



Complaint Ref No: 414/03/2015/KZN

Complainant/s:

Her Rights Initiative (HRI)

**International Community of Women
Living with HIV (ICW)**

And

Respondent/s:

**National Department of Health
Provincial Departments of Health**

**INVESTIGATION REPORT ON THE FORCED STERILISATION OF WOMEN LIVING
WITH HIV/AIDS IN SOUTH AFRICA**

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Acronyms

ACHPR	African Commission on Human and Peoples' Rights
AIDS	Acquired Immunodeficiency Syndrome
BPA	Beijing Platform for Action
CEDAW	Convention on the Elimination of all Forms of Discrimination Against Women
CGE	Commission for Gender Equality
CGE Act	Commission for Gender Equality Act (39 of 1996, as Amended)
DOH	Department of Health
GP	Gauteng Province
HIV	Human Immunodeficiency Virus
HPCSA	Health Professions Council of South Africa
HRI	Her Rights Initiative
ICCPR	International Convention on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights

ICPD	International Conference on Population and Development
ICW	International Community of Women Living with HIV
KZN	KwaZulu-Natal
MDGs	Millennium Development Goals
SDGs	Sustainable Development Goals
SALRC	South African Law Reform Commission
TB	Tuberculosis
NDOH	National Department of Health
PDOH	Provincial Department of Health
UNCEF	United Nations Children's Fund
UNDP	United Nations Development Programme
WHO	World Health Organisation
WLC	Women's Legal Centre

1. Introduction

- 1.1. The Commission for Gender Equality (hereinafter referred to as “the Commission”) is a Constitutional body established in terms of Chapter 9, and more specifically Section 181 of the Constitution of the Republic of South Africa, 108 of 1996 (hereinafter referred to as “the Constitution”).
- 1.2. Pursuant to Section 187(1) of the Constitution, the Commission is vested with powers and functions necessary for the effective execution of its mandate which include:
 - 1.2.1 Promote respect for gender equality and the protection, development and attainment of gender equality;
 - 1.2.2 Monitor, investigate, research, educate, lobby, advise and report on issues concerning gender equality;
 - 1.2.3 Assess the observance of gender equality.
- 1.3 The operations of the Commission are also guided by the enabling Act of the Commission, namely the Commission for Gender Equality Act (39 of 1996), as amended (hereinafter referred to as “the CGE Act”). The Act stipulates the powers, functions and duties of the Commission vis- a vis its Constitutional mandate. The Commission, by virtue of Section 11(1)(a) of the CGE Act, has the power to monitor and evaluate practices and policies of, amongst others, public bodies and private institutions. Section 11(1)(e) of the CGE Act enables the Commission to investigate any gender related issue of its own accord or upon receipt of a complaint.
- 1.4 This report is based on the complaint lodged with the Commission by two entities against the National and Provincial Departments of Health. The two entities alleged that the sexual and reproductive rights of their clients (amongst other rights) were violated when their

clients were subjected to forced and/or coerced sterilisation in public hospitals. Forced sterilisation occurs when an individual is sterilized without their knowledge, coerced into giving consent, or consent is obtained based on false or incomplete information.

1.5 Forced and/or coerced sterilisation is a gross human rights and medical ethics violation it is often described as an act of torture and cruelty, inhuman, and degrading treatment by the United Nations' (UN) Special Rapporteur on torture and other cruel, inhuman, or degrading treatment or punishment.¹ Forced sterilisation, a coercive contraceptive method, which involves surgically removing or disabling reproductive organs without full or informed consent, is a clear violation of bodily integrity, privacy and bodily autonomy, and when endorsed by the State, it constitutes institutional violence. Forced and/or coerced sterilisation often occurs due of intimidation, financial or other incentives or misinformation. In certain cases, it is required as a condition of health services or employment. The persons usually targeted by this procedure include people living with HIV, persons with disabilities, indigenous peoples and ethnic minorities, transgender and intersex persons and poor women.

1.6 Forced and/or coerced sterilisation has life-long implications and negatively impacts on the quality of life of an individual. This may include mental, social and future fertility plan amongst others. Sterilisation, when done without the free and full consent of an individual, amounts to violence against girls, women, transgender people and gender non-conforming people and falls within the ambit of actions that are prohibited under Article 7 of the

¹ J Méndez Human Rights Council Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (2013) <http://www.refworld.org/docid/51136ae62.html> Accessed 30 May 2019.

International Covenant on Civil and Political Rights (ICCPR) and Article 5 of the African Charter on Human and People's Rights .

1.7 Human rights in South Africa are enshrined Chapter 2 of the Constitution. Chapter 2 of the Constitution, which is referred to as the Bill of Rights, makes provision for the protection and promotion of fundamental human rights principles and affirms democratic values of human dignity, equality and freedom. The Bill of Rights also authoritatively provides that the state has a duty to respect, protect, promote and fulfil the rights enshrined therein. In the context of the Bill of Rights, forced and/or coerced sterilisation is a form of violence against women that violates their fundamental human rights and freedoms.

Limitation of Report

The Commission would like to state that due to a number of factors beyond the Commission's control, the report could not be finalised timeously. Some of the contributing factors included the following:

- a) Reluctance from women to lay complaints with the Commission. This results in difficulties for the Commission to obtain sufficient numbers to establish a pattern of forced sterilisation practices warranting investigation.
- b) The Commission needed to obtain consent forms from the complainants in order to access medical records, this took a long period of time.
- c) Poor record management at hospitals (during site visits) made it difficult or impossible to obtaining Patients' records.
- d) Lengthy interdepartmental consultation with the Department of Health (DOH) and consultation with the Women's Legal Centre (WLC) also contributed to the delay.

- e) Onsite visits were difficult to coordinate due to the geographical spread of the various hospitals under investigation. Additionally, due to a lack of sufficient resources and personnel, the Commission could not conduct onsite visits within a short space of time.
- f) Finally, the lack of cooperation from a number of hospital staff who were not keen on providing information and generally had a negative attitude towards the investigation process.

That notwithstanding, the Commission submitted a preliminary National Report on Maternity, and Obstetric Functions in South Africa to the National Department of Health. This was done in fulfilment of the Commission's obligation to monitor the implementation of the Millennium Development Goals ('MDG's') as well as assessing the DOH's compliance with the said MDG's. The report amongst other things, looked into sterilisation and forced and/or coerced sterilisation in National and Provincial Hospitals in South Africa.

The investigation was instituted by the Legal Department of the Commission in 2015, following reports it (the Commission) received of alleged violations of gender rights in South Africa's public health sector. The study focused on how Hospitals operate within their obstetric and gynaecological facilities in order to ensure that the best interests of Patient are the primary consideration in all medical procedures.

2. Parties to the Complaint

Complainants

2.1 The complainants in this case are two entities that, at the time of instituting the complaint, were being legally represented by the WLC.² However, the entities were subsequently represented by Jody-Lee Fredericks, an Attorney previously employed by WLC after WLC ceded working on the matter.

2.1.1 The First Complainant is a feminist social impact organisation called Her Rights Initiative (HRI) established in 2009. HRI is an advocacy organisation based in Durban but has a national, regional and international reach on issues pertaining to Sexual and Reproductive Health and Rights. In addition to advocacy, the organisation uses evidence-based research as a key component of achieving its policy objectives.³

2.1.2 The Second Complainant is a regional and global network called International Community of Women Living with HIV (ICW). The network focuses on advocating for and advancing the protection of the rights of women living with HIV (Human Immunodeficiency Virus).⁴ Through its work, the ICW brings to light the plight of women living with HIV/AIDS (Acquired Immunodeficiency Syndrome). Some of the cases involve women who have been victims of critical human rights abuses such as, violation of the right to the highest attainable standards of health specifically, sexual and reproductive health and rights.

² Women's Legal Centre is a non-profit law centre that seeks to achieve equality for women, particularly black women through impact-based litigation, the provision of free legal advice, legal support and advocacy campaigns run by other organisations and training.

³ Complaint Form 1.

⁴ As detailed on page one of the Complaint Form.

Furthermore, the organisation plays a big role in advocating against forced and/or coerced sterilisation, discrimination and stigma directed towards persons living with HIV/AIDS, domestic violence, and other forms of private as well as institutionalised violence against women living with HIV. These initiatives led to positive outcomes in that action has been taken to address the problems in a number of instances through litigation, dialogue at a global and regional platforms and policy change.⁵

2.2 The Respondents are the National and Provincial Departments of Health (hereinafter referred to as “NDOH” and “PDOH” respectively).⁶

The National Department of Health (NDOH) is the executive department of the South African government that deals with matters of health. Its mandate is ‘to improve the status of health through the prevention of illnesses, and the promotion of healthy lifestyles. The department is required to consistently improve the healthcare delivery system by ensuring access to quality health care and health related services, and promoting equity, efficiency, and sustainability in all areas pertaining to health care’.⁷

Provincial Department/s of Health: The provincial departments’ functions and responsibilities are to deliver a comprehensive health package and service to people in their respective provinces.

⁵ <http://www.icwglobal.org>.

⁶ Public or State-owned hospitals.

⁷ www.health.gov.za/vision-mission

3. Nature & Background of the Complaint

3.1 On 20 March 2015, the WLC lodged a complaint with the Commission on behalf of Her Rights Initiative (HRI), and International Community of Women Living with HIV (ICW).

3.2 The complaint was lodged on behalf of 48 (forty-eight) women whose cases of forced or coerced sterilisation were documented as a matter of public interest.⁸ It must be pointed out that the initial evidence presented in support of the complaint was not in the form of sworn affidavits but rather, 48 documented cases.⁹

3.3 The WLC intimated that, upon the request of the Commission, and subsequent receipt of duly signed consent forms from the affected women, sworn affidavits from the relevant parties would be made available. This request was ultimately granted.

3.4 The complaint lodged is grounded on the gross human rights violations of women living with HIV in South Africa; as they were allegedly subjected to forced and/or coerced sterilisation in public hospitals. The rights violated include the following:

3.4.1 The right to equality;

3.4.2 The right to dignity;

3.4.3 The rights to act autonomously and to choose one's own method of birth control;

3.4.4 The right to the highest attainable standards of health including, sexual and reproductive health and rights;

3.4.5 The right to adequate and comprehensive information.

⁸ As detailed in the Complaint form.

⁹ The attachment can be described as accounts of women of forced and/or coerced sterilisations. The names of the women were not disclosed / detailed.

Other grounds include the following:

3.4.6 The Complainants, who are women and are HIV positive, were forced to consent to sterilisation in circumstances that undermined their ability to act voluntarily and amounted to cruel or degrading treatment.

The Department of Health has not recognised the devastating impact that a sterilisation can have on a woman who has not consented.¹⁰

3.5 The Complainants took cognisance of the fact that, pursuant to the law of prescription, there was a limited opportunity for legal redress and remedy. A substantial amount of time had lapsed between the time the cases were documented and lodging of the complaint. That notwithstanding, the complainants sought the following remedies:

3.5.1 Investigate the allegations contained herein;

3.5.2 If necessary, conduct further research into the practices of forced sterilisation of women living with HIV to determine its prevalence in South Africa;

3.5.3 Engage the National Department of Health regarding the cases of forced sterilisation in South Africa;

3.5.4 Investigate compliance with International and Regional treaties in relation to forced sterilisations in South Africa;

3.5.5 Petition the South Africa Law Reform Commission (SALRC) for amendments to legislation or development of legislation that ensures that consent is properly obtained, such as providing

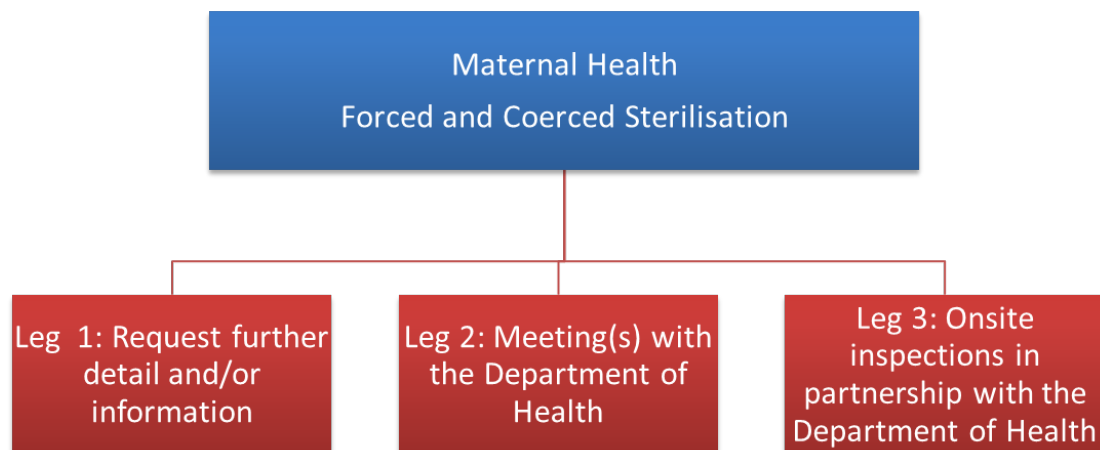
¹⁰ As detailed on the Complaint form, pages seven to twelve.

counselling prior to consent, the timing of obtaining consent and compulsory information that must be provided;

3.5.6 Government should provide redress to women who have been forced and coerced into sterilisation.

3.5.7 Recommend measures, ways and means, at national, regional and local levels to eliminate the practice of forced and coerced sterilisation of women living with HIV.¹¹

In light of the forgoing, the Commission adopted a three-pronged approach to address the complaint:



¹¹ As detailed on page 18 of the Complaint Form.

4. Applicable Legislative Framework

4.1 International Context

International human rights law affirms specific general principles applicable to all persons without discrimination, and these include;

- (i) The Right to Universal Enjoyment of Human Rights¹² 0[09
- (ii) The Rights to Equality and Non-discrimination;
- (iii) Right to Security of the Person;
- (iv) The Right to Freedom from Torture and Cruel, Inhuman or Degrading Treatment or Punishment;
- (v) The Right to the Highest Attainable Standard of Health – including the right to access health without discrimination;
- (vi) The Right to Protection from Medical Abuses – including the right of children to be protected and not subjected to medical abuse;

The principles above are of general application and are affirmed in various international human rights instruments.

South Africa is party to a number of international human rights instruments, and by virtue of Section 39 of the Constitution, the courts, tribunals or forums, have the power, when interpreting the Bill of Rights, to consider international law. Consequently, this report, in interpreting the rights violations, took into account provisions provided for in various international human rights instruments:

a) International Covenant on Civil and Political Rights (ICCPR) 1966

Article 2.3 of ICCPR guarantees every person the right to effective remedy for persons acting in an official capacity. All persons have the

¹² UN General Assembly, Universal Declaration of Human Rights, 10 December 1948, 217 A

right to equality and equal protection of the law; pursuant to Article 26 of ICCPR'.

b) The International Covenant on Economic, Social and Cultural Rights

Article 12 of the Covenant recognises the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. It provides that all services, goods and facilities must be available, accessible, acceptable and of good quality. The right to health also contains freedoms. These freedoms include the right to be free from non-consensual medical treatment, such as medical experiments and research or forced sterilisation, and to be free from torture and other cruel, inhuman or degrading treatment or punishment.¹³

In its General Comment No. 22 (2016), the United Nations Committee on Economic, Social and Cultural Rights identified laws requiring sterilisation for legal recognition of one's gender identity as violating States' obligation to respect the right to sexual and reproductive health. It further highlighted that States must take 'effective steps to prevent forced sterilisation, including through effective monitoring and regulation of healthcare providers'.¹⁴ 'States violate their obligation when they do not progressively ensure that sexual and reproductive health care is available, accessible, acceptable, and of good quality'.¹⁵ The Committee also stated that states have an obligation to provide access to justice and effective remedy to victims for violations of the right to sexual and reproductive health. They should ensure that those violations are investigated and prosecuted.

¹³ General Comment No. 22 (2016) on the Right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights)

¹⁴ As above

¹⁵ As above

c) Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)

South Africa ratified the Convention on the Elimination of All Forms of Discrimination against Women (hereinafter referred to as "CEDAW") in 1995. The Convention creates an obligation upon the State to ensure the advancement and protection of women's rights provided for in the Convention through legislation and enforcement of good policies, practices and programmes to support gender transformation.

The Convention, which is aimed at 'eliminating all forms of discrimination against women, defines discrimination as any distinction, exclusion or restriction made on the basis of sex, which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field'.¹⁶

CEDAW under its Article 12, mandates 'states party to the convention to take all appropriate measures to eliminate discrimination against women in the field of health care and ensure both men and women have equal access to health-care services, including those related to family planning, and information and education'. It continues to state that, 'women must be provided with appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation'.¹⁷

¹⁶ Convention on the Elimination of All Forms of Discrimination against Women Adopted and opened for signature, ratification and accession by General Assembly resolution 34/180 of 18 December 1979 entry into force 3 September 1981 Article 1

¹⁷ As above article 12

The article places a duty upon States to the Convention, to develop a legislative and policy framework for implementation of their obligations under the convention. They must also put in place a system that ensures effective judicial action and remedy in case of violation. Failure to do so constitutes a violation of Article 12.

Furthermore, Article 16 expressly requires 'parties to take all appropriate measures to ensure, both men and women are accorded equal rights to decide freely and responsibly, the number and spacing of their children, and to have access to the information, education and means to enable them to exercise these rights'.¹⁸

The CEDAW Committee in its General Recommendation No. 19 on Violence against women stated that 'Compulsory sterilisation is a form of violence against women because it adversely affects women's physical and mental health and infringes on the right of women to decide on the number and spacing of their children'.¹⁹

In addition, in the General Recommendation No. 21 on Equality in marriage and family relations, the Committee stated that, 'decisions to have children or not, while preferably made in consultation with spouse or partner, must not nevertheless be limited by spouse, parent, partner or Government'.²⁰ In order to make an informed decision about safe and reliable contraceptive measures, women must have information about contraceptive measures and their use, and guaranteed access to sex education and family planning services, as provided in article 10(h) of the Convention.

¹⁸ As above article 16

¹⁹ UN Committee on the Elimination of Discrimination Against Women (CEDAW), CEDAW General Recommendation No. 19: Violence against women, 1992.

²⁰ UN Committee on the Elimination of Discrimination Against Women (CEDAW), CEDAW General Recommendation No. 21: Equality in Marriage and Family Relations, 1994.

General Recommendation No. 24 on Women and Health provides an elaborate guideline to State Parties on women's rights.²¹ The Committee stated that, the obligation to respect and protect requires States parties, their agents and officials to refrain from obstructing action taken by women in pursuit of their health goals, and to take action to prevent and impose sanctions for violations of rights by private persons and organisations. They should also report on how public and private health care providers meet their duties to respect women's rights to have access to health care. States parties should facilitate²²:

- (a) The enactment and effective enforcement of laws and the formulation of policies, including health-care protocols and hospital procedures to address violence against women and sexual abuse of girl children and the provision of appropriate health services;
- (b) Gender-sensitive training to enable health-care workers to detect and manage the health consequences of gender-based violence;
- (c) Fair and protective procedures for hearing complaints and imposing appropriate sanctions on health-care professionals guilty of sexual abuse of women patients;
- (d) The enactment and effective enforcement of laws that prohibit female genital mutilation and marriage of girl children.

²¹ UN Committee on the Elimination of Discrimination Against Women (CEDAW), CEDAW General Recommendation No. 24 1999.

²² As above para 15

d) Universal Declaration of Human Rights UDHR (1948)

The UDHR guarantees all human beings the enjoyment of 'all the rights and freedoms set forth in the Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status'. Article 25 of the UDHR specifically provides for the right to means for adequate health by providing that:

'Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care...'

e) The International Conference on Population and Development Program of Action

The International Conference on Population and Development (ICPD) Program of Action introduced a rights-based approach to laws and population policies in addition to placing women's sexual and reproductive health and rights at the centre of national and global development agenda. The Programme of Action called for all people to have access to comprehensive reproductive health care, including voluntary family planning, safe pregnancy and childbirth services, and the prevention and treatment of sexually transmitted infections. It affirmed sexual and reproductive health as a fundamental human right.

While the ICPD does not create any new international human rights, it affirms the application of universally recognized human rights standards to all aspects of population programmes. States committed to support the principle of voluntary choice in family planning, and to move away from targeted approaches to practices such as sterilisation. States made a commitment towards empowerment of individuals, especially women, to increase their capacities to make autonomous, informed decisions about their reproductive options.

f) Vienna Declaration (of 1993) and the South African National Action Plan for the Promotion and Protection of Human Rights

Article 8 highlights the importance of working towards the elimination of violence against women in public and private life, the elimination of all forms of sexual harassment, exploitation and trafficking in women, the elimination of gender bias in the administration of justice and the eradication of any conflict which may arise between the rights of women, and the harmful effects of certain traditional or customary practices, cultural prejudices and religious extremism.

g) The Beijing Platform for Action (BPA)

The BPA requires governments, international communities and civil society, including non-governmental organisations and the private sector, to take strategic action to address twelve critical areas of concern including violence against women. Involuntary sterilisation has been described as 'a form of violence against women by the Beijing Declaration and Platform for Action (BPA)'.²³ The BPA 'reaffirms the rights of women with disabilities to make decisions concerning reproduction free from discrimination, coercion, and violence.'²⁴

h) Sustainable Development Goals (SDGs): 2030 Agenda

Goal 5 of the sustainable development goals aims at achieving gender equality and seeks to empower all women and girls. One of its targets includes ending all forms of discrimination and violence against women and girls, as well as the elimination of harmful practices, and the recognition of the value of unpaid care and domestic work.

i) Who Health Organisation (WHO) Paper on Eliminating Forced, Coercive and Otherwise Involuntary Sterilisation

The Interagency statement made by WHO and other agencies inclusive of United Nations Children's Fund (UNICEF) and United Nations

²³ UN *The Beijing Declaration and the Platform for Action: Fourth World Conference on Women A/CONF.177/20/Add.1.* (1995) paras. 95-96

²⁴ As above

Development Programme (UNDP) proclaim that 'like any other contraceptive method, sterilisation should only be provided with the full, free and informed consent of the individual'.²⁵

It reaffirmed that sterilisation as a method of contraception and family planning should be available, accessible, acceptable, of good quality, and free from discrimination, coercion and violence, and that laws, regulations, policies and practices should ensure that the provision of procedures resulting in sterilisation is based on the full, free and informed decision-making of the person concerned.'

4.2 Regional Context

a) Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (Maputo Protocol)

The Protocol on the African Charter on Human and People's Rights (ACHPR) in Africa on the Rights of Women in Africa is the first legal instrument to officially recognise sexual and reproductive rights as human rights in Africa.²⁶ The protocol categorically provides for the sexual and reproductive rights of women in Africa, and mandates parties to the Protocol to commit to the full realisation of these rights.

South Africa is a party to the Protocol after it ratified it in December 2004. Article 14 of the Maputo Protocol states that 'parties shall ensure that the right to health of women, including sexual and reproductive health, is respected and promoted including the right to control their fertility and the right to decide whether to have children, the number of children and the spacing of children'.²⁷

²⁵ Eliminating Forced, Coercive and Otherwise Involuntary Sterilisation. An interagency statement, OHCHR, UN Women, UNAIDS, UNDP, UNFPA, UNICEF and WHO
https://www.who.int/reproductivehealth/publications/gender_rights/eliminating-forced-sterilisation/en/

²⁶ African Union, Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa,

²⁷ As above article 14

b) The African Charter on Human and People's Rights

The ACHPR is the main instrument for the protection and promotion of human rights in Africa. South Africa being a member of the African Union, has ratified the ACHPR and is thereby bound by its provisions.

Article 2 of the Charter provides that, 'every individual shall be entitled to the enjoyment of the rights and freedoms recognised and guaranteed in the present Charter without distinction of any kind such as race, ethnic group, colour, sex, language, religion, political or any other opinion, national and social origin, fortune, birth or any status'.²⁸ Article 3 further provides that everyone shall be equal before the law and shall be entitled to equal protection before the law.

In the Charter, the right to health is guaranteed under Article 16 which states that 'all persons are entitled to the highest standards of physical and mental health'. The provision goes further and mandates State Parties to 'take the necessary measures to protect the health of their people, and to ensure that they receive medical attention when they are sick'.²⁹ To bolster the importance of protecting women in Africa, the Charter under Article 5 directs State Parties to ensure the 'elimination of every discrimination against women and also ensure the protection of the rights of women and the child as stipulated in international declarations and conventions'.

As a result of the concern on the prevalence of forced sterilisation in Africa, the ACHPR adopted Resolution 260 on Involuntary Sterilisation in 2013.³⁰

²⁸ African (Banjul) Charter on Human and Peoples' Rights (Adopted 27 June 1981, OAU Doc. CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982), entered into force 21 October 1986)

²⁹ As above article 16

³⁰ Adopted by the African Commission on Human and Peoples' Rights at its 54th Ordinary Session held from 22 October to 5 November 2013, in Banjul, The Gambia.

This was a landmark resolution that condemns involuntary sterilisation as a gross human rights violation. The resolution called upon states to:

1. Allocate adequate resources to HIV and reproductive health services;
2. Ensure that the existing international medical and ethical principles of free and informed consent with regards to all medical procedures, including sterilisation are reflected in national laws and are enforced in the provision of healthcare services to women living with HIV;
3. Put in place mechanisms to ensure that women living with HIV are not subjected to coercion, pressure or undue inducement by healthcare providers and/or institutions in order to secure consent for sterilisation or other medical procedures;
4. Ensure that women living with HIV are provided with all information on available HIV and reproductive health services in a language that they understand;
5. Ensure regular training of medical personnel on the protection of human rights in the context of health care, including the principles of informed consent and non-discrimination;
6. Ensure meaningful involvement of women living with HIV in the drafting of laws, policies and guidelines concerning sexual and reproductive health and rights;
7. Investigate allegations of involuntary sterilisation conducted on women living with HIV and practices involving health practitioners, institutions and all persons involved in cases of involuntary sterilisations of women living with HIV; and
8. Put in place complaint mechanisms, legal assistance, and reparation for women living with HIV and victims of involuntary sterilisation.

c) SADC Declaration on Gender and Development (2008)

The Declaration notes that gender equality is a fundamental human right and commits State Parties to protecting the rights of women and girls by amending Constitutions, enacting empowering gender sensitive laws and changing social practices that are derogatory and discriminate against women.

d) Addendum to 1997 Declaration on Gender and Development by SADC Heads of State

The Addendum expresses concern at the rate of physical and sexual violence occurring in the family, including traditional practices that are harmful to women. It commits State Parties to eradicate traditional norms and practices which legitimise and exacerbate the persistence and tolerance of violence against women and children.

4.3 Domestic Context

(a) The South African Constitution, 108 of 1996

The right to equality (Section 9)

Section 9 of the Constitution states that all persons are equal before the law. It guarantees everyone equal protection and benefit of the law without discrimination. This section further prohibits the state or any other person from unfairly discriminating anyone on any grounds including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth. This was confirmed in *Harksen v Lane*.³¹

It must be noted that the Constitutional Court also held that the Constitution contemplates two categories of discrimination – specified and unspecified. Unspecified or analogous grounds include those

³¹ *Harksen v Lane NO and Others (CCT9/97) [1997] ZACC 12; 1997 (11) BCLR 1489; 1998*

grounds 'based on attributes or characteristics which have the potential to impair the fundamental dignity of persons as human beings, or to affect them adversely in a comparably serious manner; in this particular instance it would be the HIV status of the majority of women who were targeted for coercive sterilisation.'³² HIV/AIDs was recognised as an analogous ground of discrimination in the case of *Hoffman v South African Airways*³³.

The right to dignity (Section 10)

Section 10 of the Constitution guarantees everyone the right to dignity.

Dignity is arguably the cornerstone of human rights and inextricably linked to the principles of equality and non-discrimination. It is a right that is inherent in all human beings because its basis is autonomy of self and self-worth. All human rights values and principles must ensure that the dignity of the person is at the epicentre of all rights.

In *S v Makwanyane*³⁴ the Constitutional Court re-affirmed the importance of the right to dignity by stating that, recognising a right to dignity is an acknowledgement of the intrinsic worth of human beings, independent of his or her situation in life. It further stated that, without dignity, human life is substantially diminished. It is only when a person is treated with dignity that they feel worthy and important in society. This right is violated when persons are subjected to conduct that is degrading and humiliating³⁵.

³² Above, para 46.

³³ *Hoffman v South African Airways* (CCT 17/00) [2000]; 2001 (1) SA 1; 2000 (11) BCLR 1211; [2000] 12 BLLR 1365 (CC) (28 September 2000).

³⁴ *S v Makwanyane and Another* (CCT3/94) [1995] ZACC 3; 1995 (6) BCLR 665; 1995 (3) SA 391; [1996] 2 CHRLD 164; 1995 (2) SACR 1 (6 June 1995).

³⁵ G Devenish, *A Commentary on the South African Bill of Rights* (Butterworths, 1999) at page 79.

The right to freedom and security of the person (Section 12)

The right to physical integrity is the right to make one's own decisions concerning one's body without undue interference or influence by another party. It promotes bodily autonomy and independence.

Section 12(2)(b) guarantees the right to bodily and psychological integrity, which includes the right to make decisions concerning reproduction and to security in and control over their body. The right to security in one's body prevents unwanted disturbance of bodily integrity.

Section 12(1)(c) guarantees the right to freedom and security of the person, which includes the right to be free from all forms of violence from either public or private sources.

In *Christian Lawyers Association v Minister of Health*³⁶, the High Court held that informed consent was not only permitted by the Constitution in relation to reproductive health but was indeed required by the Constitution³⁷. Although this decision was made within the context of termination of pregnancy it is applicable to reproductive health choices in general, including sterilisation.

Limitation of rights (Section 36)

This right pertains to the limitation of enjoyment of rights enshrined in the Constitution. It provides that 'the rights in the Bill of Rights may be limited only in terms of law of general application and only to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors, including— (a) the nature of the right; (b) the importance of the purpose of the limitation; (c) the nature and extent of

³⁶ *Christian Lawyers Association v Minister of Health*, Case No. 7728/2000; 2004 (10 BCLR) 1086 (T) (24 May 2004).

³⁷ Above, para 28.

the limitation; (d) the relation between the limitation and its purpose; and (e) less restrictive means to achieve the purpose.'

(b) The Commission for Gender Equality Act (39 Of 1996, as amended)

The constitutive Act of the Commission for Gender Equality gives the Commission jurisdiction over matters pertaining to gender and gender relations. It has the power to investigate any gender related issues either on its own volition or upon the receipt of a complaint pursuant to Section 11(1)(e) of the CGE Act. This jurisdiction is not only applicable to public bodies but is extended to private bodies. Once a complaint is lodged with the commission, the commission is empowered to resolve it by either mediation, conciliation or negotiation processes in line with Section 11(1)(e) of the CGE Act.

(c) Promotion of Equality and Prevention of Unfair Discrimination Act (4 of 2000) (PEPUDA)

This is an Act that is meant to give effect to section 9 read with item 23(1) of Schedule 6 to the Constitution of the Republic of South Africa, 1996. Its aim is to prevent and prohibit unfair discrimination and harassment; to promote equality and eliminate unfair discrimination; to prevent and prohibit hate speech; and to provide for matters connected therewith. It prohibits unfair discrimination by the government, private organisations and individuals, and forbids hate speech and harassment.

Section 1 of PEPUDA defines discrimination as any act or omission, including a policy, law, rule, practice, condition or situation which directly or indirectly imposes burdens, obligations or disadvantages, or withholds benefits, opportunities or advantages from any person on one or more of the prohibited grounds outlined in Section 9 of the Constitution.

To bolster the importance of not discriminating against persons with HIV, Section 34 of PEPUDA makes provision for the direct inclusion of HIV status as a ground for discrimination and it provides the following:

(1) 'In view of the overwhelming evidence of the importance, impact on society and link to systemic disadvantage and discrimination on the grounds of HIV/AIDS status, socio-economic status, nationality, family responsibility and family status-

- special consideration must be given to the inclusion of these grounds in paragraph (a) of the definition of 'prohibited grounds' by the Minister;
- the Equality Review Committee must, within one year, investigate and make the necessary recommendations to the Minister.'³⁸

(d) Health Professions Council of South Africa (HPCSA) Guidelines for Good Practice in The Health Care Professions. Seeking Patients' Informed Consent: The Ethical Considerations

In its preamble, the guidelines state that;

'Practice, as a health care professional is based on a relationship of mutual trust between patients and health care practitioners.³⁹ The term profession means a dedication, promise or commitment publicly made. To be a good health care practitioner, requires a life-long commitment to sound professional and ethical practices and an overriding dedication to the interests of one's fellow human beings and society'.⁴⁰

³⁸ Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000 Section 34.

³⁹ Health Professions Council of South Africa (HPCSA) Guidelines for Good Practice in The Health Care Professions. Seeking Patients' Informed Consent: The Ethical Considerations Booklet 9, May 2008.

³⁹ n 32 above 20.

⁴⁰ As above

According to the guidelines, 'a successful relationship between healthcare practitioners and patients is dependent upon mutual trust. To establish that trust practitioners must respect patients' autonomy, their right to decide whether or not to undergo any medical intervention, even where a refusal may result in harm to themselves or in their own death.

To enable patients to make informed decisions pertaining to their health care, sufficient information regarding their health must be given to them in a manner that they can fully comprehend the gravity of the situation. This is what is meant by an informed consent.⁴¹

It is also important to note, that the guidelines provide that treatment options must be discussed with patients at a time when they are best able to understand and retain the information. Clear explanations must be given, and patients must be given time to ask questions.⁴²

(e) The South African Nursing Council (SANC): CODE OF ETHICS FOR NURSING Practitioners in South Africa⁴³

Value Statement

This Code is based on the belief that nurses value:

- human life;
- respect, dignity and kindness for oneself and others;
- the uniqueness of individual healthcare users and also acknowledge the diversity of people in their care;
- the right to access to quality nursing and healthcare for all;

⁴¹ As above.

⁴² As above.

⁴³ The South African Nursing Council (SANC): CODE OF ETHICS FOR NURSING Practitioners in South Africa Value Statement (2013) point 4

- the provision of accurate and truthful information in accordance with informed consent or refusal of treatment to enable individuals to make informed decisions in respect of matters affecting their health;
- integrity of persons in their care as well as the image of the profession;
- confidentiality and privacy of personal information and belongings of healthcare users; and
- a culture of safety and an ethically-friendly environment, which includes the protection of healthcare users from colleagues who may be unfit to practise due to impairment or disability, posing a threat to the health and wellbeing of healthcare users.

(f) National Health Act (61 of 2003)

Section 7(1)(a) of the National Health Act provides that a health service may not be provided to a user without the user's informed consent unless, the user is unable to give informed consent. In such a situation, consent may be given by a person who is authorized either by the user to consent on their behalf or a person who is given such powers by the operation of the law.

(g) Sterilisation Act (44 of 1998)

South Africa has a sterilisation Act which provides for the right to sterilisation; to determine the circumstances under which sterilisation may be performed and the circumstances under which sterilisation may be performed on persons incapable of consenting or incompetent to consent due to mental disability; and to provide for matters connected therewith. The Sterilisation Act categorically prohibits sterilisations without informed consent.

The Sterilisation Act⁴⁴ recognises that both men and women have equal rights to be informed of, and have access to safe, effective, affordable and acceptable methods of fertility regulations. It however limits the circumstances in which sterilisations may occur by prohibiting sterilisation on persons under the age of 18 and setting strict procedural guidelines for sterilising persons who lack the capacity to consent. Furthermore, only authorised institutions can perform sterilisation procedures and such institutions are required to keep records of such procedures.⁴⁵

Persons electing to undergo the sterilisation procedure must consent voluntarily to the sterilisation. Consent is recognised as consent under the Act only if it is given freely and voluntarily without any inducement. It may only be given if the person giving it has–

- (a) been given a clear explanation and adequate description of the–
 - (i) proposed plan of the procedure; and
 - (ii) consequences, risks and the reversible or irreversible nature of the sterilisation procedure;
- (b) been given advice that the consent may be withdrawn any time before the treatment; and
- (c) understood and signed the prescribed consent form."

⁴⁴ The Sterilisation Act 44 of 1998.

⁴⁵ As above Sections (5) – (6).

5. The Doctrine of Informed Consent

No medical treatment should be provided without medical consent.⁴⁶ 'Everyone has the right to make decisions concerning their reproduction, and bodily and psychological integrity, which includes the right not to be subjected to medical or scientific experiments without their informed consent'.⁴⁷ 'Informed consent means consent for the provision of a specified health service, given by a person with legal capacity to do so and who has been informed about diagnostic procedures, and treatment options available to them as well as the benefit, risk, cost and consequences of the said procedures'.⁴⁸ It is one of the foundational pillars of medical ethics, hinged on respecting autonomy and dignity of the person which are Constitutional rights.⁴⁹ A healthcare service provider may not provide any service without the user's consent unless some justification as detailed in section 7 subsection 1 (a) – (e) can be met.

The Doctrine requires that the patient should be informed of their right to refuse treatment or procedure, and the repercussions of doing so. This information must be provided to the patient in a language that they understand considering the literacy level of the patient.⁵⁰ It is incumbent upon a health care provider to take all reasonable steps to obtain the user's informed consent.⁵¹ Patients have a right to information about their condition and the treatment options available to them.

It is the healthcare practitioner who is providing treatment that has the duty to give the patient the necessary information and to obtain consent. 'Where this is not practicable, healthcare practitioners may

⁴⁶ *Stoffberg v Elliott* 1923 CPD 148+.

⁴⁷ Constitution of the Republic of South Africa 1996 section 12 (2) (b) and (c).

⁴⁸ National Health Act 61 Of 2003 section 6; National Patient's Rights Charter 2.8 Informed Consent; P Appelbaum 'Assessment Of Patient's Competence To Consent To Treatment' (2007) 357 *New England Journal of Medicine* 1834-1840.

⁴⁹ T Beuchamp & J Childress *Principles Of Biomedical Ethics* (2001) 'New York: Oxford University Press'.

⁵⁰ A Hassim & others *The National Health Act 61 of 2003: A Guide* (2008) 24 (

⁵¹ n3 above Section 7

delegate these tasks provided they ensure that the person to whom they delegate:⁵² is suitably educated, trained and qualified; has sufficient knowledge of the proposed investigation or treatment and understands the risks involved; and acts in accordance with the HPCSA guidelines'⁵³. Healthcare practitioner will remain responsible for ensuring that, before they start any treatment, the patient has been given sufficient time and information to make an informed decision and has given consent.

For consent to be deemed operational, the following requirements must be satisfied:

- a) The consenting party 'must have had knowledge and been aware of the nature and extent of the harm or risk';
- b) The consenting party 'must have appreciated and understood the nature and extent of the harm or risk'
- c) The consenting party 'must have consented to the harm or assumed the risk';
- d) The consent 'must be comprehensive, that is extend to the entire transaction, inclusive of its consequences'.⁵⁴

A signed consent form is not sufficient evidence that a patient has given, or still gives, informed consent to the proposed treatment in all its aspects'.⁵⁵ Consent must at all times be expressed and not implied'.⁵⁶ In the South African context, the doctor's duty to disclose a material risk must be seen in the contractual setting of an unimpeachable consent to the operation and its sequelae.⁵⁷ Health care practitioners must check how well the patients have understood the details and implications of what is proposed, and not simply rely on the form in which their consent

⁵² Health Professions Council of South Africa Guidelines for Good Practice In The Health Care Professions

⁵³ As above

⁵⁴ *Ackermann J Castell v De Greef [1994] 4 All SA 63 (C)*

⁵⁵ As above para 11.

⁵⁶ As above

⁵⁷ As above

has been expressed or recorded especially where the initial consent was obtained by a third party’.

After a thorough analysis of some of the consent forms, the Commission noted that the consent forms in their current form are substandard and do not meet the threshold necessary to ensure women are protected from forced sterilisation.

6. Case Law

The understanding of the doctrine of informed consent above is taken directly from South African case law. Various cases have pronounced that informed consent rests on the three independent legs of knowledge, appreciation and consent⁵⁸ Elucidating on the requirement of informed consent, the High Court endorsed the articulations of the requirement in the case of *Waring and Gillow Ltd v Sherborne*⁵⁹;

“It must be clearly shown that the risk (of a medical procedure) was known, that it was realised, that it was voluntarily undertaken. Knowledge, appreciation, consent – these essential elements; but knowledge does not invariably imply appreciation, and both together are necessarily equivalent to consent.”

The Court went on to further elaborate that “the requirement of appreciation implies more than mere knowledge. The woman who gives consent [to sterilisation] must also comprehend the nature and extent of the harm or risk.”⁶⁰

6.1 **Hoffmann v South African Airways CC 17/00 (2000) ZA CC 17**

Discrimination on the grounds of gender is expressly prohibited, and in the Hoffmann case, the Constitutional Court found that HIV status is also a ground of discrimination. At paragraph 28 and 29, the court commented

58 Christian Lawyers Association n 36 above, para 20.

59 *Waring & Gillow Ltd v Sherborn* 1904, at 344.

60 Christian Lawyers Association n 36 above, para 21.

in passing that HIV positive people, for a multitude of reasons, "... (should) enjoy special protection in our law."

6.2 Stoffberg v Elliot⁶¹

This case was decided on 73 years before the current Constitution and Sterilisation Act were promulgated. In this case, Dr Elliott had amputated Mr Stoffberg's penis without consent being given by Mr Stoffberg. Mr Stoffberg then sued the doctor for performing an act which he had not given informed consent for. In his judgment, Ingram CJ stated that: "every person has certain absolute rights which the law protects. They are not dependent upon statute or upon a contract, but they are rights to be respected and of these rights is the right to absolute security of the person".⁶²

6.3 Castell v De Greef⁶³

In this case, after a surgical operation was done on her breasts and complications occurred, the appellant claimed that she was not properly informed of the operation to be done and that she would not have given consent had she had all the information at her disposal and had she known about the possible risk of complications.

In his judgment, Ackermann J stated that: "In the South African context the doctor's duty to disclose a material risk must be seen in the contractual setting of an unimpeachable consent to the operation and its sequelae".⁶⁴

⁶¹ 1923 CPD 948.

⁶² As above para 148.

⁶³ (1994) 4 All SA63(C).

⁶⁴ As above para 79.

6.4 **A.S. v Hungary**⁶⁵

A Hungarian woman of Roman origin was coercively sterilised in a public hospital after signing a statement of consent to a caesarean section that contained a barely legible consent note for sterilisation. The Committee on the Elimination of Discrimination Against Women found that by failing to provide information and advice on family planning, the State had violated the victim's rights. The Committee established that the victim had a right "to specific information on sterilisation and alternative procedures for family planning in order to guard against such an intervention being carried out without her having made a fully informed choice."⁶⁶

6.5 **María Chavez v Peru**⁶⁷

A rural woman was forced by public health officials to undergo sterilisation surgery which resulted in her death. In 2002, the Peruvian government signed a friendly settlement and "admitted international responsibility for the facts described and pledged to take steps for material and moral reparation of the harm done and to initiate a thorough investigation and trial of the perpetrators and to take steps to prevent the recurrence of similar incidents in the future."⁶⁸

⁶⁵ *A.S. v. Hungary, Communication No. 4/2004 (2006), para. 11.2.*

⁶⁶ *Ibid.*

⁶⁷ *Inter-American Commission on Human Rights, María Chávez v. Peru, Case 12.191, Report No. 71/03 (2003), para. 14.*

⁶⁸ *As above.*

7. Assessment of the Complaint

After the complaint was lodged with Commission, the Commission's investigation team proceeded to obtain sworn affidavits from the Complainants, that gave an account of the alleged events. The Complainants also submitted duly signed consent forms to the investigation team, legally authorising them to access their hospital records.

The investigative team also convened several meetings with the NDOH to engage them on this matter. The Commission and the NDOH subsequently conducted joint onsite inspections at various hospitals which were alleged to have staff that conducted forced or coerced sterilisations.

The summary of the allegations are as follows:

From the affidavits, it is evident that all the women who had lodged the complaint were Black women who were mostly HIV positive and whom, at that time of the alleged forced/coerced sterilisations, were pregnant, and in the process of seeking medical assistance at various hospitals in the country. Just before giving birth, but either while in labour and/or in extreme pain, they were coerced or forced to sign forms that they later learnt through various means were consent forms allegedly permitting the hospital to sterilise them. In addition, all women who were allegedly subjected to this process of sterilisation gave birth through caesarean section.

As stated in the women's statements, majority of the women were either humiliated and/or threatened by medical personnel who told them that they would not be attended to if they did not sign the forms. Furthermore, there are those that stated that, due to the extreme pain that they were in they did not understand the contents and consequence of the forms they were signing.

The Commission, in accepting the complaint, made a preliminary assessment of the matter and determined that the issue falls within its jurisdiction. The purpose of the Commission is to transform society by exposing gender discrimination in laws, policies and practices, subsequently advocating for change in attitudes and negative gender stereotypes and ultimately promoting and protecting the recognition of sexual and reproductive rights, as human rights.

The Commission adopts a human rights-based approach in addressing issues brought to its attention. A rights-based approach is a concept that ensures human rights standards and principles are reflected in policies, legislation and practice. This approach helps in addressing inequalities which lie at the heart of development such as discrimination and unjust distribution of power that impede the development progress.

7.1 Steps taken by the Commission (2015-2019)

- 7.1.1 After receiving the complaint, the Commission sent a letter to the Minister and the Director General of the NDOH on the 2nd of May 2015, detailing the allegations complained of by the affected women;
- 7.1.2 A follow up letter was also sent on the 27th July 2015 to which, the NDOH acknowledged receipt;
- 7.1.3 In a letter dated 04 September 2015, the NDOH assured the Commission of its commitment to cooperate and collaborate with the Commission to resolve the matter, but also raised their concern about the fact that they had not been provided with sufficient details necessary for them to proceed with the investigations. Some of the information required include the details of the Complainants which would allow the NDOH to access medical records to ascertain the 'clinical circumstances of their experiences';

7.1.4 A meeting was held with the NDOH to discuss the investigation strategy and to which an official was assigned by NDOH to deal with this matter in early 2016;

7.1.5 The Commission subsequently requested WLC to obtain individual written consent forms from the Complainants, permitting the Commission through its team, to gain access to the Complainant's medical records and for possible interviews;

7.1.6 In an endeavour to concretise a strategy on a joint investigation into the status of maternal health in the hospitals across the country that had been implicated, a meeting between the Commission and the NDOH was convened in January 2017. It was then resolved that:

- Both entities would commit a total of nine (9) staff members to spearhead the investigation.
- Letters were sent to Heads of Departments (HODs) of the sampled health care facilities by the team from NDOH and a meeting between the Commission and NDOH held in order to ascertain the purpose and overview of the investigation.
- The Commission obtained written consent to peruse medical files from the Complainants and an investigation strategy was formulated and agreed upon by the Commission and NDOH. The strategy was as follows: once a sample was drawn, visits to the implicated hospitals would be scheduled to assess the Complainant's files, and to interview staff. To cover more ground, the team would break into two groups with an equal number of Commission and NDOH staff in each group. An analysis of the information gathered would then be made. There was a standardised questionnaire that

was formulated and used for purposes of collecting the data;

7.1.7 The Commission requested the full particulars of the Complainants and the specific complaints from the WLC because it was crucial in the investigation of the complaint. To achieve this, meetings were held with WLC where the Commission requested this crucial information in the form of sworn affidavits. The information that the Commission had received prior had insufficient details and the Commission needed more specific information in order to access their hospital records;

7.1.8 Onsite visits were thereafter conducted in fifteen (15) hospitals across Gauteng Province (GP) and KwaZulu-Natal (KZN) by officials from the Commission and NDOH;

7.1.9 Onsite visits were conducted in the following hospitals:

GP

- Tambo Memorial Hospital in Boksburg;
- Tembisa Hospital;
- Far East Rand Hospital in Springs;
- Edenvale Hospital;
- Leratong Hospital in Johannesburg;

KZN

- Prince Mshiyeni Hospital in Umlazi;
- Addington Hospital in Durban;
- Stanger Hospital in Durban;
- Albert Luthuli Hospital in Durban;
- Edenvale Hospital in Pietermaritzburg;
- St Mary's Hospital in Melmoth;
- Hlabisa Hospital in Nongoma;

- Lower Umfolozi Hospital in Empangeni;
- Port Shepstone Provincial Hospital in Port Shepstone; and
- GJ Crookes in Scottburgh.

7.1.10 After several meetings and numerous written correspondence between the Commission and WLC and thereafter between the Commission and Jody Fredericks, who was now representing the Complainants, sworn affidavits were ultimately furnished to the Commission.

The Commission experienced challenges with some of the hospitals due to the ancient nature of the complaints. There were files that were missing and could not be retrieved, though some were identified, and information sourced to verify these complaints. It should be noted that some of these files contained consent forms, even though the Complainants had initially indicated that they had never consented to the sterilisation but were coerced into these acts of sterilisation.

To further verify these allegations, the Complainants were then requested to depose sworn affidavits and present them to the Commission outlining the series of events to weigh against the disaggregated data. A total of 14 (fourteen) affidavits were availed, and this was through the assistance of a representative from Jody Fredericks Attorneys who has been a part of the investigation⁶⁹. The Commission received these affidavits on 16 July 2018.

⁶⁹ Sworn Affidavits received on 16 July 2018 from Jody Fredericks.

8. Analysis of information contained in the Sworn Affidavits

A thorough analysis of the affidavits by the investigative team has revealed that most Complainants have been suffering from depression from the time they learnt that they would never be able to conceive due to the coerced/ forced sterilisation they had been subjected to⁷⁰. Most of these complaints are women from the KwaZulu-Natal region and a number of them stated that their partners have since left them due to their inability, and failure to conceive more children. They could no longer fulfil their partners' wishes for larger families.

8.1 Ms. A for example alleges that she went to Nkandla hospital for antenatal care in September 2011. She was then informed that she would be giving birth via caesarean section and an appointment was set for 18th September 2011. She was also told by the nurse that she should make sure she goes to the hospital on the set date even if she was not experiencing any pain. Ms. A could however not make it on the appointment date due to transport problems but was able to make it on the 19th September 2011. She was admitted to hospital and when she got to the ward, the nurse asked her whether the family was aware she was having a caesarean procedure that day. She informed the nurse that she had not informed the family and the nurse immediately asked her to call them. She called the family and informed them she was giving birth via caesarean.

The doctor then arrived and asked Ms. A if she was aware that she was giving birth via caesarean to which she answered in the affirmative. The doctor then asked if she was aware, she was being sterilised to which she answered no.

⁷⁰ Information sourced from sworn affidavits dispatched by the complainants.

The doctor said that she was sterilising her because she had too many children, but she protested against it. The nurses then proceeded to shout at her saying she must be sterilised, and one even said that if she gave birth again, she would die.

She averred that she was alone in hospital without the support of her family and when she tried to contact them, her handbag containing her mobile phone was allegedly taken away from her by a nurse. Ms. A further alleges that she was coerced into filling the sterilisation forms because she was told by the hospital staff that they would not assist her in giving birth until the forms were duly completed. She ultimately signed the forms but under duress.

After giving birth, the doctor told her that she was going to be sterilised and to be certain, he was going to twist her womb. He also said that it was the law of the country that said she must be sterilised.

After a few months of the sterilisation process, she disclosed to her fiancé that she had been sterilised. Her fiancé, who was infuriated by the information he had just received and after 3 months decided to call for a family meeting that included extended family members. Even though some expressed sympathy, others ridiculed and expressed their disappointment in Ms. A. The Complainant avers that in the end, the marriage could not proceed because the fiancé was no longer interested in pursuing the relationship.

- 8.2 A second example is Ms. B who was allegedly seven months pregnant when she went to Addington hospital on 14

October 2001 for antenatal care. Upon her arrival, it was allegedly discovered that she had extreme high blood pressure, but the nurses said that they would try to lower it. Unfortunately, the nurses were supposedly unable to lower the pressure nor stabilise it and was subsequently booked in for a caesarean procedure the following day, 15 October 2001. Ms. B alleges that she was then given forms by one of the nurses who informed her that she needed to sign the forms for the caesarean before they take her to the theatre. She thus signed the forms presented to her under the impression that they were for the caesarean section procedure. She gave birth via caesarean section and was allegedly sterilised without her knowledge.

The following day, the wound from the caesarean was infected and two weeks later it still had not healed despite the hospital treating it. She had to be transferred to King Edwards Hospital which was apparently more equipped to handle her situation. She was admitted at the hospital for two and half months and was never told what exactly had happened to her and why her wound was taking so long to heal. After a few years, she went to a private doctor, after she noticed that she was failing to conceive. Upon proper examination, the results revealed that she had been sterilised by cutting of her fallopian tubes and as a result, was unable to conceive. Her partner has since left her and now has children with another woman.

- 8.3 Ms. C, who was about 20 (twenty) years of age at the time of her pregnancy allegedly went to Steve Biko hospital by an ambulance after experiencing labour pains. Samples of

blood had allegedly been found in her urine, and she was then allegedly advised that she would have to give birth through caesarean section. The doctor also allegedly explained that it would be best to sterilise her, to prevent her from bleeding to death should she fall pregnant again.

Ms. C at that stage indicated that she did not understand what it meant to be sterilised. She also mentioned that whilst signing the forms she was in so much pain and that she did not understand what it was that she was signing. She finally gave birth to a son through the caesarean delivery and was sterilised thereafter. A year later her son allegedly died from tuberculosis. Her efforts to conceive another child bore no fruits. She then visited a private gynaecologist, who examined her and discovered that she had been sterilised. The gynaecologist informed her that her fallopian tubes had been damaged and that she can no longer have children, she explained that her heart sank and has been experiencing bouts of depression due to being unable to conceive.

- 8.4 Ms. D was 8 months pregnant, felt sick and weak whilst pregnant and allegedly went to Magwaza hospital where a doctor examined her and diagnosed her with tuberculosis (TB). The doctor allegedly informed her that the TB would infect the child thus could only give birth via caesarean. Furthermore, the doctor told her that she could only start TB treatment after giving birth. She was booked in for the procedure four days later and admitted within three days after diagnosis.

On the 25th of September 2002, she was admitted to hospital and the doctor spoke to her and the nurse translated into Zulu. He informed her that she would be sterilised, because if she were to have children again, she would die. The doctor also told her that women with HIV should not have children and allegedly informed her about the forms she needed to sign.

The doctor did not explain what sterilisation is. She alleges that she was then injected and felt dizzy and does not remember whether she signed the sterilisation forms or not. She gave birth and was allegedly sterilised. A few years later, she tried to conceive but could not. She has been suffering from depression since then and to her, her body has never been the same.

9. Issues for Determination

The Commission narrowed down the following as the key issues for determination within the complaint:

- 9.1 Whether the Complainants were subjected to either forceful and/or coerced sterilisation.
- 9.2 Whether the Complainants had their rights to: (a) highest attainable standards of health including sexual and reproductive health; (b) right to dignity; (c) right to information, (d) freedom and security of the person; (d) right to equality and non-discrimination and (e) right to bodily autonomy, violated by the hospital staff.
- 9.3 Whether the Department of Health could be held liable for the gross violations of human rights if the claims are substantiated.

- 9.4 Whether the victims are entitled to any form of redress.
- 9.5 Whether the Department of Health has put measures in place to prevent forced and/or coerced sterilisation, including public sensitisation.

10. Analysis

Sterilisation is a medical procedure performed on women either through tubal ligation, or hysterectomy that permanently blocks one's fertility. Forced sterilisation occurs when an individual is sterilised without their knowledge or is coerced into giving consent, for instance when financial or other incentives, misinformation, or intimidation tactics are used to compel one into the procedure, or consent is obtained based on false or incomplete information.⁷¹ Examples of coerced and forced sterilisation have been documented in southern Africa.⁷²

As a result of the research study conducted by Ann Strode, Sethembiso Mthembu, and Zaynab Essack (2012) on women living with HIV, showed a pattern of coercive and forced sterilisation in South Africa.⁷³ The study, undertaken between 2010 and 2011, screened 32 HIV positive women in Gauteng and KwaZulu-Natal provinces using a questionnaire. This identified 25 (68%) of those screened, as having undergone an involuntary sterilisation procedure. Additionally, the South Africa National Aids Council's 2015 stigma index revealed that, out of 6,719 HIV positive women interviewed, an estimated 500 said they had been forcibly

⁷¹ Eliminating Forced, Coercive and Otherwise Involuntary Sterilisation: An Interagency Statement, OHCHR, UN Women, UNAIDS, UNDP, UNFPA, UNICEF and WHO, World Health Organization (2014) 3.

⁷² AIDS and Rights Alliance for Southern Africa (ARASA) Sexual and Reproductive Health Rights Advocacy Workshop Report. 21–22 October 2008, Johannesburg, South Africa.

⁷³ A Strode and Others 'She Made up a Choice for Me: 22 HIV-Positive Women's Experiences of Involuntary Sterilisation in Two South African Provinces' (2012) 20(s39) *Reproductive Health Matters* 61

sterilised.⁷⁴ According to this report, 7% of respondents responded that they 'were forcefully sterilised'.⁷⁵

Every woman has the right to bear children regardless of their status. To subject women to forced sterilisation because they are HIV positive is a fundamental human rights violation. The Complainants in this case alleged that a number of them were expressly told that they ought to be sterilised because HIV positive women could not be allowed to bear children. To deny women the right to have children because of their status amounts to discrimination. Furthermore, section 12(2) of the Constitution guarantees everyone the right to make decisions pertaining to their bodily and psychological integrity, which includes the right to make decisions concerning reproduction. The term 'everyone' is emphasised in the Bill of Rights and echoed by Ngcobo J (as he then was) in *Khosa v Minister of Social Development*.⁷⁶ In this case, the court held that: 'the word 'everyone' is a term of general import and unrestricted meaning.'⁷⁷

It is therefore accepted that the word 'everyone' in section 12(2) of the Constitution includes all persons irrespective of their HIV status. Suffice it to say, the complainants are entitled to equal protection and treatment under the law as envisaged under section 12(2) of the Constitution.

The law in South Africa categorically provides that, for a person to undergo the process of sterilisation, informed consent ought to be obtained. Using force, or any other form of coercion is prohibited, and

⁷⁴ South African National AIDS Council, 'The People Living with HIV Stigma Index, South Africa: Summary Report' (2015) <http://www.stigmaindex.org/sites/default/files/reports/Summary-Booklet-on-Stigma-Index-Survey%20South%20Africa.pdf> accessed 19 May 2019.

⁷⁵ Ibid.

⁷⁶ *Khosa v Minister of Social Development* 2004 (6) SA 505 (CC) para 111

⁷⁷ As above.

amounts to a violation of human rights. Based on the contents of the affidavits received by the Commission, it must be pointed out that, even though duly completed consent forms were present in some instances, the said forms were allegedly completed under duress. Many of the complainants had been forced by the health care professionals to sign the said consent forms as the hospital staff had threatened not to assist them in giving birth. Further, there are those who allege that they were humiliated by the health care providers which then exerted pressure on them to sign the forms. For example, one of the Complainants in her affidavits narrated the following:

'When I asked the nurse what the forms were for, the nurse responded by saying: "You HIV people don't ask questions when you make babies. Why are you asking questions now, you must be closed up because you HIV people like making babies and it just annoys us. Just sign the forms, so you can go to theatre"⁷⁸' she said.

Part of the requirement for sterilisation is that alternative care and treatments must be explained to the patient before a person is sterilised. These allegations suggest that the Complainants were coerced and/or forced to sign the consent forms without alternative methods being presented or explained to them. Moreover, the permanent or irreversible nature of the procedure was not explained to them. One Complainant averred that the attending healthcare practitioner told her that she was signing a standard delivery form.

In some instances, Complainants were given the forms while they were in extreme labour pain and were told that they would not receive medical assistance until they had signed the forms. From the foregoing, the question arising is neither whether consent was obtained nor whether

⁷⁸ Affidavit deposed by complainant during investigation.

forms were signed but rather, how the consent was obtained. That is, was it informed, free and valid given the circumstances the women were in.

The Commission also took into consideration the Tubal Ligation Guidelines of 2014 set out for the Department of Health in KwaZulu-Natal. The purpose of the guidelines is, 'to provide clarity for all health facilities in the area regarding the provision of female sterilisation (tubal ligation) service to ensure;

- a) that all women who choose sterilisation as their preferred method of family planning have access to it, and
- b) that no woman is coerced into being sterilised or is sterilised without an appropriate consent procedure'.

The Guidelines also provide that, 'for any woman to undergo sterilisation, they must have gone through an informed consent procedure which includes counselling, where the advantages and disadvantages of the procedure are laid out, and information on other forms of contraception available given'.⁷⁹ 'In particular, the alternative of a long-acting reversible contraceptive (intra-uterine device or sub-dermal implant) must be discussed and offered'. The Guidelines further state that 'the process of obtaining informed consent must be conducted in a language the woman understands and must be witnessed by at least one other health worker who must also sign the consent form to confirm that informed consent was indeed obtained'.

Over and above domestic legislation, the International Conference on Population and Development Programme of Action in 1994 and the 1995 Beijing Platform for Action, amongst other instruments, changed the landscape with regards to sexual and reproductive rights. They introduced a rights-based approach to population policies, and the provision of comprehensive sexual and reproductive health services and programmes. States Parties committed to support the principle of

⁷⁹ Tubal ligation guidelines of 2014

voluntary choice in family planning, and to move away from targeted approaches to practices such as sterilisation.

States made a commitment towards empowerment of individuals, especially women, to increase their capacities to make autonomous, and informed decisions about their reproductive options.

11. Findings

The Commission encountered a number of challenges and limitations when conducting these investigations. Some of these include the fact that; some files could not be retrieved due to the Department's policy on retention of files (some files were too old and had therefore been destroyed); in other cases, records that had been kept manually and could not be located; lack of sufficient detail contributed to certain hospitals not being able to locate files; and there was also considerable delay in getting sworn affidavits from the Complainants.

Members of the Commission who interviewed staff at the various hospitals also reported they experienced hostile reception from the hospital staff who were in most cases not very cooperative. The hostility was from both management and medical personnel. In some instances, members of the Commission reported that in some hospitals (in Durban) the hospital staff tried to hide documents from them while others blatantly refused to indulge them.

Allegations made by the Complainants in the Complaint lodged with the Commission:

The following allegations were levelled by the complainants:

- The rights of women with HIV to act autonomously and choose their own method of birth control are not being respected in

practice and this results in women living with HIV being unfairly discriminated against;

- Women living with HIV are not being provided with adequate knowledge before being asked to consent to a sterilisation;
- HIV Positive women are being asked to consent to sterilisation in circumstances that undermine their ability to act voluntarily;
- Healthcare workers equate a signed consent form to informed consent;
- The Department of Health has not recognised the devastating impact that a sterilisation can have on a woman who has not consented.⁸⁰

The Constitution is the supreme law of the land. It is founded on the basic principles of human dignity, equality, and the general advancement of human rights and freedoms. Law, or conduct that is inconsistent with the Constitution is invalid to the extent of its inconsistency.⁸¹ The practice of forced sterilisation amounts to a direct attack on important Constitutionally enshrined rights and must be stopped.

Additionally, the Sterilisation Act⁸² clearly states that, 'a person undergoing sterilisation is supposed to give voluntary consent free from any form of inducement'.⁸³ On top of this, a clear explanation and proper description of the proposed procedure must be given to the patient. The consequences of the procedure, possible risks and the irreversible nature of sterilisation should be explained comprehensively,

⁸⁰ As detailed on the Complaint form, pages seven to twelve.

⁸¹ Constitution of The Republic of South Africa Section 2.

⁸² Sterilisation Act 44 of 1998 as amended.

⁸³ As above Section 4.

and the patient advised that consent may be withdrawn at any time before treatment and any time before the prescribed forms are signed.⁸⁴

The Commission drew inspiration from *the case of Harksen v Lane* in determining this matter.⁸⁵ In this matter, the court had to decide whether differentiation amounts to discrimination, and the court devised the following test:

1. If the differentiation is on a listed ground, then discrimination is established;
2. If the differentiation is not on a listed ground, then the discrimination will depend on whether it affects the human dignity of the complainant or causes them harm.

It is clear from the above that the nature of discrimination mentioned in this complaint falls within listed grounds which includes status and gender. The CEDAW Committee in its General recommendation 19 stated that discrimination as provided for in Article 1 of the Convention includes violence that is directed against a woman because she is a woman, or that affects women disproportionately.⁸⁶ It includes acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty.⁸⁷

Sterilisation, when performed without informed consent, violates an individual's rights to dignity, humane treatment, health, family, information, privacy, and to freely decide the number and spacing of children, among others. A signed form is not tantamount to informed consent. All other options that are available to a person must be discussed and one must be accorded ample time and environment to decide.

⁸⁴As above.

⁸⁵ *Harksen v Lane NO and others (CCT9/97) [1997] ZACC 12, paragraph 50.*

⁸⁶ n 16 above article 1

⁸⁷ As above

Four key principles outlined in the human rights in patient care framework highlight the importance of a finding that the prohibition of discrimination was violated in cases of forced sterilisation⁸⁸:

- the need to highlight the vulnerability of marginalized populations to discrimination in health care settings;
- the importance of the rights of medical providers;
- the role of the state in addressing systemic human rights violations in health care settings;
- and the application of human rights to patient care.

Consequently, the Commission makes the following findings:

- 11.1 The complainants had their right to equality and freedom from discrimination violated;
- 11.2 The Complainants' right to dignity, bodily integrity and freedom and security over their bodies, were violated;
- 11.3 The right to the highest attainable standards of health including sexual and reproductive rights were violated;
- 11.4 The Complainants were not provided with adequate knowledge on the sterilisation procedure before being asked to consent thus violating their right to information;
- 11.5 The Complainants were not advised on other alternative methods of contraception;
- 11.6 The Complainants were subjected to cruel, torturous or inhuman and degrading treatment;
- 11.7 The medical staff breached their duty of care to the patients.
- 11.8 While some files had consent forms, this cannot be equated to informed consent. The consent forms do not reflect the nature of the discussions that took place prior to such consent being

⁸⁸ P Patel 'Forced 'sterilisation of women as discrimination' *Public Health Rev* (2017) 38, 15.

given, and they are also not indicative of the language that was used to explain the procedure. This begs the question of whether the Complainants even understood the procedure at all;

11.9 There is a lack of a uniform file management systems within the DOH and including electronic file management and backup;

11.10 The Complainants could not reasonably be said to have consented to the procedure given the current structure of the consent forms and the alleged unethical process used to obtain consent. They were therefore forced and/or coerced into being sterilised.

In regard to the remedies sought by the Complainants, the Commission notes as follows: -

- If necessary, conduct further research into the practices of forced sterilisation of women living with HIV to determine its prevalence in South Africa;
 - Given the Commission's capacity constraints, the Commission will consider the possibility of engaging the Health Professions Council of South Africa to determine the way forward.
- Engage with the National Department of Health in relation to the forced and coerced sterilisation practices against women living with HIV;
 - The Commission has held numerous meetings with NDOH in relation to forced and coerced sterilisation practices against women living with HIV as captured in this report.
- Investigate compliance with International and Regional treaties in relation to forced sterilisations in South Africa;
 - South Africa has signed and ratified various International and Regional treaties and from the facts presented, it is rather

apparent that South Africa is in violation of several international instruments it is a party to.

- Petition the Law Reform Commission for amendments to legislation that ensure that consent is properly obtained such as, counselling prior to consent, the timing of obtaining consent and compulsory information that must be provided;
 - The Commission is of the opinion that in as much as there is already an enabling policy and legislative framework in place to curb the practice of forced sterilisation, a hiatus still does exist. A robust and comprehensive legislative and policy framework is still required to ensure sterilisation is performed in voluntarily and according to set medical standards. Furthermore, an effective system of checks and balances should be put in place to ensure policies and laws are implemented.

Recommend measures, ways and means, at the national, regional and local levels to eliminate the practice of forced and coerced sterilisation on women living with HIV.⁸⁹

12. Recommendations

12.1 The Commission will refer this report and its findings to the Health Professions Council of South Africa (Health Professions Council of South Africa) and the complaints contained herein. The HPCSA guides and regulates health professions on all aspects pertaining to professional conduct and ethical behaviour. Thus, they ought to engage with this report on this matter as they have the necessary capacity to investigate the professional conduct and behaviour of the implicated health care practitioners;

⁸⁹ As detailed on page 18 of the Complaint Form.

- 12.2 The Commission will refer this report and its findings to the South African Nursing Council (SANC) and the complaints contained herein. The SANC guides and regulates nurses on all aspects pertaining to professional conduct and ethical behaviour. Thus, they ought to engage with this report on this matter as they have the necessary capacity to investigate the professional conduct and behaviour of the implicated health care practitioners;
- 12.3 The NDOH, upon receipt of this report must interrogate and scrutinise the provisions of the Sterilisation Act and interrogate consent forms for sterilisations to ascertain whether the provisions contained therein provide for and protect the principle of informed consent in all respects. The NDOH must report to the CGE within 3 (three months) of receipt of this report as to what concrete steps the Department will take in order to ensure that the eradication of the harmful practice of forced sterilisation;
- 12.4 The NDOH, upon receipt of this report must facilitate dialogue between themselves and the complainants in order for them to find ways of providing redress to the Complainants.
- 12.5 The Commission will present this report as part of its petition to the SALRC for amendments to legislation that ensure consent is properly obtained such as counselling prior to consent, the timing of obtaining consent and compulsory information that must be provide.
- 12.6 The NDOH must revise consent forms to bring them into conformity with the guidelines provided by International Federation of Gynaecology and Obstetrics and standardised for all sterilisation procedures. The NDOH should also print consent forms in all official languages, and the explanation around the procedure, particularly its irreversible nature should be given in the patient's language of choice. This must be executed and attested to;

- 12.7 The NDOH must make it an operational policy requirement that where a patient agrees to sterilisation, they must be given a “cooling off” period in order to fully appreciate the risks and consequences of their sterilisation procedure.
- 12.8 Standard timeframes should be put in place in relation to when the discussion around sterilisation should take place. Patients cannot be informed about this process minutes before going to theatre. Patients must also be informed that they are at liberty to change their minds at any time before the procedure takes place;
- 12.9 The DOH must ensure that their filing systems, both manual and electronic are standardised for ease of coordination. Feedback to the latter must be provided within 3 months from date of this report.
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SIGNED IN

ON THE **24** DAY OF **February 2020**.



Chief Executive Officer: Keketso Maema

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2017