social Charter and the European Committee of Social Rights*

Article 11 of the European Social Charter guarantees the right to protection of health:

*With a view to ensuring the effective exercise of the right to protection of health, the Contracting Parties undertake, either directly or in co-operation with public or private organisations, to take appropriate measures designed inter alia:*

- 1. to remove as far as possible the causes of ill-health;*
- 2. to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health;*
- 3. to prevent as far as possible epidemic, endemic and other diseases.<sup>759</sup>*

756 See *Ihan v. Turkey*, Grand Chamber, application no. 22277/93, § 87, and *Sarban v. Moldova*, application no. 3456/05, § 90.

757 Case number 146/1996/767/964, 2 May 1997.

758 See *Karara v. Finland* (no. 40900/98, Commission decision of 29 May 1998, *S.C.C. v. Sweden*, (application no. 46553/99, Court decision of 15 February 2000), *Arcila Henao v. The Netherlands* (application no. 13669/03, Court decision of 24 June 2003), *Ndangoya v. Sweden* (application no. 17868/03, Court decision of 22 June 2004), *Amegnigan v. the Netherlands* (application no. 25629/04, Court decision of 25 November 2004), and *N. v. United Kingdom* (application no. 26565/05, Court decision of 27 May 2008).

759 This article has the same wording in both versions of the Charter.

To date, the European Committee of Social Rights has not addressed the issue of HIV/STI treatment under Article 11 in any of its decisions on the merits, but it has highlighted in one of its country conclusions that states must arrange for special treatment of AIDS patients.<sup>760</sup>

### 3. European Union

The issue of access to STI/HIV health services falls outside of the scope of binding EU law.

### 4. Domestic legislation, policy, and case law

Residents in the **Netherlands** are legally obliged to take out health insurance for themselves and their dependents.<sup>761</sup> Health insurance companies cannot refuse to cover individuals for the standard insurance package, regardless of the applicant's age or state of health; however, the amount of contribution required may vary.<sup>762</sup> Those whose income falls under a minimum level are entitled to a health care allowance to assist in paying part of the contribution.<sup>763</sup>

All citizens have access to municipal public services for preventative care, including care for infectious diseases. Hospitals must provide basic health care in emergencies; additional care is available upon the discretion of the medical staff.<sup>764</sup> Temporary residence permits are available for undocumented people who suffer an acute medical situation, defined as a condition where lack of access to treatment in the country of origin would result in death within three months or severe physical or psychological damage.<sup>765</sup>

The Public Health Act (2008)<sup>766</sup> was formulated to implement WHO's International Health Regulations (2005) in Dutch national legislation.<sup>767</sup> It places responsibility for implementing HIV/AIDS and STI prevention efforts on municipal councils and health departments. The Public Health Decree<sup>768</sup> associated with the Act does not include explicit provisions concerning AIDS prevention, as there exists a "general consensus that HIV/AIDS prevention is integral to the control of sexually transmissible diseases." The need to assist HIV patients and to coordinate care organizations and other preventative activities are now "implicit in the general control duty" created by the Public Health Act (Decree, Art 11). A recent policy letter on sexual health from the Dutch minister of Health clarifies that relevant sources in interpreting the Netherlands' STI and HIV/AIDS policies are (1) the UNGASS Declaration of Commitment on HIV/AIDS (2001), by which the Netherlands pledged to pursue an integrated policy on HIV/AIDS and endorsed the principle that people living with HIV/AIDS should be involved in the design of the policy and implementation; (2) the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia (2004); and (3) the Political Declaration (2006), which commits the country (with other UN nations) to universal access to comprehensive prevention, treatment, care, and support.<sup>769</sup>

Curative care for STIs is provided by general practitioners, dermatologists, and venerologists; there are also six government-funded STI clinics in four large urban areas and STI clinics at municipal health departments.<sup>770</sup> The Minister of Health funds a programme for the rapid detection and treatment of

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760 Conclusions XVII-2, Latvia, p. 504 (2004).

761 Ministry of Health, Welfare, and Sport, "Obligatory Health Insurance" (March 2008), available at <http://www.minvws.nl/en/folders/z/2008/obligatory-health-insurance1.asp>. Last visited on 29 December 2009.

762 Ibid.

763 Ibid.

764 According to TAMPEP, "Sex Work, Migration, Health: A Report on the Intersections of Legislations and Policies Regarding Sex Work, Migration, and Health in Europe," 2009, p. 107. Available at [http://TAMPEP.eu/documents/Sexworkmigrationhealth\\_final.pdf](http://TAMPEP.eu/documents/Sexworkmigrationhealth_final.pdf). Last visited on 31 December 2009.

765 Ibid, p. 108.

766 Public Health Act, 460 Act of 9 October 2008, regulating public health care matters. Available in official English translation. The Public Health Act repealed the Public Health (Preventative Measures) Act, the Infectious Diseases Act, and the Quarantine Act.

767 According to the Dutch Minister of Health, Welfare and Sport in a Parliamentary document: Policy letter – Sexual Health, to the President of the House of Representatives, 27 November, 2009, PG/CI-2965226, p. 7. Available at <http://english.minvws.nl/en/kamerstukken/pg/2010/sexual-health.asp>. Last visited on 29 April 2010.

768 461 Decree of 27 October 2008, laying down new requirements regarding public health matters (Public Health Decree). Available in official translation to English.

769 Dutch Minister of Health, Welfare and Sport in a Parliamentary document: Policy letter – Sexual Health, to the President of the House of Representatives, 27 November, 2009, PG/CI-2965226, p. 7. Available at <http://english.minvws.nl/en/kamerstukken/pg/2010/sexual-health.asp>. Last visited on 29 April 2010.

770 STI AIDS Netherlands, "A Delicate Balance: The State of Affairs of HIV and Other STIs in the Netherlands" (2004), written at the request of the Dutch Ministry of Health, Welfare and Sports, at 62. Available at <http://www.soaaids.nl/documenten/delicate-balance1.pdf>, last visited on 30 April, 2010.

STIs among high-risk groups, who can receive free, anonymous testing for STIs and HIV and get treatment, if necessary.<sup>771</sup> Such care is supplementary to that provided by the general practitioner and is funded from the budget of the Ministry of Health, Welfare and Sport. Furthermore, on 1 January 2010 the Minister of Health introduced a uniform HIV testing policy with the goal of combating the stigmatization of people living with HIV by making testing “a routine affair.” The policy provides that every client of municipal health services throughout the Netherlands will be given a routine HIV test, with the possibility of opting out.<sup>772</sup>

Uninsured people and those without a residence permit are entitled to “medically necessary care,” as described in the National Health Insurance Act (ZFW) and the Exceptional Medical Expenses Compensation Act (ZFW).<sup>773</sup> All care in relation to HIV, AIDS and other STIs is deemed medically necessary.<sup>774</sup> The Dutch organization AIDS Fonds indicates that uninsured people and those without residence permits can always get tested for HIV and that the results of these tests do not affect asylum or residency permits.<sup>775</sup> Some specialty clinics provide free HIV treatment and support to HIV positive persons, regardless of their legal status. Further, some university hospitals offer confidential (albeit not anonymous) treatment even though this is not part of an official policy or programme; rather, the scope of treatment depends on the discretion of the health care provider.<sup>776</sup> Because such treatment does not include other services, such as counselling or referral to specialized clinics, there is often a substantial lag time between diagnosis and actual treatment.<sup>777</sup> However, rapid tests are increasingly available, particularly in Amsterdam, and promise to improve access to testing.

In the **United Kingdom**, citizens, asylum applicants, and those who have been lawfully living in the UK for 12 months are entitled to free treatment by the National Health Service (NHS). Medical treatment for emergencies is always free for all people, including for undocumented migrants. Treatment for certain STIs and infectious diseases is also free. HIV testing, diagnosis, and initial counselling sessions are free for all, but additional HIV treatment and hospital care are chargeable for those who do not meet the criteria for free NHS services. Undocumented persons, those whose asylum appeal has had a final refusal and are waiting for deportation, individuals on visitor visas, and overstayers may be charged for HIV treatment.<sup>778</sup>

The rights of HIV positive people in the UK to access health services are protected by the Disability Discrimination Act (DDA) of 2005.<sup>779</sup> The Act makes it illegal to discriminate against people with HIV, from the point of diagnosis, in health care, employment, education, and the delivery of other goods and services. For example, it is unlawful for service providers to refuse to provide services to HIV positive persons, to provide a lower standard of service or to provide it on worse terms. The Act fundamentally altered the approach of earlier anti-discrimination legislation by placing positive duties and responsibilities on public bodies to promote equality for disabled people, removing the burden of seeking legal recourse from disabled individuals.

In 2009, the British government published the NHS Constitution, which guarantees the rights of patients.<sup>780</sup> Access to NHS service is based on clinical need and free of charge, except in limited conditions sanctioned by the parliament. In determining what treatment a patient should receive, British law prohibits health and social care providers from discriminating unlawfully on grounds of

771 “High-risk groups” include for people who “1) belong to social sub-groups with an increased risk of STI; 2) have already received a warning about STI from the services that trace sources and contacts; 3) have symptoms characteristic of STI; 4) are 25 years old or younger or; 5) wish to undergo an anonymous test.” See Dutch Minister of Health, Welfare and Sport in a Parliamentary document: Policy letter – Sexual Health, to the President of the House of Representatives, 27 November, 2009, PG/CI-2965226, p. 15. Available at <http://english.minvws.nl/en/kamerstukken/pg/2010/sexual-health.asp>. Last visited on 29 April 2010.

772 Dutch Minister of Health Policy letter, pp. 26–27.

773 “A Delicate Balance,” at 63.

774 *Ibid.* at 62.

775 See AIDS Fonds website providing information on testing and treatment in the Netherlands (in Dutch), available at [http://www.aidsfonds.nl/hiv\\_en\\_aids\\_artikel/test\\_onverzekerd\\_illegaal](http://www.aidsfonds.nl/hiv_en_aids_artikel/test_onverzekerd_illegaal). Last visited on 30 April 2010.

776 TAMPEP, 107–108.

777 TAMPEP, 108.

778 See “Will I have to pay?”, National AIDS Trust (2007), available at <http://www.nat.org.uk/Media%20library/Files/PDF%20documents/2009/Feb/Will%20I%20Have%20to%20Pay%20April%202007-1.pdf>. Last visited on 26 December 2009.

779 Enacted 7 April 2005, amending the Disability Discrimination Act 1995.

780 The NHS Constitution was created by the Health Act 2009. The NHS Constitution is available at [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_093442.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_093442.pdf). Last visited on 30 April 2010.

race, sex, disability, gender identity, religion, belief, or sexual orientation.<sup>781</sup> The NHS Constitution guarantees patients the “right to be treated with dignity and respect” in accordance with human rights standards and mandates that service providers adhere to equality and human rights legislation.<sup>782</sup> Finally, the NHS Constitution also sets out patients’ rights to complaint and redress, including the right to make a claim for judicial review if a patient believes she or he has been directly affected by an unlawful act or decision of an NHS body.

*Case law: ensuring non-discriminatory health services for HIV positive individuals*

The Disability Discrimination Act was recently used to challenge discrimination against an HIV positive person by a National Health Service trust in Northern Ireland. According to news reports, the staff at a Northern Irish hospital refused to perform an endoscopy on a HIV positive man even though the hospital had the facilities and appropriate procedures in place to do so. The NHS trust informed the claimant in a letter that the treatment had been denied him on the basis of his HIV status. The claimant had to wait four months for an alternative form of examination and suffered substantial anxiety and distress because of the delay.<sup>783</sup>

Thought to be the first case in which the Disability Discrimination Act has been invoked to challenge discrimination against an HIV positive person accessing health care services, the Equality Commission for Northern Ireland supported the patient’s case challenging the discriminatory treatment he received from the hospital. The NHS trust settled the case in April 2009, giving the claimant £4,000 and issuing an apology for denying him the care to which he was entitled and the distress he experienced as a result. The trust also agreed to review policies related to the provision of services for HIV patients.<sup>784</sup>

The **Moldovan Law on Prevention and Control of HIV/AIDS** (2007)<sup>785</sup> addresses the issue of right to prevention of and treatment for HIV/AIDS and has incorporated a clear rights-approach. Citizens, foreign citizens, and stateless persons who live or temporarily reside in Moldova have the right to a free, anonymous medical test to determine HIV status (Art 11). The law allows “immigrants, emigrants, refugees and asylum seekers [the] benefit of [anti-retroviral treatment] and treatment of opportunistic infections according to the legislation in force” (Art 10(3)). The law does not identify the laws that govern these categories of non-nationals or specify whether undocumented migrants are included in this group. According to Article 19(1), “the state shall ensure universal access of all [persons living with HIV] to [anti-retroviral] treatment and treatment of opportunistic infections . . . free of charge through the National Programme on Prevention and Control of HIV/AIDS and STIs.” The law also prohibits discrimination of HIV positive persons in the health care setting, namely: “each individual shall have access to medical services, regardless of perceived or actual HIV status” (Art 25 (1)), and no health institutions “shall deny access to health care services to [persons living with HIV] or those perceived or suspected to be HIV infected, nor charge the said persons higher fee” (Art 25 (2)).

All HIV tests require written voluntary and informed consent, and mandatory testing is prohibited; for minors, both the child and parents or legal guardians must provide written informed consent (Art 13). All HIV tests and diagnoses are confidential (Art 14), although HIV infected individuals are required to disclose their status to spouses or sexual partners.

## 5. Concluding remarks

It is difficult to draw any general conclusions about European approaches to HIV/STI treatment for the reasons noted above (lack of specific regulations, policy- rather than law-regulated, local variations, etc.). Suffice to conclude here that the jurisprudence of the European Court of Human Rights, as well as the Dutch and British regimes, indicate that the application of human rights norms to the treatment of sexually transmitted infections, including HIV/AIDS, is an approach that is gaining recognition in the region. The European Court concluded both in Yakovenko and in D. that failure to provide treatment for HIV/AIDS can amount to inhuman treatment under the Convention; thus placing the positive duties of the state to protect and promote the right to health on par with the fundamental obligation not

781 Equality and Human Rights Commission, “Treatment,” at <http://www.equalityhumanrights.com/your-rights/rights-in-different-settings/health-and-social-care/access-to-services-treatment-and-support/treatment/>. Last visited on 30 April 2010.

782 NHS Constitution, at p. 6 and p. 11.

783 See the Equality Commission for Northern Ireland, “Disability Cases Highlight Need for Change,” 29 April 2009, at [http://www.equalityni.org/sections/Default.asp?cms=News\\_News&cmsid=1\\_2&id=173&secid=1\\_1](http://www.equalityni.org/sections/Default.asp?cms=News_News&cmsid=1_2&id=173&secid=1_1), and the Guardian, “HIV-positive man wins damages against Northern Ireland hospital,” 29 April 2009, at <http://www.guardian.co.uk/uk/2009/apr/29/northern-ireland-hospital-hiv-damages>. Both sites last visited on 31 March, 2010.

784 Ibid.

785 Nr. 23-XVI of 16.02.2007. Translation to English is probably unofficial.

to subject a person to maltreatment. In the United Kingdom, both the Disability Discrimination Act and the NHS Constitution have clear rights-based approaches to state responses to ill-health. This is particularly important in regard to sexually transmitted infections and HIV/AIDS, given the social stigma that tends to accompany such conditions precisely due to their (perceived) relation to sexuality and non-conforming sexual behaviour. The Northern Irish case shows that the British regulations also have teeth – that the guarantees to non-discriminatory treatment can be enforced and, when violated, can lead both to sanctions against the wrongdoer and to a revision of practices. In Moldova, the universal right to treatment for persons living with HIV and AIDS has been guaranteed in law, which, in combination with the same law's prohibition of discrimination against HIV positive persons, provides significant legal protection for members of this group.

As pointed out above, undocumented migrants are particularly vulnerable to violations of their rights to sexual health services in Europe due to their illegal status and lack of health insurance and/or difficulties in practical opportunities to access care. The Netherlands, Moldova, and to some extent the United Kingdom attempt to tackle the rights-related problems that arise when this group suffers from serious health conditions, such as from HIV/AIDS. The Netherlands appears to have established a regime where migrants can access health services regardless of their legal status, at least theoretically with the guarantee that coming forward for (sexual) health reasons will not attract the attention of immigration authorities or the police. The Moldovan law acknowledges the specific need of treatment for migrants and refugees, while not clearly stating what services and protection they can expect in practice. However, it should be reiterated that regardless of legal guarantees, the practice can be very different, and the very fear of being subjected to deportation may impede undocumented migrants from seeking treatment, regardless of whether medical confidentiality will in fact be respected by the health provider. One big obstacle to real access to qualitative and non-discriminatory care is also lack of trustworthy information. By the very nature of living 'underground,' it is difficult for undocumented migrants to access information in relevant languages about services and treatment. Needless to say, these problems must be tackled by a wider approach than by legal means alone.