CHAPTER 6

Justifications for violations of sexual and reproductive self-determination and discrimination

6.1 Introduction

In cases of violations of sexual and reproductive self-determination and discrimination in accessing SRH services, a court will need to enquire into whether the violation is justified and thus lawful or whether it is in fact unlawful. This chapter looks at the most common arguments raised to justify such laws, policies, and practices, how these arguments can be countered and how the courts have assessed such justifications.

Relevant cases discussed in this chapter

- Isaacs v Pandie
- LM and Others v Government of the Republic of Namibia
- NB v Slovakia
- Odafe and Others v Attorney General and Others
- VC v Slovakia

The chapter is divided into three sections:

- Scientific and medical information relating to women's SRH
- Arguments to justify infringements on the right to sexual and reproductive self-determination
- Arguments to justify discrimination in access to SRH information, goods and services

6.2 Scientific and Medical Information Relating to Sexual and Reproductive Health

Scientific and medical evidence is a vital component of women's sexual and reproductive health litigation. Scientific and medical evidence can provide the court with critical information about the health status of an individual plaintiff, the impact of pregnancy on the health status of women, including WLHIV or women with disabilities, and the risks, benefits and alternatives to medical procedures such as abortion and sterilisation for pregnant women.

The failure to provide scientific evidence may create barriers to successful litigation, as was found in *Odafe and Others v Attorney General and Others*, where the Nigerian High Court noted that the failure to provide scientific evidence relating to the effect of treatment for HIV meant that it was unable to adjudicate on the infringement of the right to life in the circumstances. It stated that "[t]his is for an expert in the medical area concerned to tell the Court and there is no expert evidence before me."[371]

Use of expert evidence

It is advisable to always prepare expert evidence to address case specific issues relating to sexual and reproductive health.

There is a wide range of possible expert evidence that may be raised in sexual and reproductive health litigation, depending on the legal and factual issues at stake and justifications raised in defence of the violation. In cases relating to forced or coerced sterilisation or abortion or discrimination in access to sexual and reproductive health services, one may want to seek the services of the following experts to provide evidence:

- A medical practitioner to provide medical evidence relating to various issues such as the risks, benefits and alternatives to sterilisation as a contraceptive option for women; the risks, benefits and alternatives to abortion as a means of preventing mother-to-child transmission of HIV; the impact of labour pain on a women's capacity to provide informed consent; evidence relating to a person with HIV or a person with a disability's medical history and health status, including physical and mental health;
- A psychologist to provide evidence relating to the impact of an unwanted abortion or sterilisation on the mental health and well-being of a woman;
- A public health expert to provide evidence on systems and processes for obtaining and documenting informed consent in public health facilities;
- A human rights expert to provide evidence on the nature and extent of discrimination against specific populations such as women, WLHIV and/or women with disabilities; and

[371] *Odafe and Others v Attorney General and Others supra* note 53 at para 37.

- An economist to provide evidence on the cost and benefit of providing access to a specific SRH service.

When using expert evidence, it is important that any relevant documents of international and national health authorities pertaining to the issues are incorporated into the court record through reference to them in expert affidavits and by attaching them as annexures to the affidavits.

There are a number of ways lawyers can introduce medical and scientific evidence relating to sexual and reproductive health, HIV and disability in particular cases. The specific procedural details will vary from jurisdiction to jurisdiction. However, two primary methods relevant within common law jurisdictions in southern Africa are to introduce expert evidence via affidavit or in legal submissions through citing court decisions which have made specific findings related to the medical and scientific aspects of sexual and reproductive health, HIV and disability.

In the case of *LM and Others v Government of the Republic of Namibia*, a medical expert provided expert testimony on the risks, benefits and alternatives to sterilisation as a contraceptive option for women, amongst other things.[372] His evidence included the following facts regarding sterilisation which he argued should form part of the informed consent process:

- Sterilisation by means of tubal litigation is not the best method of contraception for a woman who is single, has not had a child or still wishes to have more children;
- Sterilisation by means of tubal litigation is expensive to try to reverse;
- Women aged 30 years or less at the time of the operation are more likely than older women to be dissatisfied and seek reversals, often because their domestic circumstances have changed;
- There are a number of acceptable long-term methods of contraception which can be instituted at the same time as a caesarean section without any problems, such as an intra-uterus device; and
- Sterilisation could be performed when a woman returned after childbirth at the six week check-up, through a laparoscope which is a one-day procedure.

In addition, he medically assessed each individual plaintiff providing the Court with detailed evidence on her medical history and the impact of the sterilisation.

In the South African case of *Isaacs v Pandie* a clinical psychologist testified on the impact of a forced sterilisation procedure on the plaintiff in the matter.[373] He testified to the significant sense of loss felt by the plaintiff as a result of the sterilisation procedure.

[372] *Id* at para 31.

[373] *Isaacs v Pandie supra* note 340 at paras 19 – 22.

Similarly, in the ECHR case of *VC v Slovakia*, the Court heard evidence of the serious medical and psychological after-effects of the forced sterilisation including that she had been treated by a psychiatrist for a number of years since the sterilisation.[374]

6.3 Justifications for Violations of the Right to Sexual and Reproductive Self-Determination

This section examines three common justifications invoked for undertaking forced or coerced sexual and reproductive health interventions services:

- Consent was, in fact, provided to the intervention;
- The need to protect the patient (acting in the best interests of the patient); and
- The need to protect the health of others (acting in the interests of public health).

Consent

The primary defense raised in a number of cases relating to medical interventions conducted without voluntary and informed consent is that consent was in fact provided. In the case of *LM and Others v Government of the Republic of Namibia*, the High Court emphasised that determining whether or not informed consent was present is a factual issue not a legal issue.[375] This factual dispute requires the Court to examine the presence or absence of the various elements of lawful consent, including, amongst others:

- The capacity of the individual to provide consent;
- The nature and extent of information provided (and/or omitted) to the individual;
- The manner and circumstances in which the information was provided, including the patient's ability to understand the information; the patient's ability to provide consent in the circumstances; and the voluntariness of the consent.

Capacity to consent

The capacity of an individual to provide informed consent is integral to establishing valid consent in each circumstance. Where the justification of consent is raised, it will be important for a court to first establish that the patient in question had the capacity to consent.

In the South African case of *Christian Lawyers' Association v National Minister of Health and Others*, the Supreme Court of Appeal examined capacity to consent to a termination of pregnancy. The Court was asked to examine the constitutionality of the Choice on Termination of Pregnancy Act in providing minors with the independent right to consent to a termination of pregnancy. The Christian Lawyers' Association argued that a minor was not able to provide informed consent since she lacked capacity.

The Court held that "valid consent can only be given by someone with the intellectual and emotional capacity for the required knowledge, appreciation and consent. Because consent is a manifestation of will, capacity to consent depends on the ability to form an

[374] *Id* at para 19.

[375] *Id* at para 28.

intelligent will on the basis of an appreciation of the nature and consequences of the act consented to".[376] Where a medical practitioner is not satisfied that a pregnant minor (or adult) has the capacity to give informed consent, s/he should not perform a termination of pregnancy since "he or she will be doing so without the informed consent of his or her patient, and his or her conduct will not be in accordance with the [Choice on Termination of Pregnancy] Act and will accordingly be unlawful."[377]

In Re R.B. (a Mental Patient),[378] the English Court of Appeal (Civil Division) was presented with a situation in which it had to decide on when a sterilisation procedure can be performed on someone who cannot legally consent. The Court stated that the test for such a determination is what is in the best interest of the person who is to be subjected to the procedure. The Court ultimately ruled that it was not in the best interest of a 28-year-old man with Down Syndrome to be subjected to a sterilisation procedure at the request of his mother who was worried that the man may conceive a child who he would be unable to provide for. In finding that the procedure was not in the man's best interest, the Court noted that the procedure would not allow the man to enjoy life more freely because he would still face close supervision by his mother and others regardless of whether or not he was able to father a child. The Court also found that being sterilised would not shield him from the emotional turmoil of a sexual relationship. While noting that an application on behalf of a man for sterilisation was not the equivalent of an application in respect of a woman, the Court however cited a string of cases that confirmed that the principle of the best interests applied and the principle was applied to the individual facts of each case.[379]

Nature and Extent of Information

Access to, understanding of and the comprehensive nature of the information regarding the medical procedure is a central component of informed consent and courts have often spent considerable time determining whether the standards in each case have been met.

In *VC v Slovakia*, the ECHR addressed whether a Romani woman was forcibly sterilised. In reaching its decision that she had been subjected to forced sterilisation, the Court examined the information provided to the woman, amongst other things, and noted that the woman had been told by medical personnel that a future pregnancy may kill her, but had not been told of "the proposed sterilisation and/or its alternatives."[380]

In *LM and Others v Government of the Republic of Namibia*, the Namibian High Court examined various forms of evidence put before the Court, including expert evidence, witness statements and the written consent forms, in order to determine the nature and extent of the information and counseling provided to the women in obtaining their alleged informed consent to be sterilised. In particular, the Court examined the information

[376] *Christian Lawyers' Association v National Minister of Health and Others supra* note 338, 37.

[377] *Id*, 38.

[378] [2000] 1 F.L.R. 549 (Eng.) *available at* http://www.cirp.org/library/legal/Re_A2000/ (accessed 26 August 2013).

[379] *Id,* 9 – 10.

[380] *VC v Slovakia supra* note 239 at paras 112 -113.

provided to the women regarding sterilisation; the information regarding alternative options to sterilisation and the counseling provided to the women. The Court stressed the need to ensure patients understood the information provided to them, meaning that medical acronyms should be removed from consent forms.[381]

The Court further held that "…one of the factors which should be taken into account in reaching informed consent is for a patient to be aware of and be able to evaluate alternative options available after having been duly informed of such alternatives. In this regard it would appear to me that where sterilisation, as one of the methods of contraception, is considered the patient should be informed of advantages and disadvantages of alternative contraception methods."[382]

In *Isaacs v Pandie* in the South African High Court, the plaintiff claimed that the defendant, Dr Pandie, had sterilised her without her consent. Although Dr Pandie claimed that the plaintiff had consented to sterilisation in a previous consultation, there was no consent form for sterilisation in the patient's hospital records. The Court found that Dr Pandie was negligent for not checking the consent form before commencing the sterlisation procedure and that the procedure was not done in accordance with the [South African health professional] guidelines which clearly provide that the treating doctor must also check the patient consent form.[383]

The manner and circumstances in which the information was provided
Courts also consider the circumstances surrounding the provision of information in order to determine the manner in which information is provided and the ability of the patient to understand the information.

In *LM and Others v Government of the Republic of Namibia,* the Namibian High Court considered the circumstances surrounding the obtaining of informed consent, including the hurried nature of the informed consent process; the fact that the women were in many cases spoken to in a language other than their first language; and the fact that they were in labour. The Court considered expert evidence regarding the pain and "loss of reality" women experience during labour and how this impacts on their ability to provide informed consent.[384] The Court noted in the case of a particular plaintiff that:

> The doctor spoke English. A nursing student translated. The doctor did not mention anything about sterilisation to her. She testified that before she could be taken to the theatre a nurse came into the delivery room and told her that she will be sterilised since all women who are HIV positive go through that procedure. The nurse then brought documents for her to sign. She did not know whether the documents were in respect of their consent to undergo the operation or whether it was in respect of consent for sterilisation. She was given these forms when she was on a stretcher just before she went into the theater. The nurse did not explain anything about the procedures she would

[381] *LM and Others v Government of the Republic of Namibia supra* note 345 at para 68.

[382] *Id* at para 70.

[383] *Isaacs v Pandie supra* note 340 at para 87.

[384] *LM and Others v Government of the Republic of Namibia supra* note 345 at para 24.

> be undergoing. It is common cause that she signed only one document where she consented to "c/s due to CPD and BTL". She did not know what caesarean section or the other acronyms on the consent form meant. She testified that the way the nurse conveyed the information to her sounded forceful, and that it was "a compelling thing." She testified that she was in severe pain and no alternatives to the procedure were explained to her by the hospital personnel. She did not ask the nurse any questions since it sounded that the nurse was forcing her. She only discovered afterwards that she had been sterilised.[385]

The Court further noted that "knowledge of the nature and extent of the harm and risk and an appreciation thereof do not necessary equal consent."[386]

Similarly, in *VC v Slovakia*, the ECHR also examined the circumstances surrounding the woman's consent in determining whether she had provided informed consent to be sterilised. The Court found that VC was pressurised to provide immediate consent and did so in a situation where the voluntariness of her consent was compromised by the fact that she was in labour and feared for her health and life. The Court found that she was asked to sign a typed record after she had been in labour and lying down for several hours. Furthermore, she had been prompted to sign the document after being told by medical staff that if she had one more child, either she or the baby would die.[387] The Court furthermore noted that her signature was shaky and her maiden name had been split into two words.[388] Thus, the Court reasoned that the information, timing and circumstances did not result in her having provided informed consent to the procedure.

In *NB v Slovakia*, the applicant was asked to sign a consent form for sterilisation while under the influence of tranquilising medication. She was also told by one of the doctors present that she should sign the form as her life was at risk. The ECHR held that "by removing one of the important capacities of the applicant and making her formally agree to such a serious medical procedure while she was in labour, when her cognitive abilities were affected by medication, and then wrongfully indicating that the procedure was indispensable for preserving her life, violated the applicant's physical integrity and was grossly disrespectful of her human dignity."[389]

Protecting the rights of the patient

Another justification that may be raised for forced or coerced medical interventions is that it is in the best interests of the patient and protects the patient's health rights: for instance, where it is argued that continued pregnancy or future pregnancies may damage the physical and/or mental health of the women. This defense is often used to justify the sterilisation of disabled women and girls. The Committee on the Rights of the Child has identified forced sterilisation of girls with disabilities as a form of violence[390]

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[385] *Id* at para 33.

[386] *Id* at para 69.

[387] *VC v Slovakia supra* note 239 at para 117.

[388] *Id* at para 14.

[389] *NB v Slovakia supra* note 240 at para 77.

[390] Committee on the Rights of the Child: General Comment No 13 The right of the child to freedom from all forms of violence UN Doc CRC/C/GC/13 (2011) at para 23(a) *available at* http://www2.ohchr.org/english/bodies/crc/docs/CRC.C.GC.13_en.pdf (accessed 26 August 2013).

explained that the principle of the "best interests of the child" cannot be used to justify practices which conflict with the child's human dignity and right to physical integrity.[391]

The ECHR has rejected the justification of protecting rights of a patient in the case of forced or coerced sterilisation. In the case of *VC v Slovakia*, the government sought to justify the forced sterilisation on the basis that it was aimed at preventing a possibly life-threatening deterioration of the women's health in the event of a future pregnancy. The Court rejected this argument, stating that:

> According to the Government, the applicant's sterilisation was aimed at preventing a possibly life-threatening deterioration of her health. Such a threat was not imminent as it was likely to materialise only in the event of a future pregnancy. It could also have been prevented by means of alternative, less intrusive methods. In those circumstances, the applicant's informed consent could not be dispensed with on the basis of an assumption on the part of the hospital staff that she would act in an irresponsible manner with regard to her health in the future.[392]

While there is limited case law reflecting this justification in the region, the same justification has been raised in cases relating to mandatory HIV testing, where it is argued that HIV testing for purposes of determining a person's HIV status is in the best interests of the patient herself and helps to protect her health interests. The approach of the courts in relation to HIV testing helps to give us some indication of how courts may examine the issue.

In the case of HIV testing for purposes of protecting the patient's rights, courts have not readily accepted this justification given the patient's capacity to make these decisions for herself. In Zambia, the High Court took issue with a doctor who decided the two petitioners in *Kingaipe and Another v Attorney General* [393] should be tested for HIV and arranged for the tests without their informed consent. The High Court found that a patient's right to refuse HIV testing, even when testing is in his best interests, must be respected.[394] The Zambian Court quoted the United Kingdom's House of Lords in *Airedale NHS Trust v Bland*, which held:

> If the patient is capable of making a decision on whether to permit treatment and decides not to permit it his choice must be obeyed, even if on any objective view it is contrary to his best interests. A doctor has no right to proceed in the face of objection, even if it is plain to all, including the patient that adverse consequences and death will or may ensue.[395]

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english/bodies/crc/docs/CRC.C.GC.13_en.pdf (accessed 26 August 2013).

[391] *Id* at para 61.

[392] *VC v Slovakia supra* note 239 at para 113.

[393] (2010) 2009/HL/86 *available at* https://www.rocketsite.co.za/old_uploads/ZAF%20High%20Court%20judgment.pdf (accessed 26 August 2013).

[394] *Id,* J43.

[395] *Id.*

The Court found that the petitioners were in a position to make their own decision regarding HIV testing and as a result the question of what was arguably in their best interests was legally irrelevant.[396]

For a more comprehensive discussion on additional comparative case law on HIV testing see *Protecting Rights: Litigating Cases of HIV Testing and Confidentiality of Status*.[397]

Protecting rights of others

A final justification provided for violations of a person's sexual and reproductive self-determination is that the violation is necessary in order to protect the health rights of others; that is, the intervention is conducted to protect the unborn child (e.g. preventing HIV transmission to the unborn child) or for the broader public health good (e.g. for purposes of family planning or HIV prevention). This argument may be raised as a justification for denying WLHIV or women with disabilities the right to bear children through forced abortion or sterilisation. Two main arguments are made in cases related to women with disabilities: the first argues that disabled women are more likely to produce children with genetic defects; the second argues that women with disabilities would not be able to take care of their children and thus would unfairly utilise the resources of the State and community. A related argument is the added burden of care that menstrual and contraceptive management places on families and carers.[398]

The argument that disabled persons may produce children with genetic defects was rejected by the Canadian Court of Queen's Bench of Alberta in *Muir v Alberta*.[399] In that case, a woman described as mentally defective was subjected to several medical procedures without her informed consent when she was a child enrolled in a special school for mentally disabled children. One of the tests included a sterilisation procedure which was undertaken on the grounds that Muir might pass a genetic defect on to her children. Muir later brought suit as an adult and the State agreed to pay her damages for the wrongful sterilisation.

While there is limited case law dealing with these justifications, important considerations for a court in determining whether there is a justifiable limitation of women's rights may include, amongst other things:

- An examination of the nature and extent of key rights, including a women's right to reproductive self-determination, granting a woman the right to decide for herself whether or not to bear children and a women's right to equality and non-discrimination, amongst others;
- An examination of the impact coerced or forced sterilisation or forced abortion on the particular woman;

[396] *Id.*

[397] "Protecting Rights: Litigating Cases of HIV Testing and Confidentiality of Status" *supra* note 24.

[398] "The Sterilisation of Girls and Young Women in Australia: Issues and Progress" *Brady et al available at* http://www.wwda.org.au/brady2.htm (accessed 26 August 2013).

[399] (1996) 179 A.R. 321 (Can. Alta. Q.B.) *available at* http://canlii.org/eliisa/highlight.do?language=en&searchTitle=Search+all+CanLII+Databases&path=/en/ab/abqb/doc/1996/1996canlii7287/1996canlii7287.html (accessed 26 August 2013).

- An analysis of whether forced abortion or sterilisation did in fact help to protect the rights of others; and
- A consideration of other less restrictive means to achieve similar goals of protecting the rights of others.

6.4 Justifications for Discrimination in Access to Sexual and Reproductive Health Services

Violations of the right to equality and non-discrimination in sexual and reproductive health are frequently justified on the basis that they are not acts of discrimination on the particular ground in question or are justifiable acts of discrimination for reasons, such as those cited above (that is, they are necessary in order to protect the rights of the women herself, or to protect the rights of others).

It may be challenging to prove that practices, such as forced or coerced abortions and sterilisations of particular populations of women, discriminate against a specific population, where these are unwritten practices as opposed to written laws or policies. In the absence of written evidence or witness statements, a litigant may need to lead evidence to show a pattern of discrimination against a specific population in access to sexual and reproductive health care services.

Disappointingly, the Namibian High Court in *LM and Others v Government of the Republic of Namibia* and the ECHR in three cases on forced sterilisation did not find the conduct in question to be a violation of the right to non-discrimination.[400] In Namibia, the plaintiffs argued that they were sterilised without their consent because they were HIV-positive. In *VC v Slovakia*, before the ECHR the applicant argued she was coercively sterilised because she was of Roman origin.

In *LM and Others v Government of the Republic of Namibia*, the plaintiffs were unable to corroborate their testimony regarding the reasons health care providers provided for their sterilisation on the basis of their HIV status. Similarly, in *VC v Slovakia*, the ECHR held that it was unable to find, on the evidence, that the forced sterilisation reflected a pattern of discrimination against Roma women. The Court did reject the government's arguments relating to the need to protect the health interests of the applicant as a result of her alleged failure to undergo regular check-ups and her neglect of her health during her pregnancy, but failed to call the arguments discriminatory.[401]

[400] *LM and Others v Government of the Republic of Namibia supra* note 353 at para 82.

[401] *VC v Slovakia supra* note 247 at para 113.

6.5 Conclusion

Courts around the world have addressed justifications for violating women's SRHR. In many cases, courts have rejected these justifications, relying on scientific, medical and other expert evidence. Thus, it is critical for lawyers to ensure that they brief courts with the relevant expert evidence and that they present various forms of evidence on the presence or absence of elements of consent. It may further be useful for lawyers to use decisions of other courts that have previously addressed the specific justification at issue in the case in support of their litigation.