

The Price of Failure of Informed Consent Law: Coercive Sterilizations of HIV- Positive Women in South Africa

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“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.”

—Purohit and Another v. the Gambia, *heard by the African Commission on Human and Peoples’ Rights*¹

Introduction

There have been many recent occurrences of sterilizations of HIV-positive women around the world after giving birth (often to HIV-negative children) in attempts to prevent mother-to-child HIV transmission.² Many times, the women have been unaware or did not understand that they were being asked to consent to tubal ligation procedures during their deliveries.³ Some of those women were also unconscious or illiterate and were asked to sign a document that they could not understand was an authorization for a sterilization procedure.⁴ Other women have been told that the sterilization procedure was government-mandated for all HIV-

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1. CENTRE FOR HUMAN RIGHTS, UNIVERSITY OF PRETORIA, AFRICAN HUMAN RIGHTS LAW REPORTS 108 (2003) (detailing that the right to health includes “the right to health facilities, access to goods and services to be guaranteed to all without discrimination of any kind”).

2. Janine Kossen, *Rights, Respect, Responsibility: Advancing the Sexual and Reproductive Health and Rights of Young People Through International Human Rights Law*, 15 U. PA. J. L. & SOC. CHANGE 143, 160 (2012) (recognizing recent reports of coercive sterilizations of HIV-positive women in Namibia, Chile, the Dominican Republic, Mexico, South Africa, and Venezuela).

3. SETHEMBISO MTHEMBU ET AL., ‘I FEEL LIKE HALF A WOMAN ALL THE TIME’: A QUALITATIVE REPORT OF HIV-POSITIVE WOMEN’S EXPERIENCES OF COERCED AND FORCED STERILISATIONS IN SOUTH AFRICA 16 (2011), <http://www.africawln.org/download/5/>.

4. Henry Kibira, *Kenya: Women Seek Justice over Sterilisation*, THE STAR, Aug. 23, 2012, <http://allafrica.com/stories/201208240201.html>.

positive women.⁵ Even more disturbing is that some of the women were threatened with having their supply of life-sustaining antiretroviral drugs stopped if they did not agree to the sterilization.⁶ HIV-positive women have also been detained in hospitals after giving birth until they agree to be sterilized.⁷ Sterilization procedures should be voluntary medical surgeries due to the generally irreversible nature of sterilization, which leaves a lasting change on one's bodily functions and capabilities to exercise one's right to reproduce.⁸ Women should be fully informed of what a sterilization procedure entails.⁹

Her Rights Initiative (HRI), a nonprofit women's group in South Africa, joined forces with the Health Economics AIDS Research Division, the University of KwaZulu-Natal, Justice and Women, the Positive Women's Network group, and the AIDS Legal Network to conduct the first of its kind qualitative study to document HIV-positive women's experiences with sterilizations in South Africa.¹⁰ The study conducted semi-structured interviews with a total of twenty-two participants, gathering specific information about their sterilization experiences.¹¹ These interviews shed light on the extreme stigma that HIV-positive women face in medical settings. When asked what her health care provider's justification was for sterilization, an HIV-positive participant replied, "[t]hey just said that a person with this

5. *Id.*

6. *Id.*

7. MTHEMBU ET AL., *supra* note 3, at 16 (recounting one woman's experience about her coercive sterilization, "I stayed [three] months in hospital and they were keeping me so that I could not go home and conceive again.") (citation omitted).

8. *Id.* at 6.

9. *Id.* (arguing that medical providers should completely inform women of what the sterilization procedure is, the risks and benefits of sterilizations, the permanency of sterilizations, and other options available which may be more appropriate for that individual).

10. *Id.* at 10. The study was conducted between June 2010 and June 2011 based on interviews about HIV-positive women's experiences with sterilization procedures. South African HIV-positive women over eighteen years old were recruited via support groups and through a snowball sampling method where current participants were asked to identify other potential participants. A majority of the participants were unemployed and unmarried. *Id.*

11. *Id.* The study's goals were to document the experiences of some of the HIV-positive women in South Africa who underwent coercive sterilizations, uncover the "social, psychological[,] and financial impacts" of coercive sterilizations, and identify the immediate and long term needs to support these women. *Id.* The sample size of this study may be small, but it is impossible to know how many women are affected by coercive sterilizations, and recruiting them to participate in such studies is difficult because of the deeply personal and highly stigmatized nature of coercive sterilizations. See *infra* text accompanying note 40.

disease is not allowed to have more children.”¹² Another participant said, “I was told that if I was pregnant and HIV[-] positive . . . that I would die since we are always told that HIV[-] positive pregnant women are most in danger during this period. Because of this, you are then simply sterilised and instructed to accept this decision.”¹³ These severe violations of informed consent and human rights laws have had serious negative effects on these women. Besides creating problems with victims’ families, romantic partners, and within South African society, involuntary sterilizations of HIV-positive women often cause them to experience depression and a sense of loss of their womanhood.¹⁴ An HRI participant disclosed, “[i]t makes me feel incomplete that I am not a proper woman[:] first that I’m HIV[-]positive and secondly I cannot bear children. Men don’t want HIV[-]positive women but the inability to have a child is an added problem.”¹⁵ Another HRI participant revealed, “I feel like half a woman all the time.”¹⁶

This Note outlines the current international laws surrounding sterilizations and informed consent, focusing on the national laws of South Africa as a case study. In Part I, the Note begins by discussing the severity of the coercive sterilizations taking place around the world and explores the infringements on these women’s informed consent rights based on international sexual and reproductive human rights law, as well as South African national laws. Part II analyzes any potential legal and policy changes that can be instituted to prevent future coercive sterilizations. Lastly, the Note concludes with a call to action to end coercive sterilizations of HIV-positive women in South Africa and worldwide.

I. Coercive Sterilizations and the Informed Consent Predicament

Coercive sterilizations of HIV-positive women have become a serious global human rights issue in the past decade.¹⁷ However,

12. *Id.* at 12.

13. *Id.* at 13.

14. *See id.* at 9, 24, 26 (describing the hardships that sterilized women face in rediscovering their roles in society, their familial and romantic relationships, as well as their relationships with themselves).

15. *Id.* at 26.

16. *Id.*

17. Pooja Nair, *Litigating Against the Forced Sterilization of HIV-Positive Women: Recent Developments in Chile and Namibia*, 23 HARV. HUM. RTS. J. 223, 223–24, 229 (2010).

many recent cases have occurred in South Africa, a country that is traditionally a leader in informed consent laws, warranting a closer study of the inequities arising in this nation.¹⁸ Exploration of international and South African national laws demonstrates that while there are plenty of regulations in place that address informed consent issues surrounding sterilizations, these laws and treaties are failing to halt the numerous cases of coercive sterilizations,¹⁹ meriting revision of the enforcement mechanisms of these laws and demonstrating a need for international interventions.

A. *Coercive Sterilizations of HIV-Positive Women Worldwide*

In a 2008 study of 230 HIV-positive women in Namibia, forty of these women were sterilized without their consent.²⁰ Coercive sterilizations are also widespread in Kenya, where an August 2012 report documented over forty testimonies of forcibly sterilized HIV-positive women.²¹ These testimonies were like that of Rose, a woman who was sterilized after an emergency second trimester delivery of a baby who did not survive and was not told about the sterilization until six months later.²² A 2004 survey of Chilean HIV-positive women found that fifty-six percent of the women were pressured to avoid pregnancy because of their positive status.²³ In the Chilean case *F.S. v. Chile*, twenty-year-old Francisca was forcibly sterilized without any knowledge or consent during her Caesarian delivery because she was HIV-positive.²⁴ After receiving no relief for this injustice, Francisca brought her case to the Inter-American Commission on Human Rights, making her case the first fight for the reproductive rights of HIV-positive women, even though the unfair practice of coercive sterilizations

18. Rachel Rebouché, *The Limits of Reproductive Rights in Improving Women's Health*, 63 ALA. L. REV. 1, 12–13 (2011) (suggesting that the South African post-apartheid movement facilitated the formation of gender-equal and just reproductive health laws, granting affirmative rights to women in making decisions whether to become pregnant or terminate pregnancy).

19. *Id.*

20. Nair, *supra* note 17, at 229.

21. Catherine Wambua-Soi, *Forced Sterilisations Stoke Kenyan Anger*, AL JAZEERA, Oct. 9, 2012,

<http://www.aljazeera.com/indepth/features/2012/10/2012108132844521409.html>.

22. *Id.*

23. *F.S. v. Chile Full Case Description*, CTR. FOR REPROD. RIGHTS, 3 (2010), [http://reproductiverights.org/sites/crr.civicaactions.net/files/flash/Toolkit%20-%20FS%20v.%20Chile%20\(Dec.%202010\).PDF](http://reproductiverights.org/sites/crr.civicaactions.net/files/flash/Toolkit%20-%20FS%20v.%20Chile%20(Dec.%202010).PDF).

24. *Id.* at 1.

had been documented for over a decade worldwide.²⁵ In a 2011 study, thirteen percent of HIV-positive Swazi women were advised by medical providers not to have children, and three percent of these women were coerced into undergoing sterilization by their medical providers.²⁶

In all of the above instances, HIV-positive women have been forced to relinquish their reproductive rights to obtain access to health care services, such as abortions, labor and delivery care, and HIV medications.²⁷ Medical professionals have been shown to act paternalistically in performing coercive sterilizations upon HIV-positive women as a result of their beliefs that HIV-positive women are irresponsible and unfit to have children due to their supposed heightened risk of early deaths.²⁸ Such discriminatory, negative perceptions fail to acknowledge the high success rate of antiretroviral medication, which enable HIV-positive people to live long and healthy lives.²⁹ Additionally, some medical providers view HIV-positive women as vectors of the disease, responsible for spreading HIV to their partners or children,³⁰ rather than considering that the infection originated with the male partner. Desires to reproduce and have a family are just as strong for HIV-positive people and should not be discounted or interfered with, as was the case with the participants in the HRI study.³¹ Coercive

25. Kossen, *supra* note 2, at 163.

26. Mbabane, *Swaziland: HIV Stigma Still a Barrier*, INTEGRATED REG'L INFO. NETWORKS (Nov. 12, 2012), <http://www.irinnews.org/Report/96761/SWAZILAND-HIV-stigma-still-a-barrier>.

27. MTHEMBU ET AL., *supra* note 3, at 8 (arguing that involuntary sterilization forces HIV-positive women to use their bodies as bargaining chips in order to receive various forms of medical treatment, causing them to give up their right to bodily integrity and autonomy to choose the appropriate method of birth control).

28. Carol Levine & Nancy Neveloff Dubler, *Uncertain Risks and Bitter Realities: The Reproductive Choices of HIV-Infected Women*, 68 MILBANK Q. 321, 338, 341 (1990) (noting that forced sterilizations of mothers who are using drugs, are HIV-positive, or are using the welfare system have been favored by doctors in the United States).

29. Nair, *supra* note 17, at 224–25 (revealing that the rate of mother-to-child transmission of HIV is as low as 1.8% with the use of consistent antiretroviral therapy and medical attention).

30. KAREN STEFISZYN ET AL., CENTRE FOR HUMAN RIGHTS UNIVERSITY OF PRETORIA, ADDRESSING THE REPRODUCTIVE HEALTH RIGHTS OF WOMEN LIVING WITH HIV IN SOUTHERN AFRICA 6, 34 (2009), *available at* <http://www.docstoc.com/docs/95125946/Swiss-Initiative-to-Commemorate-the-60th-Anniversary-of#> (revealing the opinion of one health care worker, in reference to HIV-positive women, “these people make me sick. I am tired of them, why do they go on and sleep with men when condoms are everywhere. All they want to do is to infect us and our partners.”).

31. MTHEMBU ET AL., *supra* note 3, at 24 (reporting that many of the HRI study participants felt robbed of their choice to conceive; one participant stated, “I didn’t

sterilization of HIV-positive women is undoubtedly a widespread unequal treatment problem internationally, necessitating justiciable interventions and remedies.

B. *Why Focus on South Africa*

South Africa is uniquely positioned to institute changes in the treatment of HIV-positive women's reproductive rights and set an example for the rest of the world for a multitude of reasons. First, the prevalence of HIV/AIDS in South Africa is among the highest in the world, with a rate of thirty percent of the national population.³² The highest rates of HIV in South Africa are among women of reproductive age.³³ Additionally, South Africa has extensive national laws and is a party to international laws and treaties that dictate proper sterilization and informed consent protocol, making its continued violation of these regulations via consistent coercive sterilizations even more egregious.³⁴ South Africa has established informed consent laws in other major areas of health law and human treatment, making it a leader in informed consent laws globally.³⁵ South Africa was the first nation to recognize positive rights to reproductive decisions and reproductive health care within its national constitution,³⁶ again indicating it should be a leader in the enforcement of strong

have the immediate desire of having a child, you know[,] but I sort of kept thinking that it would be nice if I had the option of what is it that I want to do with my future") (citation omitted); see also Mzikazi Nduna & Lindiwe Farlane, *Women Living with HIV in South Africa and Their Concerns About Fertility*, 13 AIDS BEHAV. S62, S62 (2009) ("Research in Cape Town demonstrates that HIV[-]positive men and women believe pregnancy and child birth is a right [sic] of passage and that having a child brings greater meaning to life."); see also Diane Cooper et al., *Life Is Still Going On: Reproductive Intentions Among HIV-Positive Women and Men in South Africa*, 65 SOC. SCI. & MED. 274, 274, 277 (articulating that HIV-positive women in South Africa have actually demonstrated a stronger desire to reproduce than the regular cultural norm, since children represent hope and a reason for living in the midst of their bleak HIV-positive status).

32. Jane Harries et al., *Policy Maker and Health Care Provider Perspectives on Reproductive Decision-Making Amongst HIV-Infected Individuals in South Africa*, 7 BIOMED CENT. PUB. HEALTH 1, 2 (2007), available at <http://www.biomedcentral.com/content/pdf/1471-2458-7-282.pdf>.

33. MTHEMBU ET AL., *supra* note 3, at 4 (reporting that HIV prevalence in adolescent women is three to seven times higher than their male counterparts).

34. Melissa Turley, *South Africa: Motherhood Denied to HIV-Positive Women*, THE PULITZER CTR., <http://pulitzercenter.org/reporting/south-africa-hiv-aids-health-access-sterilization-women> (last visited Sept. 5, 2012).

35. See Rebouché, *supra* note 18, at 12–13, 23.

36. *Id.*; see also B. Jessie Hill, *Reproductive Rights as Health Care Rights*, 18 COLUM. J. GENDER & L. 501, 518–19 (2009) (explaining that the South African Constitution grants the right to health, which is understood to grant an entitlement to "health care, including reproductive health services").

informed consent protocols for sterilization procedures. Therefore, South Africa's governance structure should be well-equipped to attack the issue of coercive sterilizations and may be able to establish a framework for other countries to use in bringing an end to these heinous crimes.³⁷ There are also two pending cases in the South African national court system regarding coercive sterilization which may set precedent on the issue, making analysis in the country most timely.³⁸

Furthermore, sterilizations have exceptionally grave consequences in South African society. South African culture makes motherhood a central feature of women's social identities, in turn creating potential for marginalization and lowered social status for sterilized women who are unable to conceive.³⁹ Sterilized women have greater difficulties accessing marriage due to the widespread stigma associated with childlessness in South Africa.⁴⁰ Lacking marital options can result in economic instability and ostracism from one's family.⁴¹ Such stigma can lead to expulsion from the community; for example, infertile women may be shunned from social events, such as weddings, due to the belief that a sterilized woman has a "bad eye," which would make other people infertile and spoil joyous occasions.⁴² Sterilized women are also at risk for violence and abandonment by their partners as a result of the heightened stigma in South Africa.⁴³ Thus, many

37. See Rebouché, *supra* note 18, at 12–13; Hill, *supra* note 36, at 519.

38. Alex Duval Smith, *Women's Legal Centre Hails Wider Import of Namibia Sterilisation Verdict*, THE GUARDIAN, July 31, 2012, <http://www.theguardian.com/global-development/2012/jul/31/womens-legal-centre-hails-namibia-verdict>.

39. See MTHEMBU ET AL., *supra* note 3, at 9 ("Being unable to conceive children could inadvertently serve to further marginalise women and may diminish their social status.")

40. *Id.* ("The impact of this practice [coercive sterilization] is the further social exclusion and marginalisation of women living with HIV. In addition to the negative impact on a woman's self-]worth, affected women may not be valued by their families or may be looked down upon by women who are able to have children.") *Id.*

41. *Id.*

42. Karen Springen, *What it Means to Be a Woman*, NEWSWEEK, Sept. 14, 2008, available at <http://www.thedailybeast.com/newsweek/2008/09/14/what-it-means-to-be-a-woman.html>; see also Mbabane, *supra* note 26 (remarking that the Stigma Index in a Swazi study showed "[eleven] percent of HIV-positive people are regularly excluded from family activities; while [nine] percent are prevented from attending social gatherings such as weddings and funerals").

43. See MTHEMBU ET AL., *supra* note 3, at 22, 26 (quoting HRI participants' experiences, "I tried telling this (that I was sterilised) and the man just chased me out . . . my husband has even gone outside [inaudible] he got another girl pregnant," and "[After I was sterilized and my boyfriend left me] I'd get SMSs from his [new] girlfriend saying, 'I got his child,' you see things like that, 'you barren

sterilized women keep the injustices committed against them a secret from family and partners to avoid further unjust treatment and discrimination.⁴⁴ A participant in the HRI study disclosed that “generally, we [involuntarily sterilised women] all agreed that we have to get into marriage without telling a man [we] are sterilised.”⁴⁵ Another participant, speaking to the abandonment that is common among sterilized women, stated, “[h]e has choices, he can go anywhere and have children with whomever he chooses, and I, I can’t.”⁴⁶ Financial concerns, revolving around the traditionally practiced “lobola” (bride price), add more burdens on involuntarily sterilized women.⁴⁷ Another HRI participant expressed concerns about her husband’s perception of her sterilized status since “he doesn’t have a child like you know and he had just paid lobola [. . . s]o he wants a child.”⁴⁸ Thus, women who are HIV-positive and sterilized may be doubly stigmatized for their disease and their inability to have children in South African society.⁴⁹ However, many women in the HRI study felt ostracized as a result of their sterilized status rather than their HIV status, due to the high prevalence and commonplace of HIV in South Africa.⁵⁰

The geographically diverse nature of the participants across South Africa in the HRI study demonstrates that there is a widespread culture of coercive sterilizations and medical stigma towards HIV-positive women in the country.⁵¹ The paternalistic attitudes in the medical profession create a widespread power

thing”)(alteration in original).

44. *Id.*

45. *See id.* at 23.

46. *Id.*

47. *Id.* at 26–27. Lobola refers to the South African term for bride price. Although lobola was traditionally paid for in cattle, it is currently paid in cash for a bride, meaning that the husband and his family bought the wife and any future children. *See id.* at 27.

48. *Id.* at 24 (revealing that inability to bear children has been known to be grounds for divorce, where the husband and his family’s lobola would be returned). Some HRI participants expressed concerns that lobola would not be paid for them or it would be revoked for some of those already married due to their sterilized status: “[t]he lobola that people [pay—]I mean it’s like buying a woman and the chances are that if you can’t bear children they wouldn’t pay lobola for you.” *Id.* at 26.

49. *See id.* at 22.

50. *Id.* One participant stated, “you can live with the fact that they said ‘ingculaza’ you have AIDS. You know it’s like, who doesn’t have it, but inyumba [being an infertile, worthless woman] it’s like at the centre of you being a woman, it’s the core. So it really hurts.” *Id.* (alteration in original).

51. *See id.* at 30 (concluding that the HRI study reveals systematized abuse of HIV-positive patients’ reproductive rights nationwide).

imbalance between the patient and provider, disproportionately affecting illiterate women.⁵² Some medical providers have argued that pregnancy poses a health risk to HIV-positive women, since it can cause these women to become more symptomatic; however, the average pregnant, HIV-positive woman's cell counts and symptoms generally return to pre-pregnancy levels shortly after delivery, which therefore may not constitute a life-threatening risk to the mother nor necessitate medical intervention via sterilization procedures.⁵³ Still others argue that since HIV is a widespread, life-threatening pandemic, sterilizations are warranted to prevent mother-to-child transmission, which some countries with high rates of HIV infection classify as a serious public health risk.⁵⁴ Other medical professionals argue that this negative belief is unfounded due to the high efficacy of antiretroviral medication in preventing disease transmission, as mentioned above, which provides a great chance of successful health for the mother and child, while upholding the mother's reproductive freedom.⁵⁵ In fact, there is a higher risk of women bearing children with genetic defects than the risk of mother-to-child transmission of HIV for those women receiving antiretroviral treatment.⁵⁶ This problem is not limited to a handful of corrupt medical professionals—the country is experiencing nationwide medical violence towards HIV-positive women, resulting in deplorable loss of reproductive rights that must be rectified.

52. Farida A.U. Mamad, *Forced Sterilization of Women Living with HIV/ AIDS in Africa* 8 (Oct. 30, 2009) (unpublished L.L.M. dissertation, University of Mauritius) (on file electronically with the University of Mauritius), available at <http://repository.up.ac.za/bitstream/handle/2263/12645/mamad.pdf?sequence=1> (“[T]he power imbalance between the health care provider and the one to be treated may influence the decision making by the latter. It has to be born in mind that the subjects of this study are women, who ‘make up two[-]thirds of the world[']s illiterate people’ which often results in the deprivation of adequate health services, especially in Africa where usually the poor and uneducated are more likely to use public health care facilities . . .”).

53. Ruth Bessinger et al., *Pregnancy Is Not Associated with the Progression of HIV Disease in Women Attending an HIV Outpatient Program*, 147 AM. J. EPIDEMIOLOGY 434, 438–39 (1998); L.O. Omo-Aghoja et al., *Is Pregnancy Associated with Biochemical and Haematological Changes in HIV-Infected Nigerian Women?*, 17 S. AFR. J. OF HIV MED. 45, 48 (2010).

54. See Nair, *supra* note 17, at 224–25.

55. *Id.*

56. Mamad, *supra* note 52, at 28 (“[T]he overall risk of women having a child with [a] major defect is 2% to 3% compared to 1% for women with HIV infection.”).

C. Sterilizations Absent Informed Consent

There are myriad ways that doctors fail to obtain informed consent for sterilization procedures. Whether forcing women to sign waivers while physically in labor, failing to disclose the risks and consequences of sterilizations, or preying on illiterate women, all of these tactics take advantage of women in vulnerable situations and would never constitute informed consent in a South African court of law.⁵⁷ The cultural belief among many doctors is that the HIV-positive women are irresponsible for becoming pregnant and are unable to manage the needs of their family and their own health, requiring paternalistic action via sterilization.⁵⁸ Many health care workers have been known to believe that HIV-positive women “should not reproduce under any circumstances.”⁵⁹ However, with proper treatment, mother-to-child HIV transmission during childbirth is extremely low, making antiretroviral treatment a feasible alternative to sterilization as a method of preventing mother-to-child HIV transmission.⁶⁰ Access to antiretroviral treatment is now more widespread due to successful litigation attempts to lower the costs of antiretroviral drugs during the beginning of the century in South Africa.⁶¹ The lifespan of HIV-positive people is also increasing dramatically due to incredible advancements in antiretroviral therapies, resulting

57. See Kossen, *supra* note 2, at 160.

58. Nduna & Farlane, *supra* note 31, at S64. Nduna and Farlane show the widespread goal of health care professionals to prevent orphans and unhealthy babies, rather than protecting the health of the HIV-positive mother. For instance, some healthcare workers were heard saying, “why are you making babies, what is going to happen if you die . . . there should be no orphans.” *Id.* See also Lynne M. Mofenson, *Tale of Two Epidemics—The Continuing Challenge of Preventing Mother-to-Child Transmission of Human Immunodeficiency Virus*, 187 J. INFECTIOUS DISEASES 721, 722 (2003). “Even in settings where HIV counseling and testing services are available, the social stigma associated with HIV infection inhibits many women from using such services to learn their HIV infection status and, therefore, from taking steps to prevent transmission of HIV to their infants.” *Id.*

59. MTHEMBU ET AL., *supra* note 3, at 5 (identifying the rampant stigmatization towards pregnant, HIV-positive women expressed by health care workers via coercive HIV testing, denial of HIV medication and exposing one’s confidential HIV status).

60. COMM. FOR THE STUDY OF ETHICAL ASPECTS OF HUMAN REPROD. & WOMEN’S HEALTH, ETHICAL ISSUES IN OBSTETRICS AND GYNECOLOGY 75 (Int’l Fed’n of Gynecology & Obstetrics, 2012), <http://www.figo.org/files/figo-corp/English%20Ethical%20Issues%20in%20Obstetrics%20and%20Gynecology.pdf>.

61. Mark Heywood, *South Africa’s Treatment Action Campaign: Combining Law and Social Mobilisation to Realise the Right to Health*, 1 J. OF HUM. RTS. PRAC. 14, 24 (2009) (pronouncing the drastic price changes in antiretroviral therapies due to lobbying and litigation in South Africa, where the cost of the drugs decreased from sixty-four dollars per month to forty-two dollars per month).

in many fewer instances of abandoned and orphaned children.⁶² Thus, doctors and nurses are largely unjustified in influencing women's reproductive decisions or mandating that HIV-positive women should not be able to bear children and create a family.

D. International Sexual and Reproductive Human Rights Law, Policies, and Standards

1. Sterilization

Many international human rights treaties are directly or indirectly related to coercive sterilization. Health is one of the most basic human rights outlined in the founding human rights document, the Universal Declaration of Human Rights (UDHR), which includes the right to health,⁶³ and the right to have a family.⁶⁴ As the first international treaty to address women's rights exclusively, the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) states that women are entitled to equal access to family planning services, including the right "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."⁶⁵ In the Protocol to the African Charter on Human and Peoples'

62. MTHEMBU ET AL., *supra* note 3, at 13. Though medical advancements have significantly extended the lifespan of those who are HIV-positive, South African medical professionals' popular beliefs still affect the manner in which they practice medicine. One HRI participant reported, "[t]hey then told me that I had to be sterilised because I was HIV positive. They only had a file but they said if I were to have a child again, who would raise it because I was going to die soon." *Id.*

63. Universal Declaration of Human Rights, *adopted* Dec. 10, 1948, art. 25, G.A. Res. 217A (III), U.N. Doc. A/810 at 71 (1948) [hereinafter UDHR] (detailing that "[e]veryone has the right to a standard of living adequate for the health and well-being of himself and of his family . . .").

64. *Id.* (granting the right to begin a family as a protected human right due to consideration of family units as fundamental groups for all societies in Articles 12 and 16); Diana D.M. Babor, *Population Growth and Reproductive Rights in International Human Rights Law*, 14 CONN. J. INT'L L. 83, 99-100 (1999) (describing UDHR's recognition that the choice of the size of one's family rests with the family itself, where no one else can make that decision for the family).

65. Convention on the Elimination of All Forms of Discrimination Against Women, *adopted* Dec. 18, 1979, art. 16(e), G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46, U.N. T.S. 13 (*entered into force* Sept. 3, 1981) [hereinafter CEDAW] (declaring in its introduction, "[a]side from civil rights issues, the Convention also devotes major attention to a most vital concern of women, namely their reproductive rights. The preamble sets the tone by stating that 'the role of women in procreation should not be a basis for discrimination.' The link between discrimination and women's reproductive role is a matter of recurrent concern in the Convention . . . Accordingly, provisions for maternity protection and child-care are proclaimed as essential rights and are incorporated into all areas of the Convention . . .").

Rights on the Rights of Women in Africa (Maputo Protocol), to which South Africa is a signatory, states pledged to protect the right to control fertility, including the right to decide whether to have children, the number of children, and the spacing of the children.⁶⁶ Another important overarching framework is the Continental Policy Framework on Sexual and Reproductive Health and Rights under the African Union Commission, which declares that reproductive rights “impl[y] that people are able to have a satisfying and safe sex life, and that they have the capability to reproduce and the freedom to decide if, when[,] and how often to do so.”⁶⁷ Thus, coerced sterilization is a direct infringement on these declared rights due to the lack of freedom in one’s own family planning process.⁶⁸

There are many international projects also directed at women’s reproductive health, such as the United Nation’s Millennium Development Goals (MDGs).⁶⁹ MDG 6 is targeted to stop and reverse the spread of HIV/AIDS, but the international community has fallen short on this goal in several realms, including failure to fulfill contraception goals for women.⁷⁰ Thus,

66. Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa, 2nd Ordinary Sess., Assembly of the Union, *adopted* July 11, 2003, art. 14, CAB/LEG/66.6 (*entered into force* Nov. 25, 2005) [hereinafter Maputo Protocol].

67. AFRICAN UNION COMMISSION, SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS: CONTINENTAL POLICY FRAMEWORK 9 (2006), *available at* http://www.ippfar.org/NR/rdonlyres/0EAD868D-2E89-4D91-B661-BCC971933AD8/0/Continental_Policy_Framework_English.pdf.

68. *See id.* (determining that countries are obligated to offer institutional advice on family planning via reproductive education and create family codes which enable one’s free choices in family planning).

69. U.N., MILLENNIUM DEVELOPMENT GOALS REPORT 2010, at 3, *available at* <http://www.un.org/millenniumgoals/pdf/MDG%20Report%202010%20En%20r15%20-low%20res%2020100615%20-.pdf#page=22> (“The Goals represent human needs and basic rights that every individual around the world should be able to enjoy—freedom from extreme poverty and hunger; quality education, productive and decent employment, good health and shelter; the right of women to give birth without risking their lives; and a world where environmental sustainability is a priority, and women and men live in equality. Leaders also pledged to forge a wide-ranging global partnership for development to achieve these universal objectives.”).

70. *See* CTR. FOR HEALTH & GEND. EQUITY (CHANGE) ET AL., FULFILLING REPRODUCTIVE RIGHTS FOR WOMEN AFFECTED BY HIV: A TOOL FOR MONITORING ACHIEVEMENT OF MILLENNIUM DEVELOPMENT GOALS 4 (2005), *available at* <http://www.ipas.org/~media/Files/Ipas%20Publications/RRHIVE04en.ashx> (detailing the need for specific policies to ensure that the reproductive rights of HIV-positive women are protected and to shift cultural stigma including, “[e]xpanding access to, and ensuring that no woman is coerced into, voluntary HIV counseling and testing, including women receiving postpartum care, emergency contraception and rape crisis services, and abortion-related care.” . . . “[e]nsuring that HIV-positive women have the right to have children when they want to, and should be supported to do so, without judgment and with access to antenatal,

several policies have been identified as needing more careful attention and implementation, including promoting all choices for family planning and ensuring informed consent regarding the permanence of sterilization procedures.⁷¹ Furthermore, the International Federation of Gynecology and Obstetricians has set standards to be fulfilled during contraceptive and reproductive health counseling, which require that providers specifically denote the permanent nature of sterilization, the fact that life circumstances may change due to the sterilization procedure, and that the woman may experience regret after the sterilization procedure.⁷² The World Health Organization (WHO) also provides guidelines for sexual health counseling in its technical statement on contraception and HIV, “Medical Eligibility Criteria for Contraceptive Use,” noting that people should be properly counseled about the permanency of sterilization procedures and other available alternatives.⁷³

2. Informed Consent

International policy has determined that in order to exercise the right to health, individuals need to be ensured proper information to make the best medical decisions for themselves.⁷⁴ International treaties have recognized that access to reproductive and sexual education is essential to one’s right to health.⁷⁵ CEDAW General Recommendation 24 states that proper health care information required for informed consent includes

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[,]

perinatal and postnatal care,” . . . “[e]nsuring that sterilization of HIV-positive women only occurs when each woman concerned gives her full, informed and unpressured consent”).

71. *Id.*

72. COMM. FOR THE STUDY OF ETHICAL ASPECTS OF HUMAN REPROD. & WOMEN’S HEALTH, *supra* note 60, at 74; *see also* Mamad, *supra* note 52, at 35 (commenting on the especially grave potential outcomes for young HIV-positive women becoming sterilized, whose fertility timeframes could outlast potential cures or enhanced treatments for HIV which would make childbearing a safer option).

73. WORLD HEALTH ORG. (WHO), MEDICAL ELIGIBILITY CRITERIA FOR CONTRACEPTIVE USE (4th ed. 2009), http://whqlibdoc.who.int/publications/2010/9789241563888_eng.pdf.

74. *See* Committee on Economic, Social, and Cultural Rights, *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12)*, (22nd Sess., 2000), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, at para. 3, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I)(2008) [hereinafter *ESCR Committee, Gen. Comment No. 14*].

75. *Id.* (interpreting the right to health as encompassing educational health services to be made available for women).

and is sensitive to her needs and perspectives. States . . . should not permit forms of coercion, such as non-consensual sterilization . . . that violate women's rights to informed consent and dignity.⁷⁶

Likewise, non-consensual medical treatment is a violation of the right to be free from torture according to the Committee on Economic, Social, and Cultural Rights' (ESCR Committee) general comment on the Right to the Highest Attainable Standard of Health.⁷⁷ These regulations demonstrate a definitive need for educated and informed consent in all medical procedures, including sterilizations.

E. South African National Laws

1. Sterilization

The South African Sterilisation Act ("SASA") provides that consenting individuals over the age of eighteen have the right to be sterilized.⁷⁸ The only scenarios in which someone else can consent for a patient is when not receiving treatment would result in endangerment of the patient's life or if the patient is severely mentally disabled.⁷⁹ Specifically, SASA requires that patients be given a "clear explanation and adequate description" of the sterilization procedure, including the risks and future implications.⁸⁰ Additionally, unlike informed consent requirements for other medical procedures, SASA requires consent for sterilization procedures to be obtained in writing.⁸¹ The HRI study participants did not have the ability to refuse to undergo the sterilizations, which removed an essential element of informed consent.⁸²

76. Committee on Elimination of Discrimination Against Women, *General Recommendation No. 24: Article 12 of the Convention (Women and Health)*, (20th Sess., 1999) in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II)(2008) [hereinafter CEDAW Committee, *Gen. Recommendation No. 24*].

77. See ESCR Committee, *Gen. Comment No. 14*, *supra* note 74, at para. 8. .

78. Sterilisation Act 44 of 1998 § 4 (S. Afr.).

79. Jerome A. Singh et al., *South Africa a Decade After Apartheid: Realizing Health Through Human Rights*, 12 GEO. J. ON POVERTY L. & POL'Y 355, 375 (2005).

80. MTHEMBU ET AL., *supra* note 3, at 8 (arguing that the elements of an adequate description of the sterilization procedure should include "information on the procedure, its risks, and implications").

81. See Sterilisation Act 44 of 1998 § 4 (S. Afr.). According to Section 4(c) of SASA, consent is only deemed acceptable if in writing; this is a requirement unique to this Act, as general medical informed consent does not have to be in writing. MTHEMBU ET AL., *supra* note 3, at 8.

82. For a general summary and discussion of the trials and tribulations behind coercive sterilizations in South Africa, see MTHEMBU ET AL., *supra* note 3.

2. Informed Consent

Informed consent rights in South Africa are founded in its national constitution as the right to “freedom and security of the person.”⁸³ More specifically, the South African National Health Act (“SANHA”) contains two sections that reference the legal necessity of informed consent.⁸⁴ Section 6 of the law states that the “user [is] to have full knowledge [of] . . . (b) the range of diagnostic procedures and treatment options generally available . . . (c) the benefits, risks, costs and consequences . . . [and] (d) the user’s right to refuse health services.”⁸⁵ Section 7, “Consent of User,” describes the process for obtaining informed consent.⁸⁶ The health care provider must take all reasonable steps to obtain the user’s informed consent, except in situations that are life-threatening or present serious public health risks.⁸⁷

SANHA goes on to require that health care providers deliver information to patients in a language the patient understands and should take into account the patient’s literacy when obtaining informed consent.⁸⁸ SASA mandates that consent be “given freely and voluntar[il]ly without any inducement” and may only be considered given if the person has: (1) been given a clear explanation and adequate description of the procedures, consequences, and risks and (2) signed the prescribed consent form.⁸⁹

South African case law has reiterated the necessity for informed consent to the procedure before one is actually sterilized.⁹⁰ Cases have established that consent can be used as a defense to an unlawful act, but the elements are stringent.⁹¹ The patient must have knowledge of the nature and extent of the harm

83. S. AFR. CONST., sec.12, 1996.

84. National Health Act 61 of 2003 §§ 7, 55 (S. Afr.).

85. *See id.* at § 6.

86. *Id.*

87. *See id.*; Mitra Ebadolahi, *Using Structural Interdicts and the South African Human Rights Commission to Achieve Judicial Enforcement of Economic and Social Rights in South Africa*, 83 N.Y.U. L. REV. 1565, 1573 (2008) (distinguishing the unique circumstances afforded to someone in South Africa during an emergency medical situation).

88. National Health Act 61 of 2003 § 6 (S. Afr.).

89. Sterilisation Act 44 of 1998 § 4 (S. Afr.).

90. MTHEMBU ET AL., *supra* note 3, at 8 (noting the duty established for medical professionals to inform patients of any material risk associated with medical treatment before it is performed, especially in the case of irreversible procedures such as sterilizations).

91. *Id.* at 7.

or risk involved,⁹² understand the nature of that harm and risk,⁹³ and voluntarily consent to and assume the risk.⁹⁴ Furthermore, according to case law, consent to sterilization procedures is deemed "informed consent" only if it is based on substantial knowledge of the nature and effect of the procedure, allowing for self-determination in undergoing medical procedures.⁹⁵ Still other cases have established that consent should be obtained voluntarily and free from coercion or fear.⁹⁶

Most of the participants in the HRI study did sign some sort of consent document; however, all of them felt as though they were under duress to sign.⁹⁷ Thus, although SASA requires specific consent forms to be signed for sterilization procedures, this has not been shown to be effective in preventing coercive sterilizations.⁹⁸ Rather than complying with the consent protocols by explaining the procedure and risks involved, these forms seem to be treated as a formality in order to comply with the law—to be signed rather than understood.⁹⁹

II. South African Action in Preventing Coercive Sterilizations via Law and Policy Changes

Continued reports of coercive sterilizations in South Africa indicate that there is a failure in the current legal and policy scheme for sterilization and informed consent law, both nationally

92. *Id.*

93. *Id.*; *C v. Minister of Corr. Serv's* 1996 (4) SA 292 (T) at 304 (S. Afr.) (establishing deviation from acceptable informed consent practices for HIV-positive counseling was unacceptable because of the devastation that could result).

94. MTHEMBU ET AL., *supra* note 3, at 7; *Esterhuizen v. Adm'r, Transvaal* 1957 (3) SA 710 (TPD) (S. Afr.), in 31 S. AFR. MED. J. 908, 910 (1957) (stating that specific consent is needed to perform procedures, rather than blanket consent to treatment by a medical professional).

95. *Castell v. de Greef* 1994 (4) SA 408 (CC) at 426 (S. Afr.) (determining the reasonable patient standard for providing proper disclosure in the context of informed consent relies on one's capability to exercise the fundamental right of self-determination as well as the right to individual autonomy).

96. MTHEMBU ET AL., *supra* note 3, at 8 (asserting that consent "should not be induced by fear, force, threats, duress, coercion, compulsion, deceit, fraud, undue influence, perverse incentive[,] or financial gain").

97. *Id.* at 18 (discussing the pressure that HRI study participants felt to appease health care workers and make hasty decisions, resulting in their disempowerment in the provider-patient relationship, and in turn in their reproductive autonomy).

98. *Id.* (describing studies in which women signed consent forms under duress or in which they did not receive information on the risks, benefits, or implications of sterilization).

99. *Id.* at 19 (quoting one HRI study participant's experience that, "[n]o form was given to me to read, I was just told to sign").

and internationally.¹⁰⁰ Thus, this Part offers recommendations in an attempt to bring coercive sterilizations of HIV-positive women in South Africa to a halt. First, this Part explores the possibility of changing the current South African sterilization law by limiting the timeframe as to when informed consent can be given for sterilization. Next, this Part discusses enforcement mechanisms for obtaining proper informed consent; this Part also explores the potential for different penalties applicable for violating SASA and SANHA and the possibility of awarding reparations for the victims. This Part finally proposes two methods in which South Africa can reform medical provider policy to attempt to change the current cultural stigmatization toward childbearing HIV-positive.

A. Failures of National Law and Litigation

Thus far, national laws have not been enforced to make any meaningful change in the South African outbreaks of coercive sterilizations of HIV-positive women.¹⁰¹ While both SASA and SANHA have extensive provisions detailing the circumstances when one can consent to sterilization, neither of these laws is stopping instances of coercive sterilizations from occurring.¹⁰² One 2007 South African study highlighted the varied opinions between lawmakers and medical professionals on how to approach the reproductive rights of HIV-positive persons, demonstrating the need for more cohesive and explicit policies for this disparately treated subpopulation.¹⁰³ Furthermore, this study shed light on

100. *Id.* at 3 (asserting that existing legal requirements for informed consent in South Africa are not being implemented in practice, where “[t]he study findings point to a disjuncture between policy and practice rooted in persistent discrimination against HIV-positive women[,] which results in a severe violation of their rights”).

101. *Id.* at 3, 8 (demonstrating a clear disconnect between policy and practice, and asserting that despite SANHA and SASA, aimed at preventing coercive sterilizations, incidences are still arising with little or no action against the perpetrators).

102. *See id.*

103. Harries et al., *supra* note 32, at 5. (“Providers felt that they had insufficient knowledge of the possible interactions between different [antiretroviral] treatment regimens and hormonal contraceptives. In the absence of specific contraceptive guidelines, providers developed their ‘own’ guidelines which were often not based on clinical evidence. . . . Policy makers recognized providers’ concerns about a general lack of reproductive health guidelines for HIV-infected individuals. Most policy makers felt that developing counselling guidelines on reproductive options for HIV-infected individuals would be valuable. Without these guidelines providers would continue ‘bumbling along’ and make decisions in an ‘ad hoc’ manner. However, a few expressed reservations about designing reproductive health guidelines specifically targeting HIV-infected individuals, as a large number of peoples’ HIV status was unknown and favoured focusing on improving reproductive health services for all.”).

the fact that both policy makers' and medical providers' concerns about the country's overburdened health care system overpower the role of childbearing on South African women's social identities,¹⁰⁴ again necessitating some sort of overhaul of the current health care system in order to protect reproductive rights.

There is pending litigation in the national court system that may offer hope for a change in the consequences for performing coercive sterilizations.¹⁰⁵ The Women's Legal Centre of South Africa ("WLCSA") is currently representing two HIV-positive women who were victims of coercive sterilizations and may legally represent other eligible participants of the HRI study whose sterilizations have not passed the three-year statute of limitations.¹⁰⁶ However, the attorneys at WLCSA estimate that the case will take one to one-and-a-half years to litigate, and other immediate action is necessary.¹⁰⁷

B. *Difficult Enforcement of International Law*

A 2010 review of the MDGs uncovered severe delays in progress in improving women's reproductive rights across the African continent.¹⁰⁸ This holds true of improving the coercive sterilization outbreaks in South Africa, where international laws and treaties surrounding women's reproductive rights have not been upheld in practice.¹⁰⁹ Although there are plenty of international regulations in place to stop coercive sterilizations of HIV-positive women, these grand ideas and frameworks have little or no effective enforcement mechanisms to ensure compliance.¹¹⁰ For example, CEDAW's mandate that all women have a guaranteed freedom to determine the timing and spacing of their children is completely disregarded by coercive sterilizations, which

104. *Id.* at 6 ("While providers stated they respected HIV-infected women's reproductive rights, it was clear that they felt substantial reservations about HIV-infected women having children.").

105. Smith, *supra* note 38, at 2.

106. Nonandi Diko, *Legal Analysis on Forced Sterilization in South Africa*, WOMAN'S LEGAL CENTRE, 1, 4, <http://www.wlce.co.za/images/health/Forced%20Sterilization.pdf> (last visited Sept. 27, 2013); MTHEMBU ET AL., *supra* note 3, at 11.

107. See Turley, *supra* note 34, at 2 (noting that litigation is a race against time as the success rate of reversing sterilizations decreases over time).

108. Liesl Gerntholtz et al., *The African Women's Protocol: Bringing Attention to Reproductive Rights and the MDGs*, 8 PLOS MED. e1000429, 1 (2011) (expressing that goals for protection of maternal health and women's reproductive rights are not progressing satisfactorily, which has a disproportionate impact in Africa where women are especially vulnerable).

109. See discussion *supra* Part I.D.

110. See discussion *supra* Part I.D.

leave women no element of autonomy to make their own reproductive choices.¹¹¹ The African Charter on Human and People's Rights (Banjul Charter) also calls for combating discrimination against all women via appropriate legislation and institutional methods,¹¹² including protecting women's decisions surrounding fertility.¹¹³ South Africa is currently in violation of this international regulation as well, due to the fact that coercive sterilizations are only performed on women, resulting in severe discrimination against women and undermining their reproductive autonomy.¹¹⁴ Introducing targeted legal reforms and implementing stronger enforcement mechanisms would bring South Africa closer to fulfilling its international human rights obligations.

C. Recommendations: Informed Consent Legal and Policy Solutions Domestically and Internationally

1. Changing the Law

Particular legal reforms would move toward preventing instances of coerced consent in the context of sterilizations.¹¹⁵ Amending SASA to prohibit informed consent from being given or implied once labor starts would decrease the amount of medical professionals attempting to take advantage of HIV-positive women in such a vulnerable position. Medical professionals would thus be forced to discuss sterilizations before women actually begin any kind of labor process,¹¹⁶ making it more likely that the women are able to fully comprehend that the sterilization procedure does not affect the health or delivery of the baby whatsoever.¹¹⁷ This provision, along with the effective enforcement of other aspects of the law that require the consent to be presented in one's mother tongue and in writing,¹¹⁸ will begin to decrease the amount of coercive sterilizations occurring in South Africa.

As previously established, South African informed consent laws are progressive and extensively define what constitutes informed consent.¹¹⁹ However, South African sterilization and

111. See CEDAW, *supra* note 65, at art. 16(e).

112. See Maputo Protocol, *supra* note 66, at art. 2.

113. See *id.* at art. 14.

114. See MTHEMBU ET AL., *supra* note 3, at 21. ("[T]here are no public reports of HIV-positive men being targeted for sterilisation in order to prevent pregnancies.").

115. See MTHEMBU ET AL., *supra* note 3, at 30–31.

116. *Id.* at 29.

117. *Id.*

118. See National Health Act 61 of 2003 §§ 6,7 (S. Afr.).

119. See Rebouché, *supra* note 18, at 12–13.

informed consent law should more completely specify what will happen to those who sterilize hospital patients without their consent. SASA has an "offences and penalties" section which states, "[a]ny person who contravenes or fails to comply with the provisions of this Act is guilty of an offence and liable on conviction to a fine or to imprisonment for a period not exceeding five years."¹²⁰ This penalty has proved to be an insufficient deterrent for coercive sterilization, thus further penalties should be considered.¹²¹ Suspension or revocation of one's medical or nursing license is also a valid option to punish those who conduct sterilizations without proper informed consent.¹²² This additional penalty could prove to be more just from the victims' perspective, because for many medical professionals, it would affect their entire future, as opposed to receiving a mere fine or a small jail sentence. This punishment is also more accurately reflects the gravity of an irreversible sterilization procedure.

2. Medical Staff Training and Counseling

Due to the failures of national and international laws and regulations in correcting the coercive sterilization issue, there is a strong argument for reforming the training of health care professionals across the country. South African health care providers currently have a tendency to follow societal norms in avoiding discussion of treatment options and counseling surrounding sexuality and sexual health due to the taboo nature of these health issues in society.¹²³ Understandably, cultural perceptions of HIV-positive women will take time to change. However, sexual health counseling and special trainings about proper informed consent procedures in hospitals and medical and nursing schools can make a dramatic difference in the prevalence of coercive sterilizations.¹²⁴ The power to control one's body and fertility is best achieved with proper information and education

120. Sterilisation Act 44 of 1998 § 9 (S. Afr.).

121. See MTHEMBU ET AL., *supra* note 3, at 32.

122. See Health Professions Act 56 of 1974 § 19 (S. Afr.); see also Diko, *supra* note 106, at 1.

123. Mamad, *supra* note 52, at 25 (describing the instance of one South African social worker's response to HIV risk and sexuality among women with mental illnesses, "mental health and sexuality are two things that you just don't talk about. We have come from a society where those are taboos."); see also STEFISZYN ET AL., *supra* note 30, at 41 (articulating the tendency for many women in Southern Africa to be poor and disempowered, making these women more vulnerable to medical providers' personal opinions and coercive tactics absent any fulfillment of human rights).

124. Levine & Dubler Navelhoff, *supra* note 28, at 322.

regarding sterilization and birth control options, especially for women with added health risks as a result of their HIV status.¹²⁵ Because lack of professional acceptance of the methods to properly communicate with patients poses a grave risk for the health and reproductive freedoms of all HIV-positive women, medical professionals in South Africa must focus on improving their communication skills.

Therefore, South African medical providers and medical and nursing students need to undergo training programs designed to distinguish their personal views from their professional responsibilities, enabling improvement in the quality of care and reproductive health outcomes of HIV-positive women.¹²⁶ The WHO guidelines on contraception for HIV-infected individuals can inform South African guidelines for proper communication and education for HIV-positive patients on their reproductive options.¹²⁷ Reproductive health communication between patients and medical professionals must consist of a wide array of options, as well as outcomes and side effects, to enable informed and independent choices to be made by HIV-positive women of reproductive age.¹²⁸ This is especially vital in the sterilization context, as women deserve the right to understand that it is a procedure which is very unlikely to be reversed and is of such a permanent nature.¹²⁹ Along with that, the informed consent process should be a true process, rather than an event, allowing HIV-positive women time to consider treatment which will change their lives forever.¹³⁰ By instituting a policy that makes pre-sterilization counseling mandatory at least twice before one is able to give informed consent, the discussion about the consequences of the procedure would be started sooner in the pregnancy, allowing

125. STEFISZYN ET AL., *supra* note 30, at 41.

126. MTHEMBU ET AL., *supra* note 3, at 32 (recommending the need for medical professions to have training on the legal and ethical principles of informed consent due to the widespread lack of understanding of viable informed consent in the context of sterilizations).

127. Harries et al., *supra* note 32, at 6 (“[WHO] guidelines on contraception for HIV-infected individuals exist and appropriate guidelines need to be developed and adapted for reproductive counseling of HIV-infected individuals in South Africa.”).

128. MTHEMBU ET AL., *supra* note 3, at 26 (recounting one HRI study participant’s view that, “sometimes I would wake up and say, ‘you know what, she (the nurse) snatched something that I wanted,’ you know? She made up a choice. She made up a choice for me.”) (alteration in original).

129. *Id.* at 28.

130. *Id.* at 29 (relaying that one participant’s opinion about potential suggestions for coercive sterilization prevention was, “I suppose the consenting process, it has to be a process not an event so that women are really able to choose what is good for them”).

women proper time to comprehend the medical and social significance of sterilization.¹³¹ Though such institutional change may be met with resistance and take time to implement, this is an imperative paradigm shift that must be made in order to ensure consistent enforcement of HIV-positive women's reproductive rights.

Lastly, changing the framework of informed consent may necessitate a compliance officer in hospitals to monitor adherence to the new training. Beyond ensuring adherence to receipt of informed consent in sterilization and other reproductive procedures, these compliance officers could be charged with leading trainings in the hospitals they serve and safeguarding continued education to develop and implement proper informed consent. Although this may be unfeasible in the current state of hospital affairs due to low resources and under-staffing in South African hospitals, it may be a promising future step.¹³²

3. Improving Enforcement

In order for penalties and repercussions to be effective, a strong enforcement mechanism is imperative. Currently, the South African legal system is largely inaccessible to HIV-positive women experiencing wrongful sterilizations; accessing the court system requires not only money, but also the courage and capability to represent their cases before powerful people.¹³³ These barriers are difficult for many women who feel unable to seek justice due to their guilt or shame for their HIV or sterilized status.¹³⁴ Furthermore, cultural roles in South African society

131. *See id.*

132. *See* Katharina Kober & Wim Van Damme, *Scaling Up Access to Antiretroviral Treatment in Southern Africa: Who Will Do the Job?*, 364 LANCET 103, 103 (2004) (arguing that the lack of financial resources is less prohibitive than the lack of human resources in terms of implementing national HIV treatment plans).

133. MTHEMBU ET AL., *supra* note 3, at 28 (articulating one participant's claim that if she had money, she would have taken her unjust, coercive sterilization complaint to the South African High Court); *see also* Marius Pieterse, *Health, Social Movements, and Rights-based Litigation in South Africa*, 35 J. L. & SOC'Y 364, 379 (2008) ("[T]he extent to which the participatory potential of socio-economic rights litigation is realized depends largely on the willingness and ability of the poor to actually voice their needs in court, and on the responsiveness of the judiciary to their claims. Both of these factors are problematic in South Africa, as is evidenced especially by the small number of socio-economic rights cases that have been brought in over a decade and by the fractional percentage of these claims that have been initiated by poor individuals or groups themselves (as opposed to being brought by social movements on their behalf).").

134. *Id.* at 365, 379–80 (exposing that nearly fifty percent of South Africans live in extreme poverty and lack access to basic social and health services, and

inhibit many women's beliefs in their capabilities to stand up for their rights as women, as they are often treated as second-class citizens.¹³⁵ Thus, they may believe that coercive sterilizations are not as unusual or as unjust as the procedures truly are. Due to this hesitation, many HIV-positive South African women who have experienced coercive sterilizations are now past the three-year statute of limitations to bring a claim.¹³⁶

Due to structural inequalities and barriers to access faced by many South African women, looking to other forums of adjudication may provide more effective alternatives.¹³⁷ A separate grievance process should be established to properly redress the harm suffered from coercive sterilizations. This system could mirror the structure of a specialty court or alternative dispute resolution setting, where the procedures are less formal and there is less intimidation than in a court room.¹³⁸ For example, panels could consist of all-female adjudicators or allow participants to give testimony behind a screen to avoid revealing their identities in public.¹³⁹ Flexibility and potential modifications to adjudication procedures such as these could greatly reduce the fears of some women and better enable them to bring their claims forward. Beyond making justice more accessible to those who have suffered wrongful sterilizations in the past, a new system that is more easily and frequently accessed will serve as a better deterrent to medical providers in committing coercive sterilizations in the future. Only when medical providers and the health care facilities are held accountable for their wrongdoings can we begin the process of breaking down the widespread culture of using violence

acknowledging that several structural barriers prevent those in low socioeconomic positions from bringing their own claims, including lack of rights awareness, lack of access to initial legal advice, distance from the courts, distrust of the legal system, skepticism of chances of winning, and costs).

135. It is more socially acceptable to be HIV-positive than it is to be sterilized. MTHEMBU ET AL., *supra* note 3, at 23 (indicating that of the twenty-two women in the HRI study, only one woman has publicly disclosed her sterilization status and that all of the participants agreed it was more socially acceptable to be HIV-positive). As one participant said, "I can understand being HIV-positive but telling your partner that you cannot have children is too much." *Id.*

136. *Id.* at 11. Of the twenty-two participants in the HRI study, only five of the women could potentially bring claims of damages against the health care facilities due to the three-year limit on bringing a claim. *Id.*

137. Ramona Vijayarasa, *Putting Reproductive Rights on the Transitional Justice Agenda: The Need to Redress Violations and Incorporate Reproductive Health Reforms in Post-Conflict Development*, 15 NEW ENG. J. INT'L & COMP. L. 41, 53 (2009) (noting the effectiveness of "truth commissions" in reducing gendered violence and encouraging testimony).

138. *Id.*

139. *Id.*

against marginalized HIV-positive pregnant women for their perceived wrongful conduct in South African society.¹⁴⁰

4. Granting Reparations

Lastly, South Africa should consider offering reparations to HIV-positive women who have suffered coercive sterilizations. Extending the three-year statute of limitations for sterilization violations may be unfeasible under constitutional law and set an unjust precedent for bringing complaints for sterilization violations too late after they are committed.¹⁴¹ Instead, offering reparations for past suffering will benefit the victims of these horrific sterilizations without needing to adjust other substantive law.¹⁴² Not only do reparations offer some form of monetary compensation for the wrongs committed, but reparations can also act as a means of healing and recovery when it is acknowledged that these HIV-positive victims of coercive sterilizations were wronged.¹⁴³ HIV-positive women who have suffered coercive sterilizations embody the definition of “victim” under the Truth and Reconciliation Commission Act (“TRCA”), enabling these women to access reparations, which are defined as “any form of compensation, *ex gratia* payment, restitution, rehabilitation[,] or recognition.”¹⁴⁴ However, the current system for reparations under TRCA is laced with bureaucratic limitations, making receipt of reparations slow and difficult.¹⁴⁵ Thus, there is a need to design a new framework for reparations. This restructuring could potentially require offering free post-trauma counseling to women, in which many participants of the HRI study expressed great

140. *Id.*; MTHEMBU ET AL., *supra* note 3, at 30 (explaining that pregnant HIV-positive women face medical discrimination in the form violent, involuntary sterilization procedures because of their gender, disease status, and exercise of their reproductive rights).

141. See Vijayarasa, *supra* note 137, at 55.

142. *Id.*

143. *Id.*

144. Christopher J. Colvin, *Overview of the Reparations Program in South Africa*, in THE HANDBOOK OF REPARATIONS 176, 182 (Pablo de Greif ed., 2006) (defining “victim” under the TRCA as someone who “suffered harm in the form of physical or mental injury, emotional suffering, pecuniary loss[,] or substantial impairment of human rights, (i) as a result of a gross violation of human rights . . .”).

145. *Id.* In order to actually receive reparations, the victim must be deemed qualified by the Committee on Reparations and Rehabilitation, which makes recommendations to the President for reparations. *Id.* Next, the President considers these recommendations and brings his or her own recommendation to Parliament, where this recommendation is debated before potentially becoming approved for a Parliamentary Resolution. *Id.*

interest.¹⁴⁶ If financial reparation for emotional suffering or payment for medical care or reversal procedures is too burdensome on the state, victims should, at minimum, be provided with free mental health care and counseling as automatic compensation for the sterilization violation.¹⁴⁷

Conclusion

Coercive sterilization needs to be promptly addressed to avoid the spread of violations of reproductive rights of HIV-positive women globally. South African and international laws have proven unsuccessful in preventing sterilizations absent truly informed consent.¹⁴⁸ Small modifications to SASA can enable easier access to justice, as well as limit the situations in which consent for sterilization procedures is deemed valid. Along with changing its national sterilization laws, South Africa can begin to combat the stigma, improve the treatment of HIV-positive women, and prevent future coercive sterilizations through medical training focused on proper informed consent protocols and patients' rights.

Coercive sterilization is a grave human rights abuse, destroying one's fundamental right to reproduce.¹⁴⁹ Rather than spend precious resources on a costly surgical procedure, money should be spent providing more HIV-positive women with antiretroviral therapy to reduce mother-to-child transmission and promote healthier lives, with ample reproductive options. Promise Mthembu, the founder of HRI, has experienced firsthand discrimination in the form sterilization due to her HIV-positive status; she proclaims that the effects of wrongful sterilization are long-lasting: "[t]he pain of coerced sterilization never ends . . . [a]t every point in your life you interact with it[—]if you start a new relationship, if a new child is born into the family, or if you start a new job and people ask you about your life."¹⁵⁰

146. MTHEMBU ET AL., *supra* note 3, at 28 (revealing that at least one participant desired free psychological counseling, "I think that they can help me a lot as I need counseling[] about how . . . I can deal with . . . having been sterilised").

147. Smith, *supra* note 38 (noting that counseling is the number one request that HIV-positive women who faced sterilizations bring forward; they also often request a public apology or help with adopting a child).

148. *Id.* (showing that the law remains ineffective in preventing forced sterilizations).

149. Vijayarasa, *supra* note 137, at 47 (stating redress for reproductive rights is a matter of international law and classifying reproductive rights violations as matters that "require a particularly effective response").

150. Smith, *supra* note 38 (describing Promise Mthembu's coercive sterilization at the age of twenty-two after a hospital refused to treat her HIV without performing a sterilization first).

