CHAPTER 1

Background

1.1 Introduction

Health is central to the development of all people and is essential to the realisation and enjoyment of other fundamental rights. This fundamental right to health includes the right to both sexual and reproductive health. As far back as 1948, the Universal Declaration of Human Rights (UDHR) recognised the importance of health and well-being. The UDHR provides for all people "the right to a standard of living adequate for the health and well-being" of the person and of his or her family.[1] In particular, the UDHR also acknowledged the importance of providing reproductive health care for women, noting that motherhood requires "special care and assistance."[2] Since that time, the importance of sexual and reproductive health rights (SRHR) in meeting international development goals has increasingly been recognised by the international community.[3]

However, throughout the world impoverished and marginalised communities continue to struggle to access health information, goods and services including sexual and reproductive health (SRH) prevention and treatment services, such as:

- Family planning services;
- Maternal health care;
- Treatment and care of HIV; and
- Treatment and prevention of sexually transmitted infections, reproductive tract illnesses (such as cervical cancer) and other gynaecologic and urologic problems.

Both men and women have SRHR, however, the SRHR of women in developing countries in particular are compromised by broader gender inequalities, harmful gender norms, gender-based violence and other socio-economic and cultural factors that limit women's control over their lives and increase their sexual and reproductive health risks. This is compounded by the fact that women's SRHR are often overlooked or under-prioritised by governments. As a result, reproductive health problems remain the leading cause of

[1] Universal Declaration of Human Rights (1948), article 25 *available at* http://www.un.org/en/documents/udhr/ (accessed 26 August 2013).

[2] *Id*, article 25(2).

[3] ***See***, for instance, the High Level Plenary Meeting of the 60th Session of the General Assembly, 14-16 September 2005, which came up with a resolution which also includes focus on HIV/AIDS, 57(g) and 58 (c) *available at* http://www.un.org/webcast/summit2005/statements14.html (accessed 26 August 2013).

ill health and death for women of child bearing age worldwide. Such health problems account for one-third of the global burden of disease among women of reproductive age and one-fifth of the burden of disease among the general population.[4]

In particular, southern Africa faces a plethora of SRH challenges. The region faces excessively high maternal mortality rates,[5] a high burden of cervical cancer[6] as well as widespread gender-based violence.[7] Although contraceptive use in southern Africa is higher than in other parts of sub-Saharan Africa, the region nonetheless faces a significant unmet contraceptive need.[8] The highest rates of abortion-related deaths occur on the African continent.[9] Fourteen percent of all maternal deaths on the continent were due to complications from unsafe abortions.[10]

Despite the significant SRHR violations occurring in the region, laws, policies and practices often fail to provide support services for the specific needs of SRH.

1.2 Purpose and Scope of the Manual

This manual seeks to address the high prevalence of SRHR violations in southern Africa arming domestic lawyers with the necessary information to hold individuals and others to account for violating SRHR. It will focus on violations of self-determination and

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[4] Executive Summary of "Adding It Up: The Benefits of Investing in Sexual and Reproductive Health Care" *Guttmacher Institute/UNFPA* (2003) *available at* http://www.unfpa.org/webdav/site/global/shared/documents/publications/2004/addingitup.pdf (accessed 26 August 2013).

[5] Hogan et al "Maternal Mortality for 181 Countries, 1980–2008: A Systematic Analysis of Progress Towards Millennium Development Goal 5" (2010) *Lancet Online available at* http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(10)60518-1/fulltext (accessed 26 August 2013). ***See also***, "Trends in Maternal Mortality 1990-2010" *WHO, UNICEF, UNFPA and The World Bank* (2012), 23 *available at* http://www.unfpa.org/webdav/site/global/shared/documents/publications/2012/Trends_in_maternal_mortality_A4-1.pdf (accessed 26 August 2013).

[6] "World Cancer Report 2008" *World Health Organisation, International Agency for Research on Cancer* (2008), 34 *available at* http://www.iarc.fr/en/publications/pdfs-online/wcr/2008/wcr_2008.pdf (accessed 26 August 2013).

[7] "Global Report "UNAIDS Report on the Global AIDS Epidemic" (2010), 135 *available at* http://www.unaids.org/globalreport/documents/20101123_GlobalReport_full_en.pdf (accessed 26 August 2013) which shows data for violence against women in two southern Africa Countries, Namibia and Zimbabwe. ***See also*** "Preventing Gender-Based Violence in the Horn, East and Southern Africa: A Regional Dialogue" *Raising Voices and UN-HABITAT* (2004), 3 *available at* http://www.unhabitat.org/pmss/listItemDetails.aspx?publicationID=1920 (accessed 26 August 2013).

[8] "Adding It Up: Costs and Benefits of Contraceptive Services" *Guttmacher Institute/UNFPA (*2012*) available at* https://www.unfpa.org/public/global/publications/pid/4461 (accessed 26 August 2013).

[9] "Facts on Induced Abortion Worldwide Briefing Paper" *Guttmacher Institute* (2012), 2 *available at* http://www.guttmacher.org/pubs/fb_IAW.html (accessed 26 August 2013).

[10] "Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2008" *WHO* (2011), 28 *available at* http://whqlibdoc.who.int/publications/2011/9789241501118_eng.pdf (accessed 26 August 2013). A further 1.7 million African women are hospitalised yearly due to complications from unsafe abortions. See Singh et al "Hospital admissions resulting from unsafe abortion: estimates from 13 developing countries" (2006) *Lancet* 1887, 1890 *available at* http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(06)69778-X/fulltext (accessed 26 August 2013).

discrimination against particular groups of women in accessing SRH services.[11]

For the purpose of this manual, sexual and reproductive self-determination is defined as a woman's right to make her own decisions regarding her SRH. In some cases, violations of a woman's sexual and reproductive self-determination result from entrenched stigma against women and particular groups within a population. Such violations can include:

- Obstacles to the availability and use of SRH services;
- Withholding of information or options on SRH due to stigma;
- Providing women with misinformation regarding various options;
- Providing desired SRH services only on condition of undertaking procedures; and
- Performing procedures without informed consent.

In other instances, law and practice may restrict a woman's sexual and reproductive self-determination, for example, by limiting her control over whether to carry a child to term or terminate a pregnancy. In 2008, approximately 92% of women of childbearing age in Africa were subject to restrictive termination of pregnancy laws, contributing to high rates of maternal mortality due to unsafe abortions.[12]

Violations of women's sexual and reproductive self-determination have a particularly harsh impact on impoverished and marginalised women. As such, this manual specifically focuses on litigating violations of the SRHR of two particularly vulnerable groups: women living with HIV (WLHIV) and women with disabilities. There are a number of other populations of women who are recognised to be particularly vulnerable in the context of SRH, including adolescent women, girl children, refugees, rural women and women in situations of armed conflict. These women are not a specific focus of this manual; however, the broader legal principles in the manual can be used to address the violations of the SRHR of all women. Men can also be victims of SRHR violations such as forced circumcision or vasectomies; however the focus of this manual is on violations of SRHR of women.

[11] Both men and women have sexual health rights. However, in this manual we are focusing on SRH violations experienced primarily by women due to their reproductive capabilities.

[12] "Facts on Abortion in Africa" *Guttmacher Institute* (2012), 2 *available at* http://www.guttmacher.org/pubs/IB_AWW-Africa.pdf (accessed 26 August 2013).

Women Living with HIV

It is impossible to discuss SRHR in southern Africa without taking into account the high rates of HIV in the region. In 2010, approximately "68% of all people living with HIV resided in sub-Saharan Africa, a region with only 12% of the global population".[13] According to the latest UNAIDS statistics, southern Africa has the highest number of people living with HIV in the world. [14]

Women continue to be more likely to have HIV than men. Approximately, "76% of all HIV-positive women in the world live in sub-Saharan Africa".[15] Young women aged 15-24 in sub-Saharan Africa are at least eight times more likely to be HIV positive than similarly-situated men.[16]

In addition to general violations that many women in southern Africa face in accessing their SRHR, WLHIV face specific obstacles due to their HIV status. WLHIV in southern Africa are more vulnerable to sexual and reproductive illnesses, such as cervical cancer[17] and have a higher rate of maternal deaths.[18] Additionally, having HIV means that WLHIV must consider how best to have children and how to reduce mother-to-child transmission of HIV during pregnancy. Furthermore, research shows that WLHIV generally have a greater unmet need for contraception, counselling on pregnancy planning, addressing infertility and information about sexuality.[19]

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[13] "World AIDS Day Report" *UNAIDS* (2011), 7 *available at* http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/jc2216_worldaidsday_report_2011_en.pdf (accessed 26 August 2013).

[14] "Global Report" *supra* note 7, 28.

[15] *Id,* 130.

[16] "Latest data and statistics, Gender equality, women and HIV" *UN Women* (2011) *available at* http://www.unwomen.org (accessed 26 August 2013).

[17] L Odendal "Cervical Cancer in Women with HIV" (2011) 174 *HIV & AIDS Treatment in Practice*, 6 *available at* http://www.aidsmap.com/pdf/HATIP-174-February-17th-2011/page/1669154/ (accessed 26 August 2013). ***See also*** Atashili et al "Potential Impact of Antiretroviral Therapy and Screening on Cervical Cancer Mortality in HIV-Positive Women in sub-Saharan Africa: A Simulation" (2011) 6 *PLoS ONE* e18527,e18527 *available at* http://www.plosone.org/article/fetchObject.action?uri=info%3Adoi%2F10.1371%2Fjournal.pone.0018527&representation=PDF (accessed 26 August 2013) and M Moodley et al, "Invasive Cervical Cancer and Human Immunodeficiency virus (HIV) Infection: A South African Perspective" (2001) 11 *Int J. Gynecological Cancer* 194, 194 *available at* http://onlinelibrary.wiley.com/doi/10.1046/j.1525-1438.2001.01022.x/abstract (accessed 26 August 2013).

[18] "Trends in Maternal Mortality 1990-2010" *supra* note 5, 24. Nine countries have a proportion of maternal deaths attributed to HIV of 20% or more: Swaziland (67.3), South Africa (59.9), Namibia (59.4), Botswana (56.4), Lesotho (41.5), Zimbabwe (38.8), Zambia (30.7), Malawi (29.3) and Mozambique (26.8).

[19] Gay et al "What Works for Women and Girls: Evidence for HIV/AIDS Interventions" (2010), 185-186 *available at* http://www.whatworksforwomen.org/system/attachments/2/original/what-works-for-women-and-girls.pdf?1278700491 (accessed 26 August 2013).

Women with Disabilities

People with disabilities make up around 10% of the world's population and around 20% of the world's population living in poverty.[20] Women with disabilities may have even greater SRH needs due to the fact that they may have special health care needs during pregnancy, labour, delivery and childrearing. Evidence also shows that people with disabilities are probably more likely to be at risk of HIV transmission.[21] As a group they fit the most common pattern for structural risks of HIV: high rates of poverty; illiteracy; lack of access to health resources and lack of power when negotiating sex.

Despite their various reproductive health needs and risks, women with disabilities face a range of barriers in accessing SRH information and services. They are denied information about SRH services, denied the right to establish relationships and to decide whether, when and with whom to have a family and are subjected to coerced or forced sterilisation, forced abortion and forced marriage.[22] Their limited access to SRH care is frequently based on ignorance or stigma against people with disabilities that assume they are not, or should not be sexually active nor should they be able to bear and raise children.[23] The needs of women with mental disabilities, including developmental disabilities and mental illness, pose particularly significant challenges in the human rights context because States tend to equate mental disability with lack of legal capacity. This manual will not specifically address the particular situation of women with mental disabilities, opting instead to focus more generally on all women living with disabilities.

The primary SRHR violations examined in this manual are:

a. Violations of sexual and reproductive self-determination, where women are provided SRH services, in particular abortion or sterilisation, ***without voluntary and informed consent***, e.g.
    - Women are forced to undergo mandatory abortion or sterilisation procedures.
    - Women are forced to undergo abortion or sterilisation procedures on the basis of consent obtained from a third party despite the capacity of the woman to provide individual informed consent.

[20] "Emerging Issues, Sexual and Reproductive Health of Persons with Disabilities" *UNFPA*, 2 *available at* http://www.unfpa.org/upload/lib_pub_file/741_filename_UNFPA_DisFact_web_sp-1.pdf (accessed 26 August 2013).

[21] *Id*.

[22] *Id*, 4.

[23] "Promoting Sexual and Reproductive Health for Persons with Disabilities: Guidance Note" *WHO/UNFPA* (2009), 10 *available at* http://whqlibdoc.who.int/publications/2009/9789241598682_eng.pdf (accessed 26 August 2013).

- WLHIV and women with disabilities who are given inadequate information for informed consent: for example, not being provided with full information on the risks, benefits and alternatives to the procedure at issue.
- Where the consent of WLHIV and women with disabilities to abortion or sterilisation procedures is obtained through coercion: for example, women are not given adequate time to consider the information and options available; they are in pain or in labour and unable to reflect adequately on their decision; they are subjected to undue pressure by health care providers, partners and family members; or their consent is premised on obtaining another desired or medically necessary procedure.

b. ***Discrimination*** in accessing appropriate, affordable and quality SRH services, e.g.

- WLHIV and women with disabilities are denied equal access to existing SRH services as a result of discrimination on the basis of HIV status or disability.
- Pregnant women are singled out for mandatory HIV testing for various reasons including as a condition for access to SRH services.[24]
- Services fail to make provision for the specific SRH needs of WLHIV and women with disabilities.

There are numerous other SRH violations faced by women throughout southern Africa, including where laws and policies restrict access to SRH services (e.g. where laws provide for abortion only under restricted medical or social circumstances) or where the State fails to provide for a range of accessible and acceptable SRH services (e.g. where service availability is limited by resource constraints). However, while these aspects of reproductive self-determination may be referred to in passing, these violations will not be discussed in detail.

This manual seeks to be a resource for private and public lawyers in southern Africa who are litigating cases in domestic courts to challenge laws, policies and practices around SRHR. It will also assist civil society organisations (CSOs) seeking to use litigation as part of their advocacy strategy in promoting and protecting the rights of women, particularly women affected by HIV and with disabilities. It aims to provide concrete legal arguments for use in litigation before domestic courts.

Domestic lawyers will be familiar with the laws of their respective jurisdiction and thus, the manual does not discuss, in any detail, domestic constitutional and legislative frameworks. However, they may fail to use international, regional and comparative jurisprudence to support and bolster their arguments before domestic courts. This is often due to a lack of awareness of international, regional and comparative law and a misconception that

[24] Mandatory HIV testing is a common violation of the right to reproductive self-determination of pregnant women prevalent in the region. It has been dealt with extensively in another manual, and is not a primary focus of this manual. What needs to be noted is that it is often specifically women who are targeted for HIV testing programmes as a condition for access to other services. ***See*** "Protecting Rights: Litigating Cases of HIV Testing and Confidentiality of Status" *Southern Africa Litigation Centre* (2012) *available at* http://www.southernafricalitigationcentre.org/2012/11/14/wp-contentuploads201211litigating-cases-of-hiv-testing-and-confidentiality-of-status-final-pdf/ (accessed 26 August 2013).

they are not useful in domestic litigation. This manual attempts to address these issues in the hope that more private and public lawyers will utilise international, regional and comparative law in domestic litigation.

Firstly, the manual will outline arguments one can make for why domestic courts should look to international, regional and comparative law in their deliberations. It then discusses the international and regional law, including jurisprudence, relevant to litigating SRHR cases. The international and regional law sections are organised according to specific rights. This is to provide lawyers easy access to needed information as they are drafting arguments based on particular rights. There has been limited jurisprudence on SRHR at the African regional level; hence this section of the manual includes examples from other regional human rights mechanisms such as the European Court of Human Rights (ECHR)[25] and the Inter-American Commission on Human Rights (IACHR).[26] Next the manual will address comparative jurisprudence from countries where courts have addressed cases related to SRHR. Finally, the manual outlines legal and factual responses to justifications that have routinely been offered in cases of violations of SRHR.

Most of the sections begin with a checklist aimed at guiding lawyers in constructing arguments to support their cases before domestic courts. In addition, all of the sections offer a list of important documents and cases discussed in each respective chapter. Finally, each section is extensively referenced, with the footnotes providing online locations for the supporting documentation. In addition, the manual includes a list of useful online resources for lawyers.

[25] The ECHR, based in Strasbourg, France monitors respect for the human rights of 800 million Europeans in the 47 Council of Europe member States that have ratified the European Convention on Human Rights. The ECHR is an international court set up in 1959. It rules on individual or State applications alleging violations of the civil and political rights set out in the Convention. Since 1998 it has sat as a full-time court and individuals can apply to it directly. In almost fifty years the Court has delivered more than 10 000 judgements. These are binding on the countries concerned and have led governments to alter their legislation and administrative practice in a wide range of areas. *Available at* http://www.echr.coe.int/ECHR/homepage_en (accessed 26 August 2013).

[26] The Inter-American human rights system was born with the adoption of the American Declaration of the Rights and Duties of Man in Bogotá, Colombia in April of 1948. The IACHR was created in 1959. The IACHR is a principal and autonomous organ of the Organisation of American States ("OAS") whose mission is to promote and protect human rights in the American hemisphere. It is composed of seven independent members who serve in a personal capacity. *Available at* http://www.oas.org/en/iachr/ (accessed 26 August 2013).