

UNIVERSITY OF CAPETOWN
SCHOOL OF ADVANCED LEGAL STUDIES
Faculty of Law
Department of Public Law

NAME: **PHILOMENA APIKO**
STUDENT NUMBER: **APKPHI001**
DEGREE: **MASTER OF LAWS (LLM) IN**
HUMAN RIGHTS LAW
SUPERVISER: **DR. DEE SMYTHE**

TITLE: DENIED MOTHERHOOD: FORCED STERILISATION OF
HIV-POSITIVE WOMEN AS A VIOLATION OF THEIR
HUMAN RIGHTS

Research dissertation presented for the approval of Senate in fulfilment of part of the requirements for the Master of Laws (LLM) in approved courses and a minor dissertation. The other part of the requirement for this qualification was the completion of a programme of courses.

I hereby declare that I have read and understood the regulations governing the submission of Master of Laws (LLM) dissertations, including those relating to length and plagiarism, as contained in the rules of this University, and that this dissertation conforms to those regulations.

The copyright of this thesis vests in the author. No quotation from it or information derived from it is to be published without full acknowledgement of the source. The thesis is to be used for private study or non-commercial research purposes only.

Published by the University of Cape Town (UCT) in terms of the non-exclusive license granted to UCT by the author.

TABLE OF CONTENTS

ACKNOWLEDGEMENT	4
ABBREVIATIONS	5
CHAPTER 1: INTRODUCTION	8
1.1 Background of the study	8
1.2 A brief historical discussion of forced sterilisations	10
1.3 Problem statement	13
1.4 Objective and relevance of the research.....	14
1.5 Theoretical and legal framework.....	15
1.6 Overview of chapters	19
CHAPTER 2: FORCED STERILISATION AS A VIOLATION OF THE DOCTRINE OF INFORMED CONSENT	21
2.1 Introduction	21
2.2 Exploring the doctrine of informed consent.....	22
2.2.1 Disclosure: need for informed decision-making.....	25
2.2.2 Comprehension: ability to fully understand the information given.....	31
2.2.3 Competence: issues of legal capacity	33
2.2.4 Voluntariness: free decision making.....	36
2.2.5 Consent: individual autonomy versus spousal and familial consent	37
2.3 Conclusion.....	39
CHAPTER 3: FORCED STERILISATION AS A VIOLATION OF THE RIGHT TO DIGNITY AND RIGHT TO SECURITY OF THE PERSON.	40
3.1 Introduction	40

3.2	Violation of the right to dignity.....	40
3.3	Violation of right to security of the person	45
3.4	Conclusion.....	48

CHAPTER 4: FORCED STERILISATION AS A VIOLATION OF THE RIGHT TO EQUALITY/ NON-DISCRIMINATION AND THE RIGHT TO HEALTH50

4.1	Introduction	50
4.2	Violation of the right to equality	50
4.2.1	HIV/AIDS as a ground of discrimination.....	52
4.2.2	Possible protection against discrimination based on HIV/AIDS under the ground of disability	54
4.3	Violation of the right to health	57
4.3.1	Discrimination in access to health services	57
4.3.1.1	Segregational treatment of HIV-positive patients.....	59
4.3.1.2	Denial of appropriate services and information specific to HIV/AIDS.....	63
4.4	Denial of the right to benefit from scientific progress	66
4.5	Conclusion.....	67

CHAPTER 5: FORCED STERILISATION AS A VIOLATION OF REPRODUCTIVE RIGHTS AND THE RIGHT TO BE FREE FROM VIOLENCE69

5.1	Introduction	69
5.2	Evolution of reproductive health and rights	69
5.3	Violation of reproductive rights	72
5.3.1	Right to found a family	72
5.3.2	Right to have family planning and choose the method of contraception.....	75

5.3.3	Right to control one’s fertility.....	79
5.3.4	Right to decide freely and responsibly on the number and spacing of children	81
5.4	Violation of the right to be free from violence (violence against women).	82
5.6	Conclusion.....	87
CHAPTER 6: CONSEQUENCES OF FORCED STERILISATION OF HIV-POSITIVE WOMEN		88
6.1	Introduction	88
6.2	Social stigma and rejection	88
6.3	Emotional and mental distress.....	91
6.4	Negative impact on governmental programmes aimed at HIV-prevention and the promotion of reproductive health and rights.....	93
6.5	Affect the work of international institutions like the UN and WHO	95
6.6	Conclusion.....	97
CHAPTER 7: CONCLUSION.....		98
BIBLIOGRAPHY		Error! Bookmark not defined.

ACKNOWLEDGEMENT

I would like to thank my parents and family for their unqualified support of all my dreams. For letting me be the best I can be and for their love and guidance. I would like to especially thank my supervisor, Dr. Dee Smythe for agreeing to supervise this paper and for her patience and guidance when I needed it. You are a true inspiration.

I would like to thank all my friends for their encouragement, you guys rock. Lindiwe for the help in editing and making sure I finished this paper, Teresa for the grammatical edits and support, Ashi for reading my first draft and encouraging me to keep going. Sophie, Melody and dear Chantal, for taking time to indulge my opinions and give feedback.

I dedicate this paper to all HIV-positive women. To those who are mothers and those looking forward to becoming mothers: Motherhood is a gift- no one can take that away from you.

ABBREVIATIONS

ACHPR	African Charter on Human and Peoples Rights
ACRWC	African Charter on the Rights and Welfare of the Child
AWP	Protocol to the African Charter on Human and Peoples Rights on the Rights of Women
AIDS	Acquired Immune Deficiency Syndrome
ARVDs	Anti Retroviral Drugs
CAT	Convention Against Torture and Other Cruel, Inhuman and Degrading Treatment or Punishment
CCEDAW	Committee on the Convention on the Elimination of All forms of Discrimination against Women
CEDAW	Convention on the Elimination of All forms of Discrimination against Women
CESCR	Committee on Economic Social and Cultural Rights
CRC	Convention on the Rights of the Child
CRPD	Convention on the Rights of People with Disabilities
CTOP	Choice on Termination of Pregnancy Act

DEVAW	Declaration on the Elimination of Violence Against Women
ECHR	European Convention on Human Rights
FIGO	International Federation of Gynaecology and Obstetrics
GC	General Comment
GR	General Recommendation
HAART	Highly Active Anti Retroviral Treatment
HIV	Human Immunodeficiency Virus
HRC	Human Rights Committee
ICCPR	International Covenant on Civil and Political Rights
ICERD	International Convention on the Elimination of Racial Discrimination
ICESCR	International Covenant of Economic Social and Cultural Rights
ICPD	International Conference on Population and Development
ICRMW	International Convention on the Rights of Migrant Workers and Members of their Families
ICW	International Community of Women Living with HIV/AIDS
MDGs	Millennium Developmental Goals
NASA	Namibian Abortion and Sterilisation Act
NC	The Constitution of the Republic of Namibia
PLWHA	People Living With HIV/AIDS
PMTCT	Prevention of Mother-to-Child Transmission
SAC	The Constitution of the Republic of South Africa
SACC	South African Constitutional Court
SADC	Southern African Development Community

SADCPGD	Southern African Development Community Protocol on Gender and Development
SADCPH	Southern African Development Community Protocol on Health
SANHA	South African National Health Act
SASA	South African Sterilisation Act
UDHR	Universal Declaration of Human Rights
UN	United Nations
UNICEF	United Nations Children's Fund
WHO	World Health Organisation

CHAPTER 1: INTRODUCTION

'Before I found out I was HIV positive and I was having a child I was okay. But after I tested positive they treated me badly. They said 'why do you want to have a baby if you are HIV positive?' - Positive Woman, Namibia, 2008¹

1.1 Background of the study

Forced sterilisation of HIV positive women has recently been focussed on in Southern Africa where reports of women who had been sterilised in government hospitals without their consent was made public.² Sterilisation is defined as a surgical procedure whereby a person could be rendered incapable of fertilisation or reproduction³ by blocking of the sex organs.⁴ Forced sterilisation is sterilisation that occurs without the consent and knowledge of the patient. For the purposes of this paper forced sterilisation will include instances where the HIV-positive woman was sterilised during a caesarean section (c-section) and was not made aware of the procedure. It will also encompass instances where women were coerced against their will by health officials to undergo sterilisation.

The International Community of Women Living with HIV/AIDS (ICW) carried out a study in Namibia (ICW Namibia report) between 21 January and 22 April 2008, in which 230 HIV positive women were interviewed.⁵ The results showed that about 40 per cent of the

¹ The International Community of Women Living with HIV/AIDS 'The forced and coerced sterilisation of HIV positive women in Namibia' (2009) at 4, (hereafter ICW Namibia report) at 4. Available at <http://www.icw.org/files/The%20forced%20and%20coerced%20sterilization%20of%20HIV%20positive%20women%20in%20Namibia%2009.pdf> [accessed 24 September 2010].

² Ibid.

³ See the South African Sterilisation Act 44 of 1998 (hereafter SASA), section 1; and the Namibian Abortion and Sterilisation Act 2 of 1975 (hereafter NASA), section 1.

⁴ Definition available at <http://www.oxforddictionaries.com/definition/sterilize?view=uk> [accessed on 7 October 2010]. Both women and men can be sterilised. Female sterilisation is done through a process of either tubal ligation that involves the blocking of the fallopian tube or a hysterectomy that involves the removal of the uterus. Male sterilisation takes place in the form of a vasectomy. Female sterilisation is an invasive procedure that requires an operation under hospital setting as compared to vasectomy that can be performed by a physician and takes about 30 minutes.

⁵ ICW Namibia report supra note 1 at 4.

women stated that they had been coerced or forced into sterilisation. Currently three cases involving forced sterilisation of HIV-positive women are being litigated in the Namibian High Court. One of the cases, *L.M v The Government of the Republic of Namibia*,⁶ involves the alleged forceful sterilisation of a 32 year old woman who was sterilised without her consent after being rushed to the theatre to undergo a c-section following complications from natural birth. She had not received prior information about sterilisation and was sterilised without her knowledge after having forms for her to sign, thrust in front of her face while in labour. In South Africa, there have also been reports of sterilisation, with an investigation being made public by, *3rd degree*⁷ television journalists on Monday 21 June 2010. *3rd degree* issued a press release on forced sterilisation stating that, ‘forced sterilisation was a misguided but cruel attempt by health workers to stop the spread of the HI-virus, intended to punish ‘wayward’ women for getting infected’.⁸ This mirrors the concerns raised by the ICW that women were forcefully sterilised as health workers felt it was their social responsibility to prevent the spread of AIDS, by preventing HIV-positive women from having children. Nonandi Diko from the Women Legal Centre and Promise Mthembu from Her Rights Initiative are currently collecting data on the incidence of forced sterilisation in South Africa.⁹ Mthembu herself was forcefully sterilised at 22 years after she sought abortion services. When the health personnel found out she was HIV-positive, she was told she would only be given abortion services if she agreed to be sterilised.¹⁰ This is contrary to the Choice on Termination of Pregnancy Act¹¹ (CTOP) that states that any woman may access an abortion and does not list sterilisation as a pre-requisite for abortion.¹²

⁶ *LM v The Government of the Republic of Namibia* Case Number I 1603/08 (forthcoming).

⁷ *3rd degree* is an investigative journalism show that airs on etv on Tuesdays at 21:30pm and is hosted by Debora Patta. More information is available at <http://www.etv.co.za>

⁸ e- press release: *3rd degree*-forced sterilisation TX: Tuesday 22 June 2010 9:30 pm. Available at <http://www.etv.co.za/files/press/3rd%20Degree%20-%2020Forced%20Sterilisation.pdf> [accessed on 24 September 2010].

⁹ N Diko ‘ Legal Analysis on Forced Sterilization in South Africa’ available at http://www.wlce.co.za/morph_assets/themelets/explorer/health/Forced%20Sterilization.pdf [accessed on 12 January 2011].

¹⁰ A Lombard ‘South Africa: HIV-positive women sterilised against their will’ 7 June 2010. Available at http://www.southernafricalitigationcentre.org/news/item/South_Africa_HIV_positive_women_sterilised_against_their_will [accessed on 8 October 2010].

¹¹ 92 of 1996.

¹² Sections 2 and 5 of the CTOP.

Forced sterilisation of HIV-positive women has occurred in a number of other countries. A 2004 study conducted in Chile by Vivo Positivo Universidades Arcis and Facultad LatinoAmericana de Ciencias Sociales¹³ found that 12.9 per cent of sterilised HIV positive women had the procedure performed without their consent, and a further 29 per cent had agreed to be sterilised only after being coerced by hospital staff who told them that ‘seropositive mothers should not get pregnant’.¹⁴ An example of such an incident is evident in the case of F.S. who was sterilised without her consent due to her HIV-positive status.¹⁵ Vivo Positivo and the Centre for Reproductive Rights subsequently filed a complaint in the Inter-American Commission for Human Rights recommending it acknowledge the fact that Chile had violated F.S.’s human rights.¹⁶ Similarly, in Mexico there have been reports of HIV-positive women being forcefully sterilised due to their HIV-status. In a workshop sponsored by the United Nations Population Fund (Mexico Office) and by a Mexican NGO Colectivo Sol in February 2007, 16 HIV-positive women revealed that they had suffered violation to their reproductive rights.¹⁷ Forced sterilisation on the basis of HIV status is argued in this paper to be a violation of the human rights of the affected HIV-positive women especially their rights to dignity, security of the person, equality and non-discrimination, access to health services, reproductive rights and the right of women to be free from violence.

1.2 A brief historical discussion of forced sterilisations

Forced sterilisation as a means of controlling a population and ridding society of the unwanted has roots in the eugenics movement. Eugenics is defined as the practice of trying to influence human heredity by encouraging the transmission of 'desirable' characteristics and

¹³ F Vidal and M Carrasco, *Mujeres Chilenas Viviendo Con VIH/SIDA? Derechos Sexuales y Reproductivos? Un Estudio de Correlaciones en Ocho Regionales del Pais* {Chilean Women Living with HIV/AIDS: What are their sexual and reproductive rights? A study of correlations in eight regions of the Country} (2004). Available at <http://www.vivopositivo.org/portal/sitio/-pag/ficha.asp?Id=69> [accessed on 10 October 2010].

¹⁴ Ibid.

¹⁵ Press Release, Centre for Reproductive Rights ‘Forcibly sterilized woman files international case against Chile (3 February 2009). Available at <http://www.reproductiverights.org/en/press-room/forcibly-sterilized-woman-files-international-case-against-chile> [accessed on 10 October 2010].

¹⁶ Ibid; see P Nair ‘Litigating against the forced sterilization of HIV-positive women: Recent developments in Chile and Namibia’ (2011) 23 *Harvard Human Rights Journal* 223.

¹⁷ T Kendall ‘Reproductive rights violations reported by Mexican women with HIV’ (2009) 11(2) *Health and Human Rights: An International Journal*. Available at <http://www.hhrjournal.org/index.php/hhr/article/viewArticle/175/260> [accessed on 13 October 2010].

discouraging the transmission of 'undesirable' ones.¹⁸ Eugenics was a fundamental aspect of some of the most important cultural and social movements of the twentieth century.¹⁹ As a political project, it was intimately linked to ideologies of race, nation, and sex, inextricably meshed with population control, social hygiene, state hospitals, and the welfare state.²⁰ The most infamous example is the Nazi-Germany eugenics movement, which attempted to create a pure German-Aryan race under the banner of racial hygiene by carrying out experimentation and extermination in concentration camps.²¹ This included forced sterilisations and extermination of homosexuals, the mentally and physically disabled and those considered racially impure namely Jews, Blacks and the Gypsy community.²²

The eugenics movement was present in several other countries including the United States of America²³ (USA). Forced sterilisation in the USA was mainly directed at those who were mentally unfit. For example in 1907, the state of Indiana became the first of the American states to adopt legislation aimed at compulsory sterilisation of people who were 'mentally retarded'.²⁴ Other states include the state of Virginia which enacted law allowing for compulsory sterilisation of patients in state mental institutions in 1927. The constitutionality of this law was challenged in the United States Supreme Court case of *Buck v Bell*²⁵ where the court upheld the constitutionality of the compulsory sterilisation of the mentally unfit 'for the protection and health of the state'.²⁶

Forced sterilisations continue to be used as a radical means of birth control mainly targeted at women, which has implications for their reproductive freedom.²⁷ Indigenous women have been victims of forced sterilisation in a bid to control such populations. This

¹⁸ Definition available at www.genetics.com.au/glossary/e.asp [accessed on 10 October 2010].

¹⁹ F Dikotter 'Race culture: Recent perspectives on the history of Eugenics' (1998) 103(2) *The American Historical Review* 467- 478 at 467.

²⁰ Ibid.

²¹ M Frost 'Eugenics'. Available at <http://www.martinfrost.ws/htmlfiles/mar2007/eugenics.html> [Accessed 20 October 2010].

²² Ibid.

²³ A M Stern 'Sterilized in the name of public health' (2005) 95 *American Journal of Public Health* 1128.

²⁴ Eugenics Legislation: Act of 1907, available at <http://www.in.gov/judiciary/citc/cle/eugenics/docs/acts.pdf> [accessed on 23 October 2010].

²⁵ 274 U.S. 200 (1927).

²⁶ Ibid at 205.

²⁷ Stern supra note 23 at 1128.

practice was carried out on Native American women in the USA,²⁸ aboriginal women in Australia,²⁹ and indigenous women in Peru.³⁰ Forced sterilisations are also used as a means to combat poverty where sterilisation is used as an incentive for welfare, in a bid to control the population of poor people.³¹ For example in California (USA), women were found to have been forcefully sterilised using funds from federal agencies, in conjunction with family planning initiatives from the War on Poverty that was launched by President Lyndon Johnson in 1964.³² An example of such sterilisations was seen in the class-action case of *Madrigal v Quilligan*³³ where women of Mexican- origin had been coerced into postpartum tubal ligation after birth by c-section. The doctors had sterilised these women in the belief that it was their social responsibility to prevent the reproduction of ‘unfit’ populations that they believed exhausted government resources.³⁴ The court held that the physicians were not liable for the sterilisations despite the fact that they were performed without informed consent.

Currently forced sterilisation is practised as national policy in China for people who do not conform to the government’s one child policy.³⁵ Such measures are a violation of the reproductive rights of women (and men) because they violate the pro-choice principle of reproductive rights. Although this paper does not focus on the eugenics movement, or on the forced sterilisation of ethnic minorities, reference to such practices will be made to show the overwhelming violations forced sterilisation can cause to those affected.

²⁸ L Glauner ‘The Need for Accountability and Reparation: 1830-1976 The United States Government’s Role in the Promotion, Implementation, and Execution of the Crime of Genocide Against Native Americans’ (2002) 51 *DePaul Law Review* 911.

²⁹ See P Andrews ‘Violence against Aboriginal women in Australia: Possibilities of redress within the human rights framework’ (1996-1997) 60 *Albany Law Review* 917.

³⁰ BBC News ‘Mass sterilisation scandal shocks Peru’ (24 July 2002). Available at <http://news.bbc.co.uk/2/hi/americas/2148793.stm> [Accessed 19 October 2010]. According to the BBC News President Alberto Fujimori (in office from 1990-2000) has been accused of genocide and crimes against humanity as a result of a sterilisation program put in place by his administration. Peru put in place a program of forced sterilisations against indigenous people namely the Quechuas and the Aymaras in the name of a ‘public health’ plan.

³¹ Stern supra note 23 at 1128.

³² Ibid.

³³ 639 F.2d 789 (9th Cir. 1981).

³⁴ R M Kluchin ‘Locating the voices of the sterilised’ (2007) 29(3) *The Public Historian* 131-144 at 133.

³⁵ T Hesketh, L Lu and Z Wei Xing ‘The effect of China’s One Child’s Policy after 25 years’ (2005) 353 *The New England Journal of Medicine* 1171; See also ‘One Child Policy in China’ Available at <http://factsanddetails.com/china.php?itemid=128&catid=4&subcatid=15> [Accessed on 17 October 2010].

1.3 Problem statement

Given the increase in HIV/AIDS infections, there have been calls for HIV-positive women (and men) not to procreate, or for policies to be established to try and limit or influence the reproductive choices of such women.³⁶ Such policies are advanced with the misguided belief that sterilisation is in the greater interests of society and public health, and that HIV-positive mothers should not be allowed to have children given the high risk of possible transmission from mother to child.³⁷ The poignant truth is that such acts are based on discriminatory and essentialist stereotypes. For example, some people, including health personnel, perceive HIV-positive mothers as being ‘unfit parents’ given the stigma associated with HIV infection namely promiscuity, prostitution and drug use.³⁸ Others believe HIV-positive women should not have children given the fact that AIDS is a killer disease and the children will be left without parents.³⁹ Forced sterilisation of HIV-positive women is therefore a way of preventing them from having children who would be considered ‘unwanted’ as they are assumed to be HIV-positive as well.

Forced sterilisation of HIV-positive women is a violation of human rights in particular the rights to dignity, bodily integrity and non-discrimination (equality) as the women are being targeted for sterilisation because they are HIV-positive. It is also a violation of reproductive rights as it removes the possibility of a sterilised HIV-positive woman having children in future. Furthermore, forced sterilisation violates the right of women to be free from violence. This paper argues that there is a less restrictive way to reduce the spread of

³⁶ N E Kass ‘Policy, ethics, and reproductive choice: Pregnancy and childbearing among HIV-infected women’ (1994) 83 *Acta Paediatrica* 95.

³⁷ L London, P J Orner and L Myer ‘“Even if you’re positive, you still have rights because you are a person”’: Human rights and the reproductive choice of HIV-positive persons’ (2008) 8(1) *Developing World Bioethics* 11 at 15.

³⁸ S B Kirshenbaum et al. ‘Throwing the dice: Pregnancy decision-making among HIV-positive women in four U.S cities’ (2004) 36(3) *Perspectives on Sexual and Reproductive Health* 106 at 111; M Sandelowski and J Barroso ‘Motherhood in the context of maternal infection’ (2003) 26 *Research in Nursing and Health* 470 at 476; International Federation of Health and Human Rights Organisations ‘Forced and coerced sterilisation’. Available at <http://www.ifhhro.org/news-a-events/campaign-news/121-forced-or-coerced-sterilisation> [Accessed 13 October 2010].

³⁹ Vivo Positivo and Centre for Reproductive Rights ‘Dignity denied: Violations of the Rights of HIV-positive women in Chilean health facilities’ 2010 at 18. Available at http://reproductiverights.org/sites/crr.civicactions.net/files/documents/chilereport_single_FIN.pdf [accessed on 13 October 2010].

HIV from mother-to-child than through forced sterilisation. As will be discussed in later chapters, an HIV-positive woman is capable of having a HIV- negative baby if the required Anti- Retroviral drugs (ARVs) are accessed in time.

1.4 Objective and relevance of the research

This study is intended to raise awareness of the human rights violations that are committed by the forceful sterilisation of HIV-positive women in sub-Saharan Africa. The focus will be on South Africa and Namibia, although reference might be made to other countries. The focus on these two countries reflects their geographical proximity and similar legal structures. Namibia is currently litigating the issue of forced sterilisations following the report made by the ICW. In South Africa the report on forced sterilisations has not been officially published but the Women's Legal Centre (WLC) is in the process of collecting data on the incidences of these practices. True life case studies from the ICW Namibia report will therefore be used to illustrate and supplement the discussion.

Member states of the United Nations are legally bound to respect, protect, promote and fulfil human rights enshrined in the international human rights instruments they have ratified.⁴⁰ It is hoped that by shedding light on these violations governments will realise that women's reproductive health and autonomy needs to be protected. The cases of forced sterilisation in the ICW Namibia report and on the *3rd degree* documentary on South Africa were performed in public hospitals. Public medical personnel are employed by the Ministry of Health so the state is vicariously liable for the acts of its employees performed during the scope of employment. States also has a general obligation under international and national law to protect people from any violation of their human rights by either public or private individuals. The focus of this paper will be to highlight the human rights violations that arise from forced sterilisation.

The paper hopes to address the misguided belief by health professionals that sterilising HIV-positive women will prevent the spread of AIDS. HIV/AIDS in sub-Saharan

⁴⁰ See section discussion under section 1.5 on the theoretical and legal framework.

Africa is mainly spread through sexual intercourse and the incidence of mother-to-transmission, if properly managed through the prevention of mother-to-child treatment (PMTCT), and the use of Anti Retroviral Drugs (ARVs) like Nevezapine, can be controlled.

1.5 Theoretical and legal framework

This paper will assume a human rights-based approach as interpreted internationally and incorporated into national law. A human rights-based approach is a conceptual framework normatively based on international human rights standards and operationally directed to promoting and protecting human rights.⁴¹ This approach recognises that all human rights are interrelated and indivisible and are applicable to all human beings.⁴² It identifies rights-holders and their entitlements and corresponding duty-bearers and their obligations, simultaneously working towards strengthening the capacity of rights-holders to make their claims and correspondingly of duty-bearers to meet their obligations.⁴³ A human rights framework will be instrumental in addressing both the international and national obligations of states to protect and promote human rights.

International law has three sources namely, customary international law, treaties and conventions, and soft law (guidelines and non-binding judgments).⁴⁴ Treaties and conventions become part of national law by ratification or accession.⁴⁵ There are eight core international human rights treaties that have come into force and deal with a variety of human rights. They are: the International Covenant on Civil and Political Rights⁴⁶ (ICCPR), the

⁴¹ Office of the High Commissioner on Human Rights, available at <http://www.ohchr.org/Documents/Publications/FAQen.pdf> [accessed on 11 October 2010].

⁴² Ibid.

⁴³ United Nations *The Human Rights-Based Approach to Development: Towards a Common Understanding Among UN Agencies* (2003) New York: UN. Available at http://www.unescobkk.org/fileadmin/user_upload/appeal/human_rights/UN_Common_understanding_RBA.pdf [accessed on 15 October 2010].

⁴⁴ 'The role of international law in South African health law and policy-making' at 131. Available at <http://www.section27.org.za/wp-content/uploads/2010/04/Chapter5.pdf> [Accessed 15 October 2010].

⁴⁵ Ibid. A treaty (or charter, convention or covenant) is a formal agreement between states that defines and modifies their mutual duties towards their own citizens, or between each other as states. Treaties may be either bilateral (between two parties) or multilateral (between more than two parties). A treaty system is based on the agreement of states signing and ratifying the treaty.

⁴⁶ International Covenant on Civil and Political Rights, 16 December 1966, United Nations, Treaty Series, vol. 999, p. 171. Adopted by the United Nations General Assembly Resolution 2200A (XXI) of 16 December 1966.

International Covenant on Economic Social and Cultural Rights⁴⁷ (ICESCR), the International Convention on the Elimination of Racial Discrimination⁴⁸ (ICERD), Convention on the Elimination of All forms of Discrimination against Women⁴⁹ (CEDAW), Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment⁵⁰ (CAT), Convention on the Rights of the Child⁵¹ (CRC), International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families⁵² (ICPRMW), Convention on the Rights of Persons with Disabilities⁵³ (CRPD). There is a ninth convention; the

It entered into force on 23 March 1976, in accordance with article 49, for all provisions except those of article 41; 28 March 1979 for the provisions of article 41 (Human Rights Committee), in accordance with paragraph 2 of the said article 41. South Africa ratified this treaty on 10 December 1998. Namibia acceded to this treaty on 28 November 1994 (hereafter ICCPR).

⁴⁷ International Covenant on Economic, Social and Cultural Rights, 16 December 1966, United Nations, Treaty Series, vol. 993, p. 3. Adopted and opened for signature, ratification and accession by General Assembly resolution 2200A (XXI) of 16 December 1966. It entered into force on 3 January 1976, in accordance with article 27. South Africa signed this treaty on 3 October 1994 but has not yet ratified it. Namibia acceded to this treaty on 28 November 1994 (hereafter ICESCR).

⁴⁸ International Convention on the Elimination of All Forms of Racial Discrimination, 21 December 1965, United Nations, Treaty Series, vol. 660, p. 195. Adopted and opened for signature and ratification by General Assembly resolution 2106 (XX) of 21 December 1965. It entered into force on 4 January 1969, in accordance with Article 19. South Africa ratified this treaty on 10 December 1998. Namibia acceded to this treaty on 11 November 1982.

⁴⁹ Convention on the Elimination of All Forms of Discrimination Against Women, 18 December 1979, United Nations, Treaty Series, vol. 1249, p. 13. Amendment to article 20, paragraph 1 of the Convention on the Elimination of All Forms of Discrimination against Women is part of the document. The amendment is not yet in force. Adopted and opened for signature, ratification and accession by General Assembly resolution 34/180 of 18 December 1979. It entered into force on 3 September 1981, in accordance with article 27(1). South Africa ratified this treaty on 15 December 1995. Namibia acceded to this treaty on 23 November 1992 (hereafter CEDAW).

⁵⁰ Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 10 December 1984, United Nations, Treaty Series, vol. 1465, p. 85. Adopted and opened for signature, ratification and accession by General Assembly resolution 39/46 of 10 December 1984. It entered into force on 26 June 1987, in accordance with article 27 (1). South Africa ratified this treaty on 10 December 1998. Namibia acceded to this treaty on 28 November 1994 (hereafter CAT).

⁵¹ Convention on the Rights of the Child, 20 November 1989, United Nations, Treaty Series, vol. 1577, p. 3. The Convention on the Rights of the Child was adopted and opened for signature, ratification and accession by General Assembly resolution 44/25 of 20 November 1989. It entered into force on 2 September 1990, in accordance with article 49. South Africa ratified treaty this on 16 June 1995. Namibia ratified this treaty on 30 September 1990 (hereafter CRC).

⁵² International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families, 18 December 1990, A/RES/45/158. Adopted by General Assembly Resolution 45/158, on 18 December 1990. It entered into force on 1 July 2003. South Africa and Namibia have neither signed nor ratified this treaty.

⁵³ Convention on the Rights of Persons with Disabilities: resolution / adopted by the General Assembly, 13 December 2006, A/RES/61/106. Adopted without vote, 76th plenary meeting; Issued in GAOR, 61st sess., Suppl. no. 49. "Annex: Convention on the Rights of Persons with Disabilities": p. 2-29. It entered into force on 3 May 2008. South Africa ratified this treaty on 30 November 2007. Namibia ratified this treaty on 4 December 2007 (hereafter CRPD).

International Convention for the Protection of All Persons from Enforced Disappearance,⁵⁴ which was adopted and approved by the United Nations General Assembly in 2006 but is not yet in force. Regionally, human rights are enshrined in the African Charter on Human and Peoples Rights⁵⁵ (ACHPR), the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa⁵⁶ (AWP) and the African Charter on the Rights and Welfare of Children⁵⁷ (ACRWC). The countries in the Southern Africa Development Community⁵⁸ (SADC) have signed and adopted a Protocol on Gender and Development⁵⁹ (SADCPGD) and a Protocol on Health⁶⁰ (SADCPH) which protect some of the human rights that are violated through forced sterilisation.

This paper will discuss how forced sterilisation is a violation of the human rights protected by these international treaties which cover a wide array of universal human rights. Reference will also be made to the Constitutions of South Africa⁶¹ (SAC) and the Constitution of Namibia⁶² (NC) in regard to the rights that are violated by forced sterilisation. Section 231(4) of the SAC provides that international law becomes law in the Republic when it is enacted by Parliament⁶³ and section 232 states that customary international law that is in

⁵⁴ International Convention for the Protection of All Persons from Enforced Disappearance, 20 December 2006. Adopted by General Assembly resolution 61/177 on 12 January 2007. Entry into force on 23 December 2010, in accordance with article 39(1) which reads as follows: "This Convention shall enter into force on the thirtieth day after the date of deposit with the Secretary-General of the United Nations of the twentieth instrument of ratification or accession." South Africa and Namibia have neither signed nor ratified this treaty.

⁵⁵ African [Banjul] Charter on Human and Peoples' Rights, adopted June 27, 1981, OAU Doc.CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982), entered into force Oct. 21, 1986. Adopted in Nairobi, Kenya in June 1981. It entered into force on 21 October, 1986 (hereafter ACHPR).

⁵⁶ Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa. Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, Adopted by the 2nd Ordinary Session of the Assembly of the Union, Maputo, CAB/LEG/66.6 (Sept.13, 2000); reprinted in 1 Afr. Hum. Rts. L.J. 40. Adopted in Maputo, Mozambique on 11 July 2003. It entered into force on 25 November 2005 (hereafter AWP)

⁵⁷ African Charter on the Rights and Welfare of the Child. OAU Doc. CAB/LEG/24.9/49 (1990). Adopted in Addis Ababa, Ethiopia on 11 July 1990. It entered into force on 29 November, 1999.

⁵⁸ South Africa and Namibia are parties to SADC (hereafter ACRWC).

⁵⁹ South African Development Community, Protocol on Gender and Development, signed at Johannesburg on 17 August 2008. Available at <http://www.sadc.int/index/browse/page/465> [accessed on 21 October 2010] (hereafter SADCPGD).

⁶⁰ Southern Africa Development Community, Protocol on Health signed at Maputo on 18 August 1999. Available at <http://www.sadc.int/index/browse/page/152> [accessed on 21 October 2010] (hereafter SADCPH).

⁶¹ The Constitution of the Republic of South Africa 1996 (hereafter SAC)

⁶² The Constitution of the Republic of Namibia 1990 (hereafter NC).

⁶³ Section 231(4) of the SAC.

line with the Constitution is binding on the Republic.⁶⁴ South Africa has signed but not ratified the ICESCR, however as per *S v Makwanyane*,⁶⁵ both binding and non binding international law may be used as an interpretive tool of the SAC, therefore, reference will be made to the relevant rights protected in the ICESCR. Article 144 of the NC states that general rules of public international law and the treaties binding on Namibia shall form part of the country's law.⁶⁶ International human rights treaties that have been ratified or acceded to by the respective countries will be referenced, in order to address specific rights that are violated through forced sterilisation and also to address rights not provided for in national law.

Declarations like the Universal Declaration of Human Rights⁶⁷ (UDHR) form part of international 'soft law'⁶⁸ which 'refers to all sources of non-binding international law that can provide guidance on the interpretation of international treaties'.⁶⁹ The Declaration on Violence against Women⁷⁰ (DEVAW) will also be useful in addressing the fact that forced sterilisation can be seen as a form of violence against women. CEDAW does not directly address violence against women and the DEVAW, although soft law can potentially be useful in investigating whether states have met their obligation to protect women from harm. More so, the United Nations (UN) and the various Committees of the treaty bodies have been instrumental in interpreting the scope and meaning of human rights. Reference will therefore be made to UN documents, General Comments and Recommendations in discussing the obligation of states to fulfil, protect, promote and respect human rights. The paper will also focus on national legislation related to sterilisation, issues of consent and access to health to see the extent to which national law is breached.

⁶⁴Section 232 of the SAC.

⁶⁵ *S v Makwanyane* 1995 (3) SA 391 (CC) at par 35; 1995 6 BCLR 665 (CC).

⁶⁶ Article 144 of the NC.

⁶⁷ United Nations General Assembly, Universal Declaration of Human Rights, G.A res 217A (III) 10 December 1948 (hereafter UDHR).

⁶⁸ *Ibid.* Soft law refers to all sources of non-binding international law that can provide guidance on the interpretation of international treaties. Examples include (a) declarations, as non-binding international instruments, that can be made by any international organisation or body of experts); (b) guidelines produced by international organisations such as the UN and WHO that can be helpful to courts that do not have expertise in a particular field; (c) respected experts in their field, who can provide guidance in interpreting particular rights.

⁶⁹ The role of international law in South African health law and policy-making *supra* at 132.

⁷⁰ United Nations General Assembly, Declaration on the Elimination of Violence against Women, 20 December 1993, A/RES/48/104 (hereafter DEVAW). Available at: <http://www.unhcr.org/refworld/docid/3b00f25d2c.html> [accessed 20 October 2010].

1.6 Overview of chapters

Chapter 1 is an introduction to the concept of forced sterilisation and the problems that arise from it. It outlines the problem statement that forced sterilisation is a violation of HIV-positive women's human rights. It also links the current discourse of forced sterilisation to the eugenics era in which such procedures were used for social engineering to control population and to get rid of the unwanted in society by preventing them from procreating.

Chapter 2 deals with the doctrine of informed consent which requires that before a medical intervention is performed on a patient their consent must be obtained. This doctrine is present in both legal terms and medical ethics. This chapter argues that forced sterilisation infringes on the doctrine of informed consent thereby violating the rights to self autonomy and bodily integrity. It is important to have an understanding of what comprises 'informed consent' in order to assess whether such consent was indeed obtained. Understanding the doctrine of informed consent is important for the discussion of the later chapters as the violation of human rights flows from the fact that no consent was obtained.

Chapter 3 makes the argument that forced sterilisation is a violation of the rights to dignity and security of the person. Dignity is an intrinsic right of all human beings and a founding value in the human rights jurisprudence. It is important as both a right in itself and a value in the interpretation of other rights. The right to security of the person protects one from unlawful interference by others upon their body without consent. Forced sterilisation which is performed without the patient's consent violates the rights to dignity and security of the person as one's right to freely decide on their bodily integrity is not respected.

Chapter 4 deals with the violation to the right to non-discrimination/equality and the right to access health services, because the basis on which HIV-positive women are being discriminated is their sero-status. This chapter argues for the possible inclusion of HIV status under the ground of disability, an already protected ground in international and domestic laws

so as to provide HIV-positive people with firm protection under the law. Due to stigma attached to the disease, HIV-positive people are discriminated against in society, including in the health system. This is a violation of their right to health as they are denied appropriate care.

Chapter 5 discusses forced sterilisation as a violation of reproductive rights and the right of women to be free from violence (violence against women). Reproductive rights are intrinsic to individuals especially the right to procreate and found a family. Sterilisation being a permanent procedure prevents one from having children once it is performed. This chapter also looks at forced sterilisation as violence against women which is prohibited under international law.

Chapter 6 looks at the social consequences of forced sterilisation of HIV-positive women. Such women face double stigma due to the fact that they are HIV-positive and that they cannot bear children. Given the importance placed on children especially in Africa, such women would be abandoned and rejected which leads to mental anguish. The section also looks at the broader societal impact of such acts in that they will discourage HIV-positive women from seeking medical help when pregnant for fear of being sterilised.

Chapter 7 is a conclusion of the thesis summarising the discussion that forced sterilisation of HIV-positive women is indeed a violation of their human rights.

CHAPTER 2: FORCED STERILISATION AS A VIOLATION OF THE DOCTRINE OF INFORMED CONSENT

'Unfortunately there was one form that I was not aware of and I had already signed it.' - Positive woman Namibia, 2008.⁷¹

2.1 Introduction

Before a medical procedure is performed, independent informed consent based on complete, accurate and appropriately conveyed and understood information should be obtained from the patient.⁷² The notion of informed consent is an important factor both in legal and medical terms. Legally, medical intervention performed in the absence of a legal ground of justification is *prima-facie* unlawful or wrongful.⁷³ Medically, health personnel have an ethical duty to treat their patients with due care, and breach of this duty leads to liability. Consent is important as it is a defence to liability before the law. An individual has the rights to dignity, privacy and bodily integrity which protect one from being subject to unlawful medical intervention.⁷⁴ If one consents to a medical procedure, they are deemed to accept all the risks that accompany such a procedure.⁷⁵ For consent to be valid, it must be given freely without coercion after the patient has received all the necessary information.⁷⁶ This chapter seeks to define the meaning of informed consent as it has interpreted in practical terms. This will involve a discussion of the key elements that should be present before one can be said to have given informed consent namely disclosure, comprehension, competence, voluntariness and consent.⁷⁷ It is important to understand what the doctrine of informed

⁷¹ ICW Namibia report supra note 1 at 10.

⁷² G Lindegger & L Richter 'HIV vaccine trials: Critical issues for informed consent' (2000) 96 *South African Journal of Science* 317.

⁷³ P Carstens & D Pearmain *Foundational Principles of South African Medical Law* (2007) Lexis Nexis Durban at 871.

⁷⁴ *Ibid.*

⁷⁵ *Ibid.*

⁷⁶ G A Ogunbanjo and D Knapp van Bogaert 'Ethical issues in family practice: Informed consent- disclosure of information in clinical practice' (2004) 46(3) *South African Family Practice* 35 at 35.

⁷⁷ See A Dhali 'Informed consent' (2008) 1(1) *South African Journal on Business Law* 27 that lists the legal elements of informed consent.

consent is before a discussion of what actual human rights have been violated by forced sterilisation can be explored. This is because the violation of human rights stems from the fact that no informed consent was obtained from the women who were forcefully sterilised.

2.2 Exploring the doctrine of informed consent

Historically the doctrine of informed consent in medical ethics gained recognition after the Nuremberg trials that exposed the medical experiments that were being carried out in Nazi Germany during the Second World War.⁷⁸ The atrocities of the experiments presented the world with evidence of shocking medical malevolence. The widely held perception of doctors as being all benevolent and beneficence was shattered.⁷⁹ The principle of beneficence places a duty on health professionals to do good for their patients, while the principle of non-maleficence obliges health professionals not to do harm to their patients.⁸⁰ During the Nuremberg trials, it was discovered that not all medical practitioners were benevolent and beneficent and that the paternalistic approach used by medical practitioners, could no longer be considered acceptable after it was used to justify horrific experiments.⁸¹ As a result, the Nuremberg Code⁸² was drafted in which the voluntary consent of the human subject was made absolutely essential for medical experimentation.⁸³ This Code set the foundation for the doctrine of informed consent as it bestowed the individual with the right to autonomously decide what should be done to his/ her body free of coercion and threat. The World Medical Association thereafter passed the Declaration of Geneva⁸⁴ which outlines a list of ethical guidelines for medical practitioners.

⁷⁸ J Miola *Medical ethics and medical law: A symbiotic relationship* (2007) at 33.

⁷⁹ *Ibid* at 34.

⁸⁰ T L Beauchamp and J F Childress *Principles of Bioethics* 4th Edition (1994).

⁸¹ *Ibid*.

⁸² The Nuremberg Code (1947) in: A Mitscherlich and F Mielke *Doctors of infamy: the story of the Nazi medical crimes* (1949) New York: Schuman, xxiii-xxv. Available at <http://www.cirp.org/library/ethics/nuremberg/> [Accessed 30 October 2010].

⁸³ *Ibid* at paragraph 1.

⁸⁴ Declaration of Geneva adopted by the 2nd General Assembly of the World Medical Association, Geneva, Switzerland, September 1948. Amended by the 22nd World Medical Assembly, Sydney, Australia, August 1968 and the 35th World Medical Assembly, Venice, Italy, October 1983 and the 46th WMA General Assembly, Stockholm, Sweden, September 1994 and editorially revised at the 170th Council Session, Divonne-les-Bains, France, May 2005 and the 173rd Council Session, Divonne-les-Bains, France, May 2006.

In *Castell v De Greef*,⁸⁵ a South African case that dealt with the meaning of informed consent under common law, Ackermann J explained that the doctrine of informed consent flowed from patients' 'fundamental right to self-determination' and 'rights of bodily integrity and autonomous moral agency'.⁸⁶ Autonomy is defined as the right to self-govern and act 'freely in accordance with a self-chosen plan',⁸⁷ and is a fundamental ethical principle underlying informed consent. The doctrine of informed consent therefore connotes the right of an individual to autonomously decide on issues that concern their own body. In healthcare, the respect for an individual's autonomy requires acknowledging that individuals after being fully informed of the implications of a particular medical intervention that affects their life and wellbeing possess the freedom to accept or refuse such intervention.⁸⁸ The Committee on CEDAW in General Recommendation 24 on women and health, notes that women have the right to be fully informed of their options in agreeing to treatment or research, including the likely benefits and potential adverse effects of proposed procedures and available alternatives'.⁸⁹

The doctrine of informed consent entails a process of information sharing and decision making based on mutual respect and participation.⁹⁰ Informed consent seeks to transfer some power to the patient in areas affecting their self determination, so as to create the optimal relationship between doctor and patient, namely a partnership of shared endeavour in pursuit of the client's interests.⁹¹ This doctor-patient relationship that allows for patient autonomy, can be set against the traditional paternalistic 'doctor knows best approach' to medical decision making.⁹² Paternalism, the belief that the health care practitioner should protect or advance the interests of the patient even if contrary to the patient's own immediate desires or freedom of choice, therefore no longer has a place in the modern health care

⁸⁵ 1994 (4) SA 408 (C).

⁸⁶ Ibid.

⁸⁷ Beauchamp and Childress *supra* note 80.

⁸⁸ Dhai *supra* note 77 at 27.

⁸⁹ Committee on the Elimination of Discrimination against Women, General Recommendation 24, Women and Health (Twentieth session, 1999), U.N. Doc. A/54/38 at 5 (1999), reprinted in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, U.N. Doc. HRI/GEN/1/Rev.6 at 271 (2003) (hereafter CCEDAW GC 24).

⁹⁰ Dhai *supra* note 77 at 27.

⁹¹ I Kennedy *Treat Me Right: Essays in Medical Law and Ethics* (1991) at 78.

⁹² P Foster 'Informed consent in practice' in S Sheldon and M Thomson *Feminist Perspectives on Healthcare Law* (1998) at 53.

context.⁹³ The process of obtaining informed consent should be considered a procedure and not merely an affirmation, ritual or signature on a piece of paper at a particular point in time.⁹⁴

Informed consent encompasses informed decision making, which involves the giving of relevant information to the patient in order for them to be able to make a decision. According to the International Federation of Gynaecology and Obstetrics (FIGO) Committee for the study of Ethical Aspects of Human Reproduction and Women's Health (FIGO Guidelines), informed consent is consent obtained freely, without threats or improper inducements, after appropriate disclosure to the patient of adequate and understandable information in a format and language understood by the patient.⁹⁵ The purpose and function of the doctrine of informed consent is to ensure the patient's right to self-determination and freedom of choice, and to encourage rational decision-making by enabling the patient to balance the benefits and disadvantages of the proposed intervention in order to reach a decision to accept or refuse it.⁹⁶

The doctrine of informed consent in South Africa is present in the South African National Health Act⁹⁷ (SANHA). Section 7(1) provides that a health service may not be provided to a user without informed consent.⁹⁸ Section 7(2) of SANHA defines informed consent as provision of a specified health service to a person with legal capacity after the person has been given relevant information.⁹⁹ Namibia does not have a clear health act but the Patient Charter of Namibia¹⁰⁰ governs the rights of patients to medical treatment.

⁹³ Dhai supra note 77 at 27.

⁹⁴ Ibid; A Dhai and D McQuoid-Mason *Bioethics, human rights and health law: principles and practice* (2011) at 72.

⁹⁵ International Federation of Gynaecology and Obstetrics (FIGO) Committee for the study of Ethical Aspects of Human Reproduction and Women's Health 'Ethical issues in Obstetrics and Gynaecology' (2009) (hereafter FIGO Guidelines). Available at <http://www.figo.org/files/figo-corp/Ethical%20Issues%20-%20English.pdf> [accessed on 15 October 2010].

⁹⁶ Carstens & Pearmain supra note 73 at 883.

⁹⁷ 61 of 2003.

⁹⁸ Section 7(1) of the SANHA.

⁹⁹ Section 7(2) of the SANHA.

¹⁰⁰ Minister of Health and Social Services *The Patient Charter of Namibia* Directorate: Primary Health Care & Nursing Services. Windhoek, July 1998. Available at <http://www.healthnet.org.na/documents/policies/Patient%20Charter.pdf> [accessed on 2 November 2010].

Informed consent consists of five key elements namely: disclosure, comprehension, competence, voluntariness and consent.¹⁰¹ These elements are at times framed as knowledge, appreciation and acquiescence.¹⁰² The five key elements of informed consent will be discussed in detail in the following sub-sections, taking note of both international human rights law and the domestic law of South Africa and Namibia. The factors that affect informed consent like cultural barriers, literacy, and language barriers will be explored in the discussion of the key elements.

2.2.1 Disclosure: need for informed decision-making

Before one can make an informed decision they need the relevant information to make their decision. Article 19 of the ICCPR provides that everyone has the right to seek, receive and impart information.¹⁰³ CEDAW particularly emphasises that women have the right to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning.¹⁰⁴ Regionally, article 9 of the ACHPR guarantees every individual the right to receive information.¹⁰⁵ Section 32 of the SAC provides that everyone has the right of access to any information that is held by another person and is required for the exercise or protection of any rights.¹⁰⁶ The NC does not expressly provide for the right to access of information but since it has ratified the ICCPR, CEDAW and ACHPR, it is bound by the relevant articles that protect the right to information. Access to information is therefore important for one to be able to make an informed decision.

¹⁰¹ Ogunbanjo and Knapp van Bogaert supra note 76.

¹⁰² See Carstens & Pearmain supra note 73 at 878.

¹⁰³ Article 19 of the ICCPR.

¹⁰⁴ Article 10(h) of CEDAW.

¹⁰⁵ Article 9 of the ACHPR.

¹⁰⁶ Section 32 of the SAC.

Informed decision-making denotes the health service provider's duty to disclose information to the patient in order for them to give consent.¹⁰⁷ This disclosure should include all relevant information about a proposed procedure or treatment prior to obtaining the consent of the patient, to carry out the procedure or treatment.¹⁰⁸ Disclosure must take place in a doctor-patient discussion and the mere use of brochures will not suffice.¹⁰⁹ The information discussed must be comprehensive but should not go to the extreme so as to scare the patient.¹¹⁰ The legal duty of medical personnel is to present information that is material to the choice that the patient has to make and it must be presented in a manner that the patient can understand and recall.¹¹¹ The manner in which the information is conveyed is also important therefore there is a need to develop medical practitioners' communication skills.

Section 6 of the SANHA outlines the information that must be given to a user that is relevant for them to give informed consent.¹¹² This include inter alia: the user's health status; the range of diagnostic procedures and treatment options generally available to the user; the benefits, risks, costs and consequences generally associated with each option; and the user's right to refuse health services and an explanation of the implications, risks, obligations of such refusal.¹¹³ Likewise, the Patient Charter of Namibia provides that a patient has the right to get an explanation regarding their illness, be given detailed information on the appropriate treatment as well as to be consulted when choices exist.¹¹⁴ The FIGO Guidelines provide for the disclosure of alternative methods including those that are less intrusive.¹¹⁵ The obligation to disclose extends to providing accurate information on any questions asked by the patient as well as imploring upon a patient the necessity of a medical intervention where they decline it.¹¹⁶ Section 6 of the SANHA recognises that patients have a

¹⁰⁷ R Cook, B M Dickens and M F Fathalla *Reproductive health and human rights: Integrating medicine, ethics and law* (2003) at 109.

¹⁰⁸ Ibid.

¹⁰⁹ Ogunbanjo and Bogaert *supra* note 76 at 36.

¹¹⁰ Ibid.

¹¹¹ Cook, Dickens and Fathalla *supra* note 106 at 109.

¹¹² Section 6 of the SANHA.

¹¹³ Ibid at subsections 6(1)(a)- (d).

¹¹⁴ Patient Charter of Namibia *supra* note 100 at 4.

¹¹⁵ FIGO Guidelines *supra* note 95 at 14.

¹¹⁶ M Pieterse 'The interdependence of rights to health and autonomy in South Africa' (2008) 125 (3) *South African Law Journal* 553 at 565; Carstens & Pearmain *supra* note 73 at 887.

right to refuse treatment but obliges doctors to warn patients of the dangers of refusing such treatment.¹¹⁷ The decisions to accept or decline recommended care should also be recorded.¹¹⁸

The problem that arises when dealing with disclosure is deciding how much information should be disclosed. Carstens & Pearmain note that the doctrine of informed consent is fraught with controversy because of number of reasons *inter alia*: inconsistent interpretation due to multi-layered laws and policies;¹¹⁹ the manner in which consent is obtained;¹²⁰ discrepancies between public and private health care which has an effect of compromising the process of obtaining informed consent due to poor infrastructure and lack of resources.¹²¹ They also state that informed consent is procedure-specific which means that health personnel need to make sure the consent obtained is specific to a particular medical intervention.¹²² Medical personnel have therapeutic privilege to withhold information where disclosure of such information would be more harmful than non-disclosure.¹²³ However, therapeutic privilege has some safeguards including that it cannot be justified where it is administered contrary to the patients will, or where the doctor has reason to believe or knows that the patient would not undergo the procedure once properly informed.¹²⁴ In the context of forced sterilisation of pregnant HIV-positive women, before such a woman can be seen to make an informed decision she should have had accurate information about mother-to-child infection and sterilisation as a medical procedure. These two points will now be expounded upon.

¹¹⁷ Section 6 of SANHA.

¹¹⁸ *Ibid.*

¹¹⁹ Carstens & Pearmain *supra* note 73 at 877.

¹²⁰ *Ibid.*

¹²¹ *Ibid.*

¹²² *Ibid* at 878.

¹²³ See L C Coetzee 'Medical therapeutic privilege, a separate and independent defence *eo nomine*' (2004) 3 *TSAR* 464, who defines therapeutic privilege as a defence that allows doctors to withhold information if it would be detrimental to the patient's health.

¹²⁴ Carstens and Pearmain *supra* note 73 at 910- 911.

2.2.1.1 Accurate information about mother-to-child transmission

One of the ways in which HIV/AIDS spreads is by infection from mother-to-child (vertical transmission). Unlike in the past, it is now possible with modern science and proper treatment for HIV-positive mothers to have HIV- negative babies.¹²⁵ It is very important in the prevention of HIV/AIDS infection for women to be aware of the facts regarding mother-to-child transmission. According to the United Nations Children’s Fund (UNICEF) reducing HIV transmission from a pregnant woman living with HIV to her child requires a range of interventions beginning with voluntary and confidential counselling and HIV testing for pregnant women; provision of antiretroviral prophylaxis for pregnant women with HIV and their newborn baby, or antiretroviral therapy for the mother if eligible; safe delivery practices and guidance in selecting a suitable infant-feeding option in order to prevent mother-to-child transmission (PMTCT) of HIV.¹²⁶ Article 12(2) of CEDAW provides that state parties shall ensure that women have appropriate services in connection with pregnancy.¹²⁷ This could be interpreted to include the provision of all information on prevention of mother-to-child infection (PMTCT) for pregnant HIV-positive mothers.

The UNICEF statistics show that more than 90 per cent of HIV infections in infants are passed on by mothers during pregnancy, labour, delivery or breast feeding.¹²⁸ Without any intervention, between 15 per cent and 45 per cent of infants born to mothers living with HIV will become infected (5–10 per cent during pregnancy, 10–20 per cent during labour and delivery and 5–20 per cent through breastfeeding).¹²⁹ The transmission of HIV infection from mother to child can be sharply reduced if antiretroviral drugs are administered to a woman during pregnancy and delivery and to her infant shortly after birth.¹³⁰ These statistics show the necessity for pregnant HIV-positive women to be informed of the urgency for them to be tested and to be on treatment if they want to prevent mother-to-child transmission. Such

¹²⁵ UNICEF ChildInfo ‘Prevent mother-to-child transmission of HIV’. Available at http://www.childinfo.org/hivaids_mother_to_child.html [accessed on 4 November 2010].

¹²⁶ Ibid; A Ramkissoon et al. ‘Sexual and reproductive health and rights’ 2010 *South African Health Review* 33 at 40.

¹²⁷ Article 12(2) of CEDAW.

¹²⁸ UNICEF ‘Prevention of mother to child transmission’ supra note 125.

¹²⁹ Ibid.

¹³⁰ Ibid.

statistics are also vital for an HIV-positive women who due to fear of transmitting the virus to her child (should she have one), is considering sterilisation as her only option. Information that reveals that there is a possibility of having an HIV-negative child is vital before she can be said to have considered all other options.

The reason given for forcefully sterilizing HIV-positive women in Namibia was that doctors felt a social responsibility to prevent the spread of HIV because infected mothers would infect their children.¹³¹ HIV-positive women however have the right to reproduce just like any other individual, and forced sterilisation infringes on this right. The rationale provided by the ‘social responsibility’ argument is unjustified because a less restrictive means to prevent vertical transmission by undertaking proper ARV treatment is widely available. Some countries have mandatory testing for all pregnant women for example Botswana. In South Africa HIV counselling and testing is provided as standard care in antenatal and postnatal care.¹³² However, the patient has the option to opt out and testing can only be done with informed consent.¹³³ Following testing, those found to be HIV-positive are then required to be informed of all the available measures that can prevent mother-to-child transmission. Apart from the use of Nevarapine, HIV-positive women should also be informed of the use of a c-section to prevent infection at birth, and the benefits and risks of this procedure.¹³⁴ Caesarean sections that are properly performed have been shown to prevent transmission of the HI-virus at birth.¹³⁵ Where c-sections are not available, pregnant HIV-positive women should be informed of the possibility of safe vaginal birth which can be ensured by avoidance of invasive tests and vaginal cleaning.¹³⁶ This information is important particularly for women in rural areas who may not have access to such knowledge and may therefore be more easily coerced into accepting sterilisation as the only option.

¹³¹ ICW Namibia report supra note 1 at 8.

¹³² South African National AIDS Council. *The National HIV Counselling and Testing Campaign Strategy*. South Africa, 2010.

¹³³ Ibid.

¹³⁴ A Ramkissoo et al. ‘Options for HIV-positive women’ (2006) 19 *South African Health Review* 315 at 322.

¹³⁵ Ibid, Ramkissoo et al. note that the possible risks of c-sections include that they are ‘costly and have an increased risk of post-operative complications, morbidity and mortality. Complications such as postnatal infections are five to seven times more likely to occur after [c-sections] with labour or membrane rupture compared to vaginal delivery.’

¹³⁶ Ibid.

2.2.1.2 Accurate information about sterilisation

Female sterilisation by tubal ligation is irreversible and permanent which means it is a decision that has to be undertaken with thorough knowledge of the benefits, risks, alternatives and possible health and social implications.¹³⁷ Sterilisation as a means of contraception should therefore only be undertaken with free and informed consent. The Committee on CEDAW in its General Recommendation 21¹³⁸ stresses the importance of access to information particularly in the context of sterilisation. It states that in order to make an informed decision about safe and reliable contraceptive measures, women must have (accurate) information about contraceptive measures and their use. In addition to this, women should be guaranteed access to sex education and family planning services as provided in article 10(h) of CEDAW.¹³⁹ Similarly, FIGO in their Ethical Considerations on Sterilisation state that the process of informed choice should precede informed consent to surgical sterilisation.¹⁴⁰ However, the ICW report in Namibia revealed that medical personnel failed to provide women with a full description of the nature of the sterilisation procedure and its consequences.¹⁴¹

In South Africa, the Sterilisation Act¹⁴² (SASA) clearly outlines the relevant type of information that must be conveyed to a patient before the threshold of disclosure is met. It mandates that consent be given freely and voluntarily without any inducement¹⁴³ and only after the person has been given clear explanation and adequate description of the proposed plan of the procedure,¹⁴⁴ consequences and risks including whether the procedure is reversible or irreversible.¹⁴⁵ The person must also be given advice that consent may be

¹³⁷ FIGO Guidelines supra note 95 at 98.

¹³⁸ Committee on the Elimination of Discrimination against Women, General Recommendation 21, Equality in marriage and family relations (Thirteenth session, 1992), U.N. Doc. A/49/38 at 1 (1994), reprinted in Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, U.N. Doc. HRI/GEN/1/Rev.6 at 250 (2003).

¹³⁹ Article 10(h) of CEDAW.

¹⁴⁰ FIGO Guidelines supra note 95.

¹⁴¹ ICW Namibia report supra note 1 at 11.

¹⁴² 44 of 1998.

¹⁴³ Section 4 of SASA.

¹⁴⁴ Section 4(a)(i) of SASA.

¹⁴⁵ Section 4(a)(ii) of SASA.

withdrawn anytime before the procedure.¹⁴⁶ The SANHA similarly provides that all material risks of a procedure must be clearly explained.¹⁴⁷ Risks are regarded as material if a reasonable person in the position of the patient, if warned of the risk, would attach significance to it, and if the medical practitioner concerned should have been reasonably aware that the patient, if warned of the risk, would attach significance to it.¹⁴⁸ Since sterilisation is irreversible, this material information should be communicated to the patient. A person privy to such information would be able to weigh the risks and benefits before making an informed decision.

2.2.2 Comprehension: ability to fully understand the information given

Comprehension refers to the ability of the patient to clearly understand what she/ he is consenting to. Ascertaining whether or not the patient understands what they are consenting is one of the challenges to the doctrine of informed consent.¹⁴⁹ Literacy therefore forms a critical dimension of consent as one should be able to read and understand the consent form before they are said to be able to give informed consent. In Africa where there are high levels of illiteracy, people may consent to medical treatment when they have not even read the consent form. Carstens and Pearmain note that many physicians are of the opinion that it is not possible to normatively obtain informed consent as many patients are illiterate and ignorant.¹⁵⁰ The SASA provides that before consent can be said to have been given the patient must have understood the consent form and signed it.¹⁵¹ A mere signature although a prima facie indication that consent was obtained, should not be taken to be binding where one did not understand what they were consenting to.

Language barriers are also problematic as one may not fully understand the meaning of consent unless it is explained in one's mother tongue. This is especially important in rural

¹⁴⁶ Section 4(b) of SASA.

¹⁴⁷ Section 6(1)(c) of SANHA.

¹⁴⁸ *Castell v De Greef* supra note 85 at 426; D J Mcquoid-Mason & M A Dada 'The National Health Act: some implications for family practice' (2006) 24(1) *Continuing Medical Education* at 13.

¹⁴⁹ Carstens and Pearmain supra note 73 at 878.

¹⁵⁰ Ibid.

¹⁵¹ Section 4(c) of SASA.

areas where the women may be fluent in their mother tongue but be unable to understand English, yet the consent forms are written in English. The ICW Namibia report recorded that many of the doctors in Namibia are not natives and do not speak the native languages which leads to language barrier and lack of communication.¹⁵² This is problematic particularly where there is a need to translate scientific terms and there is no equivalence in the native language. Failure to comprehend such scientific terms may affect the ability of the patient to accurately give informed consent.¹⁵³ More so, information may not be available in the native language and even though one can read, they may not be able to understand the information in another language. Furthermore, the available translations may contain information that is inaccurate, incomplete, or even misleading.¹⁵⁴ In this case informed consent cannot be said to have been achieved.

Straightforward language should be used to explain information to the patient especially where the procedural explanation is very technical. In the case of sterilisation, medical terminology such as ‘tubal ligation’ needs to be explained in lay-man’s terms so that the patient is able to understand what they are consenting to. To remedy problems that may arise from the failure to comprehend medical treatment or procedures, section 6(2) of the SANHA provides that where possible, the health provider must give the user the information in a language that they understand and in a manner that takes to account the user’s level of literacy.¹⁵⁵

The comprehension of information is also affected by the way patients view the doctor as a symbol of authority.¹⁵⁶ Patients might be intimidated by the authority of the doctor and due to lack of scientific knowledge, be scared to question the doctor where they are unclear.¹⁵⁷ This is especially a problem in cultures that promote respect for authority and

¹⁵² ICW Namibia report at 11.

¹⁵³ K Mystakidou et al. ‘Ethical and practical challenges in implementing informed consent in HIV/AIDS clinical trials in developing or resource-limited countries’ (2009) 6 (2) *Journal of Social Aspects of HIV/AIDS* at 51.

¹⁵⁴ Ibid.

¹⁵⁵ Section 6(2) of the SANHA.

¹⁵⁶ Mystakidou et al. supra note 153 at 49.

¹⁵⁷ Ibid.

discourage one from challenging authority. There is a paternalistic belief that a doctor has the best interests of the client at heart so if they decide that a particular procedure or medication is appropriate, the patient will just accept it, because they fear that challenging the doctor will ruin the doctor-patient relationship.¹⁵⁸ Such a situation could affect the patient's autonomous decision to either accept or refuse such treatment. This explains why some of the Namibian women who were sterilised simply agreed to the procedure and they did not question the health professionals.¹⁵⁹ Although doctors have therapeutic privilege to decide what is best for the patient, they should not use this position to influence a patient's judgement. Mystakidou et al. found that comprehension of the consent process increased when there were several meetings where the relevant information was given as opposed to a single session.¹⁶⁰ In addition to that, the presence of counsellors who are more skilled in communication than physicians also aided in comprehending the meaning of informed consent.¹⁶¹ Since sterilisation has irreversible consequences, counselling of patients is necessary in order to prepare them to cope with their decision.

2.2.3 Competence: issues of legal capacity

Legally one must be capable of giving consent in law for it to be valid. One's legal capacity points to the element of comprehension which involves the patient understanding the information so that he/she can comply with it. The patient's legal capacity affects whether they can be said to acquiesce to the medical procedure. The SASA provides that in order for one to be sterilised they must be capable of consenting in law¹⁶² and must be 18 years of age and above.¹⁶³ Sterilisation of a person below the age of 18 can only be performed if failure to do so would jeopardise the person's life or seriously impair his/ her health.¹⁶⁴ The extra protection offered to a minor means that they cannot choose to be sterilised if the reason is

¹⁵⁸ Ogunbanjo and Knapp van Bogaert supra note 76 at 36; J Kehler et al 'Where are the human rights for pregnant women? Scale up of provider-initiated HIV testing and counselling of pregnant women: The South African experience 2010.

¹⁵⁹ ICW Namibia report supra note 1.

¹⁶⁰ Mystakidou et al supra note 153 at 52.

¹⁶¹ Ibid.

¹⁶² Section 2 (1)(a) of SASA.

¹⁶³ Section 2(1)(b) of SASA.

¹⁶⁴ Section 2(3) of SASA.

not to save their life. This view is supported by the South Africa the Children's Act¹⁶⁵ which provides that a child above 12 years can consent to a medical treatment without parental consent¹⁶⁶ but in cases of surgical procedures for example sterilisation, parental consent is needed.¹⁶⁷ This is because sterilisation is generally irreversible and a minor may not be able to fully comprehend the consequences of such a decision.

The Namibian Abortion and Sterilisation Act¹⁶⁸ (NASA) provides that a person capable of consenting to law may consent to sterilisation.¹⁶⁹ The Act does not explicitly provide for the age at which one can consent to sterilisation, but the common law in Namibia currently provides that a person of 18 and above can consent to medical treatment and surgical procedures.¹⁷⁰ The NASA has been criticised as being outdated.¹⁷¹ Although section 4 of the NASA deals with sterilisation for mentally incompetent patients¹⁷² it does not clearly regulate the sterilisation procedure of mentally competent patients. This gap in the law is subject to abuse as there is no clear legislation governing how mentally competent persons can consent to sterilisation. An example of such abuse is evidenced in the cases reported by the ICW in Namibia where the (mentally competent) HIV-positive women who had been forcefully sterilised were unaware that their consent was required by law. That they were sterilised before getting consent is a violation of the doctrine of informed consent. The patient should be informed of the law in relation to consent to medical treatment where they are unsure.

Regarding persons that are not capable of consenting in law, section 7 of the SANHA provides for substituted consent for cases where the patient is unable to themselves consent which includes consent from either a spouse or partner and failing so, from a parent, grandparent, adult child or a brother or sister of the user in the specified order.¹⁷³ Section 3

¹⁶⁵ 38 of 2005.

¹⁶⁶ Section 129(2)(a) of the Children's Act.

¹⁶⁷ Section 129(3)(c) of the Children's Act.

¹⁶⁸ 2 of 1975.

¹⁶⁹ Section 4(3) of NASA.

¹⁷⁰ The current age of consent to medical treatment is 18 years.

¹⁷¹ L D Chicalu 'Litigating the cases of sterilisation without informed consent of HIV positive women in Namibia' Kopanong Conference Centre Johannesburg 12 – 13 August 2009. Available at <http://arasa.info/sites/default/files/Litigating%20the%20cases%20of%20sterilisation.pdf> [accessed 23 October 2010].

¹⁷² Section 4 of NASA.

¹⁷³ Section 7 of SANHA.

of SASA provides that sterilisation may be performed on a person incapable of consenting upon request by the person in charge of the hospital with the consent of a parent, spouse, guardian or curator.¹⁷⁴ In addition to this, the approval by a panel comprising of a psychiatrist or medical practitioner if no psychiatrist is available, a psychologist or a social worker and a nurse who consider the relevant information as contemplated in the SASA is also needed for the sterilisation to be done.¹⁷⁵ Similarly, section 4 of the NASA provides that sterilisation of a person incapable of consenting can only be performed after written consent from two medical practitioners (one being a psychiatrist),¹⁷⁶ written consent by a person who in law may consent to an operation beneficial to the incompetent person¹⁷⁷ and written authority for the sterilisation by the Minister of Health.¹⁷⁸

According to the SASA, the relevant information needed before sterilisation of a person unable to consent can be performed includes the person's age; presence of other alternatives to sterilisation; person's mental and physical health and wellbeing; nature of sterilisation procedure; likelihood that the person will become incapable of consenting to sterilisation; whether sterilisation is in the best interest of the person; and the benefit which the person may derive from sterilisation.¹⁷⁹ Even where a person is mentally incompetent there is a stringent process to follow before they can be sterilised, highlighting the importance of getting informed consent before the procedure is performed. During the eugenics movement mentally incompetent women were forcefully sterilised in the name of preventing the spread of genetic disorders and it was held to be in the interest of the state for them to be sterilised.¹⁸⁰ This practice has been condemned as it violated the rights of the sterilised patients.

¹⁷⁴ Section 3(1)(a) of SASA.

¹⁷⁵ Section 3(2) of SASA.

¹⁷⁶ Section 4(1)(a) of NASA.

¹⁷⁷ Section 4(2) of NASA.

¹⁷⁸ Section 4(3) of NASA.

¹⁷⁹ Section 3(1)(b) of SASA.

¹⁸⁰ See *Buck v Bell* supra note 25.

2.2.4 Voluntariness: free decision making

Consent must be given voluntarily and free of coercion for it to be valid. It must be clear, unequivocal and comprehensive in that it extends to the whole proposed treatment including the consequences.¹⁸¹ Physicians have a very limited therapeutic privilege to moderate how they deliver information, however they cannot lawfully use this privilege to manipulate or direct patient choice.¹⁸² Sometimes the patient may be coerced by the health practitioner to give consent through direct or indirect methods. A patient's decision may be influenced by the withholding of vital information that would have made them decide to the contrary. The ICW Namibia report revealed that in some cases vital information about sterilisation as a medical procedure and its consequences were withheld.¹⁸³ More so, information about other forms of contraception was withheld as well as information on the possibility of the prevention of mother-to-child transmission.¹⁸⁴ On the contrary, some women were told that sterilisation was a routine procedure and that they had to comply with it.¹⁸⁵

Emotional duress was also used to coerce the women into giving consent. For example some of the affected women were told that they were endangering the lives of their future children by being pregnant while HIV- positive and that their future children will die due to HIV infection.¹⁸⁶ The women ended up agreeing to sterilisation out of guilt. Coercion was also done through threats. The ICW report revealed that some HIV positive women were forced to sign consent forms while in labour, by being told that if they did not sign the forms they would not have a c-section performed on them.¹⁸⁷ Caesarean sections if performed properly are known to prevent the risk of mother-to-child infection during birth. The women were forced to sign the forms in order to save the lives of their unborn children. In some cases, consent to sterilisation was demanded before the women could access other services.

¹⁸¹ Cook et al supra note 106.

¹⁸² Ibid at 108.

¹⁸³ ICW Namibia report supra note 1 at 11.

¹⁸⁴ Ibid.

¹⁸⁵ Ibid.

¹⁸⁶ Ibid.

¹⁸⁷ Ibid.

The ICW Namibia report revealed that a pregnant woman who learnt she was HIV-positive and later attempted suicide was told that in order to have an abortion she had to agree to a bilateral tubal ligation.¹⁸⁸ This occurred after she was tested for HIV without any counselling leaving her emotionally vulnerable. She agreed to the procedure in order to access the abortion even though it was against her will. Her story is as follows:

'I was admitted for a pregnancy and the doctor came to tell me I am HIV positive and I was confused and I took the poison [overdose]. They say when we do this abortion we will also do BTL [bilateral tubal ligation]. I say no I don't want. If you don't want it we can not do the abortion. I am stuck. Later I agree to sign the form for operation -not my -will.' – Positive woman, Namibia, 2008¹⁸⁹

Coercion through emotional duress or actual threats results in one giving consent against their will. Such consent is not given freely and would not be valid in law.

2.2.5 Consent: individual autonomy versus spousal and familial consent

A person who has the legal capacity to consent to medical procedures has the right to autonomously decide to give, or withhold such consent. In cases where a person cannot legally consent to medical procedures, the law makes provision for substituted consent from the spouse, parent, grandparent or sibling.¹⁹⁰ The concept of consent in relation to complex medical care is fraught with difficulty because the autonomy of patients to decide is dependent on other factors.¹⁹¹ Firstly, 'investigators need to reconstruct the standards of informed consent in the developing world, with full recognition of cultural diversities, cultural preservation and plurality of standards'.¹⁹² One needs to be aware of the ethical considerations in different cultural contexts¹⁹³ as the meaning of informed consent varies with the cultural context of the person. The doctrine of informed consent is premised on the

¹⁸⁸ Ibid at 10.

¹⁸⁹ Ibid.

¹⁹⁰ See discussion on substituted consent both in the SASA and NSA above under the heading of capacity.

¹⁹¹ K Mysatkidou et al. supra note 153.

¹⁹² Ibid at 47.

¹⁹³ Ibid.

Western view of the individual autonomy of a person.¹⁹⁴ Mkhize argues that the principle of first-person informed consent has come to be accepted universally as it is in line with the respect for self autonomy under ethics.¹⁹⁵ However the meaning of informed consent in the developing world is different from the developed world. In developing countries especially in rural Africa the informed consent of an individual is usually linked to that of the community because decision making is a process that involves the spouse, extended family and community leaders.¹⁹⁶ Under the cultural relativism debate, the universal acceptance of individual autonomy would not be easily accepted,¹⁹⁷ because in the African context an individual's existence is embedded in social and communal relationships.¹⁹⁸

Culturally, most African societies are paternalistic and decision-making is left to the male members as head of the family, or at community level to the elders who are usually men. A problem then arises in whether such decision-making leaves room for a woman's autonomous consent to health and in particular to reproductive issues. There is a need to reconcile the clash between communitarian and autonomous interest.¹⁹⁹ In the context of HIV/AIDS, this is especially important because of the social effect the disease has on people's way of life, both those infected and affected by the disease. Similarly, concerning sterilisation which prevents one from having children, one cannot ignore the communal influence of such a decision. In the traditional African context especially where one is married, emphasis is placed on having children and a decision to be sterilised albeit one that falls under a patient's autonomy, cannot in practice be undertaken without consulting the spouse. However, lack of spousal consent does not derogate from the fact that ultimately the patient has the autonomy to consent to treatment.²⁰⁰ It is important in obtaining full informed consent that a patient is made aware of their autonomy to consent but to keep in mind whether cultural factors like spousal or familial consent would influence their decision.²⁰¹

¹⁹⁴ N Mkhize 'Communal personhood and the principle of autonomy: The ethical challenges' (2006) 24 *Continuing Medical Education* 26 at 27.

¹⁹⁵ Ibid.

¹⁹⁶ Mysatkidou et al. supra note 153 at 49.

¹⁹⁷ Mkhize supra note 194 at 27.

¹⁹⁸ Ibid at 28.

¹⁹⁹ Ibid.

²⁰⁰ Ibid, this is in line with the right to security of the person which will be discussed in Chapter 3.

²⁰¹ Ibid.

Finally, consent should be clear and concise and the patient should be given adequate time depending on the circumstances to make their decision.

2.3 Conclusion

The importance of informed consent arose after the medical atrocities committed upon Jews and other minority communities in Nazi Germany. There was a realisation that medical personnel did not always act under the principle of non-maleficence that obliged them not to harm their patients. The doctrine of informed consent is premised on individual autonomy and requires that a patient's consent is obtained before any procedure is performed on them. Informed consent consists of five elements namely disclosure, comprehension, capacity, voluntariness and consent. Before one can make an informed decision they should have the relevant information which in the context of HIV-positive pregnant women includes accurate information about PMTCT and sterilisation.

It is not always easy to assess whether the patient actually comprehends the information given factors like illiteracy and language barriers that make it hard to communicate. Even where translators are available translations may not capture the exact medical terms. More so, one's individual capacity affects whether they can legally give informed consent. Most importantly, informed consent should be given freely without coercion. Forced sterilisation which is done without the patient's informed consent violates this requirement. According to the SASA and NASA a woman above the age of 18 can autonomously give consent to sterilisation. However given the cultural context and importance of children, she should be informed that she can consult with her family, although she ultimately has the final decision. Understanding the doctrine of informed consent is important before a discussion of the human rights violation arising from forced sterilisation can ensue, as these violations flow from the fact that no consent was obtained.

CHAPTER 3: FORCED STERILISATION AS A VIOLATION OF THE RIGHT TO DIGNITY AND RIGHT TO SECURITY OF THE PERSON.

3.1 Introduction

The right to dignity is an intrinsic and inalienable right that all humans have. It is also important as a value in the interpretation of other rights. Dignity encompasses individual autonomy and the right to consent to medical treatment. The right to security of the person protects individuals from violation of their body by others without permission. This chapter seeks to explore how forced sterilisation is a violation of the rights to dignity and security of the person. The chapter will firstly look at the right to dignity and how it has been interpreted by the courts to protect the rights of individuals and groups. Next the chapter will look at the right to security of the person as has been interpreted by international and national law. This section will involve a discussion of the right not to be subject to cruel, inhuman and degrading treatment as forced sterilisation involves an element of cruel treatment.

3.2 Violation of the right to dignity

Dignity according to Justice Ackerman can be defined as a:

‘concept comprising all the aspects of human personality that arise from human intellectual and moral capacity; which in turn separate humans from the impersonality of nature, enables them to exercise their own judgment, to have self-awareness and a sense of self worth, to exercise self-determination, to shape themselves and nature, to develop their personalities and to strive for self-fulfilment of their lives’.²⁰²

²⁰² LWH Ackerman ‘The significance of Human Dignity for Constitutional Jurisprudence’ Lecture, Stellenbosch Law Faculty, 15 August 2005 cited in S Woolman ‘Dignity’ in S Woolman et al (eds) *Constitutional Law of South Africa 2nd Edition* 2005 Juta & Co Ltd.

The right to dignity is enshrined in a number of international human rights instruments. The UDHR in its preamble recognises the inherent dignity of all members of the human family²⁰³ and in article 1 provides that all human beings are born free and equal in dignity and rights.²⁰⁴ The ICCPR in its preamble reiterates the importance of acknowledging the inherent dignity of all human beings. The ACHPR in article... protects the right to dignity. The South African Constitution in section 10 provides that everyone has the right to dignity. Similarly, the Namibian Constitution in section 8(1) protects the inviolable right to human dignity. Dignity is not only a right but a founding value in the constitutions of both countries which signifies its importance as not only a right in itself but also as an interpretative tool for other rights. Dignity as a right has its history in the idea that justice consists of the refusal to turn away from suffering.²⁰⁵ This is evidenced in the use of dignity to condemn the use of concentration camps in the Nuremburg trials and the abuse of blacks in Apartheid.

Immanuel Kant's theory of dignity is one of the most widely used theories in academia. It is premised on the 'categorical imperative' which posits that conduct is right if it treats others as ends in themselves and not as means to an end.²⁰⁶ More so, respect for the intrinsic worth of every person means that individuals are not to be perceived or treated merely as instruments or objects of the will of others, and individuals are ends in themselves and should never be used as tools to achieve a desired goal.²⁰⁷ In the context of forced sterilisation of HIV-positive women, the reason given by health officials was that they had a social responsibility to prevent the spread of HIV/AIDS through mother-to-child transmission. The HIV-positive women in this case are used as means to achieve the larger societal goal of preventing HIV/AIDS. The problem is that these HIV-positive women's right to dignity is infringed on as they are sterilised without their consent. The recognition of individuals as ends furthers two insights namely that, others are entitled to the same degree of concern and respect that we demand for ourselves; and that others are possessed of faculties

²⁰³ The preamble of the UDHR.

²⁰⁴ Article 1 of the UDHR.

²⁰⁵ Woolman supra note 202 at 36-2.

²⁰⁶ I Kant *Groundwork of the Metaphysics of Morals* (2002) 46-47 cited in Woolman 'Dignity' ibid.

²⁰⁷ O Schachter 'Human dignity as a normative concept' (1983) 77 *American Journal of International Law* 848 at 849.

that enable them to pursue ends which give their lives meaning.²⁰⁸ This means that individuals are autonomously capable of determining how they should live their lives and no one should infringe on their rights without permission.

Human dignity is not only a universal right but also has corresponding obligations. The preamble of the UDHR provides that ‘whereas recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world and implies obligations or responsibilities’.²⁰⁹ This means that an individual has to respect the right of others to dignity. Dignity can be used to encompass the collective rights of a group as a whole. The South African Constitution Court (SACC) has used dignity to argue for the rights of groups that were disadvantaged and discriminated against. For example in *Port Elizabeth Municipality v Various Occupiers*²¹⁰, the SACC held that the commitment to dignity does not flow only from the inalienable rights of individuals, it also affects the dignity of the entire community where such violations occur. The forced sterilisation of HIV-positive women without informed consent therefore not only violates the dignity of HIV-positive women as a group but also the dignity of their families who are denied the joy of having future children. It further infringes on the dignity of society to have such violations upon members of the society. In this case dignity binds together a community based on mutual recognition of collective rights of groups.

Communal dignity in Africa is best understood under the notion of *ubuntu* which requires that people be treated with humanness. Desmond Tutu best describes *ubuntu* as follows:

A person with Ubuntu is open and available to others, affirming of others, does not feel threatened that others are able and good, for he or she has a proper self-assurance that comes from knowing that he or she belongs in a greater whole and is diminished when others are humiliated or diminished, when others are tortured or oppressed.²¹¹

²⁰⁸ Woolman supra note 202 at 36-17.

²⁰⁹ The preamble of the UDHR.

²¹⁰ 2005 (1) SA 217 (CC) at para 18.

²¹¹ D Tutu *No future without forgiveness* (1999) Doubleday New York at 31.

The SACC in *S v Makwanyane*²¹² interpreted ubuntu to be synonymous with humanness, solidarity and fairness and used it to abolish the death penalty stating that dignity is violated where we treat others with less respect.²¹³ Ubuntu recognises a person's status as a human being, entitled to unconditional respect, dignity, value and acceptance from the community; also the corresponding duty to give the same respect, dignity, value and acceptance to each member of the community.²¹⁴

Dignity has a multiplicity of roles. To begin with, it functions as a first order rule and can be invoked where no other right is directly identified as being violated.²¹⁵ In *Booyesen v Minister of Home Affairs*²¹⁶ dignity was used as a first order right to protect the interest of couples in marriage where the court could not identify any other specific right. The SACC declared that the provision of the Aliens Act that placed an obligation on foreign spouses seeking to work in South Africa to apply for a work permit while outside the country and then not to enter the country until the permit has been issued was unconstitutional.²¹⁷ More so, the provisions failed to give proper recognition to the importance of family life, particularly the reciprocal rights and duties of the spouses to cohabitation and to financial support.²¹⁸ The Namibian Supreme Court highlighted the importance of the right to dignity in *Ex parte Attorney- General: In re Punishment by Organs of State*,²¹⁹ a case dealing with the issue of corporal punishment of prisoners and of pupils in schools. Mohammed AJA held that the manner in which corporal punishment is administered is intended to result in acute pain and suffering which invades the dignity and the self-respect of the recipient.²²⁰ These two cases therefore reaffirm that every human being has the inviolable right to dignity which has to be protected.

²¹² *S v Makwanyane* supra note 65 at paragraphs 224, 225, 237, 243 and 250.

²¹³ Ibid.

²¹⁴ Ibid.

²¹⁵ Woolman supra note 202.

²¹⁶ 2004 (5) SA 331 (CC).

²¹⁷ Ibid, the section was also challenged because it stipulated that work permits would only be issued to spouses of South African citizens if they did not pursue an occupation for which a sufficient number of persons are available in South Africa was inconsistent with section 10 of the Constitution which guarantees the right to dignity.

²¹⁸ Ibid at 489.

²¹⁹ 1991 NR 178 (SC).

²²⁰ Ibid at 188.

In the context of forced sterilisation the mere fact that the procedure is done without consent, violates one's right to dignity at the outset. The right to dignity requires at the very least that persons be treated as recipients of rights and not as objects subject to statutory (or any other) mechanisms without a say in the matter.²²¹ Medically, the process of obtaining consent from a patient involves a participatory discussion in order for the patient to make an informed decision. Failure to do so not only violates the doctrine of informed consent but also the patient's right to dignity²²² as they are not consulted before a decision that affects their lives is made. Provision of information during consultation empowers the patient to make the most suitable choice which is in line with Kant's theory of dignity as self fulfilment.

Secondly, dignity operates as a second order rule meaning it determines how a first order rule (the main right being invoked) disposes of a given issue and can be invoked as an additional right where a more specific right is violated.²²³ Dignity features more prominently with the right to equality. The interrelatedness of dignity and equality will be dealt with in Chapter 4 which discusses how forced sterilisation violates the right to non-discrimination/equality. Dignity has also been used to interpret the right to life, religion, and freedom from cruel, inhuman and degrading punishment. Forced sterilisation violates the right to dignity as a first order rule and a second order rule. Violation of dignity as a first order rule occurs because a person is not treated as an ends and subject to what others perceive to be right namely that HIV-positive mothers should not have children. Dignity as a second order rule is violated in that if any other rights for example the right to equality or life is invoked, the threshold for violation depends on whether one's dignity is violated. In South Africa the test for whether a law can limit a right in the Bill of Rights is if the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom.²²⁴ Forced sterilisation would only be justifiable if it meets this test. However as argued above, forced sterilisation violates the right to dignity (a major tenet of the South African Constitution) so it is not likely to be justifiable. The right to dignity in the Namibian Constitution is inviolable hence forced sterilisation an act that infringes on this right can never be justifiable.

²²¹ *Advance Mining Hydraulics v Botes NO 2000(2) BCLR 119 (T)* at 127.

²²² Dhai and McQuiod-Mason supra note 94 at 70.

²²³ Woolman supra note 202.

²²⁴ Section 36(1) of the SAC.

3.3 Violation of right to security of the person

The right to security of the person is protected in a number of international human rights instruments. Article 3 of the UDHR and article 9(1) of the ICCPR provide that everyone has the right to liberty and security of the person.²²⁵ Regionally, the ACHPR in article 4 protects the right to security of the person.²²⁶ The AWP in article 4(1) provides that every woman shall be entitled to respect for her life and the integrity and security of her person.²²⁷ Domestically, SAC provides that everyone has the right to freedom and security of the person²²⁸ which includes the right to bodily and psychological integrity.²²⁹ The NC does not expressly provide for the right to security of the person but since it is party to the ICCPR and the ACHPR, the state is bound to protect this right.

The right to security in and control over one's body points to the importance of autonomous consent. Currie and de Waal interpret the right to security of the person as the right to be left alone and in relation to one's body, it creates a sphere of individual inviolability.²³⁰ This means that one cannot interfere with the body of another without permission. The authors argue that the term 'security in' denotes the protection of bodily integrity against intrusions by the state and others while 'control over' denotes the protection of what could be termed bodily autonomy or self-determination which can colloquially mean the right to live one's life the way they choose.²³¹ The importance of the constitutional right to security of the person was stated in *Minister of Safety and Security v Hamilton*²³² where the South African Supreme Court of Appeal held that 'as is abundantly clear from the inclusion of this right in the Bill of Rights in both the 1993 and 1996 Constitutions, it is most certainly a right 'deemed worthy of protection'.'²³³

²²⁵ Article 3 of the UDHR.

²²⁶ Article 4(1) of the ACHPR.

²²⁷ Article 4(1) of the AWP.

²²⁸ Section 12(1) of the SAC.

²²⁹ Ibid section 12(2).

²³⁰ I Currie and J de Waal *The Bill of Rights handbook* 5th Edition (2005) Juta & Company at 308.

²³¹ Ibid.

²³² 2004 (2) SA 216 (SCA).

²³³ Ibid at 230-231.

In South Africa, section 12(2) of the Constitution protects one's autonomous decision in health-related matters.²³⁴ Section 12(2) (a) specifically protects the right of an individual to make decisions concerning reproduction.²³⁵ This provision has been regarded as guaranteeing substantive equality to women in that they are able to decide on issues like abortion and sterilisation.²³⁶ In *Christian Lawyers Association v Minister of Health and Others*,²³⁷ the court held that any limitation upon the freedom of any woman, including any girl under the age 18 years to have her pregnancy terminated constituted a limitation of her fundamental rights as enshrined in section 12 (2) (a) and (b), and such limitation would be valid only if justified in terms of section 36(1) of the SAC. This judgement shows that the courts have recognised the importance of individual autonomy in reproductive decisions. Sterilisation affects one's reproductive fertility hence is a decision that has to be taken after one has acquiesced the relevant information. Any coercion or forceful sterilisation therefore amounts to a violation of the right to security of the person.

The right to security of the person is placed together with the right to be free from cruel, inhuman and degrading treatment in some human rights instruments and as a separate right in some. Although these two rights give rise to human rights violations on their own, this paper chooses to look at them together given the subject matter of forced sterilisation which points to an echelon of inhuman treatment. The right to be free from cruel, inhuman and degrading treatment is internationally protected in article 5 of the UDHR, article 7 of the ICCPR and article 4(1) of the AWP. The SAC includes the right not to be tortured or treated in a cruel, inhuman and degrading way under the right to security of the person.²³⁸ The NC does not have a right to security of the person but provides that no persons shall be subject to torture or to cruel, inhuman or degrading treatment or punishment.²³⁹ The Human Rights

²³⁴ Section 12(2) of the SAC.

²³⁵ Section 12(2)(a) of the SAC.

²³⁶ M Pieterse 'The interdependence of rights to health and autonomy in South Africa' (2008) 125 (3) *South African Law Journal* 553 at 558.

²³⁷ 2005 (1) SA 509 (T) at 528 F-G.

²³⁸ Sections 12(1) (d) and (e) of the SAC.

²³⁹ Section 8(2) of the NC.

Committee (HRC) in General Comment 20²⁴⁰ on the prohibition of torture and cruel treatment and punishment defines such treatment to include both physical and mental anguish.²⁴¹ The HRC also extends the prohibition of torture, cruel and inhuman treatment to patients in medical institutions²⁴² which means that any medical activity that is carried out without one's consent could be seen to amount to cruel and inhuman treatment especially where the violation is grave. Forced sterilisation by its definition is not done voluntarily which suggests that the victim is subject to a degree of bodily intrusion. The HRC does not give a defined test as to what constitutes torture, cruel, inhuman or degrading treatment but states that the distinctions depend on the nature, purpose and severity of the treatment.²⁴³ Given the fact that the sterilisation procedure is permanent and poses a risk of emotional and social consequences for the victim, this paper argues that it amounts to cruel and inhuman punishment but not to torture²⁴⁴ which is specifically defined in the CAT.

In addition to the above, article 7 of the ICCPR particularly points out that no one shall be subjected to medical and scientific experimentation without consent. Article 4(2) (h) of the AWP similarly prohibits all forms of medical and scientific experimentation on women without their prior consent.²⁴⁵ This right is incorporated in section 12(2)(c) of the SAC which provides that everyone has the right not to be subjected to medical or scientific experiments without their informed consent. Forced sterilisations as discussed in Chapter 1 were used under the eugenics era to prevent mentally-ill patients from reproducing. These actions were widely regarded as cruel treatment as they were performed on mentally ill patients without their consent. The text of article 7 of the ICCPR allows for no limitation which means that in

²⁴⁰ Human Rights Committee 'General Comment 20, (replaces general comment 7), Article 7, 'Prohibition of torture and cruel treatment or punishment' (44th Session 1992), Compilation of Comments and General Recommendations adopted by Human Rights Treaty Bodies, U.N.Doc.HRI/GEN/1/REV.1 at 30 (1994) (hereafter HRC GC 20).

²⁴¹ Ibid at paragraph 5.

²⁴² Ibid at paragraph 7.

²⁴³ Ibid.

²⁴⁴ Article 1 of CAT defines torture as 'any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions'.

²⁴⁵ Article 4(2)(h) of the AWP.

times of emergency the states cannot derogate from the provisions of the article.²⁴⁶ According to the HRC no justification or extenuating circumstances may be invoked to excuse a violation of the right to not be subjected to cruel, inhuman or degrading treatment.²⁴⁷ Sterilisation is *never* an emergency procedure therefore therapeutic privilege which allows a doctor to decide what is best for the patient cannot be used to justify sterilisation without informed consent.

3.4 Conclusion

This chapter focussed on how forced sterilisation violates the rights to dignity and security of the person. Dignity is an intrinsic right guaranteed to all human beings. Kant's theory of dignity posits that people are ends and should not be treated as means to an end. Forced sterilisation of HIV-positive women treats them as a means to an end which is the prevention of the spread of HIV/AIDS. Given the fact that PMTCT is available this reasoning is not justified as there is a less restrictive means to achieve the purpose which is the timely provision of Nevirapine, an ARV that has proved to lower the chances of transmission from mother to child. Forced sterilisation also denies one the possibility of bearing any future children which violates the right to dignity and self fulfilment through reproduction. More so, subjecting HIV-positive women who are a vulnerable group to forceful sterilisation violates dignity of the community as protected by the notion of *ubuntu*.

The right to security of the person protects one from physical and psychological violation by others. The South African Constitution extends this right to decisions concerning reproduction, which is instrumental in protecting one's choice to have an abortion or sterilisation procedure. The right not to be subject to cruel, inhuman and degrading treatment is interrelated to the right to security of the person. The ICCPR has interpreted the former right to include treatment in medical institutions, which means that forced sterilisation

²⁴⁶ HRC GC 20 supra note 240 at paragraph 3.

²⁴⁷ Ibid.

amounts to cruel and inhuman treatment as the procedure is done without the patient's consent yet it has permanent irreversible consequences.

CHAPTER 4: FORCED STERILISATION AS A VIOLATION OF THE RIGHT TO EQUALITY/ NON-DISCRIMINATION AND THE RIGHT TO HEALTH

4.1 Introduction

The right to equality and non-discrimination is guaranteed in various international instruments. Article 7 of the UDHR provides that ‘all are equal before the law and are entitled without any discrimination to equal protection of the law’.²⁴⁸ Furthermore, everyone is entitled to equal protection against any discrimination and against any incitement to such discrimination.’²⁴⁹ The UDHR guarantees equality before the law and equal protection against discrimination which means that there is no legal justification for treating people who are HIV-positive less than would those who are HIV-negative. However, in practice people who are HIV-positive have met with discrimination due to the stigma associated with the disease in several settings including in health care. Such discrimination includes not being given adequate treatment for their condition, being separated from other patients and met with verbal abuse by hospital staff. This chapter will firstly discuss HIV/AIDS as a ground of discrimination arguing for its explicit recognition in human rights law, given that the amount of discrimination against People Living with HIV/AIDS (PLWHA) is rife. The chapter will then look at forced sterilisation as a violation of HIV-positive women’s right to health. This chapter meshes the rights to health and non-discrimination in the discussions as the reason why PLWHA are discriminated against is their sero-status.

4.2 Violation of the right to equality

The concept of equality requires that people in similar conditions be treated alike and those in unlike situations be treated unlike.²⁵⁰ There are two types of equality. Formal equality (found in Anglo-America) is premised on the idea that all persons are equal and that

²⁴⁸ Article 7 of the UDHR.

²⁴⁹ Ibid.

²⁵⁰ A Fagan ‘Dignity and unfair discrimination: a value misplaced and a right misunderstood’ (1998) 14 *South African Journal of Human Rights* 239.

and that any differential treatment on the basis of arbitrary grounds, such as race or gender, is almost inevitably suspect and irrational.²⁵¹ It assumes a legal formalism that requires that all persons are equal bearers of rights and inequality can be eradicate extending the same rights and entitlements to all in accordance with the same neutral standard of measurement.²⁵²

Formal equality does not take into consideration actual social and economic disparities. Substantive equality on the other hand recognises that inequalities stem from deeply systemic differences among people.²⁵³ It seeks to address the inequalities in society by examining the actual social and economic conditions of groups and individuals.²⁵⁴ Furthermore, substantive equality does not focus on the differences per se but on the nature of the harm that could flow from them.²⁵⁵ It also acknowledges that equality can consequently be advanced through similar or differential treatment depending on the context.²⁵⁶

Dignity is an intrinsic value that is used in equality enquiries. Dignity is premised on the Kantian notion that all humans are of equal moral worth as should be treated with equal concern and respect.²⁵⁷ The notion of ‘equal concern and respect’ is synonymous with the egalitarian principle that that demands equal concern for all people at all levels.²⁵⁸ The SACC has used the notion of equal concern and respect in deciding some landmark cases. In *National Coalition for Gay and Lesbian Equality v Minister of Home Affairs*,²⁵⁹ the SACC looked at equal concern and respect in relation to the social consequences of legal exclusion for gay and lesbian couples. This exclusion was said to reinforce harmful stereotypes of gay and lesbian relationships, in particular the message that gay and lesbian people lacked the inherent humanity to constitute families and live within the protection of the law. The Court found such gross invasion of individual self-worth to constitute a violation of dignity and,

²⁵¹ C Albertyn and B Goldblatt ‘Equality’ in Woolman et al *Constitutional law of South Africa* 2nd Edition (2009).

²⁵² Currie and de Waal supra note 230 at 233.

²⁵³ Albertyn and Goldblatt supra note 251.

²⁵⁴ Ibid.

²⁵⁵ Ibid.

²⁵⁶ Ibid.

²⁵⁷ See Kant supra note 206 and Chapter 3 on discussion on dignity.

²⁵⁸ Albertyn and Goldblatt supra note 251.

²⁵⁹ 1999 (1) SA 6 (CC).

therefore, of equality. This reasoning is analogous to the situation of HIV-positive women who are socially criticised for wanting to have children due to the stigma attached to the disease. The Namibian Supreme Court in *Muller v President of the Republic of Namibia and Another*²⁶⁰ held that any discrimination based on other grounds than those mentioned in art 10(2) will have to be dealt with either under article 10(1) and/or article 8(1) of the NC which provides that the dignity of all persons shall be inviolable.²⁶¹

4.2.1 HIV/AIDS as a ground of discrimination

Article 2(1) of the ICCPR and article 2 of the ACHPR guarantee the right to be free from discrimination and oblige state parties to ensure to all individuals the rights in the Covenant and the Charter respectively without distinction based on the listed grounds.²⁶² The right to be free from discrimination is reinforced by articles 3 and 26 of the ICCPR which protect the right to equality. Article 3 requires states parties to undertake the equal protection of men and women to the enjoyment of all civil and political rights.²⁶³ Article 26 provides that:

All persons are *equal before the law* and are entitled without discrimination to the *equal protection of the law*. In this respect the law shall prohibit any discrimination and guarantee to all persons equal protection against discrimination on any grounds such as race, colour, sex, religion, political or other opinion, national or social origin, property, birth or other status (emphasis mine).²⁶⁴

The right to equality in article 26 is similar to article 7 of the UDHR and article 3 of the ACHPR.²⁶⁵ Article 26 of the ICCPR offers two dimensions of protection: firstly, equality before the law requires that all people are treated equally before a court of law or any form of tribunal; secondly, equal protection of the law is aimed at preventing the enactment of

²⁶⁰ 1999 NR 190 (SC).

²⁶¹ Articles 10(1) and 8(1) of the NC.

²⁶² Article 2(1) of the ICCPR and article 2 of the ACHPR.

²⁶³ Article 3 of the ICCPR.

²⁶⁴ Article 26 of the ICCPR.

²⁶⁵ See article 7 of the UDHR and article 3 of the ACHPR that are similarly worded to article 26 of the ICCPR.

legislature that is discriminatory in nature.²⁶⁶ The UDHR offers an additional safeguard by providing that all people are entitled to protection not only from discrimination but also from incitement to discrimination. The right to non-discrimination has become a *ius cogens* norm in international law especially the right to non-discrimination based on sex, ethnicity and race.²⁶⁷ The right to racial non-discrimination gained recognition following gross human rights violations under systems of segregation according to race like in Nazi Germany and apartheid South Africa.

Discrimination based on HIV status is not expressly listed as one of the grounds of non-discrimination in either article 2 of the UDHR or articles 2(1) or 26 of the ICCPR. Nevertheless, it can be read into the ground of 'other status'. Article 26 extends the protection from non-discrimination on any ground which could include socio-economic rights. This is useful especially when looking at discrimination against HIV-positive women in the health care system which has implications on the right to health, a social economic right. Although each of the protected grounds can be addressed separately, discrimination on the basis of HIV/AIDS tends to encompass several forms of discrimination for example when it works together with social origin issues of class and race. Most of the cases reported in the ICW Namibia report were on black women from rural backgrounds which has implications for discrimination on the basis of race and class.²⁶⁸ Nationally, neither the SAC nor the NC explicitly provides for HIV as a protected ground but the courts have offered protection from discrimination based on ones HIV status. In *Hoffmann v South African Airways*,²⁶⁹ the SACC held that the refusal to employ Mr. Hoffmann as a cabin attendant because he was HIV-positive impaired his dignity and amounted to unfair discrimination.²⁷⁰ In the Namibian case of *Nanditume v Minister of Defence*²⁷¹ the court held that the refusal to enlist the applicant into the Namibian Defence Force because he was HIV-positive was unfair discrimination in contravention of section 107 of the Labour Act.²⁷²

²⁶⁶ Article 26 of the ICCPR.

²⁶⁷ The right to non-discrimination in article 4 of the ICCPR is a non-derogable right.

²⁶⁸ ICW Namibia report.

²⁶⁹ 2001 (1) SA 1(CC).

²⁷⁰ Ibid at paragraph 40.

²⁷¹ 2000 NR 103 (LC).

²⁷² 6 of 1992 (which has been repealed by the current Labour Act 11 of 2007).

Discrimination and stigma constitute the greatest barriers to the effective management of HIV/AIDS. As a result those affected are often discriminated against and have their human rights violated. There have been calls for the creation of an international human rights convention to address discrimination and other human rights violations against PLWHA.²⁷³ Currently other human rights treaties have been able to address discrimination of PLWHAs for example in access to health care which will be dealt with further in section 4.3.

4.2.2 Possible protection against discrimination based on HIV/AIDS under the ground of disability

Discrimination on the basis of HIV status has at times been placed under the ground of disability. The Convention on the Rights of Persons with Disabilities (CRPD) addresses discrimination faced by PLWHA however it does not include HIV/AIDS as one on the grounds under the definition of disability. The preamble of the CRPD recognises that ‘disability is an evolving concept and that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others.’²⁷⁴ The acknowledgement that disability is an evolving concept is important as it points to the fact new types of disability can arise. This definition is in line with the ecological perspective of disability which does not only focus on disability as a health problem or abnormality that is situated in an individual’s body or mind (impairment perspective), but rather as resulting from the interaction of impairment, activity limitations and participation restrictions in a specific social or physical environment.²⁷⁵ The ecological model therefore allows for an expansive definition of disability given the context.

Article 1 of the CRPD states that, ‘persons with disabilities include those who have long term physical, mental, intellectual or sensory impairments which in interaction with

²⁷³ Canadian HIV/AIDS Legal Network, Canadian Working Group on HIV and Rehabilitation Interagency Coalition on AIDS and Development ‘HIV, Disability and Human Rights: Opportunities offered by the United Nations Convention on the Rights of Persons with Disabilities, A Discussion Paper’ 2008.

²⁷⁴ The preamble of the CRPD.

²⁷⁵ Canadian HIV/AIDS Legal Network *supra* note 273 at 5.

various barriers may hinder their full and effective participation in society on an equal basis with others'.²⁷⁶ Discrimination on the basis of disability is defined in the Convention as 'any *distinction, exclusion or restriction* on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field' (emphasis mine). According to Makkonen²⁷⁷ the terms distinction, exclusion and restriction may constitute an act of discrimination even if it does not have the purpose of discrimination but has the effect of nullifying or impairing the enjoyment of human rights and fundamental freedoms.²⁷⁸

Due to the similar stigma and discrimination faced by PLWHA and those with disabilities, for example through exclusion and separate treatment, it would legally be to the benefit of PLWHA for HIV/AIDS to be considered as a disability. This is because countries that ratify the CRPD would be legally bound to respect, promote, protect and fulfill the rights of PLWHA protected in the Convention. More so, this would be particularly beneficial to disabled people who have HIV/AIDS as they would be protected from both types of discrimination. The Joint United Nations Programme on HIV/AIDS (UNAIDS) in collaboration with the Office of the United Nations High Commissioner for Human Rights (OCHRE) came up with Guidelines²⁷⁹ (UNAIDS Guidelines) in 1996, (later revised in 2000)²⁸⁰ that urge states to take steps to prevent discrimination against people with HIV. There are twelve guidelines that cover discrimination in a number of scenarios including *inter alia* discrimination in public health legislation, criminal laws, regulation of information and legal support services. Although these guidelines are not legally binding, they are a persuasive framework that states can rely upon.

²⁷⁶ Article 1 of the CRPD.

²⁷⁷ T Makkonen 'The principle of non-discrimination in international human rights law and EU law' (2005). Available at http://iom.fi/elearning/files/national_law/estonia/essentialreading/PrincipleofNonDiscrimination.pdf [accessed on 16 November 2010].

²⁷⁸ *Ibid* at 14.

²⁷⁹ Office of the United Nations High Commissioner for Human Rights (OCHRE) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) *Handbook for legislators on HIV/AIDS, Law and Human Rights* (1999).

²⁸⁰ Office of the United Nations High Commissioner for Human Rights (OCHRE) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) *International Guidelines on HIV/AIDS and Human rights 2006 Consolidated version* (hereafter UNAIDS Guidelines). Available at http://data.unaids.org/Publications/IRC-pub07/jc1252-internguidelines_en.pdf [accessed on 7 November 2010].

Guideline 5 provides that states should enact or strengthen antidiscrimination and other protective laws that protect vulnerable groups, people living with HIV/AIDS and people with disabilities from discrimination in both the public and private sectors.²⁸¹ UNAIDS urges states to enact and revise laws and policies to cover people living with asymptomatic HIV infection, people living with AIDS and those merely suspected of having HIV or AIDS.²⁸² They also urge governments to include HIV/AIDS under the definition of disability.²⁸³ Strode and Grant compiled a report on the implementation of the Guidelines in the Southern African Development Community (SADC).²⁸⁴ They noted that most countries did not have legislation that explicitly dealt with HIV as a ground of discrimination, although it was covered under government policy.²⁸⁵ HIV was also not listed as a ground under disability legislation in any of the SADC countries.²⁸⁶

Some countries have included HIV/AIDS as a under the ground of disability for example the United Kingdom Disability Amendment Act²⁸⁷ was amended in 2005²⁸⁸ to include HIV under the definition of disability. The American Disability Act²⁸⁹ does not expressly list HIV as one of the grounds but in interpretation of cases HIV has been included in the grounds of disability. The position of whether HIV is a disability is not certain in South Africa. The SAC in article 9(3) does not list HIV status as one of the prohibited grounds of discrimination but provides for discrimination of other grounds which could include HIV status. The SACC in *Hoffmann v South African Airways*²⁹⁰ avoided deciding whether the airline's policy of not employing HIV-positive persons amounted to discrimination on the basis of disability and instead decided the case on the fact that the policy infringed on Mr.

²⁸¹ Ibid Guideline 5.

²⁸² Ibid.

²⁸³ Ibid.

²⁸⁴ A Strode and B Grant 'A critical review of the extent to which the *HIV/AIDS and Human Rights International Guidelines* have been implemented in the Southern African Development Community' 2007 *Obiter* 70.

²⁸⁵ Ibid at 79- 80.

²⁸⁶ Ibid.

²⁸⁷ United Kingdom, *Disability Discrimination Act 1995*, amended 2005 c. 50.

²⁸⁸ Section 18 provides that "a person who has cancer, HIV infection or multiple sclerosis is to be deemed to have a disability, and hence to be a disabled person"

²⁸⁹ Americans with Disabilities Act of 1990,

²⁹⁰ Supra note 269.

Hoffmann's dignity and equality.²⁹¹ The NC does not include HIV status as one of the listed grounds of discrimination in article 10(2). Given that no international human rights instrument explicitly covers HIV/AIDS as a ground of non-discrimination, states should make use of UNAIDS Guideline 5 to enact legislation to include HIV/AIDS under disability. This would then place a legal binding obligation on states to prevent discrimination based on HIV as an explicit ground.

It may be questioned why HIV status as opposed to just any other health status should be made an explicit ground. This paper argues that given the level of stigma and discrimination attached to symptomatic, asymptomatic, and relatives of PLWHA, the impact is grave given that since its discovery AIDS is at present still an incurable disease. Compared to other incurable diseases, it is spread through not only sexual intercourse but from mother-to-child, blood transfusions and intravenous drug use. It is also a disease that is associated with prostitution, promiscuity, homosexuality and drug use. Women especially in Africa do not have power to negotiate condom use and may be the innocently affected by their partners. However the method of infection is rarely considered by society and the focus will be on the fact that one is HIV- positive hence subject to stigma and discrimination. It is hoped that once HIV/AIDS is protected as an explicit ground, the rights of PLWHA will be respected and protected.

4.3 Violation of the right to health

4.3.1 Discrimination in access to health services

HIV-positive patients are met with a number of discriminatory practices in access to health services. For the purposes of this section the focus will be on the public health system as this is the most commonly used system in Africa and also because the women who were sterilised had the procedure performed in public hospitals. The International Covenant on Economic and Social Cultural Rights (ICESCR) in article 12(1) guarantees everyone the right

²⁹¹ Ibid at paragraph 40.

to the enjoyment of the highest attainable health.²⁹² In the African context, article 16 of the African Charter on Human and Peoples Rights (ACHPR) provides that every individual shall have the right to enjoy the best attainable state of physical and mental health. The SAC similarly guarantees everyone the right to have access to health care services.²⁹³ The NC does not provide for the right to access health services; however, the Namibian HIV/AIDS Charter of Rights²⁹⁴ provides that HIV status should not be considered as a ground for depriving any person of their right to the highest attainable standard of physical and mental health.²⁹⁵

The Committee on Economic Social and Cultural Rights (CESCR) in General Comment 14²⁹⁶ (CESCR GC14) has interpreted the normative content of the right to the highest attainable health as containing both freedoms and entitlements. The freedoms include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation.²⁹⁷ These freedoms are protected under the right to bodily integrity and the doctrine of informed consent which was discussed in chapters 3 and 2. By contrast, the entitlements include the right to a system of health protection which provides *equality of opportunity* for people to enjoy the highest attainable level of health.²⁹⁸ Substantive equality is therefore important in order to determine whether HIV-positive women's right to health is being fulfilled.

HIV/AIDS is a global problem and as a result the definition of the right to health includes access to treatment, information on prevention, care and support of those affected by HIV. The right to the highest attainable standard of health has both positive and negative obligations to be met. The negative aspect of the right demands that the health status of an

²⁹² Article 12(1) of the ICCPR.

²⁹³ Section 27 of the Constitution.

²⁹⁴ Namibian HIV/AIDS Charter of Rights (11 December 2000). Available at http://www.ilo.org/aids/legislation/lang--en/docName--WCMS_140593/index.htm [accessed 13 December 2010].

²⁹⁵ Ibid at paragraph 14.

²⁹⁶ Committee on Economic, Social and Cultural Rights, General Comment 14, The right to the highest attainable standard of health (Twenty-second session, 2000), U.N. Doc. E/C.12/2000/4 (2000), reprinted in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, U.N. Doc. HRI/GEN/1/Rev.6 at 85 (2003).

²⁹⁷ Ibid.

²⁹⁸ Ibid.

individual should not be harmed by intrusions from others while the positive aspect requires that others provide care.²⁹⁹ Cook forwards that this right includes the right to health protection which accommodates rights of self-care and access to necessary services, the benefits of scientific progress, the education necessary to understand the benefits of health protection, and information that others, bound by duties to render treatment only with informed consent of patients, are obliged to provide.³⁰⁰ The CESCR has interpreted the right to the highest attainable standard of health to be closely related to and dependent upon the realisation of other human rights *inter alia* the rights to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information, and the freedoms of association, assembly and movement.³⁰¹ According to the CESCR these rights and freedoms address integral components of the right to health. This reasoning affirms that all rights are interrelated and indivisible, for example in the context of PLWHA, the right to health is linked to the right to life since ARVs have been proven to sustain one's life. States are therefore obliged to provide the necessary medication to those infected. The next sections will now explore ways through which HIV-positive women are discriminated against in the health services system including segregational treatment and denial of appropriate services.

4.3.1.1 Segregation of HIV-positive patients

HIV/AIDS is met with direct and indirect stigma from people including those in the public health service, and HIV-positive people may be separated from the other patients.³⁰² The ICW report revealed that in Otjiwarongo hospital HIV-positive women were kept in separate waiting rooms from the negative patients.³⁰³ Similarly in Chile HIV-positive women were given delayed care.³⁰⁴ This practice of separating and denying HIV patients relevant care is discriminatory. CESCR GC 14 interprets the right to the highest standard of health to include available, accessible and acceptable quality services.³⁰⁵ Acceptability requires that

²⁹⁹ Ibid.

³⁰⁰ R Cook 'Human rights and reproductive self-determination (1995) 44 *American University Law Review*.

³⁰¹ CESCR GC14 supra note 296 at paragraph 3.

³⁰² Vivo Positivo and Centre for Reproductive Rights 'Dignity Denied' supra note 31.

³⁰³ ICW Namibia report supra note 1 at 9.

³⁰⁴ Vivo Positivo and Centre for Reproductive Rights 'Dignity Denied' supra note 31 at 19.

³⁰⁵ CESCR GC14 supra note 296.

health care personnel respect medical ethics when dealing with all patients, treat their patients with dignity and respect patients' bodily integrity and confidentiality.³⁰⁶ Accessibility requires that services are physically within easy reach and are open to all types of patients including those with HIV/AIDS without discrimination.³⁰⁷

The UNAIDS Guidelines provide a useful framework in assessing whether states have put measures in place to protect the rights of HIV-positive people. Guideline 3 specifically deals with discrimination in public health legislation. It provides that states should review and reform public health legislation to ensure that they adequately address the public health issues raised by HIV/AIDS.³⁰⁸ In addition to this, states should ensure that provisions applicable to casually transmitted diseases are not inappropriately applied to HIV and that they are consistent with international human rights obligations.³⁰⁹ Public health is interpreted to go beyond the management of communicable diseases to encompass access to medical services, and management of the physical, biological and social environment by the regulation of pollution, food standards, drug safety, water hygiene and sewage.³¹⁰ The public health and sanitation movement emphasised collective rather than individual responsibility for health which meant that utilitarian principles like treatment were aimed at the protective welfare of people and preventative actions like vaccinations were required to prevent the spread of diseases unto others.³¹¹

The utilitarian principle was used to curb epidemics like plague, leprosy, that were spread through contact.³¹² HIV/AIDS is a disease that it mainly transmitted through exchange of blood and sexual intercourse and one cannot contract the disease by touching or sharing utensils with an infected person.³¹³ However, PLWHA are often treated as if they are

³⁰⁶ Ibid.

³⁰⁷ Ibid.

³⁰⁸ UNAIDS Guideline 3.

³⁰⁹ Ibid.

³¹⁰ Ibid.

³¹¹ Ibid

³¹² Ibid

³¹³ Information on how HIV/AIDS is spread is available at <http://www.cdc.gov/hiv/topics/basic/> [accessed on 6 December 2010].

contagious on contact. HIV-positive people are discriminated against as their illness is associated with contagious diseases like tuberculosis (TB). Understandably there is a need to have preventative measures like isolation for people infected with seriously contagious diseases for the good of public health. In *Minister of Health, Western Cape v Goliath*³¹⁴ the court dealt with a challenge to the policy of separating four prisoners who were infected with a strain of drug resistant TB. Griesel J held that isolation of patients with infectious diseases is universally recognised in open and democratic societies as a measure that is justifiable in the protection and preservation of the health of citizens.³¹⁵ TB is spread through air when an infected person coughs, sneezes or spits which makes it highly contagious.³¹⁶ Since AIDS is not an airborne disease one cannot justify the isolation of HIV-positive patients. Strode and Grant note that most countries in the SADC have not reviewed existing public health legislation or introduced new legislation to adequately address the public health issues raised by HIV/AIDS.³¹⁷ They also note that since many countries have existing public health legislation that pre-dated the HIV epidemic, it is possible that this legislation could still be inappropriately applied to PLWHAs.³¹⁸ The CESCR in General Comment 20 notes that the protection of public health is often cited by states as a basis for restricting human rights in the context of a person's health status.³¹⁹ For example the medical health personnel who forcefully sterilised the HIV-positive women in Namibia (erroneously) believed they were doing so in the interest of public health. States are therefore urged to adopt measures to address widespread stigmatisation of persons on the basis of their health status.

Du Plessis and Bezuidenhout³²⁰ argue that biomedical hegemonic power is asserted by labelling one as HIV-positive and once labeled, the tag is immutable and ineradicable which forces one to accept their position leaving them subject to the stigma attached to

³¹⁴ 2009 (2) SA 248 (C).

³¹⁵ Ibid at paragraph 19.

³¹⁶ Information on how tuberculosis is spread is available at <http://www.who.int/features/qa/08/en/index.html> [accessed 6 December 2010].

³¹⁷ Strode and Grant supra note 284 at 73.

³¹⁸ Ibid.

³¹⁹ Committee on Economic, Social and Cultural Rights, General Comment No. 20, Non-Discrimination in Economic, Social and Cultural Rights (art. 2, para. 2) U.N. Doc. E/C.12/GC/20 (2009) (hereafter CESCR GC20) at paragraph 33.

³²⁰ G du Plessis and F Bezuidenhout 'Capital, habitus and symbolic violence in the field of reproductive rights: women and HIV' (2009) 41(2) *Acta Academica* 132.

HIV.³²¹ For example in India there is dire discrimination against HIV-positive patients in the public health sector evidenced in practices such as labelling the beds of HIV-positive patients, including the beds of infants born to HIV-positive mothers, with signs like ‘danger’ and ‘high risk’ to warn the staff of the person sero status.³²² This is contrary to Guideline 3 which provides that public health legislation should ensure that people not be subjected to coercive measures such as isolation, detention or quarantine on the basis of their HIV status. This means that separating HIV- positive patients and treating them with a lesser duty of care is discriminatory.

Furthermore, negative attitudes and bias by health workers denies PLWHA proper care. HIV-positive pregnant women reported that they were denied proper care while preference was given to HIV-negative patients first.³²³ The ICW report revealed that HIV-positive women were told to stand at the back of the line or left unattended to while in labour.³²⁴ In Chile the Centre for Reproductive Rights and Vivo Positivo documented similar discriminatory treatment.³²⁵ An example is the case of Julia, a pregnant HIV-positive woman, who was left unattended (in favour of HIV-negative patients) after she experienced uterine bleeding which later led to a miscarriage.³²⁶ One of the paramedics later informed her that ‘it is because God knows, because you were going to have a sick child.’³²⁷ This lack of care is a violation of the right to equality in access to health. Another major problem faced by HIV patients is the violation of the doctor-patient confidentiality.³²⁸ Arguably it is sometimes as a result of the need for translation that a third party is made aware of the patients’ sero-status, but most times it is because medical personnel inform others of the patient’s status without consent. This is in breach of the right to privacy and non interference which is protected in section 14 of the SAC³²⁹ and article 13 of the NC.³³⁰ HIV-positive women in Namibia also

³²¹ Ibid at 143.

³²² VS Mahendra et al. ‘Understanding and measuring AIDS-related stigma in health care settings: A developing country perspective’ (2007) 4(2) *Journal of Social Aspects of HIV/AIDS* at 620.

³²³ S Bharat and VS Mahendra ‘Meeting the Sexual and reproductive health needs of people living with HIV: Challenges for health care providers’ (2007) 15(29 Supplement) *Reproductive Health Matters* 93- 112 at 99.

³²⁴ ICW Namibia report supra note 1 at 9.

³²⁵ Centre for Reproductive Rights and Vivo Positivo ‘Dignity denied’ supra note 39.

³²⁶ Ibid.

³²⁷ Ibid.

³²⁸ Bharat and Mahendra supra note 323 at 99.

³²⁹ Section 14 of the SAC.

reported being denied access to their medical passports and were only provided access under the doctor's supervision and were thus not aware of what procedures had been performed on them.³³¹ For example those sterilised had passports stamped with the letters 'BTL' which stands for bi-tubal ligation, a form of sterilisation, but they were unaware of what the abbreviation meant.³³²

4.3.1.2 Denial of appropriate services and information specific to HIV/AIDS

HIV-positive people especially women due to gender and power inequalities are often not given the requisite information and services that are needed to effectively manage HIV/AIDS.³³³ In the context of pregnant HIV-positive women the right to access to health is a wide package which includes antenatal, prenatal and postnatal care as well as access to ARVs.³³⁴ Article 12 of CEDAW specifically obliges states to take all measures to eliminate discrimination against women in the field of health care and ensure access to health care (on the basis of equality with men) to health care services including family planning.³³⁵ Specifically states shall ensure to women appropriate services in connection with pregnancy and grant free services where necessary.³³⁶ Section 27(1)(a) guarantees everyone the right to have access to health care including reproductive health.³³⁷ The CCEDAW GR 24 notes that special attention should be given to health needs and rights of women belonging to vulnerable groups.³³⁸ With all these international obligations on states to ensure that women have access to 'appropriate' health care, it is dismal that the right to health continues to be violated. The literal meaning of the word 'appropriate' is suitable, acceptable or correct for the particular circumstances.³³⁹ This means that states must adapt the health services to suit a particular

³³⁰ Section 13 of the NC.

³³¹ ICW Namibia report supra note 1 at 12.

³³² Ibid.

³³³ Pieterse supra note 115; Kehler et al. supra note 158.

³³⁴ See UNICEF Childinfo supra note 125 on methods of prevention of mother- to- child transmission.

³³⁵ Article 12(1) of CEDAW.

³³⁶ Ibid.

³³⁷ Section 27(1)(a) of the SAC.

³³⁸ CCEDAW GC 24 supra note 89 at paragraph 26.

³³⁹ Definition from the Oxford Advanced Learner's Dictionary. Available at <http://www.oxfordadvancedlearnersdictionary.com/dictionary/appropriate> [accessed on 7 December 2011].

group of people. HIV-positive pregnant women by virtue of their sero-status deserve more than just basic care. They require antenatal care, access to ARV's for their own health as well as to prevent mother-to-child transmission and information about post natal prevention.

UNAIDS Guideline 6 (as revised in 2002) provides that states should enact legislation to provide for the regulation of HIV-related goods, services and information; ensure widespread availability of quality prevention measures and services; adequate HIV prevention and care information; and safe and effective medication at an affordable price.³⁴⁰ States are therefore obliged to ensure that PLWHA have access to information and services particular to HIV/AIDS. More so, states should also take measures necessary to ensure for all persons, on a sustained and *equal* basis, the *availability* and *accessibility* of quality goods, services and information for HIV prevention, treatment, care and support, including antiretroviral and other safe and effective medicines.³⁴¹ Guideline 6 buttresses the importance of available, accessible and quality services as required under GC14 of the ICESCR.³⁴²

In addition to the above, states have to ensure that information and services particular to HIV/AIDS are available to PLWHA with specific attention being paid to vulnerable and marginalised groups.³⁴³ Similarly, the CESCR in GC 14 provides that health care services should be guaranteed for all on a non-discriminatory basis, taking into account the situation of vulnerable and marginalised members of society, such as women and PLWHA. Pregnant HIV-positive women are vulnerable firstly because of their biological condition, secondly because of their positive sero-status and thirdly because they are women. Women worldwide are most affected by the AIDS pandemic and there has been a steady increase in HIV infection among women in sub-Saharan Africa.³⁴⁴ Women and girls account for more than 50% of all people infected with HIV.³⁴⁵ In South Africa 3,300,000 out of the 5,600,000

³⁴⁰ UNAIDS Guidelines supra note 280, guideline 6.

³⁴¹ Ibid.

³⁴² CESCR GC 14 supra note 296 at paragraph 12.

³⁴³ Ibid.

³⁴⁴ Joint United Nations Programme on HIV/AIDS, Global report: UNAIDS report on the global AIDS epidemic 2010 [herein UNAIDS report 2010].

³⁴⁵ Ibid.

PLWHA were women and in Namibia 95,000 out of 180,000 PLWHA were women in 2009.³⁴⁶

Women in Africa are not able to access ARVs for a number of reasons including poverty and power relations.³⁴⁷ There have been arguments for gender equity in access to HIV treatment because although states may have services in place, women are often not able to access these drugs. There is a need to adopt an egalitarian rather than libertarian concept of equity.³⁴⁸ Libertarian equity demands that everyone be treated equally without discriminating arbitrarily on the basis of 'irrelevant' grounds such as race, gender or sexual orientation.³⁴⁹ This type of equity is similar to the concept of formal equality and is problematic as it may fail to take into account the plight of the marginalised and vulnerable in society. Egalitarian equity on the other hand requires that distribution of resources take into account the differences in society to take account of the vulnerable and marginalised.³⁵⁰ Even among this vulnerable group, focus should be on equal distribution, taking into account fair gender distribution.³⁵¹ This is important in assessing whether ARVs are accessible to women. An advantage of egalitarian equity is that it goes beyond merely achieving justice in the provision of health care. It also allows for choice in the health care as at the bare minimum it must provide for free services to those who cannot afford health care.³⁵² This is in line with article 12(2) of CEDAW that obliges states to ensure that women have appropriate services in connection with pregnancy and during the postnatal period by providing for free services where necessary.³⁵³

In the context of HIV-positive women, these pregnancy-related services would include both treatment and information about PMTCT and care after birth. This information

³⁴⁶ AVERT Sub-Saharan African HIV and AIDS statistics. Available at <http://www.avert.org/africa-hiv-aids-statistics.htm> [accessed on 14 November 2010].

³⁴⁷ R Amollo 'Advancing women's access to health services in South Africa: Legal and policy responses to HIV/AIDS (2009) 10(1) *Economic and Social Rights Review* 3.

³⁴⁸ E Durojaye 'Advancing gender equity in access to HIV treatment through the Protocol on the Rights of Women in Africa' (2006) 6 *African Human Rights Law Journal* 188.

³⁴⁹ *Ibid* at 191.

³⁵⁰ *Ibid*.

³⁵¹ *Ibid*.

³⁵² *Ibid*.

³⁵³ Article 12 of CEDAW.

is helpful to both women planning to have children and those already pregnant and need information on how to prevent transmission. However, this information is not always available to HIV-positive women as evidenced in the ICW Namibia report where some of the women reported not to have been aware of what to do once they received their HIV-positive results.³⁵⁴ Nevertheless, even where pregnant women are given the relevant information and access ARVs in form of Nevirapine, the concern is for the life of the child as opposed to the life of the woman. In the *Treatment Action Campaign*³⁵⁵ case, the court's reasoning focused on the life of new born babies who would be at risk of infection without the drug. Article 12(2)(a) of the ICESCR obliges states to take measures to reduce the still-birth rate and infant mortality.³⁵⁶ The health of the mother is integral to the achievement of reduced infant mortality and states need to ensure that HIV-positive mothers promptly receive the necessary medication.

4.4 Denial of the right to benefit from scientific progress

Article 15 of the ICESCR provides that everyone has the right to enjoy the benefits of scientific progress and its applications.³⁵⁷ Similarly article 27 of the UDHR protects the right to share in scientific advancement and its benefits.³⁵⁸ The Report of the Experts' Meeting on the Right to Enjoy the Benefits of Scientific Progress³⁵⁹ held that this right is strongly interrelated with the right to health and that all developments in science and technology should always take cognisance of human dignity.³⁶⁰ This is because some scientific developments like in human genomes have the ability to infringe on the right to dignity.³⁶¹ More so, the right to benefit from scientific progress is closely tied to the concept of self-determination/ autonomy and should encompass ethics and ethical principles.³⁶² In this sense,

³⁵⁴ ICW Namibia report supra note 1.

³⁵⁵ *Minister of Health and Others v Treatment Action Campaign and Others* (No.2) 2002 (5) SA 721 (CC).

³⁵⁶ Article 12(2) (a) of CEDAW.

³⁵⁷ Article 15 of the ICESCR.

³⁵⁸ Article 27 of the UDHR.

³⁵⁹ UNESCO, Amsterdam Centre for International Law and the Irish Centre for Human Rights 'Report of the Experts' Meeting on the Right to Enjoy the Benefits of Scientific Progress and its Applications' Amsterdam 7-8 June 2007. Available at <http://unesdoc.unesco.org/images/0015/001545/154583e.pdf> [accessed on 15 November 2010].

³⁶⁰ Ibid at 18.

³⁶¹ Ibid.

³⁶² Ibid at 23.

forced sterilisation (as a scientific surgical procedure) is a violation of ethical standards owed by the doctor to the patient and as the patient is sterilised without their informed consent, a violation of the patient's bodily autonomy.

The right to benefit from scientific progress is applicable to reproductive health in that scientific developments allow for methods of fertility regulation, for example through the provision of assisted reproduction to aid in procreation and use of contraception to prevent pregnancy.³⁶³ Forced sterilisation violates the right to benefit from scientific progress as it denies HIV-positive women the chance to benefit from technology that could assist them in having HIV-negative children. This is due the fact that the procedure permanently prevents one from having any children in future. The availability of Highly Active Anti retroviral treatment (HAART) gives hope to women who are HIV-positive to be able to have a lowered rate of infection during pregnancy, thereby improving their chances of having a healthy infant.³⁶⁴ New technology like microbicides can also be used to prevent against transmission of the HI-virus.³⁶⁵ A study conducted by the Centre for the AIDS Programme of Research in South Africa at the University of KwaZulu-Natal, found that tenofovir containing vaginal microbicides had a statistically significant protective effect against HIV.³⁶⁶ Successful use of microbicides will give HIV-positive women the opportunity to have children with a reduced chance of infection to their partners.

4.5 Conclusion

This chapter dealt with forced sterilisation as a violation of the right to equality and secondly as a violation of the right to health. The right to equality provides that everyone has equal protection before the law and should be treated with equal care and concern. HIV is not listed as one of the grounds in the ICCPR or UDHR. This paper argues that it should be

³⁶³ Ibid.

³⁶⁴ World Health Organisation, Joint United Nations Programme on HIV/AIDS and United Nations Children's Fund *Toward universal access: Scaling up priority HIV/AIDS interventions in the health sector*. Progress Report 2010. Available at <http://www.who.int/hiv/pub/2010progressreport/report/en/index.html> [accessed 15 November 2010].

³⁶⁵ Ibid.

³⁶⁶ Ibid at 43.

included as one of the grounds of discrimination or under the meaning of the term disability in order for PLWHA to have additional protection under the ICRD. The right to the highest attainable standard of health is a right guaranteed to all people regardless of their sero-status. HIV-positive people are vulnerable to abuse in the health care system because of the stigma attached to the disease. The CESCR has interpreted the right to health to include the provision of available, accessible, affordable and quality health services. This means that there is no justification for denying HIV-positive people adequate care and services including information on reproductive health.

CHAPTER 5: FORCED STERILISATION AS A VIOLATION OF REPRODUCTIVE RIGHTS AND THE RIGHT TO BE FREE FROM VIOLENCE

5.1 Introduction

This chapter seeks firstly discuss the reproductive rights violations that occur when women are forcefully sterilised and secondly, to explore how forced sterilisation violates the right to be free from violence thereby, amounts to violence against women. The chapter will trace the evolution of reproductive rights and right as it is protected in international law. The chapter will then elaborate on some of the reproductive rights for example the right to right to family planning and to decide freely on the number and spacing of children. Having discussed reproductive rights, the chapter will then explore how forced sterilisation amounts to violence against women.

5.2 Evolution of reproductive health and rights

Reproductive health and rights were globally recognised at the International Conference on Population and Development's Programme of Action held in Cairo in 1994³⁶⁷ (ICPDPA). The ICPDPA was instrumental in recognising reproductive rights as human rights. The main drive behind the recognition of reproductive rights was the need to acknowledge women as subjects and not objects of population policies.³⁶⁸ In the past in a bid to control rapid population growth states defined family planning as an essential part of their demographic control and reproduction was not seen as an individual right but as part a state policy to control the population as a means to facilitate development and end poverty.³⁶⁹ An example of this is China which enforces a one-child policy prohibiting women from having more than one child and enforcing sterilisation on those who contradict this policy.³⁷⁰ It is for

³⁶⁷ United Nations, International Conference on Population and Development Programme of Action, Cairo Egypt, September 1994. Available at <http://www.un.org/popin/icpd/conference/offeng/poa.html> [accessed 22 November 2010] (herein ICPDPA).

³⁶⁸ N Reilly *Women's Human Rights* (2010) at 84.

³⁶⁹ F Banda *Women, Law and Human Rights: An African Perspective* (2005) at 182.

³⁷⁰ See the discussion of China's one child policy above in Chapter 1.

this reason that the ICPDPA was revolutionary in highlighting the need for reproductive rights of women to be respected. The ICPDPA defines reproductive health as:

[A] state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.³⁷¹

Reproductive rights are then said to:

[E]mbrace certain human rights that are already recognised in national laws, international human rights documents and other relevant United Nations consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes the right of all to make decisions concerning reproduction free of discrimination, coercion and violence as expressed in human rights documents.³⁷²

The ICPDPA definition of reproductive health encompasses the well being of the whole body as well as the freedom to reproduce and the decision on when and how often to do so.³⁷³ The definition of reproductive rights embraces already existing rights which reaffirms the principle that all human rights are indivisible and interrelated. Reproductive rights are linked to the rights to dignity, non-discrimination, information, bodily integrity and freedom from coercion in decisions concerning whether or not to have children.³⁷⁴ The definition of reproductive health and reproductive rights were subsequently reiterated in the Beijing Declaration and Platform of Action³⁷⁵ (BDPA) that was adopted in Beijing in 1995. The BDPA reiterated the need to protect reproductive and sexual rights. Paragraph 96 states that the human rights of women include their right to have control over and decide freely and

³⁷¹ Paragraph 7.2 of the ICPDPA.

³⁷² Paragraph 7.3 of the ICPDPA.

³⁷³ Ibid.

³⁷⁴ Ibid.

³⁷⁵ Beijing Declaration and Platform for Action, Fourth World Conference on Women, 15 September 1995, A/CONF.177/20 (1995) and A/CONF.177/20/Add.1 (1995). Available at <http://www.un.org/womenwatch/daw/Beijing/platform/declar.html> [accessed 24 November 2010] (hereafter BDPA).

responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence.³⁷⁶ The legal status of the ICPDPA and BDPA is that although they are not legally binding under the norms of international law they have great persuasive authority since they have been endorsed by a majority of governments including South Africa and Namibia.³⁷⁷ They are useful for interpretation of the reproductive health and rights and obligations that states must undertake in order to fulfil these rights.

From the ICPDPA definition reproductive health is much more complex than only the provision of family planning. The right to reproduce safely and freely includes that right to access appropriate health care services that will enable women go safely through pregnancy and childbearing and to provide couples with the best chance of having a healthy infant.³⁷⁸ Reproductive health is not limited to child bearing years alone and applies to both women and men of all ages, which indicates that reproductive health should be available to adolescents, adults and the aged population.³⁷⁹ In sub-Saharan Africa due to the prevalence of teenage pregnancies it is vital that girls are aware of their reproductive rights and have access to reproductive health. The ICCPR, ICESCR and ACHPR do not expressly provide for reproductive rights and what they encompass. CEDAW refers to some examples of reproductive rights namely family planning and the same rights of women and men to equally decide freely and responsibly on the number and spacing of their children and to have the information to be able to access these rights.³⁸⁰ The AWP is so far the most elaborate in listing what reproductive rights entail.³⁸¹ The next sections will look at how forced sterilisation violates one's reproductive rights. The focus will be on the rights that are protected in human rights instruments as some of the reproductive rights mentioned in the in the ICPD do not have explicit protection in either South African or Namibian law.

³⁷⁶ Paragraph 96 of the BDPA.

³⁷⁷ See statements by Mr. A Williams on behalf of South Africa and Dr. N Iyambo on behalf of Namibia at the International Conference on Population and Development held in Cairo on 8 September 1994. Available at <http://www.un.org/popin/icpd/conference/gov/index.html> [accessed 22 November 2011].

³⁷⁸ Paragraph 7.2 of the ICPDPA.

³⁷⁹ Paragraph 7.3 of the ICPDPA.

³⁸⁰ Articles 12 and 16(3) of CEDAW.

³⁸¹ See discussion in 5.3 below on the violation of reproductive rights for the relevant articles of the AWP.

5.3 Violation of reproductive rights

5.3.1 Right to found a family

Article 16(1) of the UDHR³⁸² and article 23(2) of the ICCPR³⁸³ provide that women and men of marriageable age have the right to marry and to found a family. The ACHPR does not explicitly have a right to found a family but recognises the importance of the family unit. Similarly, the ACRWC stipulates that the family is the natural unit and basis of society and requires protection by the State. The SAC does not have a right to found a family but the NC in article 14 protects the right to marry and found a family.³⁸⁴ The UDHR and ICCPR place the right to found a family right within the context of a ‘couple’s right’ and ‘within marriage’. Historically, the right to found a family was placed within the context of marriage. However, due to the changing world and the shift in the structure of families, brought on by the incidence of single motherhood, unmarried parents and same sex partnerships, the principle of non-discrimination in international law requires that the right to found a family is extended to such groups.³⁸⁵ The ICW report revealed that single HIV-positive women were ridiculed by nurses who said they had no business having children since they had no husband to support them and were told that by the hospital staff that it was best if they were sterilised.³⁸⁶ Based on the principle of non-discrimination, the absence of a marriage cannot be used to deny one the right to found a family.

Furthermore, one’s HIV status is not a valid reason for denying one the right to found a family. Forced sterilisation during the eugenics era was used to rid society of the unwanted burden posed by off spring of those who were mentally unfit.³⁸⁷ In today’s setting HIV/AIDS as an incurable disease, is perceived as the unwanted burden of society and some health personnel (and public), feel it is their responsibility to prevent the spread of HIV/AIDS by preventing HIV-positive women from having children. The repercussions of forced

³⁸² Article 16(1) of the UDHR.

³⁸³ Article 23(2) of the ICCPR.

³⁸⁴ Article 14 of the NC.

³⁸⁵ See discussion on the right to equality in Chapter 4.

³⁸⁶ ICW report at 7.

³⁸⁷ See *Buck v Bell* supra note 25.

sterilisation deny the affected persons the right to found a family as the procedure is permanent and reversible, thereby removing the possibility of having children in future.

The HRC in General Comment 19³⁸⁸ elaborates on the scope of the right to marry and found family and states that in principle the right implies the possibility to procreate and live together.³⁸⁹ The right to procreate is not expressly listed in any of the international human rights instruments, but it can be inferred from the right to family life. The right to procreate developed in two main contexts. Firstly, it arose in opposition to forced sterilisations that had been performed on women during the widespread eugenics movements and the involuntary sterilisations based on race, ethnicity and poverty.³⁹⁰ Secondly, the right to procreate arose in response to claims not to have a child. Specifically it arose to challenge of the lack of access to contraceptives and abortion services in response to restrictive governmental policies like the one-child policy in China and countries that criminalise abortion services even to save the life of the mother.³⁹¹ The right to procreate therefore encompasses both the right to have children and the right not to have children.

The right to procreate can also be protected under the right to privacy. Article 17(1) of the ICCPR provides that no one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence by either state or non-state actors. Domestically, both the SAC and NC protect the right to privacy and non-interference. Since the decision to have a child is a private affair, the right to procreate can be linked to the right to privacy. Eijkolt forwards that the right to privacy better protects the right to procreate because it can be extended to all persons and not only couples or within the context of marriage, and it can also be invoked to protect the right to procreate using assisted reproduction methods.³⁹² This

³⁸⁸ Human Rights Committee General Comment 19, Protection of the family, the right to marriage and equality of spouses (Article 23) (Thirty-ninth session, 1990), Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, U.N. Doc. HRI/GEN/1/Rev.1 at 28 (1994) (herein HRC GC19).

³⁸⁹ Ibid at paragraph 5.

³⁹⁰ M Eijkholt 'The right to found a family as a still born right to procreate' (2010) 18 *Medical Law Review* 127 at 133.

³⁹¹ Ibid.

³⁹² Ibid at 142.

is important especially as an HIV-positive person whose partner is HIV-negative may be in need of assisted reproduction methods like sperm washing and artificial insemination.³⁹³ Forced sterilisation as a procedure involves interference with a patient's body without their consent thereby violating their private right to procreate.

In addition to the above, the right to found a family is also linked to one's dignity and worth as a human being. According to Kant's third maxim,³⁹⁴ the central aspect of humanity is the ability to will its ends through reason.³⁹⁵ The SACC in *Ferreira v Levine*³⁹⁶ stated that human dignity cannot be respected unless humans are able to develop their humanity to the full extent of their potential, which includes being given freedom for personal development and fulfilment.³⁹⁷ The right to have children and found a family is tied to one's self actualisation and fulfilment. Motherhood in most societies is a symbol of femininity and fulfilment of one's role as a woman.³⁹⁸ Motherhood in the ICW report on HIV-positive women, pregnancy and motherhood reveals that an HIV positive woman's decision to have a child is influenced by their family, society even health personnel.³⁹⁹ Women who already had children when diagnosed with HIV often feel they do not want to have more children, while those who have none, want to have children or feel pressured into having them.⁴⁰⁰ Those who desire children feel that the advancement in treatment which translates to longer life for the woman, coupled with the availability of medication to prevent mother-to-child infection can increase the likelihood of giving birth to an HIV-negative child.⁴⁰¹ Unfortunately, HIV-positive women are rarely told about assisted and safer conception methods like artificial insemination; how to protect their health during pregnancy; or how to reduce mother-to-child

³⁹³ S Sunderam et al. 'Safe conception for HIV discordant couples through sperm washing: Experience and perceptions of patients from Milan, Italy' (2008) 16(31) *Reproductive Health Matters* 211-219.

³⁹⁴ Kant's third maxim states that, 'Act only on the maxim through which you can at the same time will that it should become universal law'

³⁹⁵ See discussion of dignity as self-actualisation in Woolman 'Dignity' supra note 202 at 36-11.

³⁹⁶ 1996 (1) SA 984 (CC).

³⁹⁷ Ibid paragraph 49.

³⁹⁸ M Sandelowski and J Barroso 'Motherhood in the context of maternal HIV infection' (2003) 26 *Research in Nursing and Health* 470 at 475.

³⁹⁹ International Community of Women Living with HIV/AIDS (ICW) 'HIV positive women, pregnancy and motherhood' (2008).

⁴⁰⁰ Ibid.

⁴⁰¹ Ibid.

transmission particularly after the birth.⁴⁰² This can be due to a lack of available services or a lack of information but it can also be due to discrimination against HIV-positive women wishing to become pregnant or who are pregnant. Denial of information that could assist in safe motherhood is a violation of one's dignity and worth as a human being, as it denies them vital information that would enable them to have HIV-negative children.

5.3.2 Right to have family planning and choose the method of contraception

Family planning is an important aspect of reproductive health care as both men and women need to be able to freely choose the method of contraception to prevent unplanned pregnancy. Family planning encompasses both the right to procreate and the right not to procreate. Women particularly should be able to access information on family planning and knowledge on the various forms of contraception because they are most affected by virtue of them being child bearers. Article 12 of CEDAW provides that state parties should eliminate discrimination in the access of health care services including those related to family planning.⁴⁰³ The Committee on CEDAW in General Recommendation 21 states that women must be guaranteed access to information about safe contraceptive methods, sex education and family planning services.⁴⁰⁴ CEDAW further urges states to put in place family planning clinics at state hospitals and to ensure that women can access such treatment and specifically obliges states to ensure women in rural areas have access to adequate health care facilities including information, counselling and services in family planning.⁴⁰⁵ Similarly, the AWP in article 14(2) obliges states to provide family planning services to women in rural areas.⁴⁰⁶ This is important given the fact that in rural African settings which are usually patriarchal societies, women do not yield a lot of power in decisions on how many children to have.

⁴⁰² Ibid.

⁴⁰³ Article 12 of CEDAW.

⁴⁰⁴ Committee on the Elimination of Discrimination against Women, General Recommendation 21, Equality in marriage and family relations (Thirteenth session, 1992), U.N. Doc. A/49/38 at 1 (1994), reprinted in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, U.N. Doc. HRI/GEN/1/Rev.6 at 250 (2003) (hereafter CCEDAW GR21).

⁴⁰⁵ Article 14(b) of CEDAW; CCEDAW GR24 supra note 89 at paragraph 28.

⁴⁰⁶ Article 14(2) of the AWP.

Reproductive health eludes many people around the world because of such factors as: inadequate levels of knowledge about human sexuality and inappropriate or poor-quality reproductive health information and services; the prevalence of high-risk sexual behaviour; discriminatory social practices; negative attitudes towards women and girls; and the limited power many women and girls have over their sexual and reproductive lives.⁴⁰⁷ Rural women especially still cannot freely gain access to contraceptives as their husbands may see this as a sign of them being unfaithful. CEDAW urges states to eliminate barriers to access to health care services for example requirements for preliminary authorisation by spouse, parent or hospital authorities before a woman can access health services.⁴⁰⁸ PLWHA are also met with discrimination when trying to access information on family planning. The right to family planning is a right to be enjoyed by everyone regardless of their sero-status and one's positive HIV status should therefore not be used to deny them information on family planning.

Apart from having a general right to family planning, women have the right to choose the method of contraception.⁴⁰⁹ This right requires that women should not be coerced into a particular type of contraception, but should rather be advised and counselled on the suitable method of contraception.⁴¹⁰ Cook argues that when women have the power to control key decisions over their reproduction they are less vulnerable to coercive governmental attempts to control or promote population growth.⁴¹¹ The World Health Organisation has published a comprehensive handbook (WHO handbook) on family planning⁴¹² which lists various methods of family planning and their side effects. The listed methods include oral contraceptive pills (including emergency contraceptive pills), injectable contraceptives, implants, condoms (both male and female), intrauterine devices (IUD (both copper-bearing

⁴⁰⁷ ICPDA at par 7.3.

⁴⁰⁸ CCEDAW GR 24 supra note 89 at paragraph 21.

⁴⁰⁹ Article 14(1)(c) of the AWP.

⁴¹⁰ CCEDAW General Comment 24.

⁴¹¹ R Cook 'Human rights and reproductive self determination' (1995) 44 *American University Law Review* 975 at 996.

⁴¹² World Health Organisation Department of Reproductive Health and Research (WHO/RHR) and Johns Hopkins Bloomberg School of Public Health Center for Communication Programs (CCP), INFO Project. *Family Planning: A Global Handbook for Providers*. Baltimore and Geneva: CCP and WHO, 2007 (hereafter WHO handbook). Available at <http://www.globalhandbook.org/handbook.pdf> [accessed on 24 November 2010].

and levonorgestrel)), contraceptive patches, spermicides, diaphragms, cervical caps and sterilisation (both male and female).⁴¹³

The WHO has also drafted an elaborate guide on family planning for people living with HIV⁴¹⁴ (WHO PLHIV guide). It is designed to be an interactive tool to be used by medical personnel and patients and address a wide range of issues like choices on contraception, prevention of sexually transmitted infections, decisions on whether to have children and methods of PMTCT. According to the WHO PLHIV guide, women with HIV or AIDS can use most methods of family planning even when on treatment.⁴¹⁵ As seen from the list of available methods of family planning, sterilisation is just one of these methods and there are other available methods of family planning that can be effective in preventing pregnancy without the drastic effects posed by sterilisation.

The WHO handbook on family planning contains eligibility criteria to determine who is suitable for what type of contraception. This is important as it provides a list of questions to assess which type of contraception would best suit the needs of the woman. According to the WHO handbook, women with HIV can safely use oral contraceptive pills, injectable contraception and implants; however they should also be urged to use condoms as they offer extra contraceptive protection by preventing the spread of HIV to their partner or from being cross-infected.⁴¹⁶ Generally ARVs do not conflict with contraceptives but Rifampicin (used for TB treatment) lowers effectiveness of contraceptive pills and implants.⁴¹⁷ HIV-positive patients on ARVs and TB treatment need to be made aware of this. Concerning the copper-bearing IUD, women who are at risk of HIV or are infected with HIV can safely have the IUD inserted.⁴¹⁸ Also women who have AIDS, are on ARV therapy, and are clinically well can safely have the IUD inserted.⁴¹⁹ However, women who have AIDS, are not on ARV

⁴¹³ Ibid.

⁴¹⁴ World Health Organisation *Reproductive choices and family planning for people living with HIV: Counselling tool*, Geneva WHO (2006) (hereafter WHO PLHIV guide). Available at http://whqlibdoc.who.int/publications/2006/9241595132_eng.pdf [accessed 24 November 2010].

⁴¹⁵ Ibid.

⁴¹⁶ WHO handbook supra note 412 at 9.

⁴¹⁷ WHO PLHIV guide supra note 414 at 6.

⁴¹⁸ WHO handbook supra note 412 at 138.

⁴¹⁹ Ibid.

therapy and are not clinically well, should not have the IUD inserted.⁴²⁰ If a woman develops AIDS while she has an IUD in place, it does not need to be removed but she should be monitored for pelvic inflammatory disease.⁴²¹ Women who are at a high risk of HIV infection, have HIV or AIDS cannot use spermicides as it increases the risk of infection.⁴²² This information is vital as a woman needs to be fully informed of the side effects of a particular contraception before they make their choice.

The ICW Namibia report revealed that HIV-positive women were being pressured to use contraceptives especially Depo-Provera an injectable hormonal contraceptive. One woman is quoted saying:

'In my case they said I must have the injection- I am HIV positive and I am not working- what will you give the child and so I agreed' - Positive woman, Namibia 2008.⁴²³

The women reported that the side effects and drug interactions of the contraceptives were not discussed. However due to the power dynamics they felt that they could not refuse the contraceptives. This type of coercion infringes on the right of HIV-positive women to decide freely on the type of contraception and thus undermines the trust in the health care provider.⁴²⁴

Concerning female sterilisation, the WHO handbook stresses that the procedure is meant to be permanent and reversal is usually not possible.⁴²⁵ Sterilisation is an effective method of family planning and statistics show that less than 1 pregnancy per 100 women over the first year after having the sterilisation procedure (5 per 1,000).⁴²⁶ This means that 995 of every 1,000 women relying on female sterilisation will not become pregnant.⁴²⁷ One of the most effective techniques is cutting and tying the cut ends of the fallopian tubes after

⁴²⁰ Ibid.

⁴²¹ Ibid.

⁴²² Ibid at 223.

⁴²³ ICW Namibia report supra note 1 at 9.

⁴²⁴ London, Phyllis and Myer supra note 37 at 17.

⁴²⁵ WHO handbook supra note 142 at 165.

⁴²⁶ Ibid.

⁴²⁷ Ibid.

childbirth (postpartum tubal ligation).⁴²⁸ According to the ICW Namibia report most of the women were sterilised immediately after child birth and in some cases bi-tubal ligation was performed.⁴²⁹ This is when both sides of the fallopian tube are cut. The FIGO Guidelines note that although tubal ligation is one of the most widely used types of sterilisation, hysterectomy should never be used as a form of sterilisation because of the risks involved in it.⁴³⁰ Most importantly, sterilisation as a method of contraception should only be performed with the informed consent of the patient and no woman including those who are HIV-positive, should be coerced into sterilisation.⁴³¹ This requirement of informed consent acknowledges the woman's right to self-determination and bodily integrity.

5.3.3 Right to control one's fertility

CEDAW does not expressly provide for the regulation of fertility as part of reproductive rights. The AWP in article 14(1)(a) provides for the right to control one's fertility.⁴³² This right is listed as a separate right from the right to family planning. The SADC PH in article 16(d) obliges states to formulate policies and programmes aimed at empowering men, women and communities at large to have access to safe, effective, affordable and acceptable methods for the regulation of fertility.⁴³³ However, neither the AWP nor the SADC PH define what this right entails. Fertility is colloquially defined as the ability to conceive children.⁴³⁴ The concept of 'regulation of fertility' arose during the ICPDA discussion on reproductive rights. The International Planned Parenthood Federation defines fertility regulation as the process by which individuals and couples control their fertility through methods like abortion, delayed childbearing, use of contraception, treatment of infertility and breast feeding.⁴³⁵ The most controversial aspect of the right to control one's fertility arises in whether there is an international right to abortion. This issue is still unsettled

⁴²⁸ Ibid at 166.

⁴²⁹ ICW Namibia report supra note 1.

⁴³⁰ FIGO Guidelines supra note 95 at 98.

⁴³¹ WHO handbook supra note 142 at 171.

⁴³² Article 14(1) of the AWP.

⁴³³ Article 16(d) of the SADC PH.

⁴³⁴ Definition available at <http://oxforddictionaries.com/definition/fertility> [accessed on 25 November 2010].

⁴³⁵ International Planned Parenthood Federation, definition of fertility regulation available at <http://www.ippf.org/en/Resources/Glossary.htm> [accessed 25 November 2010].

as many states with strong religious ideologies are opposed to the idea of abortion being legalised. CCEDAW in GR 24 notes that states have an obligation to respect women's rights by refraining from obstructing action taken by women in pursuit of their health goals including access to medical procedures that women alone need and to punish women who go through those procedures for example by criminalising abortion.⁴³⁶ Some countries criminalise transmission of HIV through mother-to-child.⁴³⁷ Not only do such laws prevent a pregnant woman from seeking and accessing the necessary ARVs in time,⁴³⁸ but also the threat of imprisonment frightens HIV-positive women who are contemplating having children from doing so, thereby denying them the right to control their fertility.

Sterilisation is a method of contraception that enables women to control their fertility because it offers one the option of never falling pregnant once the procedure is performed. The WHO handbook however warns that once sterilisation is performed fertility will not return as the procedure cannot generally be reversed⁴³⁹ Likewise, the FIGO guidelines emphasise that sterilisation should never be coerced.⁴⁴⁰ The pertinent issue in the context of HIV-positive women is that some women reported being denied access to abortion services unless they agreed to be sterilised. An example of this is Promise Mthembu who was given access to abortion services only after she agreed to sterilisation at the tender age of 22.⁴⁴¹ This is contrary to the CTOP which allows a girl of the age of 12 and above to consent to an abortion.⁴⁴² Neither the CTOP nor the NASA list sterilisation as a prerequisite for an abortion, therefore, doctors who insist on HIV-positive women agreeing to be sterilised before accessing abortion services are acting contrary to the law.

⁴³⁶ CCEDAW GR 24 supra note 89 at paragraph 14.

⁴³⁷ A Ahmed 'HIV and women: Incongruent policies, criminal consequences' 2011 *Yale Journal of International Affairs* 32. Countries that criminalise mother- to –child transmission include Guinea, Guinea-Bissau and Sierra Leone.

⁴³⁸ Ibid at 37

⁴³⁹ See supra note 37 on the discussion of China's one Child policy under Chapter 1, section 1.2

⁴⁴⁰ FIGO Guidelines supra note 95.

⁴⁴¹ M Kardas-Nelson 'Sterilised without consent' (21 June 2009) Mail & Guardian Online. Available at <http://www.mg.co.za/article/2009-06-21-sterilised-without-consent> [accessed on 11 October 2010].

⁴⁴² Section 2 of the CTOP.

5.3.4 Right to decide freely and responsibly on the number and spacing of children

All women regardless of their sero-status have the right to decide on the number and spacing of their children. Article 16(3) of CEDAW states that women and men have the same rights to decide freely and responsibly on the number of spacing of their children and to have access and information to exercise these rights.⁴⁴³ Although this right is placed within the context of a couple what is important is that it recognises the right of women to exercise this right. Similarly, the AWP in article 14(1)(b) provides that women have the right to decide whether to have children and on the number and spacing of children.⁴⁴⁴ The FIGO Guidelines interpret the right to decide freely on the number of children to include the right to decide *whether* and *when* to have children and to have access to the means to exercise that right.⁴⁴⁵ This means that women should have access to information on contraception, abortion and on assisted methods on conception like *in vitro* fertilisation (IVF) and surrogacy. The negative element of the right to decide freely on number of children includes the right to decide not to have any children, in other words to remain childless. CCEDAW in General Recommendation 21 acknowledges that women's right to decide on the number of children should be protected especially as women bear the burden of child care which in turn affects their education, and employment opportunities.⁴⁴⁶ More so, the right to have or not to have any children should not be limited by spouse or government.⁴⁴⁷

The right to decide on the number and spacing of children is linked to one's right to dignity and bodily integrity which means that before sterilisation can be performed a woman's informed consent is vital. The BDPA provides that the right of a woman to decide on the number of children should be done free of coercion, discrimination and violence.⁴⁴⁸ In the context of forced sterilisation, the fact that the HIV-positive woman does not freely give consent the procedure means her right to freely determine the number of children is violated.

⁴⁴³ Article 16(3) of CEDAW.

⁴⁴⁴ Article 14(1)(b) of the AWP.

⁴⁴⁵ *Ibid.*

⁴⁴⁶ CCEDAW GR 21 *supra* note 404.

⁴⁴⁷ *Ibid* at paragraph 22.

⁴⁴⁸ BDPA at paragraph 96.

Some of the women in the ICW Namibia report stated that after they had been sterilised they realised that they could no longer have more children as they desired.

5.4 Violation of the right to be free from violence (violence against women).

The CEDAW does not explicitly have an article that prohibits violence against women but the CCEDAW in General Recommendation 19 states that violence directed against a woman because she is a woman or violence that affects women disproportionately is recognised and addressed as discrimination under the Convention.⁴⁴⁹ The AWP does address violence against women in a number of articles. Article 1(j) defines violence against women as:

‘[A]ll acts perpetrated against women which cause or could cause them physical, sexual, psychological, and economic harm, including the threat to take such acts; or to undertake the imposition of arbitrary restrictions on or deprivation of fundamental freedoms in private or public life in peace time and during situations of armed conflicts or of war’.⁴⁵⁰

The AWP has a wide interpretation of violence to include physical, sexual, psychological and economic harm. Violence against women occurs in the form of domestic abuse, rape, harmful cultural practices like female genital mutilation and virginity testing, sexual exploitation through human trafficking, mass rapes during war, enforced pregnancies and coerced sterilisations.⁴⁵¹ The right of women to be free from violence encompasses the right to bodily integrity but is broader than the latter right, as these violent acts are perpetrated systematically and are aimed specifically at women.

Several human instruments have tried to address violence against women by urging states to take measures to protect women from violence. For example, article 6 of CEDAW

⁴⁴⁹ Committee on the Elimination of Discrimination against Women, General Recommendation 19, Violence against women (Eleventh session, 1992), U.N. Doc. A/47/38 at 1 (1993), reprinted in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, U.N. Doc. HRI/GEN/1/Rev.6 at 243 (2003) (herein CCEDAW GR 19).

⁴⁵⁰ Article 1(j) of the AWP.

⁴⁵¹ Paragraphs 113- 115 of the BDPA.

provides that state parties shall take all appropriate measures, including legislation, to suppress all forms of traffic in women and exploitation of prostitution of women.⁴⁵² Article 4(2)(b) of the AWP obliges states to adopt such other legislative, administrative, social and economic measures as may be necessary to ensure the prevention, punishment and eradication of all forms of violence against women.⁴⁵³ Article 19(1) of the CRC obliges states to protect children from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent.⁴⁵⁴ Although this article is gender-neutral, it recognises the need to protect girl child from violence. The Rome Statute⁴⁵⁵ in article 7(1) defines enforced sterilisations as a crime against humanity. The forced sterilisation of HIV-positive women could constitute a crime against humanity as it is targeted on a specific group of the population namely HIV-positive women. The ICPDPA and BDPA also urge states to prevent violence against women.⁴⁵⁶ The Vienna Declaration highlights that gender-based violence is incompatible with the dignity and worth of the human person, and must be eliminated.⁴⁵⁷ Domestically section 12(1)(c) of the SAC in provides that everyone has the right to be free from violence by either public or private sources.⁴⁵⁸

Article 1(j) of the AWP is instrumental as it also prohibits verbal violence against women.⁴⁵⁹ This wide interpretation to include verbal violence is imperative as PLWHA are met with ridicule especially through gossip and harsh words. The ICW Namibia report revealed that some HIV-positive women were called ‘dirty’ and ‘smelly’ by the hospital staff and met with verbal abuse for wanting to have children.⁴⁶⁰ Verbal abuse violates one’s right to dignity and to be free from degrading treatment and can lead to emotional and psychological distress. Violence against women is not limited to the actual act but includes

⁴⁵² Article 6 of CEDAW.

⁴⁵³ Article 4(2)(b) of the AWP.

⁴⁵⁴ Article 19(1) of the CRC.

⁴⁵⁵ Rome Statute of the International Criminal Court U.N. Doc. 2187 U.N.T.S. 90, entered into force July 1, 2002, article 7(1).

⁴⁵⁶ Paragraph 4.9 of the ICPDA and paragraph 124 of the BDPA.

⁴⁵⁷ Vienna Declaration, World Conference on Human Rights, Vienna, 14 - 25 June 1993, U.N. Doc. A/CONF.157/24 (Part I) at 20 (1993). paragraph 18.

⁴⁵⁸ Section 12(1)(c) of the SAC

⁴⁵⁹ Article 1(j) of the AWP.

⁴⁶⁰ ICW Namibia report supra note 1 at 8.

instances of threats and coercion which influence the affected woman's choice and encompasses both acts in private and public.⁴⁶¹ The DEVAW in article 1 defines violence as any 'act of gender-based violence that results in, or is likely to result in, physical or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty whether occurring in private or public.' Article 2 of the DEVAW further elaborates on examples of violence against women to include physical, sexual and psychological violence occurring in the family, within the community or those perpetrated or condoned by the state.⁴⁶² Forced sterilisation can fit into the second and third categories namely violence by the community and by the state if condoned or where the state fails to protect against any form of violence.

Although the DEVAW is not legally binding, it is instrumental in highlighting what constitutes violence against women. The CCEDAW realising the urgency in the need to address violence against women drafted General Recommendations 12⁴⁶³ and 19⁴⁶⁴ which deal with violence against women. CCEDAW GC 19 urges states are to identify the causes and consequences of violence against women and take appropriate measures to prevent and eliminate such violence.⁴⁶⁵ Likewise the AWP obliges states to prohibit and condemn all forms of harmful practices which negatively affect the human rights of women.⁴⁶⁶ Harmful practices are defined as 'all behaviour, attitudes and/or practices which negatively affect the fundamental rights of women and girls, such as their right to life, health, dignity, education and physical integrity.'⁴⁶⁷ Forced sterilisation negatively impacts on the health and physical integrity of the affected woman. States are therefore required to take all necessary legislative and others measures to eliminate such harmful practices.⁴⁶⁸ Most of the reported cases of forced sterilisation occurred in public hospitals. The governments of Namibia and South Africa should strive to educate society about the dangers of discrimination against PLWHA.

⁴⁶¹ Article 1(j) of the AWP.

⁴⁶² Article 2 of DEVAW.

⁴⁶³ Committee on the Elimination of Discrimination against Women, General Recommendation 12, Violence against women (Eighth session, 1989), U.N. Doc. A/44/38 at 75 (1990), reprinted in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, U.N. Doc. HRI/GEN/1/Rev.6 at 237 (2003).

⁴⁶⁴ CCEDAW GR 19 supra note 449.

⁴⁶⁵ Ibid at paragraph 24(e).

⁴⁶⁶ Article 5 of the AWP.

⁴⁶⁷ Article 1(g) of the AWP.

⁴⁶⁸ Article 5 of the AWP.

Medical personnel especially should be educated on human rights of patients so as to prevent instances where they act without proper consultation with patients.

The targeting of HIV positive women and not men for forceful sterilisation has implications for discrimination on the basis of sex and gender. The SAC explicitly prohibits discrimination on the basis of gender.⁴⁶⁹ Although the NC does not explicitly provide for gender as one of the grounds, discrimination on the basis of sex is prohibited.⁴⁷⁰ Historically, forced sterilisations have been performed on more women than men despite the fact that tubal ligation as a medical procedure poses more risks than a vasectomy.⁴⁷¹ Violence against women is rooted in patriarchal norms that unfairly burden women.⁴⁷² The paternalistic approach of medical personnel assumes a position of ‘doctor knows best’ thereby subjugating the autonomous decision of women to freely make decisions concerning their reproduction.⁴⁷³ Feminists have been ardent in criticizing the patriarchal and paternalistic norms and laws that aim at the subjugation of women through practices aimed at controlling their bodies for example the way women are seen and treated in law reflects same way that gender inequality is exercised in society.⁴⁷⁴ This is especially evident in traditional African homes which are predominantly patriarchal and women are considered subordinate to men. There is a need to eliminate the ‘fallacy of the law reducing women to their bodies and reproductive functions’⁴⁷⁵ and instead acknowledge the importance of the body without being subsumed into the irrational and biologically determined nature of women.⁴⁷⁶ Women are at a greater risk for violation of their reproductive rights because they are biologically capable of giving birth. Article 12 of CEDAW obliges states to embody the principle of equality among men and women in access to healthcare services including family planning.⁴⁷⁷ This principle is reinforced by article 16 (e) of CEDAW which obliges the state to ensure equality in

⁴⁶⁹ Section 9(3) of the SAC.

⁴⁷⁰ Section 10(2) of the NC.

⁴⁷¹ M K Eriksson *Reproductive freedom: In the context of International Human Rights and Humanitarian law* (2000) at 257.

⁴⁷² N M Naylor ‘“Cry the beloved continent...” Exploring the impact of HIV/AIDS and violence on women’s reproductive and sexual rights in Southern Africa’ (2005) 30(2) *Journal for Juridical Science* 52.

⁴⁷³ *Ibid.*

⁴⁷⁴ *Ibid* at 58.

⁴⁷⁵ *Ibid.*

⁴⁷⁶ *Ibid.*

⁴⁷⁷ Article 12 of CEDAW.

connection with reproductive rights which include *inter alia* to decide freely on the number and spacing of children.⁴⁷⁸ Therefore, targeting HIV-positive women and not men to be forcefully sterilised does discriminate against them based on gender and amounts to violence against women.

The interrelation between the spread of HIV and gender-based violence cannot be disregarded. Domestic violence in homes accounts for the rapid spread of HIV where women are at the mercy of their husbands and male partners and cannot negotiate safe sex.⁴⁷⁹ By only targeting HIV-positive women for forced sterilisation, neglecting the social context of transmission, is in itself perpetration of violence against such women. The reason HIV-positive women are being sterilised is that health personnel believe it is their social responsibility to prevent the spread of HIV from mother-to-child.⁴⁸⁰ However HIV infection can occur through several other methods including sexual intercourse, intravenous drug use, contaminated blood through blood transfusions and open cuts, and through sharing of unsterilized instruments in health settings.⁴⁸¹ Of these forms heterosexual intercourse accounts for the highest method through which HIV is spread in sub-Saharan Africa.⁴⁸² On the contrary, properly planned pregnancies with adequate information about PMTCT have shown that HIV transmission from mother-to-child is reduced to 1 in 10 infections.⁴⁸³ It is difficult to reconcile how sterilisation solely aimed at HIV-positive women can effectively reduce the spread of HIV. What needs to be focused on is prevention at the point of birth as there is a high chance of infection and prevention of post-natal exposure through breast feeding. With today's scientific developments in HIV/AIDS research especially with the advancement of HAART, it is possible for an HIV-positive woman to have an HIV-negative child. The avoidance of pregnancy will not prevent the spread of HIV neither will it prevent cross-infection as sexual intercourse still remains the predominant method of infection in sub-Saharan Africa. CEDAW in General Recommendation 15 urges states to prevent specific

⁴⁷⁸ Article 16 of CEDAW.

⁴⁷⁹ Naylor *supra* note 472 at 61; M S Jansen van Rensburg 'A comprehensive programme addressing HIV/AIDS and gender based violence' (2007) 4 (3) *Journal of Social Aspects of HIV/AIDS* 695 at 701.

⁴⁸⁰ See ICW Namibia report *supra* note 1.

⁴⁸¹ See WHO handbook *supra* note 142.

⁴⁸² UNAIDS 2010 report *supra* note 344.

⁴⁸³ *Ibid.*

discrimination aimed at women in response to AIDS.⁴⁸⁴ Therefore, enforcing forced sterilisation upon HIV-positive women yet there exists a less restrictive means of preventing mother-to-child transmission, by the use of Nevezapine, consequently amounts to violence against women.

5.6 Conclusion

Forced sterilisation is a violation of the reproductive rights of women as it denies them the right to procreate and found a family. This right is guaranteed to all people and one's positive sero-status should not affect their ability to have children. Furthermore, forced sterilisation violates the rights to family planning and to choose the method of contraception. CEDAW urges states to provide women with information on family planning. HIV-positive people have the right to choose the method of contraception and should not be forced into accepting a particular type of contraception. As discussed above there are several types of contraception, some not suitable for PLWHA. HIV-positive women should be advised of all possible methods of contraception and even when discussing sterilisation as an option, should be advised of other alternatives. In addition to this, forced sterilisation violates the right of HIV-positive women to freely decide on one's fertility and on the number and spacing of children. This chapter also discussed the right to be free from violence. Violence against women occurs in the context of sexual and reproductive health through rape, female genital mutilation, domestic violence, sexual exploitation, forced pregnancy. Forced sterilisation of HIV-positive women amounts to violence against women as it performed upon the affected women without their consent. The targeting of women not men for forced sterilisation due to their reproductive ability has implications for gender discrimination as well as perpetuating violence aimed specifically at women.

⁴⁸⁴ Committee on the Elimination of Discrimination against Women, General Recommendation 15, Avoidance of discrimination against women in national strategies for the prevention and control of acquired immunodeficiency syndrome (AIDS), (Ninth session, 1990), U.N. Doc. A/45/38 at 81 (1990), reprinted in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, U.N. Doc. HRI/GEN/1/Rev.6 at 240 (2003).

CHAPTER 6: CONSEQUENCES OF FORCED STERILISATION OF HIV-POSITIVE-WOMEN

'I almost forget what happened to because of counselling but from 2007 I started to think about having a baby and how can I do it if this has been done. It has caused me a problem. When I have a boyfriend who marries me- when I am stopped to have birth how can he accept this issue?' - Positive Woman, Namibia, 2008.⁴⁸⁵

6.1 Introduction

Forced sterilisation is an irreversible permanent procedure that prevents a woman (or man) from having any future children. In order to assess the extent to which forced sterilisation violates human rights it is important to look at the consequences that follow from such a procedure. Sterilisation of HIV-positive women has implications for the affected women firstly as HIV-positive women and secondly as women who can no longer bear children. This chapter seeks to look at the consequences of forced sterilisation by analysing the issues related to HIV and conceptualising the stigma and discrimination against women unable to have children. It will look at the consequences to the woman personally such as emotional and psychological stress as well as her placing in the community given the importance of children in the African society. The chapter will also look at the consequences has on governmental efforts to deal with the AIDS pandemic as well as how forced sterilisation could impact on the international effort of institutions like the UN the which in aims at managing the effects of HIV/AIDS globally.

6.2 Social stigma and rejection

The conceptual framework for understanding HIV/AIDS stigmatisation and discrimination is to see it as a product of social processes which can only be challenged and

⁴⁸⁵ ICW Namibia report supra note 1.

addressed by social action.⁴⁸⁶ Stigma against PLWHA includes blaming them for their disease and even saying they deserve it.⁴⁸⁷ Forced sterilisation based on HIV-positive status reinforces HIV stigma which in turn contributes to the stigmatisation of the sterilised woman. On one hand HIV- positive women are scorned by society for being pregnant while infected, on the other hand they may also face stigma for being unable to have children especially if the reason is related to their being HIV-positive. As a result stigma attached to PLWHA and to infertile women applies to HIV-positive women who have been forcefully sterilised.

A number of women in the ICW Namibian report indicated that they still have not informed their partners that they have been sterilised without consent for fear of being deserted.⁴⁸⁸ In the African context children are highly valued and motherhood is seen as a transitional period in a woman's life. Women who have children are given a higher social status than those who do not.⁴⁸⁹ Infertility in some societies is considered a calamity in some African societies for example in Chad a proverb goes 'a woman without children is like a tree without branches'⁴⁹⁰ or in Kikuyu 'a barren woman is like a leaking pot'.⁴⁹¹ Women who are sterilised without their husband's knowledge could be seen to be denying their husbands the right to have children (heirs). London et al. note that 'stigma associated with childlessness may mean that denying HIV-infected women the right to have children may compound pre-existing psychological concerns for many women.'⁴⁹² In some societies a woman with no children is not allowed to inherit as is often at the mercy of relatives and likely to suffer violence during property grabbing.⁴⁹³ Being unable to conceive also leads to loss of marriage prospects as bearing children to serve as heirs and in some societies as labour, is highly

⁴⁸⁶ E M Etinosa 'The social-psychological consequences of HIV/AIDS stigmatisation on social relations in Nigeria' (2007) 15(2) *IFE Psychologica: An International Journal* 10 at 14.

⁴⁸⁷ Ibid.

⁴⁸⁸ ICW Namibia report supra note 1.

⁴⁸⁹ Ramkissoo et al supra note 134.

⁴⁹⁰ Available at <http://www.special-dictionary.com/proverbs/keywords/barren/> [accessed 13 January 2011].

⁴⁹¹ Available at <http://www.special-dictionary.com/proverbs/keywords/barren/> [accessed 13 January 2011].

⁴⁹² London, Orner and Myer supra note 37 at 18.

⁴⁹³ See Save the Children and the Food and Agriculture Organisation, 'Children and women's rights to property and inheritance in Mozambique' (2009). Available at <http://www.fao.org/docrep/012/a1131e/a1131e00.pdf> [accessed 21 January 2011]. The authors explain that in Mozambique property inheritance is along the male line and if a woman has no sons to inherit from her deceased husband the property will pass on to his male siblings which leaves her at the risk of property grabbing.

valued.⁴⁹⁴ Women who are sterilised are afraid that if they made known that they were sterilised their marriage prospectus would be lowered. HIV-positive women who have no children or those who only have girls when sterilised face more stigma and ridicule from relatives who demand boys for the continuity of the family. The following example illustrates this:

*‘If the in-laws paid lobola, then they decide how many children, because they brought you to sustain the clan. Even if you have many children you should continue falling pregnant until you have a boy. If you don’t have children you are less of a woman. You lose everything even your inheritance. I have five children and am expected to have another because I do not have a son.’ “My husband paid lobola and he must have a child’ - ICW Voices and Choices Workshop, Zimbabwe 2002.*⁴⁹⁵

Apart from stigma attached to women who are not able to have children, HIV-positive women who have been sterilised have to face the double stigma due to their sero-status. Ignorance about HIV transmission, fear of those living with HIV, and lack of access to and understanding of treatment is at the very core of HIV stigma.⁴⁹⁶ This stigmatisation leads to discrimination against those infected and affected by the disease. Although HIV/AIDS affects both men and women, women are more affected by the disease. Women and girls are especially vulnerable to HIV infection due to a host of biological, social, cultural and economic reasons, including women’s entrenched social and economic inequality within sexual relationships and marriage.⁴⁹⁷ Furthermore, the spread of HIV/AIDS is driven and entrenched by gender inequality.⁴⁹⁸ Women are often accused and seen to be the bringer of the virus as the disease is associated with prostitution and unfaithfulness.⁴⁹⁹ The fact that women are often the first to be tested for HIV through antenatal testing of pregnant women

⁴⁹⁴ Save the Children and Food Agriculture Organisation supra note 493.

⁴⁹⁵ International Community of Women Living with HIV/AIDS, Voices and Choices Workshop (2002). Available at <http://www.icw.org/icw/files/VoicesChoices.pdf> [accessed 27 November 2010].

⁴⁹⁶ Stein, J ‘HIV/AIDS stigma: The latest dirty secret’ CSSR Working Paper 46 (2003) Centre for Social Science Research, University of Cape Town. Available at <http://www.heart-intl.net/HEART/010105/HIVAIDSStigmaTh.pdf> [accessed 18 December 2010]; G M Wingwood et al. ‘HIV stigma and mental health status among women living with HIV in the Western Cape, South Africa’ (2008) 104 *South African Journal of Science* 237.

⁴⁹⁷ E Elspen ‘Women and girls living with HIV/AIDS: Overview and Annotated Bibliography’ (2007) at 4. Available at http://www.bridge.ids.ac.uk/reports/BB18_HIV.pdf [accessed 10 January 2011].

⁴⁹⁸ K De Cock, D Mbori-Ngacha and E Marum ‘Shadow on the continent: public health and HIV/AIDS in Africa in the 21st Century’ (2002) *The Lancet* 360.

⁴⁹⁹ Kehler et al. supra note 158 at 12.

which is compulsory in some countries (and may be done without the woman's knowledge or consent) may place the blame of HIV infection on the woman.⁵⁰⁰ This is reinforced where the doctor-patient confidentiality is breached and other family members are informed of the woman's positive status without her consent. Women are also seen as transmitters of the virus to their children through mother-to-child infection and the decision to have children is often met with criticism from society.⁵⁰¹ The stigma associated with HIV in some societies results in denying women who are infected the right to inherit, causing them to be disowned and abandoned.⁵⁰² In the context of HIV-positive women who have been forcefully sterilised, this would prejudice them as they would not be able to inherit due to their status and also due to the fact that they cannot bear any more children (especially if there are no male heirs).

6.3 Emotional and mental distress

Stigma is not only exhibited outwardly by the actions of others but internalised by the affected individual thereby causing them to act in a particular way for example by living in shame.⁵⁰³ Such shame can have a powerful psychological influence over how PLWHA adjust to their status, making them vulnerable to blame, depression and self-imposed isolation.⁵⁰⁴ This in turn reinforces societal stigmatisation and discrimination which may impinge on the affected individual's self worth and dignity. Forced sterilisation not only violates ones' right to physical bodily integrity but also one's right to be free from psychological harm. The HRC GC 20 has interpreted the right to be free from cruel, inhuman and degrading treatment to include both physical and emotional treatment.⁵⁰⁵ The SAC in section 12(2) guarantees

⁵⁰⁰ Ibid; De Cock, Mbori-Ngacha and Marum supra note 498.

⁵⁰¹ Kehler et al. supra note 158 at 12.

⁵⁰² H Swaminathan, N Bhatla and S Chakraborty 'Women's property rights as an AIDS response: Emerging efforts in South Asia' 2007. Available at <http://www.icrw.org/files/publications/Womens-Property-Rights-as-an-AIDS-Response-Emerging-Efforts-in-South-Asia.pdf> [accessed 27 November 2010].

⁵⁰³ P Rohleder and K Gibson 'We are not fresh: HIV-positive women talk of their experience of living with their soiled identity' (2005) CSSR Working Paper 110, Centre for Social Sciences Research, University of Cape Town. Available at <http://www.cssr.uct.ac.za/sites/cssr.uct.ac.za/files/pubs/wp110.pdf> [accessed 16 December 2010]; Joint United Nations Programme on HIV/AIDS, *HIV-related stigma, discrimination and human rights violations: Case studies of successful programmes* (UNAIDS best practice collection) 2005 at 5. Available at http://data.unaids.org/publications/irc-pub06/jc999-humrightsviol_en.pdf [accessed on 17 November 2010].

⁵⁰⁴ Rohleder and Gibson ibid at 10.

⁵⁰⁵ HRC GC 20 supra note 240.

everyone the right to psychological integrity. The NC does not have a right to psychological integrity but this right could be read into the right not to be subject to cruel, inhuman or degrading treatment. The discovery that one has been sterilised without their consent and the comprehension of the consequences that they may never bear children again is bound to cause one emotional stress. Vivo Positivo revealed that many of the women who were forcefully sterilised in Chile reported being emotionally and mentally distressed as they were unable to have any more children.⁵⁰⁶

Minaar and Bodkin conducted research that aimed at exploring bereavement and grief or a sense of loss in HIV-positive women attending antenatal clinics.⁵⁰⁷ They revealed that women who tested positive experienced a sense of loss and worried about their prospects of having healthy children. In the contest of forced sterilisation, the shock of an HIV-positive woman realising she has been sterilised would increase her health concerns, firstly from the stress related to the fact that she suffers from a disease that is deadly and incurable (although manageable with ARVs) and secondly from realisation that she cannot have any more children in future. In most societies procreation is one of paramount reasons for marriage and infertility or inability to bear children is met with criticism and hostility from the male partner and the extended family.⁵⁰⁸ In many African societies infertility is erroneously blamed on the woman and rarely on the man.⁵⁰⁹ Pressure from male partners who want children may contribute to the mental stress of sterilised women in the form of verbal abuse for example by referring to the woman as being ‘just a corpse.’⁵¹⁰ In the case of a woman who is forcefully sterilised (for example being made to sign the form while in labour before they can be given a c-section), this might be taken to be her decision and she may be seen to have agreed to the procedure without the approval of her partner or family. Such consent which although not legally required may be socially implied.

⁵⁰⁶ Vivo Positivo and Centre for Reproductive Rights ‘Dignity denied’ supra note 39 at 28.

⁵⁰⁷ A Minaar and C Bodkin ‘The mourning of HIV positive mothers’ (2009) 11(2) *Africa Journal of Nursing and Midwifery* 5.

⁵⁰⁸ G K Fatoye, AT Owolabi, F O Fatoye, B A Eegunranti ‘Emotional burden of infertility: a controlled study of women managed at a Nigerian teaching hospital’ *Gender and Behavior* 1645 at 1648.

⁵⁰⁹ Ibid at 1648.

⁵¹⁰ London, Orner and Myer supra note 37 at 18.

The inability to have children as a result of forced sterilisation deprives the affected woman of a sense of belonging in a particular community. The traditional African context strongly emphasises the notion of community as expressed in many African sayings like *umuntu ngumuntu ngabantu*.⁵¹¹ An individual cannot exist by themselves in a community and needs the help of others to co-exist in harmony. Society usually determines and shapes how people in a community live. Societies where children are highly valued place emphasis on fertility. In some societies abortion, sterilisation and even contraception pills are considered a taboo.⁵¹² Women who undergo sterilisation will be seen as ‘useless’ especially in patrilineal societies, where they will be unable to continue a man’s lineage by producing children. A woman's fertility or potential fertility can also influence her status in the community and in her own family (in terms of marriage prospects), as well as ensure her economic survival.⁵¹³ Infertility is also considered a valid ground for divorce in some African societies and a man may take up another wife.⁵¹⁴ Motherless women also risk the chance of being excluded from social gatherings for example mothers’ unions where women meet to discuss issues of parenthood. If she is excluded based on the fact that she was forcefully sterilised and cannot have children, this will contribute to her emotional and mental stress.

6.4 Negative impact on governmental programmes aimed at HIV-prevention and the promotion of reproductive health and rights

The incidence of forced sterilisation procedures due to ones positive sero-status may drive HIV-positive women underground for fear of being sterilised if they are to access desperately needed health care services such as the delivery of their babies. In South Africa and Namibia this would be drastic as the majority of women depend on the health care system. This would in turn affect governmental plans aimed at the prevention and management HIV/AIDS for example the expansion of PMTCT programme would be negated because pregnant HIV-positive women would accessing further health care once it was

⁵¹¹ Zulu proverb which translates to ‘a person is a person because of people’.

⁵¹² J Replogle ‘Sex and the Catholic Church in Guatemala’ (2005) 36(9486) *The Lancet* 622- 623.

⁵¹³ S Gruskin ‘Negotiating the relationship of HIV/AIDS to reproductive health and reproductive rights’ (1995) 44 *The American University Law Review* 1191.

⁵¹⁴ U Larsen and M Hollos ‘The importance of motherhood: A study of infertility in urban Northern Tanzania’. Available at <http://paa2005.princeton.edu/download.aspx?submissionId=50023> [accessed on 4 February 2011].

discovered that they are HIV-positive.⁵¹⁵ Given the rate of maternal and infant mortality it is important that pregnant women access the necessary treatment and care to ensure the safety of both mother and child. Furthermore, the lack of confidentiality regarding disclosure of one HIV-status to family members may discourage women from seeking medical help.⁵¹⁶ States are obliged to respect and protect an individual's right to health which means preventing violations of one's privacy and bodily integrity through procedures like forced sterilisation which are performed without informed consent.⁵¹⁷ More so, the obligation to protect requires states to prevent third parties from perpetrating any violation of human rights upon an individual.

In order to combat infectious diseases, there must be a reliable health system that people trust. PLWHA should be able to seek medical advice on various issues like contraception, decisions to have children, medication and preventive measures to avoid re-infection without feeling that their right to privacy and bodily integrity will be infringed. The HRC in General Comment 28 urges state parties to provide information on the prevention of forced abortions and sterilisations.⁵¹⁸ Women specifically as affirmed by CEDAW, should be able to freely access information on family planning and should be given full access to reproductive health services with information about the effects and consequences of these options.⁵¹⁹ These types of services respect bodily integrity and enhance trust in health care providers. This is drastically different from the outcomes of forced and coerced sterilisation that, aside from the traumatic physical and emotional consequences, lead to mistrust in and fear of the health care system. Lack of trust in the health system can further exacerbate negative health outcomes as HIV-positive women who fear sterilisation might avoid hospitals

⁵¹⁵ Wingwood et al. 'HIV stigma and mental health status among women living with HIV in the Western Cape, South Africa' (2008) 114 *South African Journal of Science* 237- 240.

⁵¹⁶ See discussion of breach of confidentiality above in section 4.3.1.1.

⁵¹⁷ See discussion of violation of the right to bodily integrity in Chapter 3.

⁵¹⁸ Human Rights Committee, General Comment 28, Equality of rights between men and women (article 3), (Sixty-eighth session, 2000), U.N. Doc. CCPR/C/21/Rev.1/Add.10 (2000), reprinted in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, U.N. Doc. HRI/GEN/1/Rev.6 at 179 (2003) at paragraph 11.

⁵¹⁹ Article 12 of CEDAW.

during childbirth, or choose not to approach the health care system for necessary care and treatment around HIV.⁵²⁰

Given the high rate of teenage pregnancy in sub-Saharan Africa, mistrust of health care system could lead to incidence of back-street abortions as girls may be scared of being coerced by medical personnel to agree to sterilisation before they can receive abortion services. An example of such an occurrence was reported in South Africa where a 14 year old Orange Farm resident who went to get an abortion and was informed that the hospital would only operate if she agreed to get sterilised.⁵²¹ In the context of pregnancy- related matters, states should ensure that informed consent is obtained before sterilisation and abortion procedures are performed, and should take measures to initiate criminal proceedings against those who practice forced sterilisations and abortions.⁵²²

6.5 Affect the work of international institutions like the United Nations

The UN in its Millennium Developmental Goals⁵²³ (MDGs) seeks to *inter alia* promote gender equality and empower women⁵²⁴, reduce the child mortality rate,⁵²⁵ improve maternal health,⁵²⁶ and combat HIV/AIDS, malaria and other diseases.⁵²⁷ These goals are in a way aimed at the protection of women's reproductive health.⁵²⁸ Goal 4 deals with the reduction of infant mortality and is aimed at reducing the infant mortality rate of children under the age of five by two thirds between 1990 and 2015. The 2010 UNMDG statistics

⁵²⁰ See Vivo Positivo and Centre for Reproductive rights 'Dignity denied' supra note 39 at 35 where it is reported that mistreatment of HIV-positive women can deter them from returning for necessary treatment.

⁵²¹ Lombard supra note 10.

⁵²² F van Leeuwen *Women's Rights are human rights: The practice of the United Nations Human Rights Committee and the Committee on Economic, Social and Cultural Rights* (2010) at 77.

⁵²³ United Nations The Millennium Developmental Goals Report (2010) (herein UNMDG 2010 report). Available at <http://www.un.org/millenniumgoals/pdf/MDG%20Report%202010%20En%20r15%20-low%20res%2020100615%20-.pdf>. [accessed on 10 January 2011].

⁵²⁴ Ibid MDG 3.

⁵²⁵ Ibid MDG 4.

⁵²⁵ Ibid MDG 3.

⁵²⁶ Ibid MDG 5.

⁵²⁷ Ibid MDG 6.

⁵²⁸ See B Dickens 'The challenges of reproductive and sexual rights' (2008) 98 (10) *American Journal of Public Health* 1738.

revealed that the highest rate of child mortality continues to be found in sub-Saharan Africa.⁵²⁹ Although there has been a decline in child mortality rates of children under 5 years by 22 per cent from 1990 the rate has not reduced enough to meet the target.⁵³⁰ The MDG 5 is aimed at improving maternal care by providing for antenatal and post natal care. The statistics revealed that the leading cause of maternal death in developing countries is haemorrhage (35 per cent).⁵³¹ These deaths can be prevented through proper medical care administered by skilled health personnel.⁵³² Although South Africa has been vigilant in trying to meet the MDGs, the problem lies in the failure of government to hold to account those who provide essential services and to ensure that health, education and other systems are managed so as to deliver quality services.⁵³³ Public health personnel in South Africa have recently been scrutinised for their lack of dedication and professionalism towards the health of patients as evidenced in the 2010 strike that left patients exposed to further health complications.⁵³⁴ Similarly, medical personnel in Namibia have been found to maltreat HIV-positive women and deny them appropriate care.⁵³⁵ Nurses in some government hospitals are harsh towards pregnant mothers and will neglect to give them the appropriate care. A study in Ghana of midwives attitudes towards women in labour revealed that despite their being skilled midwives in the hospitals, pregnant women were scared to go to the hospital for fear of being treated badly by the nurses while in labour.⁵³⁶ This perception is common in many sub-Saharan countries where pregnant teenagers, unmarried women and HIV-positive women are vulnerable to such abuse as there is stigma attached to the circumstances of these pregnancies. Such biased attitudes will prevent HIV-positive women from seeking treatment which will in turn affect the infant and maternal mortality rates, thereby impeding on the targets aimed by the MDGs.

⁵²⁹ UNMDG 2010 report at 27.

⁵³⁰ Ibid.

⁵³¹ Ibid at 31.

⁵³² Ibid.

⁵³³ D J Ncayinyana 'Millennium Developmental Goals: How are we doing?' (2010) 100(11) *South African Medical Journal* 689.

⁵³⁴ Ibid.

⁵³⁵ See ICW Namibia report supra note 1.

⁵³⁶ L D'Ambruso, M Abbey & J Hussein 'Please understand when I cry out in pain: Women's accounts of Maternity Services during labour and delivery in Ghana' (2005) *BMC Public Health*, 5. Available at www.biomedcentral.com/1471-2458/5/140 [accessed 14 January 2011].

MDG 6 addresses the importance of PMTCT programmes. The UNMDG 2010 report revealed that 90 per cent of the 2.1 million children living with HIV were infected while in the womb, during child birth and through breastfeeding.⁵³⁷ This shows that there is a need to encourage HIV-positive women to seek proper antenatal care and access Neveapine in order to prevent infection from mother-to-child. The report notes that progress has been made for example in 2008, 45 per cent of HIV-positive pregnant women, approximately about 628, 000 out of 1.4 million received treatment in 149 low and middle income countries, which represented an increase of 10 percent from the previous year.⁵³⁸ Such progress will however halt or regress if practices like forced-sterilisation of HIV-positive women continue because women will be discouraged from accessing preventative health services.

6.6 Conclusion

Forced sterilisation due to its permanent and irreversible nature has dire consequences if it is performed without full informed consent. Forced sterilisation results in social stigma and discrimination towards the affected woman. In some Africa emphasis is placed on the value of children, and a sterilised woman will be ostracised as she is perceived as not contributing to her husband's lineage by having children. This could result in emotional and mental distress as the decision was taken without her consent. In addition to this, forced sterilisation may negatively impact on governmental policies aimed at the prevention and management of HIV/AIDS. HIV-positive women will be discouraged from seeking maternity care for fear of being sterilised. This distrust in the health system will negatively impact on programmes like PMTCT. On a global scale, forced sterilisation negatively impacts on the efforts of the UN to achieve its MDGs. Currently the UNMDGS aim to reduce infant and maternal mortality rates as well as combat the spread of HIV/AIDS by 2015. However, increased incidences of practices that violate human rights, such as forced sterilisation, will prevent individuals from accessing health care, thereby affecting the rates of maternal and infant mortality.

⁵³⁷ UNMDG 2010 report supra note 521 at 41.

⁵³⁸ Ibid.

CHAPTER 7: CONCLUSION

Forced sterilisation occurs when an individual is sterilised without their informed consent. Forced sterilisation as discussed in the preceding chapters is a violation of one's human rights in particular the rights to dignity, security of the person, equality, health and reproductive rights and right to be free from violence. The doctrine of informed consent although not a human right is important in the discussion of forced sterilisation as a violation of human rights, as such violations flow from the fact that proper consent was not obtained from the patient. Informed consent comprises of five major elements namely: disclosure, comprehension, competence, voluntariness and consent. These elements have to be fulfilled before informed consent can be said to be obtained. As seen in the discussion in chapter 2, the doctrine of informed consent is controversial specifically in assessing whether the patient was given all the relevant information needed to make an informed decision. In the context of HIV-positive pregnant women, this information includes accurate information about PMTCT and sterilisation.

Lack of information or misinformation is a problem that arises when dealing with informed consent. The SASA, SANHA and NHA require that a woman is given information on the benefits, risks, and alternatives to sterilisation before the procedure is performed. Women should not be coerced to accept sterilisation and since it is not an emergency operation, a doctor cannot use their own discretion to sterilise a patient. Some of the instances of forced sterilisation occurred when the pregnant woman was forced to sign consent forms during labour. Even though there was *prima facie* a signed consent form, such signature was received during duress when the woman was threatened that she either agree to be sterilised or forfeit a c-section leaving her child at a higher risk of infection during birth.

The right to dignity is an intrinsic value of all human beings and should be respected. Dignity is a founding value both in the SAC and NC and is protected internationally in the UDHR, ICCPR, ACHPR, and AWP. Dignity according to Kant demands that people are treated as ends in themselves and not as means to ends. Forced sterilisation infringes on the

right to dignity as women as HIV-positive women are sterilised based on the erroneous belief that they should not have children as the children will be infected. Dignity as argued above is linked with ones' self-fulfilment. Motherhood in most societies is seen as a period of transition and having children contributes to one's self fulfilment as a parent. Sterilisation as a permanent irreversible procedure prevents one from having any more children and if performed without one's consent strips them of their dignity and autonomy to decide for themselves. Forced sterilisation is also an infringement of the right to security of the person which is tied to the right to autonomy and not to have one's body interfered with without permission. This paper discussed the right not to be subject to cruel, inhuman and degrading treatment under the right to security of the person and argued that forced sterilisation does amount to cruel and inhuman treatment.

Forced sterilisation violates the right to equality/ non discrimination as the context in which HIV-positive women are being sterilised is because of their sero-status. The UDHR, ICCPR and ACHPR guarantee the right to equality and non-discrimination on the grounds of race, colour, sex, religion, political or other opinion, national or social origin, property, birth or other status. The right to equality demands that all be treated as equal before the law and with equal concern and respect. Although HIV is not listed as one of the explicit grounds this paper has argued that HIV status should be made an explicit ground of discrimination as the disease has impacted on a large number of people namely those infected and affected. PLWHA are faced with discrimination by the community and this practice at times extends to medical personnel. The implications of stigma and discrimination are that PLWHA are discriminated against in the health care system which is contrary to article 12 of the ICESCR which provides that every one is entitled to the highest attainable standard of health. PLWHA are discriminated in hospital settings *inter alia* by segregational treatment, denial of adequate information, lack of proper care as well as being ridiculed. This is contrary to article 12 that requires the provision affordable, accessible and quality health care to everyone.

Reproductive rights have in the past been subject to state control as they were used as a means to control population growth. However the ICPDA and BDPDA highlighted the importance of recognising and protecting reproductive rights. The ICCPR and ACHPR do

not expressly protect reproductive rights. CEDAW provides for the right to family planning but does not elaborate on what this right entails. The AWP does provide for reproductive (and sexual) rights which include the right to family planning, the right to decide on the number and spacing of children, control one's fertility and choose the method of contraception. Forced sterilisation affects all these rights as it removes the chance of women having any further children and also the choice of controlling their fertility as the procedure is permanent. The paper also discussed forced sterilisation as violence against women. There is a need to prevent acts of violence targeted specifically at women. All the reports of forced sterilisation as per the ICW Namibia report occurred on women not men. Forced sterilisation of HIV-positive women as argued does amount to gender-based violence against women.

In conclusion therefore, this paper has discussed how forced sterilisation is indeed a violation of human rights. Governments should adhere to their obligations to respect, protect, and fulfil the rights enshrined in international human rights instruments. Given that there is a less restrictive way of preventing mother-to-child infection, societal views that HIV-positive women should not have children are not a justifiable reason to sterilise women. Medical personnel owe all patients a duty of care regardless of their sero-status. It is hoped that this paper will be instrumental in highlighting the need for reform in attitudes adopted by the public healthcare system as well as urge governments to take measures to prevent further violations of the rights of HIV-positive pregnant women and PLWHA in general.

BIBLIOGRAPHY

1. Primary Sources

Constitutions

The Constitution of the Republic of South Africa 1996.

The Constitution of the Republic of Namibia.

South African Legislation

Children's Act 38 of 2005.

Choice on Termination of Pregnancy Act 92 of 1996.

National Health Act 61 of 2003.

Sterilisation Act 44 of 1998.

Namibian Legislation

Abortion and Sterilisation Act 2 of 1975.

Foreign Legislation

Americans with Disabilities Act of 1990.

United Kingdom, *Disability Discrimination Act 1995*, amended 2005.

South African cases

Advance Mining Hydraulics v Botes NO 2000(2) BCLR 119 (T).

Booyesen v Minister of Home Affairs & Another 2004 (5) SA 331 (CC).

Castell v De Greef 1994 (4) SA 408 (C).

Hoffmann v South African Airways 2001 (1) SA 1(CC).

National Coalition for Gay and Lesbian Equality v Minister of Home Affairs 1999 (1) SA 6 (CC).

Port Elizabeth Municipality v Various Occupiers 2005 (1) SA 217 (CC).

S v Makwanyane 1995 6 BCLR 665 (CC).

Namibian cases

LM v The Government of the Republic of Namibia Case Number I 1603/08 (forthcoming).

Muller v President of the Republic of Namibia and Another 1999 NR 190 (SC).

Nanditume v Minister of Defence 2000 NR 103 (LC).

Foreign cases

Buck v Bell 274 U.S. 200 (1927).

Madrigal v Quilligan, 639 F.2d 789 (9th Cir. 1981).

International Treaties and Declarations

African [Banjul] Charter on Human and Peoples' Rights, adopted June 27, 1981, OAU Doc.CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982), entered into force Oct. 21, 1986. Adopted in Nairobi, Kenya in June 1981. It entered into force on 21 October, 1986.

African Charter on the Rights and Welfare of the Child. OAU Doc. CAB/LEG/24.9/49 (1990). Adopted in Addis Ababa, Ethiopia on 11 July 1990. It entered into force on 29 November, 1999.

Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 10 December 1984, United Nations, Treaty Series, vol. 1465, p. 85. Adopted and opened for signature, ratification and accession by General Assembly resolution 39/46 of 10 December 1984. It entered into force on 26 June 1987, in accordance with article 27 (1).

Convention on the Elimination of All Forms of Discrimination Against Women, 18 December 1979, United Nations, Treaty Series, vol. 1249, p. 13. Adopted and opened for signature, ratification and accession by General Assembly resolution 34/180 of 18 December 1979. It entered into force on 3 September 1981, in accordance with article 27(1).

Convention on the Rights of the Child, 20 November 1989, United Nations, Treaty Series, vol. 1577, p. 3. The Convention on the Rights of the Child was adopted and opened for signature, ratification and accession by General Assembly resolution 44/25 of 20 November 1989. It entered into force on 2 September 1990, in accordance with article 49.

Convention on the Rights of Persons with Disabilities: resolution / adopted by the General Assembly, 13 December 2006, A/RES/61/106. Adopted without vote, 76th plenary meeting;

Issued in GAOR, 61st sess., Suppl. no. 49. "Annex: Convention on the Rights of Persons with Disabilities": p. 2-29. It entered into force on 3 May 2008.

International Covenant on Civil and Political Rights, 16 December 1966, United Nations, Treaty Series, vol. 999, p. 171. Adopted by the United Nations General Assembly Resolution 2200A (XXI) of 16 December 1966. It entered into force on 23 March 1976. in accordance with article 49.

International Covenant on Economic, Social and Cultural Rights, 16 December 1966, United Nations, Treaty Series, vol. 993, p. 3. Adopted and opened for signature, ratification and accession by General Assembly resolution 2200A (XXI) of 16 December 1966. It entered into force on 3 January 1976, in accordance with article 27.

International Convention on the Elimination of All Forms of Racial Discrimination, 21 December 1965, United Nations, Treaty Series, vol. 660, p. 195. Adopted and opened for signature and ratification by General Assembly resolution 2106 (XX) of 21 December 1965. It entered into force on 4 January 1969, in accordance with Article 19.

International Convention for the Protection of All Persons from Enforced Disappearance, G.A. res. 61/177, U.N. Doc. A/RES/61/177 (2006), 20 December 2006. Adopted by General Assembly resolution 61/177 on 12 January 2007. Entry into force on 23 December 2010, in accordance with article 39(1).

International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families, 18 December 1990, A/RES/45/158. Adopted by General Assembly Resolution 45/158, on 18 December 1990.

Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa. Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, Adopted by the 2nd Ordinary Session of the Assembly of the Union, Maputo, CAB/LEG/66.6 (Sept.13, 2000); reprinted in 1 Afr. Hum. Rts. L.J. 40. Adopted in Maputo, Mozambique on 11 July 2003. It entered into force on 25 November 2005.

South African Development Community, Protocol on Gender and Development, signed at Johannesburg on 17 August 2008. Available at <http://www.sadc.int/index/browse/page/465> [accessed on 21 October 2010].

Southern Africa Development Community, Protocol on Health signed at Maputo on 18 August 1999. Available at <http://www.sadc.int/index/browse/page/152> [accessed on 21 October 2010].

United Nations General Assembly, Universal Declaration of Human Rights, G.A res 217A (III) 10 December 1948.

South African Government Documents

South African National AIDS Council. The National HIV Counselling and Testing Campaign Strategy. South Africa, 2010.

Namibian Government Documents

Government of Namibia, Ministry of Health and Social Services 'Namibian HIV/AIDS Charter of Right 2000.

Minister of Health and Social Services *The Patient Charter of Namibia* Directorate: Primary Health Care & Nursing Services. Windhoek, July 1998. Available at <http://www.healthnet.org.na/documents/policies/Patient%20Charter.pdf> [accessed on 13 December 2010].

United Nations Documents

Beijing Declaration and Platform for Action, Fourth World Conference on Women, 15 September 1995, A/CONF.177/20 (1995) and A/CONF.177/20/Add.1 (1995). Available at <http://www.un.org/womenwatch/daw/Beijing/platform/declar.html> [accessed 24 November 2010].

Committee on Economic, Social and Cultural Rights, General Comment 14, The right to the highest attainable standard of health (Twenty-second session, 2000), U.N. Doc. E/C.12/2000/4 (2000), reprinted in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, U.N. Doc. HRI/GEN/1/Rev.6 at 85 (2003).

Committee on Economic, Social and Cultural Rights, General Comment No. 20, Non-Discrimination in Economic, Social and Cultural Rights (art. 2, para. 2) U.N. Doc. E/C.12/GC/20 (2009).

Committee on the Elimination of Discrimination against Women, General Recommendation 12, Violence against women (Eighth session, 1989), U.N. Doc. A/44/38 at 75 (1990), reprinted in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, U.N. Doc. HRI/GEN/1/Rev.6 at 237 (2003).

Committee on the Elimination of Discrimination against Women, General Recommendation 15, Avoidance of discrimination against women in national strategies for the prevention and control of acquired immunodeficiency syndrome (AIDS), (Ninth session, 1990), U.N. Doc. A/45/38 at 81 (1990), reprinted in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, U.N. Doc. HRI/GEN/1/Rev.6 at 240 (2003).

Committee on the Elimination of Discrimination against Women, General Recommendation 19, Violence against women (Eleventh session, 1992), U.N. Doc. A/47/38 at 1 (1993), reprinted in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, U.N. Doc. HRI/GEN/1/Rev.6 at 243 (2003).

Committee on the Elimination of Discrimination against Women, General Recommendation 21, Equality in marriage and family relations (Thirteenth session, 1992), U.N. Doc. A/49/38 at 1 (1994), reprinted in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, U.N. Doc. HRI/GEN/1/Rev.6 at 250 (2003).

Committee on the Elimination of Discrimination against Women, General Recommendation 24, Women and Health (Twentieth session, 1999), U.N. Doc. A/54/38 at 5 (1999), reprinted in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, U.N. Doc. HRI/GEN/1/Rev.6 at 271 (2003).

Human Rights Committee General Comment 19, Protection of the family, the right to marriage and equality of spouses (Article 23) (Thirty-ninth session, 1990), *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, U.N. Doc. HRI/GEN/1/Rev.1 at 28 (1994).

Human Rights Committee 'General Comment 20, (replaces general comment 7), Article 7, 'Prohibition of torture and cruel treatment or punishment' (44th Session 1992), *Compilation of Comments and General Recommendations adopted by Human Rights Treaty Bodies*, U.N.Doc.HRI/GEN/1/REV.1 at 30 (1994) (hereafter HRC GC 20).

Human Rights Committee, General Comment 28, Equality of rights between men and women (article 3), (Sixty-eighth session, 2000), U.N. Doc. CCPR/C/21/Rev.1/Add.10 (2000), reprinted in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, U.N. Doc. HRI/GEN/1/Rev.6 at 179 (2003).

United Nations International Conference on Population and Development Programme of Action, Cairo Egypt, September 1994. Available at <http://www.un.org/popin/icpd/conference/offeng/poa.html> [accessed 22 November 2010].

UNESCO, Amsterdam Centre for International Law and the Irish Centre for Human Rights 'Report of the Experts' Meeting on the Right to Enjoy the Benefits of Scientific Progress and its Applications' Amsterdam 7- 8 June 2007. Available at <http://unesdoc.unesco.org/images/0015/001545/154583e.pdf> [accessed on 15 November 2010].

2. Secondary Sources

Books

Amnesty International *Human rights for human dignity: A Primer on social, economic and cultural rights* (2005) Amnesty International Publications Alden press, Oxford, United Kingdom.

Beauchamp, T L and Childress, J F *Principles of Biomedical Ethics* 4th Edition (1994) New York: Oxford University Press.

Banda, F *Women, law and Human rights; An African Perspective* (2005) Hart Publishing, Oxford.

Carstens, P and Pearmain D *Foundational principles of South African medical law* (2007) Lexis Nexis Durban.

Cook R J, Dickens B M, Fathalla M *Reproductive health and human rights: Integrating medicine, ethics and law* (2003) Clarendon Press, Oxford.

Dhai, A and McQuoid-Mason, D *Bioethics, human rights and health law: principles and practice* (2011) Juta Academic.

Eriksson M K *Reproductive freedom in the context of international human rights and humanitarian law* (2000) Martinus Nijhoff publishers, The Hague.

Fineman, M A *Transcending the boundaries of law, generations of feminism and legal theory* (2011) Routledge, Oxon.

Foster, P 'Informed consent in practice' in S Sheldon and M Thomson *Feminist Perspectives on Healthcare Law* (1998) Cavendish Publishing Limited: United Kingdom.

Health Professions Council of South Africa, Guidelines for good practice in the Health care Professions. General Ethical Guidelines for Reproductive Health. Booklet 13. Pretoria May 2008.

Herring J *Medical law and ethics* (2006) Oxford University Press, New York.

Joint United Nations Programme on HIV/AIDS & Inter-parliamentary Union *Handbook for Legislators on HIV/AIDS, law and human rights: Action to combat HIV/AIDS in view of its devastating human, economic and social impact* (1999) Geneva, Switzerland.

Kennedy, I *Treat Me Right: Essays in Medical Law and Ethics* (1991) Oxford: Clarendon Press.

Lockwood, B *Women's rights: A Human Rights Quarterly Reader* (2006) John Hopkins University Press Baltimore, Maryland.

Miola, J *Medical ethics and medical law: A symbiotic relationship* (2007) Oxford: Hart.

Reilly, N *Women's human rights* (2009) Polity Press, Cambridge.

United Nations *The Human Rights-Based Approach to Development: Towards a Common Understanding Among UN Agencies* (2003) New York: UN. Available at http://www.unescobkk.org/fileadmin/user_upload/appeal/human_rights/UN_Common_understanding_RBA.pdf [accessed on 15 October 2010].

Van Leeuwen, F *Women's rights are human rights: The practice of the United Nations Human Rights Committee and the Committee on Economic, Social and Cultural Rights* (2010) Intersentia, Antwerp.

Woolman, S, Roux, T, Klaaren, J, Stein, A and Chaskalson, M (eds) *Constitutional Law of South Africa 2nd Edition* 2005 Juta & Co Ltd.

Online books

International Federation of Gynecology and Obstetrics (FIGO) Committee for the Study of Ethical Aspects of Human Reproduction and Women's Health. *Ethical issues in Obstetrics and Gynecology*, (2009). FIGO House, United Kingdom. Available at <http://www.figo.org/files/figo-corp/Ethical%20Issues%20-%20English.pdf> [accessed on 15 October 2010].

Joint United Nations Programme on HIV/AIDS, *HIV-related stigma, discrimination and human rights violations: Case studies of successful programmes*. (UNAIDS best practice collection) (2005). Available at http://data.unaids.org/publications/irc-pub06/jc999-humrightsviol_en.pdf [accessed on 17 November 2010].

Office of the United Nations High Commissioner for Human Rights. *Frequently asked questions on a Human rights-based approach to Development Cooperation*, (2006). Available at <http://www.ohchr.org/Documents/Publications/FAQen.pdf> [accessed 15 October 2010].

Office of the United Nations High Commissioner for Human Rights and the Joint United Nations Programme on HIV/AIDS, *International Guidelines on HIV/AIDS and Human Rights* (2006 Consolidated Version). UNAIDS, Geneva Switzerland. Available at http://data.unaids.org/Publications/IRC-pub07/jc1252-internguidelines_en.pdf [accessed on 7 November 2010].

World Health Organization, *Reproductive choices and family planning for people living with HIV; counselling tool*. Geneva, WHO (2006). Available at http://whqlibdoc.who.int/publications/2006/9241595132_eng.pdf [accessed 24 November 2010].

World Health Organization Department of Reproductive Health and Research (WHO/RHR) and Johns Hopkins Bloomberg School of Public Health/ Centre for Communication Programs (CCP), INFO Project. *Family Planning: A Global Handbook for Providers*. Baltimore and Geneva: CCP and WHO (2007). Available at <http://www.globalhandbook.org/handbook.pdf> [accessed on 24 November 2010].

World Health Organization. Joint United Nations Programme on HIV/AIDS and United Nations International Children's Fund, *Towards universal access: Scaling up priority HIV/AIDS interventions in the health sector*. Progress report 2010. Available at

<http://www.who.int/hiv/pub/2010progressreport/report/en/index.html> [accessed 15 November 2010].

United Nations, *The Millennium Developmental Goals Report 2010*. Available at <http://www.un.org/millenniumgoals/pdf/MDG%20Report%202010%20En%20r15%20-low%20res%2020100615%20-.pdf>. [accessed on 11 January 2011].

Articles

Ackermann, D M 'Seeing HIV and AIDS as a gendered pandemic' (2004) 44(2) *Supplementum* 214.

Amollo, R 'Advancing women's access to health services in South Africa: Legal and policy responses to HIV/AIDS (2009) 10(1) *Economic and Social Rights Review* 3- 7.

Andrews, P 'Violence against Aboriginal women in Australia: Possibilities of redress within the human rights framework' (1996-1997) 60 *Albany Law Review* 917.

Andrews, S 'Informed consent and HIV: A review of the topic with reference to the particular problems posed by the HIV pandemic' 2001 *The Southern African Journal of HIV Medicine* 10- 12.

BBC News 'Mass sterilisation scandal shocks Peru' (24 July 2002). Available at <http://news.bbc.co.uk/2/hi/americas/2148793.stm> [Accessed 10 October 2010].

Bharat, S and Mahendra, V S 'Meeting the Sexual and Reproductive health needs of people living with HIV: Challenges for Health Care Providers' (2007) 15 (29 Supplement) *Reproductive Health Matters* 93 -112.

Canadian HIV/AIDS Legal Network Canadian Working Group on HIV and Rehabilitation Interagency Coalition on AIDS and Development 'HIV, Disability and Human Rights: Opportunities offered by the United Nations Convention on the Rights of Persons with Disabilities: A Discussion Paper' 2008.

Centre for Reproductive Rights 'The Protocol on the Rights of Women in Africa: An instrument for advancing reproductive and sexual rights' (2006). Available at www.reproductiverights.org [accessed on 13 October 2010].

Chirwa, D M 'An overview of the impact of the International Covenant on Economic Social and Cultural Rights in Africa'. Available at http://www.communitylawcentre.org.za/clc-projects/socio-economic-rights/research/socio-economic-rights-international-and-comparative-law/socio-economic-rights-international-and-comparative-law-1/Socio-economic_rights_in_Africa.pdf [accessed on 13 October 2010].

Chicalu, D L 'Litigating the cases of sterilisation without informed consent of HIV positive women in Namibia' Kopenong Conference Centre Johannesburg 12 – 13 August 2009.

Available at

<http://arasa.info/sites/default/files/Litigating%20the%20cases%20of%20sterilisation.pdf>
[accessed 23 October 2010].

Cook, R J 'Human rights and reproductive self-determination' (1994-1995) 44 *The American University Law Review* 975- 1016.

Dhai, A 'Informed consent' (2008) 1 (1) *South African Journal of Business Law* 27- 30.

Dickens, B 'The challenges of reproductive and sexual rights' (2008) 98(10) *American Journal of Public Health* 1738- 1740.

Diko, N 'Legal Analysis on Forced Sterilization in South Africa' available at
http://www.wlce.co.za/morph_assets/themelets/explorer/health/Forced%20Sterilization.pdf
[accessed on 12 January 2011].

Dikotter, F 'Race culture: Recent perspectives on the history of Eugenics' (1998) 103(2) *The American Historical Review* 467- 478.

Du Plessis, G and Bezuidenhout, F 'Capital, habitus and symbolic violence in the field of reproductive rights: women and HIV' (2009) 41(2) *Acta Academica* 132-157.

Durojaye, E 'Advancing gender equity in access to HIV treatment through the Protocol on the Rights of Women in Africa' (2006) 6 *African Human Rights Law Journal* 188- 207.

Eijkholt, M 'The right to found a family as a still born right to procreate' (2010) 18 *Medical Law Review* 127- 151.

Esplen, E 'Women and girls living with HIV: Overview and annotated bibliography' (2007) 18 *Bridge, development-gender*. Available at
http://www.bridge.ids.ac.uk/reports/BB18_HIV.pdf [accessed on 10 January 2011].

Etinosa, EM 'The social- psychological consequences of HIV/AIDS stigmatization on Social Relations on Social Relations in Nigeria' (2007) 15(2) *Ife Psychologica* 10-24.

Fatoye, GK, Owolabi, AT, Fatoye, FO, Eegunranti, BA 'Emotional burden of infertility: A controlled study of women managed at a Nigerian teaching hospital' (2008) 6(1) *Gender and Behaviour* 1645- 1650.

Fovargue, S and Miola, J 'One step forward and two steps back? The GMC. The common law and 'informed' consent' (2010) 36 *Journal of Medical Ethics* 494-497.

Glauner, L 'The Need for Accountability and Reparation: 1830-1976 The United States Government's Role in the Promotion, Implementation, and Execution of the Crime of Genocide Against Native Americans' (2002) 51 *DePaul Law Review* 911.

Gruskin S 'Negotiating the relationship of HIV/AIDS to reproductive health and reproductive rights' (1994- 1995) 44 *The American University Law Review* 1191- 1205.

Hesketh, T, Lu L and Wei Xing Z 'The effect of China's One Child's Policy after 25 years' (2005) 353 *The New England Journal of Medicine* 1171-1176.

Human Rights Watch 'A test of inequality: Discrimination against women living with HIV in the Dominican Republic' (2004) 16(4B) *Human Rights Watch*.

International Community of Women Living with HIV/AIDS 'HIV positive women, pregnancy and motherhood' 2008. Available at <http://www.icw.org/files/briefingpaper-%20motherhood%2009-08.pdf> [accessed 12 November 2010].

International Community of Women Living with HIV/AIDS 'Sexual and Reproductive Health Rights Briefeigng' Updated 2008. Available at <http://www.icw.org/files/SRH%20rights.pdf> [accessed 10 November 2010].

International Community of Women Living with HIV/AIDS 'The forced and coerced sterilisation of HIV positive women in Namibia' (2009). Available at <http://www.icw.org/files/The%20forced%20and%20coerced%20sterilization%20of%20HIV%20positive%20women%20in%20Namibia%2009.pdf> [accessed 24 September 2010].

Jansen van Rensburg, M S 'A comprehensive programme addressing HIV/AIDS and gender based violence' (2007) 4 (3) *Journal of Social Aspects of HIV/AIDS* 695- 706.

Kass, N E 'Policy, ethics, and reproductive choice: Pregnancy and childbearing among HIV-infected women' (1994) 83 *Acta Paediatrica* 95.

Kendall, T 'Reproductive rights violations reported by Mexican women with HIV' (2009) Vol 11 No 2 *Health and Human Rights: An International Journal*. Available at <http://www.hhrjournal.org/index.php/hhr/article/viewArticle/175/260> [accessed on 13 October 2010].

Kirshenbaum, S B et al. 'Throwing the dice: Pregnancy decision-making among HIV-positive women in four U.S cities' (2004) 36(3) *Perspectives on Sexual and Reproductive Health* 106.

Kluchin, R M 'Locating the voices of the sterilised' (2007) 29(3) *The Public Historian* 131-144.

Knobel, G J 'Consent, with particular reference to HIV and AIDS' (2006) 24 (2) *CME* 79-82.

Lindegger, G and Richter, L M 'HIV vaccine trials: critical issues of informed consent' (2000) 96 *South African Journal of Science* 313-317.

Lombard, A 'South Africa: HIV-positive women sterilised against their will' 7 June 2010. Available at

http://www.southernafricalitigationcentre.org/news/item/South_Africa_HIV_positive_women_sterilised_against_their_will [accessed on 8 October 2010].

London, L, Orner, P J, and Myer L “‘Even if you’re positive, you still have rights because you are a person’”: Human rights and the reproductive choice of HIV-positive persons’ (2008) 8(1) *Developing World Bioethics* 11-22.

Mahendra, V S, Gilborn, L, Bharat, S, Mudoi, R, Gupta, I, George, B, Samson, L, Daly, C and Pulerwitz, J ‘Understanding and measuring HIV-related stigma in health care settings: A developing country perspective’ (2007) 4(2) *Journal of Social Aspects of HIV/AIDS* 616-625.

Makkonen, T ‘The principle of non-discrimination in International Human rights law and EU law’ 2005. Unpublished thesis available at http://iom.fi/elearning/files/national_law/estonia/essentialreading/PrincipleofNonDiscrimination.pdf [accessed on 16 November 2010].

McCrudden, C ‘Human dignity and judicial interpretation of human rights’ (2008) 19 (4) *The European Journal of International Law* 655- 724.

Mcquoid-Mason, D J and Dada, M A ‘The National Health Act: some implications for family practice’ (2006) 24(1) *CME* 12-14.

Minnaar, A and Bodkin, C ‘The mourning process of HIV-positive pregnant women’ (2009) 11 (2) *Africa Journal of Nursing and Midwifery* 5–17.

Minnie, K, Klopper, H, and Van der Walt, C ‘Factors contributing to the decision by pregnant women to be tested for HIV’ (2008) 13 (4) *Health SA Gesondheid* 50- 65.

Mkhize, N ‘Communal personhood and the principle of autonomy: the ethical challenges’ (2006) 24 (1) *Continuing Medical Education* 26- 29.

Moodley, K ‘Ethics in clinical practice: an overview’ (2006) 24 (1) *Continuing Medical Education* 30- 34.

Mystakidou, K, Panagiotou, I, Katsaragakis, S, Tsilika, E, Parpa, E ‘Ethical and practical challenges in implementing informed consent in HIV/AIDS clinical trials in developing or resource-limited countries’ (2009) 6 (2) *Journal of Social Aspects of HIV/AIDS* 46- 57.

Nair, P ‘Litigating against the forced sterilization of HIV-positive women: Recent developments in Chile and Namibia’ (2011) 23 *Harvard Human Rights Journal* 223.

Naylor, N M “‘Cry the beloved continent...’ Exploring the impact of HIV/AIDS and violence on women’s reproductive and sexual rights in Southern Africa’ (2005) 30(2) *Journal for Juridical Science* 52- 79.

Neethling, J ‘Delictual protection of the right to bodily integrity and security of the person against omissions by the state’ *The South African Law Journal* 572-590.

Ogunbanjo, G A and Knapp van Bogaert, D 'Ethical issues in family practice: Informed consent – Disclosure of information in clinical practice' (2004) 46 (3) *South African Family Practice* 35- 37.

Okonofua, F E, Harris, D, Odebiyi, A, Kane, T and Snow, R C 'The social meaning of infertility in Southwest Nigeria' (1997) 7 *Health Transition Review* 205- 220.

Orner, P, de Bruyn, M, Harries, J, Cooper, D 'A qualitative exploration of HIV-positive pregnant women's decision-making regarding abortion in Cape Town, South Africa' (2010) 7 (2) *Journal of Social Aspects of HIV/AIDS* 44- 51.

Patel P 'How did we get here and where to now? The coerced sterilisation of HIV-positive women in Namibia' *Agenda* 75. Available at <http://endforcedsterilisation.wordpress.com/about/background/> [accessed on 13 November 2010].

Pieterse, M 'The interdependence of rights to health and autonomy in South Africa' (2008) 125 (3) *South African Law Journal* 553-572.

Pieterse, M and Hassim, A 'Placing human rights at the centre of public health: A critique of *Minister of Health, Western Cape v Goliath*' (2009) 126 (2) *The South African Law Journal* 231- 245.

Press Release, Centre for Reproductive Rights 'Forcibly sterilized woman files international case against Chile (3 February 2009). Available at <http://www.reproductiverights.org/en/press-room/forcibly-sterilized-woman-files-international-case-against-chile> [accessed on 10 October 2010].

Ramkissoon, A, Coutsooudis, A, Coovadia, H, Mthembu, P, Hlazo, J and Smit, J 'Options for HIV-positive women' (2006) 19 *South African Health Review* 315- 332.

Ramkissoon, A et al. 'Sexual and reproductive health and rights' 2010 *South African Health Review* 33.

Rohleder, P and Gibson, K 'We are not fresh: HIV-positive women talk of their experience of living with their soiled identity' (2005) CSSR Working Paper 110, Centre for Social Sciences Research, University of Cape Town.

Sam, D L 'Value of children: Effects of globalization on fertility behaviour and child-rearing practices in Ghana' (2001) 17 (2) *Research Review* 5- 16.

Sandelowski, M and Barroso, J 'Motherhood in the context of maternal infection' (2003) 26 *Research in Nursing and Health* 470- 482

Seguardo, A C and Paiva, V 'Rights of HIV positive people to sexual and reproductive health: Parenthood' (2007) 15 (29 Supplement) *Reproductive Health Matters* 27–45.

Stein, J 'HIV/AIDS stigma: The latest dirty secret' CSSR Working Paper 46 (2003) Centre for Social Science Research, University of Cape Town. Available at <http://www.heart-intl.net/HEART/010105/HIVAIDSSigmaTh.pdf> [accessed 23 October 2010].

Stern, A M 'Sterilized in the name of public health' (2005) 95 *American Journal of Public Health* 1128- 1138.

Strode, A and Grant, B 'A critical review of the extent to which the *HIV/AIDS and Human Rights International Guidelines* have been implemented in the Southern African Development Community' 2007 *Obiter* 70- 83.

Swaminathan, H, Bhatla, N and Chakraborty, S 'Women's property rights as an AIDS response: Emerging efforts in South Asia' 2007. Available at <http://www.icrw.org/files/publications/Womens-Property-Rights-as-an-AIDS-Response-Emerging-Efforts-in-South-Asia.pdf> [accessed 27 November 2010].

Veriava, F 'Ought the notion of 'informed consent' to be cast in stone? *VRM v The Health Professions Council of South Africa*' (2004) 20 *SAJHR* 309- 320.

Vidal, F and Carrasco, M 'Mujeres Chilenas Viviendo Con VIH/SIDA:¿ Derechos Sexuales y Reproductivos?: Un Estudio de Correlaciones en Ocho Regionales del Pais '[Chilean Women Living with HIV/AIDS: What are their sexual and reproductive rights?: A study of correlations in eight regions of the Country] (2004). Available at <http://www.vivopositivo.org/portal/sitio/-pag/ficha.asp?Id=69> [accessed on 10 October 2010].

Vivo Positivo and Centre for Reproductive Rights 'Dignity denied: Violations of the Rights of HIV-positive women in Chilean health facilities' 2010 at 18. Available at http://reproductiverights.org/sites/crr.civicactions.net/files/documents/chilereport_single_FIN.pdf [accessed on 13 October 2010].

Wingood, G M, Reddy, P, Peterson, S H, DiClemente, R J, Nogoduka, C, Braxton, N, and MBewu, A D 'HIV stigma and mental health status among women living with HIV in the Western Cape, South Africa' (2008) 114 *South African Journal of Science* 237- 240.