

SALC Litigation Manual Series

Dismantling the Gender Gap: Litigating Cases Involving Violations of Sexual and Reproductive Health Rights



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About the Southern Africa Litigation Centre

The Southern Africa Litigation Centre (SALC), established in 2005, aims to provide support—both technical and financial—to human rights and public interest initiatives undertaken by domestic lawyers in southern Africa. SALC works in Angola, Botswana, Democratic Republic of Congo, Lesotho, Malawi, Mozambique, Namibia, Swaziland, Zambia and Zimbabwe. Its model is to work in conjunction with domestic lawyers in each jurisdiction who are litigating public interest cases involving human rights or the rule of law. SALC supports these lawyers in a variety of ways, including, as appropriate, providing legal research and drafting, training and mentoring, and monetary support. While SALC aims primarily to provide support on a specific case-by-case basis, its objectives also include the provision of training and the facilitation of legal networks within the region.

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List of Acronyms and Abbreviations

African Charter	African Charter on Human and Peoples' Rights
African Commission	African Commission on Human and Peoples' Rights
AU	African Union
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CEDAW Committee	Committee on the Elimination of All Forms of Discrimination against Women
CESCR	Committee on Economic, Social and Cultural Rights
CIDT	Cruel, inhuman and degrading treatment
CSO	Civil society organisation
ECHR	European Court of Human Rights
FIGO	International Federation of Gynaecology and Obstetrics
HIV	Human immuno-deficiency virus
HRC	Human Rights Committee
IACHR	Inter-American Commission on Human Rights
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICPD	International Conference on Population and Development
Protocol on Women	Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa
SADC	Southern African Development Community
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health rights
UDHR	Universal Declaration of Human Rights
UN	United Nations
WLHIV	Women living with HIV

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 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 cancer⁶ 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

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](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](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 cancer¹⁷ 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

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-content/uploads/201211litigating-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).

CHAPTER
2

Utilising international, regional and comparative law in domestic courts

2.1 Introduction

This chapter outlines some of the arguments for use of international, regional and comparative law in domestic courts in southern Africa.

Checklist

- ▶ Is your domestic legal system monist or dualist?
- ▶ If monist, then international and regional law is directly enforceable.
- ▶ If dualist, does your Constitution provide any guidance on the relevance of international, regional and comparative law in domestic litigation?
- ▶ If dualist, is there any jurisprudence that outlines the relevance of international, regional and comparative law in domestic litigation and/or which uses international, regional or comparative law in reaching its decision?
- ▶ If dualist, cite jurisprudence from other similarly-situated countries where courts have taken into account international, regional and comparative law.

Selection of relevant cases discussed in this chapter

- Attorney-General v Dow
- Ephraim v Pastory
- Ex-Parte Attorney General: In re Corporal Punishment by Organs of State
- Government of the Republic of Namibia and Others v Mwilima and Others
- Legal Resources Foundation v Zambia
- Mojekwu v Ejikeme
- Odafe and Others v Attorney General and Others

- President of the Republic of Mozambique v Ncomacha
- Rono v Rono
- Société des Femmes Tchadiennes Transitaires v Ministère des Finances
- Ts'epe v The Independent Electoral Commission and Others
- Zimbabwe Human Rights NGO Forum v Zimbabwe

2.2 Use of International, Regional and Comparative Law in Domestic Courts

International and regional human rights law may offer a more robust jurisprudence than what is available from domestic precedent, allowing for more expansive interpretations and firmer defense of progressive principles. The main role of international and regional human rights law in public interest litigation should be to assist domestic courts in interpreting constitutionally-recognised rights, especially given that international human rights treaties have influenced the constitutions of many African countries.²⁷

Most countries in southern Africa have dualist legal systems where international and regional legal obligations are neither justiciable nor directly enforceable in domestic courts without further action on the part of domestic legislatures. However, a few countries in the region, such as Mozambique, have monist legal systems whereby ratified international and regional treaties automatically become part of domestic law.

It should be noted that, in practice direct applicability of international and regional human rights law is sometimes avoided by the courts, even in monist civil law African courts.

An example is the Chadian Supreme Court case of *Société des Femmes Tchadiennes Transitaires v Ministère des Finances*²⁸ where the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) is briefly mentioned to support the Court's interpretation of a constitutional non-discrimination clause.²⁹ Similarly, the Supreme Court of Rwanda recently referred to CEDAW, as well as comparative case law

²⁷ For example, international human rights law substantially influenced the drafting of the South African Bill of Rights. The influence of the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the Convention on the Rights of the Child (CRC) is evident in the economic, social and cultural rights and the children's rights included in the Bill of Rights, and section 31 of the Bill of Rights was clearly modeled on article 27 of the International Covenant on Civil and Political Rights (ICCPR). Moreover, State obligations in the CRC have been enacted in numerous domestic African jurisdictions, such as the Ghanaian Children's Act (1998) and Juvenile Justice Act (2003) as well as the Kenyan Children's Act (2001). **See** O G Odhiambo "The Domestication of International Law Standards on the Rights of the Child with Specific Reference to Juvenile Justice in the African Context" Thesis submitted at the University of the Western Cape, South Africa, (2005) available at http://etd.uwc.ac.za/usrfiles/modules/etd/docs/etd_init_9110_1176963955.pdf (accessed 26 August 2013).

²⁸ AHRLR 104 (ChSC2005) (2005) 13 December 2005 available at <http://www1.chr.up.ac.za/index.php/browse-by-subject/250-chad-societe-des-femmes-tchadiennes-transitaires-v-ministere-des-finances-2005-ahrlr-104-chsc-2005.pdf> (accessed 26 August 2013).

²⁹ *Id* at para 14.

from South Africa, the United States and Canada in reaching a decision.³⁰

In Namibia, where international law is directly applicable, unless otherwise provided for by the Constitution or an Act of Parliament, the Supreme Court held in *Ex-Parte Attorney General: In re Corporal Punishment by Organs of State*,³¹ that constitutional interpretation was “a value judgement which requires objectively to be articulated and identified, regard being had to the contemporary norms, aspirations, expectations and sensitivities of the Namibian people as expressed in its national institutions and its Constitution and further having regard to the emerging consensus of values in the civilised international community which Namibians share”.³²

However, in a handful of instances, courts in monist countries have directly applied international human rights treaties. For example, the Supreme Court of Mozambique held in *President of the Republic of Mozambique v Ncomacha*³³ that traditional authorities were required to consider both constitutional principles and international human rights law in making their judicial decisions.³⁴ In that case, the Supreme Court held that traditional authorities had breached both the Convention on the Rights of the Child (CRC) and the International Covenant on Civil and Political Rights (ICCPR) by forcing a six-year-old girl to leave her family to live with a man until she gave birth to a daughter, in order to compensate him for the death of one of his children.³⁵

Interestingly, the Namibian Supreme Court recently held in *Government of the Republic of Namibia & Others v Mwilima & Others*³⁶ that article 14(3) (d) of the ICCPR took precedence over conflicting provisions in domestic law, namely the Legal Aid Act.³⁷

If the domestic legal system is dualist, whereby a country’s international and regional legal obligations are not directly enforceable in domestic courts, international and regional law can still impose obligations on countries that have ratified particular treaties. The African Commission on Human and Peoples’ Rights (African Commission), which is responsible for monitoring compliance with regional human rights treaties, in *Legal Resources Foundation (LRF) v Zambia*³⁸ noted that “international treaties which are not

³⁰ See RS/Inconst/Penal. 0001/08/CS, Supreme Court of Rwanda 26 September 2008 cited in M Killander & H Adjolohoun, “International Law and Domestic Human Rights Litigation in Africa: An Introduction” in M Killander (ed.), *International Law and Domestic Human Rights Litigation in Africa*, 2010, 8 available at http://www.pulp.up.ac.za/pdf/2010_17/2010_17.pdf (accessed 26 August 2013).

³¹ 1991 (3) SA 76 (NmSc) available at <http://www.saflii.org.za/na/cases/NASC/1991/2.pdf> (accessed 26 August 2013).

³² *Id.*, 20.

³³ Supreme Court (Tribunal Supremo), Criminal section I, Proc.5/2004-A cited in M Killander & H Adjolohoun *supra* note 30, 9.

³⁴ M Killander & H Adjolohoun *supra* note 30, 9.

³⁵ *Id.*

³⁶ [2002] NASC 8 (7 June 2002) available at <http://www.saflii.org.za/na/cases/NASC/2002/8.html> (accessed 26 August 2013).

³⁷ *Id.*, 72.

³⁸ African Commission Communication No. 211/98 (2001) available at <http://www1.umn.edu/humanrts/africa/comcases/211-98.html> (accessed 26 August 2013).

part of domestic law and which may not be directly enforceable in the national courts, nonetheless impose obligations on State Parties.”³⁹

Moreover, the African Commission noted in *Zimbabwe Human Rights NGO Forum v Zimbabwe*⁴⁰ that:

Human rights standards do not contain merely limitations on State’s authority or organs of State. They also impose positive obligations on States to prevent and sanction private violations of human rights. Indeed, human rights law imposes obligations on States to protect citizens or individuals under their jurisdiction from the harmful acts of others. Thus, an act by a private individual and therefore not directly imputable to a State can generate responsibility of the State, not because of the act itself, but because of the lack of due diligence to prevent the violation or for not taking the necessary steps to provide the victims with reparation.⁴¹

Given that a country’s international and regional legal agreements does impose obligations, lawyers should first look to domestic law to persuade courts to take into account international, regional and comparative jurisprudence.

In some countries, domestic constitutional provisions provide for courts to look at international, regional and comparative law in reaching their decisions. For example, section 11(2)(c) of the Malawi Constitution states that, in interpreting the provisions of the Constitution, courts shall, “where applicable, have regard to current norms of public international law and comparable foreign case law”.⁴²

Similarly, in South Africa, the Constitution provides under article 39(1) that:

When interpreting the Bill of Rights, a court, tribunal or forum-

- a. ...;
- b. *must* consider international law; and
- c. *may* consider foreign law. (emphasis added)

In other countries, statutes on interpretation provide for courts to look to international, regional or comparative law. For example, section 24(1) of the Interpretation Act of Botswana⁴³ provides that a court may have regard to relevant international human rights treaties to support interpretation of the Constitution and of statutory laws.

In addition, lawyers should look to decisions by domestic courts to ascertain the accepted

³⁹ *Id* at para 60.

⁴⁰ African Commission Communication No. 245/2002 (2006) *available at* <http://www1.chr.up.ac.za/index.php/browse-by-subject/506-zimbabwe-zimbabwe-human-rights-ngo-forum-v-zimbabwe-2006-ahrlr-128-achpr-2006.pdf> (accessed 26 August 2013).

⁴¹ *Id* at para 143.

⁴² Constitution of the Republic of Malawi, 1994 *available at* <http://www.malawilii.org/mw/legislation/act/1994/20> (accessed 26 August 2013).

⁴³ Interpretation Act of Botswana 20 of 1984 [Chapter 01:04] *available at* <http://www.elaws.gov.bw/law.php?id=1399> (accessed 26 August 2013).

In addition, lawyers should look to decisions by domestic courts to ascertain the accepted relevance of international and regional law. In some countries, courts have held that international and regional law obligations should be looked at in interpreting rights under domestic law. For example, in Botswana, the Court of Appeal in *Attorney General v Dow*,⁴⁴ a case challenging a provision of the Citizenship Act as discriminatory against women, noted that though the provisions of the African Charter on Human and Peoples' Rights (African Charter) did not confer enforceable rights, it was nevertheless an important guide to the interpretation of national constitutional provisions. The Court further noted that constitutional provisions should be interpreted so as not to conflict with obligations under the African Charter. The Court held that:

Even if it is accepted that those treaties and conventions do not confer enforceable rights on individuals within the state until Parliament has legislated its provisions into the law of the land, in so far as such relevant international treaties and conventions may be referred to as an aid to construction of enactments, including the Constitution, I find myself at a loss to understand the complaint made against their use in that manner in the interpretation of what no doubt are some difficult provisions of the Constitution... I am in agreement that Botswana is a member of the community of civilised states which has undertaken to abide by certain standards of conduct, and, unless it is impossible to do otherwise, it would be wrong for its courts to interpret its legislation in a manner which conflicts with the international obligations Botswana has undertaken.⁴⁵

Likewise, in the Lesotho case of *Ts'epe v the Independent Electoral Commission and Others*⁴⁶ the Court of Appeal referred to several ratified, but undomesticated international and regional instruments including the African Charter, the ICCPR, CEDAW and the SADC Declaration on Gender and Equality in reaching its decision.⁴⁷ In the case, the appellant had challenged the constitutionality of a law that reserved one third of local government seats for women, contending that the law was discriminatory on the basis of sex. The Court of Appeal dismissed this argument and found that Lesotho was bound by its international obligations to take measures to promote women's equality. The Court specifically referred to article 18(4) of the African Charter.⁴⁸

The Tanzania High Court case of *Ephraim v Pastory*⁴⁹ found that a customary law rule denying daughters the right to sell inherited land "flies in the face of our Bill of Rights as well as the international conventions to which we are signatories" in discriminating

⁴⁴ (2001) AHRLR 99 (BwCA 1992) available at <http://www1.chr.up.ac.za/index.php/browse-by-country/botswana/1117-botswana-attorney-general-v-dow-2001-ahrlr-99-bwca-1992.pdf> (accessed 26 August 2013).

⁴⁵ *Id* at paras 108-109.

⁴⁶ AHRLR 136 (LeCA 2005) available at <http://www.chr.up.ac.za/index.php/browse-by-subject/343-lesotho-tsepe-v-the-independent-electoral-commission-and-others-2005-ahrlr-136-leca-2005-.html> (accessed 26 August 2013).

⁴⁷ *Id* at paras 17-21.

⁴⁸ *Ts'epe v the Independent Electoral Commission and Others supra* note 46 at para 20.

⁴⁹ AHRLR 236 (TzHC 1990) available at <http://www.chr.up.ac.za/index.php/browse-by-subject/469-tanzania-ephraim-v-pastory-2001-ahrlr-236-tzhc-1990.html> (accessed 26 August 2013).

against women.⁵⁰

In Kenya, the Court of Appeal considered Kenya's international law obligations when determining whether succession laws that disinherited women were discriminatory.⁵¹

In Nigeria, the Court of Appeal in *Mojekwu v Ejikeme*⁵² held that a cultural practice violated women's rights to non-discrimination, citing CEDAW in support of its findings.

The Nigerian High Court went further in 2004, in the case of *Odafe and Others v Attorney General and Others*⁵³ where it found that the refusal to provide HIV-positive, pre-trial prisoners access to antiretroviral treatment violated their right to enjoy the best attainable state of physical and mental health as guaranteed under the African Charter.⁵⁴ Though there is no right to health care in the Nigerian Constitution, the High Court held that Nigeria was obligated to provide for adequate medical treatment under the African Charter.⁵⁵

Lawyers should also look at decisions from their domestic courts in persuading a court to take into account comparative case law in determining the scope of domestic rights.

Courts in southern Africa have also referred to non-binding international and regional guidelines, especially when there is no relevant domestic jurisprudence, to interpret the breadth of domestic constitutional and statutory rights. For instance, a number of HIV-related cases have referred to International Labour Organisation's guidelines on HIV in adjudicating on HIV discrimination in the workplace.⁵⁶

Not all countries' judiciaries have directly examined the role of international, regional and comparative law in their domestic courts. If the courts have failed to do so in a given country (or have done so disfavourably), then lawyers may look to similarly-situated countries where international, comparative and regional law have been used. This may assist the lawyer in crafting a compelling argument for why these sources of law should

⁵⁰ *Id* at para 10.

⁵¹ *Rono v Rono* (2005) AHRLR 107 (KeCA 2005) at para 24 available at <http://www.chr.up.ac.za/index.php/browse-by-subject/332-kenya-rono-v-rono-2005-ahrlr-107-keca-2005.html> (accessed 26 August 2013).

⁵² (2000) 5 NWLR 402. The summary is available at, http://www.equalrightstrust.org/ertdocumentbank/Mojekwu%20&%20others%20v%20Ejikeme%20&%20others%20_2000_%205%20NWLR%20402.pdf (accessed 26 August 2013).

⁵³ (2004) AHRLR 205 (NgHC 2004) available at <http://www.chr.up.ac.za/index.php/browse-by-subject/419-nigeria-odafe-and-others-v-attorney-general-and-others-2004-ahrlr-205-nghc-2004.html> (accessed 26 August 2013).

⁵⁴ *Id* at para 37.

⁵⁵ *Id* at para 34.

⁵⁶ **See**, for instance, *PFG Building Glass v CEPPAWU*, (2003) 5 BLLR 475 at para 77. Guidelines often represent multilateral consensus on best practices in a particular field, for example gender equality, health administration or HIV and AIDS, and can offer valuable insight into how the international community views human rights issues that may be too specific or "niche" to warrant separate conventions.

be accepted in his or her own jurisdiction. In applying this strategy, the lawyer must draw careful comparisons between the similarly-situated country and his or her own country, with specific reference to the case at bar.

2.3 Conclusion

International and regional law can be useful tools in assisting domestic courts to determine the scope of constitutional and other fundamental rights. In monist systems, where international and regional legal obligations are part of domestic law, lawyers can technically rely on international and regional obligations in litigation.

In dualist legal systems, where international and regional treaties have not been domesticated, lawyers may be able to rely on domestic constitutional provisions, previous court decisions relying on international and regional law and guidelines to persuade a court to take into account international and regional law. In addition, in cases where courts have not addressed international and regional law, lawyers can look to similarly situated countries in attempting to persuade a court to look to international and regional law.

Examples of Specific Rights Violations

Violations of a person's SRHR, such as failure to obtain informed consent prior to a health procedure or discriminating against specific populations in the provision of sexual and reproductive health services, infringe a number of fundamental human rights commonly found in international and regional instruments as well as national constitutions.

The table below looks at some of the common types of violations of women's sexual and reproductive self-determination and discrimination against specific populations in accessing sexual and reproductive health services. It considers the particular right violated by each act and the source of this right in international and regional human rights instruments. Note that in many instances, a single act may violate a number of or all of the different human rights set out below.

The table is not exhaustive nor is it intended to be. It merely highlights the major rights that are likely to be implicated in certain common situations. Any litigation should include brainstorming and research about other possible claims a litigant may have.

The international and regional treaties included in this table are:

- International Covenant on Civil and Political Rights (ICCPR)
- International Covenant on Economic, Social and Cultural Rights (ICESCR)
- Convention on the Elimination of all Forms of Discrimination against Women (CEDAW)
- Convention on the Rights of Persons with Disabilities (CRPD)
- African Charter on Human and Peoples' Rights (African Charter)
- Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Protocol on Women)

Event	Human Right Implicated	Source
A health procedure (e.g. abortion or sterilisation) is conducted without voluntary and informed consent	Right to liberty and security of the person	Article 9(1) ICCPR Article 14 CRPD Article 6 African Charter Article 4 Protocol on Women
	Right to be protected from cruel, inhuman or degrading treatment	Article 7 ICCPR Article 15 CRPD Article 5 African Charter Article 4 Protocol on Women
	Right to dignity	Preamble ICCPR Article 5 African Charter Article 3(1) Protocol on Women
	Right to information (in particular, information relating to SRH)	Articles 10(h) CEDAW Article 23(1) CRPD Article 9 African Charter Article 14(2) Protocol on Women
A health procedure (e.g. abortion or sterilisation) is conducted with consent of person other than the patient	Right to privacy	Article 17(1) & (2) ICCPR
SRH services are provided in a way that discriminates against a population (e.g. pregnant women are tested for HIV without consent or a particular procedure is not offered to a specific group of women)	Right to health including SRH	Articles 12(1) & (2) ICESCR Articles 12(1), 12(2) and Article 14(2) CEDAW Article 25 CRPD Article 16 African Charter Article 14 Protocol on Women

Event	Human Right Implicated	Source
	Right to equality and non-discrimination	Article 2(1) ICCPR Article 2(2) ICESCR Articles 1 and 3 CEDAW Article 5 CRPD Articles 2 & 3 African Charter Article 2 Protocol on Women
	Right to life	Article 6(1) ICCPR Article 10 CRPD Article 4 African Charter Article 4 Protocol on Women

CHAPTER
3

Relevant international law

3.1 Introduction

This chapter outlines some of the most important fundamental rights set out in relevant international human rights documents that can be raised in litigating cases related to violations of SRHR. It discusses the expanse and nature of specific rights based on decisions, concluding observations, and general comments of various United Nations (UN) monitoring bodies as well as reports and statements by UN special procedures. The chapter explains how specific rights recognised in international law will apply to certain scenarios and which actions could be argued as violating these rights. In this way, it aims to support the use of international law principles in domestic SRHR-related lawsuits.

For a discussion on why domestic courts should look to international law, please refer to Chapter 2.

Checklist

- ▶ Which international human rights are violated in your particular case?
- ▶ Which international treaties provide for the particular rights you have identified? *[See pages 15-17 for case examples of specific rights violations]*
- ▶ Has your country ratified the particular treaty?
- ▶ Did the events in your case take place after the ratification of the treaty?
- ▶ Has your country made any reservations to the treaty that may exclude its application to the facts of your case?
- ▶ Has the treaty monitoring body made any General Comments or General Recommendations that elaborate on the identified right(s)?
- ▶ Has there been any concluding observations or statements from UN bodies that are relevant to your case? *[See Chapter 7 for a list of relevant online resources]*
- ▶ Are there any relevant international guidelines that provide additional support for your case?

Relevant documents discussed in this chapter

- Beijing Declaration and the Platform for Action, United Nations Fourth World Conference on Women (1995)
- Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984)
- Convention on the Elimination of All Forms of Discrimination against Women (1979)
- Convention on the Rights of Persons with Disabilities (2006)
- International Covenant on Civil and Political Rights (1966)
- International Covenant on Economic, Social and Cultural Rights (1966)
- International Guidelines on HIV/AIDS and Human Rights (as consolidated in 2006)
- Programme of Action, United Nations International Conference on Population and Development (1994)
- United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (1991)
- United Nations Standard Rules on the Equalisation of Opportunities for Persons with Disabilities (1993)
- Vienna Declaration and Programme of Action, United Nations World Conference on Human Rights (1993)
- World Health Organisation, World Health Assembly Resolution (2005)

Relevant cases discussed in this chapter

- AS v Hungary
- Karen Noelia Llantoy Huamán v Peru
- LMR v Argentina
- Pimentel v Brazil

The chapter is divided into the following sections:

- Overview of the sources of relevant international law;
- Introduction to SRHR;
- Right to non-discrimination and equality;
- Right to health including SRH care;
- Right to information;
- Right to liberty and security of the person;
- Freedom from cruel, inhuman and degrading treatment;
- Right to life; and
- Right to privacy.

3.2 Overview of the Sources of International Law

International treaties and conventions provide the primary sources of international law. Internationally, these agreements are negotiated and finalised within the UN system. There are nine core human rights treaties.⁵⁷

Once ratified, a treaty or convention becomes legally binding on the State.⁵⁸ Depending on their legal systems, some States are required to domesticate international laws by the enactment of national laws. For other States, the ratification of the treaty or convention means that it is immediately directly applicable at national level. Regardless, States are required to take steps to ensure that the provisions of the treaty or convention are respected, protected, promoted and fulfilled at national level.⁵⁹

Lawyers defending the rights of complainants in cases related to violations of SRHR can use a number of important international treaties to support their arguments. It is important for lawyers to determine at an early stage of the litigation whether and when these treaties were ratified by their State, in order to determine whether they may be applied to the facts of the case.

Table: Dates of ratification of key international instruments⁶⁰

Country	ICCPR	ICESCR	CEDAW	CRPD
Angola	10/1/1992	10/1/1992	17/9/1986	-
Botswana	8/9/2000	-	13/8/1996	-
Dem. Rep. of Congo	1/11/1976	1/11/1976	17/10/1986	Signed
Lesotho	9/9/1992	9/9/1992	22/8/1995	2/12/2008
Malawi	22/12/1993	22/12/1993	12/3/1987	27/08/2009
Mozambique	21/7/1993	-	21/4/1997	30/01/2012
Namibia	28/1/1994	28/11/1994	23/11/1992	4/12/2007

⁵⁷ These are the International Covenant on Civil and Political Rights (ICCPR); International Covenant on Economic, Social and Cultural Rights (ICESCR); Convention on the Elimination of All Forms of Discrimination against Women (CEDAW); Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT); Convention on the Rights of the Child (CRC); Convention on the Rights of Persons with Disabilities (CRPD); International Convention on the Elimination of All Forms of Racial Discrimination (CERD); International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (ICRMW); and International Convention for the Protection of All Persons from Enforced Disappearance (CPED).

⁵⁸ It should be noted that, even where States have not signed or ratified conventions or treaties, these can still be binding if their principles form part of customary international law. In addition, signing a treaty obliges the country to abide by the object and purpose of the treaty. **See** article 18(a) of the Vienna Convention on the Law of Treaties (1969) *available at* <http://www.worldtradelaw.net/misc/viennaconvention.pdf> (accessed 26 August 2013).

⁵⁹ However, States can make reservations when ratifying treaties and conventions, expressing their reservation from adhering to certain provisions within the treaty.

⁶⁰ As of December 2012.

Country	ICCPR	ICESCR	CEDAW	CRPD
Swaziland	26/3/2004	26/3/2004	26/3/2004	24/09/2012
Zambia	10/4/1984	10/4/1984	21/6/1985	1/2/2010
Zimbabwe	13/5/1991	13/5/1991	13/5/1991	-

In addition, various UN institutions have applied and provided guidance on the nature and scope of rights enshrined in the various conventions. All UN systems have a wide array of mechanisms to monitor, advance and protect human rights, including country reports, on-site visits and special reports. A UN committee has been created to oversee each treaty. These expert committees are tasked with monitoring country compliance with the treaties. Countries that have ratified treaties are obliged to make periodic reports to the relevant committee, setting out progress towards the realisation of rights enshrined in the particular treaty. In fulfilling this function, the committees may issue general comments and recommendations to define and clarify the scope and nature of the rights enshrined within the respective treaties. They also issue concluding observations after considering country reports, and statements with respect to individual country activities. These documents provide additional guidance to lawyers on the nature of relevant rights, their application within States as well as, in some cases, their specific application in the context of violations of SRHR.

Some of the bodies or committees incorporate an individual complaints procedure to carry out their mission. This procedure is similar to traditional litigation in which a victim of human rights violations sues a State for its non-compliance with obligations imposed by particular treaties the State has ratified. The committee or other relevant body carries out quasi-judicial proceedings and decides if the State can be declared liable. Committees may offer decisions or recommendations on individual cases. The individual complaint procedure is often incorporated through an optional protocol.

Table: Relevant international treaties and their monitoring bodies

International UN Treaty	UN Human Rights Monitoring Body
International Covenant on Civil and Political Rights (ICCPR) (including its first Optional Protocol)	Human Rights Committee (HRC)
International Covenant on Economic, Social and Cultural Rights (ICESCR)	Committee on Economic, Social and Cultural Rights (CESCR)
Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) (including its Optional Protocol)	Committee on the Elimination of Discrimination against Women
Convention on the Rights of Persons with Disabilities (CRPD)	Committee on the Rights of Persons with Disabilities

The Human Rights Council⁶¹ has also established mechanisms, known as special procedures, to address human rights. Individuals, known as special rapporteurs, examine, monitor, advise and publicly report on human rights situations. Of particular relevance to SRHR are the Special Rapporteur on the Right of Everyone to Enjoyment of the Highest Attainable Standard of Physical and Mental Health; Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment; and the Special Rapporteur on Violence against Women, Its Causes and Consequences. Their reports may provide valuable guidance on the application of various rights to individual cases.

In addition to binding treaties, a number of guidelines and declarations can also be useful when litigating cases of violations of SRHR. Although these international human rights documents are not legally binding, they nevertheless contain persuasive guidance on SRH-related human rights. They expand upon key human rights principles and apply them directly to the situation of SRHR. Important documents and guidelines for litigating SRHR-related cases, especially cases involving WLHIV and women with disabilities include:

- United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (1991);⁶²
- Vienna Declaration and Programme of Action, United Nations World Conference on Human Rights (1993);⁶³
- United Nations Standard Rules on the Equalisation of Opportunities for Persons with Disabilities (1993);⁶⁴
- Programme of Action, United Nations International Conference on Population and Development (1994);⁶⁵
- Beijing Declaration and the Platform for Action, United Nations Fourth World Conference on Women (1995);⁶⁶
- UNAIDS and OHCHR International Guidelines on HIV/AIDS and Human Rights (1996 and 2006);⁶⁷

⁶¹ The Human Rights Council of the UN is an inter-governmental body that is responsible for the promotion and protection of human rights globally. It consists of 47 member states that are elected periodically by the General Assembly of the UN.

⁶² UN Doc A/RES/46/119 (1991) available at <http://www.ohchr.org/EN/ProfessionalInterest/Pages/PersonsWithMentalIllness.aspx> (accessed 26 August 2013).

⁶³ UN Doc. A/CONF.157/23 (1993) available at <http://www.ohchr.org/EN/ProfessionalInterest/Pages/Vienna.aspx> (accessed 26 August 2013).

⁶⁴ UN Doc A/RES/48/96 (1993) available at <http://www.un.org/documents/ga/res/48/a48r096.htm> (accessed 26 August 2013).

⁶⁵ Available at <http://www.un.org/popin/icpd2.htm> (accessed 26 August 2013).

⁶⁶ Available at <http://www.un.org/womenwatch/daw/beijing/platform/> (accessed 26 August 2013).

⁶⁷ Available at http://data.unaids.org/Publications/IRC-pub07/jc1252-internguidelines_en.pdf (accessed 26 August 2013).

- World Health Organisation, World Health Assembly Resolution on Disability, including prevention, management and rehabilitation (2005);⁶⁸ and
- UNFPA and WHO Sexual and Reproductive Health of Women Living with HIV/AIDS: Guidelines on care, treatment and support for women living with HIV/AIDS and their children in resource-constrained settings (2006).⁶⁹

3.3 Introduction to Sexual and Reproductive Health Rights

SRH is recognised as an essential human right guaranteed in various international and regional human rights instruments as well as some national laws and policies. While the notion of “the right to SRH” is relatively new and is sometimes not expressly provided for in domestic law, SRHR encompasses rights which have long been recognised in international human rights law and national laws.

Reproductive rights were first officially recognised as such in 1994 at the International Conference on Population and Development (ICPD) in Cairo, Egypt.⁷⁰ The definition of SRH agreed to in Cairo moved beyond safe motherhood, family planning and fertility control, and was notable for being broad and comprehensive, and for placing reproductive health in the context of human rights and the right to health. The ICPD’s subsequent Programme of Action (PoA)⁷¹ for universal access to SRH by 2015 linked governments’ *existing* legally binding obligations under various treaties and conventions to their duty to protect reproductive rights, particularly those of women, stating that:

[R]eproductive rights embrace certain human rights that are already recognised in national laws, international human rights documents and other relevant UN consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes the right of all to make decisions concerning reproduction free of discrimination, coercion and violence...⁷²

Although all human rights are in some way implicated in SRHR, there are twelve rights that are most often cited as forming a SRHR framework to empower women and advance their SRH.⁷³ These are:

⁶⁸ World Health Assembly Resolution 58.23 58th World Health Assembly (2005) *available at* http://www.who.int/disabilities/WHA5823_resolution_en.pdf (accessed 26 August 2013).

⁶⁹ *Available at* http://www.unfpa.org/webdav/site/global/shared/documents/publications/2006/srh_women_aids.pdf (accessed 26 August 2013).

⁷⁰ ICPD PoA *supra* note 65.

⁷¹ The ICPD PoA commitment was later reaffirmed in various other international meetings such as the Beijing Declaration and Platform for Action.

⁷² ICPD PoA *supra* note 65 at para 7.3.

⁷³ “Twelve Human Rights Key to Human Rights” *Center for Reproductive Rights* (2008), 1 *available at* <http://reproductiverights.org/en/document/twelve-human-rights-key-to-reproductive-rights> (accessed 26 August 2013). **See also** L Gerntholtz & C Grant “International, African and Country Legal Obligations on Women’s Equality in Relation to Sexual and Reproductive Health, Including HIV and AIDS” *HEARD and ARASA* (2010), 14 *available at* <http://www.heard.org.za/downloads/international-african-and-country-legal-obligations-on-womens-equality-in-relation-to-sexual-and-reproductive-health-including-hiv-and-aids.pdf> (accessed 26 August 2013).

- The right to life;
- The rights to liberty and security of the person;
- The right to health, including reproductive and sexual health;
- The right to decide the number and spacing of children;
- The rights to consent to marriage and to equality in marriage;
- The right to privacy;
- The rights to equality and non-discrimination;
- The right to be free from practices that harm women and girls;
- The right not to be subjected to torture and cruel, inhuman and degrading treatment or punishment;
- The right to be free from sexual and gender-based violence;
- The right to access sexual and reproductive health education and family planning information; and
- The right to enjoy scientific progress.

All of these rights may be implicated in violations of a person's SRHR. In this chapter we focus on those rights which are likely to be specifically provided for in domestic law and discuss how international law can be used to support litigation relating to violations of sexual and reproductive self-determination and discrimination against particular groups of women in accessing SRH care services. In particular, we look at the right to equality and non-discrimination; the right to health, including SRH; the right to information; the rights to liberty and security of the person; the right to freedom from cruel, inhuman and degrading treatment; the right to life; and the right to privacy. We do not cover the other rights which form part of the SRHR framework as they are less likely to be provided for under domestic law. However, lawyers should consider whether including violations of the other rights listed above may be beneficial in domestic litigation.

3.4 Right to Non-Discrimination

The right to non-discrimination protects women from discrimination in their enjoyment of all aspects of the right to SRH. This includes access to SRH information and services provided on the basis of informed consent, as well as respecting their rights to dignity, privacy and confidentiality. This right is particularly relevant in cases where specific populations are denied access to SRH services due to, for example, their gender, HIV status or a disability. Laws, policies and practices that permit coercive health interventions such as forced abortion and sterilisation against women and/or specific populations of women may violate the right to non-discrimination.

A number of international treaties protect individuals from discrimination on the basis of gender, HIV status and disability. The relevant treaties discussed in this manual are the ICCPR, ICESCR, CEDAW and CRPD.

The ICCPR guarantees freedom from discrimination under article 2(1), which states:

Each State Party to the present Covenant undertakes to respect and to ensure to all individuals within its territory and subject to its jurisdiction the rights recognised in the present Covenant, 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*.⁷⁴

The ICESCR has a similar provision under article 2(2), which states:

The States Parties to the present Covenant undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.⁷⁵

Both article 2(1) of the ICCPR and article 2(2) of the ICESCR only guarantee non-discrimination with respect to the rights provided for in each treaty. Thus, for example, in a case challenging the coercive sterilisation of women due solely to their HIV status, one must argue that the coercive medical intervention violated article 2(2) of the ICESCR because it discriminated against the patient in her trying to exercise her right to health as provided for under article 12 of the ICESCR. Simply arguing discrimination as a violation of article 2(2) of the ICESCR is not enough.

Discrimination against women

CEDAW is particularly relevant when addressing cases of discrimination against women, including addressing cases of WLHIV and women with disabilities. For example, CEDAW would be relevant in cases where a woman with a disability has been subjected to a forced abortion especially when such treatment is based on her disabled status.

CEDAW's basic principle of non-discrimination is set forth in article 2 as follows:

States Parties condemn discrimination against women in all its forms, agree to pursue by all appropriate means and without delay a policy of eliminating discrimination against women and, to this end, undertake:

- (a) To embody the principle of the equality of men and women in their national constitutions or other appropriate legislation if not yet incorporated therein and to ensure, through law and other appropriate means, the practical realisation of this principle;
- (b) To adopt appropriate legislative and other measures, including sanctions where appropriate, prohibiting all discrimination against women;
- (c) To establish legal protection of the rights of women on an equal basis with men and to ensure through competent national tribunals and other public institutions the effective protection of women against any act of discrimination;

⁷⁴ Article 2(1) of the ICCPR (emphasis added).

⁷⁵ Article 2(2) of the ICESCR.

- (d) To refrain from engaging in any act or practice of discrimination against women and to ensure that public authorities and institutions shall act in conformity with this obligation;
- (e) To take all appropriate measures to eliminate discrimination against women by any person, organisation or enterprise;
- (f) To take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women;
- (g) To repeal all national penal provisions which constitute discrimination against women.⁷⁶

In addition to the protection under article 2, article 12(1) of CEDAW urges States to work towards the elimination of “discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.”⁷⁷ Article 14 specifically addresses discrimination against women in rural areas.⁷⁸ Article 16 of CEDAW also states that “parties shall take all appropriate measures to ... ensure, on a basis of equality of men and women ... the same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights.”⁷⁹

Recognising the particular discrimination experienced by women, the ICCPR under article 3 specifically provides that all countries “undertake to ensure the equal right of men and women to the enjoyment of all civil and political rights set forth in the [ICCPR]”.⁸⁰ The HRC has stressed the importance of article 3 stating that “the full effect of this provision is impaired whenever any person is denied the full and equal enjoyment of any right. Consequently, States should ensure to men and women equally the enjoyment of all rights provided for in the Covenant.”⁸¹

Similarly, article 3 of the ICESCR obliges States to ensure equality between men and women in the enjoyment of all economic, social and cultural rights set forth in the ICESCR. Of particular relevance in SRHR cases, the ICESCR under article 12 guaranteeing the right to health provides specifically for the elimination of discrimination against women in accessing health. The CESCR has noted:

Interventions aimed at the prevention and treatment of diseases affecting women, as well as policies to provide access to a full range of high quality and affordable health care, including sexual and reproductive services...the

⁷⁶ Article 2 of the CEDAW.

⁷⁷ *Id.*, article 12(1).

⁷⁸ *Id.*, article 14.

⁷⁹ *Id.*, article 16.

⁸⁰ Article 3 of the ICCPR.

⁸¹ General Comment No 28: Equality of Rights between Men and Women (Article 3) Human Rights Committee 68th Session UN Doc CCPR/C/21/Rev.1/Add.10 (2000) (HRC General Comment No 28) at para 2 *available at* <http://www.unhchr.ch/tbs/doc.nsf/0/13b02776122d4838802568b900360e80> (accessed 26 August 2013).

removal of all barriers interfering with access to health services, education and information, including in the area of sexual and reproductive health...[and] undertake preventive, promotive and remedial action to shield women from the impact of harmful traditional cultural practices and norms that deny them their full reproductive rights.⁸²

Discrimination against WLHIV

Neither the ICCPR nor the ICESCR specifically list HIV as a prohibited ground of discrimination. However, the CESCR explicitly stated that the inclusion of “other status” in the ICESCR is a clear indication that the list is not exhaustive and that “other grounds” may be incorporated into this category. The CESCR stated that:

A flexible approach to the ground of “other status” is thus needed in order to capture other forms of differential treatment that cannot be reasonably and objectively justified and are of a comparable nature to the expressly recognised grounds in article 2, paragraph 2 [of the ICESCR].⁸³

The CESCR has recognised several other prohibited grounds in a non-exhaustive list that includes health status, including HIV, as well as age, disability, nationality, marital and family status, sexual orientation and gender identity, place of residence, and economic and social situation.⁸⁴ With respect to discrimination on the basis of HIV status, it urges States to “ensure that a person’s actual or perceived health status is not a barrier to realising the rights under the Covenant”.⁸⁵ It refutes the view that restricting human rights in the context of a person’s health status is necessary for the protection of public health, noting that such restrictions are discriminatory, including “when HIV status is used as the basis for differential treatment with regard to access to education, employment, health care, travel, social security, housing and asylum.”⁸⁶

In the same way, the HRC has found that the non-discrimination provision of the ICCPR protects individuals from discrimination on the basis of HIV status. In its Concluding Observations on the State Report of the Republic of Moldova, the HRC noted its concern that people living with HIV were subjected to discrimination in a myriad of situations in Moldova in violation of article 2 of the ICCPR.⁸⁷

⁸² General Comment No 14: The Right to the Highest Attainable Standard of Health Committee on Economic Social and Cultural Rights 22nd session UN Doc E/C.12/2000/4 (2000) (CESCR General Comment No 14) at para 21 *available at* [http://www.unhchr.ch/tbs/doc.nsf/\(symbol\)/E.C.12.2000.4.En](http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En) (accessed 26 August 2013).

⁸³ General Comment No 20: Non-discrimination in Economic, Social and Cultural rights (art. 2, para 2) Committee on Economic Social and Cultural Rights 42nd Session UN Doc E/C.12/GC/20 (2009) (CESCR General Comment No 20) at para 27 *available at* <http://www.refworld.org/docid/4a60961f2.html> (accessed 26 August 2013).

⁸⁴ *Id* at paras 28-35.

⁸⁵ *Id* at para 33.

⁸⁶ *Id*.

⁸⁷ Concluding Observations of the Human Rights Committee: Republic of Moldova 97th Session UN Doc CCPR/C/MDA/CO/2 (2009) at para 12 *available at* <http://www.refworld.org/docid/4afc28752.html> (accessed 26 August 2013).

The prohibition against discrimination on the basis of HIV is echoed in a number of international resolutions, declarations, and guidelines. The International Guidelines states:

States should enact or strengthen anti-discrimination and other protective laws that protect vulnerable groups, people living with HIV and people with disabilities from discrimination in both the public and private sectors, ensure privacy and confidentiality and ethics in research involving human subjects, emphasise education and conciliation, and provide for speedy and effective administrative and civil remedies.⁸⁸

The World Health Assembly—the highest decision-making body of the World Health Organisation (WHO)—in 1988 urged member States to “avoid discriminatory action against, and stigmatisation of [people living with HIV] in the provision of services, employment and travel”.⁸⁹

Similarly, the UNGASS Declaration of Commitment on HIV/AIDS adopted by the UN General Assembly urges States to:

Enact, strengthen or enforce, as appropriate, legislation, regulations and other measures to eliminate all forms of discrimination against...people living with HIV/AIDS and members of vulnerable groups, in particular to ensure their access to, inter alia, education, inheritance, employment, health care, social and health services, prevention, support and treatment, information and legal protection.⁹⁰

This was reaffirmed by the General Assembly in 2006 in its Political Declaration on HIV/AIDS.⁹¹

Of particular relevance to the SRHR of WLHIV, the Committee on the Elimination of Discrimination Against Women (CEDAW Committee) has noted the limited access women have to HIV-related health care and has recommended that States intensify HIV programmes that “give special attention to the rights and needs of women and children, and to the factors relating to the reproductive role of women and their subordinate position in some societies which make them especially vulnerable to HIV infection.”⁹²

⁸⁸ Guideline 5 of the International Guidelines on HIV/AIDS and Human Rights *supra* note 67.

⁸⁹ World Health Assembly Resolution 41.24 on the Avoidance of Discrimination in Relation to HIV-infected People and People with AIDS (1998) in UNDP, *Compendium of key documents relating to human rights and HIV in Eastern and Southern Africa*, 39 available at http://www.pulp.up.ac.za/pdf/2008_03/2008_03.pdf (accessed 26 August 2013).

⁹⁰ Declaration of Commitment on HIV/AIDS UN General Assembly 26th Special Session UN Doc A/RES/S-26/2 (2001) at para 58 available at <http://www.un.org/ga/aids/docs/aress262.pdf> (accessed 26 August 2013).

⁹¹ Political Declaration on HIV/AIDS UN General Assembly Resolution 60/262 60th Session UN Doc A/RES/60/262 (2006) at para 29 available at http://www.unaids.org/en/media/unaids/contentassets/dataimport/pub/report/2006/20060615_hlm_politicaldeclaration_ares60262_en.pdf (accessed 26 August 2013).

⁹² General Recommendation No 15: Avoidance of Discrimination against Women in National Strategies for the Prevention and Control of Acquired Immunodeficiency Syndrome (AIDS) Committee on the

For a more detailed discussion on the right to equality and non-discrimination and its application to HIV please see *Equal Rights for All: Litigating Cases of HIV-Related Discrimination*.⁹³

Discrimination against women with disabilities

Neither the ICCPR nor the ICESCR specifically list disability as a prohibited ground of discrimination. However, as highlighted above, the CESCR explicitly stated that the inclusion of “other status” in the ICESCR is a clear indication that the list is not exhaustive and that “other grounds” may be incorporated into this category.⁹⁴

The CESCR has recognised several other prohibited grounds in a non-exhaustive list that includes health status, and disability.⁹⁵ With regard to disability-based discrimination, despite no explicit recognition of persons with disabilities in the ICESCR, the CESCR noted that:

Since the Covenant’s provisions apply fully to all members of society, persons with disabilities are clearly entitled to the full range of rights recognised in the Covenant. In addition, in so far as special treatment is necessary, States parties are required to take appropriate measures, to the maximum extent of their available resources, to enable such persons to seek to overcome any disadvantages, in terms of the enjoyment of the rights specified in the Covenant, flowing from their disability. Moreover, the requirement contained in article 2 (2) of the Covenant that the rights “enunciated ... will be exercised without discrimination of any kind” based on certain specified grounds “or other status” clearly applies to discrimination on the grounds of disability.⁹⁶

The CESCR has furthermore reaffirmed the importance of addressing the needs of persons with disabilities in the context of the right to physical and mental health and to ensure that “not only the public health sector but also private providers of health services and facilities comply with the principle of non-discrimination in relation to persons with disabilities.”⁹⁷ The Convention on the Rights of Persons with Disabilities (CRPD), which entered into force in May 2008, aims to promote the human rights of people with disabilities, eradicate disability-based discrimination and protect people with disabilities against discrimination by others. The CRPD under article 5(2) “prohibit[s] all discrimination on the basis of disability and guarantee[s] to persons with disabilities equal and effective legal protection against discrimination on all grounds.”

Elimination of Discrimination against Women 9th Session UN Doc A/45/38 (1990) available at <http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm#recom15> (accessed 26 August 2013).

⁹³ “Equal Rights for All: Litigating Cases of HIV-Related Discrimination” *Southern Africa Litigation Centre* (2011) available at <http://www.southernafricalitigationcentre.org/1/wp-content/uploads/2012/10/HIV-and-Discrimination-Manual-pdf.pdf> (accessed 26 August 2013).

⁹⁴ CESCR General Comment No 20 *supra* note 83 at para 27.

⁹⁵ *Id* at paras 28 and 33.

⁹⁶ General Comment No 5: Persons with Disabilities Committee on Economic Social and Cultural Rights 11th Session UN Doc E/1995/22 (1994) at para 5 available at <http://www.unhcr.ch/tbs/doc.nsf/0/4b0c449a9ab4ff72c12563ed0054f17d> (accessed 26 August 2013).

⁹⁷ CESCR General Comment No 14 *supra* note 82 at para 26.

Article 6 of the CRPD deals explicitly with the rights of women with disabilities to equality and non-discrimination. It obliges countries to recognise that “women and girls with disabilities are subject to multiple discrimination, and in this regard [requires countries to] take measures to ensure the full and equal enjoyment by them of all human rights and fundamental freedoms.”⁹⁸

Article 23 of CRPD further obliges States to take measures “to eliminate discrimination against persons with disabilities in all matters relating to marriage, family, parenthood and relationships, on an equal basis with others,”⁹⁹ which includes “the rights of persons with disabilities to decide freely and responsibly on the number and spacing of their children and to have access to age-appropriate information, reproductive and family planning education...and the means necessary to enable them to exercise these rights,¹⁰⁰ as well as the protection of the fertility rights of persons with disabilities.¹⁰¹ Article 25 of the CRPD, dealing with health rights, furthermore states that people with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability and obliges States to provide equitable health care, including reproductive health care,¹⁰² as well as to prevent discriminatory denial of health care services.¹⁰³

The ICPD Programme of Action also speaks of equality of men and women in health services and specifically states that “Governments should take effective action to eliminate all forms of coercion and discrimination in policies and practices.”¹⁰⁴ With regard to people with disabilities, the Programme of Action provides that governments should recognise the SRH needs of people with disabilities and should “eliminate specific forms of discrimination that persons with disabilities may face with regard to reproductive rights”.¹⁰⁵

The UN Standard Rules on the Equalisation of Opportunities for Persons with Disabilities require States to ensure that their laws do not discriminate against persons with disabilities with respect to sexual relationships, marriage and parenthood and provide that “persons with disabilities must have the same access as others to family-planning methods, as well as to information in accessible form on the sexual functioning of their bodies.”¹⁰⁶

⁹⁸ Article 6(1) of the CRPD.

⁹⁹ *Id.*, article 23 (1).

¹⁰⁰ *Id.*, article 23(1) (b).

¹⁰¹ *Id.*, article 23(1) (c).

¹⁰² *Id.*, article 25(a).

¹⁰³ *Id.*, article 25(f).

¹⁰⁴ ICPD PoA *supra* note 65 at para 5.5.

¹⁰⁵ *Id.* at para 6.30.

¹⁰⁶ Rule 9(2) of the UN Standard Rules on the Equalisation of Opportunities for Persons with Disabilities *supra* note 64.

Definition of discrimination

The HRC has defined discrimination as:

Imply[ing] any distinction, exclusion, restriction or preference which is based on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status, and which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise by all persons, on an equal footing, of all rights and freedoms.¹⁰⁷

This definition has been adopted by the CESCR with respect to the discrimination provisions in the ICESCR.¹⁰⁸

CEDAW under article 1 provides a more particular definition of discrimination against women:

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.¹⁰⁹

The CRPD defines discrimination on the basis of disability as “any distinction, exclusion or restriction on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.”¹¹⁰

The protection against discrimination under the ICESCR and ICCPR extends to both direct and indirect discrimination. Direct discrimination “occurs when an individual is treated less favourably than another person in a similar situation for a reason related to a prohibited ground”.¹¹¹ Denying a person a medical procedure based on their HIV status is an example of direct discrimination. Indirect discrimination, on the other hand, “refers to laws, policies or practices which appear neutral at face value, but have a disproportionate impact on the exercise of rights [under each treaty] as distinguished by prohibited grounds of discrimination”.¹¹² A policy requiring all people accessing ante-natal services to be tested for HIV is an example of indirect discrimination as it may discriminate against women as they are the only gender accessing ante-natal services.

¹⁰⁷ General Comment No 18: Non-discrimination Human Rights Committee 37th session UN Doc HRI/GEN/1/Rev.1 at 26 (1989) (HRC General Comment No 18) at para 7 available at [http://www.unhcr.ch/tbs/doc.nsf/\(Symbol\)/3888b0541f8501c9c12563ed004b8d0e?Opendocument](http://www.unhcr.ch/tbs/doc.nsf/(Symbol)/3888b0541f8501c9c12563ed004b8d0e?Opendocument) (accessed 26 August 2013).

¹⁰⁸ CESCR General Comment No 20 *supra* note 83 at para 7.

¹⁰⁹ Article 1 of the CEDAW.

¹¹⁰ Article 2 of the CRPD.

¹¹¹ CESCR General Comment No 20 *supra* note 83 at para 10(a).

¹¹² *Id* at para 10(b).

State obligations to eradicate discrimination extends to both ending it formally in laws and substantively in practice.¹¹³ That is, merely addressing formal discrimination in a State’s constitution, laws and policy documents “will not ensure substantive equality” as intended by article 2(2) of the ICESCR. The CESCR has stated that:

Eliminating discrimination in practice requires paying sufficient attention to groups of individuals which suffer historical or persistent prejudice instead of merely comparing the formal treatment of individuals in similar situations. States Parties must therefore immediately adopt the necessary measures to prevent, diminish and eliminate the conditions and attitudes which cause or perpetuate substantive or de facto discrimination.¹¹⁴

What acts amount to discrimination in relation to sexual and reproductive health?

It is likely that in addition to discriminatory access to SRH services, failure to permit a patient to exercise their sexual and reproductive self-determination could violate the right to non-discrimination.

The CEDAW Committee noted, in General Recommendation 19, that coercive acts can amount to discrimination, stating that “[d]iscrimination against women includes acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty.”¹¹⁵ This includes subjecting women to coercive medical procedures which can result in physical, mental or sexual harm to the women.

Case Example: Lack of Appropriate Maternal Health Services

In *Pimentel v Brazil*,¹¹⁶ the CEDAW Committee found that the lack of appropriate maternal health services in Brazil that clearly fail to meet the specific, distinctive health needs and interests of women constitutes discrimination against women under article 12, paragraph 1, and article 2 of CEDAW. The CEDAW Committee established that Pimentel had not only been discriminated against because she was a woman, but also because she was poor and of African descent.¹¹⁷ The CEDAW Committee has noted that “special attention should be given to the health needs and rights of women belonging to vulnerable and disadvantaged groups” and that the duty to eliminate discrimination in access to health care includes the responsibility to take into account the manner in which societal factors, which can vary among women, determine health status.¹¹⁸

¹¹³ *Id* at para 38.

¹¹⁴ *Id* at para 8.

¹¹⁵ CEDAW General Recommendation No 19: Violence against Women Committee on the Elimination of Discrimination against Women 11th session UN Doc A/47/38 (1992) at para 6 available at <http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm> (accessed 26 August 2013).

¹¹⁶ CEDAW/c/49/D/17/2008 (*Alyne da Silva Pimentel v Brazil*) at para 7.6 available at <http://www.escr-net.org/sites/default/files/CEDAW-C-49-D-17-2008.pdf> (accessed 26 August 2013).

¹¹⁷ *Id* at para 7.7.

¹¹⁸ CEDAW General Recommendation No 24: Article 12 of the Convention (Women and Health) Committee on the Elimination of Discrimination against Women 20th Session UN Doc A/54/38/Rev.1, chap. I

In *AS v Hungary*,¹¹⁹ the CEDAW Committee found that Hungary had violated the complainant's rights to protection from discrimination in health care provided for under article 12, amongst other rights, in forcing her to be sterilised, and cited its General Recommendations 19 and 24 with approval.

3.5 Right to Equality

The ICCPR provides for the right to equality under article 26 and broadly requires that all national laws be free from discrimination stating:

All persons are equal before the law and are entitled without any discrimination to the equal protection of the law. In this respect, the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or *other status*.¹²⁰

This article does not limit the scope of the rights protected from discrimination. In SRHR cases, it is useful to allege both violations of article 26 of the ICCPR and the non-discrimination articles of the appropriate treaties discussed in section 3.4 above.

With respect to women with disabilities, the CRPD under article 5(1) requires all countries to “recognise that all persons are equal before and under the law and are entitled without any discrimination to the equal protection and equal benefit of the law.”¹²¹

The HRC has specifically found that coercive acts (such as requiring women to be sterilised without their consent) can be a violation of the right to equality under article 26.¹²²

Limitation on rights to equality and non-discrimination

According to the HRC, States are permitted to differentiate in treatment but only if “the criteria for such differentiation are reasonable and objective and if the aim is to achieve a purpose which is legitimate under the [ICCPR]”.¹²³

Similarly, the CESCR warns that “differential treatment based on prohibited grounds will be viewed as discriminatory unless the justification for differentiation is reasonable and objective”.¹²⁴ However, the CESCR does make it clear that failure to remedy differential treatment “on the basis of a lack of available resources is not an objective and reasonable

(1999) (CEDAW General Recommendation No 24) at para 6 *available at* <http://www.refworld.org/docid/453882a73.html> (accessed 26 August 2013).

¹¹⁹ CEDAW/C/36/D/4/200 at paras 11.3-11.4 *available at* http://www2.ohchr.org/english/law/docs/Case4_2004.pdf (accessed 26 August 2013).

¹²⁰ Article 26 of the ICCPR (emphasis added).

¹²¹ Article 5(1) of the CRPD.

¹²² Concluding Observations of the Human Rights Committee: Slovakia 78th Session UN Doc CCPR/CO/78/SVK (2003) at para 12 *available at* [http://www.unhcr.ch/tbs/doc.nsf/\(Symbol\)/CCPR.CO.78.SVK.En?Opendocument](http://www.unhcr.ch/tbs/doc.nsf/(Symbol)/CCPR.CO.78.SVK.En?Opendocument) (accessed 26 August 2013).

¹²³ HRC General Comment No 18 *supra* note 107 at para 13.

¹²⁴ CESCR General Comment No 20 *supra* note 83 at para 13.

justification unless every effort has been made to use all resources that are at the State Party's disposition in an effort to address and eliminate the discrimination, as a matter of priority".¹²⁵

Whether discriminatory behaviour in the context of provision of SRH services can be deemed as justifiable as provided for under the ICCPR and ICESCR and other relevant law is discussed in more detail in chapter 5.

3.6 Right to Health, Including Sexual and Reproductive Health

Violations of reproductive self-determination and discrimination in accessing health care services will most often result in a violation of the right to health, recognised in several international human rights treaties. However, relying on other rights such as the right to be free from cruel, inhuman and degrading treatment or the right to life may be more persuasive in jurisdictions where the right to health is not provided for in the domestic law.

International human rights law recognises the right of every person to health, including SRH, on the basis of a broad understanding of health as the "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"¹²⁶ and as being dependent on and indispensable for the exercise of other human rights such as the right to non-discrimination, equality, privacy and the prohibition against torture.¹²⁷

The ICESCR is the first binding instrument that recognises the right to health under article 12 and makes mention of an aspect of reproductive health - maternal health - as a key element of the right to health. It requires State Parties to recognise "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health"¹²⁸ and to take steps to reduce infant mortality¹²⁹ and to protect mothers for a reasonable period before and after childbirth.¹³⁰

The right to health, including sexual and reproductive health has since been expanded upon in CEDAW¹³¹ and the CRPD,¹³² where it has moved beyond a focus on maternal health to encompass a wide range of SRHR.

¹²⁵ *Id.*

¹²⁶ Preamble to the Constitution of the World Health Organisation as adopted by the International Health Conference New York (1946). This was signed on 22 July 1946 by the representatives of 61 States and entered into force on 7 April 1948. Available at <http://www.who.int/about/definition/en/print.html> (accessed 26 August 2013).

¹²⁷ CESCR General Comment No 14 *supra* note 82 at para 3.

¹²⁸ Article 12(1) of the ICESCR.

¹²⁹ *Id.*, article 12 (2).

¹³⁰ *Id.*, article 10(2).

¹³¹ Articles 12, 16 and particularly 16(e) of the CEDAW.

¹³² Articles 23 and 25 of the CRPD.

Article 12 of CEDAW provides:

1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.
2. Notwithstanding the provisions of paragraph 1 of this article, States Parties shall ensure to women 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.

While article 16 provides in relation to SRHR:

1. States Parties shall take all appropriate measures to eliminate discrimination against women in all matters relating to marriage and family relations and in particular shall ensure, on a basis of equality of men and women:
 - ...
 - (e) The same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights;

The right to health includes making available and accessible SRH information and SRH prevention and treatment services. The CESCR's General Comment No. 14 notes the importance of making SRH information and services available, accessible and acceptable.¹³³

Similarly, article 12 of CEDAW provides for the equal rights of women to health care services, including family planning; this has been described in the CEDAW Committee's General Recommendation 24, as including an obligation on States to ensure that health services are accessible and acceptable.¹³⁴ The CRPD specifically identifies the right to SRH as a human right and emphasises the availability and accessibility of services for people living with disability.¹³⁵ Article 9 of the CRPD obliges States to take measures to ensure people with disabilities have access to a range of information and services to allow them to participate fully in all aspects of life.

¹³³ Note that the CESCR is in the process of drafting a General Comment specifically on SRHR. **See** A Yamin "Remarks Prepared for Day of General Discussion: General Comment on the Right to Sexual and Reproductive Health" *United Nations Committee on Economic, Social and Cultural Rights 45th Session* (2010), 1 available at <http://www2.ohchr.org/english/bodies/cescr/docs/discussion/AliciaYamin.pdf> (accessed 26 August 2013) **and** "Background Paper to Support the Development of a General Comment on the Right to Sexual and Reproductive Health by the Committee on Economic, Social and Cultural Rights (CESCR Committee): International Standards on Women's Sexual and Reproductive Rights and Gaps in the International Legal Framework" *Centre for Reproductive Rights* (2010) (CRR Background Paper), 2 available at http://www2.ohchr.org/english/bodies/cescr/docs/discussion/CRR_DGD15112010.pdf (accessed 26 August 2013).

¹³⁴ CEDAW General Recommendation No 24 *supra* note 118 at paras 21 and 22.

¹³⁵ Articles 9, 24 and 25 of the CRPD.

There are two central components of making available and accessible SRHR information and services relevant to cases of sexual and reproductive self-determination and discrimination in accessing health care services: the obligation to obtain informed consent prior to conducting a medical procedure; and non-discrimination in making health care services available and accessible.

Voluntary, informed consent

The CESCR notes that the right to health includes the right to freely consent to medical treatment. The CESCR explains: “[t]he right to health contains both freedoms and entitlements. The freedoms include the right to control one’s health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation.”¹³⁶

The right to health in both CEDAW and the CRPD also includes the concept of informed consent. Article 12(1), which includes the right to quality health care services under CEDAW has been interpreted to include the concept of voluntary, as well as *informed* consent to health services by the CEDAW Committee’s General Recommendation No. 24.¹³⁷ The General Recommendation states that the right to quality health care services under article 12(1) of CEDAW includes an obligation that States provide acceptable services, which “are those that are delivered in a way that ensures that a woman gives her fully informed consent, respects her dignity, guarantees her confidentiality and is sensitive to her needs and perspectives.”¹³⁸ It further recommends that countries ensure health services are consistent with the human rights of women, including the rights to autonomy, informed consent, choice as well as privacy and confidentiality.¹³⁹

The CEDAW Committee has stressed that this means that women “have the right to be fully informed, by properly trained personnel, of their options in agreeing to treatment or research, including likely benefits and potential adverse effects of proposed procedures and available alternatives”.¹⁴⁰

Similarly, article 25(d) of the CRPD requires State Parties to provide health care on the basis of “free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities.” The Committee on the Rights of Persons with Disabilities is new and has not yet offered any guidance on how to interpret the CRPD right to health provision.

UN bodies and international guidelines have noted that for informed consent to be

¹³⁶ CESCR General Comment No 14 *supra* note 82 at para 8.

¹³⁷ CEDAW General Recommendation No 24 *supra* note 118 at paras 20, 22 and 31.

¹³⁸ *Id* at para 22.

¹³⁹ *Id* at para 31(e). CEDAW General Recommendation No 24 *supra* note 118. Protection of the right to confidentiality is furthermore seen as a core component of creating acceptable health care services in terms of the ICESCR right to health. CESCR General Comment No 14 at para 12(b) and (c) acknowledges that accessibility to health information should not impair the right to have medical information treated confidentially and that all health facilities, goods and services must be designed to protect the right to confidentiality.

¹⁴⁰ CEDAW General Recommendation No 24 *supra* note 118 at para 20.

established, the patient must be provided with information on the nature and effect of the medical procedure and in a language and manner which she understands.¹⁴¹ In addition, they have noted that there can be no coercion, duress, or undue influence on the patient to consent.¹⁴²

With respect to sexual and reproductive self-determination, subjecting women to mandatory or coercive reproductive health interventions – including mandatory HIV testing and forced or coerced sterilisation and abortion – has been found in many cases to violate the right to health.

The CEDAW Committee specifically provides that “States Parties should not permit forms of coercion, such as non-consensual sterilisation, mandatory testing for sexually transmitted diseases or mandatory pregnancy testing as a condition of employment that violate women’s rights to informed consent and dignity”.¹⁴³ In addition, the CEDAW Committee’s General Recommendation No. 19 on Violence against Women also provides that “[c]ompulsory sterilisation or abortion adversely affects women’s physical and mental health, and infringes the right of women to decide on the number and spacing of their children,”¹⁴⁴ a right protected by article 16(1)(e) of CEDAW.

Case Example: Forced Sterilisation

In the case of *AS v Hungary*, the CEDAW Committee found that Hungary had violated both articles 12 and 16 of CEDAW relating to a woman’s right to appropriate healthcare services and her right to decide freely and responsibly on the number and spacing of her children, respectively, when AS was sterilised without being given adequate information to provide informed consent.¹⁴⁵ In the case, AS had been subjected to a sterilisation during a surgical intervention in connection with a miscarriage in a public hospital in Hungary. She had not received any information on the procedure in a manner which she could comprehend nor was she informed of the effects the procedure would have on her fertility. In finding a violation of article 12, the CEDAW Committee stressed that “[a]cceptable services are those that are delivered in a way that ensures that a woman gives her fully informed consent”.¹⁴⁶

Similarly, the UN Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health (UN Special Rapporteur on the Right to Health) has affirmed that the ICESCR’s section 12 includes the concept of

¹⁴¹ “Report to the General Assembly (Main Focus: Right to Health and Informed Consent) *Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health* UN Doc A/64/272 (2009) (Report of the Special Rapporteur on Health: Informed Consent) at paras 15 and 23 available at <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/N09/450/87/PDF/N0945087.pdf?OpenElement> (accessed 26 August 2013).

¹⁴² *Id* at paras 13 and 14.

¹⁴³ CEDAW General Recommendation No 24 *supra* note 118 at para 22.

¹⁴⁴ General Recommendation No 19 *supra* 115 at para 22.

¹⁴⁵ *AS v Hungary supra* note 119 at paras 11.3 and 11.4.

¹⁴⁶ *Id* at para 11.3.

informed consent to health services¹⁴⁷ and defines a rights-based approach to health services as one where counselling, testing and treatment for all diseases are part of a “voluntary health-care continuum”.¹⁴⁸ He has stressed that informed consent is not passive acceptance that a procedure is going to take place, but a “voluntary and sufficiently informed decision” that protects the patient’s right to be involved in decisions about his or her own health and body. The patient’s judgement is decisive.¹⁴⁹

The WHO explains that information must be communicated to the patient in a way appropriate to the latter’s capacity for understanding, minimising the use of unfamiliar technical terminology. It further notes that if the patient does not speak the common language, some form of interpretation should be available.¹⁵⁰

The UN Special Rapporteur on the Right to Health has furthermore emphasised that coercion includes “conditions of duress such as fatigue or stress” and that “undue influences include situations in which the patient perceives there may be an unpleasant consequence associated with refusal of consent.”¹⁵¹

Notably, he emphasised that certain populations, including women, are at increased risk of violations of their right to informed consent due to social, economic and cultural inequalities.¹⁵² The UN Special Rapporteur on the Right to Health notes that:

Gender inequalities reinforced by political, economic and social structures result in women being routinely coerced and denied information and autonomy in the health-care setting. Women’s SRHR demand special considerations; pregnant women are at times denied consent along an appropriate health-care continuum justified by the best interests of the unborn child. Social and legal norms limit women’s independent access to sexual and reproductive health services. Evidence reveals that women are often entirely excluded from decision-making in health care. Women are often coerced into “routine” HIV/AIDS testing in ante-natal care settings without links to counselling and treatment. Forced sterilization or contraception continues to affect women, injuring their physical and mental health and violating their right to reproductive self-determination, physical integrity and security. Women are often provided inadequate time and information to consent to sterilization procedures, or are never told or discover later that they have been sterilized. ..Stigma and discrimination against women from marginalized communities, including indigenous women, women with disabilities and women living with HIV/AIDS, have made women from these communities particularly vulnerable to such abuses.¹⁵³

¹⁴⁷ Report of the Special Rapporteur on Health: Informed Consent *supra* note 141 at para 18.

¹⁴⁸ *Id* at para 24.

¹⁴⁹ *Id* at para 9.

¹⁵⁰ “A Declaration on the Promotion of Patients’ Rights in Europe” WHO (1994), article 2.4 *available at* http://www.who.int/genomics/public/eu_declaration1994.pdf (accessed 26 August 2013).

¹⁵¹ Report of the Special Rapporteur on Health: Informed Consent *supra* note 141 at para 14.

¹⁵² *Id* at para 46.

¹⁵³ *Id* at paras 54 and 55.

In addition to the WHO, other international SRH instruments and professional bodies also note the need for voluntary and informed consent for all SRH procedures. The ICPD Programme of Action emphasises that “reproductive health care programmes should provide the widest range of services without any form of coercion”,¹⁵⁴ and ensure that all people have the information and access to services to exercise their right to decide if, when and how often to reproduce.¹⁵⁵

Professional bodies such as the International Federation of Gynaecology and Obstetrics (FIGO) have also issued guidelines confirming the right to control and decide on matters of one’s own sexuality and reproductive health. FIGO has specifically issued a guideline on sterilisation which highlights that coerced or forced sterilisation can be a violation of rights, including the right to health.¹⁵⁶

Informed Consent in a Nutshell

- A medical procedure may only be performed with the informed consent of the patient. Informed consent requires information, understanding as well as consent in order to satisfy the requirements of legality. This requires that a woman has information, understands the information and agrees to undergo the relevant SRH procedure.
- In order for a woman to give free and informed consent to reproductive health care services, she needs to have information about the purpose of the service as well as the material risks, benefits and alternative options, including non-treatment.
- The information must be provided in a manner that is easy to understand.
- Finally, consent is only present if it is provided freely, without undue influence, coercion, fraud, misrepresentation or mistake. At its simplest level, this requires that women not be forced to consent. It also means that the circumstances surrounding the provision of consent should also be those which do not exert pressure on the woman providing consent.

Non-Discrimination

The right to health set out in the ICESCR includes the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable standard of health, according to the CESCR.¹⁵⁷ The CESCR has described accessibility of health care as meaning that “[h]ealth facilities, goods and services have to be accessible to everyone without discrimination... especially the most vulnerable or marginalised sections of the population” and specifically mentions “persons with disabilities and persons with HIV/

¹⁵⁴ Principle 8 of the ICPD PoA *supra* note 65.

¹⁵⁵ *Id* at para 7.2.

¹⁵⁶ “New Guidelines on Sterilisation of Women” *The International Federation of Gynaecology and Obstetrics* (2011).

¹⁵⁷ CESCR General Comment No 14 *supra* note 82 at para 8.

AIDS.”¹⁵⁸ The CESCR furthermore views this as one of the minimum core obligations in relation to the right to health.¹⁵⁹

Likewise, both CEDAW and the CRPD recognise the importance of non-discrimination in access to health care; the CRPD emphasises that people with disabilities have the right to reproductive and family planning information and services on the same basis as other persons.¹⁶⁰ For a more detailed discussion of the right to non-discrimination, see section 3.4.

3.7 Right to Information

Access to information is closely linked to the attainment of other human rights. Without information regarding sexual and reproductive health and rights, women would be less likely to access services, even when they are available. In addition, without adequate, accurate information women will not be able to make informed decisions. The right to information is critical in ensuring that women have sexual and reproductive self-determination. For example, if they have not been provided the needed information prior to consenting women cannot be found to have provided voluntary, informed consent to health procedures.

The right to information can be found in a number of human rights treaties. Article 19(2) of the ICCPR states that “[e]veryone shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds.” Although there is no specific international jurisprudence on the interpretation of this right in the ICCPR, the right to information “of all kinds” implies that the right is broad enough to include reproductive health information. In addition, article 10 of CEDAW specifically provides:

States Parties shall take all appropriate measures to eliminate discrimination against women in order to ensure to them equal rights with men in the field of education and in particular to ensure, on a basis of equality of men and women:

...

(h) Access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning.¹⁶¹

The CEDAW Committee, highlighting their concern that many countries fail to provide access to sexual health information, emphasised that countries “should ensure, without prejudice or discrimination, the right to sexual health information, education and services

¹⁵⁸ *Id* at para 12 (b).

¹⁵⁹ *Id* at paras 43-44.

¹⁶⁰ **See**, for instance, articles 23 and 25.

¹⁶¹ Article 10(h) of the CEDAW.

for all women and girls”.¹⁶²

One of the core aspects of the right to health under article 12(1) of the ICESCR is the duty of governments to ensure the provision of health information, including methods of preventing and controlling particular illnesses.¹⁶³ According to the CESCR, the right to health includes “access to health-related education and information, including on sexual and reproductive health”.¹⁶⁴ Health-related information and education should include information on the availability of services and be available in local languages.¹⁶⁵ The CESCR has raised concern over the lack of sexual and reproductive health information noting that access to such information could reduce maternal mortality, abortion and adolescent pregnancy.¹⁶⁶

In the context of HIV, the CESCR has made calls for States to “ensure that all persons know about the disease and how to protect themselves”.¹⁶⁷ The CRPD obliges countries to take effective and appropriate measures to ensure “[t]he rights of persons with disabilities . . . to have access to age-appropriate information, reproductive and family planning education are recognised, and the means necessary to enable them to exercise these rights are provided . . .”¹⁶⁸

The CESCR has confirmed that health information cannot be withheld or intentionally misrepresented.¹⁶⁹ The UN Special Rapporteur on the Right to Health has affirmed this when he recommended that Poland adopt:

Mandatory, age-appropriate, comprehensive, science and evidence-based, non-discriminatory and gender-sensitive sexuality education taught by appropriately trained personnel, including non-judgemental information and education on healthy relationships and family life, sex and relationships, and comprehensive sexual and reproductive health.¹⁷⁰

¹⁶² CEDAW General Recommendation No 24 *supra* note 118 at para 18.

¹⁶³ CESCR General Comment No 14 *supra* note 82 at para 44(d).

¹⁶⁴ *Id* at para 11.

¹⁶⁵ *Id* at paras 36–37. **See also** “Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Mission to Uganda” Committee on Economic, Social and Cultural Rights 62nd Session UN Doc E/CN.4/2006/48/Add.2 (2006) (Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health) at paras 33 and 35.

¹⁶⁶ CRR Background Paper *supra* note 133, 7.

¹⁶⁷ Concluding Observations of the Committee on Economic Social and Cultural Rights: Russian Federation 31st Session UN doc E/C.12/1/Add.94 (2003) at para 62 *available at* [http://www.unhchr.ch/tbs/doc.nsf/\(Symbol\)/E.C.12.1.Add.94.En](http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/E.C.12.1.Add.94.En) (accessed 26 August 2013).

¹⁶⁸ Article 23(1) (b) of the CRPD.

¹⁶⁹ CESCR General Comment No 14 *supra* note 82 at para 34.

¹⁷⁰ “Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Anand Grover: Mission to Poland” Human Rights Council 14th Session U.N. Doc. A/HRC/14/20/Add.3 (2010) *available at* <http://www.refworld.org/docid/4c0770ee2.html> (accessed 26 August 2013).

Access to information can be a particular concern for women with disabilities when countries fail to put in place mechanisms to ensure that women with disabilities (such as blind women, women with hearing disabilities and women with mental disabilities) can access appropriate information in order to make use of sexual and reproductive health services. This failure to put in place mechanisms may be discriminatory.

Health information, whether preventive or curative, needs to be accurate and sufficiently detailed. Failure to provide enough information to enable women to make decisions in specific situations may also be a violation of SRHR. In the case of *AS v Hungary*, the CEDAW Committee in finding a violation of article 12 of CEDAW noted that seventeen minutes was not adequate time for hospital personnel to provide AS with the necessary counselling and information about sterilisation, including alternatives, risks and benefits, for her to make an informed decision.¹⁷¹

3.8 Rights to Liberty and Security of the Person

Various treaties provide for the rights to liberty and security of person.¹⁷² These rights include protection for all people from coercive medical interventions that take place without voluntary and informed consent and is relevant in cases of sexual and reproductive self-determination.

Article 9(1) of the ICCPR states that “[e]veryone has the right to liberty and security of person... No one shall be deprived of his liberty except on such grounds and in accordance with such procedure as are established by law.”

There is limited discussion by UN committees on the rights to liberty and security of the person in the context of SRHR. However, the UN Special Rapporteur on the Right to Health has stated that “[g]uaranteeing informed consent is a fundamental feature of respecting an individual’s autonomy, self-determination and human dignity in an appropriate continuum of voluntary health care services...”¹⁷³ The Special Rapporteur has also noted that informed consent invokes several elements of human rights that are indivisible, interdependent and interrelated and that in addition to the right to health, these include security and dignity of the human person.¹⁷⁴

Similarly, the UN Special Rapporteur on Violence against Women, its Causes and Consequences expressed concern that practices such as coerced or forced sterilisation and forced abortions may violate a woman’s right to physical integrity and security.¹⁷⁵

¹⁷¹ *AS v Hungary supra* note 119 at para 11.2.

¹⁷² **See** article 3 of the UDHR, article 9(1) of the ICCPR, and article 14 of the CRPD.

¹⁷³ Report of the Special Rapporteur on Health: Informed Consent *supra* note 141 at para 18.

¹⁷⁴ *Id.*

¹⁷⁵ “Report of the Special Rapporteur on Violence Against Women, its Causes and Consequences: Policies and Practices that Impact Women’s Reproductive Rights and Contribute to, Cause or Constitute Violence against Women, Radhika Coomaraswamy” Commission on Human Rights 55th Session UN doc E/CN.4/1999/68/Add.4 (1999) at paras 45 and 51 *available at* <http://www.unhchr.ch/Huridocda/Huridoca.nsf/0/4cad275a8b5509ed8025673800503f9d?Opendocument#IIB> (accessed 26 August 2013).

With respect to women with disabilities, the CRPD under article 17 provides “[e]very person with disabilities [has] a right to respect for his or her physical and mental integrity on an equal basis with others.”

The Committee on the Rights of Persons with Disabilities has noted its concern that forced or coerced medical treatment would violate the right to physical and mental integrity under article 17. In its concluding observations to Tunisia, the Committee on the Rights of Persons with Disabilities recommended that Tunisia “incorporate into the law the abolition of surgery and treatment without the full and informed consent of the patient” to ensure it was in line with the requirements under article 17.¹⁷⁶

Mandatory HIV testing of vulnerable women as a violation of the right to liberty and security of person finds support in international guidelines. The International Guidelines on HIV/AIDS and Human Rights note that “compulsory HIV testing can constitute a deprivation of liberty and a violation of the right to security of person” and that “respect for the right to physical integrity requires that testing be voluntary and that no testing be carried out without informed consent”.¹⁷⁷

3.9 Freedom from Cruel, Inhuman and Degrading Treatment

Several international human rights treaties protect the right not to be subjected to cruel, inhuman or degrading treatment or punishment (CIDT) or torture.¹⁷⁸ They include the ICCPR under article 7; the CAT under article 16(1); and the CRPD under article 15(1).

While there is no specific definition of what constitutes CIDT, it has been held to cover a broad range of acts. In its General Comment on article 7, the HRC has stated that the purpose of the article is to protect both dignity and the physical and mental integrity of the individual.¹⁷⁹ It further explains that “[t]he prohibition in article 7 relates not only to acts that cause physical pain but also acts that cause mental suffering to the victim...” and that the prohibition applies to patients in medical institutions.¹⁸⁰

This means that violations of women’s SRHR that cause harm, whether physical or mental, may also violate the right to protection from cruel, inhuman or degrading treatment or punishment.¹⁸¹

¹⁷⁶ Concluding Observations of the Committee on the Rights of Persons with Disabilities: Tunisia 5th Session U.N. Doc. CRPD/C/TUN/CO/1 (2011) at para 29 available at <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G11/427/92/PDF/G1142792.pdf?OpenElement> (accessed 26 August 2013).

¹⁷⁷ International Guidelines on HIV/AIDS and Human Rights *supra* note 67 at para 135.

¹⁷⁸ Article 7 of the ICCPR, article 16(1) of the CAT and article 15(1) of CRPD.

¹⁷⁹ Human Rights Committee: General Comment No 20 Article 7 (Prohibition of Torture, or Other Cruel, Inhuman or Degrading Treatment or Punishment) 44th Session UN Doc HRI/GEN/1/Rev.1 at 30 (1992) at paras 2 available at <http://www.refworld.org/docid/453883fb0.html> (accessed 26 August 2013).

¹⁸⁰ *Id* at para 5.

¹⁸¹ **See** “Protecting Rights: Litigating Cases of HIV Testing and Confidentiality of Status” *supra* note 24 for more information on mandatory HIV testing as a breach of the right to protection from cruel, inhuman or degrading treatment or punishment.

More specifically, the provision against cruel, inhuman or degrading treatment or punishment includes protection from *coercive health interventions* that are undertaken without an individual's consent. Forced sterilisation and abortion has been specifically held to violate the right to protection from cruel, inhuman or degrading treatment or punishment. For instance, General Comment 28 to the ICCPR articulates specifically that forced abortion and forced sterilisation is a concern that must be addressed by States in complying with the article 7 protection from CIDT.¹⁸² A recent report by the UN Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment re-emphasised that treatment without consent and denial of medical treatment may lead to a violation of the right to be protected from torture and cruel, inhuman, or degrading treatment.¹⁸³ The report notes that:

International and regional human rights bodies have begun to recognize that abuse and mistreatment of women seeking reproductive health services can cause tremendous and lasting physical and emotional suffering, inflicted on the basis of gender. Examples of such violations include abusive treatment and humiliation in institutional settings; involuntary sterilization; denial of legally available health services such as abortion and post-abortion care; forced abortions and sterilizations; female genital mutilation; violations of medical secrecy and confidentiality in health-care settings, such as denunciations of women by medical personnel when evidence of illegal abortion is found; and the practice of attempting to obtain confessions as a condition of potentially life-saving medical treatment after abortion.¹⁸⁴

Denial of abortion services (which also interferes with a woman's right to reproductive self-determination) has also been found to be a violation of the protection against CIDT.¹⁸⁵

¹⁸² HRC General Comment No 28 *supra* note 81 at para 11.

¹⁸³ "Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Juan E. Méndez" Human Rights Council 22nd Session UN Doc A/HRC/22/53 (2013) (Report of The Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Juan E. Méndez) at para 32 *available at* http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf (accessed 26 August 2013). **See also** the comments of a previous special rapporteur: "Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Manfred Nowak" Human Rights Council 7th Session UN Doc A/HRC/7/3 (2008) at para 38 *available at* <http://www.unhcr.org/refworld/docid/47c2c5452.html> (accessed 26 August 2013).

¹⁸⁴ Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Juan E. Méndez *supra* note 183 at para 46.

¹⁸⁵ *Id.*

Case Examples: Denial of Legally Available Health Services Such As Abortion and Post-Abortion Care

In the case of *Karen Noelia Llantoy Huamán v Peru*,¹⁸⁶ a minor who was carrying a foetus with a fatal anomaly was denied an abortion. The HRC found a violation of article 7 of the ICCPR, reasoning that the complainant suffered mental distress due to being denied a therapeutic abortion.¹⁸⁷

Similarly, in *LMR v Argentina*,¹⁸⁸ the HRC found that the State Party's omission, in failing to guarantee LMR's right to a termination of pregnancy, as provided under the law when her family so requested, "caused LMR physical and mental suffering constituting a violation of article 7 of the ICCPR that was made especially serious by the victim's status as a young girl with a disability".¹⁸⁹ LMR, a young woman with a mental disability, sought an abortion after suffering a rape. Under the domestic law, she was entitled to an abortion provided her disability was diagnosed and her legal representative gave consent.¹⁹⁰ However, she was unable to access a legal abortion as the original hospital where she sought treatment refused to assist her and then the judiciary issued an order against her getting an abortion.¹⁹¹ By the time the judicial decision was overturned, the hospital staff refused the abortion on the grounds that she was too late in her pregnancy.¹⁹²

The UN Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment notes that some women may experience multiple forms of discrimination on the basis of their sex and other status or identity and recognised that women from ethnic and racial minorities, women from marginalised communities and women with disabilities are particularly targeted for involuntary sterilisation "because of discriminatory notions that they are 'unfit' to bear children is an increasingly global problem."¹⁹³ Protection of minority and marginalised groups has thus been identified as a critical component of the right to be free from cruel, inhuman and degrading treatment.¹⁹⁴ In affirming this, the Committee against Torture further noted that women are particularly vulnerable when accessing SRH services.¹⁹⁵

¹⁸⁶ Communication No 1153/2003 UN Doc CCPR/C/85/D/1153/2003 (2005) available at <http://www1.umn.edu/humanrts/undocs/1153-2003.html> (accessed 26 August 2013).

¹⁸⁷ *Id* at para 6.3.

¹⁸⁸ Communication No 1608/2007 UN Doc CCPR/C/101/D/1608/2007 (2011) available at <http://www.esrnet.org/sites/default/files/Decision.pdf> (accessed 26 August 2013)

¹⁸⁹ *Id* at para 9.2.

¹⁹⁰ *Id* at para 2.3.

¹⁹¹ *Id* at paras 2.4- 2.5.

¹⁹² *Id* at para 2.7.

¹⁹³ Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Juan E. Méndez *supra* note 183 at para 48.

¹⁹⁴ Committee Against Torture: General Comment No 2 Implementation of Article 2 by States Parties UN Doc CAT/C/GC/2 (2008) at para 21 available at <http://www.refworld.org/docid/47ac78ce2.html> (accessed 26 August 2013).

¹⁹⁵ *Id* at para 22.

3.10 Right to Life

The right to life may be implicated in cases where access to SRH services are hindered resulting in a loss of life due either to the denial of services as a result of discrimination. Article 6(1) of the ICCPR and article 10 of CRPD guarantee the right to life.

The HRC has noted that the right to life must be viewed broadly and as such, requires that countries take positive steps to protect the right to life.¹⁹⁶

The UN committees have yet to address cases of sexual and reproductive self-determination that violate the right to life, but they have addressed cases where lack of services due to discrimination has resulted in violations of the right to life. The HRC has found that restrictive abortion laws, lack of access to reproductive health services, including emergency obstetric services and high rates of maternal mortality may violate the right to life.¹⁹⁷

Similarly, the CEDAW Committee has noted that inadequate sexual and reproductive health services violate the right to life. For example, the CEDAW Committee has found that unsafe abortions violate a woman's right to life as they lead to a high likelihood of maternal mortality.¹⁹⁸ In *Pimentel v Brazil* the CEDAW Committee noted that "the lack of appropriate maternal health services has a differential impact on the right to life of women".¹⁹⁹ The HRC also found a violation of the right to life in *Karen Noelia Llanto Huamán v Peru*, a case involving the denial of a legally available termination of pregnancy noting that "the authorities were aware of the risk to the author's life, since a gynaecologist and obstetrician in the same hospital had advised her to terminate the pregnancy, with the operation to be carried out in the same hospital. The subsequent refusal of the competent medical authorities to provide the service may have endangered the author's life."²⁰⁰

¹⁹⁶ Human Rights Committee: General Comment No 6 Article 6 (Right to Life) 66th Session UN Doc HRI/GEN/1/Rev.1 at 6 (1982) at para 5 *available at* <http://www.refworld.org/docid/45388400a.html> (accessed 26 August 2013).

¹⁹⁷ Concluding Observations of the Human Rights Committee: El Salvador 78th Session U.N. Doc. CCPR/CO/78/SLV (2003) at para 14 *available at* <http://www.unhcr.ch/tbs/doc.nsf/0/3557ff1fd8be8377c1256db200552abe?OpenDocument> (accessed 26 August 2013) **and** Concluding Observations of the Human Rights Committee: Kenya 83rd Session U.N. Doc. CCPR/CO/83/KEN (2005) at para 14 *available at* <http://www.unhcr.org/refworld/country,,HRC,,KEN,456d621e2,42d16c4d4,0.htmlt> (accessed 26 August 2013) **and** Concluding Observations of the Human Rights Committee: Mali 77th Session U.N. Doc. CCPR/CO/77/MLI (2003) at para 14 *available at* <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G03/413/09/PDF/G0341309.pdf?OpenElement> (accessed 26 August 2013).

¹⁹⁸ Concluding Observations of the Committee on the Elimination of Discrimination against Women: Colombia 20th Session U.N. Doc. A/54/38 (1999) at para 393 *available at* <http://www.unhcr.ch/tbs/doc.nsf/0/0a318a243ffa4eff8025673200507f7a?OpenDocument> (accessed 26 August 2013).

¹⁹⁹ *Pimentel v Brazil supra* note 116 at para 7.6.

²⁰⁰ *Karen Noelia Llanto Huamán v Peru supra* note 186 at para 6.2.

3.1.1 Right to Privacy

Article 17(1) of the ICCPR and article 22(1) of CRPD protect the right to privacy. The right to privacy encompasses both respect for physical privacy and privacy of an individual's medical information. Cases involving a woman's sexual and reproductive self-determination may implicate the right to privacy.

The HRC has stated that the right to privacy includes instances where women are denied the opportunity to make their own decisions about health, and need the consent of a third party like a parent or spouse for procedures such as sterilisation and “where general requirements are imposed for the sterilisation of women, such as having a certain number of children or being of a certain age or where States impose a legal duty upon doctors and other health personnel to report cases of women who have undergone abortion.”²⁰¹

In *Karen Noelia Llantoy Huamán v Peru*, the HRC found that the refusal to act in accordance with the complainant's decision to terminate her pregnancy was not justified and amounted to a violation of article 17 of the ICCPR.²⁰² Similarly, in *LMR v Argentina*, the HRC found that unnecessary judicial intervention in a request for an abortion was a violation of the petitioner's right to privacy.²⁰³ The HRC found that LMR's right to privacy under the ICCPR was violated due to the interference of the judiciary in what should be a matter between the patient and her physician.²⁰⁴

In relation to protection of an individual's medical information, protection of the right to confidentiality is furthermore seen as a core component of creating acceptable health care services in terms of the ICESCR right to health. The CESCR in paragraph 12(b) of its General Comment No. 14 acknowledges that accessibility to health information should not impair the right to have medical information treated confidentially and that all health facilities, goods and services must be designed to protect the right to confidentiality. This right has been violated in many cases related to abortions where information on a woman's health status has been made available to third parties resulting in undue pressure on the woman not to terminate a pregnancy.²⁰⁵

²⁰¹ HRC General Comment No 28 *supra* note 81 at para 20.

²⁰² *Karen Noelia Llantoy Huamán v Peru supra* note 186 at para 6.4.

²⁰³ *LMR v Argentina supra* note 188 at para 9.3.

²⁰⁴ *Id.*

²⁰⁵ **See** for example *Id* at para 2.9.

3.12 Conclusion

Numerous fundamental rights are implicated when women are denied the opportunity to decide freely on matters relating to their SRH, such as the rights to non-discrimination and equality, health, information, liberty and security of the person, freedom from cruel, inhumane and degrading treatment, privacy and life.

Though international bodies have not fully interrogated and applied all of these rights in cases of violations of reproductive self-determination, international law can still be useful in identifying the scope and nature of these fundamental rights.

CHAPTER
4

Relevant regional law

4.1 Introduction

This chapter focuses on those rights which are specifically provided for in African regional treaties and other documents. It also discusses how regional law can be used to support litigation relating to violations of sexual and reproductive self-determination and discrimination against particular groups of women in accessing SRH care services. The chapter explains how specific rights recognised in regional law will apply to certain factual scenarios and which actions can be argued to violate these rights. In this way, it aims to support the use of regional law principles in domestic SRHR- related litigation.

This chapter will also discuss relevant jurisprudence from other regional bodies, including the ECHR and the IACHR, which can assist domestic courts in determining the scope and nature of constitutional rights.

For a discussion of why domestic courts should look to regional law, please refer to Chapter 2.

Checklist

- ▶ Which regional human rights are violated in your particular case?
- ▶ Which regional treaties provide for the particular rights you have identified? *[See page 15-17 for case examples of specific rights violations]*
- ▶ Has your country ratified the particular treaty?
- ▶ Did the events in your case take place after the ratification date of the treaty?
- ▶ Has your country made any reservations to the treaty that may be applicable to the facts of your case?
- ▶ Has the African Commission on Human and Peoples' Rights, African Court on Human and Peoples' Rights, or Southern African Development Community (SADC) issued any relevant decisions on these rights? *[See Chapter 7 for a list of relevant online resources]*
- ▶ Are there any relevant resolutions, statements or guidelines issued by the African Commission on Human and Peoples' Rights or SADC institutions?

Relevant documents discussed in this chapter

- African Charter on Human and Peoples' Rights
- African Union Declaration and Continental Plan of Action on African Decade of the Disabled Persons 1999-2009 extended to December 2019
- Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa
- SADC Protocol on Gender and Development
- SADC Protocol on Health

Relevant cases discussed in this chapter

- Chávez v Peru
- Doebbler v Sudan
- Good v Botswana
- Huri-Laws v Nigeria
- IG and Others v Slovakia
- IV v Bolivia
- Jacinto v Mexico
- Legal Resources Foundation v Zambia
- NB v Slovakia
- Open Door and Dublin Well Woman v Ireland
- P and S v Poland
- Purohit and Moore v The Gambia
- RR v Poland
- Social and Economic Rights Action Center (SERAC) and Center for Economic and Social Rights (CESR) v Nigeria
- Sudan Human Rights Organisation and Centre on Housing Rights and Evictions (COHRE) v Sudan
- Tysiac v Poland
- VC v Slovakia
- Zimbabwe Lawyers for Human Rights (ZLHR) & Associated Newspapers of Zimbabwe (ANZ) v Zimbabwe

The chapter is divided into the following sections:

- Overview of relevant regional law;
- Right to freedom from discrimination;
- Right to equality;
- Right to health;
- Right to information;
- Rights to liberty and security of the person;
- Freedom from cruel, inhuman and degrading treatment and the right to dignity; and
- Right to life.

4.2 Overview of Relevant Regional Law

Lawyers litigating cases involving violations of SRHR in southern Africa can use a number of regional treaties promulgated by the African Union (AU) to support their arguments, including:

- The African Charter on Human and Peoples' Rights (African Charter);²⁰⁶ and
- The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Protocol on Women).²⁰⁷

The process of ratification for these regional human rights instruments is similar to that of the international instruments, described in Chapter 3.

The African Commission is responsible for protecting and promoting human rights and monitoring country compliance with the African Charter and the Protocol on Women.

The African Commission has a number of special experts and committees that oversee and monitor country compliance of specific human rights issues. The most relevant to the issues covered in this manual are the Special Rapporteur on the Rights of Women in Africa, the Special Rapporteur on Refugees, Asylum Seekers, Migrants and Internally Displaced Persons in Africa, and the Committee on the Protection of the Rights of People Living with HIV and Those at Risk, Vulnerable to and Affected by HIV. These special experts and committees sometimes expand on the context of rights through mission reports and other documents.

The African Charter provides that the African Commission shall:

[D]raw inspiration from international law on human and peoples' rights, particularly from the provision of various African instruments on human and peoples' rights, the Charter of the United Nations, the Charter of the Organization of African Unity, the Universal Declaration of Human Rights, other instruments adopted by the United Nations and by African countries...

²⁰⁶ Available at http://www.achpr.org/files/instruments/achpr/banjul_charter.pdf (accessed 26 August 2013).

²⁰⁷ Available at <http://www.au.int/en/sites/default/files/Protocol%20on%20the%20Rights%20of%20Women.pdf> (accessed 26 August 2013).

as well as from the provisions of various instruments adopted within the Specialized Agencies of the United Nations...²⁰⁸

It furthermore notes that as subsidiary principles of law, the African Commission shall:

[T]ake into consideration... other general or special international conventions... expressly recognised by member states of the Organization of African Unity, African practices consistent with international norms on human and peoples' rights, customs generally accepted as law, general principles of law... as well as legal precedents and doctrine.²⁰⁹

The African Court on Human and Peoples' Rights (African Court) was set up to complement the work of the African Commission. It has jurisdiction over all disputes concerning the application and interpretation of the African Charter and its protocols as well as other human rights instruments ratified by African States.²¹⁰

Recommendations, reports and decisions of the African Commission and the African Court as well as recommendations reports and other documents of Special Rapporteurs and Committees assist in determining the nature and scope of regional and national legal obligations.

In addition, resolutions, protocols and declarations issued by regional and sub-regional bodies, including the African Union and the Southern African Development Community (SADC) can provide guidance to domestic courts in southern Africa on the nature and scope of rights enshrined in national constitutions and legislation.

Relevant sub-regional resolutions, protocols and declarations include:

- Treaty of SADC;²¹¹
- SADC Protocol on Health;²¹² and
- SADC Protocol on Gender and Development (SADC Protocol on Gender);²¹³

The African Union Declaration and Continental Plan of Action on the African Decade of the Disabled Persons is also important in relation to the rights of people living with disabilities.²¹⁴

²⁰⁸ African Charter *supra* note 206, article 60.

²⁰⁹ *Id.*, article 61.

²¹⁰ Protocol to the African Charter on Human and Peoples' Rights on the Establishment of an African Court on Human and Peoples' Rights June 9 1998 OAU Doc. OAU/LEG/EXP/AFCHPR/PROT (III), article 3 available at <http://www.african-court.org/en/images/documents/Court/Court%20Establishment/africancourt-humanrights.pdf> (accessed 26 August 2013).

²¹¹ (1992) available at http://www.sadc.int/files/9113/5292/9434/SADC_Treaty.pdf (accessed 29 August 2013).

²¹² (1999) available at http://www.sadc.int/documents-publications/show/Protocol_on_Health1999.pdf (accessed 26 August 2013).

²¹³ (2008) available at http://www.sadc.int/files/8713/5292/8364/Protocol_on_Gender_and_Development_2008.pdf (accessed 26 August 2013).

²¹⁴ Available at <http://www.africa-union.org/child/Decade%20Plan%20of%20Action%20-Final.pdf> (accessed 26 August 2013).

Table: Dates of ratification/accession to regional instruments

Country	African Charter	Protocol on Women	Treaty of SADC	SADC Protocol on Health	SADC Protocol on Gender
Angola	2/3/1990	30/9/2007	20/8/1993	-	2010
Botswana	17/7/1986	-	7/1/1998	9/2/2000	-
Dem. Rep. of Congo	20/7/1987	9/6/2008	28/2/2009	-	-
Lesotho	10/2/1992	26/10/2004	26/8/1993	31/7/2001	2010
Malawi	17/11/1989	20/5/2005	12/8/1993	7/11/2000	-
Mozambique	22/2/1989	9/12/2005	30/8/1993	13/11/2000	2010
Namibia	30/7/1992	11/8/2004	14/12/1992	10/7/2000	2009
Swaziland	15/9/1995	Signed 7/12/2004	16/4/1993	-	2012
Zambia	10/1/1984	2/5/2006	16/4/1993	-	2012
Zimbabwe	30/5/1986	15/4/2008	17/11/1992	13/5/2004	2009

African regional human rights mechanisms have yet to specifically examine SRHR related issues but other regional mechanisms such as the IACHR, the European Commission on Human Rights and the ECHR have considered some SRHR issues such as the coerced or forced sterilisation of women and denial of access to services such as abortion. Although the decisions of comparative regional systems are not binding on domestic courts in southern Africa they can be of persuasive value especially where they involve similarly situated countries. The African Commission has cited the ECHR and the European Commission on Human Rights in the decisions of at least three cases brought before it, although none of these African Commission cases specifically dealt with SRHR issues.²¹⁵

4.3 Right to Freedom from Discrimination

The right to freedom from discrimination is central in protecting women's SRH. Sexual and reproductive health laws and practices that deny rights to certain populations, such as pregnant women, WLHIV or women with disabilities may violate the right to non-discrimination. For instance, laws or practices that deny or provide conditional access to SRH services, such as pre-natal care or abortion services, for pregnant women, WLHIV

²¹⁵ *Civil Liberties Organisation Legal Defence Centre, Legal Defence and Assistance Project v. Nigeria* African Commission Communication No. 218/98 (1998) at paras 27, 37 and 41 available at <http://www1.umn.edu/humanrts/africa/comcases/218-98.html> (accessed 26 August 2013); *Social and Economic Rights Action Centre (SERAC) and Centre for Economic and Social Rights (CESR) v Nigeria* African Commission Communication No. 155/96 (2001) at para 57 available at http://www.chr.up.ac.za/chr_old/indigenous/documents/Nigeria/Cases/SERAC1.pdf (accessed 26 August 2013) and *Doebbler v Sudan* African Commission Communication No. 236/2000 (2003) at para 38 available at <http://www1.umn.edu/humanrts/africa/comcases/236-2000.html> (accessed 26 August 2013).

or women with disabilities may amount to discrimination. Similarly, medical procedures, such as forced abortion or sterilisation of WLHIV or women with disabilities may violate the right to non-discrimination.

The African Charter protects the right to be free from discrimination on various grounds under article 2. The right to non-discrimination is often discussed in conjunction with the right to equality in article 3. Article 2 of the African Charter protects every person from discriminatory treatment in the enjoyment of their various rights set out in the African Charter. It states:

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 *other status*.²¹⁶

The African Commission has emphasised the importance of the principle of non-discrimination, describing it as “a fundamental principle in international human rights law.”²¹⁷ The African Commission has also noted that “all international and regional human rights instruments and almost all countries’ constitutions contain provisions prohibiting discrimination. The principle of non-discrimination guarantees that those in the same circumstances are dealt with equally *in law and practice*.”²¹⁸

The African Commission has also linked the right to non-discrimination to the enjoyment of all other rights. In *LRF v Zambia*, the African Commission considered the African Charter’s article 2 protection against discrimination. It found that the Zambian constitutional provisions that rendered persons not of Zambian descent ineligible for presidential office violated article 2 of the African Charter.²¹⁹ It explained as follows:

Article 2 of the Charter abjures (sic) discrimination on the basis of any of the grounds set out, among them ‘language...national or social origin...birth or other status...’. The right to equality is very important. It means that citizens should expect to be treated fairly and justly within the legal system and be assured of equal treatment before the law and equal enjoyment of the rights available to all other citizens. The right to equality is important for a second reason. Equality or the lack of it affects the capacity of one to enjoy many other rights.²²⁰

Discrimination against WLHIV and women with disabilities

Women’s right to non-discrimination is specifically protected in regional law. Article 18(3) of the African Charter specifically protects women from discrimination and furthermore links the protection to that contained in international law. It states that countries “shall ensure the elimination of every discrimination against women and also

²¹⁶ African Charter *supra* note 206, article 2 (emphasis added).

²¹⁷ *Good v Republic of Botswana* African Commission Communication No. 313/05 (2010) at para 218 available at <http://www.interights.org/userfiles/Documents/Decisiononthemerits31305KennethGoodvRepublicofBotswana.pdf> (accessed 26 August 2013).

²¹⁸ *Id* (emphasis added).

²¹⁹ *LRF v Zambia supra* note 38 at para 71.

²²⁰ *Id* at para 63 (omissions in original) (first [sic] in original).

ensure the protection of the rights of [women and children] as stipulated in international declarations and conventions.”²²¹

Article 2 of the Protocol on Women states that “[s]tate parties shall combat all forms of discrimination against women through appropriate legislative, institutional and other measures.” It also states that legislative or regulatory measures shall include “prohibiting and curbing all forms of discrimination particularly those harmful practices which endanger the health and general well-being of women.”²²²

Discrimination against women is defined in article 1 of the Protocol on Women as:

[A]ny distinction, exclusion or restriction or any differential treatment based on sex and whose objectives or effects compromise or destroy the recognition, enjoyment or the exercise by women, regardless of their marital status, of human rights and fundamental freedoms in all spheres of life.²²³

The SADC Protocol on Gender reinforces article 6(2) of the Treaty of SADC, which emphasises the obligation to prohibit discrimination on the basis of gender and links this to access to health rights; it obliges States to take various measures, including changing national laws that discriminate against women, recognising, protecting and promoting the SRHR of women and girls and ensuring women’s access to health services. The SADC Protocol on Gender also specifically recognises the importance of addressing both HIV and disability issues in strengthening gender equality.²²⁴

Women with disabilities are specifically guaranteed protection from discrimination in various regional human rights documents. Article 18(4) of the African Charter specifically provides people with disabilities with the right to special measures of protection in keeping with their “physical or moral needs”. Article 23 of the Protocol on Women provides special protection for women with disabilities from discrimination based on disability and emphasises their right to be treated with dignity. Similarly, objective 1 of the AU Declaration and Continental Plan of Action on the African Decade of the Disabled Persons which was extended to 2019 requires States to formulate and implement national laws, policies and programmes to promote the full and equal participation of persons with disabilities.²²⁵

The African Commission has not directly addressed whether discrimination on the basis of HIV status is covered under article 2. However, the Protocol on Women is the only international human rights treaty to make specific mention of HIV, noting that women have the right to self-protection and to be protected from HIV and AIDS.²²⁶ Similarly, the African Commission in interpreting the breadth of articles 14(1)(d) and 14(1)(e)

²²¹ African Charter *supra* note 206, article 18(3).

²²² Protocol on Women *supra* note 207, article 2(b).

²²³ *Id.*, article 1.

²²⁴ SADC Protocol on Gender *supra* note 213, articles 9 and 27.

²²⁵ The African Union Declaration and Continental Plan of Action on the African Decade of the Disabled Persons *supra* note 214.

²²⁶ Protocol on Women *supra* note 207, articles 14 (1)(d).

of the Protocol on Women, providing for the right to self-protection against sexually transmitted infections and knowing one's health status, noted that discrimination on the basis of HIV status, among others, limits a woman's ability to access her rights under the Protocol on Women, namely the right to SRHR and self-protection from sexually transmitted diseases.²²⁷

Additionally, in 2001, the African Commission called upon African governments to protect the rights of people living with HIV in its 2001 Resolution on the HIV/AIDS Pandemic²²⁸ and has also recently passed a resolution creating a Committee on the Protection of the Rights of People Living with HIV and Those at Risk, Vulnerable to and Affected by HIV to look specifically at the rights of people living with and affected by HIV, including discrimination.²²⁹

In addition, numerous sub-regional resolutions and declarations acknowledge the importance of non-discrimination against people living with HIV.²³⁰

While there is limited jurisprudence from the African Commission on discrimination in relation to sex, disability or "other status", such as HIV and AIDS, what is clear from the regional instruments and related documents is that the African Commission considers the rights of women, PLHIV and people with disabilities a human rights concern.

Acts that violate the right to non-discrimination

Where the African Commission is called upon to determine whether discrimination in law and practice on the basis of sex, disability or "other status", such as HIV and AIDS, is permissible or impermissible, it will look at:

- Whether equal cases are treated in a different manner;
- Whether a difference in treatment has an objective and reasonable justification; and
- Whether there is proportionality between the aim sought and the means employed.²³¹

²²⁷ General Comment on Article 14 (1)(d) and (e) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Comment on Article 14 (1)(d) and (e) of the Protocol on Women) at paras 4-5 available at <http://www.achpr.org/news/2012/11/d65/> (accessed 26 August 2013).

²²⁸ African Commission on Human and Peoples' Rights, Resolution on HIV/AIDS Pandemic – Threat against Human Rights and Humanity, AGH/229 (XXXVII) May 2001 available at <http://www.achpr.org/sessions/29th/resolutions/53/> (accessed 26 August 2013).

²²⁹ African Commission on Human and Peoples' Rights, Resolution on the Establishment of a Committee on the Protection of the Rights of People Living with HIV (PLHIV) and Those at Risk, Vulnerable to and Affected by HIV, Res 163 (XLVII) May 2001 available at <http://www.achpr.org/sessions/48th/resolutions/172/> (accessed 26 August 2013).

²³⁰ **See**, for instance SADC Code on HIV/AIDS and Employment in SADC, articles 2 and 3(1); Maseru Declaration on the Fight against HIV/AIDS in the SADC region, 3; SADC HIV AND AIDS Strategic Framework and Programme of Action 2003 – 2007, 8; SADC HIV/AIDS Business Plan: Strategic 5-year Business Plan 2005-2009 (2004), 4; SADC Health Sector Policy Framework Document 2000; and the SADC Declaration on HIV and AIDS (2003).

²³¹ *Good v Republic of Botswana supra* note 217 at para 219.

In *Purohit and Moore v The Gambia*,²³² the African Commission considered the equality and health rights of people with disabilities. It held that the legislative regime in the Gambia for mental health patients violated both articles 16 and 18(4) of the African Charter. In so doing, the African Commission explained:

Enjoyment of the human right to health as it is widely known is vital to all aspects of a person's life and well-being, and is crucial to the realisation of all the other fundamental human rights and freedoms. This right includes the right to health facilities, access to goods and services to be guaranteed to all without discrimination of any kind.²³³

The African Commission also read into article 16 “the obligation on the part of States Party to the African Charter to take concrete and targeted steps, while taking full advantage of its available resources, to ensure that the right to health is fully realised in all its aspects without discrimination of any kind.”²³⁴

Comparative Regional Law: Forced Sterilisation

In the IACHR case of *Chávez v Peru*,²³⁵ a case resolved by friendly settlement, the Peruvian State acknowledged that the forced sterilisation of a woman violated, amongst others, the right to non-discrimination protected in article 1(1) of the American Convention on Human Rights.

The case of *IV v Bolivia*,²³⁶ pending before the IACHR, alleges gender-based discrimination where the petitioner was submitted to a sterilisation procedure allegedly without her informed consent. The case was found admissible in July 2008 and a decision is pending.

The case of *FS v Chile*,²³⁷ also pending before the IACHR raises issues of discrimination on the basis of HIV. The petition alleges that the forced sterilisation of an HIV-positive woman is a violation of articles 1 and 24 of the American Convention on Human Rights, which require States Parties to combat discriminatory practices and to establish norms and other measures that recognise and ensure the effective equality before the law of each individual irrespective of sex or HIV status. The petition highlights that forced sterilisation disproportionately affects women and

²³² African Commission Communication No. 241/2001 (2003) available at <http://www1.chr.up.ac.za/index.php/browse-by-subject/304-the-gambia-purohit-and-another-v-the-gambia-2003-ahrlr-96-achpr-2003.pdf> (accessed 26 August 2013).

²³³ *Id* at para 80.

²³⁴ *Id* at para 84.

²³⁵ IACHR Report No 71/03(2003) available at <http://www1.umn.edu/humanrts/cases/71-03.html> (accessed 26 August 2013).

²³⁶ IACHR (Admissibility decision) (2008) at para 28 available at <http://www1.umn.edu/humanrts/cases/40-08.html> (accessed 26 August 2013).

²³⁷ Litigation brief of the *FS v Chile* case available at <http://reproductiverights.org/en/lbs-fs-vs-chile> (accessed 26 August 2013).

that HIV-positive women experience heightened vulnerability to forced sterilisation and other forms of discrimination in the healthcare setting, despite the fact that health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalised sections of the population.²³⁸

The ECHR has considered forced sterilisation as a violation of the right to non-discrimination in the cases of *VC v Slovakia*,²³⁹ *NB v Slovakia*²⁴⁰ and *IG and Others v Slovakia*.²⁴¹ The three cases involved the forced sterilisation of women of minority ethnic groups. However, in each of the cases the Court did not find it necessary to separately determine whether there had been a violation of the non-discrimination clause.²⁴² This finding was despite the Court acknowledging that the evidence before it indicated that the practice of sterilisation of women without their prior informed consent affected vulnerable individuals from various ethnic groups.²⁴³ The Court however, indicated that notwithstanding the fact that sterilisations without informed consent call for serious criticism, the objective evidence was not sufficiently strong in itself to convince the Court that it was part of an organised policy or that the hospital staff's conduct was intentionally racially motivated and thus discriminatory.²⁴⁴

In *VC v Slovakia*, one judge dissented noting that the failure to find a violation of the right to non-discrimination reduced the case to the individual level. The judge noted that the fact that there are other cases of this kind pending before the Court reinforced his conviction that the sterilisations performed on Roma women were not of an accidental nature, but relics of a long-standing attitude towards the Roma minority in Slovakia. Concluding that there was discrimination, the judge noted that the applicant was “marked out” and further observed that there were no medically relevant reasons for sterilising the complainant.²⁴⁵

The applicants in the sterilisation cases before the ECHR alleged not just discrimination on the basis of race but also on the basis of their sex. In the case of *IG and Others v Slovakia*, the applicants alleged that they had “suffered discrimination on the ground of their sex due to the failure by health services to accommodate the fundamental biological differences between men and women in reproduction”.²⁴⁶

²³⁸ *Id.*

²³⁹ ECHR Application no. 18968/07 (2011) available at <http://www.refworld.org/pdfid/4a648cb42.pdf> (accessed 26 August 2013).

²⁴⁰ ECHR Application no. 29518/10 (2012) available at <http://www.bailii.org/cgi-bin/markup.cgi?doc=/eu/cases/ECHR/2012/991.html> (accessed 29 August 2013).

²⁴¹ ECHR Application no. 15966/04 (2012) available at <http://www.refworld.org/docid/50a289e22.html> (accessed 26 August 2013).

²⁴² **See** *VC v Slovakia supra* note 239 at para 176, *NB v Slovakia supra* note 240 at para 120 and *IG and Others v Slovakia supra* note 241 at para 164.

²⁴³ *VC v Slovakia supra* note 239 at paras 177, *NB v Slovakia supra* note 240 at para 121 and *IG and Others v Slovakia supra* note 241 at para 165.

²⁴⁴ *Id.*

²⁴⁵ *VC v Slovakia supra* note 239 dissenting opinion of Judge Mijovic.

²⁴⁶ *IG and Others v Slovakia supra* note 241 at para 160.

The applicants argued that “their sterilisation, performed without their full and informed consent, was a form of violence against women”.²⁴⁷ They also alleged that “their ensuing infertility resulted in a psychological and social burden which was much heavier on women, in particular in the Roma community where a woman’s status was often determined by her fertility”.²⁴⁸ The Government of Slovakia maintained that the applicants had not been treated differently from other patients in a similar position.²⁴⁹ As discussed above the ECHR did not find it necessary to separately determine whether there had been a violation of the non-discrimination clause whether on the basis of sex or race.

Laws, policies and practices that deny women reproductive self-determination, such as coerced sterilisation or abortion, may be challenged as a violation of the right to non-discrimination given the broad protection against the discrimination of women. In addition, laws, policies and practices that deny SRHR to certain populations, such as practices that target women with disabilities for coerced sterilisation or abortions or practices that force pregnant women to test for HIV as a prerequisite for accessing health care services, may be challenged in a court of law on the grounds that they violate the right to non-discrimination.

4.4 Right to Equality

The African Charter under article 3 provides for the right to equal protection before the law. Article 3 states that “[e]very individual shall be equal before the law” and “entitled to equal protection of the law”. This provision is similar to article 26 under the ICCPR discussed in section 3.5.

The African Commission has held that article 3 “guarantees fair and just treatment of individuals within the legal system of a given country.”²⁵⁰

Women, including women with disabilities are specifically guaranteed protection under article 3. The African Commission has clarified that “[t]he aim of [article 3] is to ensure equality of treatment for individuals irrespective of nationality, sex, racial or ethnic origin, political opinion, religion or belief, disability, age or sexual orientation.”²⁵¹

In the Inter-American system, the IACHR has found that forced sterilisation of women violates the right to equal protection. In *Chávez v Peru*, the IACHR found that the forced sterilisation of a woman violated, amongst others, the right to equal protection of the law protected in article 24 of the American Convention on Human Rights.²⁵²

²⁴⁷ *Id.*

²⁴⁸ *Id.* at para 160.

²⁴⁹ *Id.* at para 162.

²⁵⁰ *Zimbabwe Lawyers for Human Rights (ZLHR) & Associated Newspapers of Zimbabwe (ANZ) v Zimbabwe* African Commission Communication 284/03 at para 155 available at http://www.achpr.org/files/sessions/6th-eo/communications/284.03/achpreo6_284_03_eng.pdf (accessed 26 August 2013).

²⁵¹ *Id.*

²⁵² *Chávez v Peru supra* note 235.

The African Commission has not specifically addressed whether article 3 protects against disparate treatment on the basis of HIV status. However, it is likely, given the African Commission’s indication of its concern regarding disparate treatment of people living with HIV.

To establish a claim under article 3 of the African Charter, a lawyer must show that the client was not treated the same as others in a similar situation or that another in the same situation was given more favourable treatment, in the enjoyment of a fundamental right set out in the African Charter.²⁵³

Like the right to non-discrimination, laws, policies and practices that deny women the right to sexual and reproductive self-determination, such as coerced or forced sterilisation or abortion as well as those which lead to direct or indirect differential treatment in accessing health care services may violate the right to equality.

4.5 Right to Health, Including Right to Sexual and Reproductive Health

The right to health is viewed as an important right in regional human rights law and is often linked to the enjoyment of other rights.

Article 16 of the African Charter provides every person the right “to enjoy the best attainable state of physical and mental health.” As early as 1996, in *Social and Economic Rights Action Center (SERAC) and Center for Economic and Social Rights (CESR) v Nigeria*,²⁵⁴ the African Commission emphasised the importance of the right to health. The African Commission held that it would make all efforts to apply and enforce socio-economic rights, such as the right to health, in order to meet the needs of people in Africa:

The uniqueness of the African situation and the special qualities of the African Charter imposes upon the African Commission an important task. International law and human rights must be responsive to African circumstances. Clearly, collective rights, environmental rights, and economic and social rights are essential elements of human rights in Africa. The African Commission will apply any of the diverse rights contained in the African Charter. It welcomes this opportunity to make clear that there is no right in the African Charter that cannot be made effective.²⁵⁵

In *Purohit and Moore v The Gambia*, the African Commission stated that “[e]njoyment of the human right to health as it is widely known is vital to all aspects of a person’s life and well-being, and is crucial to the realisation of all the other fundamental human rights and freedoms.”²⁵⁶

²⁵³ *ZLHR & ANZ v Zimbabwe supra* note 250 at para 158.

²⁵⁴ *SERAC and CESR v Nigeria supra* note 215.

²⁵⁵ *Id* at para 68.

²⁵⁶ *Purohit and Moore v The Gambia supra* note 232 at para 80.

Right to health includes sexual and reproductive health

The right to health includes the right to SRH and the nature and extent of this right is clearly articulated in article 14 of the Protocol on Women. It provides that States “shall ensure that the right to health of women, including sexual and reproductive health is respected and promoted.”²⁵⁷ The African Commission’s General Comment on article 14(1)(d) and (e) recognises “that women in Africa have the right to the highest attainable standard of health which includes sexual and reproductive health and rights.”²⁵⁸

Under the Protocol on Women, the right to sexual and reproductive health is linked to a range of rights and contains both freedoms and entitlements for women, including:

- The right to control their fertility;²⁵⁹
- The right to decide whether to have children, the number of children and the spacing of children;²⁶⁰
- The right to choose any method of contraception;²⁶¹
- The right to self-protection and to be protected against sexually transmitted infections, including HIV/AIDS;²⁶²
- The right to be informed on one’s health status and on the health status of one’s partner;²⁶³
- The right to have family planning education;²⁶⁴ and
- The right to have access to a range of adequate, affordable and accessible reproductive health care information and services.²⁶⁵

The right to self-protection against HIV and AIDS has furthermore been recognised as linked with other women’s rights “including the right to equality and non-discrimination, life, dignity, health, self-determination, privacy and the right to be free from all forms of violence.”²⁶⁶

Notably, the African Commission has also recognised the link between HIV and the enjoyment of SRHR. It states that:

²⁵⁷ The Protocol on Women is the first regional or international human rights convention to explicitly refer to HIV and to include a right to self-protection against HIV.

²⁵⁸ General Comment on Article 14 (1)(d) and (e) of the Protocol on Women *supra* note 227 at para 5.

²⁵⁹ Article 14(1)(a) of the Protocol on Women.

²⁶⁰ *Id.*, article 14(1)(b).

²⁶¹ *Id.*, article 14(1)(c).

²⁶² *Id.*, article 14(1)(d).

²⁶³ *Id.*, article 14(1)(e).

²⁶⁴ *Id.*, article 14(1)(f).

²⁶⁵ *Id.*, article 14(2).

²⁶⁶ General Comment on Article 14 (1)(d) and (e) of the Protocol on Women *supra* note 227 at para 11.

Amidst high prevalence and significant risk of HIV exposure and transmission, women are unable to fully enjoy [sexual and reproductive health] rights. Notably, the limitation of women's rights in the context of sexual and reproductive health increases the likelihood to HIV exposure and transmission. This is further compounded for women living with HIV whose access to these rights is severely limited or denied as a result of HIV-related discrimination, stigma, prejudices and harmful customary practices.²⁶⁷

States are required under the African Charter and Protocol on Women to make health care services available, accessible, affordable and of quality. In *Sudan Human Rights Organisation and COHRE v Sudan*,²⁶⁸ the African Commission, in examining the meaning of the right to health in the African Charter, recognised the obligations on the State to respect protect and fulfil health rights by providing services that are available, accessible, acceptable and of quality.²⁶⁹ Similarly, article 14(2) of the Protocol on Women enjoins States to take all appropriate measures to provide health services that are “adequate, affordable and accessible.”

Reproductive health information and services are recognised as important in regional law. The Protocol on Women makes specific mention of several reproductive health services critical to SRH care including:

- Information, education and communication programmes for women;²⁷⁰
- Pre-natal, delivery and post-natal health and nutrition services for women during pregnancy and while breastfeeding;²⁷¹
- Medical abortion in cases of sexual assault, rape, incest and where continued pregnancy endangers the health or life of the mother or the foetus;²⁷²
- Family planning education;²⁷³
- Services to protect women from HIV and other sexually transmitted infections; and
- Services to provide women with information on her health (including HIV) status and that of her partner.²⁷⁴

The General Comment on article 14(1)(d) and (e) provides more specifically in the case of HIV and AIDS for:

²⁶⁷ *Id* at para 5.

²⁶⁸ African Commission Communication No. 279/03 and 296/05 (2009) available at <http://www1.umn.edu/humanrts/africa/comcases/279-2003.html> (accessed 30 August 2013).

²⁶⁹ *Id* at paras 208-209.

²⁷⁰ Article 14(2)(a).

²⁷¹ *Id*, article 14(2)(b).

²⁷² *Id*, article 14(2)(c).

²⁷³ *Id*, article 14(1)(f).

²⁷⁴ *Id*, articles 14(1)(d) and (e).

- Access to procedures, technologies and services for the determination of health status, including HIV testing with pre-test and post-test counselling, CD4 count, viral-load, TB and cervical cancer screening;²⁷⁵
- Information and education on sex, sexuality, HIV, SRHR and available health services;²⁷⁶
- Available, accessible, affordable, comprehensive and quality women-centered HIV prevention methods, which include female condoms, microbicides, prevention of mother-to-child transmission and post-exposure prophylaxis to all women without discrimination.²⁷⁷

Provision of services on the basis of voluntary, informed consent

Article 14 of the Protocol on Women emphasises a woman’s right to make informed decisions about her reproductive health. Specifically noting the importance of self-determination when accessing SRH services, article 14 guarantees women the rights to control their fertility, decide whether and when to have children and to choose any method of contraception.

There has been limited expansion of the general right to sexual and reproductive self-determination. However, recently the General Comment on articles 14(1)(d) and (e) of the Protocol on Women has provided detailed information on the understanding of self-determination in the specific context of HIV and AIDS. The interpretation of the right to self-determination in the context of HIV and AIDS provides useful guidance on how the right may be applied to other SRH issues.

The General Comment notes that the right to self-protection against HIV provided under article 14(1)(d) includes access to information and education on “sex, sexuality, HIV, sexual and reproductive rights”²⁷⁸ as well as SRH services that are “free of coercion, discrimination and violence.”²⁷⁹

With particular respect to HIV testing, the General Comment notes that women must be provided with the required information and education, including pre- and post-test counselling in order to ensure informed consent is obtained.²⁸⁰ It further notes that training of health care workers should be provided to ensure amongst others, “respect for dignity, autonomy and informed consent.”²⁸¹

While the General Comment does not specifically mention medical procedures such as coerced abortion or sterilisation of WLHIV, it does note that positive test results should not be used as the basis for “coercive practices.”²⁸²

²⁷⁵ General Comment on Article 14 (1)(d) and (e) of the Protocol on Women *supra* note 227 at paras 13-14.

²⁷⁶ *Id* at paras 26-27.

²⁷⁷ *Id* at para 30.

²⁷⁸ *Id* at para 26.

²⁷⁹ *Id* at para 29.

²⁸⁰ *Id* at para 14.

²⁸¹ *Id* at para 41.

²⁸² *Id* at para 42.

Comparative Regional Law: Denial of Legally Available Health Services Such As Abortion and Post-Abortion Care

In *Jacinto v Mexico*,²⁸³ the IACHR affirmed that access to information and education was critical to accessing health care services. In that case, the patient requested an abortion. Hospital staff tried to dissuade her from the procedure by showing her a series of videos about abortion. Furthermore, a doctor inaccurately described the risks of the procedure to the patient's mother and also told the patient's mother that she would be responsible if her daughter were to die while accessing the abortion. In light of the doctor's erroneous information, the mother chose not to proceed with the abortion. The two parties reached a friendly settlement; however, the IACHR did note that "women cannot fully enjoy their human rights without having a timely access to comprehensive health care services, and to information and education."²⁸⁴

In the case of *P and S v Poland*,²⁸⁵ the ECHR in finding a violation of article 8 (right to respect for private and family life) of the European Convention on Human Rights, as regards the determination of access to lawful abortion, noted that "effective access to reliable information on the conditions for the availability of lawful abortion, and the relevant procedures to be followed", was directly relevant for the exercise of personal autonomy.²⁸⁶ The Court noted that the applicants "received contradictory information as to whether they needed a referral in addition to the certificate from the prosecutor, as to who could perform the abortion, who could make a decision, whether there was any waiting time prescribed by law, and what other conditions, if any, had to be complied with."²⁸⁷ The Court also noted that "the second applicant was requested to sign a consent form to the first applicant's abortion which warned that the abortion could lead to her daughter's death."²⁸⁸

Comparative Regional Law: Forced Sterilisation

The three ECHR sterilisation cases discuss the importance of the provision of proper health information necessary for consent as well as the requirements of informed consent for medical processes like sterilisation. In *VC v Slovakia*, the ECHR noted that it did not appear from the documents submitted that the applicant was fully informed about her health status, the proposed procedure and the alternatives to it. Furthermore, the Court indicated that asking the applicant to consent to an intervention such as sterilisation in labour clearly did not "permit her to take a decision of her own free will, after consideration of all the relevant issues and...after having reflected on the implications and discussed the matter with her partner."²⁸⁹

²⁸³ IACHR Report No. 21/07 (2007) available at <http://www1.umn.edu/humanrts/cases/21-07.html> (accessed 26 August 2013).

²⁸⁴ *Id* at para 19.

²⁸⁵ ECHR Application no. 57375/08 (2012) available at <http://sim.law.uu.nl/SIM/CaseLaw/hof.nsf/1d4d0dd240bfee7ec12568490035df05/6d7967584b877041c1257aae0035e8eb?OpenDocument> (accessed 29 August 2013).

²⁸⁶ *Id* at para 111.

²⁸⁷ *Id* at para 102.

²⁸⁸ *Id*.

²⁸⁹ *VC v Slovakia supra* note 239 at para 112.

Non-Discrimination

The right to non-discrimination in access to health is another central component of the right to health, including SRH.

The African Commission has made it clear that discrimination against people with disabilities and people living with HIV in accessing health care services violates the African Charter. In *Purohit and Moore v The Gambia*, the African Commission stated that “as a result of their condition and by virtue of their disabilities, mental health patients should be accorded special treatment which would enable them not only attain but also sustain their optimum level of independence and performance in keeping with article 18(4) of the African Charter.”²⁹⁰

Similarly, the African Commission in interpreting the breadth of articles 14(1)(d) and 14(1) (e) of the Protocol on Women, providing for the right to self-protection against sexually transmitted infections and to know one’s health status, noted that discrimination on the basis of sex, HIV status and disability, among others, prevent the full realisation of the right to self-protection.²⁹¹ The African Commission further notes that discrimination on the basis of a woman’s HIV status limits her ability to access her SRHR.²⁹²

The General Comment notes that the article 14(1)(d) right to self-protection and to be protected against HIV is intrinsically linked with the right to equality and non-discrimination,²⁹³ obliging States to ensure that women are “in the position to claim and exercise their right to self-protection in a non-discriminatory framework as articulated in article 2 of the Protocol [on Women]”.²⁹⁴ The General Comment specifically states that access to sexual and reproductive health services for HIV should be provided to all women “not based on a discriminatory assessment of risk.”²⁹⁵ It furthermore requires countries to “enact laws and policies to ensure women’s access to health and legal services” and to ensure such access is non-discriminatory.

With respect to coercive practices, such as coerced or forced sterilisation or abortion, the General Comment clearly prohibits the use of HIV testing as a condition for other SRH services and further emphasises that positive HIV test results cannot be the basis for coercing women into specific procedures nor can it be a basis for withholding desired services.²⁹⁶

It is clear that coercing women into abortions, sterilisations or other medical procedures would violate the right to health. In addition, denying women access to SRH services or hindering a woman’s ability to access SRH services could violate the right to health. Practices where pregnant women with disabilities or pregnant WLHIV are coerced into consenting to sterilisation for purposes of accessing ante-natal health care services for

²⁹⁰ *Purohit and Moore v The Gambia supra* note 232 at para 81.

²⁹¹ General Comment on Article 14 (1)(d) and (e) of the Protocol on Women *supra* note 227 at para 4.

²⁹² *Id* at para 5.

²⁹³ *Id* at para 11.

²⁹⁴ *Id* at para 35.

²⁹⁵ *Id* at para 30.

²⁹⁶ *Id* at para 35.

current pregnancies, the failure to provide equal access to services and the discriminatory treatment towards these women may violate the right to health. Additionally, health services provided without voluntary and informed consent, such as forced HIV testing for pregnant women, coerced or forced sterilisation of WLHIV and women with disabilities may breach the right to health.

4.6 Rights to Liberty, Security of the Person and Physical Integrity

Both the African Charter and the Protocol on Women provide for the rights to liberty and security of the person (also known as the rights to bodily integrity and autonomy) which may be relevant in litigation relating to forced or coerced medical procedures such as abortion or sterilisation. Although there is limited interpretation of these rights in the context of coercive medical interventions, the protection of the rights themselves is worth noting.

Article 6 of the African Charter provides that “every individual shall have the right to liberty and to the security of his person” and article 4 of the Protocol on Women protects rights to life, integrity and security of the person. The Protocol on Women goes further in mentioning specific acts that are prohibited in the context of these rights, which includes a prohibition on all forms of violence against women as well as “all medical or scientific experiments on women without their informed consent.”²⁹⁷

The African Commission has yet to address these rights specifically in cases of forced or coerced sexual or reproductive health interventions.

Comparative Regional Law: Forced Sterilisation

In the IACHR case of *Chávez v Peru*, Peru acknowledged that the forced sterilisation of a woman violated, amongst others, the right to personal integrity.²⁹⁸ Similarly, the ECHR found that the sterilisations of Roma women were carried out with complete disregard for the right to autonomy.²⁹⁹ In *VC v Slovakia*, for example, the ECHR noted that “the sterilisation procedure grossly interfered with the applicant’s physical integrity as she was thereby deprived of her reproductive capability.”³⁰⁰

²⁹⁷ *Id* at para 42.

²⁹⁸ *Chávez v Peru supra* note 235.

²⁹⁹ **See** *VC v Slovakia supra* note 239 at para 119 and *NB v Slovakia supra* note 240 at para 73.

³⁰⁰ *VC v Slovakia supra* note 239 at para 116.

Comparative Regional Law: Denial of Legally Available Health Services Such As Abortion and Post-Abortion Care

In *Tysiac v Poland*,³⁰¹ the ECHR ruled that there was a violation of the right to respect for one's private life when a woman was denied a therapeutic abortion even though she stood to lose her eyesight if she continued with the pregnancy, noting that "private life includes a person's physical and psychological integrity".³⁰²

In *P and S v Poland*, the ECHR found a violation of the right to liberty and security of the person where the essential purpose of the applicant's placement in the juvenile shelter had been to separate her from her parents and thus prevent them from carrying out an abortion.³⁰³

4.7 Rights to Dignity and Freedom from Cruel, Inhuman and Degrading Treatment and Torture

Forcing a woman to undergo any sexual or reproductive health procedure without her informed consent or denying or hindering a woman's ability to access sexual and reproductive health care services may infringe upon the right to freedom from CIDT and torture, and the right to dignity, given the wide interpretation of these rights accorded by the African Commission.

Link between CIDT, dignity and other rights of the person

Both the African Charter and the Protocol on Women protect the rights to dignity and freedom from CIDT and torture.³⁰⁴

The African Charter under article 5 states that "[e]very individual shall have the right to the respect of the dignity inherent in a human being and to the recognition of his legal status. All forms of exploitation and degradation of man, particularly slavery, slave trade, torture, cruel, inhuman or degrading punishment and treatment shall be prohibited."

The Protocol on Women provides for the right to dignity under article 3(1) which states that "[e]very woman shall have the right to dignity inherent in a human being and to the recognition and protection of her human and legal rights." It further provides for the right to be free from cruel, inhuman or degrading treatment under article 4(1), which states that: "[e]very woman shall be entitled to respect for her life and the integrity and security of her person. All forms of exploitation, cruel, inhuman or degrading punishment and treatment shall be prohibited."

³⁰¹ ECHR Application no. 5410/03 (2007) available at <http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-79812> (accessed 26 August 2013).

³⁰² *Id* at para 107.

³⁰³ *P and S v Poland supra* note 285 at para 148.

³⁰⁴ Article 5 of the ACHPR and articles 3 and 4 of the Protocol on Women.

The African Commission has made it clear that the right to dignity applies to all people without discrimination, holding that:

Human dignity is an inherent basic right to which all human beings, regardless of their mental capabilities or disabilities as the case may be, are entitled to without discrimination. It is therefore an inherent right which every human being is obliged to respect by all means possible and on the other hand it confers a duty on every human being to respect this right.³⁰⁵

The African Commission has allowed for a broad interpretation of actions that constitute torture, cruel, inhuman or degrading treatment or that violate human dignity, including acts that violate “physical and psychological integrity”,³⁰⁶ acts causing physical or psychological suffering and acts that force a person to act against their will.³⁰⁷

In *Sudan Human Rights Organisation and COHRE v Sudan*, the African Commission noted that “exposing victims to personal sufferings and indignity violates the right to human dignity” and further noted that “personal suffering and indignity can take many forms”.³⁰⁸

In the case of *Huri – Laws v Nigeria*, the African Commission noted that “the term ‘cruel, inhuman or degrading treatment or punishment’ is to be interpreted so as to extend to the widest possible protection against abuses, whether physical or mental.”³⁰⁹ In the case of *Doebbler v Sudan*,³¹⁰ the African Commission emphasised that article 5 of the African Charter prohibits not only cruel but also inhuman or degrading treatment or punishment, which includes:

Not only actions which cause serious physical or psychological suffering, but which humiliate or force the individual against his will or conscience... the prohibition of torture, cruel, inhuman or degrading treatment or punishment is to be interpreted as widely as possible to encompass the widest possible array of physical and mental abuses.³¹¹

The Protocol on Women specifically states in article 4 that the rights to life, integrity and security of the person and protection of all forms of exploitation, cruel, inhuman and degrading treatment includes a prohibition on non-consensual scientific experimentation on women.

The African Commission has not yet applied these rights in cases of violations of reproductive self-determination.

³⁰⁵ *Purohit and Moore v The Gambia supra* note 232 at para 57.

³⁰⁶ *Organisations Mondiale Contre La Torture v Rwanda* African Commission Communications 27/89, 49/91 and 99/939 (2000) at para 26 available at <http://www.chr.up.ac.za/index.php/browse-by-subject/423-rwanda-organisation-mondiale-contre-la-torture-and-others-v-rwanda-2000-ahrlr-282-achpr-1996.pdf> (accessed 26 August 2013).

³⁰⁷ **See also** *Doebbler v Sudan supra* note 215 at paras 36-37.

³⁰⁸ *Sudan Human Rights Organisation & COHRE v Sudan supra* note 246 at para 158.

³⁰⁹ African Commission Communication No. 225/98 (2000) at para 40 available at <http://www1.umn.edu/humanrts/africa/comcases/225-98.html> (accessed 26 August 2013).

³¹⁰ *Doebbler v Sudan supra* note 215.

³¹¹ *Id* at paras 36-37.

Comparative Regional Law: Forced Sterilisation

The IACHR recognised in *Chávez v Peru* that the forced sterilisation of a woman violated her right to humane treatment under article 5 of the American Convention on Human Rights.³¹²

Similarly, the ECHR has found that the sterilisation without informed consent of Roma women, a marginalised group, violated their right to be free from torture or inhuman and degrading treatment.³¹³ In *VC v Slovakia*, the Court held that sterilisation as such was not, in accordance with generally recognised standards, a life-saving medical intervention and that where sterilisation was carried out without the informed consent of a mentally competent adult, it was incompatible with the requirement of respect for human freedom and dignity.³¹⁴ In that case, the Court concluded that although there was no indication that the medical staff had acted with the intention of ill-treating the applicant, they had nevertheless acted with gross disregard for her right to autonomy and choice as a patient.³¹⁵ Such treatment was in breach of article 3 of the European Convention on Human Rights, which provides that “No one shall be subjected to torture or to inhuman or degrading treatment or punishment.”³¹⁶

In *IG and Others v Slovakia*, the Court reiterated that a “person’s treatment is considered to be ‘degrading’ when it humiliates or debases an individual, showing a lack of respect for, or diminishing, his or her human dignity, or arouses feelings of fear, anguish or inferiority.”³¹⁷ The Court further clarified that it may suffice that the victim is humiliated in his or her own eyes, even if not in the eyes of others.³¹⁸ The Court reiterated that sterilisation in the context of a delivery by Caesarean section was not a life-saving intervention.³¹⁹ The Court also found that where informed consent had not been obtained prior to the procedure, the procedure is incompatible with the requirement of respect for human freedom and dignity it can be qualified as degrading within the meaning of article 3.³²⁰

³¹² *Chávez v Peru supra* note 235.

³¹³ *VC v Slovakia supra* note 239 at para 120, *NB v Slovakia supra* note 240 at para 81 and *IG and Others v Slovakia supra* note 241 at para 124.

³¹⁴ *VC v Slovakia supra* note 239 at para 106-120.

³¹⁵ *Id* at para 119.

³¹⁶ *Id* at paras 106-120.

³¹⁷ *IG and Others v Slovakia supra* note 241 at para 121.

³¹⁸ *Id*.

³¹⁹ *Id* at para 122.

³²⁰ *Id* at paras 123-126.

Comparative Regional Law: Denial of Legally Available Health Services Such As Abortion and Post-Abortion Care

In RR v Poland,³²¹ ECHR found that the applicant had been subjected to inhuman and degrading treatment as a result of the doctors' intentional failure to provide necessary medical treatment in the form of timely prenatal examinations that would have allowed her to take a decision as to whether to continue or terminate her pregnancy within the time-limit laid down by the law. The Court noted that the applicant was in a situation of great vulnerability. She was deeply distressed by information that the foetus could be affected with some malformation. As a result of the procrastination of the health professionals, she had to endure six weeks of painful uncertainty concerning the health of the foetus, her own and her family's future.³²²

It is likely that forced or coerced sexual and reproductive health procedures, especially when they result in clear psychological suffering, may violate the rights to dignity and freedom from cruel, inhuman or degrading treatment and torture as provided for under regional law. It is also likely that where procedures are forced on specific population groups such as WLHIV and women with disabilities with the result that there is a feeling of humiliation or sense of diminished dignity, this may amount to cruel, inhuman or degrading treatment or punishment.

4.8 Right to Information

Article 9 of the African Charter protects the right of every individual to receive information.

Although the African Commission has not specifically stated that the right to information includes the right to reproductive health information, it notes that the right to information relates to information on other rights contained in the African Charter. It has stated that the denial of information on human rights, particularly rights contained in the African Charter constitutes a "particularly grave" violation of the right to information and that information relating to the protection and promotion of human rights is in need of special protection.³²³

The Protocol on Women specifically provides that a women's right to sexual and reproductive health includes an obligation on State Parties to provide health information, education and communication, in terms of article 14(2). However, the African Commission has yet to elucidate on the scope of the rights enshrined in article 14(2) or apply it to particular facts.

³²¹ ECHR Application no. 27617/04 (2011) available at <http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-104911> (accessed 26 August 2013).

³²² *Id* at paras 159-162.

³²³ *Law Office of Ghazi Suleiman v Sudan* African Commission Communication No. 228/99 (2003) at paras 49-52 available at <http://www.chr.up.ac.za/index.php/browse-by-subject/457-sudan-law-office-of-ghazi-suleiman-v-sudan-ii-2003-ahrlr-144-achpr-2003.pdf> (accessed 26 August 2013).

Comparative Regional Law: Denial of Legally Available Health Services

In the case of *Open Door and Dublin Well Woman v Ireland*,³²⁴ the ECHR held that the Supreme Court of Ireland's injunction restraining counselling agencies from providing pregnant women with information concerning abortion facilities abroad violated article 10 of the European Convention on Human Rights, which provides for the right to freedom of expression, including the right to receive and impart information. The ECHR found that the injunction interfered with the right of two non-profit organisations to provide information on family planning options and with the ability of women to receive information. The ECHR reasoned that although Ireland has a legitimate interest in protecting the life of the foetus, the injunction had a disproportionate impact, because it prohibited counselling regardless of the age, health, or circumstances of pregnant women.³²⁵ The ECHR noted that the injunction posed a health risk to women, who would likely terminate pregnancies at later stages without adequate counselling.³²⁶

4.9 Right to Life

The African Charter protects the right to life under article 4, which states that “[h]uman beings are inviolable. Every human being shall be entitled to respect for his life and the integrity of his person. No one may be arbitrarily deprived of this right.”

Article 4(1) of the Protocol on Women links the rights to life, physical integrity, security and protection from cruel, inhuman and degrading punishment or treatment.

The African Commission has yet to expand on the nature and scope of the right to life in the context of SRHR, however, it is possible that denying or hindering access to sexual and reproductive health care services to women, and particularly women with disabilities or WLHIV, which results in a loss of life would violate the right to life.

In the IACHR case of *Chávez v Peru*, a case resolved by friendly settlement, the Government of Peru acknowledged that the forced sterilisation of a woman followed by denial of follow-up health services resulting in her death violated, amongst others, the right to life protected in article 4 of the American Convention on Human Rights.³²⁷

³²⁴ ECHR Application no. 14234/88 (1992) available at <http://www.unhcr.org/cgi-bin/texis/vtx/refworld/rwmain?page=printdoc&docid=3ae6b7020> (accessed 26 August 2013). This decision was upheld in *Women on Waves v Portugal* ECHR Application No.31276/05 (2009) summary is available at <http://sim.law.uu.nl/SIM/CaseLaw/hof.nsf/0/a895393ece0e9077c1257551003239b6?OpenDocument> (accessed 26 August 2013).

³²⁵ *Id* at para 73-74.

³²⁶ *Id* at para 77.

³²⁷ *Chavez v Peru supra* note 235.

4.10 Conclusion

A number of rights under regional law may be implicated in cases of violations of sexual and reproductive self-determination, including the rights to health, liberty and security of the person, equality and non-discrimination, dignity and protection from torture and cruel, inhuman and degrading treatment.

The African regional mechanisms have yet to fully address the application of these rights specifically in cases of sexual and reproductive self-determination. However, African Commission decisions detailing the scope of these rights in other contexts can be useful in domestic litigation. Decisions of other regional bodies such as the as the IACHR and the ECHR may also be persuasive.

CHAPTER 5

Relevant comparative law

5.1 Introduction

This chapter focuses on comparative law relating to violations of reproductive self-determination and discrimination in accessing SRH services. It looks at how courts in southern Africa and other jurisdictions have addressed cases relating to sexual and reproductive self-determination and discrimination in accessing SRH services.

For a discussion of why domestic courts should look to comparative law, please refer to Chapter 2.

Relevant cases discussed in this chapter include

- Adan v Davis (Canada)
- Attorney General v Dow (Botswana)
- Castell v de Greef (South Africa)
- Christian Lawyers' Association v National Minister of Health and Others (South Africa)
- Esterhuizen v Administrator, Transvaal (South Africa)
- Isaacs v Pandie (South Africa)
- LM and Others v Government of the Republic of Namibia (Namibia)
- Mmusi and Others v Ramantele and Another (Botswana)
- R v Morgentaler (Canada)
- Roe v Wade (United States of America)
- Stoffberg v Elliott (South Africa)
- Thornburgh v American College of Obstetricians and Gynaecologists (United States of America)

5.2 Coerced or Forced Medical Sexual and Reproductive Health Procedures

Basis of autonomy in medical setting

The constitutions of many countries in southern Africa recognise a range of fundamental rights relevant to protecting individuals from medical procedures and disclosures of private medical information unless informed consent is provided. Southern African constitutions recognise rights such as the rights to the security of the person, privacy, dignity, physical integrity and protection from cruel, inhuman or degrading treatment. In addition, the common and/or civil law in most countries has long recognised the right of an individual to *dignitas* or bodily and psychological integrity. This legal principle protects individuals from unwanted medical procedures, unless the necessary consent has been provided.³²⁸

Patient autonomy and self-determination have long been recognised in health law jurisprudence in the region. In South Africa in particular it has been recognised as far back as 1923 when the High Court emphasised that any interference with a person's body – such as a medical operation – which is not consented to is a violation of that person's rights to control his own body.³²⁹ The principle of consent to medical procedures has been reaffirmed in other cases such as *Esterhuizen v Administrator, Transvaal*.³³⁰

In other jurisdictions, the right over one's own body has been located in the rights to liberty, privacy, dignity and autonomy. For instance, in *Roe v Wade*,³³¹ the US Supreme Court held that a woman had the right to determine the fate of her own pregnancy under the right to liberty (linked to the right to privacy).³³² In a later case, *Thornburgh v American College of Obstetricians and Gynaecologists*,³³³ the US Supreme Court found that “few decisions are more personal and intimate, more properly private, or more basic to individual dignity and autonomy, than a woman's decision ... whether to end her pregnancy.”³³⁴

In Canada, the Supreme Court in *R v Morgentaler*³³⁵ held that a woman had a right to determine the fate of her own pregnancy under the right to the security of person. In the landmark 1994 South African decision of *Castell v de Greef*,³³⁶ the Supreme Court

³²⁸ Common law and statutory law sometimes allow for exceptions to the requirement of voluntary informed consent by an individual to medical testing and treatment. In these instances, medical testing and treatment without consent is lawful provided that the laws are reasonable limitations of rights, in line with constitutional principles.

³²⁹ See *Stoffberg v Elliot* 1923 CPD 128.

³³⁰ 1957 (3) SA 710 (T).

³³¹ 410 US 113 (1973) (35 L Ed 2d 147) available at http://www.law.cornell.edu/supct/html/historics/USSC_CR_0410_0113_ZO.html (accessed 26 August 2013).

³³² *Id.*, 152 - 153.

³³³ (1986) 476 US 747 available at http://www.law.cornell.edu/supct/html/historics/USSC_CR_0476_0747_ZS.html (accessed 26 August 2013).

³³⁴ *Id.* at para 772.

³³⁵ (2) (1988) 44 DLR (4th) 385, 173-174 available at <http://scc.lexum.org/decisia-scc-csc/scc-csc/scc-csc/en/item/288/index.do> (accessed 26 August 2013).

³³⁶ 1994 (4) SA 408 (C).

of Appeal recognised the individual’s “fundamental right[s] of... autonomy and self-determination”.³³⁷

More recently, in *Christian Lawyers’ Association v National Minister of Health and Others*,³³⁸ the South African Supreme Court of Appeal examined a women’s right to provide informed consent to an abortion, finding that the right to do so was a fundamental expression of the right to individual self-determination. The Court reiterated that this right to self-determination is reflected in South Africa’s Bill of Rights in various provisions, including the right to bodily and psychological integrity which includes the right to make decisions concerning reproduction and the right to security and control over the body, and the rights to dignity and privacy.³³⁹

The South African High Court in *Isaacs v Pandie*³⁴⁰ found that a forced sterilisation violated the rights to privacy, dignity, reputation and safety.³⁴¹

The South African Supreme Court of Appeal outlined the elements of informed consent in *Castell v de Greef*.³⁴² In that case, a woman sued a doctor for medical negligence after various complications occurred after she had surgery to remove breast tissue to reduce the risk of cancer. The patient claimed she had not been advised of the risk of complications of such procedures or that an alternative surgical procedure existed. In examining the right to informed consent, the Court clarified the subjective, patient-centred test for informed consent. The Court held that a health practitioner must disclose all information and risks about a procedure that a “reasonable person in the patient’s position, if warned of the risk, would be likely to attach significance to it.”³⁴³ The Court found that informed consent requires not only information, but also understanding and consent. It requires a patient to:

- Know the nature and extent of the risk or harm that accompanies a procedure;
- Understand the nature and extent of the risk or harm;
- Agree in detail to the procedure under discussion; and
- Agree in detail to all parts of the risk or possible harm.³⁴⁴

The holding in *Castell v de Greef* is significant because a subjective, patient-centred test for informed consent is in line with fundamental rights to self-determination and individual autonomy.

³³⁷ *Id.*, 80 - 81.

³³⁸ 2004 (4) SA 31 (T).

³³⁹ *Id.*, 47.

³⁴⁰ [2012] ZAWCHC 47 (16 May 2012) available at <http://www.saflii.org/za/cases/ZAWCHC/2012/47.html> (accessed 26 August 2013).

³⁴¹ *Id.* at para 87.1.

³⁴² *Castell v de Greef supra* note 336.

³⁴³ *Id.*, 81.

³⁴⁴ *Id.*, 80.

Generally, when assessing whether informed consent is present, courts have looked at:

- The nature and extent of information provided to the patient;
- The manner in which this information was provided; and
- Various factors that may affect understanding of the information in providing informed consent including:
 - Whether an individual is able to understand the information provided;
 - The language in which the information is provided;
 - The time available to make a considered decision; and
 - The psychological state of the patient at the time of the decision.

In 2012, the Namibian High Court in *LM and Others v Government of the Republic of Namibia*,³⁴⁵ addressed the components of informed consent in a case involving the forced sterilisation of three HIV-positive women in public hospitals in Namibia. In reaching its decision that all three women were subjected to forced sterilisation, the Court noted that informed consent required much more than merely written consent. The Court held that for informed consent the patient must be provided with adequate and appropriate information in a language a woman understands given that most patients are lay people and not well-versed in medical matters. With particular regard to sterilisation, the Court held that the patient must be provided with information about the procedure as well as alternative options, including advantages and disadvantages of alternative methods of contraception.³⁴⁶

In applying the criteria for informed consent to the particular factual situations in *LM and Others v Government of the Republic of Namibia*, the High Court highlighted expert testimony which noted the problematic nature of including medical acronyms in consent forms. The Court further highlighted the importance of counselling regarding contraception to ensure informed decision-making prior to sterilisation.³⁴⁷

Further, the Court noted that consent obtained while a woman was in labour did not meet the criteria for informed consent, holding that consent could not be obtained in a hurried fashion.³⁴⁸

Similarly, the South African High Court in *Isaacs v Pandie* emphasised the need for a patient to have time to consider and understand information for there to be informed consent.³⁴⁹ In *Isaacs v Pandie*, the plaintiff, a woman in her thirties who was subjected to an unwanted sterilisation procedure following the birth of her fourth child, repeatedly told her physician that she did not want a sterilisation. Although she specifically noted

³⁴⁵ [2012] NAHC 211 available at <http://www.saflii.org.za/na/cases/NAHC/2012/211.html> (accessed 26 August 2013).

³⁴⁶ *Id* at para 70.

³⁴⁷ *Id* at para 68.

³⁴⁸ *Id*.

³⁴⁹ *Isaacs v Pandie supra* note 340 at paras 57 and 87.3.

in writing that she did not consent to sterilisation, it was still performed. The Court held that before a doctor starts any treatment, s/he must ensure that the patient has been given sufficient time and information. The information must be given in a way that the patient understands in order to enable them to make an informed decision.³⁵⁰

In both *LM and Others v Government of the Republic of Namibia* and *Isaacs v Pandie*, the courts held that the doctor bore the duty to obtain informed consent from the patient. The South African High Court in *Isaacs v Pandie* pointed to the health profession guidelines in South Africa, which “expressly state[s] that it is the responsibility of the doctor providing treatment to his/her patient to obtain consent” and that the treating doctor remains responsible for ensuring that, before s/he starts any treatment, the patient has been given sufficient time and information to make an informed decision and has given consent to the investigation or procedure.³⁵¹

Finally, in *Christian Lawyers’ Association v National Minister of Health and Others*, the South African Supreme Court of Appeal examined various aspects of the right to provide informed consent to an abortion, including the issue of capacity to consent. The findings of the Court with regard to capacity are relevant for women with disabilities. The Court found that the provisions of the Choice on Termination of Pregnancy Act, 1996, which allow pregnant women under the age of 18 who give their informed consent to terminate their pregnancies during the first 12 weeks of pregnancy without having to consult or obtain the consent of parents or guardians, undergo counselling, and wait for a prescribed period, are constitutional.³⁵² The Court held that the distinguishing line in the Choice Act between pregnant women who may access the option to terminate their pregnancies unassisted versus those who require assistance is the *actual capacity* of a particular pregnant woman to give informed consent, as determined on a case-by-case basis by the medical practitioner, depending on the emotional and intellectual maturity of the individual concerned.³⁵³

In all three cases cited above, the courts took special note of the particular harm women experience due to violations of their sexual and reproductive self-determination. In *Isaacs v Pandie*, for example, the Court took into account the mental and emotional state, pain, suffering and loss of amenities of life in awarding general damages.³⁵⁴ In the Canadian case of *Adan v Davis*,³⁵⁵ decided in the Ontario Court of Justice, General Division, the Court elaborated that informed consent encompassed two considerations. First, it is concerned with a patient’s ability to communicate with and to understand her physician. Second, the duty of disclosure encompasses what the physician knows or should know that the patient deems relevant to her decision and what the reasonable plaintiff in similar circumstances to the plaintiff will want to know before deciding whether to

³⁵⁰ *Id* at para 87.3.

³⁵¹ *Id* at para 68.

³⁵² *Christian Lawyers’ Association v National Minister of Health and Others supra* note 338, 49.

³⁵³ *Id*, 37.

³⁵⁴ *Isaacs v Pandie supra* note 340 at para 88.

³⁵⁵ [1998] O.J. No. 3030.

submit to treatment or surgery.³⁵⁶ The plaintiff was a Somali woman who was subjected to a sterilisation procedure without her knowledge or consent. The plaintiff spoke no English at the time of the procedure and her appointment with the doctor was conducted through an interpreter. Although the treating physician claimed that he had received a request from Adan for sterilisation, the plaintiff believed that she was only having an infection treated. The Court determined that even if the doctor had received a request from Adan for sterilisation, the requirements of informed consent were not met.

In the above case, the Court found that the standard of informed consent (the duty of disclosure) had not been met because the doctor failed to ensure that Adan understood the meaning of the procedure, which was a particularly relevant concern given the fact that she did not speak English, and because he failed to notify her that other contraception options were available. During the assessment of damages, the Court took into account the fact that the plaintiff's ability to have children was "fundamental to her status in her society," that it was of enormous significance to her culture, and that the procedure violated her religious beliefs.³⁵⁷

5.3 Discrimination in Access to Sexual and Reproductive Health Services

There is limited jurisprudence in the region on women's rights to equality and non-discrimination in the specific context of sexual and reproductive health services. However, there is relevant jurisprudence on women's rights to equality and non-discrimination in general as well as jurisprudence on the right to non-discrimination for people living with HIV and AIDS and people with disabilities. In this section we primarily consider cases relating to the equality rights of women. For a comprehensive discussion on comparative case law regarding discrimination against people living with HIV, please refer to SALC's litigation manual *Equal Rights for All: Litigating Cases of HIV-Related Discrimination*.³⁵⁸

Courts throughout the region have affirmed the importance of ensuring the equal rights of women and have supported the ending of discrimination against women. In *Attorney General v Dow*, the Botswana Court of Appeal held that though section 15 of the Botswana Constitution providing for the right to non-discrimination did not explicitly provide for sex as a prohibited grounds, an act which denied citizenship to children where their mother was Motswana but not their father violated the right to non-discrimination under the Constitution as well as the right to equality under article 3 which explicitly prohibits disparate treatment due to sex.³⁵⁹

More recently, the Botswana High Court followed the Court of Appeal ruling in *Dow* in striking down a customary law rule which denied women the right to inherit the

³⁵⁶ *Id* at para 40- 42.

³⁵⁷ *Id* at para 34.

³⁵⁸ "Equal Rights for All: Litigating Cases of HIV-Related Discrimination" *supra* note 93.

³⁵⁹ *Attorney General v Dow supra* note 44.

family home. In *Ramantele v Mmusi and Another*,³⁶⁰ the Court found that section 15(4) (d) under the Botswana Constitution which exempts all personal law matters, including inheritance, from the general prohibition against discrimination to be subjected to two limitations: that the discrimination under personal law be either in the public interest or not prejudice the rights and freedom of others.³⁶¹

Similarly, in *Prinsloo v Van der Linde and Another*,³⁶² the South African Constitutional Court in determining whether discrimination has an unfair impact on persons, examined whether the persons discriminated against were members of a group of people that have been victims of past patterns of discrimination.³⁶³

In the Namibian case of *Myburgh v Commercial Bank of Namibia*,³⁶⁴ the Supreme Court likewise found that women can claim to have been part of a prior disadvantaged group, in special need of protection from discrimination.³⁶⁵

In the South African case of the *Minister of Health and Others v Treatment Action Campaign and Others*,³⁶⁶ the South African Constitutional Court considered, among other issues, the accessibility of nevirapine – a drug used to prevent mother-to-child transmission of HIV. At the time, South Africa only provided nevirapine at two research and training sites per province. The drug was also available in the private health system. A violation of section 9 of the South African Constitution guaranteeing the right to equality was alleged on the basis that the policy of the government discriminated against poor women by allowing nevirapine to be available in the private health care system and not allowing it to be widely available in the public health care system. The Court did not specifically deal with this aspect but noted its concern that the lack of accessibility would primarily affect the poor as follows:

In dealing with these questions it must be kept in mind that this case concerns particularly those who cannot afford to pay for medical services. To the extent that government limits the supply of nevirapine to its research sites, it is the poor outside the catchment areas of these sites who will suffer. There is a difference in the positions of those who can afford to pay for services and those who cannot. State policy must take account of these differences.³⁶⁷

³⁶⁰ CACGB-104-12 available at <http://www.southernafricalitigationcentre.org/1/wp-content/uploads/2013/07/Mmusi-Court-of-Appeal-Judgment.pdf> (accessed 5 September 2013).

³⁶¹ *Id* at paras 66-72.

³⁶² 1997 (3) SA 1012 (18 April 1997) available at <http://www.saflii.org/za/cases/ZACC/1997/5.html> (accessed 26 August 2013).

³⁶³ *Id*.

³⁶⁴ [2000] NASC available at <http://www.saflii.org/za/na/cases/NASC/2000/3.html> (accessed 26 August 2013).

³⁶⁵ *Id*, 18.

³⁶⁶ 2002 (5) SA 721; 2002 (10) BCLR 1033 (5 July 2002) available at <http://www.saflii.org/za/cases/ZACC/2002/15.html> (accessed 26 August 2013).

³⁶⁷ *Id* at para 70.

Brotherton v Electoral Commission of Zambia is one of the few cases in the region dealing with discrimination on the basis of disability.³⁶⁸ In this case, the Zambian High Court found that the voting stations in Zambia failed to provide accessibility for people with disabilities and that this constituted discrimination on the basis of disability.³⁶⁹ It noted that people *without* disabilities were able to easily access the registration process whereas people *with* disabilities had difficulties; since people with disabilities were treated less favourably than people without, the Court reasoned there was discrimination.³⁷⁰

Courts in southern Africa have yet to assess whether discrimination in women's ability to access sexual and reproductive health services violate the rights to equality and non-discrimination. However, it is clear that the prohibition on discrimination against women, WLHIV and women with disabilities could apply equally to laws, policies and practices that prevent women from accessing sexual and reproductive health services.

5.4 Conclusion

Courts throughout the world have found that the right to informed consent is critical to sexual and reproductive self-determination. The right has been located in common law and a number of fundamental constitutional rights, including the right to liberty, privacy, dignity and autonomy, among others. As a critical component of informed consent, courts have held that the doctor has a duty to ensure the patient has adequate and appropriate information in a language she understands. Finally, courts have uniformly struck down laws and practices that discriminate against women and though they haven't specifically addressed discrimination in women's ability to access sexual and reproductive health services, it is likely that laws, policies and practices that prevent women from accessing such services would be prohibited.

³⁶⁸ 2011 HP/0818 available at <http://www.zambialii.org/zm/judgment/high-court/2011/32> (accessed 26 August 2013).

³⁶⁹ *Id.*, J17.

³⁷⁰ *Id.*

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 ligation 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 ligation 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 sterilisation 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 violence³⁹⁰

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

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.rockettsite.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.



Useful online resources

International Human Rights Law

- ▶ UN international human rights treaties and their monitoring bodies
<http://www.ohchr.org>
- ▶ Searchable database of decisions from international treaty monitoring bodies: Universal Human Rights Index
<http://www.universalhumanrightsindex.org>

African Human Rights Law

- ▶ African Commission on Human and Peoples' Rights (includes texts of primary African human rights treaties)
<http://www.achpr.org>
- ▶ African Court on Human and Peoples' Rights
<http://www.african-court.org/en/>
- ▶ African human rights case law and document database
<http://www.chr.up.ac.za>
- ▶ African Union
<http://www.au.int/en/>

SADC Documents

- ▶ SADC Regional Documents
<http://www.sadc.int>

Comparative Jurisprudence

- ▶ Decisions from courts throughout Africa: African Legal Information Institute
<http://www.africanlii.org>
- ▶ Decisions from courts throughout southern Africa: Southern African Legal Information Institute
<http://www.saflii.org>
- ▶ Decisions from courts around the world: World Legal Information Institute
<http://www.worldlii.org>



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