# *The coerced and forced sterilisation of women living with HIV in South Africa: A critical review of existing legal remedies.*

**By**

**Chantal Jacqueline Badul**

**932409233**

This Research Project is submitted in fulfilment of the regulations for the PhD Degree, College of Law and Management, School of Law, at the University of KwaZulu-Natal, Pietermaritzburg.

SUPERVISOR: PROFESSOR A E STRODE
CO- SUPERVISOR: MS P P SINGH

NOVEMBER 2018

# Declaration

I hereby declare that this thesis is my own unaided work, and that all my sources of information have been acknowledged. To my knowledge, neither the substance of this dissertation, nor any part thereof, is being submitted for a degree in any other University.

# Acknowledgements

Writing my thesis can be best described as a journey. Some of the best life lessons that I have learnt have come from travelling the road to reach my destination. I was extremely fortunate to have travelled this road with so many supportive and encouraging people that not mentioning them would be ungracious on my part. To my supervisor Professor Ann Strode who is truly an incredible human being, not only did you impart your knowledge so selflessly, your encouragement, commitment and belief in me was a driving factor to complete my work. After all my supervision sessions with you I emerged a much wiser and enlightened person. To Priya Singh I am grateful to you for all your valuable input and our brainstorming sessions.

To my Dad who has always instilled in me the value of continuous learning and encouraged me to undertake this further study, I am eternally grateful to you. To my Mum who sat with me through all the long and tedious nights, I appreciate your commitment to me. To my brother Deon (my personal IT specialist) who has always assisted me so patiently and checked on my progress regularly I appreciate your support. My sister Lindiwe, who provided me with daily inspiration to complete my work. Thank you for all the light-hearted moments we shared it certainly made the road easier to travel.

To my dear friends who have been so thoughtful throughout this process and always remembered to check on my progress and to spur me on, your dedication to me is valued especially Asogan who never doubted my ability to complete my work. To my colleagues Darren Subramanien who kindly completed the Turn-it-in requirements on my behalf and Dr Rosemary Kuhn who proof-read my thesis thank you for your invaluable contribution.

To Dr C Pickles, my external examiner, thank you for your insightful comments and feedback which has helped me immensely.

Thank you to the Almighty without whom, I would not have reached my destination.

# Acronyms

| | |
|---|---|
| ACHPRs | African Charter on Human and Peoples' Rights |
| CAT | Convention Against Torture |
| CEDAW | Convention on the Elimination of All Forms of Discrimination against Women |
| CGE | The Commission for Gender Equality |
| FIGO | International Federation of Gynaecology and Obstetrics (FIGO) |
| HIV | Human Immunodeficiency Virus |
| HPCSA | Health Professions Council of South Africa |
| ICCPRs | International Covenant on Civil and Political Rights |
| ICESCRs | International Convention on Economic, Social and Cultural Rights |
| MAPUTO PROTOCOL | Protocol to the ACHPR on the Rights of Women in Africa |
| PEPUDA | Promotion of Equality and Prevention of Unfair Discrimination Act |
| SAHRC | South African Human Rights Commission |
| SANC | South African Nursing Council |
| UDHR | Universal Declaration of Human Rights |

# Table of Contents

# Chapter One

# Introduction

## 1.1 Introduction

Two South African studies have documented the practice of forced or coerced sterilisation of women living with HIV.[1] These studies have shown to some extent the possible prevalence,[2] nature of and lived experiences[3] of this rights violation of women with HIV. One of the issues identified by affected women has been their desire for legal relief.[4] Women who were interviewed felt that their bodies had been violated and that they ought to be compensated through the payment of compensation and have access to medical procedures to reverse the sterilisations.[5] An under researched issue is whether the affected women are entitled to any legal remedies and whether such remedies would meet their identified needs. Further, whether these existing remedies would facilitate access to justice for them. This is done through measuring the existing remedies against five core elements of access to justice namely; functionality of the justice system, affordability of legal services; accessibility to courts and knowledge of legal rights, acceptability of the remedies provided and finally the ability of the legal system to hold the wrongdoers accountable.[6]

This chapter provides an introduction to the study of the possible legal remedies available to HIV positive women who allege that they have been the victims of coerced and forced sterilisation in South Africa. This chapter will present background to the topic which includes the medical and social aspects of involuntary sterilisation, the relevant legal framework within South Africa and a critical review of the range of legal remedies available to affected women. Core definitions, the problem statement, research questions and methodology are also provided.

---

[1] These are the studies conducted by Strode, Mthembu and Essack which is documented in A Strode et al '''She made up a choice for me'': 22 HIV-positive women's experiences of involuntary sterilization in two South African provinces' (2012) 20 (39S) *Reproductive Health Matters* 1-9 and the Human Sciences Research Council report 'The people living with HIV stigma index: South Africa 2014' (2015), available at http://www.stigmaindex.org/sites/default/files/reports/Summary-Booklet-on-Stigma-Index-Survey%20South%20Africa.pdf accessed on 18 December 2017.

[2] Human Sciences Research Council The people living with HIV stigma index: South Africa 2014' (2015), available at http://www.stigmaindex.org/sites/default/files/reports/Summary-Booklet-on-Stigma-Index-Survey%20South%20Africa.pdf accessed on 18 December 2017.

[3] Strode et al '''She made up a choice for me'': 22 HIV-positive women's experiences of involuntary sterilization in two South African provinces' (2012) 20 (39S) *Reproductive Health Matters* 1-9.

[4] Z Essack & A Strode '''I feel like half a woman all the time'': The impacts of coerced and forced sterilisations on HIV-positive women in South Africa' (2012) 26 (2) Agenda 24-34.

[5] Ibid.

[6] *Economic Freedom Fighters v Speaker of the National Assembly and Others; Democratic Alliance v Speaker of the National Assembly and Others* (CCT 143/15; CCT 171/15) [2016] ZACC 11; 2016 (5) BCLR 618 (CC); 2016 (3) SA 580 (CC) (31 March 2016) at para 52.

## 1.2 Background

South Africa lamentably, has the largest incidence of HIV infections worldwide.[7] Recent statistics in July 2017 revealed that an estimated 7 million people of our population are living with HIV.[8] Approximately 21.17% of these persons are women in their reproductive age.[9] The low status of women in our society combined with other factors such as poverty, inequality, social instability, illiteracy and limited access to good quality health care have been identified as some of the key contributors to the high rate of infection amongst women.[10] HIV was at one time regarded as a death sentence however, with significant improvements in medical care it is now regarded as a chronic condition which is manageable. It is not viewed like other chronic diseases and often does not carry with it the sympathy that other chronic illnesses enjoy. Instead, it is generally accompanied by high levels of stigma and discrimination.[11]

Despite these obligations the sexual reproductive health rights of HIV positive women has been neglected. The focus of the national response to HIV has often been, particularly in the past, on curbing the spread of the virus rather than managing the illness.[12] Ironically, HIV positive expectant mothers are identified by the prevention of mother-to-child transmission programme. A combination of antiretroviral drugs and access to prevention of mother-to-child transmission programmes can ensure that HIV positive women live long productive lives.[13] This would include delivering babies by caesarean section and encouraging HIV positive mothers to either exclusively breastfeed or feed their babies with infant formula which would have the effect of decreasing the risk of vertical transmission rates from mother to child.[14] There has been criticisms of this programme and suggestions that it does not in reality promote women's rights. In that, women feel that they are coerced into being tested often at a time at which they are not ready for the potential results and following knowledge of their HIV status they face abuse and neglect from health care workers. Research conducted by Amnesty International in two provinces in South Africa lends support to this allegation. Women and young girls have recounted that they

---

[7] UNAIDS 'South Africa: Overview' [2018], available at http://www.unaids.org/en/ regionscountries/ countries/southafrica accessed on 5 January 2018.
[8] Stats SA 'Mid-year population estimates 2017' (2017) 8, available at http://www.statssa.gov.za/ publications/P0302/P03022017.pdf accessed on 5 January 2018.
[9] Ibid.
[10] UNAIDS 'South Africa: Overview' [2018], available at http://www.unaids.org/en/ regionscountries/ countries/southafrica accessed on 5 January 2018.
[11] E Bell et al 'Sexual and reproductive health services and HIV testing: Perspectives and experiences of women and men living with HIV and Aids' (2007) 15 (29) *Reproductive Health Matters* 113-135.
[12] D Cooper 'In pursuit of social development goals and HIV-infected women's reproductive rights – South Africa as a case study' (2008) 75 *Agenda* at p 7.
[13] Open Society Foundations 'Against her will: forced and coerced sterilization of women worldwide' [2012] 5, available at https://www.opensocietyfoundations.org/sites/default/files/against-her-will-20111003.pdf accessed on 2 November 2017.
[14] V Paiva et al 'The right to love: The desire for parenthood among men living with HIV' (2003) 11 (22) *Reproductive Health Matters* 91-100 at p91.

delayed testing for HIV and seeking antenatal care largely because of the ill-treatment that they were subjected to by health care workers and the poor infrastructure of the public health care system that they had to use.[15] However, it may be submitted that the programme itself is invaluable but its current implementation is problematic as it contributes to the increased discrimination and stigma that HIV positive pregnant women and young girls have to face.[16]

Although reproductive health choices for HIV positive women, such as deciding whether or not to be tested within pregnancy fall within their rights to autonomy and dignity, Cooper holds the view that decision making on this issue is complex.[17] It requires the balancing of personal, interpersonal and social factors.[18] Studies have shown globally that HIV positive women desire having their own biological children.[19] This is evidenced by the testimony of an HIV positive woman who was coerced into being sterilised when she said that ''*the decision to have a child, is an individual's, it should not be up for debate*.''[20] An array of reasons have come through the narratives of HIV positive women on why they desire their own biological children. These reasons can be compartmentalised into reasons that come from the women themselves and for reasons that come from external sources like partners, husbands, family, religious prescripts and the community. From experiencing the feeling of being pregnant to leaving something of themselves behind when they die is a common rationale for HIV positive women wanting to have children.[21] In turn, motherhood often gives HIV positive women the motivation to remain healthy and to be hopeful about life.[22] Children give their HIV positive mothers a purpose to continue living.[23] HIV positive women

[15] ''The Struggle for maternal health, Barriers to Antenatal care in South Africa'' available at https://ep00.epimg.net/descargables/2014/10/09/5f52326b55514f90a8bfc3cc49e4bb46.pdf?rel=mas, accessed on 16 July 2018 at p 2 and 4.
[16] Ibid at p 3-5.
[17] D Cooper 'In pursuit of social development goals and HIV-infected women's reproductive rights – South Africa as a case study' (2008) 75 *Agenda* 7.
[18] Ibid.
[19] D Cooper et al 'Life is still going on: Reproductive intentions among HIV-positive women and men in South Africa' (2007) 65 *Social Science and Medicine* 274-283 at p 275-277; S Gruskin et al 'Ensuring sexual and reproductive health for people living with HIV: An overview of key human rights, policy and health systems issues'( 2007) 15 (29) *Reproductive Health Matters* 4-26 at p 7; M G van Dijk et al 'Health care experiences of HIV-infected women with fertility desires in Mexico: A qualitative study' 2013 *Journal of the Association of Nurses in Aids Care* 1-9 at 1, 5-6; L Farlane 'HIV-positive women have family planning needs too' (2008) 75 *Agenda* 31-37 at 31; J Godia 'Dialogue with women living with HIV and AIDS: a case for reproductive and sexual health rights (2008) 75 *Agenda* 46-52 and V Paiva et al 'The right to love: The desire for parenthood among men living with HIV' (2003) 11 (22) *Reproductive Health Matters* 91-100 at 97-98.
[20] African Gender and Media Initiative 'Robbed of choice: Forced and coerced sterilization experiences of women living with HIV in Kenya' (2012) 10, available at http://kelinkenya.org/wp-content/uploads/2010/10/Report-on-Robbed-Of-Choice-Forced-and-Coerced-Sterilization-Experiences-of-Women-Living-with-HIV-in-Kenya.pdf accessed on 1 July 2015 at 10.
[21] D Cooper et al 'Life is still going on: Reproductive intentions among HIV-positive women and men in South Africa' (2007) 65 *Social Science and Medicine* 274-283 at 277.
[22] M G van Dijk et al 'Health care experiences of HIV-infected women with fertility desires in Mexico: A qualitative study' 2013 *Journal of the Association of Nurses in Aids Care* 1-9 at 2.
[23] D Cooper et al 'Life is still going on: Reproductive intentions among HIV-positive women and men in South Africa' (2007) 65 *Social Science and Medicine* 274-283 at 277.

often view children as representing normality.[24] In a nutshell, having children for these women makes life worth living for.

According to Bell and Mthembu, ''all over the world HIV has been stigmatised and associated with shame, making it difficult for people to access HIV testing, treatment care or counselling for fear of being judged.''[25] This stigma has crept its way into the arena of sexual reproductive health rights of women living with HIV often, having dire consequences for this group of vulnerable women who have found themselves being forcibly or coercively sterilised.[26] Stigma and discrimination can only be understood if we examine the many layers of disadvantage.[27] Sifris refers to this as intersectional discrimination, in terms of which for example, a women may face discrimination because she is female, from a minority race group, is HIV positive, is living in poverty and illiterate.[28] All of these layers of various forms of discrimination act in a cumulative fashion to add to her disadvantage and increase her vulnerability to the possibility of receiving poor treatment in the health care system. In the current context, women living with HIV face discrimination based on amongst others their sex, gender, race, class and socio-economic status. Generally, this vulnerable group of women access public hospitals where they often experience poor treatment, and a further exacerbating factor is the power differential that exists between them and health care practitioners.[29]

Many women rely on voluntary sterilisation to control their fertility.[30] Sterilisation is a permanent contraceptive method which can be carried out in three ways. The first way is a surgical sterilisation which involves an operation in which the fallopian tubes are cut or blocked in order to prevent fertilisation.[31] The second and third ways in which a woman may be sterilised are by inserting a coil in the fallopian tubes or by administering medication which both have the effect of causing the fallopian tubes to seal respectively.[32]

The advantages of a sterilisation is that it does not affect breastfeeding, it is free from the side effects of some of the temporary contraceptive methods and it may provide some

[24] S Gruskin et al 'Ensuring sexual and reproductive health for people living with HIV: An overview of key human rights, policy and health systems issues' (2007) 15 (29) *Reproductive Health Matters* 4-26 at 7.
[25] Bell et al 'Sexual and reproductive health services and HIV testing: Perspectives and experiences of women and men living with HIV and Aids' (2007) 15 (29) *Reproductive Health Matters* 113-135 at 114.
[26] P Patel 'Forced sterilization of women as discrimination' (2017) 38 (15) *Public Health Reviews* 1-12.
[27] R Sifris 'The voluntary sterilisation of marginalised women: power, discrimination, and intersectionality' (2016) 25 (1) *Griffith Law Review* 45-70 at 46.
[28] Ibid.
[29] Ibid at 48.
[30] H Ratcliffe 'Women and forced sterilisation' (2012) *A Global Voice for Women – Soroptimist International,* available at http://www.soroptimistinternational.org/assests/med, accessed on 1 December 2014.
[31] Open Society Foundation 'Against her will: Forced and coerced sterilisation of women worldwide' [20100] 11 available at https://www.opensocietyfoundations.org/sites/default/files/against-her-will-20111003.pdf accessed on 2 November 2017.
[32] Ibid.

protection against pelvic inflammatory disease and ovarian cancer.[33] One of the disadvantages of a sterilisation as a form of contraception is that sterilisation in theory eliminates any further option to procreate.

But for some women, sterilisation is not a choice; there are reports of women from across the globe who have been forced or coerced by medical personnel to submit to permanent and irreversible sterilisation procedures often for discriminatory reasons.[34] According to Patel,[35] this practice targets marginalised populations including poor women,[36] racial minorities,[37] disabled women,[38] women with epilepsy[39] and most recently HIV positive women.[40] In South Africa, the forced and coerced sterilisation of women was linked to its apartheid policies.[41] In some instances medical practitioners employed by government, even sterilised women simply to gain experience towards their specialisation in obstetrics and gynaecology and used minority women as the means to get that experience.[42] Taking away a woman's autonomy to choose her own form of contraception, if any, is considered a violation of her human rights and medical ethics and can be described as acts of torture and cruel, inhuman, and degrading treatment.[43] Several authors have described the forced and/or coerced sterilisation of women living with HIV as a human rights violation.[44] Currently, there is a focus on the coerced and forced sterilisations of HIV positive women. This human rights violation of a marginalised group appears to be a consequence of the high levels of stigma and discrimination faced by many persons living with HIV.[45] Health care

[33] Department of Health 'National contraception clinical guidelines.'(2012), available at https://www.mm3admin.co.za/documents/ docmanager/3c53e82b-24f2-49e1-b997-5a35803be10a/ 00037761.pdf accessed on 17 February 2015.
[34] Ratcliffe 'Women and forced sterilisation' (2012) *A Global Voice for Women – Soroptimist International,* available at http://www.soroptimistinternational.org/assests/med, accessed on 1 December 2014.
[35] P Patel 'Forced sterilization of women as discrimination' (2017) 38(15) *Public Health Reviews* 1-12 at 1.
[36] G Chamberlain 'UK aid helps to fund forced sterilisation of India's poor' *The Observer* 14 April 2012, available at https://www.theguardian.com/world/2012/apr/15/uk-aid-forced-sterilisation-india accessed on 1 December 2014.
[37] *V. C. v Slovakia* Application no. 18968/07 European Court of Human Rights, available at http://www.menschenrechte.ac.at/orig/11_6/V.C..pdf accessed on 1 July 2015.
[38] Ratcliffe 'Women and forced sterilisation' (2012) *A Global Voice for Women – Soroptimist International,* available at http://www.soroptimistinternational.org/assests/med, accessed on 1 December 2014.
[39] Patel 'Forced sterilization of women as discrimination' (2017) 38 (15) *Public Health Reviews* 1-12 at 1.
[40] *LM and others v The Government of the Republic of Namibia* case no 1603/2008, available at http://www.saflii.org/na/cases/NAHC/2012/211.html accessed on 1 July 2015.
[41] Essack & Strode '"I feel like half a woman all the time": The impacts of coerced and forced sterilisations on HIV-positive women in South Africa' (2012) 26 (2) *Agenda* 24-34 at 25.
[42] J Lawrence 'The Indian Health Service and the sterilization of native American women' (2000) 24 (3) *The American Indian Quarterly* 400-419 at 410.
[43] Ratcliffe 'Women and forced sterilisation' (2012) *A Global Voice for Women – Soroptimist International* available at http://www.soroptimistinternational.org/assests/med, accessed on 1 December 2014.
[44] Essack & Strode '"I feel like half a woman all the time": The impacts of coerced and forced sterilisations on HIV-positive women in South Africa' (2012) 26 (2) *Agenda* 24-34, and Patel 'Forced sterilization of women as discrimination' (2017) 38 (15) *Public Health Reviews* 1-12, A Strode et al '"She made up a choice for me": 22 HIV-positive women's experiences of involuntary sterilization in two South African provinces' (2012) 20 (39S) *Reproductive Health Matters* 1-9.
[45] Human Sciences Research Council and South African AIDS Council 'The people living with HIV stigma index: South Africa 2014' (2015), available at http://www.stigmaindex.org/sites/default/files/ reports/Summary-

workers in many instances mirror the prejudiced views of their communities and appear to feel that women living with HIV should not reproduce as they will amongst others; leave orphans, be unable to care for their children and in earlier days of the epidemic would infect their unborn children with HIV.[46] Offering HIV positive women caesarean sections to lower the incidence and risk of HIV transmission to their children appears to have provided a vehicle for promoting sterilisations. Research in both South Africa, Namibia, Swaziland and Kenya shows that many pregnant HIV positive women were sterilised during caesarean sections.[47] Further, these studies have shown that in most instances women were coerced into being sterilised whilst in advanced labour and being prepared for a caesarean section.[48]

The concept of discrimination in South African law is broad and encompasses a number of grounds on which a person may not be discriminated against. It even goes a step further and broadens the scope of discriminatory conduct to other grounds which have the ability to undermine one's dignity and continues to perpetuate systemic disadvantage.[49] In terms of the Promotion of Equality and Prevention of Unfair Discrimination Act, any law, rule, practice, condition, situation, act or omission which directly or indirectly imposes burdens, obligations or disadvantage or conversely withholds benefits, or advantages from any person on a ground based on race, gender, sex, HIV /AIDS status, pregnancy, marital status, ethnic or social origin, colour, age, sexual orientation, disability, religion, conscience, belief, culture, language and birth is discrimination.[50]

In light of this dissertation focusing to a large extent on discrimination against women, it is useful to keep in mind the definition of discrimination against women as offered by the Committee on the Elimination of Discrimination Against Women which includes gender-based violence, that is, violence that is directed against a woman because she is a woman or that affects women disproportionately. It includes acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty.''[51]

In addition, some argue that classifying this type of discrimination as a form of violence against women helps to elevate the issue. For example, Durojaye submits that Article 1 of the Maputo Protocol read together with Articles 4 and 5(d) broadly makes provision for the

---

Booklet-on-Stigma-Index-Survey%20South%20Africa.pdf available at http://www.stigmaindex.org/sites/default/files/reports/Summary-Booklet-on-Stigma-Index-Survey%20South%20Africa.pdf accessed on 2 January 2018.

[46] Strode et al '''She made up a choice for me'': 22 HIV-positive women's experiences of involuntary sterilization in two South African provinces' (2012) 20 (39S) *Reproductive Health Matters* 1-9.

[47] Patel 'Forced sterilization of women as discrimination' (2017) 38 (15) *Public Health Reviews* 1-12 at 2.

[48] *LM and others v The Government of the Republic of Namibia* case no 1603/2008, available at http://www.saflii.org/na/cases/NAHC/2012/211.html accessed on 1 July 2015.

[49] Section 1 of Act 4 of 2000.

[50] Ibid.

[51] General Recommendations Adopted by the Committee on the Elimination of Discrimination Against Women available at http://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/1_Global/INT_CEDAW_GEC_3731_E.pdf accessed on 8 June 2018.

forced or coerced sterilisation of women to be regarded as an act of violence.[52] Adding to his voice, Coomaraswamy, the former United Nations Special Rapporteur on violence against women, has asserted that the forced sterilisation of women is in violation of their physical integrity and constitutes violence against them.[53] At the Fourth World Conference on Women in Beijing it was recognised that the forced sterilisation of women amounts to violence.[54] A further resonation of contempt for the practice of involuntary sterilisations of HIV positive women is contained in the Resolution taken by the African Commission on Human and People's Rights.[55] It was declared that all forms of involuntary sterilisations violate a host of fundamental human rights that are enshrined in regional and international human rights instruments which include amongst others the rights to equality, dignity, and the best attainable state of physical and mental health.[56]

The focus of this thesis is on the forced or coerced sterilisation of women living with HIV however, it acknowledges that this fits within the broader context of gender based violence against women and is potentially a form of obstetric violence. Obstetric violence is not a term that is commonly used in South Africa at present. However, it describes conduct that has been taking place during childbirth from time immemorial. The offensive conduct takes the form of physical and psychological abuse that women across the world face during childbirth for example denial of treatment; dehumanising or rude treatment; discriminatory treatment based on race, ethnic or socio-economic background and HIV status and verbal abuse.[57] The women in the case studies from Slovakia, Namibia, South Africa and Kenya have all experienced different forms of abuse and disrespect at the hands of health care personnel.

Pickles offers a definition of obstetric violence to be ''conduct that violates autonomy, privacy, physical and psychological security and integrity, dignity and equality. It is conduct that takes place without consent or with coerced consent.''[58] This is a very broad definition which highlights that obstetric violence can be both physical or psychological abuse. It also links this abuse to the consent process. It is submitted, that the practice of forced or coerced sterilisation of HIV positive women fits squarely within the definition of obstetric

[52] E Durojaye 'Involuntary sterilisation as a form of violence against women in Africa' (2017) *Journal of Asian and African Studies* 1-12 at 7-8.
[53] Human Rights Watch 'Sterilization of Women and Girls with Disabilities: A Briefing Paper' available at https://www.hrw.org/news/2011/11/10/sterilization-women-and-girls-disabilities accessed on 8 June 2018.
[54] Beijing Declaration and Platform for Action -The Fourth World Conference on Women, available at http://www.un.org/womenwatch/daw/beijing/pdf/BDPfA%20E.pdf accessed on 8 June 2018.
[55] African Commission on Human and Peoples' Rights '260: Resolution on Involuntary Sterilisation and the Protection of Human Rights in Access to HIV Services' available at http://www.achpr.org/sessions/54th/resolutions/260/ accessed on 25 May 2018.
[56] Ibid.
[57] MTR Borges 'A violent birth: Reframing coerced procedures during childbirth as obstetric violence' (2018) 67 *Duke Law Journal* 827 – 862 at 828, and C Pickles Eliminating abusive 'care' A criminal law response to obstetric violence in South Africa' (2015) 54 *SA Crime Quarterly* 5 – 16 at 6.
[58] Pickles Eliminating abusive 'care' A criminal law response to obstetric violence in South Africa' (2015) 54 *SA Crime Quarterly* 5 – 16 at 13.

violence as proposed by Pickles as it has the effect of robbing women of their autonomy to make reproductive health choices.

Obstetric violence has been recognised as a human rights violation and in response it has been criminalised in some Latin American countries. There are also proposals for this framework to be imported to the United States of America and for it to be adapted suitably to protect pregnant women in South Africa.[59] It is argued by Borges that a key problem in the United States is that obstetric violence takes the form of a violation of a woman's autonomy through compelling birthing mothers to have caesarean sections and have medication administered to them that accelerates labour, which is more painful for the mother, and contrary to her wish of having a natural vaginal delivery.[60] It has been argued that the effect of forced procedures on women like sterilisations or caesarean sections provoke lasting psychological trauma even in instances where there are no physical or economic consequences attached to it.[61] Pickles submits that this practices violates a number of the patient's rights including their right to equality, dignity, privacy, bodily and psychological integrity and access to reproductive health care.[62] In many instances, decisions taken at childbirth are often informed by a number of cultural, social and religious beliefs. In the African culture for example, a high premium is placed on a woman's childbearing capacity and therefore being sterilised for being HIV positive without her informed consent is an affront to her culture and inherent sense of social worth.[63]

Two issues that are interlinked and strongly resonate from the treatment that birthing mothers are subjected to, are that of gender based violence and the conduct of health care personnel. All the victims are women as pregnancy is a uniquely female experience.[64] Further, the act of denying women the opportunity to make reproductive choices reduces them to being treated like infants and perpetuates how they are perceived in patriarchal societies.[65] The manner in which birthing mothers are treated correlates with the unequal social and economic position that they occupy within society, which serves to aggravate the intersectional discrimination that they face.[66] Jewkes and Penn-Kekana submit that

[59] Borges 'A violent birth: Reframing coerced procedures during childbirth as obstetric violence' (2018) 67 *Duke Law Journal* 827 – 862 at 827 and Pickles Eliminating abusive 'care' A criminal law response to obstetric violence in South Africa' (2015) 54 *SA Crime Quarterly* 5 – 16 at 5.
[60] Borges 'A violent birth: Reframing coerced procedures during childbirth as obstetric violence' (2018) 67 *Duke Law Journal* 827 – 862 at 830.
[61] Borges 'A violent birth: Reframing coerced procedures during childbirth as obstetric violence' (2018) 67 *Duke Law Journal* 827 – 862 at 838.
[62] Pickles Eliminating abusive 'care' A criminal law response to obstetric violence in South Africa' (2015) 54 *SA Crime Quarterly* 5 – 16 at 10.
[63] Essack & Strode 'I feel like half a women all the time: The impacts of coerced and forced sterilisations on HIV-positive women in South Africa' (2012) 26 (2) *Agenda* 24-34.
[64] Borges 'A violent birth: Reframing coerced procedures during childbirth as obstetric violence' (2018) 67 *Duke Law Journal* 827 – 862 at 830.
[65] Borges 'A violent birth: Reframing coerced procedures during childbirth as obstetric violence' (2018) 67 *Duke Law Journal* 827 – 862 at 853-4.
[66] Pickles Eliminating abusive 'care' A criminal law response to obstetric violence in South Africa' (2015) 54 *SA Crime Quarterly* 5 – 16 at 7.

women's subordinate position in society devalues their lives and disempowers them which creates an enabling environment for them to be subjected to violence.[67]

In South Africa, the forced and coerced sterilisations of women living with HIV are a particular concern. Two studies have shown that although no official policy exists which promotes this practice it appears to have continued until recently.[68] Against this background, this dissertation explores possible legal remedies to address this gross violation of human rights. It is submitted that a number of human rights issues emerge from this infraction including the right to bodily integrity,[69] equality,[70] dignity[71] and access to sexual and reproductive health rights.[72] This dissertation has narrowed its focus to the rights to bodily and psychological integrity, equality and dignity as these three rights will form the foundation for any of the proposed causes of legal action in this thesis. The protection of these rights can be achieved through strategic litigation based on rights which are afforded constitutional protection. There have been two cases in which the courts have had to deal with forced or coerced sterilisation, one in Namibia and one which was settled out of court in South Africa. In Namibia, there has been a recent decision of their Supreme Court on this issue.[73] The facts briefly were that three women instituted action for damages in the High Court against the Government of the Republic of Namibia after they claimed that they were sterilised without their informed consent. The court found that their informed consent was not obtained and found in favour of the three women.[74] The Government of the Republic of Namibia subsequently appealed the decision to the Supreme Court of Namibia[75]. Chief Justice Chivute adjudicating on the matter stated that ''it is my considered opinion that none of the respondents gave informed consent because they were in varying degrees of labour and may not have fully and rationally comprehended the consequences of giving consent for the sterilisation procedure. This is especially the case given that none of the respondents made any appointment or booking to confirm their intention''.[76] The case was

[67] R Jewkes and L Penn-Kekana 'Mistreatment of women in childbirth: Time for action on this important dimension of violence against women' 2015 12 (6) *PLOS Medicine* 1-4 at 1.
[68] Strode et al '''She made up a choice for me'': 22 HIV-positive women's experiences of involuntary sterilization in two South African provinces' (2012) 20 (39S) *Reproductive Health Matters* 1-9 and see also 'The people living with HIV stigma index: South Africa 2014' (2015) note 22 above.
[69] Section 12(2) (*a*) of the Constitution of the Republic of South Africa 1996.
[70] Section 9 of the Constitution of the Republic of South Africa 1996.
[71] Section 10 of the Constitution of the Republic of South Africa 1996.
[72] Section 27 (1) (*a*) of the Constitution of the Republic of South Africa 1996. This dissertation limits its focus to three rights, the right to bodily integrity, equality, and dignity. The reason for this is that the jurisprudence in other similar jurisdictions like Namibia and Kenya has focused on these three rights. In the recommendations made in this dissertation it is suggested that further research be undertaken on the usefulness or not of trying to rely on the sexual and reproductive health rights as a means of redress.
[73] *LM and others v The Government of the Republic of Namibia* case no 1603/2008, available at http://www.saflii.org/na/cases/NAHC/2012/211.html accessed on 1 July 2015.
[74] Ibid.
[75] *Government of the Republic of Namibia v LM and Others* (SA 49/2012) [2014] NASC 19 (3 November 2014).
[76] Ibid.

remitted back to the High Court for the determination of the amount of damages payable by the Government of the Republic of Namibia to the affected women.[77]

In the South African case, Sithole was 28 years old when she was sterilised at the same time that she was giving birth by caesarean section. Her legal representatives alleged that even though a ''purported'' written consent for the sterilisation procedure was obtained it was done in violation of her right to bodily integrity and the Sterilisation Act. It was also alleged that she was pressurised into signing the consent form because of her HIV positive status.[78] This matter was settled out of court with the parties coming to an agreement that the Minister of Health was ordered to pay Sithole damages in the sum of R 470 800-00.[79]

Although litigation is possible, accessing justice through the courts is a more complex issue. Rights without access to justice can be meaningless. South Africa's Chief Justice Mogoeng Mogoeng paid homage to the concept of access to justice by stating that:

> Access to justice is a fast growing concept and practice. It encompasses the rule of law, administration of justice, good governance, and democratic ideals...It acknowledges and seeks to address the gap that exists between citizens and the law, in terms of equality of opportunity and approach in tackling issues, and providing an appropriate remedy. It attempts to eliminate, or at least counter-balance, the impact of inefficient or expensive systems of administration of justice that effectively deny the fullest protection and recourse of all litigants to the law in order to redress their grievances and vindicate their rights. It also helps to assert more precisely the scope of the role of the justice system and the courts in being part of a strategy to address the issue of exclusion of the poor from a formal system of public administration.[80]

The theoretical framework for this dissertation is the concept of access to justice. As eloquently stated by our current Chief Justice access to justice requires a system in terms of which litigants are able to ''redress their grievances and vindicate their rights.''[81] This dissertation critically reviews the South African legal framework to establish whether HIV positive women who have been the victims of involuntary sterilisations can claim compensation and vindicate their rights.

---

[77] *Government of the Republic of Namibia v LM and Others* (SA 49/2012) [2014] NASC 19 (3 November 2014). Personal communication with U Rajcoomar revealed that the matter has been settled and details of the amount paid as damages to the three women remains confidential.

[78] *Sithole v The MEC for Health and Social Development & 3 Others* – unreported case no. 19744/2012 – High Court of South Africa, Gauteng Local Division, Johannesburg.

[79] Ibid.

[80] M Mogoeng 'Speech by the Chief Justice of the Republic of South Africa at the opening of the provincial case flow management workshop in Port Alfred 19 July 2012: Keynote address' (2012) *Office of the Chief Justice*, available at http://www.judiciary.org.za/doc/Speech-CJ_19-July-2012_EL.pdf accessed on 5 January 2018.

[81] Ibid.

## 1.3 Definitions

The term 'coerced sterilisation' refers to a situation whereby women are compelled to consent to undergo a surgical procedure to permanently end their ability to reproduce by the use of incentives, misinformation or intimidation tactics.[82] 'Forced sterilisation' refers to a situation in which a woman is surgically operated on without her knowledge, or being given an opportunity to provide consent to the procedure.[83]

This proposed dissertation will proceed from the basis that coerced sterilisation is the use of incentives, misinformation, or intimidation tactics to compel a HIV positive woman to consent to undergo a surgical procedure to permanently end her ability to reproduce. Whilst forced sterilisations occur when a HIV positive woman is sterilised without her knowledge or the opportunity to provide consent to the procedure.[84] For example, participants in a recent South African study reported that heath care workers gave them one of four reasons for being sterilised, firstly, because they were HIV positive and therefore they were not allowed to have more children. Secondly, sterilisations would prevent more infants being born with HIV. Thirdly, it would lower the number of children left as orphans. Fourthly, as pregnancies had a negative effect on a positive women's health she should be prevented from harming herself.[85] This thesis argues further that the forced or coerced sterilisation referred to above is a form of unfair discrimination against HIV positive women. The types of women who are most likely to the victims of this human rights violation are those who are Black, poor, illiterate, young and HIV positive.[86]

## 1.4 The forced or coerced sterilisation of women living with HIV

Globally, women comprise 51% of all people living with HIV in low–and middle-income countries.[87] The epidemic continues to be characterised by high levels of stigma and discrimination against people living with HIV.[88] For example, the 2011 African Dialogue on HIV and the Law found that discrimination continues to be a key characteristic of the epidemic in Africa.[89] As stated above, one way in which discrimination has been manifesting itself is in the way in which health care workers approach the reproductive choices of HIV

---

[82] CJ Badul & A Strode '*LM and Others v Government of the Republic of Namibia*: The first sub-Saharan African case dealing with the coerced sterilisations of HIV –positive women – quo vadis' (2013) 13 *African Human Rights Law Journal* 214-228 at 224.
[83] Ibid.
[84] Essack & Strode '"I feel like half a woman all the time': The impacts of coerced and forced sterilisations on HIV-positive women in South Africa' (2012) 26 (2) *Agenda* 24-34 at 25.
[85] Strode et al '"She made up a choice for me': 22 HIV-positive women's experiences of involuntary sterilisation in two South African provinces' (2012) 20 (39S) *Reproductive Health Matters* 1-9 at 5.
[86] Strode et al '"She made up a choice for me'': 22 HIV-positive women's experiences of involuntary sterilization in two South African provinces' (2012) 20 (39S) *Reproductive Health Matters* 1-9.
[87] UNAIDS 'UNAIDS data 2017' (2017), available at http://www.unaids.org/sites/default/files/media_asset/20170720_Data_book_2017_en.pdf accessed on 5 January 2018.
[88] E Cameron *Justice* (2014) at 81.
[89] Global Commission on HIV and the Law 'Overview of the Africa regional dialogue' [2011], available at https://hivlawcommission.org/dialogues/africa/ accessed on 1 July 2015. See also Cameron *Justice* (2014).

positive women. Many women living with HIV have complained that health care workers have forced or coerced them to be sterilised so that they cannot continue to reproduce.[90] The forced and coerced sterilisation of women living with HIV is not confined to South Africa and has been reported globally.

The practice of sterilising women with HIV because of their HIV status appears to have its roots in the discriminatory perceptions of health care workers towards women living with HIV. This discriminatory practice plays out through the lack of concern for obtaining consent to sterilisation with health care workers either coercing or compelling women to be sterilised simply because they are HIV positive. For example, Participants in a South African study related how their consent was obtained. They made comments like *''they made me sign this paper after I had collapsed in the toilet*''.[91] Or "*I went back and she gave me a pen…if she wanted to give me an option she wouldn't have to give me a pen. You understand? She would've [asked] me if I had thought about it…Or she could've said, ''Have you read it?*''[92] Another relayed that *''He (doctor) was shouting at me while all were listening. I did not have time to say anything as we were arguing. He said all black people are careless. I was embarrassed and I just signed without getting time to read the form.*''[93]

The impact of sterilisation of women living with HIV has not been extensively researched however in a study by Essack and Strode[94] the experiences of HIV positive women who were either coercively or forcibly sterilised in Gauteng and KwaZulu-Natal were documented. This found that women were profoundly affected in different spheres of their lives. For example, Participant 9 stated ''*[H]e doesn't have a child like you know and he had just paid lobola (the bride price)…So he wants a child''.*[95] *Participant 15 noted that "I avoid conversations about children because they hurt me. Uhm you avoid going to baby showers at all costs*''.[96] Participant 4 reflected on how being sterilised had directly affected her sense of self-worth in that "*it 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*''.[97] The study also found that participants experienced physical pain, including backache after their sterilisations[98].

Participants also narrated their devastating experience of trying to have the sterilisation reversed. Participant 21 stated that "*I went to another doctor who said I could get a child. I*

[90] Strode et al 'She made up a choice for me': 22 HIV-positive women's experiences of involuntary sterilisation in two South African provinces' (2012) 20 (39S) *Reproductive Health Matters* 1-9 at 5.
[91] Ibid.
[92] Ibid.
[93] Ibid.
[94] Essack & Strode '"I feel like half a woman all the time': The impacts of coerced and forced sterilisations on HIV-positive women in South Africa' (2012) 26 (2) *Agenda* 24-34 at 25.
[95] Ibid 28.
[96] Ibid.
[97] Ibid.
[98] Ibid 29.

*kept paying and I thought I would eventually conceive. At 8 months I went to the clinic and they said that the pills I had been taking were poisonous*.''[99] Most significantly participants also expressed the feelings of not being able to disclose the fact that they had been sterilised to family and partners. Participant 20 stated that ''*I can understand being HIV-positive but telling your partner that you cannot have children is too much*.''[100]

The narratives of women who have been sterilised either forcibly or coercively clearly depict that women are being affected in more than one sphere of their lives which are inextricably linked. Feelings of worthlessness, and being incomplete were clearly evident. This in turn has impacted negatively on their psychological well-being. Women have also experienced feeling physical pain[101] and financial loss[102] because of the forced or coerced sterilisation. Interpersonal relationships that the women shared with partners and family were also reported to have become strained.[103] Women also had difficulty in disclosing the fact that they had been sterilised as it would be problematic as great value is placed on the ability of women to conceive in terms of the African culture.[104]

This thesis proceeds from the basis that the violations described above are significant. The law ought to provide legal remedies that would ensure that (a) the practice is stopped, the perpetrators responsible for committing involuntary sterilisations face legal consequences and (c) the victims of the sterilisation abuse are able to access relief. As described below and in Chapters 5 and 6 the South African legal framework includes a number of specific and administrative legal remedies that could be used. For example, our civil law allows for claims for patrimonial loss, pain and suffering and for violations of personality rights which encompass the right to bodily integrity and dignity.[105] There is also a possibility of the use of the criminal law.[106] Finally, a number of administrative bodies who have been granted certain legal powers to provide legal redress such as the South African Human Rights Commission. A key question examined in this dissertation is whether any or all of these legal remedies if used by HIV positive women who have been involuntarily sterilised would result in justice for them.

### 1.5 The legal and ethical framework for voluntary sterilisations in South Africa

The Constitution is the supreme law in South Africa and all other laws and policies must comply with its provisions. Flowing from the constitutional right to bodily integrity, equality and dignity, a number of general principles have been established. There are also a number

[99] Ibid.
[100] Ibid 30.
[101] Ibid 29.
[102] Ibid.
[103] Ibid 31.
[104] Ibid.
[105] MM Midgley & JR Loubser *The Law of Delict in South Africa* 3 ed (2017) 371.
[106] C Pickles 'Involuntary contraceptive sterilisation of women in South Africa and the criminal law' (2016) 29 (2) *South African Journal on Criminal Justice* 89-115.

of statutes which have been passed which detail when and how sterilisations may take place and describe the right to informed consent and equality. In addition, this section discusses the principles set out in ethical guidelines issued by professional health care bodies.

#### 1.5.1.1 The Constitution of the Republic of South Africa, 1996

The Bill of Rights in Chapter 2 does not make specific reference to HIV, it contains provisions that lay the basis for persons living with HIV to be free from discrimination on this ground of HIV/AIDS.[107] The most significant of these constitutional protections are found in the rights to equality, [108] human dignity,[109] life,[110] freedom and security of the person (bodily integrity),[111] privacy,[112] and health care, food, water and social security.[113] Without derogating from the importance of the above rights, section 12(2)[114] states specifically that everyone has the right to bodily and psychological integrity which includes the right to make decisions concerning reproduction. This provision clearly illustrates a human rights based approach in dealing with reproductive choices of women. For the purposes of this dissertation the rights that will be focused on are rights to equality,[115] dignity[116] and the right to bodily and psychological integrity.[117]

#### 1.5.1.2 The Sterilisation Act 44 of 1998

The Sterilisation Act[118] is clearly in keeping with the human rights based approach adopted by the Constitution.[119] It requires written consent to be obtained before the procedure is carried out. The component parts that make up consent is that it must be given freely and voluntarily by the woman after (a) she has been given a clear explanation and adequate description of the (i) proposed plan of the procedure; (ii) the consequences, risks, reversible or irreversible nature of the sterilisation procedure has been explained to her and (b) she has been made aware that she may withdraw her consent at any time before the procedure.[120] Strict compliance with the provisions of the Sterilisation Act is evidenced by section 9 which views non-compliance with the provisions of the Act as a criminal offence.[121]

---

[107] E Cameron 'Legal and human rights responses to the HIV/AIDS epidemic' (2006) (1) *Stellenbosch Law Review* 47-90 at 66.
[108] Section 9 of the Constitution of the Republic of South Africa, 1996.
[109] Section 10 of the Constitution of the Republic of South Africa, 1996.
[110] Section 11 of the Constitution of the Republic of South Africa, 1996.
[111] Section 12 of the Constitution of the Republic of South Africa, 1996.
[112] Section 14 of the Constitution of the Republic of South Africa, 1996.
[113] Section 27 of the Constitution of the Republic of South Africa, 1996.
[114] Constitution of the Republic of South Africa, 1996.
[115] Section 9 of the Constitution of the Republic of South Africa, 1996.
[116] Section 10 of the Constitution of the Republic of South Africa, 1996.
[117] Section 12 of the Constitution of the Republic of South Africa, 1996.
[118] Act 44 of 1998.
[119] Constitution of the Republic of South Africa, 1996.
[120] Act 44 of 1998.
[121] Ibid.

#### 1.5.1.3 The National Health Act 61 of 2003

The National Health Act[122] also lends its voice to the issue of informed consent. Section 6 (1) (b) and (c)[123] provides that every health care provider must inform a user of the range of diagnostic procedures and treatment options generally available to the user and the benefits, risks and consequences generally associated with each option. In addition, the user or patient must be informed in a language that the user or patient understands.[124]

#### 1.5.1.4 Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000

A further statute that affords protection to women who have been subjected to forced or coerced sterilisation for a discriminatory reason is the Promotion of Equality and Prevention of Unfair Discrimination Act.[125] This important piece of legislation has recently included HIV as a prohibited ground of discrimination.[126] For the purposes of this dissertation the other important grounds that have been recognised by the Act as being a prohibited ground of discrimination are the race group of a person and sex.[127] The Equality Act enables complainants of unfair discrimination to approach the local Equality Courts for redress.

#### 1.5.1.5 Common law on informed consent

There is a common law obligation on medical practitioners to obtain informed consent before treating or operating on patients.[128] The courts have held that informed consent means that the patient has: (i) knowledge of the nature and extent of the harm or risk; (ii) an appreciation and understanding of the nature of harm or risk; (iii) consented to the harm or assumed the risk of harm and (iv) consented to the entire transaction, including all its consequences in totality.[129] The duty to obtain informed consent rests with the treating or operating medical practitioner or treating health care practitioner.[130]

The above principles relating to informed consent were accepted by the South African judiciary in the landmark case of *Castell v De Greef*.[131] The effect of this decision is of significance with regard to the doctrine of informed consent in South African medical law, for the following reasons: (i) importing and accepting the doctrine of informed consent into South African medical law; (ii) ousting medical paternalism in favour of patient autonomy; (iii) viewing the lack of informed consent as an issue of assault and not negligence and (iv)

---

[122] Act 61 of 2003.
[123] Ibid.
[124] D McQuoid-Mason 'An introduction to aspects of health law: bioethical principles, human rights and the law' (2008) 1 (1) *South African Journal of Bio-ethics and the Law* 7-10 at 7.
[125] Act 4 of 2000.
[126] In terms of the Judicial Matters Amendment Act, 2017 available at http://www.justice.gov.za/legislation/acts/2017-008.pdf accessed on 18 December 2017.
[127] Section 1 of Act 4 of 2000.
[128] D McQuoid-Mason 'What constitutes medical negligence?' (2010) 7 (4) *SA Heart* 248-251 at 248.
[129] Ibid 248-249.
[130] Ibid 249.
[131] 1994 (4) SA 408 (C).

establishing the yardstick of the ''reasonable patient'' test for informed consent as opposed to that of the ''reasonable doctor test.'[132]

### 1.6 Professional and other guidelines

Medical guidelines serve as a yardstick for the professional conduct of all medical practitioners who are registered with their regulatory body. According to Dickens and Cook, guidelines serve to guide medical practitioners in their daily clinical and ethical practice but are not a rigid set of rules.[133] Failure to comply with ethical guidelines would be a factor that a court would take into account when assessing dolus or culpa.[134] In addition it is submitted that guidelines although not directly legally binding have the effect of improving patient care if there is compliance with them to a great extent.[135]

In South Africa, there are two sets of guidelines relevant to this thesis topic. The first is the National Contraception Clinical Guidelines issued by the Department of Health and the second is the General Ethical Guidelines for Reproductive Health issued by the Health Professions Council of South Africa. There are no guidelines specifically dealing with sterilisations that have been issued by the South African Nursing Council.

#### 1.6.1 Guidelines issued by the Department of Health

The National Contraception Clinical Guidelines were amended in 2012 in light of the background of the HIV epidemic.[136] The guidelines were drawn in consultation with the World Health Organisation and makes specific provision for contraception and HIV.[137] Apart from discussing various contraceptive options available to HIV positive women it specifically states that sterilisation for males or females is appropriate only for individuals or couples who have been thoroughly counselled about the procedure and are certain that they never wish to have more children in the future and who have considered the implications thoroughly. The decision to be sterilised should be voluntary and fully informed, with patients being cognisant of their sexual and reproductive health rights. While HIV status may affect a patient's decision to choose sterilisation, they should never be coerced into doing so.[138]

---

[132] PA Carstens 'Informed consent in South African medical law with reference to legislative developments' *The South African Medico Legal Society,* available at *http://new.samls.co.za/node/407,* accessed on 11 April 2015.
[133] BM Dickens & RJ Cook 'The legal effects of fetal monitoring guidelines' (2010) 108 *International Journal of Gynecology and Obstetrics* 170-173 at 171.
[134] *Sibisi NO v Maitin* 2014 (6) SA 533 (SCA).
[135] Dickens & Cook 'The legal effects of fetal monitoring guidelines' (2010) 108 *International Journal of Gynecology and Obstetrics* 170-173 at 171.
[136] 'National contraception clinical guidelines' available at http://www.mm3admin.co.za/ documents/ docmanager/...24F2.../00037761.PDF, accessed on 17 February 2015.
[137] Ibid.
[138] Ibid

### 1.6.2 Guidelines issued by the Health Professions Council of South Africa

The Health Professions Council of South Africa is a statutory body which regulates all health professions in the country.[139] The Health Professions Council of South Africa has General Ethical Guidelines for Reproductive Health.[140] The purpose of the guidelines is to guide and direct the practice of health care practitioners.[141] It is important to note that misconduct by a registered health care professional will be measured against deviation from these guidelines.[142] In summary, medical practitioners who are involved in the sterilisation procedure should encourage patients to include other appropriate persons in the counselling process, medical care should not be withheld from the patient in exchange for the patient's agreement to undergo sterilisation, the personal beliefs of the medical practitioner should not play a role in urging a patient to be sterilised and the number of children that the patient has should not be a factor that is taken into account to coerce sterilisation.[143]

## 1.7 Remedies for addressing the forced or coerced sterilisation of women living with HIV

From the literature above it has been established that women are being sterilised forcibly or coercively in South Africa for a different number of reasons despite there being legislation and guidelines that protect women from being sterilised without their informed consent. The effects of a forced or coerced ending to a woman's reproductive ability may lead to extreme social isolation, family discord or abandonment, fear of medical professionals, and lifelong grief.[144] It is therefore necessary to consider the legal remedies available to them to ensure that the transgression of their rights do not go unnoticed and there is accountability on the part of the transgressor/s.

### 1.7.1 Civil law remedies by claiming civil damages

Women who have been sterilised forcibly or coercively may invoke the provisions of section 12 (2) of the Constitution[145] to seek redress by claiming damages. A plaintiff who wishes to claim damages must establish liability under the actio iniuriarum for the invasion of their dignity and bodily integrity.[146] They also have the option of instituting a claim under the

---

[139] Health Professions Council of South Africa, available at http://www.hpcsa.co.za/conduct/Complaints, accessed on 17 February 2015.
[140] Health Professions Council of South Africa, 'General ethical guidelines for reproductive health,' (2016), available at http://www.hpcsa.co.za/Uploads/editor/UserFiles/downloads/conduct_ethics/ Booklet%208%20.pdf accessed on 17 February 2015.
[141] Health Professions Council of South Africa, 'General ethical guidelines for reproductive health,' available at http://www.hpcsa.co.za/ethics/rules/ethical_rules/booklet_13_reproductivehealth, accessed on 17 February 2015.
[142] Ibid.
[143] Ibid.
[144] Ratcliffe 'Women and forced sterilisation' (2012) *A Global Voice for Women – Soroptimist International* available at http://www.soroptimistinternational.org/assests/med, accessed on 1 December 2014.
[145] Constitution of the Republic of South Africa 1996.
[146] J Neethling & JM Potgieter *Law of Delict* 7 ed (2015) at 12.

Aquilian action for patrimonial loss. Finally, they could also proceed with a claim for general damages which includes damages for pain and suffering, as well as for future medical expenses.[147]

The Equality Court may also be approached for relief. Every High Court is an Equality Court for the area of its jurisdiction.[148] Certain designated Magistrate's Courts also function as Equality Courts.[149] The Equality Courts have the power to order payment of any damages in respect of any proven financial loss, including future loss or in respect of impairment of dignity, pain and suffering or emotional and psychological suffering, as a result of unfair discrimination, hate speech or harassment in question.[150]

### 1.7.2 Criminal law remedies

A woman who has been forcibly or coercively sterilised also has recourse in terms of criminal law. A charge of assault may be laid against a doctor who performed the procedure without informed consent of the patient. Furthermore, a contravention of the provisions of the Sterilisation Act may attract criminal liability, in instances of a successful prosecution.[151] Further, the Equality Court can make an order directing the Clerk of the Equality Court to submit the matter to the Director of Public Prosecutions having jurisdiction for the possible institution of criminal proceedings in terms of the common law or relevant legislation.[152] It is thus evident that a criminal prosecution may arise from a complaint that is lodged in the Equality Court.

## 1.8 Administrative remedies

### 1.8.1 Health Professions Council of South Africa

Should misconduct on the part of the medical practitioner be alleged when a woman has been sterilised forcibly or coercively, a complaint may be lodged by the patient or their legal representative with the Health Professions Council of South Africa.[153] An investigation into the complaint will then be undertaken by the Council and a finding made.

### 1.8.2 South African Nursing Council

Forcing a patient to sign a consent for a surgical procedure is regarded as an act of professional misconduct by the South African Nursing Council.[154] A written complaint must

---

[147] Ibid 5.
[148] Section 16 (1) (*a*) of Act 4 of 2000.
[149] Section 16 (1) (*c*) (i) of Act 4 of 2000.
[150] Section 21 (2) (*d*) of Act 4 of 2000.
[151] Act 44 of 1998.
[152] Section 21 (2) (*n*) of Act 4 of 2000.
[153] Health Professions Council of South Africa, available at http://www.hpcsa.co.za/conduct/Complaints, accessed on 17 February 2015.
[154] South African Nursing Council, available at http://www.sanc.co.za/complain-misconduct.htn, accessed on 17 February 2015.

be made to the South African Nursing Council about the alleged misconduct on the part of the nursing sister. An investigation into the complaint will then be undertaken by the Nursing Council and a finding made.

### 1.8.3 South African Human Rights Commission

A woman who has been forcibly or coercively sterilised may also lodge a complaint with the South African Human Rights Commission to obtain appropriate redress. The South African Human Rights Commission is a state institution that supports constitutional democracy.[155] It can be said that the functions of the South African Human Rights Commission are threefold. First, the Commission must monitor and assess the observance of human rights in the country.[156] Second, it has the power to investigate the violation of human rights and take the necessary steps to secure appropriate redress for the complainant.[157] Third, its function is to undertake advocacy.[158]

### 1.8.4 The Commission for Gender Equality

The Commission for Gender Equality is empowered by statute to entertain a complaint by women who have been forcibly or coercively sterilised.[159] The functions of the Commission for Gender Equality are broad. It includes the monitoring and evaluation of policies and practices of organs of state and other public bodies with the aim of promoting gender equality.[160] Training and advocacy around gender equality is another core function of the Commission for Gender Equality.[161] Complainants may be resolved through conciliation, negotiation, mediation or through referral to the Public Protector or South African Human Rights Commission.[162]

### 1.8.5 The Public Protector

The office of the Public Protector is established by section 181 (*a*) of the Constitution.[163] The Public Protector derives its independence from being subject to the Constitution and law only.[164] In light of its autonomy, it is expected to carry out its work of investigating any improper, discourteous behaviour or abuse of power by a civil servant, without prejudice, fear or favour.[165] Further, other organs of State are obliged to protect the effectiveness,

---

[155] South African Human Rights Commission, available at http://sahrc.org/home/index/php?ipkContentID=1, accessed on 17 February 2015.
[156] Ibid.
[157] Ibid.
[158] Ibid.
[159] Act 39 of 1996.
[160] Sections 11 (1) (*a*) (i-iii) of Act 39 of 1996.
[161] S 11 (1) (*b*) of Act 39 of 1996.
[162] Section 11 (1) (*e*) (i-iii) of Act 39 of 1996.
[163] Constitution of the Republic of South Africa, 1996.
[164] CJT Mbiada 'The Public Protector as a mechanism of political accountability: The extent of its contribution to the realisation of the right to access adequate housing in South Africa' 2017(20) *PER / PELJ* 1-34 at 7.
[165] Ibid.

independence, impartiality and dignity of this office.[166] The usefulness of this institution lies in the fact that orders of remedial action made by it, are binding in nature.[167]

### 1.9 Problem statement

There are complexities associated with applying the civil, criminal and administrative law remedies to address the coerced and forced sterilisation of women living with HIV. These complexities may impact on the ability of the women to access justice, they include:

(i) Prescription- in terms of section 11 (d) of the Prescription Act,[168] a woman who has been sterilised forcibly or coercively has a period of three years from the date on which the claim arose to institute action. The biggest challenge facing women who have been sterilised forcibly or coercively is that they are unaware that being sterilised without their informed consent amounts to a violation of their bodily integrity and hence most claims have prescribed.

(ii) Costs-the legal costs of instituting a civil action may be a deterrent to women who have been sterilised forcibly or coercively as they may not have the means to litigate in the High Court. There is no state legal aid for this type of case.

(iii) Lack of legal literacy-the lack of advocacy specifically around the issue of forced or coercive sterilisation is evident from the narratives provided by the women who have been sterilised forcibly or coercively. The affected women were unaware that this amounted to a violation of their human rights and further that a number of legal remedies exist to bring relief to them.

(iv) The lack of a precedent dealing with discriminatory sterilisations. No civil case anywhere in the world has proven discrimination- In the case of *LM and Others v Government of the Republic of Namibia*[169] the court was called upon to decide on two issues: firstly, whether the three plaintiff's had given their informed consent to the sterilisation procedures and secondly, whether they were discriminated against due to their HIV status.[170] The second claim was summarily dismissed by the judge on the basis that there was no credible and convincing evidence that the sterilisation procedures had been

---

[166] Section 181 (3) of the Constitution of the Republic of South Africa, 1996.
[167] *Economic Freedom Fighters v Speaker of the National Assembly and Others; Democratic Alliance v Speaker of the National Assembly and Others* (CCT 143/15; CCT 171/15) [2016] ZACC 11; 2016 (5) BCLR 618 (CC); 2016 (3) SA 580 (CC) (31 March 2016) at para 74.
[168] Act 68 of 1969.
[169] *LM and others v The Government of the Republic of Namibia* case no 1603/2008 available at http://www.saflii.org/na/cases/NAHC/2012/211.html accessed on 1 July 2015.
[170] Badul & Strode '*LM and Others v Government of the Republic of Namibia*: The first sub-Saharan African case dealing with the coerced sterilisations of HIV –positive women – quo vadis' (2013) 13 *African Human Rights Law Journal* 223-238 at 229.

performed on them simply because they were HIV positive.[171] No further reasons were given for dismissing the claim.[172]

(v) The use of the criminal law is burdened by the requirement of proving intention. The State is faced with the onerous burden of proving intention on the part of the doctor. If the doctor is in possession of a signed consent form it is difficult to prove that the doctor had the intention to sterilise the patient without obtaining her informed consent. Victory for a complainant in these types of matters may also be hollow as criminal courts do not readily order compensation in the form of damages.

### 1.10 Research questions

The key research question in this dissertation is: are the legal remedies to address the forced or coerced sterilisation in South Africa adequate to ensure that there is access to justice for affected women? Sub-questions include:

i) Which of the existing legal remedies are most appropriate to address the rights violations within this context?

ii) What are the strengths, weaknesses and gaps within the current legal framework, which are exposed by this particular rights violation?

iii) Is the law on informed consent adequate to address the coerced and forced sterilisation of HIV positive women?

iv) Is it possible to prove that individuals or classes of women are being discriminated against on the basis of their HIV status when they are coerced or forced into being sterilised? and

v) Is law reform needed to comprehensively address this rights violation?

### 1.11 Research methodology

This thesis will not be based on an empirical study. Instead, it will be based on a desktop review of the relevant legal materials and secondary sources. Interviews with experts for first-hand information was also sought. The legal principles, rules and arguments set out in these materials will be analysed and discussed in a coherent, concise and critical manner. In other words, this thesis will be based on a qualitative review of the relevant literature.

### 1.12 Limitations of the study

The study will focus on the South African situation but will make some reference to Kenya and Namibia. These two countries have been selected as examples as they are both African

[171] Ibid at 231.
[172] Ibid.

countries with similar health care systems and problems and they are the only other two countries in the continent in which litigation in issue has been undertaken and currently underway. Whilst the legislative framework examined is that of South Africa, there is also reference to relevant regional and international instruments.

### 1.13 Structure of the thesis

Chapter 1 provides the introduction which sets the scene for the whole thesis providing a background to the topic of forced sterilisation. This background is followed by a presentation of the research problem statement, research questions and methodology, and limitations of the study. Core literature and legislation are referred to. The legal responses to the forced and coerced sterilisation from selected jurisdictions make up the second chapter. The right to bodily and psychological integrity, the right to dignity and equality are dealt with in chapters three and four respectively. Chapter 5 focuses on the legal remedies. The extent to which these remedies provide access to justice is set out in chapter 6 and the conclusion is provided for in chapter 7.

### 1.14 Conclusion

Women with HIV form part of a marginalised group facing intersectional discrimination in society. There is a need to address the difficulties that these women experience in trying to access justice when their rights are violated during childbirth. This thesis aims to contribute to the debate on the forced and coerced sterilisation of women living with HIV by critically examining the legal remedies available to them. Limited work has been done on assessing the most appropriate way forward, to firstly ensure that this practice stops and secondly by providing redress to affected women. It also aims to contribute to this debate by assessing whether the current system would facilitate access to justice for the affected women. Although this study focuses on South Africa, it is argued that the framework it creates could be used to evaluate other legal frameworks and their ability to provide justice for affected women.

# Chapter 2

# Legal responses to forced and coerced sterilisation from selected jurisdictions

## 2.1 Introduction

In the previous chapter, the sterilisation of women for an array of arbitrary and unconvincing reasons which were discriminatory in nature and undertaken without the obtaining of their informed consent, was introduced. This unlawful act is a significant human rights violation against women particularly those who fall into marginalised groups. The core focus area of this dissertation is to examine the legal remedies available to HIV positive women who have been sterilised without their consent simply because they are infected with HIV. In doing so, I will begin by discussing the international legal responses to this issue in Slovakia, Namibia, Kenya as well as South Africa.

This chapter examines the experiences of Slovakian women who have used a wide range of advocacy and legal remedies to address the forced and coerced sterilisation of Romani women. They ultimately used the regional human rights system by approaching the European Court of Human Rights. Slovakia has been identified as a useful case study even though the women were sterilised not because they were HIV positive but because they belonged to a minority ethnic group. It is a good example of the use of the civil law after protracted advocacy interventions failed. The claims made in the successful Slovakian cases were based on the twin averments of a lack of informed consent and unfair discrimination. There were also attempts in Slovakia to use the criminal law as a means of redress but this was unsuccessful.

This chapter also deals with legal responses in Namibia, Kenya and South Africa. They have been selected as they deal directly with the forced or coerced sterilisation of women living with HIV. In these countries three strategies stand out and will be focused on in this chapter. They are firstly, the use of litigation, secondly, the establishment of commissions of enquiry and thirdly research and documentation of cases of forced and coerced sterilisation.

## 2.2 Civil claims using regional human rights mechanisms

The practice of forcibly or coercively sterilising women has also found favour with some countries where the underlying reason was to prevent women from procreating because of undesirable hereditary ethnic characteristics.

### 2.2.1 Slovakia

In 2002 a human rights fact finding mission was conducted by two Non-Governmental Organisations (NGOs) namely the Center for Reproductive Rights in conjunction with the

Centre for Civil and Human Rights.[1] The fact finding mission was published as a comprehensive study.[2] The data for this study was collected through interviews with approximately 230 Romani women in parts of eastern Slovakia where there are a large concentration of Romani settlements.[3] The core areas covered in these interviews were the reproductive health rights of women focusing in particular on sterilisation practices; treatment of women at maternal health care facilities by health care professionals and access to information on reproductive health care.[4]

The Body and Soul Report[5] encapsulated the findings of the study. It found that the discrimination of Romani women has spanned over several centuries and in modern times the discrimination has been in the form of a policy of forced sterilisations dating back to the Nazi regime.[6] An example of this was a 1933 law passed by Germany during its occupation of Czechoslovakia, which permitted the ongoing forced sterilisation of Roma women and others who were considered ''undesirable''.[7] This practice also found favour during the Communist times in Czechoslovakia[8] when Romani women were targeted through government laws and programmes which provided monetary incentives and condoned the fact that women were being coerced into being sterilised by misinformation.[9] There were also coercive methods used by successive governments and health care practitioners which can be divided into three broad categories. The first being where the government offered financial incentives to Roma women in the form of money or coupons to buy furniture.[10] The second was where some doctors only agreed to perform certain medical services if there was agreement by the patient to be sterilised.[11] The third category was where women provided their consent after being given misleading information regarding their health. The study showed that Romani women who were giving birth by caesarean section were sterilised under the false notion that having multiple caesareans would very likely lead to a ruptured uterus and the possible death of themselves or the baby.[12]

---

[1] C Zampas 'Body and Soul Report: Forced sterilization and other assaults on Roma reproductive freedom in Slovakia' (2003) Center for Reproductive Rights 13, available at https://www.reproductiverights.org/sites/default/files/documents/bo_slov_part1.pdf, accessed on 23 December 2016.
[2] Ibid.
[3] Ibid.
[4] Ibid.
[5] Ibid.
[6] Ibid.
[7] Ibid at 41.
[8] On the 1 January 1993, Czechoslovakia split into two countries namely; the Czech Republic and Slovakia. Amongst some of the reasons cited for the split were differences in political ideologies and mutual historical differences. Available at http://www.pehe.cz/prednasky/2004/the-split-of-czechoslovakia-a-defeat-or-a-victory, accessed on 25 September 2017.
[9] C Zampas 'Body and Soul Report: Forced sterilization and other assaults on Roma reproductive freedom in Slovakia' (2003) Center for Reproductive Rights 13-14, available at https://www.reproductiverights.org/sites/default/files/documents/bo_slov_part1.pdf , accessed on 23 December 2016.
[10] Ibid at 42-43.
[11] Ibid at 45.
[12] Ibid at 52.

***V. C. v Slovakia***[13]

In the case of *V. C. v Slovakia*[14] the applicant became aware that a sterilisation did not amount to life-saving surgery after the publication and widespread release of The Body and Soul Report in January 2003. She was made to believe by the health care personnel at Presov Hospital that her full and informed consent was not required as a pre-cursor to the sterilisation procedure.[15]

(i) Facts

VC was 20 years old at the time that the sterilisation took place. Her highest standard of education was grade 6 and she spoke a Roma language together with a local dialect. The sterilisation took place in the year 2000 at the Presov Hospital during the delivery of her second child by caesarean section. VC was admitted to hospital just before 08h00 in prolonged labour and in a lot of pain. The delivery record indicated that VC requested to be sterilised at 10h30. The consent was obtained after she was informed by the doctor that in her next pregnancy either she or her baby would die. In response to this, VC purportedly agreed when she said ''do what you want to do'' as the delivery record had the typed words ''patient requests sterilisation''. The delivery record also made reference to the fact that the ''patient is of Roma origin''. VC's signature on the consent form was reportedly in an unsteady hand. After the procedure VC was accommodated in a room where there were only women of Roma ethnic origin. VC was prevented from using the same ablution facilities as non-Roma women.[16]

(ii) Issues before the court

The following issues were raised before the European Court of Human Rights.

a) Whether the sterilisation performed on VC was in contravention of Slovakian legislation and international human rights standards that is, without her informed consent?[17]

b) Whether the Slovakian Government acted in a discriminatory manner by coercing Roma women into being sterilised?

[13] Application no. 18968/07 European Court of Human Rights available at http://www.menschenrechte.ac.at/orig/11_6/V.C..pdf accessed on 1 July 2015.
[14] Ibid.
[15] Ibid at para 27.
[16] Ibid at paras 9-18.
[17] Ibid at para 28.

In advancing her claim that she was sterilised without her informed consent, VC relied on Articles 3,[18] 8,[19] 12[20] and 13[21] of the European Convention on Human Rights (hereinafter referred to the Convention)[22]. VC also relied on Article 5[23] of the Convention on Human Rights and Biomedicine[24] and the domestic Slovakian legislation on sterilisation[25].

In putting forward the claim of discrimination VC relied on the provisions of Article 14 of the European Convention on Human Rights which makes provision for ''the enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.''[26]

[18] Article 3 states that ''no one shall be subjected to torture or to inhuman or degrading treatment or punishment.''

[19] Article 8 (1) provides that ''everyone has the right to respect for his private and family life and 8(1) states that there shall be no interference by a public authority with the exercise of this right except as in accordance with the law and is necessary in a democratic society in the interest of security, public safety or the economic well-being of the country for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.''

[20] Article 12 states that ''men and women of marriageable age have the right to marry and to found a family, according to the national laws governing the exercise of this right.''

[21] Article 13 makes provision for ''everyone whose rights and freedoms as set forth in this Convention are violated shall have an effective remedy before a national authority notwithstanding that the violation has been committed by persons acting in an official capacity.''

[22] Came into force in 1953 and gives effect to certain of the rights stated in the Universal Declaration of Human Rights available at http://www.echr.coe.int/pages/home.aspx?p=basictexts, accessed on the 26 December 2016.

[23] An intervention in the health field may only be carried out after the person concerned has given free and informed consent to it. This person shall beforehand be given appropriate information as to the purpose and nature of the intervention as well as on its consequences and risks. The person concerned may freely withdraw consent at any time.

[24] Available at https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=090000168007cf98, accessed on 26 December 2016.

[25] The relevant legislative material from the Sterilisation Regulation, 1972 is section 2 and point XIV of the Annex to the 1972 Sterilisation Regulation. Section 2 ''permitted sterilisation in a medical institution, either at the request of the person concerned or with that person's consent where, *inter alia*, the procedure was necessary according to the rules of medical science for the treatment of a person's reproductive organs affected by disease (section 2 (a)), or where the pregnancy or birth would seriously threaten the life or health of a woman whose reproductive organs were not affected by disease (section 2(b)). Point XIV indicated the following as obstetric-gynaecological reasons justifying a woman's sterilisation:
i) During and after a repeat caesarean section, where this method of delivery was necessary for reasons which were most likely to persist during a further pregnancy and when the woman concerned did not wish to deliver again via Caesarean section.
ii) In the event of repeated complications during pregnancy, in the course of delivery and in the subsequent six-week period, where a further pregnancy would seriously threaten the woman's life or health.
iii) Where a woman had several children (four for women under the age of 35 and three for women over that age. O Lenczewska 'The fine line between the 'medically necessary' and the degrading: A Study of the Case of *V.C. v. Slovakia*', (nd), available at https://www.google.co.za/search?q=v+c+v+slovakia&oq=v+c++v+slovakia&aqs=chrome..69i57.18021j0j7&sourceid=chrome&ie=UTF-8#q=v+c+v+slovakia+olga+lenczewska accessed on 26 December 2016.

[26] European Convention on Human Rights.

(iii) Prior Proceedings

VC approached the European Court of Human Rights in 2007. The lower courts found that there was no violation of certain of VC's human rights.[27]

(iv) Judgment

With regard to the first issue, which is the failure to obtain informed consent, VC relied on the alleged breach of Article 3 (to be free from torture) and Article 8 (the right to a private life) of the Convention.[28] Even though the Court found that VC had given written consent to the caesarean section and sterilisation being performed on her it found that this was inadequate for a number of reasons which are explained below.

Firstly, the consent was obtained two and a half hours after she had been brought into hospital, whilst in labour and lying on a stretcher.[29] This trilogy of events, the court found was not compatible with the principles of respect for human freedom as embodied in the Convention and the requirement of informed consent as set out in other international treaties.[30] In addition, the court found that the conditions under which the applicant had consented to be sterilised was not conducive to decision-making.[31] It was further held that the behaviour of the hospital staff was paternalistic, since, in practice, the applicant was not offered any option but to agree to the procedure which the doctors considered necessary in view of her situation.[32] The applicant's informed consent, which was obtained whilst in advanced labour, could not be vitiated by the hospital staff's assumption that she would in future act in an irresponsible manner with regards to her protecting her reproductive health.[33]

The sterilisation procedure performed on her without her informed consent thus amounted to a form of violence against women.[34] In response, the respondent maintained as it did in all of its submissions, that there was no practice of targeted discrimination of women of Roma ethnic origin in hospitals in Slovakia and that the sterilisation was performed at the request of the applicant who signed for the procedure.[35]

The severity of the treatment that the applicant was subjected to by the hospital staff brought it within the ambit of Article 3, that is, the absence of obtaining informed consent

---

[27] O Lenczewska 'The fine line between the 'medically necessary' and the degrading: A Study of the Case of *V.C. v. Slovakia*', (nd), available at https://www.google.co.za/search?q=v+c+v+slovakia&oq=v+c++v+slovakia&aqs=chrome..69i57.18021j0j7&sourceid=chrome&ie=UTF-8#q=v+c+v+slovakia+olga+lenczewska, accessed on 26 December 2016.
[28] Available at http://www.echr.coe.int/pages/home.aspx?p=basictexts, accessed on the 26 December 2016.
[29] Ibid at para 111.
[30] Ibid at para 112.
[31] Ibid.
[32] Ibid at para 114.
[33] Ibid at para 113.
[34] Ibid.
[35] Ibid at paras 172-173.

from her amounted to inhuman or degrading treatment.[36] In concluding that the medical staff's conduct towards the applicant was in violation of Article 3, the Court stated that although there was no indication that the medical staff acted with the intention of ill-treating the applicant, they nevertheless acted with gross disregard to her right to autonomy and choice as a patient.[37] The court looked in detail at what would qualify as being ''inhuman'' and ''degrading'' treatment in the context of medical treatment. It held that the humiliation or suffering experienced by the person must go beyond that experienced by patients receiving a legitimate form of treatment.[38] It was also held that where a mentally competent adult patient refuses medical treatment, even though this would be to their detriment, this decision must be respected as the imposition of such medical treatment on the patient would amount to a violation of that patient's right to physical integrity.[39] The court noted that:

> Sterilisation constitutes a major interference with a person's reproductive health status. As it concerns one of the essential bodily functions of human beings, it bears on manifold aspects of the individual's personal integrity including his or her physical and mental well-being and emotional, spiritual and family life.[40]

Building on the above statement, the majority of the court held that the imposition of medical treatment on a mentally competent adult patient is in direct contrast with the fundamental principles of the Convention, that is, the respect for human freedom and dignity.[41] In addition, the court held that in this instance the sterilisation could not be regarded as life-saving treatment and hence the consent of the applicant could not be dispensed with.[42] The court held that there was no indication from the hospital records that the applicant was advised about her medical condition, the procedure to be performed on her and whether any alternatives to being sterilised existed.[43]

In response to the applicant's submission that she had been subjected to inhuman or degrading treatment, the Slovak Government denied the existence of any policy or practice aimed at the sterilisation of women of Roma ethnic origin.[44] A further submission by the Slovakian Government was that the sterilisation was necessary in view of protecting the health of the applicant and that the applicant was informed of the situation orally and had confirmed this with her signature.[45]

---

[36] Ibid at para 119.
[37] Ibid.
[38] *V. C. v Slovakia* Application no. 18968/07 European Court of Human Rights at para 104.
[39] Ibid at para 105.
[40] Ibid at para 106.
[41] Ibid at para 107.
[42] Ibid at para 110.
[43] Ibid at para 112.
[44] Ibid at para 92.
[45] Ibid at paras 93- 94.

The submissions made by an amicus the International Federation of Gynaecology and Obstetrics (FIGO) with the permission of the President of the Court is worthy of mention.[46] Its submissions were that it supported, in line with the relevant international instruments, informed and freely given consent of patients. Where a patient is intellectually capable of reproductive self-determination their consent must be given prior to their treatment in accordance with the ethical requirements.[47] The implications of the proposed treatment should be made clear to the patient's satisfaction in advance of its performance, particularly when the proposed treatment had permanent effects on future child-bearing and the founding of a family.[48] Further, the process of informed choice had to be preceded by informed consent to surgical sterilisation.[49] The submissions also advocated for information being provided on recognised available alternatives, especially reversible forms of contraceptives which might be equally effective.[50]

In evaluating the submissions made by the parties the court noted that the sterilisation of the applicant grossly interfered with her physical integrity as she was deprived of her reproductive functions at 20 years of age which is an extremely early stage in her reproductive life:[51]

> The sterilisation procedure, including the manner in which the applicant was requested to agree to it, was liable to arouse in her feelings of fear, anguish and inferiority and to entail lasting suffering. As to the last mentioned point in particular, owing to her infertility, the applicant experienced difficulties in her relationship with her partner and, later, husband. She indicated her infertility as one of her reasons for her divorce in 2009. The applicant suffered serious medical and psychological after-effects from the sterilisation procedure, which included the symptoms of a false pregnancy and required treatment by a psychiatrist. Owing to her inability to have more children the applicant has been ostracised by the Roma community.[52]

The Court held that, taking into account the Conventions that Slovakia was bound to at that relevant time the prior informed consent of the patient could not be dispensed with unless there was an actual medical emergency.[53]

The Court then turned to examine the impact of the failure to obtain informed consent to the sterilisation which had been argued was a violation of Article 8 (right to a private life) of the Convention. The applicant submitted that her right to a family life was severely

[46] FIGO's aim is to promote the health and well-being of women worldwide and to improve the practice of gynaecology and obstetrics. Ibid at para 96.
[47] Ibid at para 97.
[48] Ibid at para 97.
[49] Ibid at para 98.
[50] Ibid.
[51] Ibid at para 116.
[52] Ibid at para 118.
[53] Ibid at para 108.

compromised by the sterilisation procedure and that she could not undergo in-vitro fertilisation citing religious and financial reasons.[54]

In response the Slovak Government stood firm in their stance that the sterilisation was undertaken because of medical reasons, the applicant's consent had been procured and that the possibility of in-vitro sterilisation was an option.[55] Their response to these allegations were similar to the ones put forward in defence of their alleged violation of Article 3 save for the submission that they were prepared to cover the costs for an in-vitro fertilisation.[56]

In assessing the submissions made by the parties the Court began by stating that:-

> Private life is a broad term, encompassing, inter alia, aspects of an individual's physical, psychological and social identity such as the right to personal autonomy and personal development, the right to establish and develop relationships with other human beings and the right to respect for both decisions to have and not to have a child.[57]

The Court held that the purpose of Article 8 is to protect the individual against arbitrary interference by public authorities.[58] Since there are two parts to Article 8, any interference under the first paragraph of Article 8 must be justified in terms of the second paragraph, namely as being ''in accordance with the law'' and ''necessary in a democratic society'' for one or more of the legitimate aims listed therein.[59] In this instance the Court held that the applicant's rights were infringed as the sterilisation affected her reproductive health status and had repercussions for various aspects of her family and private life.[60]

The Court also observed that the Slovakian 1972 Sterilisation Regulation and the Health Care Act 1994[61] required patients' consent prior to a medical intervention.[62] However, it is evident that these provisions, in view of their interpretation and implementation in the applicant's case did not provide appropriate consent safeguards.[63] Conversely, it allowed the occurrence of a situation where an intervention of a particularly serious nature was performed without the applicant's informed consent as defined in the Convention on Human Rights and Biomedicine to which Slovakia was bound at the relevant time.[64]

---

[54] Ibid at para 134.
[55] Ibid at para 137.
[56] Ibid.
[57] Ibid at para 138.
[58] Ibid at para 139.
[59] Ibid.
[60] Ibid at para 143.
[61] Section 13 (1) made medical treatment subject to the patient's consent. A patient's consent to medical procedures of a particularly serious character or which substantially affected a person's future life had to be given in writing or in any other provable manner. Ibid at para 66.
[62] Ibid at 152.
[63] Ibid.
[64] Ibid.

With regards to the second issue, namely whether the Slovakian Government acted in a discriminatory manner by violating article 14[65] (right to equality) and coercing Roma women into being sterilised, the applicant averred that her ethnic origin played a vital role in the decision by the health care personnel to sterilise her.[66] The applicant submitted that this must not be looked at in isolation but rather in the light of the sterilisation policies and practices that existed under the communist regime and the widespread intolerance towards the Roma in Slovakia.[67] With regards to the alleged discrimination based on the grounds of sex the applicant averred that the failure by health services to accommodate the fundamental biological differences between men and women in reproduction was in breach of the prohibition on discrimination on the ground of sex.[68]

FIGO also deemed it prudent to make submissions on the issue of discrimination. FIGO found that the practice of physicians performing a sterilisation procedure as an adjunct to a caesarean section to be unethical because he / she has deemed it to be in the patient's best interest.[69] This could only be appropriate where the physician had fully discussed the matter with the patient and received her consent voluntarily.[70] FIGO also submitted that given the irreversible nature of many sterilisation procedures, physicians should not allow any language, cultural or other differences between themselves and their patients to leave the latter unaware of the nature of the sterilisation procedures being proposed to them and for which they were requested to provide prior consent.[71]

The European Court of Human Rights nevertheless held that it would be most feasible to examine the allegation of discrimination in conjunction with Article 8.[72] The Court's reasoning behind this approach was that the discrimination complained of affected one of the applicant's essential bodily functions and entailed several adverse consequences for herself, in particular her private and family life.[73] Although the Court accepted that information placed before it indicated that there was a practice of sterilising women from various ethnic groups without their informed consent, it could not be held conclusively that the doctors had acted in bad faith towards the applicant with the intention of ill-treating her.[74] The majority of the Court was not convinced that there was an organised policy in place by the hospital and its staff to target racial minorities.[75] The Court however found

[65] Makes provision for the enjoyment of the rights and freedoms set forth in [the] Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or status.
[66] *V. C. v Slovakia* Application no. 18968/07 European Court of Human Rights at para 170.
[67] Ibid.
[68] Ibid at para 171.
[69] Ibid at para 175.
[70] Ibid.
[71] Ibid.
[72] Ibid at para 176.
[73] Ibid.
[74] Ibid at para 177.
[75] Ibid.

that in light of its findings made in terms of Article 8 it was not necessary to make a separate finding with regards to the issue of discrimination.[76]

In a minority judgment it was held that the very essence of the case was the discriminatory treatment that the applicant was subjected to.[77] The learned Judge also expressed her dissatisfaction at the scant attention that was paid to the discrimination that the applicant was subjected to.[78] The Judge made special reference to the words ''patient is of Roma origin'' that appeared on the medical file.[79] The Judge went on to say that for the Court to rule that there were violations in terms of Article 3 and 8 only was tantamount to reducing the applicant's case to a once off occurrence whereas it was obvious that there existed a general State policy of sterilisation of Roma women under the communist regime.[80] The Judge stated that:-

> The fact that there are other cases of this kind pending before the Court reinforces my personal 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. To my mind, the applicant was ''marked out'' and observed as a patient who had to be sterilised just because of her origin, since it was obvious that there were no medically relevant reasons for sterilising her. In my view that represents the strongest form of discrimination and should have led to a finding of a violation of Article 14 in connection with the violations found of Articles 3 and 8 of the Convention.[81]

(v) Remedy

In respect of non-pecuniary damage the Court awarded VC 31 000 euros as opposed to the 50 000 euros claimed and 12 000 euros in respect of legal costs as opposed to the 38 930.43 euros claimed.

Two further cases similar to that of *VC*, were heard by the European Court of Human Rights dealing with the involuntary sterilisation of Romani women.[82] The judgments in these cases are substantially similar to the *VC* case and therefore not dealt with in any detail in this dissertation.

---

[76] Ibid at para 179.
[77] Ibid at page 44.
[78] Ibid.
[79] Ibid.
[80] Ibid.
[81] Ibid at pages 44-45.
[82] *N.B. vs. Slovakia* available at https://www.poradna-prava.sk/site/assets/files/1151/n-b-v-slovakia.pdf and *I. G and Others vs. Slovakia* available at https://www.poradna-prava.sk/en/documents/decision-of-the-european-court-of-human-rights-in-the-case-of-i-g-and-others-vs-slovakia/. In both of these cases three of the women were minors and the consent of their guardians was not obtained before the sterilisations.

## 2.3 Civil claims in a national court relying on international and national law

### 2.3.1 Kenya

***SWK and Others v Médecins Sans Frontières and Others*** [83]

There has only been one sterilisation case that has relied on both international and national law. This matter is currently being heard by the High Court of Kenya regarding the coerced sterilisation of four HIV positive women. This matter has been set down for trial on the 27 and 30 April 2018.[84] The litigation was a by-product of research conducted by an NGO the Africa Gender and Media Initiative Trust (GEM).[85] The study documented the sterilisation experiences of 40 HIV positive women who lived in the Nairobi and Kakamega counties.[86]

Following publicity on the outcome of the studies, litigation was initiated by the Kenya Legal and Ethical Issues Network on HIV and Aids (KELIN) and GEM. The affected women were SWK, PAK, GWK and AMM. The Respondents were Médecins Sans Frontières, France (MSF), Pumwani Maternity Hospital, Marie Stopes International, County Executive Committee Member In Charge of Health Services, Nairobi County and Cabinet Secretary, Ministry of Health.

Kenya has no specific health or sterilisation legislation in place that serves to regulate the issue of informed consent before a sterilisation procedure is carried out. KELIN and GEM placed reliance on the National Family Planning Guidelines for Service Providers (2010) which emphasises the issue of voluntary and informed consent by a women prior to a sterilisation procedure being carried out.[87] The Guidelines further note that:-

> Special care must be taken to ensure that every client who chooses this method does so voluntarily and is fully informed about the permanence of this method and the availability of alternative, long acting, highly effective methods. Further, the guidelines caution service providers against providing any incentive for one to accept any form of contraception or in recruiting potential clients to perform surgical operations.[88]

With very little domestic law to provide guidance within Kenya KELIN and GEM further relied on the International Federation of Gynecology and Obstetrics (FIGO) Guidelines on female contraceptive sterilisation to plead their case. The Guidelines are extremely useful to medical personnel and are worthy of mention in order to demonstrate what norms and

---

[83] Available at http://www.kelinkenya.org/wp-content/uploads/2016/09/Petition-605-Court-Order-July-22-2016.pdf.
[84] Personal e-mail communication with Tabitha G Tsaoya, Deputy Executive Director –Kelin, on 21 December 2017.
[85] *SWK and Others v Médecins Sans Frontières and Others* Petition No. 605 of 2014, in the High Court of Kenya at Nairobi Constitutional and Human Rights Division at para 30.
[86] Ibid.
[87] Ibid para 54.
[88] Ibid.

standards should be observed by medical personnel before performing a sterilisation procedure.

In terms of the Guidelines there are a number of minimum standards that must be adhered to including:-

(i) A doctor may not sterilise a woman under the guise of a medical emergency in order to prevent future pregnancies and hence dispense with obtaining her full, free and informed consent;[89]

(ii) The number of children that a woman has must not be used as a deciding factor by a doctor when sterilising a woman;[90]

(iii) Access to medical care and treatment, for example treatment for HIV must not be made dependent on a woman agreeing to be sterilised;[91]

(iv) Consent must not be obtained whilst a woman is in labour, or after an unpleasant experience of delivering her child;

(v) A doctor cannot obtain consent for a sterilisation from a woman who is requesting a termination of pregnancy;[92] and

(vi) Where a sterilisation is performed as a non-emergency medical procedure in addition to the doctor obtaining comprehensive consent the woman must be made aware of alternatives to the procedure and the risks or benefits attached to it.[93]

i) Facts

There are four litigants in this matter. The first is SWK who attended the Blue House Mathare Clinic for pre-natal care.[94] The Clinic was run by MSF.[95] During SWK's pre-natal visits to the Clinic she was advised by a nutritionist that if she did not agree to be sterilised at the time of having her baby ''she would not qualify to receive food portions e.g. cooking oil, porridge and *ugali* flour and payment of the maternity bill at Pumwani Maternity Hospital.''[96] Shortly before being taken into theatre SWK was given a paper to sign which in essence was giving the medical practitioner consent to perform the caesarean section and sterilisation procedures respectively.[97] She signed the consent form to the sterilisation on this basis.

[89] Ibid 56.
[90] Ibid.
[91] Ibid.
[92] Ibid.
[93] Ibid.
[94] Ibid at paras 4 and 14.
[95] Ibid at para 4.
[96] Ibid.
[97] Ibid at para 5.

A few days after being discharged from hospital she went to the Clinic to collect milk formula and was advised by the same nutritionist that she would only be able to access milk formula and other food items if she had proof that she had indeed been sterilised.[98]

The second applicant, GWK's case is similar to that of SWK. GWK sought pre-natal care at the Blue House Mathare Clinic.[99] GWK was in labour for 48 hours before being taken into theater and she was given a form by a nurse to sign to consent to a caesarean section.[100] Shortly before this, the nurse also enquired from GWK as to whether she was using any form of contraception.[101] Whilst recovering in hospital she was informed by a ward nurse that she had been sterilised.[102] The hospital fees for GWK were paid for by MSF and she had to obtain proof of the sterilisation in order to qualify for food portions and milk formula.[103]

The third applicant PAK alleges that during her visit to the Blue House Mathare Clinic to collect milk formula and food portions she was told on repeated occasions that she should choose sterilisation as a means of family planning.[104] She was informed that failure to agree to be sterilised would result in her not being eligible for the milk formula and food portions. Proof of being sterilised was a requirement.[105] On the 8th June 2005 PAK underwent the procedure to be sterilised by signing a form.[106] Being illiterate, PAK was unaware of the contents of the form and neither was the same explained to her.[107]

The last applicant, AMM experienced the identical treatment as PAK whilst collecting milk formula for her baby from Pumwani Maternity Hospital.[108] The nutritionist informed AMM that should she continue to give birth in the future this would compromise her immunity and she would die.[109] AMM provided consent to the sterilisation procedure being performed on her on the 4th May 2005.[110] Even though she signed the form she was unaware of its contents by virtue of the fact that she could not read nor were the contents explained to her.[111] In addition no other information was offered to her about other family planning methods.[112]

---

[98] Ibid at para 6.
[99] Ibid at para 4.
[100] Ibid at para 16.
[101] Ibid at para 15.
[102] Ibid at para 18.
[103] Ibid at paras 16 and 19.
[104] Ibid at para 10.
[105] Ibid at para 10.
[106] Ibid at para 11.
[107] Ibid.
[108] Ibid at para 21.
[109] Ibid at para 22.
[110] Ibid at para 23.
[111] Ibid.
[112] Ibid.

ii) Petitioners' pleadings

KELIN and GEM relied on selected provisions of the Kenyan Constitution and International and National instruments to form the basis of their litigation against the Respondents. It was alleged on behalf of the four women that their rights as afforded by the above laws and covenants had been violated by virtue of the unlawful sterilisation procedures carried out on them.

The ten provisions of the Kenyan Constitution that are being relied upon by the petitioners to demonstrate the coercive sterilisations can be divided into personal rights and socio-economic rights.

They are basing their claims on seven personal rights. The first, is a right to autonomy in terms of the right to life as enshrined in Article 26 (1); the right to equality and freedom from discrimination as under Article 27 (1-8); the right to human dignity and freedom and security of the person as contained in Articles 28 and 29 (d & f) respectively; the right to privacy encapsulated in Article 31 (a); Article 33 (1) which makes provision for the right to freedom of expression and specifically freedom to seek and receive information or ideas; the right to access information held by another person and required for the exercise or protection of any right or fundamental freedom as under Article 35 (1) (b).[113]

The socio-economic rights being relied upon are the right to the highest attainable standard of health, which includes the right to health care services including reproductive health care as contained in Article 43 (1) (a); the rights of the consumer to be given services of reasonable quality, the information necessary for them to gain full benefit of the services, and protection of their health as in Article 46 (1) (a-c) of the Constitution; withholding medical treatment from the 1st Petitioner violated her right to life under Article 26 (1) and (3) , right to equality and non- discrimination under Article 27 (1-8) and the right to the highest attainable standard of health, which includes the right to health care services, as under Article 43 (1) (a) of the Constitution of Kenya.[114]

The petitioners are relying on international and regional human rights norms as Article 2 (5-6) of the Constitution of the Republic of Kenya, 2010 makes provision for the general rules of international law and for provisions contained in any treaty or convention that has been ratified by Kenya to form part of the law of Kenya.[115]

Arising from this authority, KELIN and GEM are relying on eight international legal instruments to demonstrate the core rights that are alleged to have been violated:-

[113] Ibid at para 41.
[114] Ibid at para 41.
[115] Ibid at para 44.

i) *The right to the highest attainable standard of health* which finds protection in the UDHR[116], the ICESCR[117] CEDAW[118] ACHPR[119] and the Protocol to the ACHPR on the Rights of Women in Africa (Maputo Protocol).[120]

ii) *The right to be free from torture, cruel, inhuman and degrading treatment or punishment* which finds protection in the UDHR[121], ICCPR[122], CAT[123], ACHPR [124] and Maputo Protocol.[125]

iii) *The right to dignity of the person* which is protected by the UDHR[126], the ACHPR[127] and the Maputo Protocol.[128] In addition, the Preamble of the ICCPR, ICESCR, CEDAW and CAT recognises the inherent dignity of the human person.

[116] Article 25, makes provision for everyone to enjoy the right to a standard of living adequate for the health and wellbeing of himself and of his family.

[117] Article 12 (1) states that the State Parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Article 12 (2) the steps to be taken by the States Parties to the present Covenant to achieve the full realisation of this right shall include those necessary for: (a) the provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child; …. (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases; (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

[118] Article 12, requires State Parties to ,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.

[119] Article 16, Every individual shall have the right to enjoy the best attainable state of physical and mental health.

[120] State Parties shall ensure that the right to health of women, including sexual and reproductive health is respected and promoted. This includes:- (a) the right to control their fertility; (b) the right to decide whether to have children, the number of children and the spacing of children; (c) the right to choose any method of contraception and (f) the right to have family planning education.

[121] Article 5, No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.

[122] Article 7, No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation.

[123] Requires States to take effective legislative, administrative, judicial or other measures to prevent acts of torture in any territory under its jurisdiction‘ and establishes the absolute and unqualified nature of the prohibition of torture.

[124] Article 5, All forms of exploitation and degradation of man particularly slavery, slave trade, torture, cruel, inhuman or degrading punishment and treatment shall be prohibited.

[125] Article 4(1), Every 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.

[126] Article 1*,* All human beings are born free and equal in dignity and rights.

[127] Article 5*,* Every individual shall have the right to the respect of the dignity inherent in a human being and to the recognition of his legal status.

[128] Article 3*,* Every woman shall have the right to dignity inherent in a human being and to the recognition and protection of her human and legal rights.

iv) *The right to privacy or private life* is afforded protection in the UDHR[129], the ICCPR[130] and the European Convention on Human Rights.[131]

v) *The right to informed consent and the right to information* is specifically protected in the CEDAW[132], the UDHR[133], the ICCPR[134], the ACHPR[135] and the Maputo Protocol[136].

vi) *The right to determine the number and spacing of one's children* finds specific protection in the CEDAW[137] and the Maputo Protocol.[138]

vii) *The right to be free from discrimination and right to equality* which is found in the ICCPR[139], the CEDAW[140], the ACHPR[141] and the Maputo Protocol.[142]

In addition, the pleadings of the petitioners contained extracts from the reports by the Committee on Economic, Social and Cultural Rights (CESR) the body responsible for the interpretation and monitoring of the provisions of the ICESR and the Special Rapporteur to the United Nations.[143]

---

[129] Article 12, No one shall be subjected to arbitrary interference with his privacy, family, home or correspondence.
[130] Article 17(1), No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence.
[131] Article 8(1), Everyone has the right to respect for his private and family life, his home and correspondence. Any interference with this right must be in accordance with the requirements of Article 8(2).
[132] Article 10(h), Requires State Parties to ensure that women have ,access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning.
[133] Article 19*,* Everyone has the right to freedom of opinion and expression; this right includes freedom to hold opinions without interference and to seek, receive and impart information and ideas through any media and regardless of frontiers.
[134] Article 19(2), Everyone shall have the right to freedom of expression; this right shall include freedom to seek, receive, and impart information and ideas of all kinds, regardless of frontiers, either orally in writing or in print, in the form of art, or through any other media of his choice.
[135] Article 9(1), Every individual shall have the right to receive information.
[136] Article 14*,* also, States are obligated to ,provide adequate, affordable and accessible health services, including information, education and communication programmes to women especially those in rural areas.
[137] Article 16(1)(e), Requires state parties to ensure that women have ,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.
[138] Article 14(1)(b).
[139] Article 26, All persons are equal before the law and are entitled without any discrimination to the equal protection of the law and the law is to prohibit any discrimination on the above mentioned grounds.
[140] Article 12, Requires State Parties to ,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.
[141] Article 2, Every individual shall be entitled to the enjoyment of the rights and freedoms recognized 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. Article 18(3), The State shall ensure the elimination of every discrimination against women.
[142] Article 2, Mandates the elimination of, discrimination against women through appropriate legislative, institutional and other measures.
[143] *SWK and others v Médecins Sans Frontières and others* Petition No. 605 of 2014, in the High Court of Kenya at Nairobi Constitutional and Human Rights Division at paras 46 - 48.

This matter has not been finalised at Court and further views of the pending case are provided in the discussion section of this chapter.

## 2.4 Civil claims relying on national law – Namibia and South Africa

### 2.4.1 *LM and Others v The Government of Namibia*[144]

In this case it was common cause that all three women were HIV positive at the time that they were sterilised on different occasions at two State Hospitals in Namibia.[145]

i) Facts

The first plaintiff, LM, was 26 years old at the time of the sterilisation. LM was in hospital to deliver her third child (her first child was stillborn).[146] On 13 June 2005, LM signed a form giving consent to an operation. This form stated that she was to undergo a caesarean section and bilateral tubal ligation.[147] The consent document was a single form for both procedures.[148] She had been in labour for 14 to 15 hours before she was given the consent form to sign, [149] and it was signed by her whilst on a stretcher outside the theatre.[150] The hospital records did not indicate the type of information that was given to LM as part of the consent process prior to the bilateral tubal ligation procedure.[151] These same records also do not reflect whether she was given information on any alternative methods of contraception.[152] In her testimony, LM indicated that a nurse told her that she was to be sterilised since all women who are HIV positive go through that procedure.

The second plaintiff, MI, had previously given birth to two children. On the 8 December 2007 she was handed a standard consent form for an operation to sign. MI signed the form at the height of being in labour. On the form it indicated that she was giving consent for a 'caesar +BTL due to previous caesar'. She also signed a second separate consent form for the sterilisation (the BTL). The form that she signed contained a space for the medical practitioner performing the operation to sign a pro forma statement indicating that they had explained the procedure and related aspects of sterilisation to the patient. This section

---

[144] *LM and others v The Government of the Republic of Namibia* case no 1603/2008, available at http://www.saflii.org/na/cases/NAHC/2012/211.html accessed on 1 July 2015.
In discussing this case I relied largely on the published article by Badul & Strode '*LM and others v The Government of the Republic of Namibia*: The first sub-Saharan African case dealing with coerced sterilisation of HIV-positive women – *Quo vadis'* (2013) 13 *African Human Rights Law Journal* 223-238.
[145] *The Government of the Republic of Namibia v LM and others* case no 49/2012 para 1, available at http://www.saflii.org/na/cases/NASC/2014/19.html accessed on 1 July 2015.
[146] Badul & Strode '*LM and others v The Government of the Republic of Namibia*: The first sub-Saharan African case dealing with coerced sterilisation of HIV-positive women – *Quo vadis'* (2013) 13 *African Human Rights Law Journal* 223-238 at 226.
[147] Ibid.
[148] Ibid.
[149] Ibid.
[150] Ibid.
[151] Ibid.
[152] Ibid.

of the form was left unsigned by the surgeon. There were no hospital records to indicate that MI had received counselling on the proposed sterilisation and other alternative methods of contraception. MI was told by the doctor that she was going to be sterilised whether she liked it or not. The hospital staff also informed MI that there was a policy in place that all women living with HIV should be sterilised.[153]

The third plaintiff NH, was 46 years old and had seven children. On 13 October 2005, NH consented to a caesarean section and a bilateral tubal ligation. This was done by signing a standard consent form to an operation and a second separate consent form giving consent to the sterilisation. NH signed the forms after being in labour for a prolonged period and whilst on a stretcher waiting to go into theatre. The hospital records indicate that NH was booked for an elective caesarean due to her advanced age, the number of previous deliveries, her HIV status and her prolonged labour. The consent form included a signed *pro forma* statement from the surgeon confirming that he had explained the procedure and its related implications to the patient.[154]

(ii) Issues before the court

The two core issues that had to be decided by both the High Court and Appeal Court were firstly whether the plaintiffs were sterilised without their informed consent and secondly, whether in doing so it was part of a wrongful and unlawful practice of discrimination against them on account of their HIV positive status.[155]

(iii) Prior proceedings

The matter was first heard before the Namibian High Court. In respect of the first issue that had to be decided upon, the Court held that in order to assess whether the patient had given informed consent to the procedure, it must be established whether they have been provided with adequate information to make an informed choice.[156] The Court held that the Namibian government fell short in proving that they had provided sufficient information to the plaintiffs to enable them to make an informed choice on whether to be sterilised or not. There appeared to be three reasons for this. The first being that the notes made in the three hospital files of the affected women did not document the nature of the information that had been provided to them;[157] there was also an absence of record keeping on whether they were informed of the alternatives to sterilisation.[158] Secondly, two of the consent forms were an adequate reflection of the women's agreement to the sterilisation,

[153] Badul & Strode '*LM and others v The Government of the Republic of Namibia*: The first sub-Saharan African case dealing with coerced sterilisation of HIV-positive women – *Quo vadis'* (2013) 13 *African Human Rights Law Journal* 223-238 at 227.
[154] Ibid at 227-228.
[155] Ibid at 229.
[156] *LM and Others v Government of the Republic of Namibia* (I 1603/2008, I 3518/2008, I 3007/2008) [2012] NAHC 211 (30 July 2012) at para 16.
[157] Ibid at paras 20-23.
[158] Ibid.

and that the surgeon did not complete the second plaintiff's form giving consent to be sterilised. Thirdly, although the second and third plaintiffs' health passports indicated that they wished to have a sterilisation whilst attending antenatal services, the Court held that this did not mean that they had consented to the actual procedure on the day of the surgery.[159]

In relation to the second claim that the plaintiffs had been unfairly discriminated against, this was summarily dismissed by the judge on the basis that there was no credible and convincing evidence that the sterilisation procedures had been performed on them simply because they were HIV positive.[160] No further reasons were given for dismissing the claim.

iii) Judgment

Chief Justice Shivute writing the appeal judgment for the Supreme Court of Namibia poignantly stated at the outset of the judgment that:-

> The Namibian Constitution affords every individual in Namibia the right to dignity, to physical integrity, and to found a family. The right to found a family includes the right of women of full age to bear children and of men and women to choose and plan the size of their families. In the case of an unmarried woman, it is primarily her choice in the exercise of her right to self-determination, whether or not to bear children. Against this background, the decision of whether or not to be sterilised is of great personal importance to women. It is a decision that must be made with informed consent, as opposed to merely written consent. Informed consent implies an understanding and appreciation of one's rights and the risks, consequences and available alternatives to the patient. An individual must also be able to make a decision regarding sterilisation freely and voluntarily.[161]

The Appeal Court began by dealing with the findings of the Court a quo which relied on the case of *Castell v De Greef*[162] which is considered to be the leading South African decision on informed consent. The court a quo accepted the four requirements that must be met in order for consent to operate as a defence as was set out in *Castell*'s case.[163] Before turning to the Court's evaluation of the evidence and application of the law it is important to settle the issue regarding on whom the onus of proof rested. In *Santam Insurance Co Ltd v Vorster* the Court held that the onus of establishing the *defence of volenti non fit inuria* rests on the defendant.[164] The Supreme Court of Appeal's discussion of the applicable law began with a

[159] Ibid at paras 56 and 65.
[160] Ibid at para 83.
[161] *Government of the Republic of Namibia v LM and Others* (SA 49/2012) [2014] NASC 19 (3 November 2014) at para 3.
[162] Ibid at para 10.
[163] Ibid at para 13.
[164] Ibid at para 27.

discussion on informed consent. The Court began by referring to the Ethical Guidelines for Health Professionals which is a product of the Health Professionals Council of Namibia.[165]

Of importance is paragraph 2.8 of the Guidelines which deals with informed consent and states that ''everyone has the right to be given full information about the nature of his or her illness, diagnostic procedures, the proposed treatment and the costs involved''.[166] The Court in commenting on the Guidelines observed the following:-

> The publication recognises the importance of the principles of informed consent and self-determination, stating a health professional should 'apply the principle of informed consent as an on-going process' and that he or she should 'honour patients' rights to self-determination or to make their own informed choices, living their lives by their own beliefs, values and preferences'.[167]

The Appeal Court Judge also cited with endorsement the dictum of Mojapelo J in the *Christian Lawyers Association v Minister of Health and Others (Reproductive Health Alliance as Amicus Curiae*) case. The learned Judge Mojapelo when considering the issue of informed consent stated:-

> The concept is, however, not alien to our common law. It forms the basis of the doctrine of volenti non fit injuria that justifies conduct that would otherwise have constituted a delict or crime if it took place without the victim's informed consent. More particularly, day to day invasive medical treatment, which would otherwise have constituted a violation of a patient's right to privacy and personal integrity, is justified and is lawful only because as a requirement of the law, is performed with the patient's informed consent. It has come to be settled in our law that in this context, the informed consent requirement rests on three independent legs of knowledge, appreciation and consent.[168]

In reinforcing what the doctrine of informed consent exactly entails the Court found it prudent to quote once more from the *Christian Lawyers* case where it stated that:-

> In this context, 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 intelligent will on the basis of an appreciation of the nature and consequences of the act consented to.[169]

In applying the above case authority to the matter at hand Chief Justice Shivute deemed it necessary to determine whether the plaintiffs that had been sterilised possessed the

---

[165] *Government of the Republic of Namibia v LM and Others* (SA 49/2012) [2014] NASC 19 (3 November 2014) at para 96.
[166] Ibid.
[167] Ibid at para 97.
[168] Ibid at para 98.
[169] Ibid at para 99.

requisite intellectual and emotional capacity whilst providing their informed consent.[170] This, had be considered in light of the peculiar circumstances that the plaintiffs had found themselves in when signing the consent forms.[171]

In casu the health passports of all three plaintiffs failed to show what information had been provided to them by the doctors and nurses that were in attendance when the plaintiffs' written informed consent was obtained.[172] Further, despite there being an absence of documentation of information on the health passports of the plaintiffs the nurses and doctors maintained that there would have been a discussion of the risks inherent in a sterilisation procedure.[173]

The Court succinctly stated that:-

> In the absence of any detailed clinical notes regarding what was explained to the respondents about sterilisation, it was unsurprising that the witnesses concerned proceeded from the assumption that they had explained the nature and risks of sterilisation to the respondents just because either their signatures appeared on the consent forms or there were clinical notes bearing their handwriting. Such assumptions, however, are not borne out by the evidence.[174]

Of concern to the Supreme Court of Appeal was the opinion that the medical practitioners formed of the plaintiffs and in particular the third plaintiff regarding her choice of contraception. One of the medical practitioners put it callously that ''BTL would provide a final solution to the respondent's predicament.'' The Supreme Court of Appeal's response to this was '' with great respect, this attitude smacks of medical paternalism.''[175] The Court stated that:-

> The doctors who testified on behalf of the appellant seemed to agree that the third respondent, especially, should be sterilised. Some of the comments made about her were quite cutting, if not bordering on medical paternalism. She was, for example, described by one of the doctors as being 'unreliable concerning her life care' and that it was felt that she is 'best helped if she never falls pregnant again'. As indicated earlier, the third respondent was also asked whether she had thought of 'the final solution' to her pregnancy in light of her age, and was advised to ensure that her pregnancy 'should be the very last in her life'. It may well be that the doctors' evaluation of the third respondent was medically correct and that the views expressed about her undoubtedly reflected a genuine concern for her well-being. However, by virtue of the application of the doctrine of informed consent, our law and the policies applicable to Namibian health professionals recognise that the patient has

[170] Ibid at para 100.
[171] Ibid.
[172] Ibid.
[173] Ibid.
[174] Ibid.
[175] Ibid at para 104.

> the final say in deciding whether or not she should undergo an elective medical procedure.[176]

Commenting on the issue of medical paternalism outweighing the notion of patient autonomy, the Supreme Court of Appeal endorsed the often cited quote from the unpublished doctoral thesis by Van Oosten which was also cited in the landmark decision of *Castell v De Greef*:-

> There can be no place in this day and age for medical paternalism when it comes to the important moment of deciding whether or not to undergo a sterilisation procedure. The principles of individual autonomy and self-determination are the overriding principles towards which our jurisprudence should move in this area of the law. These principles require that in deciding whether or not to undergo an elective procedure, the patient must have the final word. Unlike some life-saving procedures that require intervention on a moment's notice, sterilisation allows time for informed and considered decisions. It is true, as already mentioned, that health professionals are under an obligation to assess the patient and point out the risks involved in particular procedures so as to enable the patient to make an informed decision and give informed consent. They may also make recommendations as to the management and/or treatment of a patient's condition based on their professional assessment. However, the final decision of whether or not to consent to a particular procedure rests entirely with the patient. I emphasise that the term 'procedure' referred to here must not be understood as including emergency operations or procedures that doctors are obliged to perform on patients even without their consent if legal or medical grounds have been established.[177]

In reaching his conclusion, the learned Judge focused on two broad issues firstly, the circumstances under which the plaintiff's consent was obtained and secondly, whether the plaintiffs' had capacity to give informed consent.[178]

With regards to the issue of how exactly the informed consent was obtained the Court observed that this had been done whilst each of the plaintiffs/respondents were in varying degrees of labour and hence in pain.[179] The Court was of the opinion that the plaintiffs should have been given the option of returning to the hospital at a later stage when they would have had the opportunity to make an informed decision without the presence of any extraneous factors like labour pains.[180] In addition, the Court noted that none of the plaintiffs/ respondents indicated their intention to be sterilised by either making an appointment or confirming their booking.

The next issue explored by the Court was whether the plaintiffs/respondents had possessed the requisite capacity to give informed capacity especially since such written consent was

[176] Ibid at para 104 -105.
[177] Ibid at para 105.
[178] Ibid at paras 107-108.
[179] Ibid at paras 107.
[180] Ibid.

procured whilst being under the influence of pain.[181] The Court commented as follows on this aspect:-

> The consent obtained was invalidated by the respondents' lack of capacity to give informed consent in light of the history of how the decision to sterilise them was arrived at and the circumstances under which the respondents' consent was obtained. It was merely written rather than informed consent, which in my opinion is not sufficient for the performance of a procedure as invasive and potentially irreversible as sterilisation. The important factor which must be kept in mind at all times is whether the woman has the capacity to give her consent for sterilisation at the time she is requested to sign consent forms. Therefore, it is not decisive what information was given to her during antenatal care classes or at the moment she signed the consent form if she is not capable of fully comprehending the information or making a decision without any undue influence caused by the pain she is experiencing.[182]

In light of the considered reasons afforded above, the Court came to the conclusion that the appellants had failed to discharge the onus cast upon them by showing on a balance of probabilities that the plaintiffs / respondents had given informed consent.[183]

The Supreme of Court Appeal dismissed the appeal and ordered that the matter be referred back to the trial Court for determination of the amount of damages payable to the plaintiffs/ respondents. The High Court's ruling with regards to the issue of the alleged discrimination remained unchanged on appeal. Like the High Court, the Supreme Court of Appeal found that there was no cogent evidence on the part of the women that they were unfairly discriminated against simply because of their HIV status.[184] The Appeal Court also rejected the submission made by the women that there was an organised policy in place to sterilise HIV positive women who were of child-bearing age.[185] The amount paid out as damages has been kept confidential.

### 2.4.2 *Sithole v The MEC for Health and Social Development & 3 Others* – unreported case no. 19744/2012 – High Court of South Africa, Gauteng Local Division, Johannesburg

The case of Sithole was the first South African case that dealt with the forced or coerced sterilisation of an HIV positive woman. This matter was settled out of Court.

[181] Ibid at para 108.
[182] Ibid at para 108.
[183] Ibid at para 107.
[184] Ibid at para 2.
[185] Ibid.

(i) Facts

LS was admitted to the maternity unit of the Chris Hani Baragwanath Hospital on the 31 May 2009 for the delivery of her third child by way of a caesarean section.[186] On the 4 June 2009 LS's baby was delivered by caesarean section and she was sterilised by way of a bilateral tubal ligation.[187] After LS's admission to hospital she signed three forms which, ''purported to reflect her written consent to be sterilised by bilateral tubal ligation.''[188] The forms signed were a consent to operation form, consent to sterilisation form and a layman's form.[189] LS's signature was procured by the ward nurse who, offered no clear explanation or adequate description of the proposed plan of the procedure; had given no clear explanation or adequate description of the consequences, risks and reversible or irreversible nature of the procedure and had not advised LS that her consent could have been withdrawn at any time before the operation.[190]

Shortly, before LS's consent was obtained a ward nurse and a cleaner were making degrading remarks about her ''perceived sexual proclivity;''[191] she felt humiliated and was pressurised into signing the forms by the ward nurse who was aware of her HIV positive status;[192] and this, was done in the presence of other patients whilst she was waiting to give birth.

(ii) Issue before the court

The plaintiff's cause of action stemmed from the allegation that the sterilisation procedure performed on her was done so without her voluntary informed consent. The essence of the plaintiff's claim is encapsulated as follows:-

(iii) Pleadings

Plaintiff's particulars of claim

LS pleaded in her particulars of claim that she relied on the contractual relationship that existed between herself as a patient and the hospital as well as between patient and health care professionals to found her claim based on a duty of care.[193] Arising out of this LS averred that the hospital and its employees had owed her a duty of care inter alia to provide her with ''medical treatment, advice, care and supervision with the professional skill, diligence and care that can be reasonably be expected of hospitals, of medical doctors,

[186] *Sithole v The MEC for Health and Social Development & 3 Others* – unreported case no. 19744/2012 – High Court of South Africa, Gauteng Local Division, Johannesburg para 10 of Plaintiff's amended particulars of claim.
[187] Ibid at para 11.2.
[188] Ibid at para 15.
[189] Ibid at para 15.1-15.3.
[190] Ibid at para 17.1.-3.
[191] Ibid at para 17.8.2.
[192] Ibid at para 17.8.1.
[193] Ibid at para 14.

nurses and of hospital employees.''[194] Further, this duty extended to acting without negligence towards LS and only to carry out medical procedures on her that she had fully given her informed consent to more specifically, to comply with the provisions of the Sterilisation Act.[195]

LS further pleaded that she did not have an adequate opportunity to read the form and understand the contents of thereof nor, did she request to be sterilised or for that matter seek information on different methods of contraception.[196] LS pleaded that she was genuinely under the impression that an intra-uterine device was to be inserted as this was the decision that she had made during her ante-natal clinic visits and that the device would be inserted at another time and not when she was undergoing the caesarean section.[197]

It was further pleaded on behalf of LS that the consent should have been obtained by a health care practitioner.[198] Another averment that was made was that the two health care practitioners who performed the sterilisation on LS, failed to provide her with any information on the planned procedure, the risks attached thereto and the irreversibility or reversibility of the procedure.[199] LS also pleaded that at no stage during her stay at hospital did she request to be sterilised nor did she seek any information about different family planning options.[200] LS's pleaded that her purported consent was procured by a ward nurse days prior to the sterilisation was performed her.[201]

LS averred that as a result of the wrongful and unlawful conduct of the health care practitioners and the ward nurse her ''rights to privacy, dignity and bodily and psychological integrity including the right to make decisions concerning reproduction and the right to security in and control over her body were violated; ''[202] the health care practitioners and the ward nurse were in further violation of section 2(2) of the Sterilisation Act read in conjunction with section 4[203] and the conduct of the health care practitioners and the ward nurse also amounted to an assault on the plaintiff.[204]

LS pleaded that as a result of the conduct of the medical professionals and the ward nurse she suffered an ''invasion of her bodily and psychological integrity, her dignity and her

[194] Ibid at para 14.1.
[195] Ibid at para 14.2-4.
[196] Ibid at para 17.4-5.
[197] Ibid at paras 17.5-6 and 19.9.2.
[198] Ibid at para 19.3.
[199] Ibid at para 19.6.
[200] Ibid at para 19.4.
[201] Ibid at para 19.1.
[202] Ibid at para 20.1.
[203] Ibid at para 20.2.
[204] Ibid at para 20.3.

privacy.''[205] She also ''experienced physical, emotional and psychological pain and suffering and ''suffered from emotional and psychological shock.''[206];

In addition, she averred that she ''has been temporarily, alternatively permanently, deprived of her ability to have children and the ability to make her own decisions regarding reproduction.''[207]

Defendant's plea

In responding to LS's case, the defendant relied on the defence that the plaintiff gave her full and informed consent to the sterilisation procedure hence there was no wrongfulness and unlawfulness on the part of the health care professionals.[208]

In taking this defence further the defendant stated that the plaintiff was ''fully informed about the nature and consequences of the sterilisation''[209] and that the relevant provisions of the Sterilisation Act had been complied with i.e. the attending doctors and ward nurse explained to the plaintiff the procedure involved, the associated consequences and risks attached to such procedure and the permanency thereof.[210]

The defendants' aver that LS was also made aware of the fact that her consent could have been withdrawn at any time before the procedure was performed on her.[211] The defendants further pleaded that LS only appended her signature to the consent forms after being made aware of the procedure and the associated risks of the procedure and that she had a period of four days within which to change her mind.[212]

(iv) Relief Claimed

An amount of R 844 304 was claimed on behalf of LS.[213] The amount was computed as follows:-

R 500 000 was claimed in respect of general damages; for past and future medical expenses a sum of R 100 800 was claimed (to assess the reversibility of the sterilisation)

[205] Ibid at para 21.1.
[206] Ibid at paras 21.2-3.
[207] Ibid at para 21.4.
[208] *Sithole v The MEC for Health and Social Development & 3 Others* – unreported case no. 19744/2012 – High Court of South Africa, Gauteng Local Division, Johannesburg para 10 of Defendant's amended plea.
[209] Ibid at para 14.
[210] Ibid at para 14.1.
[211] Ibid.
[212] Ibid at paras 14.2 & 4.
[213] *Sithole v The MEC for Health and Social Development & 3 Others* – unreported case no. 19744/2012 – High Court of South Africa, Gauteng Local Division, Johannesburg para 22 of Plaintiff's amended particulars of claim.

R 150 000 in respect of in vitro fertilisation procedures; R 60 000 in respect of counselling to assist the plaintiff with the emotional, psychological and physical pain that she had suffered; an amount of R 3 504 for transport costs and an amount of R 30 000 for loss of earnings.[214]

The matter was settled by the parties before going to trial.

(v) Outcome

The matter was settled out of Court. On the 14th March 2014, the first Defendant was ordered to pay an amount of R 470 800, within 30 days of the order being granted, to the Plaintiff for damages.

The Plaintiff was also awarded costs on a party and party scale which included the costs of two expert witnesses for the plaintiff.

### 2.4.3 *Pandie v Isaacs*

*Pandie v Isaacs* [215]is the only reported South African judgment dealing with involuntary sterilisation. It is included even though it does not deal with discrimination on the basis of HIV as it provides insight into the South African judiciary's views on consent to a sterilisation. In this case the Plaintiff instituted action against Dr Pandie, the Defendant (an obstetrician) for performing a sterilisation on her without her full informed consent.[216]

(i) Facts

The Plaintiff, was a 33 year old train driver at the time and had three children. She alleged that during her ante-natal visits to the Defendant she was asked on three different occasions whether she considered being sterilised.[217] She answered in the negative to this question.[218] At the last ante-natal consultation on the 3rd November 2004 and on the day before the caesarean section and sterilisation she again indicated that she did not want to be sterilised.[219] The Defendant then gave the Plaintiff a sealed envelope which he instructed her to take to the hospital as part of her admission process.[220] It later transpired that the envelope contained a letter to inform hospital staff that the Plaintiff was to undergo a caesarean section and sterilisation.[221] Before she signed the consent form for the operation the Plaintiff had asked for it to be amended to reflect that she did not want to be sterilised.[222] She was advised to inform the Defendant of the change on the consent form.[223]

---

[214] Ibid at paras 22.2.1-22.3.
[215] *Pandie v Isaacs* (A135/2013, 1221/2007) [2013] ZAWCHC 123 (4 September 2013).
[216] *Isaacs v Pandie* (12217/07) [2012] ZAWCHC 47 (16 May 2012) at para 1.
[217] Ibid at para 6.
[218] Ibid.
[219] Ibid at para 7.
[220] Ibid.
[221] Ibid.
[222] *Isaacs v Pandie* (12217/07) [2012] ZAWCHC 47 (16 May 2012) at para 7.
[223] *Pandie v Isaacs* (A135/2013, 1221/2007) [2013] ZAWCHC 123 (4 September 2013) at para 12.

However, this discussion did not take place.[224] The Plaintiff became aware that she had been sterilised when the theatre nurse held up a jar and shook the contents which were the severed portion of the fallopian tubes.[225]

(ii) Issues before the court

The Court was faced with one key issue, whether the legal obligations regarding the obtaining of consent before a sterilisation had been complied with.

(iii) Prior proceedings

The trial Court found that the defendant's conduct was grossly negligent and unlawful and ordered him to pay R 410 172.35 in damages to the Plaintiff.[226] The defendant appealed this judgment to the full bench of the Cape High Court.

(iv) Judgment

The Court held that consent for a sterilisation must be in writing as per the Sterilisation Act.[227] Regulations accompanying the Act[228] require the completion of two documents. The one being Form 1 of the Regulations and the other being the hospital's standard consent form.[229] It held further that performing a medical procedure without a patient's informed consent was actionable.

If a defendant has acted with dolus (encompassing knowledge of the wrongfulness of his conduct) it could amount to a criminal assault but the Act does not make provision for the payment of damages for this type of violation. The court stated that the "interference with another person's body has always been *prima facie* wrongful at common law".[230] In addressing the complex overlap between a common law and statutory duty the Court relied on *Steenkamp NO v Provincial Tender Board, Eastern Cape* 2006 (3) SA 151 (SCA) where the SCA held that if the statute does not provide for a damages remedy, and if the Court were to infer a common law remedy this would be contrary to the statutory scheme.[231]

In applying the law to the facts the Court found that written consent is required by the Act but in this case it was absent.[232] The Court observed that in the present case only one form was used namely the hospital consent form and this only provided consent for the caesarean section.[233] Furthermore, the Court held that the appellant's version that he had

[224] *Isaacs v Pandie* (12217/07) [2012] ZAWCHC 47 (16 May 2012) at paras 7, 8 & 9.
[225] Ibid at para 10.
[226] Ibid at para 90.
[227] 44 of 1998.
[228] 44 of 1998.
[229] *Pandie v Isaacs* (A135/2013, 1221/2007) [2013] ZAWCHC 123 (4 September 2013) at para 41.
[230] Ibid at paras 44-45.
[231] Ibid at para 42.
[232] Ibid at para 46.
[233] Ibid at para 41.

obtained verbal consent was also improbable.[234] Nevertheless, the Judge went onto hold that a prima facie wrongful act (failing to obtain written consent in compliance with the Act) could be legitimised by verbal consent even if it does not strictly comply with the Act.[235] In this instance the appellant had performed the sterilisation in the genuine belief that she had consented to the procedure verbally at the last consultation therefore, he did not possess the requisite intention or dolus.[236] The Court accepted that this approach to consent is was the prevailing practice in the appellant's profession and thus the appellant's conduct was not negligent.[237] In this instance, liability for the failure to obtain consent should lie at the feet of the hospital staff who were negligent in relation to the obtaining of her written consent in the manner required by the Act.[238] The Court concluded that it is unsatisfactory to hold a doctor liable where he has obtained informed oral consent but has failed to procure a written consent in accordance with the Act particularly as:[239]

i) The appellant did not stand to benefit financially nor was there any incentive to be gained by coercing the respondent into being sterilised;[240]

ii) Taking into account her age, the number of children and socio-economic status it is not unlikely that a woman in this position would refuse to be sterilised;[241]

iii) The referral letter written by the appellant requesting the hospital to prepare the respondent for a caesarean section and tubal ligation would not have been written contrary to her wishes;[242]

iv) The appellant performed the tubal ligation under the genuine belief that her verbal consent was in place and [243]

v) It is highly unlikely that the appellant would have insisted on going ahead with the sterilisation despite knowing that he did not have her consent as he would fall foul of the law and the Health Professions Council of South Africa.[244]

This led the Court to conclude that the respondent had consented to the sterilisation verbally and this absolved the appellant from liability in terms of a common law delictual claim.[245] The appellant could not be liable in terms of the criminal law as the requisite *mens*

[234] Ibid at para 51.
[235] Ibid at para 34.
[236] Ibid at para 46.
[237] Ibid.
[238] Ibid.
[239] Ibid at paras 44-45.
[240] Ibid at para 51 a.
[241] Ibid at para 51.b.
[242] Ibid at para 51.c.
[243] Ibid at para 51.d.
[244] Ibid.
[245] Ibid at para 64

*rea* did not exist.[246] Furthermore, given that the hospital staff had failed to inform the (gynaecologist) that Mrs Isaacs had refused to be sterilised or alternatively had withdrawn her written consent to be sterilised he could not be held liable for the negligence of the hospital staff. [247]

### 2.5 Commissions of Enquiry

An alternative to litigation is an inquiry into the alleged abuse. This has been used in Slovakia.

#### 2.5.1 Slovakia

In Slovakia where the Body and Soul Report revealed systematic sterilisations of Roma women the government agreed to set up a commission of enquiry. In 2001, the Commissioner for Human Rights of the Council of Europe carried out an official fact-finding visit to Slovakia with a view to obtaining an in-depth account of the current situation on the alleged forced and coerced sterilisations of Romani women.[248] Information from various stakeholders was collected before a number of recommendations were made.[249]

The finding of the Commissioner was that in this instance women from eastern Slovakia were exposed to the risk of being sterilised without proper consent.[250] Of further concern to the Commissioner was that the medical personnel opted to use sterilisation as a method to prevent future pregnancies rather than less permanent means of contraception.[251]

Some of the recommendations made in light of the Commissioner's findings to the Slovak government was that there should be enactment of new legislation which specifically encompasses the issue of free and informed consent;[252] policies to be implemented dealing with the obtaining of access to medical records of patients[253] and the creation of an independent commission that deals with redress (in the form of an apology and compensation) for the victims.[254]

The Commissioner in his 2006 follow-up report made the following observations regarding the measures put in place by the Slovak government in response to the grave human rights

---

[246] Ibid at para 34.
[247] Ibid at paras 71, 81-83.
[248] Recommendation of the Commissioner for Human Rights concerning certain aspects of law and practice relating to sterilization of women in the Slovak Republic. Accessed on 21 January 2017 http://www.coe.int/en/web/commissioner/country-report/slovak-republic.
[249] Amongst some of the stakeholders were personnel from the Deputy Prime Ministers office who were attached to the Human Rights and Minorities portfolio, the Ministry of Health, the Public Prosecutors office and the Parliamentary Ombudsman. Ibid at page 3.
[250] Ibid at 9.
[251] Ibid at 11.
[252] Ibid at 12.
[253] Ibid.
[254] Ibid.

violations that women suffered as a result of involuntary sterilisations performed on them.[255]

The Public Health Act which was passed into law on the 1 January 2005 was welcomed.[256] It addressed the shortcomings raised by the Commissioner by enacting provisions that dealt with sterilisations, informed consent and access to medical records.[257] As an added safety measure, the law now makes provision for a month's waiting period after informed consent is obtained.[258] However, the Commissioner noted with concern the failure of the Slovak government to establish an independent commission of enquiry to deal specifically with the issue of redress for the victims.[259] Whilst recognising that redress may be obtained through the court system, the Commissioner noted that this does not come without difficulties.[260] Specific mention was made of the cost implications for the victims and the extremely high evidential burdens that the victim had the onus of proving.[261] In concluding, the Commissioner once again stressed the need for a commission of enquiry to investigate and verify the violation of the women's rights and in turn provide ''effective and rapid non-judicial redress.''[262]

### 2.6 Research

The litigation on the forced/coerced sterilisation of women in Slovakia, Kenya, Namibia and South Africa has all been preceded by research and documentation of individual allegations of sterilisation abuse. It appears that research and documentation have been used to expose and obtain publicity around the issue and to identify possible litigants.

**Table 2.1: Table depicting the organisation that conducted the research, date of publication and key findings**

[255] Follow-up report on the Slovak Republic (2001 – 2005) Assessment of the progress made in implementing the recommendations of the Council of Europe Commissioner for Human Rights https://wcd.coe.int/ViewDoc.jsp?id=983969&Site=COE, accessed on 21 January 2017.
[256] Ibid at 9.
[257] Ibid.
[258] Ibid at 9.
[259] Ibid at 9.
[260] Ibid at 9.
[261] Ibid at 9.
[262] Ibid at 10.

| | Slovakia | Kenya | Namibia | South Africa |
|---|---|---|---|---|
| **Who did the report** | The Center for Reproductive Rights and the Centre for Human Rights | African Gender and Media Initiative (GEM) | International Community of Women Living with HIV/AIDS (ICW) | Zaynab Essack and Ann Strode |
| **When was it published** | 2003 | 2012 | 2009 | 2012 |
| **Key findings** | 1. Roma women were sterilised without their consent or by virtue of the fact that they received incorrect information about their medical condition.<br><br>2. Roma women were physically and verbally abused.<br><br>3. Roma women were denied access to their medical records.<br><br>4. Roma women were discriminated against on the basis of their ethnicity. They were prevented from using the same dining and ablution facilities as non-Roma women. | 1. Women did not provide their full and informed consent before being sterilised.<br><br>2. Women had to agree to be sterilised in exchange for the payment of maternity hospital fees; obtaining milk formula for their babies and for medication.<br><br>3. Partners provided consent for the sterilisation unbeknown | 1. Women were sterilised without providing their full and informed consent.<br><br>2. Women were discriminated against on the basis of their HIV positive status by health care providers. | 1. Women were sterilised without their informed consent, alternatively made their decisions after being coerced into it.<br><br>2. Women experienced physical pain, financial distress, difficulties with their relationships with their partners and rejection from the community.<br><br>3. Women experienced discrimination as a result of |

| | | | | |
|---|---|---|---|---|
| | | to the women.<br><br>4. Women were discriminated against on the basis of their HIV positive status and disability. | | their HIV positive status by health care providers. |
| **Conclusions** | 1. There has been a blatant violation of Roma women's rights in terms of receiving comprehensive and accurate information about sterilisations thus compromising their rights to providing full and informed consent to being sterilised.<br><br>2. Access to medical records have been impeded by public health officials.<br><br>3. Roma women were subjected to discriminatory treatment by health care providers.<br><br>4. There was a violation of laws on a national, regional and international level. | 1. There has been a violation of the sexual reproductive health rights of women by health care providers.<br><br>2. Consent was sought whilst some women were in active labour.<br><br>3. Incentives were offered to women to influence their decision to be sterilised which, negated the aspect of informed consent. | 1. The sexual reproductive rights violations had an effect on the physical, personal and emotional spheres of the lives of women.<br><br>2. There is a need for the Namibian government to fulfil its obligations in terms of domestic, regional and international human rights law. | 1. Despite South Africa's legal framework that makes provision for informed consent to be procured before a sterilisation is performed there are reports of involuntary sterilisations. |

| | | | | |
|---|---|---|---|---|
| | | 5. Personal circumstances of the women i.e. poverty and their HIV status affected their decision making process.<br><br>6. Women suffered from physical pain, psychological trauma and social isolation after their non-consensual sterilisation. | | |

## 2.7 Discussion

The review of key cases above has shown that civil litigation has been an effective tool in that women have received judgments in their favour however, it is doubtful that these may be deemed successful as the woman often do not receive compensation that sufficiently places them back in the position that they were in before the sterilisation. Further, there is an absence of evidence to show that these judgments have caused hospitals and doctors to reconsider the way in which consent has been obtained from patients. The following key themes have emerged from the cases.

### *(i) Most of the litigation has been driven by non-governmental organisations*

NGO's have litigated successfully, in part, in Slovakia, Namibia and South Africa on behalf of sterilised women whose sexual reproductive rights have been violated.[263] Furthermore, litigation is under way in Kenya.

### *(ii) Litigation based on the norms in national laws, constitutional rights or international*

[263] In Slovakia, the litigation was spearheaded by the Centre for Civil and Human Rights, the Legal Assistance Centre assisted the women in Namibia and in South Africa, the Women's Legal Centre litigated on behalf of Sithole.

***laws have been successful on the issue of informed consent***

These cases have been based both on national laws where they exist, on international obligations where domestic laws are insufficient and in some instances clinical guidelines. Litigating in a country that has national laws in place , such as in South Africa, where there is a Sterilisation Act[264] obviously has a higher prospect of success as the legal obligations on medical practitioners are clearly articulated in the law. *Sithole* relied on statutory law to plead her claim for the violation of her right to bodily integrity.[265] She had the benefit of relying on the Sterilisation Act,[266] which was designed to set out exactly what qualifies to be deemed as free and voluntary consent. She also relied on her constitutionally protected right to dignity, psychological and bodily integrity. Since the matter was settled out of Court, we do not have the advantage of analysing a written judgment setting out whether the provisions relied on by *Sithole* would have been sufficient to make out a case for the violation of her bodily integrity.[267]

However, in the countries reviewed above, South Africa was the only one with dedicated legislation on point. The Slovakian litigation team was able to successfully rely on international norms as it took the matter to the European Court of Human Rights. In Namibia, they were able to rely on their rights in the Constitution given the lack of domestic law on informed consent and equality. This shows that the lack of domestic law is not necessarily a key barrier to successful litigation. A key outstanding question is however whether the use of clinical guidelines as the basis of a civil claim will be successful.

***(iii) Litigation based on the norms contained in clinical guidelines has yet to be tested***

The current litigation under way in Kenya places considerable reliance on two sets of clinical guidelines to advance their case namely the Kenyan National Family Planning Guidelines for Service Providers (2010) and the International Federation of Gynaecology and Obstetrics Guidelines. The difficulty that the Kenyan litigation team will face will be its reliance on national and international clinical guidelines. Different jurisdictions place different weight on clinical guidelines.

Many jurisdictions that are based on English common law may likely follow the judgment in the case of *KR v Lanarkshire*.[268] Here the Court sets out its view succinctly on the status of guidelines in cases of medical negligence. The pursuer (plaintiff) in casu relied on the General Medical Council Guidelines[269] when arguing that the obstetrician had failed to fully

[264] Act 44 of 1998.
[265] *Sithole v The MEC for Health and Social Development & 3 Others* – unreported case no. 19744/2012 – High Court of South Africa, Gauteng Local Division, Johannesburg.
[266] Act 44 of 1998.
[267] Ibid.
[268] *KR against Lanarkshire Health Board*, available at https://www.scotcourts.gov.uk/search-judgments/judgment?id=615d1ea7-8980-69d2-b500-ff0000d74aa7 accessed on 25 May 2018.
[269] The General Medical Council is a statutory body in the United Kingdom, which amongst others regulates the medical profession.

appraise her of the risks that were associated with the delivery of her baby.[270] She further relied on the National Institute for Health and Care Excellence Guidelines (2007) and the Royal College of Obstetricians and Gynaecologists Guidelines (2001) to show that the obstetrician had not met the standards required by a professional working in this field.[271] The Court held that the guidelines came into existence after extensive deliberation by a panel of experts who took into account ''available scientific information and their own collective experience'' which, are intended to ''provide clinical guidance'' and are not binding rules.[272] A similar view was held in the South African case of *Pandie v Isaacs* where the Court observed that ''guidelines do not have the status of law and are merely part of the evidential material to be weighed in determining the standards reasonably to be observed by doctors.''[273]

Further, Lord Brailsford in the *KR v Lanarkshire* case held that a less experienced practitioner who does not have the benefit of knowledge that can only be gained from experience, should closely follow the guidelines as they are a product of distilled knowledge of experts.[274] In instances where less experienced practitioners consider the application of a particular guideline to be inappropriate, Lord Brailsford was of the view that a more experienced practitioner should be consulted for guidance before deviating from them.[275] Based on the dictum in the *KR* case it is submitted that a departure from clinical guidelines seems to be reserved for the more experienced practitioners, however, they would have to be mindful of the fact that their conduct in doing so may be reviewed or criticised in certain circumstances.[276] This approach shows that although guidelines are not directly legally enforceable they are used by courts in civil claims when assessing whether a medical practitioner is negligent.

In the *KR*[277] case the Court found that the obstetrician's conduct was negligent because she failed to comply with the relevant guidelines. In coming to this conclusion, the Court took into account her level of inexperience. The Court noted that given her inexperience she was expected to abide by the advice set out in the National Institute for Health and Care Excellence Guidelines (2007) and the Royal College of Obstetricians and Gynaecologists Guidelines (2001) or alternatively, seek the advice of a more senior obstetrician.[278]

---

[270] *KR against Lanarkshire Health Board*, available at https://www.scotcourts.gov.uk/search-judgments/judgment?id=615d1ea7-8980-69d2-b500-ff0000d74aa7 accessed on 25 May 2018 at para 6.
[271] *KR against Lanarkshire Health Board*, available at https://www.scotcourts.gov.uk/search-judgments/judgment?id=615d1ea7-8980-69d2-b500-ff0000d74aa7 accessed on 25 May 2018 at para 101.
[272] Ibid at para 129.
[273] *Pandie v Isaacs* (A135/2013, 1221/2007) [2013] ZAWCHC 123 (4 September 2013) at para 37.
[274] *KR against Lanarkshire Health Board*, available at https://www.scotcourts.gov.uk/search-judgments/judgment?id=615d1ea7-8980-69d2-b500-ff0000d74aa7 accessed on 25 May 2018 at para 129.
[275] Ibid at para 129.
[276] Ibid.
[277] *KR against Lanarkshire Health Board*, available at https://www.scotcourts.gov.uk/search-judgments/judgment?id=615d1ea7-8980-69d2-b500-ff0000d74aa7 accessed on 25 May 2018.
[278] Ibid at para 130.

Similar views have been expressed by the authors Dickens and Cook who hold the view that guidelines, if followed closely by medical practitioners, can shield them during Court proceedings and/or disciplinary proceedings and conversely may be used to attack them and attract liability if not followed.[279] In the *Sibisi* case, the gynaecologist relied on his close observance to the Royal College of Obstetricians and Gynaecologists Guidelines (2012) to assist him favourably when showing the Court that there was no mismanagement on his part during the delivery of the plaintiff's baby.[280]

### *(iv) Failure to obtain informed consent for a sterilisation has been established in a range of jurisdictions*

All the litigation bar *Isaacs v Pandie*,[281] were based on two causes of action namely the absence of fully informed consent and discrimination. Thus far, litigation has only been unsuccessful regarding the issue of bodily integrity in the case of *Pandie v Isaacs*.[282] An analysis of the litigation strategies used in these jurisdictions will be a useful indicator in gauging whether the litigation on the leg of bodily integrity will be successful in Kenya. A key factor to bear in mind is that all the litigants had signed consent forms and thus the courts had to grapple with the issue of whether ''written consent of a patient amounts to properly obtained informed consent.''

In Slovakia, the broad rights relied on were the rights to be free from torture and the right to a private life, which are enshrined in the European Convention on Human Rights. The Court took into account the circumstances surrounding the manner in which the consent was obtained and the state of mind that the patient was in at the time that consent was obtained. The Court did not hesitate in a making a finding that a combination of the manner in which the consent was obtained and the state of mind of the patient at the time consent was obtained was not ideal for an informed decision to be made. Furthermore, the sterilisation of VC was not done to save her life and therefore her right to make an informed choice as a patient cannot be disregarded.

Some of the key constitutional and common law rights relied on in the Namibian case to advance the violation of the plaintiffs rights to bodily integrity, are the rights to found a family; not to be subjected to cruel, inhuman and degrading treatment; the right not to suffer infringements of their rights to bodily and psychological integrity; and the right to dignity.[283] The issue of informed consent was discussed at great length by the Court. The Court relied on the Namibian Health Professions Council's guidelines and South African case

[279] B M Dickens & R J Cook 'The legal effects of fetal monitoring guidelines' (2010) 108 *International Journal of Gynecology and Obstetrics* 170-173 at 171.
[280] 2014 (6) SA 533 (SCA) at paras 34-35.
[281] *Isaacs v Pandie* (12217/07) [2012] ZAWCHC 47 (16 May 2012).
[282] *Pandie v Isaacs* (A135/2013, 1221/2007) [2013] ZAWCHC 123 (4 September 2013).
[283] *LM and Others v Government of the Republic of Namibia* (I 1603/2008, I 3518/2008, I 3007/2008) [2012] NAHC 211 (30 July 2012) para 6 -7.

law to emphasise the importance of patient autonomy and the patient's right to make an informed choice after being given full information regarding the proposed medical procedure. The Court focused on the circumstances under which the consent of the plaintiffs were obtained. It was obtained whilst they were in labour and experiencing extreme pain. The Court concluded that a patient in that situation would be unable to comprehend the information received and make a fully informed decision. A blind eye cannot be turned to the fact that the decision that has to be made by a woman, who is in severe pain and protracted labour, is one that has the effect of permanently ending her reproductive capacity. It is submitted that the Courts were correct as this is an extremely personal decision that has to be made without the negative influence of external factors such as pain and pressure from the hospital staff because of a patient's HIV positive status. The jurisprudence now shows that procuring consent for a life-changing decision like a sterilisation under the conditions described amounts to a gross disregard for a woman's autonomy and dignity. The outcome of the Namibian case has been welcomed however, the principle basis of the judgment has been criticised by Pickles for finding that women lack capacity during childbirth.[284] Pickles submits that this implication has far reaching consequences especially where women wish to revoke their consent or refuse consent during labour.[285] It is submitted that this is a significant issue, which has been raised by Pickles as no other South African case has found that consenting under coercive circumstances impacts on a person's legal capacity.

It is submitted that the Slovakian and Namibian cases can be used as a litmus test to indicate whether the litigants in Kenya will be successful with their claim relating to the violation of their bodily integrity. Without any domestic sexual reproductive health rights laws to rely on, the petitioners have based their claims on two sets of guidelines. As noted earlier, these guidelines are not binding but will serve an important role in assisting the Court to decide whether there was substantial deviation from them, which could together with the other evidence presented lead to an adverse finding being made regarding how the informed consent of the petitioners was taken. There was also reliance on the Kenyan Constitution, which protects amongst other rights the right to autonomy, human dignity and to reproductive health care. A violation of rights contained in international legal instruments was also pleaded.

Often, the vulnerable position of women in active labour is used as leverage when coercing them into being sterilised. In the *LM*[286] case the women were in active labour for a prolonged period of time and were only going to be taken to theatre for a caesarean section if they agreed to be sterilised. In the case of *SWK and Others v Médecins Sans Frontières*

[284] C Pickles 'Sounding the alarm: *Government of the Republic of Namibia v LM* and women's rights during childbirth in South Africa' 2018 21 *PER/PELJ* 1-34.
[285] Ibid 7.
[286] *LM and others v The Government of the Republic of Namibia* case no 1603/2008, available at http://www.saflii.org/na/cases/NAHC/2012/211.html accessed on 1 July 2015.

*and Others*, one of the women reported being in labour for 48 hours before having a caesarean section.[287] The caesarean section was only done when the woman agreed to be sterilised. The women in *VC's*[288] case also suffered a similar fate even though they were not HIV positive. It is submitted that once the Court takes into account the circumstances under which the petitioners' consent was obtained it will show that the petitioners were not in a frame of mind that was free from negative influence. Consent was obtained from one petitioner after she was told that she would die if she did not stop having babies. Milk formula for their new-born babies, food and payment of hospital fees would be withheld if there were no proof of the sterilisation. By consenting under these circumstances, it is clear that their vulnerable socio-economic position was used to influence their decisions. Furthermore, there is a clear violation of the guidelines and provisions contained in the Kenyan Constitution and international instruments.

### *(v) Courts in some instances remain biased towards medical practitioners who they perceive to be acting in the best interest of patients*

Central to the case of *Isaacs v Pandie*[289] was whether oral consent could serve as a substitute for written consent as required by the Sterilisation Act[290] in instances where the same was procured by the medical practitioner. The Appeal Court was of the view that a medical practitioner should not be liable under these circumstances. It is submitted that the Court erred in making such a finding as the Sterilisation Act[291] does not allow room for the use of one's discretion to be exercised when deciding how to obtain consent that is, either orally or in writing. Further, the Act[292] carries a criminal penalty for non-compliance with the provisions of it. Therefore, there must be a signed form consenting to the sterilisation. Given the South African legal framework, it is difficult to understand why the Court disregarded these norms in favour of an approach that found the medical practitioner was not negligent in relying on a nurse to obtain consent to the procedure. It is argued that the unequal power dynamics between the surgeon and the train driver patient played an unarticulated role in the Court's evaluation of the evidence. This reflects the difficulties that plaintiffs bear in proving that the doctor's conduct was wrongful. For example, in *Pandie's* case the Court appears to have bent over backwards in defending the doctor's conduct because there was no evidence that he had an intention to harm *Isaacs* and gain financially from performing the procedure without her consent.

---

[287] *SWK and others v Médecins Sans Frontières and others* Petition No. 605 of 2014, In the High Court of Kenya at Nairobi Constitutional and Human Rights Division at para 16.
[288] Application no. 18968/07 European Court of Human Rights, available at http://www.menschenrechte.ac.at/orig/11_6/V.C..pdf accessed on 1 July 2015.
[289] *Isaacs v Pandie* (12217/07) [2012] ZAWCHC 47 (16 May 2012).
[290] Act 44 of 1998.
[291] Ibid.
[292] Ibid.

***(vi) Medical practitioners cannot rely solely on the evidence of a signed consent document***

It appears that courts will reject defences based on the mere recording of a person's signature to operate as a form of consent. Instead, it appears that they require medical personnel to demonstrate that they obtained the patient's free and informed consent.[293]

***(vii) No court has to date accepted that forced or coerced sterilisations are occurring for a discriminatory reason***

With regards to the allegations that the sterilisations were performed for discriminatory reasons, none of the litigants succeeded on this leg of their claim. An assessment of the evidence placed before the courts will assist us in understanding this quagmire.

The following key facts were placed before the court in *VC's*[294] case in order to assist in making a finding that she was sterilised for a discriminatory reason: it was recorded on her hospital file that she was of ''Roma origin'', she did not share the same ward as non-Roma women, she had to use dining and ablution facilities that were reserved for Roma women only, she received poor treatment from the medical staff, she was only 20 years old at the time of the sterilisation and there was no request by her to be sterilised. The sterilisation was not carried out for therapeutic reasons. This was insufficient evidence presumably for the court to make a finding of unfair discrimination based on *VC's* ethnic status. It is submitted that a cause for concern is that at the time of *VC's* case there was other litigation pending on the same cause of action and the fact that the Court accepted that there was evidence before it that showing a practice of the involuntary sterilisation of women from different ethnic groups. Therefore, the involuntary sterilisation of *VC* was not an isolated incident. This is a strong indication that it cannot be co-incidental that *VC* was singled to be sterilised for her ethnicity. Despite the factual circumstances that the Court accepted, it is submitted that it was incorrect in placing emphasis on the behaviour of the doctors by finding that they acted without the intention of mistreating *VC*, which outweighed the ultimate harm suffered by her.

In the *LM*[295] case, the evidence before the Court was that the HIV positive status of all three women was a known fact to the nurses and doctors treating them. Further, two of the plaintiffs reported being told by the hospital staff that there was a policy in place to sterilise women living with HIV. None of the women indicated that they wanted to be sterilised by making a booking for this procedure.

Durojaye is of the opinion that the Namibian courts missed an opportunity to make a finding regarding the human rights implications of the involuntary sterilisation of women based on

[293] This was the approach adopted in the Slovakian and Namibian jurisdictions.
[294] Application no. 18968/07 European Court of Human Rights available at http://www.menschenrechte.ac.at/orig/11_6/V.C..pdf accessed on 1 July 2015.
[295] *LM and others v The Government of the Republic of Namibia* case no 1603/2008, available at http://www.saflii.org/na/cases/NAHC/2012/211.html accessed on 1 July 2015.

a discriminatory reason.[296] It is submitted, that the Namibian courts did indeed address the issue of discrimination against the women based on their HIV positive status but, found that there was no credible evidence by the women to sustain this allegation. In both jurisdictions, the Courts without providing much insight into why the discrimination claims were dismissed held that there was no evidence of an organised policy or practice in place that orchestrated the involuntary sterilisation of women of child-bearing age based on discriminatory reasons. It is submitted that both of these cases provided an ideal opportunity for the Courts to enlighten us on what exactly needed to be proved before it could be pronounced that the sterilisations were carried out for discriminatory reasons. It is lamentable that this was not done and that the claims based on discrimination were contemptuously dismissed. Furthermore, it is submitted that both jurisdictions were incorrect in requiring the litigants to prove that a discriminatory policy existed as it is a well established principle that the violation of the right to equality may occur from an individual action or collective practices.

The NGO[297] pursuing the matter in Kenya is optimistic that the judiciary will break the mould and make a finding that the sterilisation of the four women before Court was as a result of their HIV positive status or alternatively provide the much needed guidance on what evidence must be led in order to make a successful finding on discrimination.

It is the writer's submission that the very essence of bringing such matters to court is defeated if a finding of discrimination cannot be made. Not only is the discrimination against these women based on their ethnicity or HIV status but is accompanied by their vulnerable position in society, that is, they are poor; have limited education; compelled to use public health care facilities and ultimately have to battle with the power dynamics between themselves and health care workers. It is vitally important for our courts to recognise that vulnerable women are subjected to intersectional discrimination to which a blind eye cannot be turned.

A further issue that has not been addressed by the courts particularly in Southern Africa is the question of how one pleads a violation of the right to equality in terms of the law of delict and more specifically in terms of the Roman law actio iniuarium. The actio iniuriarum allows a plaintiff to claim for general damages for the impairment of dignity, bodily integrity (the right to make a choice), reputation, privacy and identity. It is submitted, that the only ground on which a claim for unfair discrimination could be made is if a court accepts that being treated in a discriminatory fashion is a violation of a person's dignitas however, no court has expressly pronounced on this issue leaving the way in which equality claims should be pleaded unclear.

---

[296] E Durojaye 'Involuntary sterilisation as a form of violence against women in Africa' (2017) *Journal of Asian and African Studies* 1-12 at 2.

[297] Kelin available at http://www.kelinkenya.org/ accessed on 5 October 2018.

### *(viii) The criminal law offers limited assistance to forced or coerced sterilised women*

Criminal remedies appear to have only been used in Slovakia where they were unsuccessful. The primary reason behind this may be that establishing dolus is extremely difficult as has been demonstrated by the South African case of *Pandie*.[298] This issue is explored further in Chapter 5.

### *(ix) Qualitative research plays a significant role in supporting civil claims dealing with forced and coerced sterilisation*

Another important feature of the cases discussed was that research preceded all of them except for in *Isaacs*.[299] The findings of the research was that women were being sterilised for discriminatory reasons. Apart from the *Isaacs*[300] case, all the sterilisations were carried out in State hospitals.

## 2.8 Conclusion

The forced or coerced sterilisations of HIV positive women violate their sexual reproductive health rights. The permanency of the sterilisation procedure coupled with the fact that sterilisation is a highly personal decision to be made by a woman, and the fact than it can never be justified as a medical emergency, makes the forced or coerced sterilisation of HIV positive women not only illegal but offensive and highly objectionable. The key rights relied on by the litigants to prove the lack of fully informed consent on their part were strikingly similar in all the cases. In Slovakia, the rights relied on were the right to be free from torture, inhuman and degrading treatment[301] and the right to family life.[302] The litigants in Namibia relied on similar rights and in addition, the right not to suffer infringements to one's bodily and psychological integrity was pleaded.[303] Although there has been successful civil litigation around the failure to obtain informed consent there have been no successful cases on the issue of sterilisations being performed for discriminatory reasons. There are disadvantages attached to this legal remedy which cannot be ignored. The first is the long and protracted nature of litigation. The table below depicts the time taken from the inception of the litigation to the finalisation of the matters.

---

[298] *Isaacs v Pandie* (12217/07) [2012] ZAWCHC 47 (16 May 2012).
[299] Ibid.
[300] Ibid.
[301] Application no. 18968/07 European Court of Human Rights, at para 100, available at http://www.menschenrechte.ac.at/orig/11_6/V.C..pdf accessed on 1 July 2017.
[302] Ibid 130.
[303] *LM and Others v Government of the Republic of Namibia* (I 1603/2008, I 3518/2008, I 3007/2008) [2012] NAHC 211 (30 July 2012) at para 6.5.

**Table 2.2: Table depicting the time taken from institution of action to finalisation of proceedings**

| Case name | Date of sterilisation | Date of institution of legal proceedings | Date of finalisation of matter | Number of years for the matter to be finalised from date of sterilisation |
|---|---|---|---|---|
| *V.C v Slovakia* | 2000 | 2004 | 2011 | 11 |
| *LM and others v Government of the Republic of Namibia* | 2005-2007 | 2010 | 2014 | 9 |
| *Sithole v The MEC for Health and Social Development & 3 Others* | 2009 | 2012 | 2014 | 5 |
| *Isaacs v Pandie* | 2004 | 2007 | 2013 | 9 |

# Chapter 3

# The right to bodily and psychological integrity

## 3.1 Introduction

The right to bodily and psychological integrity has been a well-recognised right which was first established within the common law over 90 years ago. Its significance was emphasised in *Stoffberg v Elliot* where the court found:

> In the eyes of the law every person has certain absolute rights which the law -protects. They are not dependant on statute or upon contract, but they are rights to be respected, and one of the rights is absolute security to person . . . . Any bodily interference with or restraint of a man's person which is not justified in law, or excused in law or consented to, is a wrong and for that wrong the person whose body has been interfered with has a right to claim such damages as he can prove he has suffered owing to the interference.[1]

The Court in this matter used the right to security (freedom) of the person to place an obligation on medical practitioners to obtain consent from a patient for surgical procedures. This was the start of the development of both the right and the defence of informed consent in our law. Many of the core principles established in this case continue to form the foundation of our law on informed consent. These principles include firstly, that voluntarily going to hospital for a procedure does not equate to informed consent for that procedure. Secondly, in hospital patients retain their rights to security and control over their bodies. Thirdly, informed consent to the procedure must be provided. Fourthly, failure to obtain informed consent means that the procedure will be a wrongful violation of the right to bodily integrity. These principles are also in line with the jurisprudence in many other foreign jurisdictions. For example O'Sullivan quotes from the Canadian case of *R v Morgenthaler* where this right was described as ''the notion of liberty in a free and democratic society as one which does not require the state to approve the personal decisions made by its citizens; it does, however, require the state to respect them.''[2]

In the post 1994 period there has been substantial development of the right to bodily and psychological integrity. It is now a fundamental constitutional right. Our courts are also required to use the norms established in public international law to assist them in interpreting these rights, and a range of health laws all addressing when and how consent must be obtained from a patient have been introduced.[3]

---

[1] 1923 CPD 148 at 148.

[2] M O' Sullivan & C *Bailey Constitutional Law of South Africa: Reproductive Rights* (1998) 16-19 at 19.

[3] These laws include amongst others: National Health Act 61 of 2003; Children's Act 38 of 2008; Sterilisation Act 44 of 1998 and Choice on Termination of Pregnancy Act 92 of 1996.

This chapter describes the right to bodily and psychological integrity in South African law and international law. This chapter includes a discussion on key issues relating to the way in which the right of freedom and security has informed the law on informed consent.[4]

### 3.2 The right to bodily and psychological integrity in international law

There are several international human rights conventions and covenants that afford everyone the right to bodily integrity, and women autonomy over their reproductive rights. South Africa has adopted and ratified many of these conventions and covenants and our courts are therefore, in terms of section 39 (1) (*b*),[5] enjoined to consider the provisions of international law when interpreting provisions contained in the Bill of Rights.[6] This means courts are required to use these provisions to interpret section 12 of our Constitution.[7] Furthermore, given that many of these conventions have been ratified by South Africa, in some instances our legislation has been reformed to bring it in line with the principles in these conventions.

Article 3 of the Universal Declaration of Human Rights (UDHR)[8] states that everyone has the right to life, liberty and security of person. Article 5[9] states further that no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. The International Convention on Civil and Political Rights (ICCPRs)[10] protects autonomy rights in Article 16[11] where it states that men and women of full age, without any limitation due to race, nationality or religion, have the right to marry and found a family. The International Covenant on Economic, Social and Cultural Rights (ICESCR)[12] recognises the importance of and accords protection of the family unit without making any direct reference to the reproductive health rights of women.[13] However, Article 12(1)[14] broadly makes provision for States Parties to recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

---

[4] 2006 (3) All SA 565 (C).
[5] Constitution of the Republic of South Africa, 1996.
[6] *DE v RH* (CCT 182/14) [2015] ZACC 18; 2015 (5) SA 83 (CC); 2015 (9) BCLR 1003 (CC) (19 June 2015) as per Madlanga J, at p 21 footnote 87.
[7] Constitution of the Republic of South Africa, 1996.
[8] Came into effect on the 10 December 1948, as a response to the atrocities committed during World War 2 http://www.un.org/en/documents/udhr/history.shtml.
[9] Universal Declaration of Human Rights.
[10] International Covenant on Civil and Political Rights, 16 December 1966 and ratified by South Africa on 10 December 1998. Article 7 and 9.
[11] Universal Declaration of Human Rights.
[12] International Covenant on Economic, Social and Cultural Rights, 16 December 1966 and ratified by South Africa on 18 January 2015.
[13] Article 10(1), International Covenant on Economic, Social and Cultural Rights.
[14] International Covenant on Economic, Social and Cultural Rights.

Article 16 (1) (e) of CEDAW[15] provides that State Parties shall take all appropriate measures to eliminate discrimination against women in all matters relating to marriage and family relations. The right is phrased in such a way as to ensure that women have autonomy on the 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. Specific mention is also made of the obligation to ensure that rural women have access to adequate health care facilities, including information, counselling and services in family planning.[16]

The African Charter on Human and Peoples' Rights, also referred to as the Banjul Charter (ACHPRs)[17] further entrenches the importance of fundamental human rights and this is evident from Article 5 which states that every individual shall have the right to the respect of the dignity inherent in a human being and to the recognition of his legal status. Article 6 protects an individual's right to liberty and security of person.[18] The Banjul Charter, like the UDHR and ICCPR, also prohibits torture, cruel, inhuman or degrading treatment. It further delineates specific protection of women in Article 18 (3)[19] which mandates States to ensure the elimination of every form of discrimination against women and also to ensure the protection of the rights of the woman and the child as stipulated in international declarations and conventions. Continuing in a similar vein as CEDAW[20] in striving to eliminate discriminatory practices against women, the Maputo Protocol has been adopted by the African Commission on Human and People's Rights. The protocol deals in more detail with the right to security of the person and the right to reproductive health.[21]

Further detail on the content of the right to bodily and psychological integrity is described in several International Declarations. The United Nations Fourth World Conference on Women held in Beijing known as the Beijing Declaration[22] provides in Article 29[23] that ''maternity, motherhood, parenting and the role of women in procreation must not be a basis for discrimination nor restrict the full participation of women in society.''[24]

[15] Convention on the Elimination of All Forms of Discrimination against Women, 18 December 1979 and ratified by South Africa on 15 December 1995.
[16] Article 14 (1) (b) of Convention on the Elimination of All Forms of Discrimination against Women.
[17]African (Banjul) Charter on the Human and Peoples' Rights, 27 June 1981 and ratified by South Africa on 9 July 1996.
[18] African (Banjul) Charter on Human and Peoples' Rights.
[19] Ibid.
[20] Convention on the Elimination of All Forms of Discrimination against Women.
[21] Article 14 extends the integrity of her person by specifically dealing with Health and Reproductive Rights. Apart from the right of a woman to control her fertility the rights contained in Articles 1 (b), (c), (g) and 2(a) of the Maputo Protocol are protected in CEDAW.
[22] The United Nations Fourth World Conference on Women, September 1995 ratified by South Africa in 1995.
[23] Beijing Declaration.
[24] Ibid.

The Cairo Declaration on Population and Development[25] assists in strengthening the call for the recognition of women's reproductive health rights. This is evident by the fact that special recognition has been given to reproductive health and family planning.[26] Parliamentarians from around the globe have committed themselves to ''remove all remaining barriers in our countries that inhibit access to family planning services, information and education, as well as to help support the provision of reproductive health and family planning services as widely as possible.''[27]

**Table 3.1: Overview of the sexual and reproductive rights protected in international law**

| **Convention/Covenant** | **Right of security of person** | **Right to found a family** | **Reproductive rights & family planning rights** |
|---|---|---|---|
| UDHR | ✓ | ✓ | |
| ICCPR | ✓ | ✓ | |
| Banjul Charter | ✓ | | |
| CEDAW | | ✓ | ✓ |
| Maputo Protocol | ✓ | | ✓ |
| Beijing Declaration | ✓ | ✓ | |
| ICESCR | | ✓ | |
| Cairo Declaration on Population & Development | | | ✓ |

It is clear from the covenants and conventions discussed that there is a significant amount of protection afforded to the right to one's bodily and psychological integrity and a recognition for the need to respect the reproductive health choices of women, see Table 3 above.

### 3.3 Right to bodily and psychological integrity in the South African Constitution

The protection of an individual's bodily and psychological integrity is now firmly entrenched in our Constitution.[28] There are two broad over-arching rights within the Constitution

[25] Cairo Declaration on Population and Development, Cairo, Egypt 3-4 September 1994.
[26] Ibid at para 5.
[27] Ibid.
[28] Section 12 of the Constitution of the Republic of South Africa, 1996.

namely the rights to psychological and bodily integrity together with our health–related autonomy rights, that is, reproductive health rights and access to reproductive health care.[29] They find protection under the umbrella of the constitutional rights to ''freedom and security of the person'' and as well as the right to access ''health care, food, water and social security.''[30] In essence, these rights provide protection for autonomous choices and services in furtherance of such choices. Interestingly, reproductive health rights and access to reproductive health care found no protection under the interim Constitution but in the final Constitution, they were expressly mentioned separately in both sections 12 and 27 making it clear that there is a duty on the State to respect reproductive health choices and ensure access to such services. In fact, the drafters of the final Constitution made general provision for everyone to access health care services without defining the minimum core of such services.[31] However, the right to access reproductive health care has been singled out by being mentioned in section 27 (1) (*a*).[32] No other type of health care service is mentioned except in section 28 (1) (*c*) where reference is made to a child's right to basic health care services.[33] It has been submitted by Bishop and Woolman that the reason the constitutional drafters took this approach is because they recognised that much of the oppression and exploitation against women comes from socially entrenched forms of physical (and psychological) violence related to their reproduction and sexuality.[34] If this rationale is correct, it is extremely significant as it recognises how fragile a woman's autonomy and decision making can be within the realm of reproductive health care.

The shift in focus from the interim to the final Constitution was the result of extensive lobbying by gender activists. According to O'Sullivan, the downplaying of sexual reproductive health rights could can be attributed to the history of reproductive rights in South Africa, which was characterised by highly invasive regulation.[35] For example, black women were subjected to the apartheid government's racist policies on birth control, which either took the form of involuntary sterilisations or the use of injectable contraceptives.[36] Further, abortions were illegal in South Africa except for under certain limited circumstances.[37] In addition, married women were assigned the downgraded status of perpetual minors and subjected to the marital power of their husbands which had the effect of curtailing their autonomy in various spheres of their lives including in relation to their

[29] Sections 12 (2) and 27 (1) (*a*) of the Constitution of the Republic of South Africa, 1996.
[30] Ibid.
[31] Section 27 (1) (a) of the Constitution of the Republic of South Africa.
[32] Constitution of the Republic of South Africa.
[33] Ibid.
[34] M Bishop and S Woolman 'Freedom and security of the person' in S Woolman and M Bishop (eds) *Constitutional Law of South Africa*(2002-, OS 07-06) 40.9.
[35] M O' Sullivan 'Reproductive rights' in S Woolman and M Bishop (eds) *Constitutional Law of South Africa*(2002-, OS 02-05) 37.5.
[36] Ibid.
[37] See section 3 of Act 2 of 1975.

reproductive health care rights.[38] Even though women gave birth to their own children they were not accorded the status of being the guardians of their children before 1993.[39] Cook and Dickens state that the underlying philosophy on sexual and reproductive rights in this era was that married women needed that assistance or in some cases even the permission of their husbands when exercising these rights.[40] Following extensive advocacy from women's organisations, the relevant sections referred to above were included in the final Constitution.[41]

An important observation to be made before delving into the meaning of section 12 is that ''the advancement of human rights and freedoms'' is one of our founding constitutional values contained in section 1 of the Constitution.[42] These constitutional values are used to assist the court in interpreting rights.[43] The constitutional value of freedom was emphasised by Justice O'Regan in the case of *NM* where she stated that this value was a recognition of every individual being a morally autonomous human to form opinions and act on them.[44] Section 12 (1) as a right refers to the ''right to freedom and security of the person'' which includes a closed list of five rights.[45]

According to O'Sullivan, who considered the right in light of its narrow interpretation in the case of *Ferreira v Levin NO and Others*, the right was construed in a narrow, context specific manner of only protecting ones physical integrity against unlawful detention and thus preventing a person from being subjected to cruel, inhuman and degrading treatment.[46] O'Sullivan reasons further that even though the learned Judge interpreted freedom to include the right of individuals to be free from State restrictions which prevent them from exercising their choices or actions, she felt that this was insufficient.[47] The difficulty that O'Sullivan has with this negative construction of the right is that it does not place a positive obligation on the State to ensure that women must have access to safe and inexpensive abortion facilities.[48] Even though O'Sullivan makes specific mention of termination of pregnancy rights when considering this right, Pickles supports and argues that the core of

[38] O' Sullivan 'Reproductive rights' in S Woolman and M Bishop (eds) *Constitutional Law of South Africa* (2002-) 37.5.
[39] Ibid.
[40] R J Cook and B M Dickens 'Voluntary and involuntary sterilisation: denials and abuses of rights' (2000) 68 *International Journal of Gynaecology and Obstetrics* 61-67 at 62.
[41] M O' Sullivan 'Reproductive rights' in S Woolman and M Bishop (eds) *Constitutional Law of South Africa*(2002-, OS 02-05) 37.5.
[42] Constitution of the Republic of South Africa.
[43] P De Vos & W Freedman *South African Constitutional Law in Context* (2014) 458.
[44] (CCT69/05) [2007] ZACC 6; 2007 (5) SA 250 (CC); 2007 (7) BCLR 751 (CC) (4 April 2007) at para 145.
[45] These are ''(a) not to be deprived of freedom arbitrarily or without just cause; (b) not to be detained without trial; (c) to be free from all forms of violence from either public or private sources; (d) not to be tortured in any way; and (e) not to be treated or punished in a cruel, inhuman or degrading way'' of the Constitution of the Republic of South Africa, 1996.
[46] O' Sullivan 'Reproductive rights' in S Woolman and M Bishop (eds) *Constitutional Law of South Africa* (2002) 37.5.
[47] Ibid.
[48] Ibid.

O'Sullivan's argument could be applied widely to include other choices relating to pregnancy continuation.[49] Pickles further suggests that in a reproductive context the ''right to freedom and security of the person'' will be meaningless if it is not supported by women having access to rights which promote reproductive health care and services.[50] Nevertheless, in the recent case of *AB and Another v Minister of Social Development*[51] Khampepe J writing the minority judgment, held that section 12 is a combination of both freedom and security rights whose purpose is to afford protection to individuals to live their lives without having constitutionally prohibited obstacles being placed in their way.[52] In this regard, it appears that Khampepe was favouring the approach taken in the earlier *Ferreira v Levin* case. In discussing the rights individually she held that section 12 (1) can be classified as a ''general right to freedom, grounded in bodily security'' that serves to protect violations against specific physical freedoms.[53] Although our focus is not on the deprivation of physical freedom, the need for protection against such infractions is important.[54]

In the context of this dissertation the right to bodily and psychological integrity has also been interpreted by the courts as including the right of patients to make autonomous choices about medical treatment, in other words to provide their consent as a means of justifying a doctor's physical interference with their body.

The right to bodily and psychological integrity finds protection under section 12 (2) which specifically encompasses the right of a person to make decisions concerning reproduction and to have security in and control over their body.[55] It is submitted by Pieterse that this right ''underlies the autonomous pursuit of health through life-style related choices, including the freedom to seek and obtain medical care.''[56] It may be submitted that the choice of HIV positive women to have more children is a life-style related choice which can be managed by them in light of mother-to-child prevention medication. The ability of a woman to make autonomous reproductive decisions goes to the heart of this aspect of the freedom right.[57] According to Bishop and Woolman, this section at the very least recognises that this is a form of a right to dignity as each person's body is of equal worth

[49] C Pickles *Pregnancy Law in South Africa* (2017) 108.
[50] Ibid.
[51] *AB and Another v Minister of Social Development* (CCT155/15) [2016] ZACC 43; 2017 (3) BCLR 267 (CC); 2017 (3) SA 570 (CC) (29 November 2016). In this case, the court had the difficult task of deciding to what extent the State may regulate the reproductive opportunities of a woman who cannot carry a pregnancy to term and cannot contribute her own gametes for a surrogate motherhood agreement.
[52] Ibid at para 61.
[53] Ibid at paras 59 and 63.
[54] Ibid at para 64.
[55] Section 12 (2) (c) also makes provision for a person ''not to be subjected to medical or scientific experiments without their informed consent.'' This sub-clause is not relevant for our purposes.
[56] M Pieterse 'The interdependence of rights to health and autonomy in South Africa' 2008 125 (3) *The South African Law Journal* 553-572 at p 558.
[57] Ibid.

and is entitled to respect.[58] From a reading of the three sub-sections of section 12, it is clear that they give bodily integrity concrete meaning. However, the same is not apparent for psychological integrity as the Constitution provides no further detail of this right.

The first case to deal with section 12 (2) (*a*) concerned the termination of pregnancy.[59] In the *Christian Lawyers Association v Minister of Health and Others (Reproductive Health Alliance as Amicus Curiae)* case, Judge Mojapelo held that the heart of the Choice on Termination of Pregnancy Act 92 of 1996 was the requirement of informed consent of the girl or woman concerned.[60] Before deconstructing the concept of informed consent in a juridical context, the learned Judge made the following observations about the concept. He held that the doctrine of informed consent is based on the defence of *volenti non fit injuria* in that it provides a justification for conduct that would otherwise be unlawful or wrongful.[61] In particular, medical treatment, which would otherwise have constituted a violation of a patient's right to privacy and personal integrity in terms of our common law and statute, is justified provided that it is carried out with the patient's informed consent.[62]

The requirement of informed consent which the court borrowed from the case of *Waring & Gillow Ltd v Sherborne*, rested on three legs that were independent of each other these are knowledge, appreciation, consent - these are the essential elements; but knowledge does not invariably imply appreciation, and both together are not necessarily equivalent to consent.[63] In unpacking these elements, the Court held that knowledge encompasses the nature and extent of the harm or risk, and goes a step further and requires that there must also be comprehension and understanding of the nature and extent of the harm or risk.[64] Lastly, consent means that there must be a comprehensive understanding of the entire procedure whilst bearing in mind all its associated consequences.[65] The court held that the personal choices of individuals in medical procedures was of significant importance and resulted in this right being given a firm place in our Bill of Rights.[66] The choice of a woman or girl to have an abortion or termination of pregnancy finds protection in these guaranteed autonomy rights. The first would be under section 12 (2) (*a*) which is the ''right to bodily and psychological integrity'' that encompasses a woman's right to make decisions

---

[58] Bishop and Woolman 'Freedom and security of the person' in S Woolman and M Bishop (eds) *Constitutional Law of South Africa* (2002-) 40.8.

[59] In the *Christian Lawyers' Association v National Minister of Health* 2005 (1) SA 509 (T) in which section 5 of the Choice on Termination of Pregnancy Act was challenged on the grounds, inter alia that it infringed section 28 (1) (b) and (d) by allowing a child to make a decision about termination without the assistance and guidance of her parents or guardian.

[60] 2005 (1) SA 509 (T) at 515.

[61] Ibid.

[62] Ibid.

[63] Ibid.

[64] Ibid.

[65] Ibid.

[66] Ibid at p 518. In addition to section 12 (2) the court was of the view that section 27 (1) (*a*) ''right to reproductive health care'', section 10 the ''right to dignity'' and the ''right to privacy'' as contained in section 14 are rights that serve as foundational rights for self-determination.

concerning her reproduction.[67] The second section concerns itself with a person having ''security and control'' over their body.[68] The autonomy rights form the foundation for a woman or girl to have an abortion or termination of pregnancy but this must be coupled with informed consent on the part of the girl or woman.[69] In this case the court held that any interference on the part of the State regarding the freedom of a woman or girl to make choices over their reproductive life would severely infringe their constitutionally guaranteed rights of autonomy and self-determination.[70]

Nevertheless, an analysis of the sparse body of case law assists in the ascertainment of what harm qualifies to be categorised as psychological harm and thus a violation of the right. In the *AB* case, Khampepe J described section 12 (2) as being a new freestanding freedom right whose core focus was on integrity and in particular psychological integrity.[71] The reasoning behind this approach taken by the learned Judge was that our ''Constitution enjoins us to actively turn away from indifference and move towards respect, empathy, compassion, and attentiveness to the decisions of others.''[72] It is her submission that the protection afforded to individuals in section 12 (2) is grounded in these ideals.[73] It was also held that the provisions of section 12 (2) should be interpreted broadly to cover all instances where a person's psychological or bodily integrity is harmed.[74] Accordingly, this requires courts to examine whether a law or conduct of another person deprives an individual of freedom or security as broadly understood.[75] Khampepe's broad approach to this right is in line with the views of authors such as O'Sullivan and Pickles. Khampepe J also highlighted the fact that our law has long since recognised that a person's psychological integrity, independent of their bodily integrity, can be harmed and this violation of their psychological integrity finds protection under the actio iniuriarum in our law of delict.[76]

Central to this right is the power that a woman has to make decisions regarding reproduction. According to this interpretation of the right, it is therefore the prerogative of a woman to (i) decide whether to terminate her pregnancy, (ii) choose the number of children should she want to have children (iii) make a choice about the type of contraceptives she wishes to use. Khampepe J made two observations regarding the phrase the ''right to make a decision.'' The first being that it is the decision that enjoys protection rather than the actual choice made by a woman and second, if a woman does not have the ability to exercise this power and make a decision free from coercion and undue influence,

[67] Ibid.
[68] Ibid.
[69] Ibid.
[70] Ibid at p 527-8.
[71] (CCT155/15) [2016] ZACC 43; 2017 (3) BCLR 267 (CC); 2017 (3) SA 570 (CC), (29 November 2016) at paras 59-60.
[72] Ibid at para 65.
[73] Ibid.
[74] Ibid at para 66.
[75] Ibid.
[76] (CCT155/15) [2016] ZACC 43; 2017 (3) BCLR 267 (CC); 2017 (3) SA 570 (CC) (29 November 2016) at para 68.

this will amount to a violation of her psychological integrity.[77] Consequently, a woman alleging a violation of this right need only show that her inability to make a decision was as a result of some law or conduct that caused her psychological harm.[78] The inquiry that the learned Judge proposes in these instances is threefold:

(i) Does the impugned law or conduct prevent or inhibit a person or group of persons from making a decision?

(ii) If the answer to (a) is yes, does the decision concern reproduction?

(iii) If the answer to (b) is yes, does preventing or inhibiting the decision detrimentally affect the psychological integrity of the person or persons concerned?[79]

The majority of the court as per Nkabinde J disagreed with the third stage of the inquiry. It held that section 12 (2) (*a*) affords protection to reproductive decisions that only have a physical effect on the person relying on it regardless of the fact that being deprived of making a decision can cause psychological harm.[80] It is submitted that this view interprets section 12 (2) (*a*) narrowly and does not acknowledge the psychological harm that may be experienced by a person who cannot make a decision regarding reproduction or the choice has been taken from them. As stated by Khampepe J:

> …infertility affects the psychological integrity of a person by placing them in a socially precarious situation. Being able to choose to have a child is almost universally accepted as central to "identity and meaning in life." Stripping a person of this choice has far-reaching personal and social ramifications. Infertility is thus harmful partly because it removes the ability to elect to have a child; a decision almost universally considered important.

The importance of having sub-clause (*b*) is that it recognises the fact that many South African women do not enjoy security in and control over their bodies.[81] This is evident from the extremely high rates of domestic violence against women, the killing of women by their intimate partners, rape, sexual abuse, forced sex and sexual intimidation.[82] According to Pickles, this is why the right needs to place positive obligations on the State as ''freedom and security in a reproductive context cannot be effectively developed or sustained where women do not have access to reproductive health-care services and other rights which support access to reproductive health care.''[83] The minority judgment in the *AB* case is clearly reflective of this view as the court relied not only on the right to freedom and security but also the right to equality and dignity.

---

[77] Ibid at paras 69 and 70.
[78] Ibid at para 70.
[79] Ibid at para 72.
[80] Ibid at para 76.
[81] O' Sullivan 'Reproductive rights' in S Woolman and M Bishop (eds) *Constitutional Law of South Africa* (2002-) 37.5.
[82] Ibid.
[83] Pickles *Pregnancy Law in South Africa* (2017) 108.

The right to bodily integrity also received attention from the Court in *McDonald v Wroe*.[84] In this case, it was alleged that the defendant negligently failed to inform the plaintiff of the risk of permanent nerve damage in a planned dental procedure.[85] The court stated that ''in South African law a medical practitioner has a duty to disclose a material risk of a planned procedure to the patient.''[86] The learned judge stated further that in obtaining the plaintiff's consent the defendant ought to have ''fully informed her of the nature and extent of the risk of permanent nerve damage, with the result that the plaintiff consented thereto without appreciating the risk of permanent nerve damage.''[87] Even though, counsel for the plaintiff did not plead a violation of the plaintiff's rights in terms of section 12(2) of the Constitution[88] the Judge found that her right to bodily integrity in terms of the Constitution was violated as she underwent surgery without proper informed consent.[89] Significantly, the court recognised the constitutional right to bodily and psychological integrity of the patient and more specifically the right to obtain the patient's informed consent.[90]

The right to bodily and psychological integrity is provided for in section 12 of the Constitution and is formulated in a unique manner as it expressly refers to the right to make reproductive health choices and protects against violations of both a person's physical or psychological integrity. Over time, the courts have broadened the scope of this right particularly with regard to psychological integrity. This has resulted in the most recent case, of *AB*, where the Court found that this right protects a woman's choice with regard to her sexual or reproductive health. Recognising a woman's autonomy to choose as being the core of this right is very significant in the context of forced or coerced sterilisations. It is argued that this approach means that the focus of the enquiry into whether there was a rights violation should shift to how and when the decision was made. In many of the narratives described by Essack and Strode in their study, it was clear that the HIV positive women did not make a choice regarding sterilisation, instead they were asked to ratify a decision made by health care practitioners.[91] Although the way the right is framed in section 12 of the Constitution is very progressive authors such as Pickles submit that more work is required in developing positive obligations on the State to provide services to ensure that this right is realised.[92]

[84] 2006 (3) All SA 565 (C).
[85] Ibid at para 38 p 575.
[86] Ibid at para 7 p 568.
[87] Ibid at para 19 p 575.
[88] Constitution of the Republic of South Africa, 1996.
[89] 2006 (3) All SA 565 (C) at para 19 p 575.
[90] 2006 (3) All SA 565 (C).
[91] Essack & Strode '"I feel like half a woman all the time'': The impacts of coerced and forced sterilisations on HIV-positive women in South Africa' (2012) 26 (2) *Agenda* 24-34.
[92] Pickles *Pregnancy Law in South Africa* (2017) 108.

### 3.4 Common law doctrine on informed consent

Medical practitioners are required by law and medical ethics to obtain the informed consent of their patients before initiating treatment.[93] The common law position regarding informed consent is set out in *Castell v De Greef.*[94] However, *Stoffberg v Elliot*[95] was the first South African case to deal with the doctor's duty to inform the patient of each individual procedure. In this matter the plaintiff's penis was removed without his express consent because during surgery the surgeon decided that to avert further growth of the cancer an amputation was necessary.[96] The plaintiff claimed for damages arising out of an assault in that he alleged that his penis was amputated without his consent. The defendant's defence was that he amputated the plaintiff's penis as it was the source of the cancer and the defendant was of the opinion that it was the most appropriate way to save his life.[97] The defendant averred further that the plaintiff gave his implied consent by being admitted to hospital and by virtue of this he had consented to have any surgical and medical treatment that was immediately necessary. Watermeyer J rejected this argument holding that by voluntarily going into hospital for a pre-agreed procedure did not amount to implied consent to a broader range of procedures that are perceived by the doctors to be necessary.[98] Further, Watermeyer J held that the failure to obtain express consent for a surgical procedure was a civil wrong for which a patient could claim damages.[99]

The above dictum is profound and set the landscape for future cases. In the later case of *Lymbery v Jefferies*[100] the court was called upon to adjudicate on the doctor's failure to inform the patient of the consequences of the procedure performed on her.[101] The facts were that the patient had suffered from fibrosis of the uterus. Her doctor recommended X-ray treatment and whilst undergoing such treatment she sustained severe burns and a great deal of pain and discomfort.[102] In an action for damages, the patient pleaded that the doctor had been negligent in the consent process by failing to warn her that her ovaries would be destroyed resulting in infertility and secondly in failing to warn her that the treatment was harmful and might cause pain and suffering.[103] In this matter, the court held that the doctor had given her sufficient information on the procedure as it was expected that she would be able to deduce that she would be infertile because her menstrual cycle

---

[93] P S Appelbaum 'Assessment of patients' competence to consent to treatment' (2007) *The New England Journal of Medicine* 1834 -1840 at 1834. In instances where patients lack the capacity to consent to medical treatment, for example where they have a severe mental disability, substitute decision makers must be sought.
[94] 1994 (4) SA 408 (C).
[95] 1923 CPD 148.
[96] 1923 CPD at 153.
[97] 1923 CPD at 148.
[98] 1923 CPD 148 at 149-150.
[99] Ibid.
[100] 1925 AD 236.
[101] FF Van Oosten *Doctrine of Informed Consent in Medical Law* (Unpublished LLD thesis, UNISA, 1989).
[102] Ibid at p 39-40.
[103] Ibid.

would have come to an end.[104] Furthermore, the court found that it may well be that it is the duty of a surgeon to inform the patient of the risks of the procedure and that it may be accompanied by great pain.[105] The patient's consent must be obtained based on this information. [106] However, in this instance, the doctor had not failed in his duty of disclosure of the potential risks and consequences of the treatment.[107] This was the first case to deal with the issue of disclosure of risks to patients. The judgment made it clear that the risks of the procedure must be disclosed to the consenter. This was the start of the evolving jurisprudence regarding the nature and extent of information that must be provided before a patient gives consent.

In a similar matter, in *Esterhuizen v Administrator, Transvaal*[108] the plaintiff instituted action against the servants of the defendant for wrongfully, unlawfully and intentionally assaulting her in that they subjected her to radium treatment which caused her serious injuries. The defendant, like the doctor in the *Stoffberg* case relied on an ''implied consent'' to the treatments.[109] The facts of this matter where that sometime, in 1945 the plaintiff, a 10 year old, was treated for a nodule that appeared on her ankle.[110] The plaintiff was diagnosed with Kaposi's disease which Dr Gouws described as a ''bloedkanker''.[111] The Plaintiff's parents were advised that the she would have to undergo a series of X-rays. However, the plaintiff's mother was not made aware of any possible dangers associated with the treatment. During 1945 to 1949 she received treatment for the disease and no pain or discomfort was reported.

In October 1949 further nodules appeared on the plaintiff. The plaintiff's grandfather took her to the Johannesburg General Hospital for further treatment. The plaintiff's mother was under the impression that her daughter would have received the same treatment and she did not anticipate any risk or danger occurring to her daughter. The plaintiff's aunt then signed a document on the 20th October 1949 which purported to consent to operative treatment on the plaintiff. The plaintiff was then seen by Dr Cohen who, was of the opinion that she needed deep therapy treatment. The evidence led by the defendants indicated that Dr Cohen was fully aware that the treatment he proposed for her would cause severe irradiation of the tissues in the treated areas which could result in disfigurement or deformation and some form of permanent harm would be caused to her growing bone. This is turn, would result in the shortening of the limbs; visible damage to the skin and the possibility of amputation. The dosage administered by Dr Cohen resulted in the subsequent amputation of her right leg, left leg and left hand.

---

[104] Ibid at p 40-41.
[105] 1925 AD 239.
[106] Van Oosten *Doctrine of Informed Consent in Medical Law* (1989) 41.
[107] Ibid.
[108] 1957 (3) SA 710 (T).
[109] Ibid at 714.
[110] Ibid.
[111] Ibid.

The issue before the court was whether the treatment took place without lawful consent.[112] Counsel for the defence argued firstly, that the plaintiff was brought to hospital for X-ray treatment and this constituted lawful consent to all treatment that she received.[113] Secondly, the position of medical professionals would be intolerable if they were to inform patients before any operation or treatment of all the consequences, the dangers and the details of the risks accompanying the operation or treatment.[114]

Bekker J stated that to establish the defence of *volenti non fit injuria* the plaintiff must show that they perceived the possibility of harm and they appreciated their consent to this danger.[115] The court quoted with endorsement from the judgment of *Rompel v Botha* where Neser J held that surgeons must obtain consent from the patient and this consent will only be valid if they inform them of any serious risks of the procedure.[116]

In applying the above dicta the Judge held that merely consenting to X-ray treatment in the belief that it is harmless or being unaware of the risks it carries cannot amount to effective consent to assume the risk or consequent harm.[117] This case was significant as it confirmed the approach taken in both *Stoffberg* and *Lymbery* where the courts rejected the notion that merely presenting oneself for treatment was equal to consent to any process that may need to be undertaken in relation thereto. Secondly, the case dealt with the issue of disclosure of risks to patients. Further, the Court held that even though a doctor may act with integrity in attempting to provide the best medical care for the patient this would not absolve him/her from liability for failing to obtain proper consent. The Judge found that if the patient's consent is not obtained it will amount to an assault.[118]

In *Richter and Another v Estate Hamman*[119] the court once again had to address the issue of disclosure by deciding whether a neuro-surgeon was negligent for failing to warn the plaintiff of the dangers inherent in having a phenol block procedure. The plaintiff's contention was that she would not have agreed to undergo the procedure had she been aware of the dangers attached to it. In this matter the Judge held that the defendant was negligent during the informed consent process by failing to warn her of the risks that may have been associated with the procedure. In this regard, the Court held that a surgeon needed to provide the patient with a general idea of the possible consequences of the

[112] 1957 (3) SA 710 (T) 718.
[113] Ibid.
[114] Ibid 721.
[115] Ibid719.
[116] Ibid.
[117] Ibid.
[118] 1957 (3) SA 710 (T) 721.
[119] 1976 (3) SA 226 (C). The facts of the case are that the plaintiff was suffering from severe pain of the coccyx and sought medical treatment which did not bring relief to her condition. Plaintiff then consulted with Dr de Villiers Hamman who suggested that a phenol block of the lower sacral nerves be performed. The phenol block did achieve the desired result of relieving the pain, however, the consequences of it were most unfortunate for the plaintiff who thereafter experienced loss of control of the bladder and bowel, loss of sexual feeling and loss of power in the right leg and foot at page 227.

procedure.[120] In assessing whether the doctor acted reasonably in describing these risks to the patient, the Court used the ''reasonable doctor test'' in other words the Court expected the doctor to disclose the risks that any other doctor in the same position as the defendant would disclose.[121] This requires medical experts to give evidence on what a reasonable doctor in the position of the doctor whose conduct is under scrutiny would have done or would not have done regarding the obtaining of consent. This is assessed by taking into consideration the prevailing circumstances of the case.[122] Nevertheless, in reaching his decision Watermeyer J held that the complications that the plaintiff suffered after undergoing the phenol block were uncommon and could not have been expected.[123] The court found that the defendant was not negligent in failing to warn the plaintiff of any complications that were associated with the procedure.

The leading case in South African law regarding informed consent is the case of *Castell v De Greef.*[124] In this matter the plaintiff's cause of action against the defendant arose from the allegation that the defendant had been under a duty to warn her of material risks and complications attached to the procedure, and to inform her of any specific alternative procedures which might minimise, reduce or exclude such risks or complications.[125] The defendant's failure to do this made his conduct negligent, wrongful and unlawful.[126] The defendant in his plea denied that he had breached his obligations towards the plaintiff and averred that the damages suffered by her were an unavoidable, normal and expected consequence of the plastic surgery.[127]

Judge Ackermann agreed with the lower Court that the key issue was whether a doctor has a duty to warn the patient of the risks involved in surgery or medical treatment.[128] The

[120] 1976 (3) SA 226 (C) 232.
[121] Ibid.
[122] Ibid at 233.
[123] Ibid at 230.
[124] 1994 (4) SA 408 (C). The Defendant, a plastic surgeon, was sued for damages by the plaintiff on account of an unsuccessful subcutaneous mastectomy. The plaintiff had a family history of breast cancer and she had previously undergone surgery for the removal of lumps in her breast. When further lumps were diagnosed, the plaintiff's gynaecologist recommended a mastectomy as a prophylaxis and referred her to the defendant. The plaintiff and her husband consulted the defendant and discussed the operation with him. It was decided to remove as much of the plaintiff's breast tissue as a possible and simultaneously reconstruct her breasts with silicone implants. However, as a result of the operation, a discolouration of the plaintiff's areolae, necrosis of the tissues and a discharge that exuded an offensive odour developed. Moreover, the plaintiff contacted a *staphylococcus aureus* infection, suffered considerable pain, embarrassment and psychological trauma, and had to undergo several further surgical procedures to repair the damage. FF Van Oosten '*Castell v De Greef* and the doctrine of informed consent: Medical paternalism ousted in favour of patient autonomy' (1995) (1) *De Jure* 164-179 at 165.
[125] Van Oosten Ibid.
[126] *Castell v De Greef* 1993 (3) SA 501 (C) 505.
[127] Ibid 506.
[128] Ibid 416.

complexity is to determine when that duty arises and what the nature and extent of the warning must be.[129]

The Judge went on to provide a very pertinent illustration of this by way of an example:

> A woman may be informed by her physician that the only way of avoiding death by cancer is to undergo a radical mastectomy. This advice may reflect universal medical opinion and may be, factually correct. Yet, to the knowledge of her physician, the patient is, and has consistently been, implacably opposed to the mutilation of her body and would choose death before the mastectomy. I cannot conceive how the 'best interest of the patient' (as seen through the eyes of her physician or the entire medical profession, for that matter) could justify a mastectomy or any other life-saving procedure which entailed a high risk of the patient losing a breast. Even if the risk of the breast-loss were insignificant, a life-saving operation which entailed such risk would be wrongful if the surgeon refrains from drawing the risk to his patient's attention, well knowing that she would refuse consent if informed of the risk. It is, in principle, wholly irrelevant that her attitude is, in the eyes of the entire medical profession, grossly unreasonable, because her rights of bodily integrity and autonomous moral agency entitle her to refuse medical treatment. It would, in my view, be equally irrelevant that the medical profession was of the unanimous view that, under these circumstances, it was the duty of the surgeon to refrain from bringing the risk to his patient's attention.[130]

In rejecting the reasonable doctor test and endorsing the notion that the patient should be ultimately responsible for making his or her own decision, the Judge held that a doctor's duty is to disclose any material risk that may be seen in the contractual setting of an unimpeachable consent to the operation and its sequelae.[131] Through this judgment, a new standard for determining what needs to be disclosed was established. Justice Ackermann used the term material risk to define the boundaries of a doctor's duty with regard to disclosure. The Judge went on to quote with approval from Van Oosten that *volenti non fit injuiria,* is a ground of justification that excludes the unlawfulness or wrongfulness element in delict.[132] The court, following on from this premise, stated that for consent to operate as a defence in medical matters the following requirements must be satisfied:

a) The consenting party must have knowledge and be aware of the nature and extent of the harm or risk;[133]

b) The consenting party must have appreciated and understood the nature and the extent of the harm or risk;[134]

[129] 1994 (4) SA 408 (C) 416-417.
[130] 1994 (4) SA 408 (C) 420-1.
[131] 1994 (4) SA 408 (C) 425.
[132] 1994 (4) SA 408 (C) 425.
[133] Ibid.
[134] Ibid.

c) The consenting party must have consented to the harm or assumed the risk of the procedure;[135] and

d) The consent must be comprehensive that is extended to the entire transaction, inclusive of its consequences.[136]

It is clear from the above that one of the requirements that must be met is the fact that the patient must have understood what particular risk(s) are inherent or attached to a specific medical procedure being performed. By accepting this approach the Court acknowledged that it is the doctor's duty to assess whether a risk was material or not. Based on the Australian case of *Rogers v Whitaker*[137] the court held that a risk is material if:-

(i) A reasonable person in the patient's position if warned of the risk, would be likely to attach significance to it or;[138]

(ii) The medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it[139].

The key question would be how do we determine if the risk is material? The court opined that expert medical evidence would be relevant to determine what risks inhere in or are the result of particular treatment (surgical or otherwise) and might also have a bearing on their materiality.[140] It went on to comment that the sole reliance on medical evidence is not sufficient. The court quoted with approval a passage from the judgment in *Reibl v Hughes* that ''the ultimate question is whether (the defendant's conduct) conforms to the standard of reasonable care demanded by the law.''[141] In casu the court found that the plaintiff had been informed of all the material risks. The *Castell* case is regarded as a seminal one as it shifted the law away from medical paternalism to patient autonomy. This approach is in line with the new constitutional framework regarding bodily and psychological autonomy. It also requires a patient-centred enquiry into what they would consider material.

Subsequent to *Castell*[142], there have been a number of informed consent cases. In the matter of *C v Minister of Correctional Services*[143] the plaintiff, a prisoner, alleged that he did

[135] Ibid.
[136] Ibid.
[137] *Rogers v Whitaker* [1992] HCA 58.
[138] Ibid at para 16.
[139] Ibid.
[140] 1994 (4) SA 408 (C) 426.
[141] Ibid.
[142] 1994 (4) SA 408 (C).
[143] 1996 (4) SA 292 (T). The facts being that the plaintiff was an inmate at the Johannesburg prison. The plaintiff was employed at the kitchen of the prison and the prison's policy was that only HIV negative people could handle the food. On the 13th September 1993 the plaintiff and other kitchen staff employees had their blood drawn and sent to the South African Institute for Medical Research for testing. The plaintiff's blood tested positive for HIV. The plaintiff alleged that his informed consent was not obtained and instituted action against the defendant for damages in the amount of R 30 000 on the grounds of alleged wrongful invasion of his right to privacy.

not provide his ''consent to prison authorities when his blood was drawn and tested for HIV.''[144] The court held that ''consent is a defence to many acts which would otherwise be a delict''[145]. ''In regard to surgery, informed consent postulated full knowledge of the risks involved and, after being made aware thereof by the surgeon, the patient is then entitled to exercise his fundamental right to self-determination.''[146] The Judge acknowledged that the ultimate decision of undergoing a surgical procedure lies with the patient. In casu the learned judge stated that this decision can only be made if the person appreciates and understands what the object and purpose of the HIV test is and what the consequences of an HIV positive result are.[147]

The court in this instance did not have much difficulty in reaching its decision as the Department of Correctional Services had a policy in place regarding HIV testing.[148] The policy unequivocally stated that informed consent must be obtained from a prisoner prior to an HIV antibody test being administered.[149]

More recently, in the Supreme Court of Appeal case of *Broude v McIntosh & another*[150] the court avoided endorsing or rejecting the test laid down in *Castell.*[151] The appellant a medical practitioner instituted action for damages against the first respondent an ear, nose and throat specialist. The appellant alleged that the first respondent failed to apprise him of the risks attached to the operation and the fact that there was an alternative.[152] Counsel for the appellant argued first, that the first respondent had wrongfully failed to get the (appellant's) real or informed consent to the operation and the first respondent had therefore committed an assault on (appellant) in operating on him.'[153] Secondly, the respondent was negligent and unskilful in failing to inform the appellant of the risks of the procedure and of any alternatives available.[154]

Whilst recognising that pleading a failure to obtain informed consent amounts to an assault, the learned Judge did not agree with the conceptual soundness of this method. He was of the opinion that:

> To the average person, and I suspect to many a lawyer, it is a strange notion that the surgical intervention of a medical practitioner whose sole object is to alleviate the pain or discomfort of the patient, and who has explained to the patient what is intended to be done and obtained the patient's consent to it being done, should be pejoratively described and

[144] 1996 (4) SA 292 (T) 295.
[145] 1996 (4) SA 292 (T) 300.
[146] Ibid.
[147] Ibid 301.
[148] 1996 (4) SA 292 (T) 303.
[149] 1996 (4) SA 292 (T) 301.
[150] 1998 (2) All SA 555 (A).
[151] 1994 (4) SA 408 (C).
[152] 1998 (2) All SA 555 (A) 562.
[153] Ibid.
[154] 1998 (2) All SA 555 (A) 562-3.

> juristically characterised as an assault simply because the practitioner omitted to mention the existence of a risk considered to be material enough to have warranted disclosure and which, if disclosed, might have resulted in the patient withholding consent. It seems to me to be inherent in the notion that even if the risk does not eventuate and the surgical intervention is successful, the practitioner's conduct would nonetheless have constituted an assault. That strikes me as a bizarre result which suggests that there is something about the approach which is unsound. There is no principle in law of which I am aware by which the characterisation as lawful or unlawful of an intentional act objectively involving the doing of bodily harm to another can be postponed until its consequences are known. Either it was an assault at the time of its commission or it was not.[155]

The learned Judge did however qualify the above statement by excluding cases in which mala fides were alleged.[156] In casu the first respondent's omission to inform the appellant of the risk of leakage of cerebrospinal fluid was of no significance.[157] No causal connection was proved between the leakage of the cerebrospinal fluid and the onset of the facial palsy.[158] The court also took into consideration the fact that the appellant did not aver that had he been made aware of the risk attached to the operation he would have refused to consent.[159] Therefore, the court found no evidence existed to bear out the appellant's allegation.

With regards to the appellant's contention that the first respondent had failed to inform him of alternative treatment options, the court held that this could not be upheld as he acknowledged in writing that the nature and possible effects of the operation had been explained to him.[160] It is submitted that the Court conflated two issues is this regard. Firstly the patient's right to choose a course of treatment based on the material risks associated with it, and secondly, the doctor's duty of care to ensure that the best treatment is provided to the patient. By confusing these two concepts the Court ended up adopting an approach in favour of medical paternalism. The mere fact that a procedure did not result in harm does not absolve a medical practitioner from their duty to disclose material risks as these may have a direct bearing on their right to choose whether or not to have treatment. In the recent *AB* case the Constitutional Court in a minority judgment made it clear that the right to bodily and psychological integrity protected a patient's decision making powers.

In a further decision by the Supreme Court of Appeal in the case of *Louwrens v Oldwage*[161] the trial court had found against the appellant, a vascular surgeon, in favour of the

[155] 1998 (2) All SA 555 (A) 562-3.
[156] 1998 (2) All SA 555 (A) 563.
[157] Ibid.
[158] Ibid.
[159] Ibid.
[160] Ibid.
[161] 2006 (2) SA 161 (SCA).

respondent on the basis that the appellant made an incorrect diagnosis.[162] On appeal, the issue was whether the appellant gave informed consent to the operation.[163]

Mthiyane JA found that the respondent had provided consent by signing a consent form to the procedure.[164] The next issue that the court had to consider was whether the respondent was warned of the risks involved in the surgical intervention.[165] Counsel for the respondent relied on the enquiry set out in *Castell's*[166] case. However, the court did not traverse through all of the requirements to ascertain whether the requirements were met. The court did however conclude after hearing expert evidence that ''the likelihood of steal occurring, with resultant claudication, was so negligible that no duty arose on the appellant to mention it and his omission to do so did not constitute negligence.''[167] It must also be mentioned that the court applied the reasonable doctor test that was postulated in *Richter's*[168] case and which was overturned in *Castell*.[169]

The most recent Supreme Court of Appeal case to deal with the issue of informed consent was the decision of *Sibisi NO v Maitin*.[170] The appellant instituted the *aquilian action* against the respondent, an obstetrician and gynaecologist for damages suffered by her daughter as a result of his negligent conduct.[171] In this instance, the court was asked to determine the following issues:-

(i) Does the doctor have a duty to disclose information about remote risks?[172]

(ii) What test should be used to determine whether the duty has been discharged?[173]

(iii) And if the doctor is not negligent in failing to disclose the remote risk on what basis liability can be founded?[174]

(iv) In addition, the appellant asked the court to develop the common law so as to recognise that the test to determine whether a doctor has discharged his duty to ensure that the consent to the procedure is properly informed is whether the reasonable patient in the position of the plaintiff would regard the risk as significant and elect not to undergo the

[162] Ibid 164.
[163] Ibid.
[164] Ibid 172.
[165] Ibid.
[166] 1994 (4) SA 408 (C).
[167] 2006 (2) SA 161 (SCA) 174.
[168] 1976 (3) SA 226 (C).
[169] 1994 (4) SA 408 (C).
[170] 2014 (6) SA 533 (SCA).
[171] 2014 (6) SA 533 (SCA) 534.
[172] Ibid.
[173] 2014 (6) SA 533 (SCA) 534.
[174] Ibid.

procedure or follow a different mode of treatment. This test would recognise the patient's right to autonomy and bodily integrity.[175]

The findings of the court, are important for the purposes of this discussion as it will direct how further cases that involve the lack of informed consent in South Africa will be dealt with.

The appellant pleaded negligence on the part of the respondent.[176] It is however not necessary for the purposes of this discussion to traverse all the grounds of negligence. Of importance is the allegation that the respondent should have foreseen the risks associated with normal childbirth, taking into account the size of the baby, namely that the baby could suffer from shoulder dystocia if born through natural childbirth and that the respondent was under a duty to warn the appellant of the material risks and complications which might arise, and inform the appellant of specific alternative procedures that could have minimised the risks.[177]

With regards to whether the respondent informed the appellant about the concomitant risks associated with natural child-birth, in this instance taking into account the size of the baby, the court accepted that the respondent at no time warned the appellant that there was a possibility of shoulder dystocia occurring and of a resultant brachial plexus injury, leading to Erb's palsy.[178] The court when assessing whether a doctor is under a duty to disclose the risks of a procedure to a patient referred to the reasonable doctor test set out in *Richter's* case.[179]

Counsel for the appellant argued that the approach in *Richter's*[180] case should not be adopted for two reasons. The first is that it leaves the determination of a legal duty to the judgment of the doctor which is analogous to them being players and referees in their own cause.[181] The second, is that in keeping with the rights to autonomy and bodily protection, now entrenched in the Constitution, the test should rather be whether the reasonable patient, in her position, if warned of the risk, would attach significance to it, as per the *Castell* case.[182]

The court stated that the full court in *Castell's*[183] case accepted the approach relied on by the appellant.[184] Further, the court agreed with the view postulated by Ackermann J in

[175] Ibid.
[176] Ibid 537.
[177] Ibid.
[178] Ibid.
[179] 1976 (3) SA 226 (C).
[180] Ibid.
[181] 2014 (6) SA 533 (SCA) 543.
[182] 2014 (6) SA 533 (SCA) 543.
[183] 1994 (4) SA 408 (C).
[184] 2014 (6) SA 533 (SCA) 543.

*Castell's*[185] case where he said that our courts ought to adopt the approach in the *Rogers's* case.[186] The Court held that patients have a right to autonomy and that doctors could not rely on medical paternalism to justify their failure to disclose information to patients.[187] Furthermore, this focus on autonomy meant that our approach would be consistent with that adopted in Canada, the United States of America and Australia, as well as judicial views on the continent of Europe.[188]

From analysing the aforesaid, the court in *Sibisi's* case stated that 'the question of informed consent goes to the wrongfulness element of the Aquilian action.'[189] A logical follow through of this would mean that ''negligent conduct on the part of the doctor will be wrongful if the patient has not given informed consent.''[190] As was established in *Castell*'s[191] case negligence is still a requirement. However, where no negligence is proved, the test for wrongfulness does not come into play.[192] The court found that in this matter the appellant did not prove that the respondent was negligent in not advising her to have a caesarean section and hence there was no need for a determination on whether the doctor acted wrongfully as it had already been established that he acted in accordance as a reasonable doctor in his position would have done.[193]

The court in employing the test to assess the materiality of the risk as formulated in the *Rogers's* case, held that in this instance the risk of injury to the child through natural child-birth was very remote and therefore did not need to be disclosed.[194]

### 3.5 The statutory framework dealing with informed consent

There are two pieces of health legislation dealing with consent that warrant being discussed. These are the Sterilisation Act 44 of 1998 and National Health Act 61 of 2003. The Sterilisation Act deals expressly with when and how a person must provide their consent to a sterilisation. On the other hand, the National Health Act provides a number of general norms governing consent to medical treatment and operations. The two pieces of legislation need to be read together in order to understand the comprehensive statutory framework governing consent to a sterilisation.

[185] 1994 (4) SA 408 (C).
[186] 2014 (6) SA 533 (SCA) 543.
[187] Ibid.
[188] Ibid.
[189] Ibid.
[190] Ibid.
[191] 1994 (4) SA 408 (C).
[192] 2014 (6) SA 533 (SCA) 543.
[193] Ibid.
[194] Ibid 544.

### 3.5.1 Sterilisation Act 44 of 1998

The Sterilisation Act gives statutory protection to one's right to bodily integrity and the right to have autonomy over their reproductive life.[195] In addition, it has safeguards in place to monitor instances where patients who are not able to consent are sterilised.[196] The key features of the Act relating to consent are:

(i) It should be a patient initiated procedure and the patient requesting the sterilisation must be older than 18 years;[197]

(ii) The patient must be capable of consenting in writing to the procedure;[198]

(iii) If they are incapable of consenting;

(iv) The written consent must obtained in a manner that is be free from coercion[199]

(v) The person obtaining the consent must give an unambiguous explanation about the proposed procedure[200] including information about the permanency or reversibility of it;[201] and

(vi) The patient must be made aware that the written consent[202] that has been given for the sterilisation can be withdrawn at any time before it is performed.[203]

Despite the detail in the Act with regard to consent it is silent on who is responsible for obtaining consent. This is problematic as the courts have also been unclear on this point as was evident in the *Pandie* matter.[204] In a recent article, Badul, Strode and Singh submitted that given that the Health Profession Council's guidelines require surgeons to ensure that consent has been obtained, the courts ought to regard a medical practitioner's failure to obtain consent as negligent as it is a failure to act in accordance with a statutory duty.[205]

In instances where there is non-compliance with the Act on the part of the medical practitioner, he or she may be found to be guilty of a criminal offence.[206] The sanctions that may be imposed by the Court could be either a fine or a period of imprisonment not exceeding 5 years.[207]

---

[195] Section 12 of Act 44 of 1998.
[196] Section 3 of Act 44 of 1998.
[197] Section 2.
[198] Sections 2 (1) (*a*) and 4 (*c*).
[199] Section 4.
[200] Section 4 (*a*) (i).
[201] Section 4 (*a*) (ii).
[202] Section 4 (*c*).
[203] Section 4 (*b*).
[204] (A135/2013, 1221/2007) [2013] ZAWCHC 123.
[205] CJ Badul, A Strode & PP Singh 'Obtaining informed consent for a sterilisation in the light of recent case law' (2018) 108 (7) *South African Medical Journal* 557-558.
[206] Section 9 of Act 44 of 1998.
[207] Ibid.

### 3.5.2 National Health Act 61 of 2003

In terms of the definitions provided in the National Health Act,[208] a health care provider encompasses medical practitioners and nurses.[209] Thus all the obligations referred to below apply to both categories of health care workers.[210] Patients must be told of the risks, benefits and consequences that are attached to the proposed treatment sought or procedure to be performed.[211] The Act[212] makes further provision for health care providers to advise patients of this information in a language of their choice.[213] They must also be told of alternatives available to the treatment that they seek or a procedure to be performed and their right to refuse treatment.[214]Although the National Health Act does deal with some exceptions to informed consent, these all relate to situations where the patient lacks capacity amongst other reasons.[215]

### 3.6 Discussion

The *Castell*[216] case has been credited for formally adopting the doctrine of informed consent into South African law, however, it is submitted that the doctrine existed prior to this case. This doctrine according to Flanigan, protects patient's medical autonomy which means that patients are entitled to make treatment decisions against medical advice.[217] It has however shown significant evolution from the *Stoffberg* case. The *Stoffberg* case was the first to set the benchmark with regards to what the notion of consent in a medical setting equated to and set the platform for patient autonomy and the right to bodily integrity. It is evident from this case that when a patient is admitted to hospital this does not give doctors wide ranging operative powers over them even though it may have been in the patient's best interest or alternatively considered to be life-saving treatment. Subsequent cases[218] have held similar views therefore it was not open for a doctor to argue that by the patient being admitted to hospital he had given his implied consent for surgical procedures to be performed on him. Therefore, the foundation was set in this case to affirm that the interference with one's body without his consent is wrongful and would amount to a civil assault.

One of the main issues that the progression of cases thereafter paid attention to was what information actually needed to be disclosed to the patient. The *Lymbery*[219] case held that

[208] 61 of 2003.
[209] Section 1 of Act 61 of 2003.
[210] Section 6 (1) (*b*).
[211] Section 6 (1) (*c*).
[212] Act 61 of 2003.
[213] Section 6 (2) of Act 61 of 2003.
[214] Section 6 (1) of Act 61 of 2003.
[215] Section 7 of Act 61 of 2003.
[216] 1994 (4) SA 408 (C).
[217] J Flanigan 'Obstetric autonomy and informed consent' (2016) *Ethical Theory Moral Pract* 225-244 at 255.
[218] 1925 AD 236 and 1957 (3) SA 710 (T).
[219] 1925 AD 236.

the risks of the procedure must be disclosed to a patient before they provide consent for surgical intervention. This was extended in the *Esterhuizen*[220] case to cover serious risks and dangers that are concomitant with the medical procedure to be performed on the patient. In *Richter and Another*[221] this approach was endorsed and in addition the ''reasonable doctor'' test was introduced. This test postulated that the attendant doctor must disclose risks to the patient that a ''reasonable doctor'' in his position would see fit to disclose. The introduction of this test signalled a move towards a paternalistic approach when dealing with the issue of disclosure of information to a patient. The life span of this test was short lived as *Castell's* case rejected this test and moved towards a patient-oriented test. It is submitted, that taking into account the time at which *Castell* was decided, this coincided with the dawning of our new constitutional era and therefore a move in this direction was inevitable. The test introduced in *Castell's* case regarding disclosure of information is still in place and has been accepted by the Supreme Court of Appeal in *Sibisi's* case. The enquiry is now centred around whether a reasonable person in the position of the patient if aware of the risk would attach significance to it or whether the patient who is undergoing surgery if warned of the risk would attach significance to it. The three key principles that have emerged are that (i) only material risks need to be disclosed; (ii) remote risks did not need to be disclosed and (iii) the test is assessing this is a patient centred one. The ''reasonable patient test'' is only used when determining the issue of disclosure of information.

Further, *Castell's* case set out four elements that must be satisfied before the consent of a patient can be used as a defence to the wrongfulness element in a delictual claim against a doctor. A patient consenting to the risk or harm must first be provided with the necessary knowledge and understanding of the risk or harm. The envisaged consent given by the patient must be comprehensive so that it has the effect of consenting to possible adverse consequences that may arise from the procedure. Consent has thus developed into a defence through the maxim volenti non fit iniuria rather than a positive right in terms of our law. The defence has influenced the nature of the doctrine in that the courts have thus far focused on the minimum standards that must be met particularly regarding the information that must be provided for there to be agreement.

Many of the principles of the doctrine are now enshrined in our statutory framework with some statutes taking the issue of consent further. The Sterilisation Act[222] for example requires the consent to be free from coercion, in writing and a full understanding by the patient of the permanency of the procedure. The National Health Act,[223] which covers all other medical procedures, apart from the termination of a pregnancy, a sterilisation and where treatment is administered to a mental health care user, directs that patients must be given information about the treatment in a language of their choice. The National Health

[220] 1957 (3) SA 710 (T).
[221] 1976 (3) SA 226 (C).
[222] 44 of 1998.
[223] 61 of 2003.

Act[224] also introduces the requirement that patients must be given possible alternatives to the treatment they seek. It is submitted that these pieces of health specific legislation add to the common law doctrine of informed consent by introducing the aspects of alternatives to the choices made by patients and the option for patients to withdraw their consent or decline treatment.

Our Constitution also bolsters these rights by giving a strong voice to patient autonomy by protecting a person's bodily and psychological integrity and more especially their decisions relating to reproduction. The *AB*[225] case delved into the nature and scope of the right and defined it as an autonomy right that has the effect of protecting ''choice'' for example a woman's decision to terminate her pregnancy or to use a non-permanent form of contraception must be respected. A similar view was expressed by the Scottish court in the *KR* case which stated that had the patient been given sufficient information she would have been in a better position to make an informed choice on the course she opted to take.[226]

The common law, constitutional principles dealing with bodily and psychological integrity and the body of legislation governing informed consent provide multi-level protection to a patient's autonomy. Therefore, a failure to obtain informed consent from a patient is actionable either in delict or in the criminal law. The long-standing debate that ensued about whether a failure to obtain informed consent amounted to negligence or assault has been put to rest in the case of *Sibisi*.[227] The judiciary has held differing views on this issue without concretely stating why one form of fault is to be preferred over the other.[228] It is submitted that this could be a contributing factor as to why actions based on the lack of informed consent are difficult to succeed on. The writer favours the approach taken in *Sibisi's* case, that is, an action based on the absence of informed consent must be grounded in negligence. Van Loggerenberg is of the view that this is a sound approach and there is no need for an ''artificial delict'' in the form of a civil assault to be pleaded when establishing liability for the lack of informed consent.[229] It is submitted that following on from the *Sibisi* case the courts should in future adopt a multi-layered approach when assessing whether the absence of informed consent amounts to negligence on the part of the medical doctor. It is submitted that the first enquiry will be whether the patient was provided with information regarding the procedure. The patient will rely on the common law, the

---

[224] Ibid.

[225] (CCT155/15) [2016] ZACC 43; 2017 (3) BCLR 267 (CC); 2017 (3) SA 570 (CC) (29 November 2016).

[226] *KR against North Lanarkshire Health Board* [2016] CSOH 133, available at https://www.scotcourts.gov.uk/search-judgments/judgment?id=615d1ea7-8980-69d2-b500-ff0000d74aa7, accessed on 16 July 2018 at para 133.

[227] 2014 (6) SA 533 (SCA).

[228] In *Lymbery v Jefferies* which was heard in 1924, it was held that the failure to obtain informed consent amounted to negligence. Similarly, this was held in the *Richter* and *Sibisi* cases. The cases of *Stoffberg v Elliot*, *Esterhuizen*, *Castell*, *Louwrens* and *Mc Donald V Wroe* support the view that a lack of informed consent amounts to common assault.

[229] A Van Loggerenberg 'An alternative approach to informed consent' (2018) 135 (1) *The South African Law Journal* 55-72 at 72.

Constitution and dedicated legislation that deals with informed consent when alleging that there was an absence of full and proper informed consent. In the event that the medical doctor fails to appraise the patient in accordance with the statutory requirements as a reasonable doctor in his position would have done, the next stage of the enquiry will assess whether the doctor's conduct was wrongful as informed consent goes to this delictual element.

The evolution of patient autonomy in our law cannot escape criticism. Courts and in particular the Supreme Court of Appeal have been inconsistent in the way in which they have approached the absence of informed consent. Cases which have come before the courts post 1996 have paid scant attention to the right to bodily and psychological integrity and the consent provisions in the National Health Act leaving the door open for strong elements of medical paternalism to pervade the air of informed consent. The *Sibisi* case is however credited for bringing certainty into this arena by endorsing the patient centred test for disclosure of information thus removing a potential element of paternalism by a doctor and confirming that negligence must be pleaded as opposed to an assault.

According to Carstens and Pearmain, medical professionals have complaints against informed consent citing the following: (i) it wastes valuable time which could be better spent on treatment as patients do not understand what they are told and that they do not want to be informed; (ii) it has the effect of undermining the trust that a patient should have in their doctor if they are to be treated successfully; (iii) the doctor will disclose only specific information to the patient that will ensure that the patient consents to the treatment; (iv) in some instances disclosure may have the effect of frightening a patient and thereby refusing treatment and (v) some patients will have a fixed mind-set about the treatment to be received and therefore disclosure of information will not have an effect on their decision.[230] Giesen holds a similar view where he opines that a patient may also make an unbalanced judgment if he is provided with too much information and is made aware of possibilities which he is not capable of assessing because of his lack of medical training, his prejudices or personality.[231] Paternalism is therefore more focused on the patient's care rather than the needs and rights of the patient.[232]

Unfortunately, it seems that from the narratives of the HIV positive women who have been sterilised without their full and proper consent that this attitude towards informed consent was present when dealing with them. It is respectfully submitted that these complaints are weak and do not have a basis to survive in our current legal landscape which has made a

[230] P Carstens & D Pearmain *Foundational Principles of South African Medical Law* (2007) at 691-692.
[231] D Giesen 'From paternalism to self-determination to shared decision making' (1988) (1) *Acta Juridica* 107-127 at 114.
[232] N H S S Tan 'Deconstructing paternalism- What serves the patient best? (2002) 43 (3) *Singapore Medical Journal* 148-151 at 148.

committed and concerted effort to move away from medical paternalism towards patient autonomy.

The Sterilisation Act requires all persons to consent in writing to a sterilisation.[233] In the literature, it is argued that prior to women exercising their right to make a choice they must be provided with sufficient information to do so which results in them making an informed decision. The Sterilisation Act[234] deals with matters connected to sterilisations and more especially the issue of consent. Likewise, the issue of consent is also covered in the National Health Act.[235] Dhai argues that the ethical and legal elements of a valid consent process are disclosure, understanding, capacity and voluntariness.[236] It is vitally important to establish whether these elements are contained in the legislation dealing with the aspect of consent. Each of these elements will now be discussed in turn.

In order for the first element of disclosure to be satisfied, the HIV positive woman should be given information on the risks and complications associated with a sterilisation.[237] She should also be supplied with information regarding possible alternatives to a sterilisation.[238] The Sterilisation Act comprehensively sets out what information must be imparted to a woman who chooses to be sterilised.[239] This legislation, being specific to sterilisations, requires the woman to be informed of the reversibility or permanency of the procedure.[240] Part of what must be disclosed to the woman is that she may retract her consent to the procedure at any time prior to it being carried out.[241] The National Health Act also sets out explicitly what information must be relayed to a patient prior to a medical treatment being administered.[242]

The second element of a sound consent is ensuring that the patient understands the proposed treatment or procedure.[243] The intrinsic requirement of this, is the ability of the patient to grasp the information given by the medical practitioner about the planned procedure.[244] According to Dhai, a key challenge to the process of obtaining informed consent is the difficulty in establishing whether or not the patient truly understands and grasps the nature of their illness and is able to consent to or refuse treatment. [245] In order to assess the level of the patient's understanding, the learned authors McQuoid- Mason and

[233] Section 4 (*c*) of Act 44 of 1998.
[234] 44 of 1998.
[235] 61 of 2003.
[236] A Dhai 'Informed consent – 2008' (2008) 1 (1) *South African Journal of Bio-ethics and the Law* 27-30 at 27.
[237] Ibid.
[238] Ibid.
[239] Section 4 of Act 44 of 1998.
[240] Section 4 (*a*) (ii) of Act 44 of 1998.
[241] Section 4 (*b*) of Act 44 of 1998.
[242] Section 6 of Act 61 of 2003.
[243] Dhai 'Informed consent – 2008' (2008) 1 (1) *South African Journal of Bio-ethics and the Law* 27- 30 at 28.
[244] Ibid.
[245] Ibid.

Dhai[246] submit that the four levels of optimal competence proposed by Appelbaum and Grisso ought to be followed. The first level would entail the patient communicating the choices that have been given to them back to the doctor.[247] The patient's ability to understand the relevant information which forms the basis on which the choice is made is the second level.[248] Our common law doctrine of informed consent also cites understanding as one of the key pillars of the volenti non fit inuria defence.[249] The third level is the patient's ability to appreciate the situation according to their own values.[250] The final level of competence is the ability of the patient to weigh various values to arrive at a decision.[251]

A positive feature of the National Health Act[252] regarding understanding is that all information conveyed to an HIV positive woman regarding the sterilisation must be in a language that she understands. This feature of the Act[253] coupled with the fact that her literacy level must be taken into account during the information sharing exercise is deserving of praise.

Adequate safeguards are contained both in the National Health Act and Sterilisation Act relating to legal capacity and mental capacity.[254] The Sterilisation Act is prescriptive regarding the age that a woman needs to be before consenting to a sterilisation.[255]

It is crucial that a decision made by an HIV positive woman to be sterilised must be made voluntarily. This goes to the very heart of patient autonomy and self-determination.[256] Therefore, for informed consent to be genuinely valid, there should be an absence of coercion or manipulation of the HIV positive woman to consent to be sterilised against her own best interests and wishes.[257] There are two built in safety mechanisms ensuring voluntariness in the Sterilisation Act.[258] It is important to note at this juncture that there are only three instances in which the written consent of a patient is required by statute before a medical procedure is performed.[259] Sterilisation has been identified as one of them. The Sterilisation Act requires the consent of a woman to be sterilised to be in writing and that it

[246] A Dhai & DJ McQuoid-Mason *Bioethics, Human Rights and Health Law Principles and Practice* (2011).
[247] Ibid 72.
[248] Ibid.
[249] See the cases of *Castell v De Greef* 1994 (4) SA 408 (C) and *Christian Lawyers' Association v National Minister of Health* 2005 (1) SA 509 (T) where this concept was discussed more fully.
[250] Dhai & McQuoid-Mason *Bioethics, Human Rights and Health Law Principles and Practice* (2011) 73.
[251] Ibid.
[252] Act 61 of 2003.
[253] Ibid.
[254] Section 2 and 3 of Act 44 of 1998 and Section 7 of Act 61 of 2003.
[255] Section 2 of Act 44 of 1998
[256] Section 12 (2) (*a*) of the Constitution of the Republic of South Africa, 1996.
[257] Dhai 'Informed consent – 2008' (2008) 1 (1) *South African Journal of Bio-ethics and the Law* 27-30 at 29.
[258] Act 44 of 1998.
[259] Apart from a sterilisation, written consent is required in terms of sections 55 and 71 of the National Health Act 61 of 2003. The former section deals with the removal of tissue, blood, blood products and gametes from a living person. The latter concerns itself with research and experimentation with living persons.

must be freely and voluntarily obtained.[260] It was held in the *LM* case that even though written consent to the sterilisation had been obtained this did not equate to voluntary consent because other factors such as prolonged labour or fear of treatment being withheld clearly played a role in their agreement to be sterilised.[261]

Neither the Sterilisation nor the National Health Acts provide expressly that a patient must understand the information they have been provided with.[262] It is submitted that this can only be achieved if a mechanism exists to ensure understanding by the women in the context that they find themselves in. The National Health Act does state that where it is possible, the patient must be given the information in a language that he/she understands and that cognisance must be taken of the literacy level of the patient.[263] This provision clearly places a duty on health professionals to promote understanding. However, it is submitted that a blind eye cannot be turned to the fact that our country has eleven official languages and in many instances an interpreter may be required and in practice a nurse fulfils this function. It is submitted that women may feel intimidated when being spoken to in a language that they do not understand and therefore will not participate in the decision making process and will provide their consent out of fear.[264]

The Sterilisation and National Health Acts[265] do not have provisions relating to value systems and cultural norms to be considered whilst dealing with the issue of consent. The learned author Dhai states that ''differences of language and culture are two major obstacles to good practitioner-patient communication, with differences in cultural understanding of the nature and cause of illness impeding the understanding of the diagnosis and treatment options provided by the practitioner.''[266] It may be argued that in the South African context this would be placing an unfair and onerous responsibility on the medical practitioner because of the diverse cultures that the women come from. However, the importance of this cannot be trivialised as an understanding of the value systems and cultural norms of African women cannot be overlooked. The studies conducted in our country and in Africa reveal the coerced or forced sterilisation of African HIV positive women only. In the African culture, high value is placed on a woman's fertility.[267]

### 3.7 Conclusion

The progression of the law on informed consent has seen immense benefits for patients in the form of a solid legal framework. Constitutional protection to the right to bodily and

[260] Section 4 and 4 (c) of Act 44 of 1998
[261] *Government of the Republic of Namibia v LM and Others* (SA 49/2012) [2014] NASC 19 (3 November 2014) at para 107.
[262] Act 44 of 1998 and Act 61 of 2003.
[263] Section 6 (2) of Act 61 of 2003.
[264] *Government of the Republic of Namibia v LM and Others* (SA 49/2012) [2014] NASC 19 (3 November 2014.
[265] Act 44 of 1998 and Act 61 of 2003.
[266] Dhai 'Informed consent – 2008' (2008) 1 (1) *South African Journal of Bio-ethics and the Law* 27-30 at 28.
[267] Essack & Strode 'I feel like half a women all the time: The impacts of coerced and forced sterilisations on HIV-positive women in South Africa' (2012) 26 (2) *Agenda* 24-34 at 31.

psychological integrity has influenced the changes in legislation dealing with the issue of consent to medical procedures. A strong focus on patient autonomy is the underlying thread in all of South Africa's health related legislation. Despite the comprehensive legal framework it is submitted that challenges lie at the level of implementation. Women who are poor, illiterate, marginalised and HIV positive may not enjoy the benefits of making autonomous informed decisions about their sexual reproductive health for an array of reasons that have been canvassed in Chapters 2 and 4. Both the civil and criminal law can assist in vindicating these violated rights.

# Chapter 4

# The rights to equality and dignity

## 4.1 Introduction

The violation of the rights to equality and dignity are key issues in the involuntary sterilisations being studied in this dissertation. Many of the women interviewed in the Strode, Mthembu and Essack study reported that they were targeted for sterilisations because they were known to be HIV positive. The constitutionally guaranteed rights to equality and dignity can only be understood if they are interpreted contextually.[1] Currie and De Waal submit that the contextual analysis should include a reflection on our colonial and apartheid past. They state that ''this requires a historical understanding of the type of society that South Africa once was and against which the new Constitution has set itself.''[2] Former Chief Justice of South Africa Judge Arthur Chaskalson used emotive language when describing apartheid as a ''wicked system of law'' that privileged whites and shamefully marginalised black people in all aspects of life.[3] South Africa's apartheid dispensation was infamously known for its unequal and discriminatory political and legal order.[4] The discriminatory treatment of black people was captured by Justice O' Regan in the first case dealing with equality in the Constitutional Court. She stated in *Brink v Kitshoff*:

> Black people were prevented from becoming owners of property or even residing in areas classified as 'white', which constituted nearly 90% of the landmass of South Africa; senior jobs and access to established schools and universities were denied to them; civic amenities, including transport systems, public parks, libraries and many shops were also closed to black people. Instead, separate and inferior facilities were provided. The deep scars of this appalling programme are still visible in our society.[5]

Whilst there has been an extensive focus on race discrimination, African women faced barriers beyond just their race. They also faced other layers of discrimination which related to their gender, sex, class and socio-economic status. In more recent decades, many African women have had to endure the additional burden of being HIV positive and all of the stigma and discrimination that has accompanied this label.[6] This chapter discusses the rights to equality and dignity. This includes how these rights are described in terms of international, national and regional law. It sets out in detail the relevant constitutional provisions and cases as well as describing the Promotion of Equality and Prevention of Unfair

---

[1] I Currie & J De Waal *The Bill of Rights Handbook* 6 ed (2013) 211.
[2] Ibid.
[3] A Chaskalson 'From wickedness to equality: The moral transformation of South African law' (2003) 1 (4) *International Journal of Constitutional Law* 590 -609 at 590.
[4] Currie & De Waal *The Bill of Rights Handbook* 6 ed (2013) 211.
[5] (CCT15/95) [1996] ZACC 9; 1996 (4) SA 197; 1996 (6) BCLR 752 (15 May 1996), 40.
[6] A Strode et al '''She made up a choice for me'': 22 HIV-positive women's experiences of involuntary sterilization in two South African provinces' (2012) 20 (39S) *Reproductive Health Matters* 1-9.

Discrimination Act.[7] It concludes with comments on the extent to which current South African law protects persons living with HIV and in particular HIV positive women.

### 4.2 The right to equality

#### 4.2.1 Understanding the right to equality in its historical context

Racial and gender discrimination in apartheid South Africa was institutionalised by a myriad of laws which were binding on all of its people and very difficult to challenge in the Courts because of the doctrine of parliamentary sovereignty.[8] The irony of this lay in the fact that although black people accounted for 80% of the population they had no say in the law making process of the country.[9]

''Parliament has the power to pass the statutes it likes, and there is nothing the Courts can do about that. The result is law. But that is not always the same as justice. The only way that Parliament can ever make legislation just is by making just legislation.''[10] This profound statement was made by Judge Didcott in *In re Dube*[11] which bore testament to the impact of apartheid legislation that black South Africans were subjected to. In that case Dube was considered to be an ''idle person'' according to the Bantu (Urban Areas) Consolidation Act 25 of 1945 by virtue of being unemployed for a period of 122 days.[12] The Judge was called upon to endorse the declaration made by the Commissioner deeming Dube an ''idle person'' and confining him to a farm colony for a period of two years unless he obtained employment within thirty days.[13] This decision was made without taking into account that Dube was an epileptic who suffered from frequent fits, required constant medication and could only perform light tasks.[14] The *Dube* case reflects the arbitrary nature of apartheid legislation that expressly aimed at excluding blacks from so called white areas. It also shows how cruel it would have been if Judge Didcott confirmed the order as Dube would be punished for being disabled. Even though, this case is more than thirty years old it still reflects how arbitrary policies or laws can have a profound personal impact on individuals. In Dube's case he would have to spend two years in a farm colony simply because he was disabled.

An example of a piece of legislation that depicted the unequal and discriminatory treatment that black people were subjected to is set out below.

---

[7] Act 4 of 2000.
[8] Chaskalson 'From wickedness to equality: The moral transformation of South African law' (2003) 1 (4) *International Journal of Constitutional Law* 590 -609 at 590.
[9] Ibid 592.
[10] *In re Dube* 1979 (3) 820 (N) 821 F.
[11] Ibid.
[12] Ibid 820 - G.
[13] Ibid 821 - F.
[14] Ibid 821 G.

The Railways and Harbours Regulation, Control and Management Act 22 of 1916 was an example of legislation that was unequal and partial in nature. This legislation was actively enforced by the apartheid Government. Persons who attempted to wilfully disobey the law were punished. In *Rex v Abdurahman*[15] the appellant was convicted for violating section 36 (b) of the Act by inciting non-white persons to sit in first class compartments of a train that was reserved for Europeans only.[16]

The implementation of unjust and partial legislation also led to the loss of lives in South Africa. On the 21 March 1960 in the township of Sharpeville, Africans marched in protest against the provisions of the Native Urban Areas Act of 1954 which was more commonly known as the pass laws. This law required Africans to carry their pass books with them which had to bear official stamps serving as proof that that person was allowed to enter an urban area or a specified town at that time.[17] Section 10 of the Urban Areas Act[18] set out the instances in which Africans were permitted to stay in an urban area for more than 72 hours. These instances included:

(i) The person must have been born and lived in that area since birth;

(ii) The person had been employed for ten years under one employer, or had lived there for 15 years without contravening any law;
(iii) The child or wife of a man as who fulfilled the conditions contemplated in sections 10 (a) and (b) and

(iv) The person was authorised to be in an urban area by virtue of a signed contract of employment for a limited period of time.[19]

An opportunity arose in *Rikhoto v East Rand Administration Board and Another*[20] to challenge the unjust consequences the Act had for many people who lived in urban areas for long periods of time but never gained any security of tenure.[21] This was done through arguing that the purpose of the provisions of section 10 of the Act[22] should be interpreted broadly. The court held that its purpose was to provide an exemption to a small category of black persons who could show that they were employed by one employer for a period of ten years and hence they could ''usefully or satisfactorily be absorbed in the economic life of the urban community in question.''[23] In addition, an African who did not contravene the

[15] 1950 (3) SA 136 (A).
[16] 1950 (3) SA 136 (A) 141.
[17] P De Vos & W Freedman *South African Constitutional Law in Context* (2014) 17.
[18] Native Urban Areas Act of 1954.
[19] 1983 (4) SA 278 (W) at 281.
[20] 1983 (4) SA 278 (W).
[21] Urban Areas Act of 1954.
[22] Ibid.
[23] 1983 (4) SA 278 (W) at 285 E.

law for 15 years was regarded as being desirable therefore could be exempt from the seventy two hour ban.[24]

Another example of legislation that had the aim of racial segregation was the Bantu Education Act of 1953. The architect of this repressive piece of legislation, H F Verwoerd, stated that "there is no place for [the Bantu] in the European community above the level of certain forms of labour ... What is the use of teaching the Bantu child mathematics when it cannot use it in practice?"[25] This white supremacist philosophy endorsed by Verwoerd was adopted as the national approach to education for Africans and it resulted in them being taught from an early age that equality was not for them.[26] In fact, this was borne out by the spending patterns of the South African government on its scholars. Approximately six and a half times more was spent on a white school-going child as opposed to a black school-going child. Table 4 below depicts the different amounts spent on scholars of different race groups.[27]

**Table 4.1: Inequality in education spending under apartheid**

| **Different race groups** | **Black** | **Coloured** | **Indian** | **White** |
|---|---|---|---|---|
| Amount spent for 1985/1986 per scholar | R 293.86 | R 708.32 | R1 182.00 | R1 926.00 |

*Source:* Rycroft, 1987.

To further entrench the divide in education the apartheid government also promulgated for Afrikaans, commonly referred to as the language of the oppressor, to be taught alongside English as the only mediums of instruction to African children.[28] On the 16 June 1976 students marched in protest against this oppressive directive which resulted in the loss of many young lives.[29] With the passing of time resistance grew stronger towards the unequal treatment that black people were receiving in South Africa. Activism gained momentum and the call for a non-racial South Africa where all people are equal before the law became commonplace. In response to the activism from non-white people and intense international pressure, the apartheid government unbanned the African National Congress and other political parties on the 2 February 1990.[30] The 11th of February 1990 saw the historic release of former president Nelson Mandela from prison.[31] As a result of extensive

[24] Ibid.
[25] 'Bantu Education Act, 1953' (2018), available at https://en.wikipedia.org/wiki/Bantu_Education_Act,_1953. Accessed on 7 April 2017.
[26] 'The June 16 Soweto Youth uprising' (2013), available at http://www.sahistory.org.za/topic/june-16-soweto-youth-uprising. Accessed on 7 April 2017
[27] A Rycroft *Race and the Law in South Africa* (1987) 237.
[28] 'The June 16 Soweto Youth uprising' (2013), available at http://www.sahistory.org.za/topic/june-16-soweto-youth-uprising. Accessed on 7 April 2017.
[29] Ibid.
[30] De Vos & Freedman *South African Constitutional Law in Context* (2014).
[31] Ibid.

negotiations a ''moral document''[32] the interim Constitution was born which signalled the end of the apartheid era and more especially unequal treatment for all who lived in South Africa.[33]

The most significant purpose of the interim Constitution was to administer South Africa's first democratic elections where all adult South Africans could vote in the same election for the first time.[34] Unjust legislation that existed in the apartheid era could not be erased from the statute books without its provisions being repealed by the new democratic Parliament or declared invalid by the Constitutional Court.[35] One such challenge that was made was in the case of *Moseneke and Others v The Master of the High Court.*[36] This case challenged a manifestly discriminatory piece of legislation in light of the provisions of the Constitution.[37] The Court held that the Black Administration Act and the attached Regulations imposed differentiation on listed grounds contained in section 9 (3) of the Constitution that is, on the grounds of colour, race and ethnic origin and as such constituted discrimination which was unfair.[38] This case like many others that have come before the Constitutional Court has shown firstly, that the Court recognises intersectional discrimination as a key factor in such cases. Secondly, even 24 years into our democracy the court continues to adjudicate equality disputes within the historical context of South Africa's unjust past.[39]

### 4.2.2 The right to equality in international and regional law

The concept of being treated equally and being equal before the law is entrenched in international, regional and national law. Article 1 of the UDHR proclaims that ''all human beings are born free and equal in dignity and rights''.[40] Article 2 extends this concept of equality and dignity by stating that ''everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status''.[41]

Similarly, the ICCPR echoes the sentiment that with equality there shall be no discrimination by stating that ''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

---

[32] Aptly described by former Chief Justice and the first President of the Constitutional Court, Judge Arthur Chaskalson.
[33] De Vos & Freedman *South African Constitutional Law in Context* (2014) 19.
[34] Section 6 of the Interim Constitution, Act 200 of 1993.
[35] See section 98 (2) (*c*) of the Interim Constitution, Act 200 of 1993 and section 172(1) (*a*) of the Constitution of the Republic of South Africa, 1996.
[36] *Moseneke and Others v Master of the High Court* (CCT51/00) [2000] ZACC 27; 2001 (2) BCLR 103 (CC); 2001 (2) SA 18 (CC) (6 December 2000).
[37] Ibid.
[38] Ibid para 22.
[39] *Duncanmec (Pty) Limited v Gaylard NO and Others* (CCT284/17) [2018] ZACC 29 (13 September 2018).
[40] Came into effect on the 10 December 1948, as a response to the atrocities committed during World War 2, available at http://www.un.org/en/documents/udhr/history.shtml.
[41] Ibid.

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''.[42]

CEDAW deals specifically with the prohibition of discriminatory treatment of women in all spheres of life including civil, social, cultural, economic and political.[43] According to the Convention discrimination means ''distinction, exclusion or restriction'' made on the basis of sex.[44]

The right to be equal before the law and have equal protection before the law is also protected at a regional level.[45] The ACHPR provides that ''every individual shall be entitled to the enjoyment of the rights and freedoms recognised and guaranteed in the present Charter without distinction of any kind…''.[46] The grounds listed are identical to the grounds contained in the UDHR and ICCPR save for the addition of ethnic group.[47] It is clear from a cursory glance at the international and regional law that there is a clear right to equality based on the listed ground of sex however, HIV is not a listed ground.

Based on our international law obligations, the Cairo Declaration mandates our government to have in place mechanisms that deal with population and development in a manner that aligns itself with human rights and takes into account the values and traditions of its citizens.[48] Although the obligations in the Cairo Declaration are not legally binding, nevertheless they are important as the Constitutional Court has made it clear that both binding and non-binding public international law can be used to assist in the interpretation of constitutional rights.[49] This means that any interpretation of constitutional rights relating to women's reproductive health care must be interpreted in line with these international norms which focus on amongst others the right to autonomy.

---

[42] International Covenant on Civil and Political Rights, 16 December 1966 and ratified by South Africa on 10 December 1998, available at http://www.ohchr.org/Documents/ProfessionalInterest/ccpr.pdf. Article 26.
[43] Convention on the Elimination of All Forms of Discrimination against Women, 18 December 1979 and ratified by South Africa on 15 December 1995, available at http://www.un.org/womenwatch/daw/cedaw/text/econvention.htm. Article 1.
[44] Ibid.
[45] African (Banjul) Charter on the Human and Peoples' Rights, 27 June 1981 and ratified by South Africa on 9 July 1996. Available at http://www.achpr.org/instruments/achpr/. Article 3.
[46] Ibid Article 2.
[47] Ibid.
[48] Ibid.
[49] *S v Makwanyane and Another* (CCT3/94) [1995] ZACC 3; 1995 (6) BCLR 665; 1995 (3) SA 391; [1996] 2 CHRLD 164; 1995 (2) SACR 1 (6 June 1995).

### 4.2.3 National Law

#### 4.2.3.1 Section 9 of the Constitution of the Republic of South Africa, 1996

According to Jugwanth equality has a central place in the South African legal framework.[50] This was echoed in the case of *Fraser v Children's Court, Pretoria North* Mohamed J stated that:

> There can be no doubt that the guarantee of equality lies at the very heart of the Constitution. It permeates and defines the very ethos upon which the Constitution is premised. In the very first paragraph of the preamble it is declared that there is a ''…need to create a new order…in which there is equality between men and women and people of all races so that all citizens shall be able to enjoy and exercise their fundamental rights and freedoms.[51]

This rings true as equality is not only a right but also a foundational value in our Constitution, as stated in sections 1 (*a*) and 7 (1).[52] Constitutional values can best be described as the ''ideals or characteristics'' to which a society deems deserving to aspire to.[53] In the South African context, these values reflect a move away from our past and serve to cement the foundation of a new society.[54] The importance of the constitutional values as set out in section 1 of the Constitution is highlighted by the fact that a 75% majority vote is required before the values of the Constitution can be changed by Parliament.[55]

The first substantive right in our Bill of Rights is the right to equality.[56] There are five subsections to the right. The first is section 9 (1) of the equality clause makes provision for everyone to be equal before the law and to have the right to equal protection and benefit of the law.[57] This is the premise from which liberal states that strive for an egalitarian society begin.[58] This is an important starting point for our law on equality as it moves us away from our discriminatory past in which there was no equal treatment. However, is it not without difficulties as Sachs J has pointed out that treating people alike does not necessarily have to

---

[50] S Jagwanth 'Expanding equality' (2005) *Acta Juridica* 131-148.
[51] *Fraser v Children's Court Pretoria North and Others* (CCT31/96) [1997] ZACC 1; 1997 (2) SA 261 (CC); 1997 (2) BCLR 153 (CC) (5 February 1997), para 20.
[52] Section 1(1) of the Constitution of the Republic of South Africa, 1996 states that the Republic of South Africa is one, sovereign, democratic state founded on the following values: human dignity, the achievement of equality and the advancement of human rights and freedoms. Section 7 (1) proclaims that the Bill of Rights is a cornerstone of democracy in South Africa. It enshrines the right of all people in our country and affirms the democratic values of human dignity, equality and freedom.
[53] De Vos & Freedman *South African Constitutional Law in Context* (2014) 59.
[54] Ibid 58.
[55] Ibid.
[56] Section 9 of the Constitution of the Republic of South Africa, 1996.
[57] Constitution of the Republic of South Africa, 1996.
[58] T Loenen 'The Equality Clause in the South African Constitution: Some remarks from a comparative perspective' (1997) 13 *South African Journal on Human Rights* 401-429 at 416.

result in uniformity, instead it is an recognition of difference.[59] This approach of identifying difference is critical in the South African context in which the jurisprudence has focused on substantive rather than formal equality.

Formal equality, according to Currie and De Waal, means the sameness of treatment, that is, individuals in like circumstances must be treated alike by the law.[60] De Vos and Freedman define formal equality as treating all people in the same manner regardless of their social and economic status; personal circumstances; their history; whether they have faced discrimination in the past and continue to face discrimination.[61] Goldstone J in *President of the Republic of South Africa and Another v Hugo* observed that treating people identically can sometimes result in inequality:

> We need, therefore, to develop a concept of unfair discrimination which recognises that although a society which affords each human being equal treatment on the basis of equal worth and freedom is our goal, we cannot achieve that goal by insisting upon identical treatment in all circumstances before that goal is achieved. Each case, therefore, will require a careful and thorough understanding of the impact of the discriminatory action upon the particular people concerned to determine whether its overall impact is one which furthers the constitutional goal of equality or not. A classification which is unfair in one context may not necessarily be unfair in a different context.[62]

It can be said that Hugo's case signalled the end of the notion of formal equality being applied exclusively when dealing with issues of equality. Substantive equality by contrast reinforces the idea that people who are not alike should not be treated the same and that the circumstances of people must be taken into account to ensure an equal outcome.[63] This is particularly important in the context of this thesis that addresses unfair discrimination against women who are HIV positive, poor and often African. The court in *Minister of Finance v Van Heerden* embraced the concept of substantive equality by noting that there are many levels and forms of differentiation which subtly impact on the way people are

[59] *National Coalition for Gay and Lesbian Equality and Others v Minister of Home Affairs and Others* (CCT10/99) [1999] ZACC 17; 2000 (2) SA 1 (CC); 2000 (1) BCLR 39 (CC) (2 December 1999), at para 132.
[60] Currie & De Waal *The Bill of Rights Handbook* 6 ed (2013) 213.
[61] De Vos & Freedman *South African Constitutional Law in Context* (2014) 421.
[62] *President of the Republic of South Africa and Another v Hugo* (CCT11/96) [1997] ZACC 4; 1997 (6) BCLR 708 (CC); 1997 (4) SA 1 (CC) (18 April 1997), para 41. The facts of this case are that on 27 June 1994 the President of the Republic of South Africa granted special remission of sentences to certain categories of prisoners. The category of prisoners that this was directed to was all mothers in prison on 10 May 1994, with minor children under the age of twelve (12) years. Hugo alleged that the Presidential Act was in violation of the provisions of section 8 (1) and (2) of the interim Constitution in as much as it unfairly discriminated against him on the ground of sex or gender and indirectly against his son in terms of section 8 (2) because his incarcerated parent was not a female. It is common cause that Hugo would have qualified for remission, but for the fact that he was the father (and not the mother) of his son who was under the age of twelve years at the relevant date. The court held that the discrimination against men was fair and was motivated by a genuine desire to assist the children of these women.
[63] J De Waal 'Equality and the Constitutional Court' (2002) 14 *SA Mercantile Law Journal* 141-156 at 141-142.

treated.[64] The Court stated that these forms of differentiation were scrutinised as part of the fairness enquiry and to ensure that equality as a constitutional value was promoted.[65]

From these early cases our jurisprudence has developed in a fashion that affirms the notion that substantive equality must prevail when interpreting issues of equality as the uniqueness of South Africa's history must be taken into account. A host of learned authors have concurred with the views favouring the notion of substantive equality.[66] Ngcobo J in *Bato Star Fishing (Pty) Ltd* sums up the concept of equality by stating that:

> The achievement of equality is one of the fundamental goals that we have fashioned for ourselves in the Constitution. Our constitutional order is committed to the transformation of our society from a grossly unequal society to one in which there is equality between men and women and people of all races. In this fundamental way, our Constitution differs from other constitutions which assume that all are equal and in so doing simply entrench existing inequalities. Our Constitution recognises that decades of systematic racial discrimination entrenched by the apartheid legal order cannot be eliminated without positive action being taken to achieve that result. We are required to do more than that.[67]

It is submitted that the Constitutional Court's focus on substantive equality is important in relation to addressing the unfair discrimination and sterilisation abuse suffered by HIV positive women. A substantial equality approach requires an examination of the social context within which the discrimination occurred. As quoted above from the *Minister of Finance v Van Heerden* case, in some instances these may be small and subtle factors but nevertheless they lead to value judgments and differential treatment. In this specific instance it is clear from the Strode study that poor African women using public health facilities whose medical records showed they were HIV positive and in some cases had other children, were treated in a discriminatory and demeaning way because they were perceived to be irresponsible in bringing potentially HIV positive children into the world.[68] This behaviour was seen as so inappropriate that they were singled out for sterilisations as part of what appears to be an unarticulated policy that HIV positive women should be sterilised for their own benefit.

---

[64] *Minister of Finance and Other v Van Heerden* (CCT 63/03) [2004] ZACC 3; 2004 (6) SA 121 (CC); 2004 (11) BCLR 1125 (CC); [2004] 12 BLLR 1181 (CC) (29 July 2004), at para 27.

[65] *Minister of Finance and Other v Van Heerden* (CCT 63/03) [2004] ZACC 3; 2004 (6) SA 121 (CC); 2004 (11) BCLR 1125 (CC); [2004] 12 BLLR 1181 (CC) (29 July 2004), at para 27.

[66] Loenen 'The equality clause in the South African Constitution: Some remarks from a comparative perspective' (1997) 13 *South African Journal on Human Rights* 401-429 at 403. C Albertyn & B Goldblatt 'Facing the challenge of transformation: Difficulties in the development of an indigenous jurisprudence of equality' (1998) 14 *South African Journal on Human Rights* 248-276 at 250. TP Van Reenen 'Equality, discrimination and affirmative action: an analysis of section 9 of the Constitution of the Republic of South Africa' (1997) 12 *SA Public Law* 151-165 at 153-154.

[67] *Bato Star Fishing (Pty) Ltd v Minister of Environmental Affairs and Tourism and Others* (CCT 27/03) [2004] ZACC 15; 2004 (4) SA 490 (CC); 2004 (7) BCLR 687 (CC) (12 March 2004), at para 74.

[68] Strode et al '''She made up a choice for me'': 22 HIV-positive women's experiences of involuntary sterilization in two South African provinces' (2012) 20 (39S) *Reproductive Health Matters* 1-9.

The remedial and restitutionary component of the equality clause is found in section 9 (2) of the Bill of Rights which makes provision for the achievement of equality of persons who have been disadvantaged by unfair discrimination through legislation.[69] This sub-section is a constitutional acceptance of the importance of substantive equality. The two pieces of legislation that are by-products of section 9 (2) are the Employment Equity Act[70] and Promotion of Equality and Prevention of Unfair Discrimination Act (hereinafter referred to as the Promotion of Equality and Prevention of Unfair Discrimination Act or the Equality Act).[71]

The third and fourth sub-sections of section 9 prohibit unfair discrimination by the state or natural persons on one or more of the listed grounds and that legislation must be enacted to prohibit such discrimination.[72] The discrimination need not be overt and can be either direct or indirect.[73] It is significant that these subsections ensure that the clause applies both vertically and horizontally. The seventeen listed grounds are race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age disability, religion, conscience, belief, culture, language and birth.[74] In commenting on the rationale behind the listed grounds O'Regan stated:

> Although our history is one in which the most visible and most vicious pattern of discrimination has been racial, other systematic motifs of discrimination were and are inscribed on our social fabric. In drafting section 8, the drafters recognised that systematic patterns of discrimination on grounds other than race have caused, and may continue to cause, considerable harm. For this reason, section 8(2) lists a wide, and not exhaustive, list of prohibited grounds of discrimination.[75]

The learned author De Waal refers to these listed grounds as illegitimate grounds.[76] In *Harksen v Lane NO* the Court stated that listed grounds are those grounds of discrimination are those grounds that have been identified in the past.[77] Some of these relate to biological characteristics such as sex and others deal with the associational life of humans such as conscience.[78]

---

[69] Equality includes the full and equal enjoyment of all rights and freedoms. To promote the achievement of equality, legislative and other measures designed to protect or advance persons, or categories of persons, disadvantaged by unfair discrimination may be taken.
[70] 55 of 1998.
[71] 4 of 2000. This Act will be discussed further in chapter 5.
[72] Constitution of the Republic of South Africa, 1996.
[73] Section 9 (3) and (4) of the Constitution of the Republic of South Africa, 1996.
[74] Section 9 (3) of the Constitution of the Republic of South Africa, 1996.
[75] *Brink v Kitshoff NO* (CCT15/95) [1996] ZACC 9; 1996 (4) SA 197 (CC); 1996 (6) BCLR 752 (CC) (15 May 1996). Section 8 of the Interim Constitution Act 200 of 1993 was the equality clause.
[76] De Waal 'Equality and the Constitutional Court' (2002) 14 *SA Mercantile Law Journal* 141-156 at 150.
[77] *Harksen v Lane NO and Others* (CCT9/97) [1997] ZACC 12; 1997 (11) BCLR 1489; 1998 (1) SA 300 (7 October 1997) at para 49.
[78] Ibid.

Discrimination can also take place on other grounds that are not listed in section 9(3) and these have become known as analogous grounds.[79] The Constitutional Court has on two occasions in the past used analogous grounds to decide whether the discrimination complained of was unfair. The first instance was in *Larbi-Odam and Others v Member of the Executive Council for Education and Another* where it was held that a regulation issued by the Minister of Education which had the effect of preventing non-citizens from being appointed as permanent educators amounted to unfair discrimination.[80] The educators who were foreign nationals and some of whom were permanent residents of South Africa, were employed as temporary teachers. The analogous ground of discrimination on which they relied was citizenship. The court held that in this case the disadvantaged group was foreign nationals.[81] Citizenship, being an unlisted ground was ''based on attributes and characteristics which have had the potential to impair the fundamental human dignity of persons as human beings or to affect them adversely in a comparably serious manner.''[82] In addition, Judge Mokgoro went on to state that ''foreign citizens are a minority in all countries, and have little political muscle and that citizenship is a personal attribute which is difficult to change.''[83]

An important question then arises as to how exactly is unfair discriminatory conduct established by our courts. According to Freedman, the Constitutional Court's analysis of the equality clause in *Harksen's* case provides for two separate inquiries which embrace three separate tests.[84] The aim of the first stage of the inquiry is:

To determine whether the law or conduct in question differentiates between individuals and groups of people. If it does so differentiate, then in order not to fall foul of section 8(1) of the interim Constitution there must be a rational connection between the differentiation in question and the legitimate governmental purpose it is designed to further or achieve.[85]

According to the majority judgment in the case of *Prinsloo*, ''the idea of differentiation lies at the heart of the right to equality.''[86] The court held that ''in order to govern a modern country efficiently and to harmonise the interests of all its people for the common good, it is necessary to classify people in countless different ways and to treat the members of each group so classified differently from members of other groups.''[87] The court concluded that

---

[79] According to Loenen the grounds mentioned in section 9(3) are extensive but not exhaustive due to the addition of the word 'including': ''The Equality Clause in the South African Constitution: Some remarks from a comparative perspective' (1997) 13 *South African Journal on Human Rights* 401-429 at 403.
[80] *Larbi-Odam and Others v Member of the Executive Council for Education (North-West Province) and Another* (CCT2/97) [1997] ZACC 16; 1997 (12) BCLR 1655 (CC); 1998 (1) SA 745 (CC) (26 November 1997).
[81] Ibid at para 3.
[82] Ibid 20.
[83] Ibid 19.
[84] W Freedman 'Understanding the right to equality' (1998) 115 (2) *South African Law Journal* 243-251 at 248.
[85] *Harksen v Lane NO and Others* (CCT9/97) [1997] ZACC 12; 1997 (11) BCLR 1489 (CC); 1998 (1) SA 300 (CC) (7 October 1997) para 42.
[86] Freedman 'Understanding the right to equality' (1998) 115 (2) *South African Law Journal* 243-251 at 245.
[87] Ibid 245.

such differentiation will seldom amount to unfair discrimination. In other words the Court accepted that differences based on a listed ground of discrimination on its own will not always per se be unfair.[88]

The second stage of the inquiry is ''to ascertain whether the law or conduct in question unfairly discriminates on a ground or two or more grounds. There are two parts to this inquiry that is, (i) a test for discrimination; and (ii) a test for unfairness.''[89]

With regards to the test for discrimination the key question is whether the differentiation amounts to discrimination.[90] In casu the court held that if the discrimination is based on one of the illegitimate specified grounds contained in section 8 (2) this would amount to discrimination.[91] The court had to then grapple with instances where the differentiation was not based on a specified ground. Judge Goldstone stated that in these instances:

> If it is not on a specified ground, then whether or not there is discrimination will depend upon whether, objectively, the ground is based on attributes and characteristics which have the potential to impair the fundamental human dignity of persons as human beings or to affect them adversely in a comparably serious manner.[92]

At this point in the inquiry if it is concluded that the differentiation does amount to discrimination, the next test that has to be administered is whether the discrimination is unfair.[93] A presumption of unfairness exits if the discrimination is on a specified ground.[94] If however, the discrimination is on an unspecified ground the onus will rest on the complainant to show unfairness.[95] To assist a Court in coming to its decision where a complainant has to show unfairness, Judge Goldstone enumerated factors that the Courts must take cognisance of when embarking on this leg of the test:

(i) The position of the complainants in society and whether they have suffered in the past from patterns of disadvantage. If the complainants are part of a group which has suffered discrimination in the past, then it is more likely that the discrimination will be unfair.[96]

(ii) The nature of the provision or power and the purpose sought to be achieved by it. If its purpose is manifestly not directed at impairing the complainant's dignity but is

[88] Ibid 245.
[89] Ibid 248.
[90] *Harksen v Lane NO and Others* (CCT9/97) [1997] ZACC 12; 1997 (11) BCLR 1489 (CC); 1998 (1) SA 300 (CC) (7 October 1997) para 45.
[91] Ibid para 46.
[92] Ibid.
[93] Ibid para 47.
[94] Ibid.
[95] Freedman 'Understanding the right to equality' (1998) 115 (2) *South African Law Journal* 243-251 at 246.
[96] Ibid.

aimed at achieving a worthy and important societal goal, such as furthering the fact suffered the impairment in question.[97]

(iii) The extent to which the discrimination has affected the rights or interests of complainants and whether it has led to an impairment of their fundamental human dignity or constitutes an impairment of a comparably serious nature.[98]

If the inquiry renders a result of unfair discrimination then a determination will have to be made as to whether the law or governmental conduct in question is a violation of s 8 (2). In other words it will be then necessary to assess whether the unfair discrimination can be justified in terms of s 33.[99]

It is trite that discrimination on one of the seventeen listed grounds will be presumed unfair.[100] With regards to unfair discrimination based on a similar ground the onus now shifts to the applicant to make out a prima facie case of discrimination. This would immediately seem a more onerous burden that rests on the applicant, however, according to Freedman the reasons set out by Judge Goldstone in *Harksen's* case make the onus relatively easy to satisfy.[101] The learned Judge in this case stated that a wide interpretation must be given to the terms ''characteristics and attributes''; the differentiation in question must have the ''potential'' to impair the applicant's dignity and the notion of dignity is broad and vague.[102] Apart from the guidance provided by the learned Judge in assessing when a ground can be considered to be analogous to a listed ground, other behaviour that leads to patterns of disadvantageous treatment may come to be considered as ''suspect''.[103] According to Kruger, stigmatisation that arises from prejudice and stereotyping is not unique to South Africa's past.[104] ''New patterns of marginalisation and exclusion hinging upon attributes like HIV-status are as constitutionally reprehensible as the old ones based on race.''[105] It has also been argued that disadvantaged groups should not only be afforded protection against unfair discrimination but such protection must extend to all persons who belong to a vulnerable group.[106]

---

[97] Ibid.
[98] Ibid.
[99] Ibid 247. The limitations clause makes provision for the limitation of fundamental rights by law of general application provided that it is reasonable and justifiable in an open and democratic society based on freedom and equality. Section 33 (1) of Act 200 of 1993.
[100] *Harksen v Lane NO and Others* (CCT9/97) [1997] ZACC 12; 1997 (11) BCLR 1489 (CC); 1998 (1) SA 300 (CC) (7 October 1997).
[101] Freedman 'Understanding the right to equality' (1998) 115 (2) *South African Law Journal* 243-251 at 250.
[102] Ibid.
[103] Loenen 'The Equality Clause in the South African Constitution: Some remarks from a comparative perspective' (1997) 13 *South African Journal on Human Rights* 401-429 at 407.
[104] R Kruger 'Equality and unfair discrimination: Refining the Harksen test' (2011) 128 (3) *South African Law Journal* 479-512 at 494.
[105] Ibid.
[106] GJ Swart 'An outcomes-based approach to the interpretation of the right to equality' (1998) 13 *SA Public Law* 217-233 at 223.

The other case that dealt with unfair discrimination on a non-enumerated ground was *Hoffmann v South African Airways*.[107] Hoffmann applied successfully to South African Airways (SAA) to be a cabin attendant. This was subject to him passing a pre-employment medical screening test. Part of the process entailed being tested for HIV. Hoffmann was found to be clinically fit and suitable for employment, however, the blood test revealed that he was HIV positive. On the basis of his HIV-positive status he was rendered unfit for employment. It was contended on behalf of Hoffmann that he was unfairly discriminated against on the listed ground of disability. The Court refused to classify HIV positive persons as being disabled but rather held that South African Airway's policy of not employing Hoffmann because he was living with HIV impaired his dignity and resulted in him being unfairly discriminated.[108] The Court applied the test used in *Harksen's*[109] case to come to this decision. The relevant sub-sections relied on by the Court were 9 (1), (3) and (5). Although the Court did not specify that it was relying on an analogous ground, it can be implied that it recognised a person's HIV status was an illegitimate reason for failing to employ them.

South African Airways is an organ of state by virtue of it being a business unit of Transnet which has public powers and performs public functions in the public interest.[110] Therefore, in terms of section 9 (3) it is expressly prohibited from discriminating against anyone. In order to determine whether there has been a violation of section 9(1) the following enquiries have to be undertaken. The first is to assess whether the challenged provision makes a ''differentiation that bears a rational connection to a legitimate government purpose.''[111] If, the differentiation bears no rational connection, there is a violation of section 9 (1) which would then warrant the second enquiry, that is, whether the differentiation amounts to unfair discrimination.[112] If the differentiation is fair, there is no violation of section 9 (3) and the enquiry will end at this point. Where there is unfair discrimination, this would necessitate an enquiry into whether the unfair discrimination can find protection under the limitations clause.[113] Judge Ngcobo did not consider it necessary to embark on the rationality enquiry in light of the views that he held regarding the unfair discrimination in this case. Judge Ngcobo stated that:

> At the heart of the prohibition of unfair discrimination is the recognition that under our Constitution all human beings, regardless of their position in society, must be accorded equal dignity. That dignity is impaired when a person is unfairly discriminated against. The determining factor regarding the unfairness of the discrimination is its impact on the person

[107] *Hoffmann v South African Airways* (CCT17/00) [2000] ZACC 17; 2001 (1) SA 1 (CC); 2000 (11) BCLR 1211; (CC) [2000] 12 BLLR 1365 (CC) (28 September 2000).
[108] Ibid para 40.
[109] *Harksen v Lane NO and Others* (CCT9/97) [1997] ZACC 12; 1997 (11) BCLR 1489 (CC); 1998 (1) SA 300 (CC) (7 October 1997).
[110] Ibid para 23.
[111] Ibid para 24.
[112] Ibid.
[113] Ibid.

> discriminated against. Relevant considerations in this regard include the position of the victim of the discrimination in society, the purpose sought to be achieved by the discrimination, the extent to which the rights or interests of the victim of the discrimination have been affected, and whether the discrimination has impaired the human dignity of the victim.[114]

The Court found that the present case is a good example of how people living with HIV are marginalised and stigmatised as a result of their positive status when it comes to employment rather, than being assessed on their ability to perform their duties.[115] Further, the learned Judge stated that HIV positive people constituted a minority and belonged to a vulnerable group in our society.[116] In turn, society's response to HIV positive people is fuelled with intense prejudice and discrimination.[117]

The employer in this case justified their unfair and discriminatory policy on three broad grounds. The first was for medical reasons, the second for operational requirements and the third being for the safety of its passengers and staff.[118] It was submitted that an employee had to be fit in order to travel world-wide.[119] World-wide duty entailed travelling to yellow fever endemic countries which meant that a cabin attendant had to be vaccinated against contracting yellow fever.[120] The difficulty in this regard was that HIV positive persons could have an adverse reaction to this vaccine as it is a live-attenuated vaccine which could be dangerous to persons with compromised immune systems.[121] The employer could not run the risk of HIV-positive cabin attendants not taking the vaccine as they could contract yellow fever and transmit it to staff and passengers.[122] A further submission made by the employer was that people living with HIV were more likely to contract opportunistic diseases ultimately leading to illness- which would render the employee unfit for duty.[123] The life span of people living with HIV was too short to justify the expenditure on training them.[124]

The medical evidence presented to the Court was contrary to the submissions made by the employer. The evidence indicated that an HIV-positive person who is not displaying the symptoms of the illness can perform the functions of a cabin attendant competently.[125] Medication, counselling and monitoring would assist in ensuring that a cabin attendant who is HIV-positive carries out his job requirements efficiently and well established

[114] Ibid para 27.
[115] Ibid para 28.
[116] Ibid.
[117] Ibid.
[118] Ibid para 7.
[119] Ibid.
[120] Ibid.
[121] Ibid.
[122] Ibid.
[123] Ibid.
[124] Ibid.
[125] Ibid para 14.

precautionary measures can be taken to ensure that no harm is caused to staff and passengers.[126] It was also submitted on behalf of Hoffmann that the employer's policy did not take into account cabin attendants who have contracted HIV subsequent to being employed as they would pose the same risks as listed by the employer.[127] In other words SAA's pre-employment HIV employment testing policy was irrational as it did not factor in the possibility that employees could become HIV positive after being employed.

The court held that discriminating against persons living with HIV is in itself devastating and to do so in the work place intensifies its impact as it robs them of the right to make a living.[128] The Court held that the reason for the discriminatory conduct on the part of South African Airways could not support its continued policy of discrimination.[129] The Court acknowledged that whilst ''legitimate commercial requirements'' play a pivotal role in dictating whether an individual should be employed this should not be a licence to allow stereotypes and prejudice to prevail.[130] The learned judge stated that:

> The greater interests of society require the recognition of the inherent dignity of every human being, and the elimination of all forms of discrimination. Our Constitution protects the weak, the marginalised, the socially outcast, and the victims of prejudice and stereotyping.[131]

The court cited with approval the dictum from the case of *MX of Bombay Indian Inhabitant v M/S ZY* which eloquently encapsulated the plight of people living with HIV and the challenges they face in the employment sphere:

> In our opinion, the State and public Corporations like respondent No. 1 cannot take a ruthless and inhuman stand that they will not employ a person unless they are satisfied that the person will serve during the entire span of service from the employment till superannuation. As is evident from the material to which we have made a detailed reference in the earlier part of this judgment, the most important thing in respect of persons infected with HIV is the requirement of community support, economic support and non-discrimination of such person. This is also necessary for prevention and control of this terrible disease. Taking into consideration the widespread and present threat of this disease in the world in general and this country in particular, the State cannot be permitted to condemn the victims of HIV infection, many of whom may be truly unfortunate, to certain economic death. It is not in the general public interest and is impermissible under the Constitution. The interests of the HIV positive persons, the interests of the employer and the interests of the society will have to be balanced in such a case.[132]

[126] Ibid.
[127] Ibid para 25.
[128] Ibid para 28.
[129] Ibid para 29.
[130] Ibid para 34.
[131] Ibid.
[132] Ibid para 38.

With regards to enquiring whether the violation of Hoffmann's right to equality was justified, the Court held that such an enquiry was not necessary as it was not dealing with a law of general application.[133] The learned Judge also stressed that our commitment to eradicating discrimination does not only stem from our Constitution but also international instruments which are committed to eliminating discrimination.[134] In this matter, the Court remedied the violation by ordering SAA to instate Hoffmann to the position of cabin attendant that he would have qualified for had it not been for their discriminatory HIV policy.[135]

Following on from the *Hoffman* decision, if a HIV positive woman was sterilised because of her status she would be able to challenge the actions of the medical practitioner and hospital on the basis of an unlisted ground. It is clear from *Hoffman* and the subsequent recognition of HIV status as being a ground for unfair discrimination in both the Employment Equity Act and the Promotion of Equality and Prevention of Unfair Discrimination Act that discrimination on this basis violates a person's dignity and is unacceptable within our constitutional framework.

#### 4.2.3.2 Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000

The drafters of the Promotion of Equality and Prevention of Unfair Discrimination Act were alive to the unequal and discriminatory treatment that affected the majority of South Africans in the social and economic spheres of life and it was recognised that significant inroads were made with regards to transformation and restructuring. However, the difficulty lies with the deep rooted prejudices, practices and stereotypes that serve to perpetuate unequal and discriminatory treatment that the majority of the people are still subjected to. Given this objective, the drafters of the Act included a number of innovative remedies which could be used to address the underlying prejudice.[136] The purpose of the Act is therefore to promote equality and prevent unfair discrimination by being guided by the principles of equality, human dignity, fairness and justice.[137]

The history of this Act has been captured admirably by Barney Pityana who was one of the key role-players in the drafting of the Equality Act.[138] According to him, there were four key objectives of the Act which deserve mention. In the first instance the Act seeks to fulfil its

---

[133] Ibid para 41.
[134] Ibid para 51. The Court relied on the African Charter on Human and Peoples' Rights to which South Africa is a member and in being so has committed itself to dismantle and prohibit all forms of discrimination. The International Labour Organisation 111, Discrimination (Employment and Occupation) Convention, 158 was referred to as well to re-iterate, the lack for tolerance for discrimination that has the effect of perpetuating unequal treatment in the employment sphere.
[135] Ibid para 63.
[136] De Vos & Freedman *South African Constitutional Law in Context* (2014) 452.
[137] Preamble to Act 4 of 2000.
[138] B Pityana 'Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000' (2002) XLIV (1) *Codicillus* 2-9.

constitutional mandate in terms of section 9 (4) of the Constitution.[139] Secondly, the Promotion of Equality and Prevention of Unfair Discrimination Act is aimed at giving effect to South Africa's international obligations in respect of The International Convention on the Elimination of All Forms of Racial Discrimination (hereinafter referred to as CERD) and CEDAW.[140] Both of these conventions have been ratified and adopted by South Africa.[141] Thirdly, the Act is aimed at being accessible to ordinary people by providing specific remedies and redress to litigants.[142] Prior to the enactment of the Promotion of Equality and Prevention of Unfair Discrimination Act the Constitutional Court pronounced on equality cases whose decisions, served to develop our equality jurisprudence.[143] The learned author argues that ''privileged classes'' of persons had the means to approach the Constitutional Court whilst for the vast majority of poor South Africans discrimination remained a ''daily fact of life.''[144] At this point it is appropriate to mention that the principle of subsidiarity requires that ''where it is possible to decide any case, civil or criminal, without reaching a constitutional issue, that is the course which should be followed.''[145] This in effect means that cases that seek to challenge issues of unfair discrimination and the right to equality must invoke the provisions of the Promotion of Equality and Prevention of Unfair Discrimination Act rather than relying on the equality clause in terms of the Constitution. Lastly, the Promotion of Equality and Prevention of Unfair Discrimination Act

seeks to reinforce the primacy of equality being a foundational value of the South African Constitutional system. [146]

According to the learned authors Pityana and Bohler-Muller, the central feature of the Equality Act is the establishment of the Equality Courts.[147] The sections of the Act [148] that

---

[139] Ibid at 3.
[140] Ibid.
[141] CERD was ratified by South Africa in 1998. Article 2 (d) of CERD states that ''each State Party shall prohibit and bring to an end, by all appropriate means, including legislation as required by circumstances, racial discrimination by any persons, group or organisation.'' Similarly, Article 2 (a) of CEDAW contains a matching provision which makes provisions for State Parties 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.''
[142] Pityana 'Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000' (2002) XLIV (1) *Codicillus* 2-9 at page 3-4.
[143] Ibid page 4.
[144] Ibid page 4.
[145] L Du Plessis 'Subsidiarity: What's in the name for Constitutional Interpretation and Adjudication?' (2006) 2 *Stellenbosch Law Review* 207-231 at 207. Similar sentiments were expressed in *Pillay* where the Constitutional Court stressed that ''claims brought under the Equality Act must be considered within the four corners of that Act. This means that a litigant cannot circumvent the Act by attempting to rely directly on the constitutional right entrenched in section 9. A Govindjee *Introduction to Human Rights Law* (2009) at page 80.
[146] Pityana 'Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000' (2002) XLIV (1) *Codicillus* 2-9 at page 4.
[147] Pityana 'Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000' (2002) XLIV 1 *Codicillus* 2-9 at page 8 and N Bohler-Muller 'The promise of equality courts' (2006) 22 *South African Journal on Human Rights* 380-404 at page 384. Established in terms of section 16 of the Promotion of Equality and Prevention of Unfair Discrimination Act. Equality Courts are discussed further in Chapter 5.
[148] 4 of 2000.

will assist in advancing the claims of HIV positive women who have been sterilised without their informed consent or coercively will be examined.

Before proceeding with the examination of the relevant sections it is imperative to ascertain what the Act prohibits and its scope. Section 6 of the Act[149] provides a very broad prohibition of unfair discrimination by stating that that no person may unfairly discriminate against any person on the ground of sex. No person encompasses the State as well.[150]

According to section 1 of the Act discrimination means ''any act or omission, including a policy, law, rule, practice, condition or situation which directly or indirectly; imposes burdens, obligations or disadvantage on; or withholds benefits, opportunities or advantages from any person on one or more of the prohibited grounds.''[151] For McGregor and Germishuys a violation of a person's dignity is the most significant factor in determining the grounds for making differentiation illegitimate and, consequently, discriminatory.[152]

The Promotion of Equality and Prevention of Unfair Discrimination Act lists a number of prohibited grounds of discrimination which are identical to the grounds listed in terms of section 9 (3) of our Constitution.[153] As of the 2 August 2017, HIV/AIDS has now been added to the prohibited grounds of discrimination.[154] In addition, the Promotion of Equality and Prevention of Unfair Discrimination Act goes further and states that a prohibited ground can also include any other ground. Discrimination based on that other ground is such when it:

(i) causes or perpetuates systemic disadvantage;

(ii) undermines human dignity; or

(iii) adversely affects the equal enjoyment of a person's rights and freedoms in a serious manner that is comparable to discrimination on a listed ground.[155]

It must be borne in mind that this is not a closed list as the Act makes provision for further grounds to be added to the list.[156] These grounds have been referred to as analogous grounds by certain authors[157] who state that differentiation on analogous grounds may also be constitutionally illegitimate as is now clearly stated by The Promotion of Equality and Prevention of Unfair Discrimination Act . The Constitutional Court has held that grounds

[149] Act 4 of 2000.
[150] Section 5 (1) of Act 4 of 2000.
[151] Act 4 of 2000.
[152] M McGregor & W Germishuys 'The taxonomy of an ''unspecified'' ground in discrimination law' (2014) 35 (1) *Obiter* 94-107 at 95.
[153] 1996 Constitution.
[154] Judicial Matters Amendment Act 8 of 2017, available at http://www.justice.gov.za/legislation/acts/2017-008.pdf accessed on 18 December 2017 at p 24.
[155] Section 1 (1) (xxii) (*b*) (i)-(iii).
[156] C Albertyn, B Goldblatt & C Roederer *Introduction to the Promotion of Equality and Prevention of Unfair Discrimination Act* (2001) 53.
[157] K Govender 'Equality, sexuality and taking rights seriously' (2008) 29 (1) *Obiter* 1-18 at 7.

such as citizenship[158] and HIV-status[159] are analogous grounds which are afforded protection by section 9 of the Constitution.[160]

The onus of proving that there has been discrimination rests with the complainant.[161] In other words, the complainant has to show that prima facie the discrimination as stipulated in section 1 was based on a ground listed in terms of the Act[162] or on an analogous ground. Discrimination based on a listed ground or analogous ground provided, that it qualifies as an analogous ground as required by the Act, is deemed to be discrimination.

### 4.3 The right to dignity

#### 4.3.1 Understanding the right to dignity in a South African context

The concept of dignity is a difficult one to define. Some authors such as Wood state that dignity means ''worthiness'' or ''excellence.''[163] This seems to imply that dignity is only accorded to persons who meet a certain standard. In terms of Kantian ethics, individuals must not be treated or perceived to be mere objects or instruments subject to the will of others.[164] All individuals, regardless of their position in society have intrinsic worth and every person must be respected.[165] Our Constitutional Court has followed the Kantian approach with Ackermann J stating in *Dodo v The State*,[166] that ''human beings are not commodities to which a price can be attached; they are creatures with inherent and infinite worth; they ought to be treated as ends in themselves, never merely as means to an end.''[167] Respect for the worth of every person, requires a recognition that a person is allowed to have their own feelings, beliefs, attitudes and ideals which, if changed by either physical or psychological coercion amounts to an affront on the dignity of that person.[168] Following on from this, a person's autonomy to make their own choices and be responsible for their own conduct irrespective of their position in society goes to the core of the right to

[158] See for example the case of *Larbi-Odam and Others v Member of the Executive Council for Education and Another* (CCT2/97) [1997] ZACC 16; 1997 (12) BCLR 1655 (CC); 1998 (1) SA 745 (CC) (26 November 1997).
[159] *Hoffmann v South African Airways* (CCT17/00) [2000] ZACC 17; 2001 (1) SA 1 (CC); 2000 (11) BCLR 1211; (CC) [2000].
[160] Govender 'Equality, sexuality and taking rights seriously' (2008) 29 (1) *Obiter* 1-18 at 7.
[161] Section 13 of Act 4 of 2000.
[162] 4 of 2002.
[163] A Wood 'Human dignity, right and the realm of ends' (2008) 1 *Acta Juridica* 47 – 65 at 48.
[164] O Schachter 'Human dignity as a normative concept' (1983) 77 (4) *The American Journal of International Law* 848-854 at 849.
[165] Ibid.
[166] *S v Dodo* (CCT 1/01) [2001] ZACC 16; 2001 (3) SA 382 (CC); 2001 (5) BCLR 423 (CC) (5 April 2001) at para 38 Ackermann J held that in instances where the length of a sentence, which has been imposed because of its general deterrent effect on others, bears no relation to the gravity of the offence. The offender is being used essentially as a means to another end and the offender's dignity assailed.
[167] Ibid.
[168] Schachter 'Human dignity as a normative concept' (1983) 77 (4) *The American Journal of International Law* 848-854 at 850.

dignity and respecting individuals.[169] This will also ring true even if the decision made by an individual is not objectively in their best interests. In *Barkhuizen v Naiper*[170] Ngcobo J held that ''self-autonomy, or the ability to regulate one's own affairs, even to one's own detriment, is the very essence of freedom and a vital part of dignity.''[171]

In *MEC for Education: KwaZulu-Natal and Others v Pillay*, our Chief Justice at the time, Justice Langa, held that a necessary element of dignity is the right to be respected for the unique set of ends that he or she pursues.[172] A number of other key elements of the right to dignity were enumerated in the Canadian Supreme Court case of *Law v Canada (Minister of Employment and Immigration)*.[173] This list of elements are useful as it provides us with an idea of the broad scope of the right to human dignity. Broadly, the Court stated that dignity includes a person's feeling of self-worth and right to autonomy with regard to a person's physical and psychological integrity and empowerment.[174] The court also linked the rights to equality and dignity.[175] In other words, unfair treatment which is based upon the personal traits or circumstances of a person has both the potential to infringe the right to equality and harm one's dignity.[176] Linking equality and dignity means that there is an acknowledgement of the contextual differences that exist between human beings and that a recognition of these differences will serve to enhance one's human dignity.[177] An example of how the Constitutional Court used this approach can be found in the case of *MEC for Education: KwaZulu-Natal and Others v Pillay* where O' Regan J stated that a learner who is seeking an exemption from a school rule should give reasons stating why this rule if applied uniformly would undermine their right to follow certain cultural practises.[178] It was submitted by the learned Judge that such a process (where other pupils and teachers would understand the significance of wearing a nose ring in terms of her culture) would have the effect of contributing towards the enhancement of human dignity and autonomy.[179] In this regard, the Court held that not allowing the learner to wear a nose ring in accordance with the South Indian culture resulted in a devaluation or a marginalisation of this sector of society and had the effect of harming their human dignity.[180]

---

[169] Ibid. In the *AB* case Khampepe J held that ''It is only by accepting that the opinions and decisions of each individual should be respected and encouraged that dignity is ensured.'' (CCT155/15) [2016] ZACC 43; 2017 (3) BCLR 267 (CC); 2017 (3) SA 570 (CC) (29 November 2016) at para 108.
[170] *Barkhuizen v Napier* (CCT72/05) [2007] ZACC 5; 2007 (5) SA 323 (CC); 2007 (7) BCLR 691 (CC) (4 April 2007).
[171] Ibid at para 57.
[172] (CCT 51/06) [2007] ZACC 21; 2008 (1) SA 474 (CC); 2008 (2) BCLR 99 (CC) (5 October 2007) at para 64.
[173] [1999] 1 RCS 497, available at https://scc-csc.lexum.com/scc-csc/scc-csc/en/1691/1/document.do accessed on 16 July 2018 at p 530.
[174] Ibid.
[175] Ibid.
[176] Ibid.
[177] Ibid.
[178] (CCT 51/06) [2007] ZACC 21; 2008 (1) SA 474 (CC); 2008 (2) BCLR 99 (CC) (5 October 2007) at para 177.
[179] Ibid.
[180] Ibid para 176.

In *Dawood and Another v Minister of Home Affairs and Others; Shalabi and Another v Minister of Home Affairs and Others; Thomas and Another v Minister of Home Affairs and Others*[181] the Court adopted a similar approach by capturing the different ways that dignity operates in our legal system:

> Human dignity therefore informs constitutional adjudication and interpretation at a range of levels. It is a value that informs the interpretation of many, possibly all, other rights. This Court has already acknowledged the importance of the constitutional value of dignity in interpreting rights such as the right to equality, the right not to be punished in a cruel, inhuman or degrading way, and the right to life. Human dignity is also a constitutional value that is of central significance in the limitations analysis. Section 10, however, makes it plain that dignity is not only a value fundamental to our Constitution, it is a justiciable and enforceable right that must be respected and protected. In many cases, however, where the value of human dignity is offended, the primary constitutional breach occasioned may be of a more specific right such as the right to bodily integrity, the right to equality or the right not to be subjected to slavery, servitude or forced labour.[182]

### 4.3.2 The right to dignity in international and regional law

A number of international human rights instruments acknowledge the concept of dignity and provide that it is a fundamental human right. Article 1 of the Universal Declaration of Human Rights recognises that all human beings are born free and equal in dignity and rights.[183] This implies that individuals possess both the ability to reason and act on their conscience.[184] The International Covenant on Civil and Political Rights[185] and the African Charter on Human and Peoples Rights[186] describe dignity as a right accorded to every person.

### 4.3.3 National law

#### 4.3.3.1 Section 10 of the Constitution of the Republic of South Africa, 1996

Woolman submits that in the South African constitutional context dignity operates in four varied ways: (i) dignity as a right; (ii) dignity that informs the right to equality; (iii) dignity as a correlative right and (iv) dignity as a foundational value.[187] The section below uses

---

[181] (CCT35/99) [2000] ZACC 8; 2000 (3) SA 936; 2000 (8) BCLR 837 (7 June 2000).
[182] Ibid para 35.
[183] Available at http://www.un.org/en/documents/udhr/history.shtml, accessed on 16 July 2018.
[184] Ibid.
[185] Article 10 states that ''All persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person.'' Available at https://www.ohchr.org/en/professionalinterest/pages/ccpr.aspx, accessed on 16 July 2018.
[186] Article 5 states that ''Every individual shall have the right to the respect of the dignity inherent in a human being and to the recognition of his legal status.'' Available at http://www.achpr.org/instruments/achpr/, accessed on 16 July 2018.
[187] S Woolman 'Dignity' in S Woolman & M Bishop (eds) *Constitutional Law of South Africa* 2 ed (2002-,OS12-05) 36.3.

Woolman's formulation to critically discuss the right to dignity as established in the constitutional era.

Section 10 of our Constitution creates the right to dignity. This right is given prominence by being placed as the second human right in the Bill of Rights directly after equality. This placement was recognised by Justice Langa when he stated that our Constitution places a very high premium on human dignity.[188] This section not only recognises that all persons have inherent dignity but also makes provision for one's dignity to be respected and protected through this independent, self-standing and enforceable right.[189] The mere fact that dignity occupies such a central role in our Constitution signifies the constitutional commitment to asserting dignity and to preventing us from returning to a system where the respect for black South Africans was cruelly denied.[190] In our post-apartheid era dignity will now be used to ensure that the intrinsic worth of all human beings is respected.[191] The Constitutional Court has interpreted the right to dignity very broadly so that it includes for example degrading, abusive, humiliating and demeaning treatment of another person as a non-human being which will qualify as a violation of the right to dignity.[192]

It is not surprising, that the early cases that have relied on dignity as a free-standing right, were challenges to unjust, oppressive and inhumane laws that were synonymous of the then political order of South Africa. The *Williams*[193] case is a good example of this approach. The issue before the Constitutional Court was whether the sentence of juvenile whipping which was permitted by section 294 of the Criminal Procedure Act was consistent with the constitutional provisions of equality, dignity, not to be subject to cruel, inhuman or degrading treatment or punishment and the rights of the child.[194] Langa J held that the act of whipping a sentenced juvenile violated their right to dignity and the right not to be subject to cruel, inhuman or degrading treatment or punishment.[195] The Court described this form of punishment as being "punishment of a particularly severe kind ... brutal in its nature ... a severe assault upon not only the person of the recipient but upon his dignity as a human being."[196] The component parts of this type of punishment were uncivil and objectionable in a society in which the right to dignity is enshrined in the Constitution. In this case, Langa J highlighted that the State appoints a stranger to intentionally inflict

[188] *S v Williams and Others* (CCT20/94) [1995] ZACC 6; 1995 (3) SA 632 ; 1995 (7) BCLR 861 (CC) (9 June 1995) at para 76.
[189] De Vos & Freedman *South African Constitutional Law in Context* (2014) 456.
[190] *Dawood and Another v Minister of Home Affairs and Others; Shalabi and Another v Minister of Home Affairs and Others; Thomas and Another v Minister of Home Affairs and Others* at para 35.
[191] Ibid.
[192] De Vos & Freedman *South African Constitutional Law in Context* (2014) 456.
[193] (CCT20/94) [1995] ZACC 6; 1995 (3) SA 632; 1995 (7) BCLR 861 (CC) (9 June 1995).
[194] Ibid at paras 1 and 15.
[195] Ibid at para 92. In light of this pronouncement, the Judge did not deem it necessary to enquire into whether the offending provision violated the other two rights relied on.
[196] Ibid at para 11.

physical pain on the juvenile.[197] This act was held not only to be incompatible with respect for the dignity of the juvenile but also the stranger administering the whipping.[198]

The Court in expressing its disquiet about this type of punishment endorsed the dictum from the American case of *Furman v Georgia* which dealt with capital punishment, where Brennan J held that:

> members of the human race are treated as nonhumans, as objects to be toyed with and discarded ...[and that this is] ... thus inconsistent with the fundamental premise of the Clause that even the vilest criminal remains a human being possessed of common human dignity.[199]

It was further submitted by the Court that an enlightened society will meter out punishment to transgressors of the law without sacrificing decency and human dignity.[200]

The Constitutional Court has also interpreted the right to dignity broadly so that it protects an individual's family relationships. In *Dawood's* case[201] it was argued that section 25 (9) (*b*) of the Aliens Control Act had the effect of denying spouses the right to live together which in turn affected their ability to sustain and have permanent intimate family relationships.[202] The affected spouses submitted that this contravened their rights to freedom of movement and that of citizens to reside in South Africa.[203] Inasmuch as O'Regan J noted that the impugned section of the Aliens Control Act may well have had the effect of limiting the rights relied on, she was of the view that the primary right offended in this instance was the right to dignity.[204] The Judge further held that legislation that had the effect of denying spouses the ability to enter into marriage relationships and honour their obligations to each other constituted an infringement of their dignity.[205]

The *Petersen v Maintenance Officer and Others*[206] case is another instance of where the right to dignity was relied on. The applicant, the mother of a child born out of marriage, submitted that her child's right to dignity was violated by the common law rule that prohibited maintenance from being claimed from the paternal grandparents of a child.[207] The court held that the common law rule that differentiated between children born out of marriage and those born out of an extra-marital relationship affected them in two ways.[208] The first being that they were denied the right to be supported by their paternal

[197] Ibid at para 17.
[198] Ibid.
[199] Ibid at para 28.
[200] Ibid at para 68.
[201] (CCT35/99) [2000] ZACC 8; 2000 (3) SA 936; 2000 (8) BCLR 837 (7 June 2000).
[202] Ibid at paras 27 and 36.
[203] Ibid at para 36.
[204] (CCT35/99) [2000] ZACC 8; 2000 (3) SA 936; 2000 (8) BCLR 837 (7 June 2000) at para 36.
[205] Ibid.
[206] (6541/03) [2003] ZAWCHC 61; [2004] 1 All SA 117 (C) (11 November 2003).
[207] Ibid at para 7.
[208] Ibid at para 19.

grandparents and the second being that this differentiation meant that they do not possess the same inherent worth and dignity that children born out of marriage do.[209]

In *Mayelane v Ngwenyama and Another*,[210] the first wife (the applicant) in a customary marriage challenged her late husband's customary marriage to his second wife (the respondent) on the basis that her consent for him to enter into a further marriage was not obtained.[211] The applicant alleged that the act of dispensing with her consent amounted to a violation of her right to dignity. In the main judgment of the Court, it was held that given the sacredness of the institution of a marriage coupled with the fact that it is highly personal in nature, the first wife's dignity will be violated by the bringing in of a new partner into the relationship without her consent.[212] It was further held by the Court that the ramifications for the first wife in instances where a subsequent customary marriage is entered into without her consent are manifold.[213] The repercussions for the first wife are that she cannot make informed decisions about the proprietary consequences of the new customary union, her personal life and her sexual or reproductive health.[214] The court held that the right to dignity encompasses the ability of the holder of the right to make key decisions about his or her life.[215] In instances where the decision to be taken is of great significance to the person, the entitlement to this justiciable right is greater.[216] Self-determination and having control over one's personal circumstances is a key aspect of human dignity.[217] The Court concluded that a first wife cannot have effective control over her family life when her husband dispenses with her consent to take a second wife, this amounts to a lack of respect for her human dignity.[218]

The *Dawood, Petersen and Mayelane* cases are examples that show the broad way that dignity as a right is used to promote the inherent respect of every individual. It is clear from these cases that dignity as a right is used broadly to encompass instances where family relationships and violations of duties emanating from them have occurred.

Our Constitution views dignity as a right and value. It explicitly sets out a quartet of founding values within which we as a society must operate.[219] For the purposes of this

---

[209] Ibid.
[210] (CCT 57/12) [2013] ZACC 14; 2013 (4) SA 415 (CC); 2013 (8) BCLR 918 (CC) (30 May 2013).
[211] Ibid at para 1.
[212] Ibid at para 74
[213] Ibid at para 72.
[214] Ibid.
[215] Ibid at para 73.
[216] Ibid.
[217] Ibid.
[218] (CCT 57/12) [2013] ZACC 14; 2013 (4) SA 415 (CC); 2013 (8) BCLR 918 (CC) (30 May 2013) at para 73.
[219] Section 1 of the Constitution of the Republic of South Africa, 1996 states that ''The Republic of South Africa is one, sovereign, democratic state founded on the following values:
(a) Human dignity, the achievement of equality and the advancement of human rights and freedoms.
(b) Non-racialism and non-sexism.
(c) Supremacy of the constitution and the rule of law.

dissertation the first set of values enshrined in section 1 (*a*)[220] are of importance to us namely; ''human dignity, the achievement of equality and the advancement of human rights and freedoms.'' The recognition of dignity as one of the founding values of our Constitution is significant.[221] Dignity was not recognised as a founding value in the interim Constitution whilst the values of democracy, freedom and equality occupied centre stage.[222] In an academic article, Chaskalson highlighted that even though dignity was ingrained in these values, the role of dignity was not acknowledged until the adoption of the final Constitution.[223] This significant shift, that is, the affirmation of inherent human dignity as a foundational value, aligned the South African legal order firmly with the development of a culture of constitutionalism.[224] Accordingly, the language and focus of our Constitution now measures up to the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights and African Charter on Human and Peoples Rights, which are key international and regional human rights instruments.[225] These instruments all place considerable weight on the inherent worth and dignity of human persons.[226]

South Africa's post-constitutional jurisprudence has relied extensively on dignity being a foundational value when called upon to adjudicate on an array of issues. In the landmark decision of *S v Makwanyane*[227] not only did the right to life which is firmly intertwined with the right to dignity receive well-deserved attention but dignity as a founding value was recognised.[228] This acknowledgement, according to Judge O'Regan was symbolic as it appreciated the fact that as a starting point, ''human beings are entitled to be treated as worthy of respect and concern.''[229] This is so especially taking into account that apartheid denied black people respect, dignity and common humanity.[230] Further, the Judge opined that the ''recognition and protection of human dignity is the touchstone of the new political order and is fundamental to the new constitution.''[231] Similar sentiments regarding dignity being recognised as a foundational value in our Constitution, were expressed by the same Judge in *Dawood's*[232] case. In *Barkhuizen's* case Ngcobo J held that the Bill of Rights

---

(d) Universal adult suffrage, a national common voters roll, regular elections and a multi-party system of democratic government, to ensure accountability, responsiveness and openness".

[220] Constitution of the Republic of South Africa, 1996.

[221] Chaskalson 'Human dignity as a foundational value of our constitutional order' (2000) 16 (2) *The South African Journal on Human Rights* 193-205 at p 196.

[222] Ibid.

[223] Ibid.

[224] Ibid.

[225] Ibid at 196-197.

[226] Ibid.

[227] (CCT3/94) [1995] ZACC 3; 1995 (6) BCLR 665; 1995 (3) SA 391; [1996] 2 CHRLD 164; 1995 (2) SACR 1 (6 June 1995). The death penalty was abolished in South Africa.

[228] Ibid.

[229] (CCT3/94) [1995] ZACC 3; 1995 (6) BCLR 665; 1995 (3) SA 391; [1996] 2 CHRLD 164; 1995 (2) SACR 1 (6 June 1995) at para 328.

[230] Ibid at para 329.

[231] Ibid.

[232] (CCT35/99) [2000] ZACC 8; 2000 (3) SA 936; 2000 (8) BCLR 837 (7 June 2000).

''enshrines the rights of all people in our country and affirms the democratic founding values of human dignity, equality and freedom."[233]

Dignity as a value has also been invoked in matters where socio-economic rights were being accessed. *In the Government of the Republic of South Africa and Others v Grootboom and Others*[234] the right to housing was invoked in terms of section 26 of the Constitution.[235] Yacoob J stated that there can be no human dignity in instances where people are denied basic necessities like shelter, food and clothing.[236] In terms of the constitutional provision regarding housing, the State is required to take reasonable action to see this materialise and in doing so must have in particular, regard for human dignity.[237] In *Minister of Health and Others v Treatment Action Campaign and Others (No 2)*[238] the respondents sought an order compelling the appellants to make nevirapine (an antiretroviral drug that has the effect of significantly reducing mother-to-child transmission of HIV) available in public health facilities. [239] In refusing to do so the appellants were effectively denying poor women and their new born babies access to ''simple, cheap and potentially life-saving intervention.''[240] Liebenberg argues that this would clearly show a lack of respect for their dignity and self-worth.[241] In doing so, the Court held that ''no one should be condemned to a life below the basic level of dignified human existence.''[242] What is evident is that these rights can only be realised within the available financial constraints of the State, however, at a minimum, human dignity must be taken into account at the very least when setting minimum standards.[243] Liebenberg submits that the *Grootboom* case invoked dignity as the central value when interpreting the reasonableness requirement attached to the fulfilment of socio-economic rights.[244] She further argues that if we are to pride ourselves as a society that respects human dignity there must be a commitment to redressing the social and economic conditions of those who are stricken by poverty.[245]

The Constitutional Court has adopted the approach that the rights contained in the Bill of Rights are ''mutually interrelated and interdependent and form a single constitutional value system.''[246] It is submitted that this is evident as in very few instances do litigants rely solely

[233] (CCT72/05) [2007] ZACC 5; 2007 (5) SA 323 (CC); 2007 (7) BCLR 691 (CC) (4 April 2007) at para 28.
[234] (CCT11/00) [2000] ZACC 19; 2001 (1) SA 46; 2000 (11) BCLR 1169 (4 October 2000).
[235] Constitution of the Republic of South Africa, 1996
[236] (CCT11/00) [2000] ZACC 19; 2001 (1) SA 46; 2000 (11) BCLR 1169 (4 October 2000) at para 23.
[237] Ibid at para 83.
[238] (CCT8/02) [2002] ZACC 15; 2002 (5) SA 721; 2002 (10) BCLR 1033 (5 July 2002).
[239] Ibid at para 2.
[240] Ibid at para 73.
[241] S Liebenberg 'South Africa's evolving jurisprudence on socio-economic rights: an effective tool in challenging poverty' (2002) 6 (2) Law*, Democracy and Development* 159 at 13.
[242] (CCT8/02) [2002] ZACC 15; 2002 (5) SA 721; 2002 (10) BCLR 1033 (5 July 2002) at para 28.
[243] Ibid.
[244] Liebenberg 'South Africa's evolving jurisprudence on socio-economic rights: an effective tool in challenging poverty' (2002) 6 (2) Law*, Democracy and Development* 159 at 3.
[245] Ibid at 12.
[246] *De Reuck v Director of Public Prosecutions (Witwatersrand Local Division) and Others* (CCT5/03) [2003] ZACC 19; 2004 (1) SA 406 (CC); 2003 (12) BCLR 1333 (CC) (15 October 2003).

on the self-standing right to dignity, instead, its value and use as a correlative right particularly in relation to equality and freedom is common. The symbiotic and interdependent nature of the right to dignity is captured by a vast body of case law which shows the interplay between the right to dignity and the rights to freedom, life and equality.[247] Key principles will be extracted from selected cases to depict how dignity interrelates with other listed rights.

In *Ferreira v Levin NO and Others; Vryenhoek and Others v Powell NO and Others*,[248] the court had to make a finding on whether section 417 (2) (*b*) of the Companies Act which had the potential to infringe the rule against self-incrimination was inconsistent with the right to freedom as protected by section 11 (1) of the interim Constitution.[249] Writing for the majority judgment of the Court, Ackermann J held that ''freedom and dignity are inseparably linked.''[250] The Judge continued by stating that in instances where an individual's personal development and fulfilment was stymied there can be no freedom; conversely, human dignity will have no worth and amount to nothing more than an idea without freedom.[251]

In the recent *AB*[252] case the primary right relied on was the right to freedom and security of the person. Coupled with that, reliance was placed on the right to dignity as a correlative right.[253] In this context, it was alleged that placing limitations on AB's reproductive autonomy was tantamount to a violation of her inherent dignity as it effectively prevented her from making her own reproductive choices.[254] Similarly, in cases of involuntary sterilisations of HIV positive women where, their right to bodily and psychological integrity were violated, this invasion would go to the core of their dignity as it takes away their ability to make choices freely about their reproductive health.

One of the key reasons behind the decision in *Makwanyane's*[255] case, which marked the end of capital punishment in South Africa, was the close-knit relationship between the rights to life and dignity. The first President of our Constitutional Court, Judge Chaskalson in his judgment, set out the purpose of South Africa moving into an era of constitutional democracy, which also served to facilitate the process of judicial review of legislation.[256] The primary purpose was to protect the rights of minorities, marginalised groups and social

[247] Woolman 'Dignity' in Woolman & Bishop (eds) *Constitutional Law of South Africa: Dignity* 2 ed (2002-,OS12-05) 36.3.
[248] (CCT5/95) [1995] ZACC 13; 1996 (1) SA 984 (CC); 1996 (1) BCLR 1 (6 December 1995).
[249] Ibid at para 2.
[250] Ibid at para 49.
[251] Ibid.
[252] (CCT155/15) [2016] ZACC 43; 2017 (3) BCLR 267 (CC); 2017 (3) SA 570 (CC) (29 November 2016).
[253] Ibid.
[254] Ibid at para 12.
[255] (CCT3/94) [1995] ZACC 3; 1995 (6) BCLR 665; 1995 (3) SA 391; [1996] 2 CHRLD 164; 1995 (2) SACR 1 (6 June 1995).
[256] Ibid at para 88.

outcasts in our society.[257] It is only through safeguarding the rights of the weakest in society that we can be assured of the protection of our own rights.[258] Judge Langa concurring with Judge Chaskalson placed a greater emphasis on the right to life.[259] The elevation of the right to life over dignity was motivated by the past patterns of mistreatment of the majority of South Africa's people.[260] The political and social order resulted in unrest at the time in which the culture of violence and retaliation thrived.[261] The respect for human life and human dignity were sacrificed by the State in two respects.[262] The first being by virtue of their involvement in the conflicts of the past and the second having in place punishments that did not accord with the respect for human life and dignity.[263] This served to diminish the value of human life and one's dignity.[264] At the epicentre of this case were the rights to life and dignity of the criminal.[265] The court described this twin set of rights as taking precedence over all other human rights and being the source of all other personal rights in the Bill of Rights.[266] The judgment by the Court showed the way in which the rights to life and dignity mutually re-inforce each other. As held by Justice O'Regan the right to life cannot be reduced to mere existence of a human being but ''it is a right to be treated as a human being with dignity: without dignity, human life is substantially diminished. Without life, there cannot be dignity.''[267]

Malherbe holds the view that ''equality cannot be pursued in isolation from human dignity and freedom.''[268] Dignity as a guiding principle is the vehicle that drives all equality litigation.[269] This operates in three specific instances: (i) when discrimination on an unlisted ground is alleged.[270] In these instances, the test in *Harksen's* case will be used and an enquiry into whether the 'differentiation in question has the effect of impairing one's dignity';[271] (ii) dignity will be used as a lodestar when determining whether the discrimination is fair in instances where the differentiation is based on one of specified or unspecified grounds[272] and (iii) where the discrimination has been deemed unfair it will have to pass through the limitations clause which enquires into whether the unfairness is

[257] Ibid.
[258] Ibid.
[259] Ibid at para 218.
[260] Ibid.
[261] Ibid.
[262] Ibid.
[263] Ibid.
[264] Ibid.
[265] Ibid at para 144.
[266] Ibid.
[267] Ibid at para 327.
[268] R Malherbe 'Some thoughts on unity, diversity and human dignity in the new South Africa' (2007) 1 *Tydskrif vir die Suid-Afrikaanse Reg* 127 – 133 at 130.
[269] S Cowen 'Can dignity guide South Africa's equality jurisprudence?' 2001 17 (1) *The South African Journal on Human Rights* 34 – 58 at 34.
[270] Ibid at 36.
[271] Ibid at 34.
[272] Cowen 'Can dignity guide South Africa's equality jurisprudence?' 2001 17 (1) *The South African Journal on Human Rights* 34 – 58 at 36.

justifiable based on the founding values of the Constitution where human dignity occupies a central space.[273] According to Cowen, this in essence means that ''it is primarily a violation of dignity that offends the equality clause. Put differently, protecting dignity is viewed as the desired outcome, or objective, of placing a value on equality.''[274]

It is submitted by the learned authors that the ills of stigma, stereotyping, prejudice and humiliation are capable of being addressed by the core notion of dignity but this is not as straightforward in instances where substantive equality is concerned.[275] It is further submitted that the reliance of dignity on its own is not ideal and in order to mitigate this shortcoming, cognisance must be given to other values like redressing social and economic disadvantage, promoting participation and by bringing about structural change by accommodating differences.[276]

The close relationship between dignity and equality was illustrated in the cases of *National Coalition for Gay and Lesbian Equality and Another v Minister of Justice and Others*[277] and *Minister of Home Affairs and Another v Fourie and Another*.[278] The Court as per Ackermann J held in the *National Coalition for Gay and Lesbian Equality* case that the criminalisation of consensual sodomy in private between consenting men could not pass constitutional muster as it violated their right not only to equality but also of dignity.[279] This type of discrimination against gay men had severe and grave impacts on them as the conduct complained of would not be a crime if committed between a woman and another woman or between a man and woman.[280] Ackermann J held that even though the central argument of the case was based on the right to equality and more especially the discriminatory treatment of gay men by targeting them as criminals, this also infringed on their right to dignity.[281] The protection of dignity forces us to acknowledge the self-worth of all individuals regardless of their sexual orientation and differences.[282] Therefore, legislation which devalues the conduct of a vulnerable group in our society for being who they are, strikes at the heart of infringing on one's dignity.[283]

Sachs J concurring with Judge Ackermann's judgment, took the baton further and re-visited the judiciary's approach to our equality jurisprudence after hearing argument from an amici regarding the role of dignity in matters where equality was challenged.[284] The basis of the

[273] Ibid at 37.
[274] Ibid at 40.
[275] C Albertyn and S Fredman 'Equality beyond dignity: Multi-dimensional equality and Justice Langa's judgments' (2015) 1 *Acta Juridica* 430 – 455 at 431.
[276] Ibid.
[277] (CCT11/98) [1998] ZACC 15; 1999 (1) SA 6; 1998 (12) BCLR 1517 (9 October 1998).
[278] (CCT 60/04) [2005] ZACC 19; 2006 (3) BCLR 355 (CC); 2006 (1) SA 524 (CC) (1 December 2005).
[279] (CCT11/98) [1998] ZACC 15; 1999 (1) SA 6; 1998 (12) BCLR 1517 (9 October 1998) at para 30.
[280] Ibid at para 2.
[281] Ibid at para 28.
[282] Ibid.
[283] Ibid.
[284] (CCT11/98) [1998] ZACC 15; 1999 (1) SA 6; 1998 (12) BCLR 1517 (9 October 1998) para 120.

attack was two pronged: (i) it was contended that the purpose of the equality clause is to advance equality and not dignity and (ii) the job of section 9 (1) being the grantor of substantive equality, is diminished to that of a gatekeeper for claims where a violation of dignity is alleged.[285] Sachs J, in addressing the argument, held that Ackermann J promoted substantive equality by addressing the disadvantage and prejudice that members of the gay community faced and how this impinged on their dignity and sense of self-worth.[286] Further, Sachs J held that by keeping human dignity at the core of equality jurisprudence it acknowledges our country's unique history and places us firmly in the context of evolving human rights concepts worldwide.[287]

The learned Judge held that there is a distinction between the violation of dignity under the equality provisions and the self-standing dignity right.[288] The violation of dignity as an independent right extends to a much broader range of situations.[289] It offers protection to individuals in their different ''multiple identities and capacities.'' This could range from being disrespected or to being treated differently because of the situation that they find themselves in.[290] This indignity of treatment will have the effect of leading to inequality as opposed to inequality producing indignity.[291]

Accordingly, Sachs J held that dignity and equality should not be viewed as competing values but rather as complementary values.[292] Further, it was held that an infringement of one's dignity is more easily ascertained when there exits an inequality of power and status between the violator and the victim.[293] This rings true especially in the case of vulnerable HIV positive women who are pitted against well-educated health care professionals. This elevated status and unequal power dynamic between health care practitioners and HIV positive women may impact on their ability to make highly personal decisions about their reproductive health.

The manner in which the unequal treatment of individuals on the enumerated grounds listed in section 9 (3) is experienced varies markedly, however the central unifying feature is injury to their dignity because of their differences.[294] It is submitted that this is how dignity in the context of equality has to be understood.[295]

[285] Ibid.
[286] Ibid.
[287] Ibid at para 123.
[288] Ibid at para 124.
[289] Ibid.
[290] Ibid.
[291] Ibid.
[292] Ibid para 125.
[293] Ibid.
[294] Ibid para 126.
[295] Ibid.

In *Minister of Home Affairs and Another v Fourie and Another*[296] the Constitutional Court endorsed Judge Cameron's Supreme Court of Appeal majority judgment. Judge Cameron held that the capacity of gay and lesbian couples to marry enhances their autonomy, liberty and dignity, which the common law definition of marriage violates.[297] The conclusion to be drawn from this instance is that the inherent dignity, self-worth and self-respect of heterosexual couples differs from that of individuals who are in same-sex relationships.[298] Judge Sachs held that in dealing with cases where the rights of same-sex couples were violated and the equality clause was invoked, the values and concepts of human dignity, equality and freedom play an extremely pivotal role.[299] The impact on the self-worth and dignity of same-sex couples who were denied the opportunity of entering into a legal union could only be assessed through our equality jurisprudence.[300]

The elevated position that dignity occupies in the equality analysis is not without criticism. Albertyn and Fredman raise several concerns around the right to equality being reduced to the single value of dignity.[301] The challenges aired by Albertyn and Fredman are (i) ''can dignity act as a placeholder for all the inequalities and harms that the idea of substantive equality seeks to address?''[302] (ii) is there no room for other principles and values in assessing whether the equality right has been violated?[303] and (iii) whether dignity on its own is not too individualistic with its focus being on stigma harms instead of broader socio-economic disadvantage?''[304] It is submitted, that given South Africa's history it is not possible to fully articulate the right to equality without the link to dignity. Discrimination in our past aimed not only at unequal treatment but also at devaluing the inherent human dignity of all persons who were not white.

### 4.4 Discussion

Even though, the global response to HIV is based on human rights principles including non-discrimination, it should then by logical extension, include the protection of the sexual and reproductive health rights of HIV positive women. It is clear that stigma and discrimination continue to fuel the way in which health care workers treat women living with HIV who seek sexual and reproductive health services.[305] The long standing practice of sterilising women globally for an assortment of reasons is widespread. These reasons have ranged from

[296] (CCT 60/04) [2005] ZACC 19; 2006 (3) BCLR 355 (CC); 2006 (1) SA 524 (CC) (1 December 2005).
[297] Ibid at para 16.
[298] Ibid at para 50.
[299] Ibid at para 48.
[300] Ibid at para 151.
[301] Albertyn and Fredman 'Equality beyond dignity: Multi-dimensional equality and Justice Langa's judgments' (2015) 1 *Acta Juridica* 430 – 455 at p 430.
[302] Ibid at 431.
[303] Ibid.
[304] Ibid.
[305] P Patel 'Forced sterilization of women as discrimination' (2017) 38 (15) *Public Health Reviews* 1-12 at 8.

physical and mental disability;[306] race and ethnicity;[307] poverty and illiteracy;[308] population control;[309] and as a pre-requisite for employment.[310] The HIV positive status of women has now become the new focus for those wanting to practise eugenics.[311] The modus operandi used by many medical practitioners and nurses in coercing or forcing HIV positive pregnant women to be sterilised is varied and reflects the multiple levels of intersectional discrimination. It appears that in many cases, given that there is no policy requiring HIV positive women to be sterilised, the actions of health care workers reflect those of the community they come from and the high level of blame that is levelled at women who become HIV positive. For example, a sterilisation is offered to HIV positive women as a trade-off for something that may be more desirable to her at that time.[312] The incentives offered to these women range from accessing medical treatment, to obtaining milk formula for their new born babies and to receiving payment of their hospital bills.[313] Health care workers have also been accused of exaggerating the medical condition of HIV in order to use fear as a means to obtain their consent.[314] In other cases women are provided with inaccurate information regarding the permanency of the procedure when obtaining an HIV positive pregnant woman's consent to be sterilised.[315] In some cases women were informed that they would not get medical attention unless they agreed to the sterilisation. An account given by one Kenyan woman of being coercively sterilised lends support to the prevalence of this practice. She said that ''*when they insisted on tubal ligation, I signed the*

[306] Open Society Foundations 'Against her will: forced and coerced sterilization of women worldwide' [2012] 6, available at https://www.opensocietyfoundations.org/sites/default/files/against-her-will-20111003.pdf accessed on 2 November 2017.
[307] As shown in the case of *V. C. v. Slovakia* where ethnicity was the reason for the coerced sterilisations of the women. Application no. 18968/07 European Court of Human Rights available at http://www.menschenrechte.ac.at/orig/11_6/V.C..pdf accessed on 1 July 2015.
[308] Open Society Foundations 'Against her will: forced and coerced sterilization of women worldwide' [2012] 4, available at https://www.opensocietyfoundations.org/sites/default/files/against-her-will-20111003.pdf accessed on 2 November 2017.
[309] G Chamberlain 'UK aid helps to fund forced sterilization of India's poor' *The Guardian* 15 April 2012, available at https://www.theguardian.com/world/2012/apr/15/uk-aid-forced-sterilisation-india accessed on 2 November 2017.
[310] Open Society Foundations 'Against her will: forced and coerced sterilization of women worldwide' [2012] 6, available at https://www.opensocietyfoundations.org/sites/default/files/against-her-will-20111003.pdf accessed on 2 November 2017.
[311] This has been documented in South Africa, Namibia, Zimbabwe, Uganda, Kenya, Chile, Mexico, Venezuela and the Dominican Republic.
[312] Essack & Strode 'I feel like half a women all the time: The impacts of coerced and forced sterilisations on HIV-positive women in South Africa' (2012) 26 (2) *Agenda* 24.
[313] *SWK and others v Médecins Sans Frontières and others* Petition No. 605 of 2014, in the High Court of Kenya at Nairobi Constitutional and Human Rights Division at paras 4 and 10.
[314] Application no. 18968/07 European Court of Human Rights available at http://www.menschenrechte.ac.at/orig/11_6/V.C..pdf accessed on 1 July 2015 at para 1.
[315] Essack & Strode 'I feel like half a women all the time: The impacts of coerced and forced sterilisations on HIV-positive Women in South Africa' (2012) 26 (2) *Agenda* 24.

*documents so that they could attend to me and relieve me of the pain I was going through*.''[316]

The category of women targeted for forced or coerced sterilisations forms part of the poor, vulnerable, illiterate and marginalised women in our community. Their poverty is used as a bargaining tool in exchange for consent. This is evidenced by the narrative of Aida a Kenyan women who stated that:

> ''*I visited Blue House and was told that I had to think about tubal ligation because I was a mother who was HIV positive and had many children. I said I did not want to because there were many methods of family planning but I was told if I did not undergo tubal ligation I would not receive the drugs again and should think of what to do after that as I would not be given the milk again*.''[317]

Similarly, another Kenyan woman Emma related her experience of being coerced into being sterilised in lieu of payment for her maternity bill:

> *''the nurse told me if I did not agree to tubal ligation then Blue House will not take care of my maternity expenses. I got to Pumwani and I was given a form, the nurses insisted I had to sign. They called me a useless woman with HIV. I took the form and signed it because I was kept waiting in the labour ward until I signed.*''[318]

Illiteracy and fear are also used as tools to coerce HIV positive mothers into being sterilised. One women stated that, in response to her question as to why she was being discriminated against because of her positive status, a nurse replied that ''*it is illegal for HIV positive women to have children.*''[319] A doctor who was discussing sterilisation as the only option for a contraceptive with an HIV pregnant mother, told her that ''*since I am about to die, I cannot give birth to a healthy child and took me to a ward that had children with extreme Aids-related infections so that I could decide if I still had the desire to have a child.*''[320] Women have also reported being told by medical practitioners and nurses that their HIV positive status prevented them from becoming mothers and if they continued to have children they would die.[321]

Research conducted in South Africa, Kenya and Namibia has shown that women are being sterilised forcibly or coercively on the basis of their HIV positive status. This is described in detail in Chapter 2. This form of discriminatory treatment which undermines human dignity

---

[316] African Gender and Media Initiative 'Robbed of choice: Forced and coerced sterilization experiences of women living with HIV in Kenya' (2012) 2, available at http://kelinkenya.org/wp-content/uploads/ 2010/10/ Report-on-Robbed-Of-Choice-Forced-and-Coerced-Sterilization-Experiences-of-Women-Living-with-HIV-in-Kenya.pdf accessed on 1 July 2015.
[317] Ibid at 22.
[318] Ibid at 24.
[319] Ibid at 25.
[320] Ibid at 3.
[321] Ibid at 8, 14, 17 and 26.

is strongly condemned in our legal framework. In this regard, South Africa is unique as it has specialist equality legislation which could be used by women living with HIV who wish to vindicate their rights.

The Promotion of Equality and Prevention of Unfair Discrimination Act aims at addressing unfair discrimination. HIV positive women wishing to challenge their forced or coerced sterilisation on the basis of discrimination have the option of seeking redress through an Equality Court and relying on the provisions of the Promotion of Equality and Prevention of Unfair Discrimination Act to advance their claims. There are a number of advantages in pursuing legal relief through this avenue. It is submitted that the most significant advantage would be that HIV/AIDS is now included as one of the prohibited grounds of discrimination in terms of the Act.[322] This inclusion has the effect of shifting the evidentiary burden to the party that is alleged to be responsible for the discriminatory conduct, as discrimination on a listed ground is unfair.[323] In our situation, the Minister of Health would have to show on a balance of probabilities that the discrimination was fair. It may be argued that this would be a difficult onus to discharge as the Promotion of Equality and Prevention of Unfair Discrimination Act is prescriptive on what factors need to be taken into account by the Equality Court before making a determination of fair discrimination.[324] For our purposes, an enquiry must be set into motion assessing whether sterilising women on the basis of their HIV positive status, reasonably and justifiably differentiates between persons;[325] whether discrimination against HIV positive women has a legitimate purpose[326] and whether there are other methods of family planning that could be suggested to HIV positive women rather than ending their ability to have more children.[327] It is submitted that the Minister of Health may have difficulty in convincing the Equality Court that sterilising HIV positive women serves a legitimate purpose as it is contrary to the principles in the National Contraceptive Guidelines. In addition, the Minister of Health would have to justify why these women were singled out to be sterilised under very coercive circumstances such as during advanced labour.

A further benefit of using the Equality Act is that it does not specifically require discrimination to be systemic in nature or for there to be a policy or practice in place before deeming the conduct to be discriminatory. The Act regards discrimination as being ''any act or omission, including a policy, law, rule, practice, condition or situation which has the effect of imposing burdens or withholding benefits on one or more of the prohibited grounds.''[328]

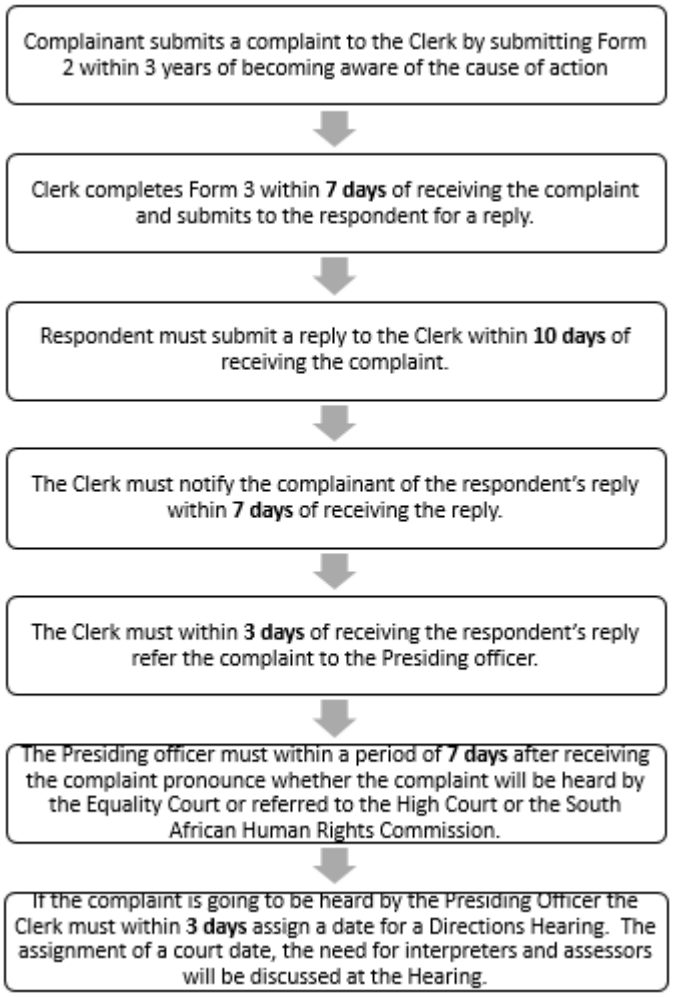
---

[322] HIV/AIDS has been added to the seventeen listed grounds of discrimination as of the 2 August 2017 in terms of the Judicial Matters Amendment Act 8 of 2017, GG 41018, p 24, available at http://www.justice.gov.za/legislation/acts/2017-008.pdf.
[323] Section 13 (2) (*a*) of Act 4 of 2000.
[324] Section 14 (2) and (3) of Act 4 of 2000.
[325] Section 14 (2) (*c*) of Act 4 of 2000.
[326] Section 14 (3) (*f*) of Act 4 of 2000.
[327] Section 14 (3) (*h*) of Act 4 of 2000.
[328] Section 1 of Act 4 of 2000.

Thus, although the Slovakian cases[329] seemed to require evidence of a particular policy which targeted particular women, this ought not to be a requirement in our context. This dissertation has shown that there is no policy of targeting HIV positive women for sterilisation in South Africa, however it has been a practice in certain circumstances.[330]

Approaching the Equality Court is affordable and expeditious. HIV positive women who wish to litigate in this forum do not require the services of a legal representative. They will be assisted by trained court officials in completing the complaint forms should they experience difficulty in doing so.[331] The diagram below outlines the process that must be followed when bringing a claim to the Equality Court[332]:

[329] *V. C. v Slovakia* Application no. 18968/07 European Court of Human Rights, available at http://www.menschenrechte.ac.at/orig/11_6/V.C..pdf accessed on 1 July 2015.
[330] Strode et al '"She made up a choice for me'': 22 HIV-positive women's experiences of involuntary sterilization in two South African provinces' (2012) 20 (39S) *Reproductive Health Matters* 1-9.
[331] J Keller 'Effective rights-based responses...? The NSP response to gender violence' (2012) 38 at 41-2, available at file:///C:/Users/badulc/Downloads/ALQ_March_April_2012.pdf accessed on 26 December 2017.
[332] JJ Hahn 'Your guide to the South African equality courts: A step by step process to empower paralegals, community leaders and human rights educators' (2015) 6-7, available at http://www.legal-aid.co.za/wp-content/uploads/2015/11/Equality-Court-Handbook-2015.pdf accessed on 26 December 2017.




A period of 37 days lapses from the date of lodging the complaint to obtaining a court date. This is an extremely short period of time compared to litigating in the High Court where it can take between six months to two years to obtain a trial date.[333] A further key feature of the Act[334] is the broad range of relief that can be ordered. It is submitted that the most appropriate form of relief that the Court should order where women have been sterilised for being HIV positive is (i) an award of damages.[335] This will enable women to use the amount awarded for damages to obtain reversals or assisted reproduction. It is submitted that the presiding officer ought to be guided by the amount of damages being awarded in cases such as *Sparrow*[336] and the only South African specific HIV coercive sterilisation out of

[333] S Pete & D Hulme et al *Civil Procedure: A Practical Guide* 3 ed (2017) at 263.
[334] 4 of 2000.
[335] Section 21 (2) (*d*) of Act 4 of 2000.
[336] (01/16) [2016] ZAEQC 1 (10 June 2016).

court settlement.[337] (ii) An unconditional apology from the medical practitioners concerned for their actions.[338] An apology is an important restorative step as it recognises that HIV positive women's dignity was undermined by taking away their ability to choose whether or not to have children simply because they are HIV positive. (iii) An order that the policies and practices of the Department of Health be audited.[339] This could for example require all hospitals to provide information on when and where consent for sterilisations were obtained and whether it was coupled with a caesarean section. This would provide data on the number of times consent is obtained during labour which is one of the indicators of consent being obtained coercively. (iv) A recommendation to the Health Professions Council of South Africa to suspend or revoke the licence of the health care practitioner who is found to be responsible for the forced or coerced sterilisation.[340]

It is argued that this combination of four different remedies addresses the need for individual relief as expressed by the women in the narratives above as well as attempting to ensure that the Department of Health takes structural steps to ensure that this practice is stopped.

The Act also makes provision for the Commission on Gender Equality and the South African Human Rights Commission to institute proceedings on behalf of a complainant.[341] The flexibility of the Promotion of Equality and Prevention of Unfair Discrimination Act in this regard, helps to ensure that litigants who are especially illiterate and have been at the receiving end of discriminatory treatment, are afforded the opportunity to access the Courts in a supportive manner.

It is submitted, that there may be a few issues that pose a challenge in using the Equality Courts to deal with the forced or coerced sterilisation of women because of their HIV positive status, successfully. Presently, the two pieces of health legislation[342] that may be relied on to advance the claims of this group of women are silent on the issue of discrimination. It is suggested that the Sterilisation Act and Health Professions Council's Guidelines on Reproductive Health[343] must contain provisions which bar sterilisations based on discriminatory reasons. It also remains unclear what evidence will be required of the complainant in order to make out a case for discrimination as there is no precedent available nationally and internationally for guidance. Proceedings in the Equality Courts are open to the public and this may deter HIV positive women from seeking redress for the

---

[337] *Sithole v The MEC for Health and Social Development & 3 Others* – unreported case no. 19744/2012 – High Court of South Africa, Gauteng Local Division, Johannesburg.
[338] Section 21 (2) (*j*) of Act 4 of 2000.
[339] Section 21 (2) (*k*) of Act 4 of 2000.
[340] Section 21 (2) (*l*) of Act 4 of 2000.
[341] Section 20 (1) (*f*) of Act 4 of 2000.
[342] Sterilisation Act 44 of 1998 and the National Health Act 61 of 2003.
[343] HPCSA '*Guidelines for good practice in the health care professions: General ethical guidelines for reproductive health'* 2ed (2007) 10-11, available at http://www.hpcsa.co.za/downloads/conduct_ethics/rules/general_ethical_guidelines_reproductivehealth.pdf accessed on 26 December 2017.

reasons mentioned above. It is submitted that if compelling reasons are placed before the Presiding Officer of the Court, it may be directed that the proceedings be conducted in camera. Prescription of the claim may be an impediment to accessing the Equality Court. This is discussed in Chapter 6. In the study by Strode et al it was shown that most of the sterilisations appeared to have taken place prior to the widespread roll out of antiretroviral treatment.[344] Accordingly many of the sterilisations took place more than three years ago and it is unclear whether these affected women could approach the Equality court.

Violations of the right to dignity were a clear theme that ran through the narratives in the various studies that have been undertaken. These show that being sterilised undermines the sense of self-worth of these women. There is often pressure on HIV positive women to have children which comes from husbands, partners, extended family and society. Motherhood is viewed as a norm for women in most societies.[345] This is particularly true for women in Africa, where culture places a high value on women's fertility.[346] A woman's sterility often carries undesirable social consequences for her as she is seen as ''half a women''.[347] Often HIV positive women do not disclose their status to their partners, husbands, family or the community for fears of being ostracised and being viewed as worthless.[348] South African women have reported, in the study by Essack and Strode, that they were unwilling to reveal their positive HIV status to their partners or husbands for fear of being abandoned and rejected because of being barren.[349] The sterility of a HIV positive woman impacts negatively on the bride price that will be paid for her or alternatively lead to the reclaiming of the bride price that was paid for her.[350] Therefore, the act of sterilising HIV positive women without their consent has a multitude of undesirable effects for them.

HIV positive women who have been sterilised without their informed consent can invoke dignity as a foundational value, as a free standing right, a right that informs equality and as a correlative right when accessing justice. In this regard they could institute a civil claim under the action iniuriarum, see Chapter 5. Relying on dignity as a value will be extremely useful when highlighting the fact that it is poor, vulnerable, black women who have limited education that are being targeted for having an illness that has a high level of stigma and prejudice attached to it. This goes against the ethos of what our Constitution represents

[344] Strode et al '''She made up a choice for me'': 22 HIV-positive women's experiences of involuntary sterilization in two South African provinces' (2012) 20 (39S) *Reproductive Health Matters* 1-9.
[345] D Cooper et al 'Life is still going on: Reproductive intentions among HIV-positive women and men in South Africa' (2007) 65 *Social Science and Medicine* 274-283 at 275.
[346] Ibid 275-277.
[347] Ibid.
[348] Essack & Strode 'I feel like half a women all the time: The impacts of coerced and forced sterilisations on HIV-positive women in South Africa' (2012) 26 (2) *Agenda* 24-34 at 31.
[349] Ibid 30-31.
[350] Ibid and L C McLaughlin 'The price of failure of informed consent law: coercive sterilizations of HIV positive women in South Africa' (2014) 32 (1) *Law and Inequality: A Journal of Theory and Practice* 69 -93 at 76.

and it serves to further entrench division instead of healing divisions on the basis of race and sex as was characteristic of apartheid South Africa.

It is submitted that pleading a violation of the right to dignity of HIV positive women who have been coercively sterilised will involve showing that their self-worth and self-respect have been eroded by the conduct of the nurses and doctors. This offensive conduct will be the act of denying the women the right to make an autonomous decision without elements of fear being added to the decision making process. It has been submitted by Schachter that conduct that would be incompatible with respect for inherent dignity is in instances where medical treatment or hospital care disregards and is insensitive to personal choice.[351]

Pleading the violation of dignity in isolation will not have the same impact as pleading it with an infringement of the women's right to bodily and psychological integrity which encompasses reproductive autonomy and equality. We must view this in a context-specific manner as we are emerging from a country that has a deeply divided past where not all individuals were accorded the same self-worth and self-respect. As a result of this, we have a society that is laced with prejudice and stereotypes. Without recognising the impact that differential treatment, prejudices and stereotypes have on individuals we will not be able to achieve a society that is ''based on democratic values, social justice and fundamental human rights.''[352] An enquiry into the impact that this has on one's dignity is a tried and tested way of assessing this.

**5. Conclusion**

There is a well-developed legal framework on equality. The legal principles flow from section 9 of the Constitution and are interpreted through a historical lens. The case of *Harksen v Lane* [353] will go down in the annals of history for being the first case to deal with the issue of the right to equality in terms of our interim Constitution.[354] Even more memorable, will be the ''equality test'' that emanated from the judgment. The test has become a firm foundation for our equality jurisprudence. In addition, other cases that came before the Constitutional Court in quick succession contributed to there being a solid framework for equality in the Constitution and the Equality Act. With the notion of equality being firmly entrenched in our Bill of Rights, discrimination on the seventeen listed grounds are presumed to be unfair. The recent inclusion of HIV/AIDS status in the Promotion of Equality and Prevention of Unfair Discrimination Act is indicative of the serious stance taken against discrimination based on this ground. Sex and pregnancy also fall into this category i.e. discrimination on these grounds are presumed to be unfair unless shown to be fair by the party responsible for the differentiation.

[351] Schachter 'Human dignity as a normative concept' (1983) 77 (4) *The American Journal of International Law* 848-854 at 852.
[352] Preamble.
[353] 1998 (1) SA 300 (CC).
[354] Constitution of the Republic of South Africa, Act 200 of 1993 (interim Constitution).

Equally the right to dignity is entrenched in South African law. In our context equality and dignity are seen as intertwined rights and values. An equality analysis requires amongst others an investigation into the impact the alleged discriminatory conduct had on the plaintiffs. This unique right to equality is important as it underscores how multiple layers of discrimination serve to devalue and dehumanise certain sectors of society. In the context of such marginalised groups seeking health care it can result in health care providers treating them as objects rather than autonomous individuals. We cannot address the inequalities that poor, illiterate, non-English speaking HIV positive women face without a process that focuses on requiring health care workers to respect their intrinsic worth despite their position in society.

# Chapter 5

# Legal and administrative remedies

## 5.1 Introduction

In a study conducted by Strode, Mthembu and Essack in 2011, the experiences of HIV positive women who were sterilised without their informed consent were documented.[1] The study also explored the impact that these rights violations had on HIV positive women and their views on possible remedies.[2] Findings included devastating psycho-social impacts that were felt by these women. They also reported on the physical pain experienced and the adverse financial consequences that flowed from their sterilisations.[3]

Extracts from the narratives of these women bear testimony to this suffering. Most participants reported ongoing and significant emotional and psychological distress because they could no longer bear children.[4] A few women even reported that they were clinically depressed and used anti-depressants to help them cope with the consequences of being infertile.[5] Participants described feelings of trauma, isolation, helplessness, stress and long-term humiliation that extended far beyond their time in hospital.[6] One woman commented that ''*I feel like half a woman all the time. I can identify with other women but I know that I'm different in a very sort of unusual way*.''[7] The intersectional discrimination that women felt from being both infertile and HIV positive increased the feeling of hopelessness that some women experienced. Another woman was recorded as saying:

> *''It 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*.''[8]

Apart from experiencing psychological distress some women in the study narrated feeling physical pain. The physical effects were perceived to be as a result of wounds taking a long

[1] A Strode et al '''She made up a choice for me'': 22 HIV-positive women's experiences of involuntary sterilization in two South African provinces' (2012) 20 (39S) *Reproductive Health Matters* 1-9 and Z Essack & A Strode 'I feel like half a women all the time: The impacts of coerced and forced sterilisations on HIV-positive women in South Africa' (2012) 26 (2) *Agenda* 24-34.
[2] Ibid.
[3] Ibid 28-29.
[4] Ibid 28.
[5] Ibid.
[6] Ibid.
[7] Ibid.
[8] Ibid.

time to heal,[9] complications with their menstrual cycles,[10] backache[11] and other post-sterilisation ailments.[12]

The study also recorded the negative financial implications experienced by some of the women as a consequence of being sterilised.[13] Many women tried to redress their lack of fertility after the sterilisation. Women reported spending money consulting doctors on reversals or alternative methods of conception.[14] In some cases women appeared to have been misled because of their desperation to conceive for example one women relayed that ''*I went to another doctor who said I could get a child. I kept paying and I thought I would eventually conceive. At 8 months I went to the clinic and they said the pills I had been taking were poisonous*.''[15] A further illustration of wasteful spending arising out of being sterilised without informed consent being obtained was evident from the narrative of one woman where she stated that:

> *''I had to pay the doctor R 7 000 for the reversal procedure. I also had to pay R 15 000 for the hospital. These were all paid in cash; I do not owe anything. No. Physically, I have no problems. My problem is financial. Since the reversal, I have paid a lot of money, it's not only R 22 000 I have paid but it goes on since I have not conceived to this day*.''[16]

The social discrimination experienced by these women as a result of not being able to bear children was captured in their interviews. These narratives reflect the way in which their dignity was impaired by their new status of being infertile, for example it was stated by one woman that:

> ''*when you consider the 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. So I mean within my networks there are young women, and one of them is actually married and she wouldn't dare tell her husband that she is sterilised because her husband will go back to the family to claim the money back.''*[17]

Essack and Strode found that the social impact of sterilisations was particularly felt by African women. They highlighted a quote in which it was stated that being infertile was a larger burden than being HIV positive. This woman stated ''*in African culture, if you are not able to have children, you are ostracised. It's worse than having HIV*.''[18]

---

[9] Ibid.
[10] Ibid 29.
[11] Ibid.
[12] Ibid.
[13] Ibid.
[14] Ibid.
[15] Ibid.
[16] Ibid.
[17] Ibid 31.
[18] Ibid.

Given the wide-ranging harms suffered by HIV positive women who have been coerced or forced into being sterilised, this chapter focuses on the different civil, criminal law and other administrative remedies that exist in the South African legal system. Section 34 of the Constitution of the Republic of South Africa expressly makes provision for everyone to have ''any dispute that can be resolved by the application of law decided in a fair public hearing before a court or, where appropriate, another independent and impartial tribunal or forum.''[19] Van der Westhuizen J in the case of *Mdeyide* reinforced this notion by stating that:

> The fundamental right of access to courts is essential for constitutional democracy under the rule of law. In order to enforce one's rights under the Constitution, legislation and the common law everyone must be able to have a dispute that can be resolved by the application of law, decided by a court. The right of access to courts is thus protected in the Constitution.[20]

In this regard South Africa can pride itself on having a conceptually sound legal framework that protects sexual reproductive health rights. However, this thesis interrogates the extent to which this framework provides access to justice for HIV positive women who allege that they were subjected to sterilisation abuse. This chapter examines the range of legal and administrative remedies available. In the discussion section the appropriateness of each of these within the specific context of coerced or forced sterilisations is critically evaluated.

### 5.2 Civil law remedies

Civil litigation has often been described as a channel through which disputes could be peacefully settled without resorting to physical violence thus averting the innate quality of vengeance possessed by humans.[21] Even though various reasons may exist for civil litigation its primary purpose still remains to have civil disputes resolved without the involvement of the State.[22] A person who has been wronged by another should be able to claim relief in the civil courts if it could be shown that that person committed a delict. As succinctly stated by Neethling and Potgieter ''a delict is the act of a person that in a wrongful and culpable way causes harm to another.''[23] It is clear from a detailed reading of the study by Strode, Mthembu and Essack that the affected women could potentially use three distinct actions in delict. These are:

(i) Damages claims under the action iniuriarum for violations of their bodily and psychological integrity and their right to dignity;

---

[19] Constitution of the Republic of South Africa, 1996.
[20] *Road Accident Fund and Another v Mdeyide* (CCT 10/10) [2010] ZACC 18; 2011 (1) BCLR 1 (CC); 2011 (2) SA 26 (CC) (30 September 2010) at para 1.
[21] E Hurter 'Seeking truth or seeking justice: Reflections on the changing face of the adversarial process in civil litigation' (2007) 2 *Tydskrif vir die Suid-Afrikaanse Reg* 240-241.
[22] Ibid.
[23] J Neethling & JM Potgieter *Law of Delict* 7 ed (2015) 4.

(ii) Claims for pain and suffering arising from the procedure itself and any long-term implications; and

(ii) A claim for any financial loss suffered such as loss of earnings and future medical costs under the Aquilian action.[24]

### 5.2.1 Elements of a delict

The elements of a delict are that there must be an act or omission (conduct) which, is wrongful; in addition there must be a causal connection between the conduct of the defendant and the consequent harm (damages) suffered by the plaintiff; and lastly, there must be the element of fault or blameworthiness that can be attributed to the defendant.[25]

(i) Harm

Plaintiffs who institute a civil claim would have to do so as a result of some harm that they have suffered to their patrimony or non-patrimonial / personality interest.[26] The harm suffered must result from a violation of the plaintiff's interest or a protected right.[27] It is therefore imperative to firstly establish whether the plaintiff has a legal interest that the law of delict protects.[28] In other words it is not sufficient to simply demonstrate that harm has been suffered even though, the plaintiff's rights may have been violated in a wrongful manner, it must be sufficient to constitute actionable harm.[29]

Harm falls into two categories, patrimonial harm[30] and non-patrimonial harm.[31] Non-patrimonial harm is further divided into two categories: pain and suffering[32] and infringement of personality interests.[33]

[24] The Aquilian action is used to claim compensation for patrimonial loss. The actio iniuriarum is used to claim compensation for a violation of a personality interest and the elements of the Germanic remedy must be satisfied before pain and suffering is claimed. R Midgley & M Loubser *The Law of Delict in South Africa* 2 ed (2012) at 46.
[25] Ibid.
[26] Midgley & Loubser *The Law of Delict in South Africa* 2 ed (2012) 45.
[27] Ibid.
[28] Ibid.
[29] Ibid 47.
[30] Patrimonial loss is defined as the reduction in the value of an element of patrimony according to JA Joubert *Law of South Africa* 3 ed (2013) 3 at 45.
[31] Non-patrimonial damage has been defined as the diminution, as a result of a damage-causing event, in the quality of highly personal (personality) interests of an individual in satisfying his or her legally recognised needs, but which does not affect the individual's patrimony. Non-patrimonial loss is defined with reference to the deterioration of highly personal or personality interests. The law recognises personality rights (and interests) in regard to physical and mental integrity, bodily freedom, reputation, dignity, privacy, feelings and identity. A deterioration of the quality of any of these interests constitutes non-patrimonial damage. Ibid.
[32] Compensation can be claimed for pain and suffering where there is a wrongful and negligent (or intentional) impairment of bodily or physical-mental integrity. Neethling & Potgieter *Law of Delict* 7 ed (2015) 5.
[33] Midgley & Loubser *The Law of Delict in South Africa* 2 ed (2012) 47.

Bodily integrity, dignity and reputation have been recognised by our common law as being the three classic personality interests.[34] According to the learned authors Neethling, Potgieter and Visser, bodily and psychological integrity is protected against "every factual infringement of a person's physique or psyche. Physical infringements may occur with or without violence and with or without pain."[35]

In the context of forced or coerced sterilisation the protected interests are the right to bodily and psychological integrity and dignity.[36] It is argued firstly, that the right to bodily integrity means that medical procedures will be unlawful unless consent is obtained.[37] Secondly, that the rights of all HIV positive women to be free from being sterilised on a discriminatory basis is an inherent element of their dignitas. Treating HIV positive women differently to HIV negative women in relation to reproductive choices implies that they are less worthy of being mothers which violates their inherent dignity. The documented cases referred to above in chapter 2, indicate that many of the women suffered patrimonial harm, for example they incurred hospital expenses for trying to reverse the procedure.[38] They also suffered non-patrimonial harm such as the loss of a partner due to an inability to conceive as well as psychological distress caused by the coerced sterilisations.[39]

(ii) Conduct

The harm suffered by the plaintiff must be caused by the wrongful conduct of the defendant[40]. The conduct complained of must be a voluntary act or omission[41] committed by a human being.[42] In this instance, it is submitted that the conduct would be both the performing of the sterilisation without full informed consent and the undignified and differential treatment of HIV positive women.

(iii) Causation

Delictual liability will not arise if it is not proved that the conduct of the wrongdoer or defendant caused the damage to the person suffering the harm.[43] It then logically follows that a person cannot be liable if he has not caused any damage.[44]

---

[34] Ibid 54.
[35] Neethling & Potgieter *Law of Delict* 7 ed (2015)345-346.
[36] Sections 12 and 9 of the Constitution of the Republic of South Africa, 1996.
[37] *Stoffberg v Elliot* 1923 CPD 148.
[38] Essack & Strode 'I feel like half a women all the time: The impacts of coerced and forced sterilisations on HIV-positive women in South Africa' (2012) 26 (2) *Agenda* 24-34 at 29.
[39] Ibid 30.
[40] Neethling & Potgieter *Law of Delict* 7 ed (2015) 25.
[41] An omission can be described as indications of legally deficient conduct. Neethling & Potgieter *Law of Delict* 7 ed (2015) 30.
[42] Neethling & Potgieter *Law of Delict* 7 ed (2015) 25. This, is in contrast to the conduct of an animal.
[43] Ibid 184.
[44] Ibid 183.

In ascertaining whether a causal link exists between the conduct of the wrongdoer and harm suffered by the plaintiff, a two stage enquiry is employed:

(i) Whether there is factual causation, that is, whether the wrongdoer's conduct caused the damage to the person suffering the harm; and[45]

(ii) Whether there is legal causation.[46]

This approach was confirmed by the Constitutional Court in the case of *Lee v Minister of Correctional Services.*[47] The Court held that this element of liability gives rise to two distinct enquiries.[48] The first is a factual enquiry into ''whether the negligent act or omission by a wrongdoer caused the harm giving rise to the claim.''[49] If it is established that the wrongdoer's conduct did not cause the harm, this will have the effect of extinguishing the plaintiff's delictual claim.[50] Progression to the next level of the enquiry which, is referred to legal causation, will only take place if it has been established that the negligent act or omission ''is linked to the harm sufficiently closely or directly for legal liability to ensue or whether the harm is too remote.''[51]

In the *Lee*,[52] case Judge Nkabinde stressed that our law does not require an inflexible application of the substitution exercise when employing the but-for test.[53] The dual set of reasons offered by the Judge for the rejection of the inflexible approach is that (i) our law makes provision for a more flexible approach to be adopted when determining factual causation and that it is not necessary to have the ''substitution of reasonable alternative measures'' and (ii) even in the event the ''substitution of reasonable alternative measures'' being used, there is no requirement in our law for evidentiary proof to be presented by the plaintiff of alternatives.[54] What is required according to the Judge is a ''notional and hypothetical lawful, non-negligent alternative.''[55]

The learned Judge quoted with approval the approach adopted in the *Gore* and the *Van Duivenboden* cases in relation to discharging the onus required to prove factual causation.[56] In *Gore's* case, the Court stated that ''application of the 'but for' test is not based on mathematics, pure science or philosophy. It is a matter of common sense, based on the

[45] Neethling & Potgieter *Law of Delict* 7 ed (2015) 184.
[46] Ibid.
[47] *Lee v Minister of Correctional Services* (CCT 20/12) [2012] ZACC 30; 2013 (2) BCLR 129 (CC); 2013 (2) SA 144 (CC); 2013 (1) SACR 213 (CC) (11 December 2012).
[48] Ibid at para 38.
[49] Ibid.
[50] Ibid.
[51] Ibid.
[52] Ibid.
[53] Ibid at para 45.
[54] Ibid at para 43.
[55] Ibid.
[56] Ibid at para 47.

practical way in which the ordinary person's mind works against the background of everyday-life experiences.[57]

*Van Duivenboden's* case echoed similar sentiments:-

> A plaintiff is not required to establish the causal link with certainty, but only to establish that the wrongful conduct was probably a cause of the loss, which calls for a sensible retrospective analysis of what would probably have occurred, based upon the evidence and what can be expected to occur in the ordinary course of human affairs rather than metaphysics.[58]

It must be noted that the flexible approach adopted in *Lee's*[59] case did not replace the traditional but-for-test used when determining factual causation. The test in *Lee's* case is relevant in instances where the harm caused is closely connected to an omission by a person who has a duty to prevent the harm and the enquiry is whether the harm would have occurred even if the omission had not taken place.[60]

Before setting out the enquiry into the second leg which is legal causation, it is important to note that on the grounds of policy and fairness, no legal system can hold a wrongdoer liable for an endless chain of harmful consequences which their act may have caused.[61] There is general agreement that some means must be found of limiting the wrongdoer's liability.[62] It is sometimes stated in general terms that the wrongdoer is not liable for harm which is ''too remote'' from the conduct.[63] There are many complexities with legal causation and ensuring that the net of liability is not cast too widely. Courts use policy principles to ensure fairness.

> This is basically a juridical problem in the solution of which considerations of policy may play a part. This inquiry, unlike the first, presents a much larger area of choice in which legal policy and accepted value judgments must be the final arbiter of what balance to strike between the claim to full reparation for the loss suffered by an innocent victim of another's culpable conduct and the excessive burden that would be imposed on human activity if a wrongdoer were held to answer for all the consequences of his default.[64]

In this case, it is submitted that the conduct complained of would be the failure of the health care professional to obtain full informed consent and the violation of the women's dignity through treating her differently to HIV negative women. In the study conducted by Strode and others it is submitted that there would be factual causation as but for the

---

[57] Ibid.
[58] Ibid.
[59] *Mashongwa v PRASA* (CCT03/15) [2015] ZACC 36; 2016 (2) BCLR 204 (CC); 2016 (3) SA 528 (CC) (26 November 2015) at para 65.
[60] Ibid.
[61] Neethling & Potgieter *Law of Delict* 7 ed (2015) 183.
[62] Ibid 197.
[63] Ibid 198.
[64] 1990 (1) SA 680 (A) 702.

sterilisations, the women would be fertile and would not have incurred the pain and suffering, additional medical costs or emotional distress associated with involuntary sterilisations. However, establishing whether legal causation exists involves a broad analysis of whether doctors and nurses should be held accountable in light of prevailing legal policy. Factors to consider would be the motivations of the health care professionals or whether the conduct was sanctioned by their professional bodies or the Department of Health. In casu it is submitted that neither the Department of Health nor the professional medical bodies sanctioned the sterilisation of HIV positive women. There is no national policy suggesting that HIV positive women should not fall pregnant or have children. Instead, the National Contraceptive Clinical Guidelines of 2012[65] specifically state that sterilisations may not be undertaken for a discriminatory purpose. Furthermore, patronising attitudes about the choices that HIV positive women should make regarding reproduction are unlikely to be accepted by a court as justification for coercing or forcing a woman to be sterilised. It is thus submitted that legal causation will also be present.

(iv) Fault

It is insufficient to show that harm to the plaintiff was caused wrongfully in order to establish delictual liability.[66] The defendant must be at fault in some way in order to be held accountable[67] and culpable[68] for their wrongful conduct.[69] There are two forms of fault namely intention and negligence.[70]

(aa) Intention

A person is considered to be at fault when that person intends to cause another person harm, knowing that it is wrong to do so.[71] It is clear from this definition that there are two components to intention; namely direction of the defendant's will and consciousness (knowledge) of its wrongfulness.[72]

(bb) Negligence

[65] National Contraceptive Clinical Guidelines of 2012, available at https://www.gov.za/sites/default/files/Contraception_Clinical_Guidelines_28jan2013-2.pdf accessed on 25 May 2018.
[66] Midgley &Loubser *The Law of Delict in South Africa* 2 ed (2012) 99.
[67] According to Midgley & Loubser, accountability is a prerequisite for finding a person blameworthy. It refers to a person's capacity to distinguish between right and wrong and then to act in accordance with that distinction. If a person is not legally accountable, we cannot impute blame, and the element of fault is not satisfied. Anger due to provocation, youth, mental illness and intoxication have been recognised as categories that affect a person's capacity. Midgley & Loubser *The Law of Delict in South Africa* 2 ed (2012) 100.
[68] Culpability refers to the law's judgment of an accountable person's state of mind (intention) or of the inadequate quality of a person's conduct (negligence). Midgley & Loubser *The Law of Delict in South Africa* 2 ed (2012) 100.
[69] Ibid 99.
[70] Ibid.
[71] Midgley & Loubser *The Law of Delict in South Africa* 2 ed (2012) 105.
[72] Neethling & Potgieter *Law of Delict* 7 ed (2015) 133.

With negligence, liability is based on the law's disapproval of a defendant's conduct[73] where, the defendant fails to adhere to the standard of care legally required of him.[74] The criterion adopted by our law to establish whether a person has acted carelessly and thus negligently is the objective standard of the reasonable person, the bonus paterfamilias.[75] In the case of *Kruger v Coetzee*[76] the test for negligence was set out succinctly and authoritatively by Holmes JA:

For the purposes of liability *culpa* arises if :

(a) a diligens paterfamilias in the position of the defendant –
(i) would foresee the reasonable possibility of his conduct injuring another in his person or property and causing him patrimonial loss; and
(ii) would take reasonable steps to guard against such occurrence; and
(b) the defendant failed to take such steps.[77]

The two pillars that form the basis of the test for negligence is the foreseeability of harm and the second being the preventability of harm.[78] In terms of the first leg, negligence cannot be imputed to a defendant unless it can be established that the harm arising from the defendant's conduct was reasonably foreseeable.[79] This is assessed by objectively taking into consideration the surrounding circumstances and the qualities that the law attributes to a reasonable person.[80]

With regard to the second part of the test, the enquiry will then progress to whether the harm was reasonably preventable.[81] The pertinent question to be asked is what steps a reasonable person in the position of the defendant would have taken to prevent the harm.[82] In addition, the plaintiff must put forward what reasonable measures the defendant should have taken in the circumstances to prevent the harm from occurring.[83]

Applying both the foreseeability test and the preventability test is the foundation for practically evaluating the defendant's conduct.[84] In terms of the Aquilian action negligence or intention is required. However, it is easier to prove negligence. With regards to negligence, it is submitted that the health care professional would have been able to foresee that the failure to obtain informed consent specifically for a sterilisation would

[73] Ibid 113.
[74] Ibid 137.
[75] Ibid.
[76] 1966 (2) SA 428 (A).
[77] 1966 (2) SA 428 (A) at 430.
[78] Ibid 120.
[79] Ibid 116.
[80] Ibid.
[81] Ibid 120.
[82] Ibid.
[83] Ibid.
[84] Ibid.

result in harm being caused to the patient because her right to choose whether or not to undergo the procedure has been violated. Furthermore, this harm could have been prevented by the health care professional by properly obtaining consent before proceeding with the operation.[85] Even in instances where the surgeon or a nurse obtained written consent to the sterilisation, the Aquilian action could be used if the Plaintiff could show that they should have foreseen their failure to fully explain the implications of signing the document would result in the consent being a coerced consent and not an informed consent. In the case of the *Government of the Republic of Namibia v LM & Others*[86] it was held that although all of the respondents had signed consent forms this did not equate to having received adequate and sufficient information about the nature and risks of sterilisation.[87]

(v) Wrongfulness

For liability to follow, the act or omission must be wrongful in other words it must infringe a legally protected interest such as a person's right to dignity or bodily and psychological integrity.[88]

The determination of wrongfulness involves a two pronged enquiry. The first would be to determine whether a legally recognised interest has been infringed which resulted in a harm.[89] Should this be answered in the affirmative then the second enquiry would ensue. The second enquiry is whether the harm occurred in a legally reprehensible way.[90] This is established by measuring it against legal norms.[91] This is an objective enquiry which includes taking cognisance of all the pertinent facts and surrounding circumstances that existed at that time together with the resultant consequences that ensued.[92]

(aa) Defences directed at the wrongfulness element

A violation of a right or breach of duty that would otherwise be wrongful could be lawful if a ground of justification exists.[93] Grounds of justification are special circumstances that make the factual violation of a right or breach of duty reasonable and therefore lawful.[94] The

[85] As decided in *Government of the Republic of Namibia v LM and Others* (SA 49/2012) [2014] NASC 19 (3 November 2014).
[86] Ibid.
[87] Ibid at para 100.
[88] For the purposes of our discussion the legally protected interest that will be relevant is the right to bodily integrity.
[89] Neethling & Potgieter *Law of Delict* 7 ed (2015) 33.
[90] Ibid.
[91] The legal norms refer to the legal convictions or boni mores of the community which, should be aligned to the norms and values enshrined in our Constitution and Bill of Rights. The boni mores test is an objective test based on the criterion of reasonableness. Neethling & Potgieter *Law of Delict* 7 ed (2015) 36-37. Midgley & Loubser *The Law of Delict in South Africa* 2 ed (2012) 140.
[92] Neethling & Potgieter *Law of Delict* 7 ed (2015) 33.
[93] Midgley & Loubser *The Law of Delict in South Africa* 2 ed (2012) 157.
[94] Ibid 156.

violation of a right is therefore not always unreasonable or contra bonos mores.[95] For example, where a person legally capable of expressing his will gives consent to an injury or harm, the causing of such harm will be lawful.[96] Consent[97] is a ground of justification where the person suffering harm has waived their right to bodily integrity thus the defendant cannot be held liable for the damage caused.[98] This is the well-known *maxim* volenti non fit iniuria.[99]

In this context of sterilisation abuse, wrongfulness can be established if there is a legally protected interest that has been infringed, a statutory duty that has not been complied with or the conduct is considered wrongful in terms of the legal convictions of the community. It is argued that this would be the medical professional's failure to obtain informed consent as required by the Sterilisation Act[100] and the violation of a patient's constitutional right to bodily integrity. Secondly, it would have to be shown that the harm is inconsistent with the legal convictions of the community. In situ it is submitted that it could be argued that consent would not be a successful defence in this instance, see the arguments made in chapter 3.

### 5.2.2 Promotion of Equality and Prevention of Unfair Discrimination Act (PEPUDA)

An additional civil law remedy that can be invoked by HIV positive women who have been sterilised without their informed consent is the use of the provisions of the Promotion of Equality and Prevention of Unfair Discrimination Act.[101] This piece of legislation confines itself to the unequal and unfair treatment of persons; hate speech and harassment of persons. As a result of its specific nature specialised Courts were created to adjudicate on these delineated types of matters.

The onus of proving that there has been discrimination rests with the complainant.[102] In other words, the complainant has to show on a prima facie basis that the alleged discrimination was based on a ground listed in terms of the Act[103] or on an analogous ground. Discrimination based on a listed ground or analogous ground, provided that it qualifies as an analogous ground as required by the Act, is deemed to be discrimination.

---

[95] Neethling & Potgieter *Law of Delict* 7 ed (2015) 87.
[96] Ibid 108.
[97] Consent has been described ''freely and lawfully given by a person who has the legal capacity to give it justifies the conduct consented to, making lawful the infliction of the ensuing harm. It is therefore a defence that operates by negativing wrongfulness.'' Neethling & Potgieter *Law of Delict* 7 ed (2015) 108.
Van der Walt and Midgley comment further by stating that ''by consent … the plaintiff unilaterally restricts his or her rights to such an extent that the defendant's conduct is not wrongful.'' Ibid.
[98] Neethling & Potgieter *Law of Delict* 7 ed (2015) 108.
[99] The literal translation of the maxim is that a willing person is not harmed. He who consents cannot be injured. Neethling & Potgieter ibid 108. This is discussed further in Chapter 3.
[100] Act 44 of 1998.
[101] Act 4 of 2000.
[102] Section 13 of Act 4 of 2000.
[103] 4 of 2002.

The onus then shifts to the respondent to prove that the discrimination did not take place as alleged by the complainant and that the respondent's conduct is not based on one or more of the prohibited grounds.[104] Should the respondent concede that the discrimination did indeed occur the respondent would then have to prove that the discrimination was fair.[105] Govender argues that it is apparent from the above that no material difference exists in the way unfair discrimination has to be proved for a listed or analogous ground.[106]

The Act[107] provides adequate guidance on the factors that ought to be taken into account when arriving at a decision. In essence, there are three categories of factors to be considered. Firstly, section 14 (2) states that in determining whether the respondent has proved that the discrimination is fair, the context, must be considered. Secondly, the factors referred to in s 14(3) must be taken into account. These factors require the court to look at the impact of discrimination on the complainant and any justifications advanced for the conduct. Thirdly, it must be asked whether the discrimination reasonably and justifiably differentiates between persons according to objectively determinable criteria, intrinsic to the activity concerned must be taken into account.[108]

According to Albertyn an understanding of the context in which laws operate has become an integral part of legal interpretation because of the diverse nature of people's life experience.[109] Therefore, a presiding officer in the Equality Court would be required to listen closely to the experience of the complainant alleging discrimination, particularly when they are narrating their version. Context helps the presiding officer to understand how such an experience has impacted on the life of the complainant.[110]

The factors which must be taken into account in terms of subsection 3[111] can be divided into a three part assessment. Firstly, the effect of the discrimination on the complainant is assessed. This is done by taking into account whether the discriminatory practice impairs the dignity of the complainant;[112] whether it impacts on the complainant[113] and whether the complainant is part of a group in society that is subjected to patterns of disadvantage.[114] The second stage of the enquiry focuses particularly on whether the discriminatory act was directed at a worthy and legitimate goal, such as remedying past disadvantage or furthering

[104] Section 1 (*a*) and (*b*) of Act 4 of 2000.
[105] Section 2 (*a*) of Act 4 of 2000.
[106] K Govender 'Equality, sexuality and taking rights seriously' (2008) 29 (1) *Obiter* 1-18 at 9.
[107] 4 of 2000.
[108] Section 14 (2) Act 4 of 2000.
[109] C Albertyn, B Goldblatt & C Roederer *Introduction to the Promotion of Equality and Prevention of Unfair Discrimination Act* (2001) at 41.
[110] Ibid at page 42.
[111] Section 14 (3) of Act 4 of 2000.
[112] Section 14 (3) (*a*) of Act 4 of 2000.
[113] Section 14 (3) (*b*) of Act 4 of 2000.
[114] Section 14 (3) (*c*) of Act 4 of 2000.

equality.[115] The last stage of the enquiry revolves around the steps taken by the respondent to address the specified disadvantage.[116]

It is clear from the reading of section 14 (3) (*a*) – (*e*) that it involves an assessment of how the discriminatory conduct impacted on the complainant or a group that the complainant belongs to. The latter part of section 14 (3) (*f*) to (*i*) focuses on the possible justifications that the respondent may raise and whether the discriminatory conduct served a legitimate purpose and therefore will be deemed fair.

Unsurprisingly, the enquiry that has to be undertaken in determining the fairness or unfairness of the discrimination in terms of PEPUDA, is striking similar to the three tier enquiry coined by Judge Goldstone in the case of *Harksen v Lane*.[117] An example of a case where the provisions of PEPUDA were invoked was the case of *Du Preez v Minister of Justice and Constitutional Development and Others.*[118] Briefly, the facts of the case were that Du Preez, a white male, who was a magistrate for 19 years, applied for a regional court magistrate's position in Port Elizabeth. Despite holding a BJuris, LLB and Master of Public Administration degree and fulfilling the minimum requirements he was not short-listed for the position. This case is significant as it was the first matter to be heard before a High Court sitting as an Equality Court.[119]

Two black females were shortlisted instead. It must be mentioned at the outset that the provisions of the Employment Equity Act[120] were not applicable to the complainant, as magistrates are not regarded as employees in terms of the Act.[121] According to Van der Walt and Kituri[122] the primary issue for determination in the *Du Preez* case was whether the criteria[123] used in shortlisting applicants for the post were fair. In arriving at his decision

---

[115] Albertyn, Goldblatt & Roederer *Introduction to the Promotion of Equality and Prevention of Unfair Discrimination Act* (2001) at 39-40.
[116] Section 14 (3) (i) (i) and (ii).
[117] *Harksen v Lane NO and Others* (CCT9/97) [1997] ZACC 12; 1997 (11) BCLR 1489 (CC); 1998 (1) SA 300 (CC) (7 October 1997).
[118] 2006 (5) SA 592 (EqC).
[119] The Equality Courts function on two levels and are staffed by judges and magistrates who have been specially trained as presiding officers in Equality Courts for a region. Section 16 of Act 40 of 2000.
[120] Act 55 of 1998.
[121] Ibid.
[122] A van der Walt & P Kituri 'The Equality Court's view on affirmative action and unfair discrimination' (2006) 27 (3) *Obiter* 674 -681.
[123] The shortlisting criteria was summarised succinctly by the court as follows:-
(a) white males with maximum points would score the same as black males and white females with minimum points;
(b) white males with only an LLB degree (presumably the majority of the prospective candidates) would automatically be outscored by all other categories of candidates;
(c) black males and white females with maximum points would score the same as black females with minimum points;
(d) black women with minimum points would outscore all other categories of candidates with only an LLB degree. 2006 (5) SA 592 (EqC) 607 A-B.

Judge Erasmus began by referring to the relevant section of PEPUDA that deals with the onus of proof. The learned Judge stated that:-

> Section 13 of PEPUDA read with the definition in section 1 thereof provides that if the complainant makes out a prima facie case of discrimination, not disproven by the respondent, therein, if the discrimination took place on the prohibited grounds of race and gender, it is unfair, unless the respondent proves that it was fair.[124]

The respondent in countering the averments made by the complainant, conceded that the shortlisting formula differentiated between the complainant and the other applicants on the grounds of race and gender, but submitted that this did not amount to discrimination.[125] Counsel for the respondent justified the discrimination employed in the shortlisting process on the grounds that the Constitution enjoins them to have regard to the racial and gender composition of South Africa when judicial officers are being appointed.[126] Counsel proceeded on the basis that there is arguably a need for such a policy to be in place in order for there to be diversification in the judiciary.[127] It was also submitted that transformation of the bench will, in addition, have the effect of promoting restorative affirmative action.[128]

The learned Judge then went on to take into account the factors set out in section 14 (2) and (3) of the Act in order to establish whether the respondent discharged the onus cast upon it. The learned Judge commented that the listed considerations contained in section 14 (2) and (3) do not replace the test for the constitutionality of an affirmative action measure outlined in the Employment Equity Act but gives substance to that test.[129] Quite importantly, the learned Judge stressed that not all the criteria mentioned are applicable in all cases.[130] Continuing in the same vein the learned Judge stated that each case is to be decided on its own particular facts and circumstances by taking into account the impact of the discrimination as part of this assessment.

Similar sentiments were expressed by Albertyn when discussing how to determine whether discrimination was reasonably justifiable.[131] The court then went on to state that the test as formulated in *Harksen v Lane* would also be of assistance.[132]

The court found that the effect of the committee's shortlisting formula was to raise an insurmountable obstacle for the complainant and that there was therefore an absolute

---

[124] 2006 (5) SA 592 (EqC) 603 G.
[125] Ibid 605 E.
[126] Ibid 606 B.
[127] Ibid 606 B.
[128] Ibid 606 C.
[129] Ibid 604 D.
[130] Ibid E.
[131] Albertyn, Goldblatt & Roederer *Introduction to the Promotion of Equality and Prevention of Unfair Discrimination Act* (2001) at 39-40.
[132] 1998 (1) SA 300 (CC).

barrier to his appointment.[133] Since the discrimination was built into a departmental policy, it was systemic in nature.[134] In the circumstances, the court held that the respondent did not discharge the onus on them to prove that the discrimination was fair.[135] The court ordered that the selection criteria be set aside and that the post be re-advertised.[136]

Relief that can be claimed in terms of the Act is varied. The Equality Court is empowered to make an order for the payment of damages in respect of any proven financial loss, including future loss, or in respect of impairment of dignity, pain and suffering or emotional and psychological suffering, as a result of the unfair discrimination, hate speech or harassment in question.[137] This order may be coupled with an appropriate costs order.[138] As with all other court orders emanating from the Magistrates' or High Courts, an order made by an Equality Court can either be reviewed or appealed against by an aggrieved party to the High Court or Supreme Court of Appeal having jurisdiction.[139] An appeal directly to the Constitutional Court is also possible provided that their rules have been complied with.[140] Another notable feature of PEPUDA is that it allows for class actions.[141]

A somewhat unique order that can be made by the Equality Court is found in section 21 (1) (o)[142] where an order can be made directing the clerk of the Equality Court to submit the matter to the Director of Public Prosecutions having jurisdiction for the possible institution of criminal proceedings in terms of the common law or relevant legislation. It is evident that the drafters of PEPUDA did not intend for this section to be without effect as section 28 (1)[143] states that if it is proved in the prosecution of any offence that unfair discrimination on the grounds of race, gender or disability played a part in the commission of the offence, this must be regarded as an aggravating circumstance for purposes of sentence.

In the *African National Congress v Sparrow* [144] case, the respondent was held to have contravened section 10 of PEPUDA.[145] The respondent was ordered to pay an amount of R 150 000 (one hundred and fifty thousand rand) in damages to the Oliver and Adelaide

[133] Van der Walt & Kituri 'The Equality Court's view on affirmative action and unfair discrimination' (2006) 27 (3) *Obiter* 674 -681 at 678.
[134] Ibid.
[135] 2006 (5) SA 592 (EqC) 612 D.
[136] Ibid.
[137] Section 21 (2) (*d*) of Act 4 of 2000.
[138] Section 21 (2) (*o*) of Act 4 of 2000.
[139] Section 23 (1) of Act 4 of 2000.
[140] Section 23 (3) of Act 4 of 2000. In terms of section 167 (6) of the Constitution, national legislation or the rules of the Constitutional Court, must allow a person, when it is in the interests of justice and with leave of the Constitutional Court to bring a matter directly to the Constitutional Court.
[141] Section 20 (*c*) of Act 4 of 2000. This is discussed further in 5.5.2.
[142] Act 4 of 2000.
[143] Ibid.
[144] (01/16) [2016] ZAEQC 1 (10 June 2016).
[145] This section deals with the prohibition of hate speech by way of publication, propagation, advocacy or communication of words to any person that could reasonably be construed to demonstrate a clear intention to be hurtful, harmful and promote hatred. Act 4 of 2000.

Tambo Foundation together with the costs of the litigation by the Equality Court.[146] In addition, the learned Magistrate directed that the Clerk of the Equality Court refer the matter to the Director of Public Prosecutions for consideration regarding the possible institution of criminal proceedings against Sparrow.[147] This case did not deal with discrimination on the grounds of HIV but dealt with hate speech. Reference to this case is made to illustrate the orders that the Court is empowered to make.

If a woman living with HIV were to approach the Equality Court to complain that she was sterilised without her consent simply because she was HIV positive, the Court would only have jurisdiction over the discrimination aspect of her claim. She would need to show on a prima facie basis that she received different treatment compared to other women who were giving birth in the same hospital. She could do this by giving her own evidence or by calling witnesses. She could also bring a copy of her medical records which would indicate she was HIV positive as this will show that the medical staff were aware of her HIV status. As HIV is a listed ground, the onus would then shift to the Minister of Health to show that she was sterilised for a reason not related to her HIV status or that sterilising HIV positive mothers is justifiable.

**5.3 Criminal law remedies**

The purpose of criminal litigation is for reparation by the accused person. This is achieved by the State who has the power as the prosecuting authority to make offenders atone for their transgressions and punish them accordingly for it.[148] This would have the effect of appeasing the victim and preventing the victim from taking the law into their own hands.[149]

According to Pickles, the role of the criminal law cannot be ignored in cases of involuntary sterilisations, as this rights violation can be categorised as a form of public harm.[150] The learned author holds the view that the act of sterilising women from a certain sector of society without informed consent amounts to a serious violation of their rights to bodily and psychological integrity that warrants punishment.[151]

Criminal liability may be attracted in three ways for involuntary sterilisations. The first being the common law crime of assault. According to Strauss where there has been no consent to a medical procedure or where the consent was so ''uninformed'' as to the nature of the procedure or consequences so that it cannot be said that there was a ''real'' consent, the

[146] (01/16) [2016] ZAEQC 1 (10 June 2016) 53.
[147] Ibid.
[148] G Kemp et al *Criminal Law in South Africa* 2 ed (2015) 7.
[149] Ibid.
[150] C Pickles 'Involuntary contraceptive sterilisation of women in South Africa and the criminal law' (2016) 29 (2) *South African Journal on Criminal Justice* 89-115 at 94.
[151] Ibid.

patient can lay a charge of assault.[152] Similar sentiments have been opined by the learned authors Carstens and Pearmain.[153]

Snyman's[154] definition of the crime of assault is that an assault consists in any unlawful and intentional act or omission:

(a) which results in another person's bodily integrity being directly or indirectly impaired, or

(b) which inspires a belief in another person that such impairment of her bodily integrity is immediately to take place.

The key elements of assault are that there must be conduct on the part of the accused either in the form of an act or omission that results in the impairment of another's bodily integrity. The conduct complained of by the complainant must be unlawful and the accused must have possessed the requisite intention to impair the complainant's bodily integrity. The element of unlawfulness refers to the causing of the impairment of the complainant's integrity which must be unlawful, in other words there must be no justification such as consent, for the conduct of the accused.[155]

The element of intention refers to the fact that the accused must have wilfully applied force either directly or indirectly to the person of another.[156] Dolus eventualis on the part of the accused must be proved in order to secure a conviction of assault.[157]

Unlike a delictual claim where a person is free to waive his or her legal right if they choose to do so and excuse the wrongdoer from liability, this is not the position in criminal law.[158] A crime is less about harm to the victim and more about harm to the community as a whole.[159] Burchell opines that the victim of a crime does not have the power to render an act not unlawful by consenting to suffer the harm involved.[160] The general rule of criminal law is that consent on the part of the victim will not serve to excuse the crime of the offender.[161] Consent by the victim in certain circumstances is an exception to this principle. This in effect means that a freely given and sufficiently informed consent by the victim will vitiate any finding of liability against the offender.[162] In order to raise consent as a

[152] SA Strauss *Doctor, Patient and the Law* 3 ed (1991) 268. Similar sentiments were expressed by Palley who stated that in law, any intentional application of force to the person of another, unless excused by some legal reason, is an assault. This would bring any application of force at all for medical purposes, into the category of assault and would include even the most minor application of force to the person of another, such as a hypodermic injection. A Palley 'Consent to operative treatment' (1953) *SA Medical Journal* 700-701 at 700.
[153] P Carstens & D Pearmain *Foundational Principles of South African Medical Law* (2007) 497.
[154] C R Snyman *Criminal Law* 6 ed (2014) 447.
[155] Ibid 452.
[156] Ibid.
[157] J Burchell *Principles of Criminal Law* 5 ed (2016)599.
[158] Ibid 208.
[159] Ibid.
[160] Ibid.
[161] Ibid.
[162] Ibid.

successful defence the offender must satisfy the following requirements: (a) the crime and type of act in question must be of such a nature that the law recognises consent to the commission of such an act as a ground of justification;[163] (b) the consent must be given voluntarily, without coercion.[164] This will be established by undertaking a factual enquiry on how the consent was obtained. Consent obtained as a result of fear or intimidation or through the application of violence does not satisfy the requirement of voluntary consent;[165] (c) the person giving the consent must be mentally capable of giving consent;[166] (d) the consenting person must be aware of the true and material facts regarding the act to which she consents;[167] (e) the consent may be given either expressly or tacitly;[168] (f) the consent must be given before the otherwise unlawful act is committed[169] and (g) consent must be given by the complainant.[170]

Although it is a long established principle that the crime of assault could be used where a medical practitioner fails to obtain consent, there have been no recorded cases of its use. This may be because the evidentiary burden of showing an intentional act of harm to the patient is difficult to establish. If a signed consent form exists in all likelihood it may indicate that the actions of the health care worker were not deliberate. In such a case, a sterilised woman would bear the burden of a reverse onus to show that the consent was invalid. In cases of forced sterilisation where there is no evidence of consent, written or verbal it is submitted that the element of intention could be established.

The second way in which criminal liability can be attracted is if the provisions of the Sterilisation Act have been contravened. Section 9 of the Sterilisation Act[171] states that non-compliance with the provisions of it and for our purposes more specifically the provisions of sections 2 and 4, will result in the commission of an offence. Section 9[172] provides for the sanction of a fine or a period of imprisonment for not more than five years in the event of there being a conviction arising from the commission of the offence.

Although the Act creates an offence it is unclear how this would operate in practice. For example section 9 of the Act[173] is silent on whether negligence or intention as a form of fault is required to invoke criminal liability. The learned, Pickles author further comments that when interpreting statutory offences there is a presumption that some degree of fault in the form of intention is required, unless there are express indications pointing to the

[163] Snyman *Criminal Law* 6 ed (2014) 123.
[164] Ibid.
[165] Ibid.
[166] Ibid 126.
[167] Ibid.
[168] Ibid.
[169] Ibid 127.
[170] Ibid.
[171] 44 of 1998.
[172] Ibid.
[173] Ibid.

contrary.[174] In this instance the legislature did not make use of the words ''negligently '' or ''without due care'' but rather employed the use of the words '' fails to comply'' in section 9.[175] A health care provider will escape criminal liability under this section if he or she can show that the consent form was signed freely and voluntarily by the woman being sterilised after receiving information about the procedure to be performed.[176]

It is argued by Pickles that it is not open for a woman who has been involuntarily sterilised to lay a charge of assault and contravention of the Sterilisation Act.[177] Accordingly it is submitted that it would be preferable for the prosecutor to pursue a conviction in terms of the Sterilisation Act because of the sanction attached to the offence is more serious as opposed to the sanction attached to an assault.[178] If the women rely on the statutory violation in terms of the Sterilisation Act, the sanction is a legislated one, which could even be a term of imprisonment for the medical practitioner.[179] Even if imprisonment is not imposed, the medical doctor or nurse will face a lifetime of consequences for having a criminal record. It is argued that it may be difficult to prosecute a medical practitioner in terms of the Act if a signed consent form exists. In such a case, the Prosecutor would have to have evidence that either the signature was not obtained voluntarily or that the woman was not fully informed of the consequences of sterilisation as required by the Act.

The third way in which the criminal law may be invoked to bring relief to women who have been involuntarily sterilised, would be to lay a charge of crimen iniuria against the wrongdoer who, in this instance may be a nurse or doctor or both. This crime is defined as the ''unlawful, intentional and serious violation of the dignity or privacy of another.''[180] The commission of this crime is either by word or deed.[181] Conduct that has been identified from the lived experiences of HIV positive women that could warrant a potential prosecution for crimen iniuria is verbal abuse, being degraded publicly for being HIV positive and being sterilised for a discriminatory reason. The protected interest that is being violated is the woman's dignity.[182] Snyman submits that the ''seriousness'' is determined by an objective test and factors that will be taken into account will be the relationship between the parties, whether the conduct complained of is ongoing, the social positions between the two parties and how this conduct is perceived within a particular community.[183] The

[174] Pickles 'Involuntary contraceptive sterilisation of women in South Africa and the criminal law' (2016) 29 (2) *South African Journal on Criminal Justice* 89-115 at 96.
[175] Ibid.
[176] Ibid 97.
[177] Ibid 97.
[178] Ibid 97.
[179] Ibid.
[180] Snyman *Criminal Law* 6 ed (2014) 461.
[181] Ibid 462.
[182] Ibid.
[183] Ibid 466-467.

wrongdoer must know that by their words or actions he or she is violating the complainant's dignity and no consent was given by the complainant to justify the offensive conduct.[184]

It is argued that the crime of crimen iniuria could be used to remedy the violation of a women's dignity relating to the conduct that she had to endure surrounding the consent procedure. Although such conduct must be intentional it is submitted that the narratives of women clearly indicate that it would be difficult to argue that such verbal abuse was not intentional. Furthermore, on an objective basis it would be difficult for a nurse or doctor to argue that treating a woman in labour with such disdain is not violating their dignity. It is submitted that the courts would frown upon public servants in positions of authority verbally abusing women in such vulnerable circumstances, particularly when this is contrary to the values in the Constitution.

### 5.4 Administrative remedies

#### 5.4.1 Chapter 9 Institutions

In the case of *Ex Parte Chairperson of the Constitutional Assembly: In Re-Certification of the Amended Text of the Constitution of the Republic of South Africa*, the court stated that the Constitution makes provision for a multi-party system of democratic government, with provision for three levels of authority to ensure accountability, responsiveness and openness.[185] This provides a protective framework for civil society, which is enhanced by institutional structures such as the Public Protector, the Human Rights Commission, the Commission for the Promotion and Protection of Rights of Cultural, Religious and Linguistic Communities, and the Commission on Gender Equality.[186]

The Constitution[187] has established the above mentioned state institutions together with the Auditor General and Electoral Commission which have collectively become colloquially known as chapter 9 institutions. As stated eloquently in the case of *SABC v DA*[188] by Judges Navsa and Poonan ''in constitutional democracies, public administrators and State institutions are guardians of the public weal''. The purpose of the chapter 9 institutions is to strengthen constitutional democracy.[189] In order to achieve this mandate section 181 (2)[190] authoritatively asserts the independence of these institutions which are subject only to the Constitution and law. Organs of state are also called upon through legislation and other measures to assist in protecting the independence, impartiality and effectiveness of these

[184] Ibid 467.
[185] 1996 (4) SA 744 (CC) 747-8.
[186] 1997 (2) SA 97 (CC) at para 25.
[187] 1996 Constitution.
[188] (393/2015) [2015] ZASCA 156.
[189] Section 181 (1) of the Constitution of the Republic of South Africa, 1996.
[190] 1996 Constitution.

institutions.[191] According to Murray[192] both the Human Rights Commission and Commission on Gender Equality, could be described as specialist human rights institutions that are modelled on the Paris Principles.[193] The learned author Murray[194] also opines that the shared roles of these two institutions are of monitoring Government and contributing to the transformation of South Africa into a society in which social justice prevails.

Three notable features of these institutions have been identified. Firstly, even though they are state institutions, they are not a branch of government and are outside of government.[195] Secondly, their mandate requires them to be independent and impartial like our courts.[196] Thirdly, they can be described as ''intermediary institutions'', that serve to provide a link between the people on one hand and government and Parliament on the other, especially for those people who are indigent and have limited access to legal services.[197]

Collectively, the work of the Human Rights Commission and Commission on Gender Equality are concerned with the investigation of the implementation of rights and to engage with government and Parliament when there is a lack thereof. [198] This task is made easier by their enabling legislation.[199]

#### 5.4.1.1 The South African Human Rights Commission

The South African Human Rights Commission is a state institution that is established in terms of section 181 (1) (b) of the Constitution.[200] The constitutional mandate of the Human Rights Commission is to promote respect for human rights and a culture of human rights;[201] promote the protection, development and attainment of human rights;[202] and monitor and assess the observance of human rights in the Republic.[203] In furtherance of the aims and objects of the Human Rights Commission the South African Human Rights Commission Act[204] sets out the powers and functions of the Commission. The salient features of the

---

[191] Section 181 (2) of the Constitution of the Republic of South Africa, 1996.
[192] C Murray 'The Human Rights Commission et al: What is the role of South Africa's Chapter 9 institutions?' (2006) 9 (2) *PELJ* 122-147 at 122.
[193] The Paris Principles are a set of international standards which frame and guide the work of National Human Rights Institutions. South Africa is a member state to the Paris Principles. It was adopted by the General Assembly resolution 48/134 of 20 December 1993 available at http://www.ohchr.org/ accessed on 20 November 2015.
[194] Murray 'The Human Rights Commission et al: What is the role of South Africa's Chapter 9 institutions?' (2006) 9 (2) *PELJ* 122-147 at 125.
[195] Ibid 126.
[196] Ibid.
[197] Ibid.
[198] Ibid 133.
[199] Human Rights Commission Act 40 of 2013 and Commission on Gender Equality Act 39 of 1996.
[200] 1996 Constitution.
[201] Section 184 (1) (*a*) of the Constitution of the Republic of South Africa, 1996.
[202] Section 184 (1) (*b*) of the Constitution of the Republic of South Africa, 1996.
[203] Section 184 (1) (*c*) of the Constitution of the Republic of South Africa, 1996.
[204] Act 40 of 2013.

Act[205] are the power of the Commission to monitor implementation of, and compliance with, international and regional conventions and treaties, international and regional covenants and international and regional charters relating to the objects of the Commission.[206]

The Commission may on its accord or upon a complaint being lodged investigate such a complaint.[207] Should the Commission find merit in the complaint lodged by a complainant, the Commission must assist by securing appropriate redress and in certain instances provide the financial means necessary for a complainant to approach a court having jurisdiction to hear the matter for appropriate relief. The Commission may also direct a complainant to an appropriate forum for necessary relief.[208]

The complaint form has three parts to it with the first part requesting biographical details of the complainant. (See Appendix A) The second part should only be completed if the complainant is not bringing the complaint in their own name or it is being brought on behalf of a class of persons. The last part of the form deals specifically with the complaint. It enquires from the complainant whether the complainant is aware of which right or rights in the Bill of Rights have been violated. Details of the person who committed the violation are also required. Similar to the complaints form of the Commission for Gender Equality, information about whether the matter has been reported to any other body, what steps have been taken to resolve the matter and what relief the complainant seeks is also requested. The completed form must then be submitted to one of the nine offices of the South African Human Rights Commission offices.

#### 5.4.1.2 The Commission for Gender Equality

The Commission for Gender Equality was established by section 181 (1) (d) of the Constitution.[209] The functions of the Commission for Gender Equality as set out in section 187 (1) of the Constitution is to promote respect for gender equality and the protection, development and attainment of gender equality.[210]

Further to the functions listed in terms of section 187 (2) of the Constitution, the Commission on Gender Equality Act[211] enumerates the powers and functions of the Commission. The Commission is empowered to monitor and evaluate policies and practices of organs of state at any level; statutory bodies or functionaries and public bodies and authorities in order to promote gender equality and make any recommendations that are

[205] Ibid.
[206] Section 13 (1) (*b*) (vi).
[207] Section 13 (3) (a) of Act 2013.
[208] Ibid.
[209] 1996 Constitution.
[210] 1996 Constitution.
[211] Act 39 of 1996.

deemed necessary.[212] The Act also makes provision for advocacy and training around issues of gender equality.[213] Section 11 (1) (e) mandates the Commission to investigate complaints regarding gender-related issues which the Commission must strive to resolve by way of mediation, conciliation or negotiation[214] or alternatively refer the complaint to the South African Human Rights Commission[215] or Public Protector.[216]

The Commission is also tasked with monitoring the compliance with regards to international conventions, international covenants and international charters in so far as they relate to gender issues.[217]

In order to set an investigation by the Commission for Gender Equality into motion the complainant is required to complete a complaint form. (See Appendix B for a copy of this form). The complaint form has two parts with the first part requesting the biographical information of the complainant. It then goes on to obtain information about the complainant's socio-economic conditions. The complaint form also enquires from the complainant whether the matter has been reported to any other body and whether the complainant is represented. It also seeks to find out what relief the complainant seeks from the Commission.

Part B of the complaint form requests a detailed explanation of the complaint and the nature of the discrimination to be stipulated. It also requires the details of the person or organisation that the complainant is lodging a complaint against.

In assisting the Commission with the investigation of complaints, the Commission may issue a subpoena to any person to appear before it, and also issue a subpoena duces tecum to any person to bring specified documentation which is under their control, to the hearing.[218]

The Commission also has the authority to request for a warrant to be issued by a Magistrate or Judge if the Commission is of the opinion that they require documents that are necessary for their investigation and cannot secure the documents by any other means.[219] The issued warrant will enable the Commission to enter premises in which it believes the documents are stored.[220]

The Commission plays more of a public watchdog role and will be effective in lobbying for change in practices and policies relating to gender equality. The Commission's role must not

[212] Sections 11 (1) (a) (i-iii) of Act 39 of 1996.
[213] S 11 (1) (*b*) of Act 39 of 1996.
[214] Section 11 (1) (*e*) (i) of Act 39 of 1996.
[215] Section 11 (1) (*e*) (ii) A of Act 39 of 1996.
[216] Section 11 (1) (*e*) (ii) B of Act 39 of 1996.
[217] Section 11 (1) (*h*) of Act 39 of 1996.
[218] Section 12 (4) (*b*) of Act 39 of 1996.
[219] Section 13 (1) & (5) of Act 39 of 1996.
[220] Section 12 (3) (*e*) (ii) B of Act 39 of 1996.

be underestimated as it serves to educate, enlighten and eradicate discrimination based on gender.

#### 5.4.1.3 The Public Protector

Sections 181 to 183 of the Constitution make provision for the establishment of the office of the Public Protector and sets out its powers and functions.[221] The powers of the Public Protector originate from the Constitution and the Public Protector Act.[222] Amongst its many functions, it is meant to protect the public from conduct that could result in impropriety or prejudice emanating from officials undertaking State affairs or from any sphere of Government.[223] This is done by undertaking an investigation into a complaint that she has received from a member of the public or through her own volition.[224] Thereafter, he/she is required to report on the conduct and take appropriate remedial action if warranted.[225] The Constitution is silent on the issue of the effect that his/her constitutional power to take remedial action has on the person or organ of State that it is made against. The *Economic Freedom Fighters v Speaker of the National Assembly and Others; Democratic Alliance v Speaker of the National Assembly and Others*[226] case sought clarification on this issue and whether such remedial action is legally binding in light of the President's non-compliance with the Public Protector's directive. Chief Justice Mogoeng in penning the judgment referred to the powers and functions of the Public Protector and held that it could not be conceived that decisions made by this institution are supposed to be ineffectual having regard to its mandate of strengthening our constitutional democracy.[227] The Court further held that decisions of the Public Protector could not have been envisaged to be inconsequential taking into account the time, money and energy expended on the investigations and findings.[228] Therefore, compliance with remedial action suggested by

[221] Constitution of the Republic of South Africa, 1996.
[222] 23 of 1994.
[223] *Economic Freedom Fighters v Speaker of the National Assembly and Others; Democratic Alliance v Speaker of the National Assembly and Others* (CCT 143/15; CCT 171/15) [2016] ZACC 11; 2016 (5) BCLR 618 (CC); 2016 (3) SA 580 (CC) (31 March 2016).
[224] Section 6 (4) (*a*) of Act 23 of 1994.
[225] Section 182 (1) (*b*) and (*c*) of the Constitution of the Republic of South Africa, 1996.
[226] In this case, the Public Protector investigated allegations of improper conduct or irregular expenditure relating to security upgrades at the private residence of the former President of the Republic, Mr J G Zuma. Her investigation stemmed out of complaints from members of the South African public and a Member of Parliament. Her findings were that the President derived an undue benefit from the irregular expenditure of State resources and in doing so breached his constitutional and ethical obligations. The Public Protector directed that the President pay a portion of the money back and reprimand the Ministers involved in the project. Her report was submitted to the President and the National Assembly to facilitate compliance with the remedial action and to hold the President accountable in line with his constitutional obligations. Neither the President nor National Assembly did what they were required to do in terms of the remedial action. *Economic Freedom Fighters v Speaker of the National Assembly and Others; Democratic Alliance v Speaker of the National Assembly and Others* (CCT 143/15; CCT 171/15) [2016] ZACC 11; 2016 (5) BCLR 618 (CC); 2016 paras 2, 3 and 5.
[227] Ibid para 49.
[228] Ibid paras 49 and 54.

him/her is not optional.[229] These wide-ranging powers that the Public Protector has are not unchecked and an aggrieved party may take the directive of remedial action on review but in the absence of requiring further judicial scrutiny it must be complied with.[230]

The office of the Public Protector is central to contributing to good governance in our constitutional dispensation and it has been described as an invaluable gift to our country.[231] The Court held that the directives of remedial action made by the Public Protector were binding and could not be disregarded, doing so would contribute to undermining its independence, impartiality, effectiveness and dignity.[232] By the very nature of its office and the source of its power a complaint to the Public Protector may be unusual but very effective in tackling the root causes of complaints of the systemic rights violations in these sterilisations cases. This is needed in dealing with the issue of HIV positive women being involuntarily sterilised as health care workers acting in a manner contrary to this will not be sanctioned by the rule of law.[233]

The third category of remedies are those that can be collectively grouped together under the banner of administrative remedies. These new forms of relief can be described as being blended. They are remedial in nature but less formal and aim at resolving the cause of the underlying disputes. These purposes are important as they remind us that as a society we must address systemic rights violations to avoid the undermining of the rule of law.

Accessing the Chapter 9 institutions does not pose a significant challenge in terms of costs. The South African Human Rights Commission and Commission on Gender Equality are situated in all nine provinces and the complainants may approach their offices directly or alternatively lodge a complaint in writing. Lodging a complaint with the Chapter 9 institutions does not attract any charges and there is no need for a legal representative. A positive feature of lodging a complaint with the Human Rights Commission in particular is that in terms of their mandate there is a possibility that funds will be provided to access legal services in selected matters.

Similar to the South African Human Rights Commission, a complaint to the Commission for Gender Equality is initiated by filling out a complaint form. Likewise, there are not costs attached to approaching the Commission for Gender Equality and no legal representation is required. The Commission for Gender Equality has the power to evaluate the practices and policies of the Health Ministry upon receiving a complaint from HIV positive women who have been sterilised on the basis of their sex and HIV positive status.[234] In 2015, Her Rights

[229] Ibid paras 49 and 54.
[230] Ibid para 71.
[231] *Economic Freedom Fighters v Speaker of the National Assembly and Others; Democratic Alliance v Speaker of the National Assembly and Others* (CCT 143/15; CCT 171/15) [2016] ZACC 11; 2016 (5) BCLR 618 (CC); 2016 (3) SA 580 (CC) (31 March 2016) paras 50 and 52.
[232] Ibid paras 81 and 103.
[233] Ibid para 68.
[234] Section 11 (1) (*a*) (i) of Act 39 of 1996.

Initiative, together with the International Community of Women Living with HIV Southern Africa (two NGO's) and forty eight women who were coercively sterilised lodged a complaint with the Commission for Gender Equality.[235] The complaint called for an investigation into the practice of coercive sterilisations in State hospitals, law reform and redress for this group of women.[236] In 2016 Her Rights Initiative disbanded due to a lack of funding and no further information has been found on the referral of this complaint to the Commission for Gender Equality.

To date no complaint on this issue has been submitted to the Public Protector. Nevertheless, it is submitted that given the binding nature of their remedial action and its ability to investigate the discriminatory conduct of a state official, this may be an avenue for positive women to consider in the future.

### 5.4.2 Professional Bodies Regulating the Conduct of Health Professionals

#### 5.4.2.1 Health Professions Council

The Health Professions Council of South Africa (hereafter referred to as the HPCSA) is a statutory body that was created in terms of the Health Professions Act 56 of 1974. All health care practitioners who practice in South Africa are obliged to register with the Health Professions Council. Their registration then serves to subject them to the Ethical Guidelines for Good Practice in the Health Care Professions.

The first set of guidelines that are important for our purpose is ''Seeking Patient's Informed Consent: The Ethical Considerations.''[237] The guidelines clearly recognise that the ethical notion of informed consent is codified in the National Health Act, various other statutes, the common law and Health Professions Council South Africa Guidelines.[238]

Many of the guidelines on informed consent are in accordance with the provisions of the National Health Act.[239] It is worth mentioning that the guidelines reiterate that it is the duty of the health care practitioner to obtain a patient's informed consent before treatment is given.[240] The definition of a 'health care practitioner' does not include a nurse in terms of the guidelines.[241] Even though the guidelines do make provision for the delegation of the

---

[235] Women's Legal Centre 'Press release: The South African government must do more to prevent coerced sterilisations in public hospitals', [2015], available at http://wlce.co.za/wp-content/uploads/2017/02/WLC-Media-Release_Coerced-Sterilisation_141116.pdf accessed on 28 December 2017.
[236] Ibid.
[237] Health Professions Council of South Africa *Guidelines for Good Practice in the Health Care Professions 'Seeking Patient's Informed Consent: The Ethical Considerations'* 2 ed (2008) Booklet 9, available at http://www.hpcsa.co.za.
[238] Ibid.
[239] Health Professions Council of South Africa available at http://www.hpcsa.co.za/Professionals.
[240] Health Professions Council of South Africa *Guidelines for Good Practice in the Health Care Professions 'Seeking Patient's Informed Consent: The Ethical Considerations'* 2 ed (2008) Booklet 9 available at http://www.hpcsa.co.za.
[241] Section 1 of National Health Act 61 of 2003.

task of obtaining informed consent[242] the guidelines unequivocally state that the responsibility for obtaining a patient's informed consent to treatment, investigation or procedure will remain the responsibility of the health care practitioner.[243]

In instances where a patient's informed consent was obtained by a third party, a health care practitioner cannot rely on the form that has recorded the patient's consent.[244] The guidelines require the health care practitioner to ascertain from the patient how well they understand the proposed procedure and the attendant risks attached to it.[245]

Besides guidelines on consent, the HPCSA has issued The General Ethical Guidelines for Reproductive Health.[246] These recognise that because none of the current methods of fertility control fully satisfies the ideal of safety, effectiveness, reversibility, ease and religious acceptance, contraceptive counselling is needed.[247] Medical practitioners are urged to respect and have regard to the autonomy of the woman when discussing contraceptive methods.[248] This requirement extends to health care personnel as well who are required to take into account the input and opinions of women wishing to access contraceptives.[249]

The guidelines also require that a range of appropriate contraceptive methods be discussed with a woman, with appropriate counselling services being at hand.[250] Choosing sterilisation as a form of contraception is significantly different from choosing other methods of contraceptives because of the permanency of the procedure and the potential irreversibility of the procedure. The rationale behind having ethical considerations for sterilisation procedures stems from the fact that decisions about sterilisation involve personal values and therefore may be subject to inappropriate practitioner bias.[251] A medical practitioner's personal values should not be thrust upon the patient when making a decision about sterilisation. The ethical considerations that have been put forth by the Health Professions Council are that a medical practitioner should strive to encourage the patient to include other appropriate persons including her partner in the decision making process as a decision to opt to be sterilised may significantly affect the lives of others.[252]

---

[242] Health Professions Council of South Africa *Guidelines for Good Practice in the Health Care Professions 'Seeking Patient's Informed Consent: The Ethical Considerations'* 2 ed (2008) Booklet 9 available at http://www.hpcsa.co.za.
[243] Ibid 6.
[244] Ibid 10.
[245] Ibid.
[246] Health Professions Council of South Africa *Guidelines for Good Practice in the Health Care Professions 'General Ethical Guidelines for Reproductive Health'* 2 ed (2008) Booklet 13, available at http://www.hpcsa.co.za.
[247] Ibid 6.
[248] Ibid.
[249] Ibid 7.
[250] Ibid.
[251] Ibid.
[252] Ibid.

A medical practitioner cannot withhold other medical care in lieu of the patient agreeing to undergo sterilisation.[253] This would be regarded as coercive and is unacceptable in terms of the Guidelines. Furthermore, the medical practitioner's personal values or sense of societal objectives should never be a basis for urging a patient to undergo sterilisation.[254] The patient's race, ethnicity, socio-economic status[255] and the number of children[256] should also never be grounds for encouraging a patient to be sterilised. Informed consent on the part of the patient is vital. With the assistance of counselling, patients are much better placed to make an informed decision as the patient would have been made aware of the permanency of the procedure; that her life circumstances may change and that she may regret her sterility.[257]

Any person who alleges unethical conduct by a medical practitioner may lodge a complaint with the Health Professions Council of South Africa. The complaints form requires full details of the patient, the medical practitioner and the nature of the complaint to be specified fully. (See Appendix C for a copy of this form).

Once the complaint has been submitted to the Registrar of the Health Professions Council of South Africa the Registrar must within 7 days refer such complaint to the medical practitioner and request a written explanation from him/her. The medical practitioner may refuse to provide a response to the complaint. Thereafter the statement of the patient and medical practitioner's response, if submitted, will be sent to the Professional Board for consideration.

Should the Professional Board be of the opinion that there are merits in the complaint a professional conduct enquiry will be held by the Professional Conduct Committee. The Professional Conduct Committee will hear oral evidence of the parties and expert witnesses. The media and members of public are permitted to be present at these hearing unless prohibited by the chairperson of the Professional Conduct Committee.

Should the medical practitioner be found guilty of misconduct the medical practitioner may appeal against this decision. The Professional Conduct Committee may impose the following penalties on a medical practitioner who has been found guilty of misconduct:-

(i) A caution or a reprimand or both;
(ii) A fine;
(iii) Suspension for a specified period from practising his/her profession;
(iv) Removal of his/her name from the relevant register;
(v) A compulsory period of professional service; or
(vi) Payment of the costs of the proceedings.[258]

[253] Ibid.
[254] Ibid.
[255] Ibid.
[256] Ibid 8.
[257] Ibid.
[258] http://www.hpcsa.co.za/Conduct/Complaints accessed on 1 July 2015.

Complaints to the HPCSA by patients, and in our case HIV positive women, who have been sterilised without their informed consent either in a State or private hospital may be made in writing. There are no cost implications for the patient and assistance is provided to the patient by the HPCSA when she is presenting her case. Even though there is no time limit within which to lodge a complaint, a difficulty that may be encountered by women who have been sterilised in State hospitals, is establishing the identity of the medical practitioner due to the passage of time.

Research that has been conducted in South Africa shows that only African women have been subjected to this gross human rights violation.[259] According to the HPCSA, racial discrimination is considered to be unprofessional conduct and disciplinary steps may be taken by the Council against a medical practitioner for discriminating on the basis of a patient's race.[260] It is submitted that if a medical practitioner is found guilty of unprofessional conduct, the sanction that is imposed will have the effect of letting the women know that the unprofessional conduct they were subjected to was unacceptable and unlawful. In some instances, a medical practitioner may be prevented from practising for a specified period of time or alternatively struck off the roll of the HPCSA.

#### 5.4.2.2 The South African Nursing Council

The South African Nursing Council (hereafter referred to as the SANC) is a professional body that sets and maintains the standards of nurses in terms of the Nursing Act 50 of 1978. The Council has listed certain acts or omissions committed on the part of nurses that are regarded as unprofessional conduct. Contained on the list is ''forcing a patient to sign a consent for a surgical procedure.''[261] Should a patient be subjected to conduct contained on the list of misconduct then that patient must under oath and in writing set out the details of the alleged misconduct; the nature of the conduct complained of; details of the nurse(s) and names of any witnesses involved.[262] Once a complaint is received it is investigated and all relevant information is collected.[263] This information is then submitted to the Preliminary Investigation Committee which has the power to either impose a fine on the nurse or refer the complaint to the Professional Conduct Committee.[264] If the latter option is chosen the Professional Conduct Committee will hold a formal enquiry where evidence will be heard

[259] Essack & Strode 'I feel like half a women all the time: The impacts of coerced and forced sterilisations on HIV-positive women in South Africa' (2012) 26 (2) *Agenda* 24-34 at 30-31.
[260] HPCSA 'Conduct and ethics', available at http://www.hpcsa.co.za/Public/ConductEthics accessed on 28 December 2017.
[261] Available at http://www.sanc.co.za/complaintsMisconduct.htm accessed on 18 February 2017.
[262] Ibid.
[263] Ibid.
[264] Ibid.

and a ruling made.[265] The sanctions that can be imposed on the nurse do not offer any monetary or other relief to the patient and only serves to punish the nurse.[266]

Unprofessional conduct by a nurse may be reported to the professional body governing the conduct of nurses. The reporting procedures are simple and do not require the services of a legal representative nor are there any cost implications. HIV positive women may lodge a complaint against a nurse for forcing them to sign a consent form to be sterilised. A finding of guilty can attract a sanction of suspension or a removal from the roll of nurses. A key problem however may be identifying the nurse on duty at the time of the sterilisation procedure being performed.

None of the administrative remedies discussed above make provision for monetary compensation to be paid to the complainants. Relief obtained from these bodies aims at reprimanding the health workers concerned or bringing about change which will benefit other HIV positive women who seek family planning options. This is a significant disadvantage as the women in the Strode et al study all expressed a desire for financial compensation.[267] Although complaints to a professional body may not bring much relief to individual women, they may assist in attempts to change the institutional culture within the health care system. Holding health care workers to account for their failure to respect the dignity of patients under their care may result in a valuable shift from patient paternalism to autonomy.

### 5.5 Discussion

An evaluation of the remedies indicates that a civil claim for damages appears to be the most appropriate in the circumstances. Although other remedies exist none of these are able to address the problem in a holistic manner. However, it is submitted that the focus on the civil law remedy would only be successful if it was driven by NGOs or Human Rights Organisations as was done in the *LM*[268] and *Sithole*[269] cases. The reasons advanced for the submission that a civil damages claim is most suited to the women who have been sterilised forcibly or coercively for a discriminatory reason are the following. Firstly, a solid legal framework on the substantive and procedural law applicable to a damages claim is in place. Secondly, using this route allows us to address both the claims of bodily and psychological integrity, dignity and equality. Thirdly, the Court has the power to award a range of remedies including damages and specific performance. Fourthly, given that this specific

[265] Ibid.
[266] The sanctions that can be imposed are the removal of the nurse from the register of nurses, suspension from practising; a caution, a reprimand, a fine or the payment of the costs of the proceedings. Available at http://www.sanc.co.za/complaintsmisconduct.htm accessed on 18 February 2017.
[267] Strode et al '"She made up a choice for me": 22 HIV-positive women's experiences of involuntary sterilization in two South African provinces' (2012) 20 (39S) *Reproductive Health Matters* 1-9.
[268] *LM and others v The Government of the Republic of Namibia* case no 1603/2008, available at http://www.saflii.org/na/cases/NAHC/2012/211.html accessed on 1 July 2015.
[269] *Sithole v The MEC for Health and Social Development & 3 Others* – unreported case no. 19744/2012 – High Court of South Africa, Gauteng Local Division, Johannesburg.

type of civil matter can only be heard in the High Court, any judgment could potentially be of precedent value and this increases media attention on the issue and could possibly place pressure on the Department of Health to address the causes of the problem. Fifthly, none of the other remedies have been successful in other jurisdictions. Nevertheless, it is submitted that for a civil claim to be successful it will require strong institutional support for individual litigants through an NGO and further research and documentation of circumstances under which the forced and coerced sterilisations continue to thrive.

When considering the use of the civil law as a remedy there would be two primary causes of action, one relating to consent and the other to violations of dignity and equality. It appears from chapter 2 and 3 that the consent would be easier to prove. In order to ensure that sterilised HIV positive women have access to justice the discriminatory and judgemental attitudes on the part of health care providers need to be addressed. It is particularly difficult to cope with the emotional abuse which has the effect of making HIV positive women reluctant to access sexual reproductive health care services.[270] In the words of Gruskin, ''HIV-related stigma and discrimination have restricted the success of HIV prevention, care and treatment programmes and reduced the willingness of people with HIV to disclose their status or to seek out sexual and reproductive health services.''[271] The end result of this is that HIV positive women shy away from approaching health care providers for advice on child-bearing and reproductive health issues.[272] The consequences of this are dire as HIV positive women have different reproductive health related needs from those of HIV negative women and require care from health care providers.[273] In particular, HIV positive women are more susceptible to contracting pre-cancerous cervical cell abnormalities, they require medication during the period of gestation and during child-birth, medication also needs to be administered to babies after their birth, in some instances a caesarean section is performed and the nursing of babies must not be through breastfeeding.[274] The severe negative reaction that HIV positive women receive from health care providers may lead to this group of women concealing their status from family and health care providers and therefore not accessing antiretroviral treatment timeously.[275] Addressing the abusive and discriminatory attitudes and conduct of health care workers is complex. Nevertheless, there are a range of legal remedies that can be used including firstly, individual civil claims that may be brought against health care workers and or the institution that employs them. This approach may well be difficult as proving the wrongful

[270] E Bell et al 'Sexual and reproductive health services and HIV testing: Perspectives and experiences of women and men living with HIV and Aids' (2007) 15 (29) *Reproductive Health Matters* 113-135 at 127.
[271] S Gruskin et al 'Ensuring sexual and reproductive health for people living with HIV: An overview of key human rights, policy and health systems issues' (2007) 15 (29) *Reproductive Health Matters* 4-26 at 12.
[272] A Ramkissoon et al 'Options for HIV-positive women' (2006) 1 *South African Health Review* 315 – 332 at 316.
[273] Gruskin et al 'Ensuring sexual and reproductive health for people living with HIV: An overview of key human rights, policy and health systems issues' (2007) 15 (29) *Reproductive Health Matters* 4-26 at 6.
[274] Ibid.
[275] J E Mantell et al 'The right to choose parenthood among HIV-infected women and men' (2009) 30 (4) *J Public Health Policy* at 3.

conduct will be hard as the plaintiff will in all likelihood have to rely on her own testimony. In the *LM*[276] case this was the approach that was used and it appears to have been insufficient even though the High Court did not expressly comment on the deficiencies of their evidence. Secondly, they could lay a criminal charge of crimen iniuria but they would have to overcome the hurdle of showing that that the health care worker's conduct was intentional. Thirdly, they could lay a complaint with the Equality Court and in all likelihood this would be the best forum for a discrimination dispute as it is speedy, cheap, accessible and its jurisdiction is limited to these types of matters, see chapter 4 for more details. Finally, they could use an administrative remedy, that is, a complaint to a professional body or complaint to a Chapter 9 institution. It is submitted that using the first two remedies would help to achieve an individual sense of justice for the women whilst the administrative remedies are more likely to help with systemic change to the health care system.

A significant problem with any civil matter which aims at remedying a violation of a woman's dignity or discrimination against her on the basis of her HIV status would be the evidentiary burden of proving unfair discrimination. Once it has been established that the HIV positive women who have been sterilised without their informed consent are afforded protection by domestic laws, regional and international covenants and conventions, it becomes important to ascertain how exactly these rights have been violated. Once this is ascertained, a strategy needs to be developed to show how evidence supporting this contention will be presented to the Court. The manner in which this will be done is by leading oral testimony of the women and through the use of documentary evidence to support the oral evidence. Documentary evidence in our case will take the form of hospital records. This includes the patient's outpatients encounter form (if applicable), the admission form, labour admission chart, obstetrical clinical records, consent to operation form, sterilisation consent by patient form, operating cases layman's form, pre and post – operative nursing care form containing detailed notes by the nurses, doctors and midwives' clinical notes, labour admission chart, caesarean section form, examination of the neonate form, summary of labour form, control chart, observation nursing care chart, results flow chart, and discharge summary form.[277]

Further important documentary evidence that will be required from the hospital will be a statement/incident form which reflects the events surrounding the sterilisation. Depending on whether the patient is aware of all the names of the health care practitioners involved in the sterilisation procedure, a request for the duty roster must be made. Without obtaining the above information it will be virtually impossible to commence with the institution of legal proceedings. The HPCSA Guidelines recommend that medical records be stored for a

[276] *LM and Others v Government of the Republic of Namibia* (I 1603/2008, I 3518/2008,/ 3007/2008) [2012] NAHC 211 (30 July 2012).

[277] This was the documentary evidence that was relied on in the *Sithole* case. The documents formed part of her hospital records. *Sithole v The MEC for Health and Social Development & 3 Others* – unreported case no. 19744/2012 – High Court of South Africa, Gauteng Local Division, Johannesburg.

period of six years from the date of the patient's file becoming dormant.[278] However, the loss of these medical records could become a real impediment for women wishing to institute a claim against the health ministry and its servants responsible for the unlawful sterilisation.

No jurisdiction either nationally or internationally has made a finding of discrimination in litigation around the forced or coerced sterilisation of women for a discriminatory reason. Despite there being findings on the lack of full and informed consent in the Slovakian[279] and Namibian[280] decisions, the Courts in both instances did not find that the sterilisations took place for a discriminatory reason. The judgments in these cases remained silent on what evidence would be required to show that the medical practitioners sterilised the women for discriminatory reasons. In the *LM* case the Court held that the plaintiffs failed to lead evidence about the discriminatory treatment that they were subjected to and hence this aspect of their claim was dismissed.[281]

In a dissenting judgment penned in the *VC* case, the learned Judge's disbelief that the majority of the Court found that it was not necessary to examine the allegations of discriminatory treatment that the Roma women were subjected to, was tangible. The Judge was of the firm belief that the discriminatory treatment based on the Roma women's ethnicity was widespread and the last remnants of the existence of a State policy into the sterilisation of Roma women was still being felt.[282] According to the learned Judge this view is supported by the fact that cases of a similar nature are pending before the Courts.[283] The mere fact that ''patient is of Roma origin'' was written on the hospital file was not coincidental. The Government argued that this was necessary as Roma women needed ''special attention'' with regards to their health care. The learned Judge was of the firm view that the ''special attention'' referred to earmarking these women to be sterilised. The coerced sterilisation of Roma women could not have been ''accidental'' as the European Commission against Racism and Intolerance on Slovakia documented ongoing sterilisation of the Roma women and found that the public attitude towards this minority group remained generally negative.[284]

---

[278] Available at http://www.hpcsa.co.za/downloads/conduct_ethics/ rules/ generic_ethical_rules/ booklet_14_keeping_of_patience_records.pdf accessed on 27 December 2017.
[279] Application no. 18968/07 European Court of Human Rights available at http://www.menschenrechte.ac.at/orig/11_6/V.C..pdf accessed on 1 July 2015.
[280] *Government of the Republic of Namibia v LM and Others* (SA 49/2012) [2014] NASC 19 (3 November 2014).
[281] C J Badul & A Strode '*LM and others v The Government of the Republic of Namibia*: The first sub-Saharan African case dealing with coerced sterilisation of HIV-positive women – *Quo vadis*' (2013) 13 *African Human Rights Law* Journal 223-238 at 231.
[282] Application no. 18968/07 European Court of Human Rights, available at http://www.menschenrechte.ac.at/orig/11_6/V.C..pdf accessed on 1 July 2015 at p 44.
[283] Ibid.
[284] Application no. 18968/07 European Court of Human Rights available at http://www.menschenrechte.ac.at/orig/11_6/V.C..pdf accessed on 1 July 2015 at p 44-45.

Likewise it would be argued that the sterilisation of HIV positive women during caesarean sections is not coincidental. The *LM* case showed that the women's HIV status was noted in their files and it is clear that the medical practitioners would have been aware of this information.[285] In the Strode study many of the women reported that they were told by the health care workers that they needed to be sterilised for reasons relating to their HIV status.[286] In a broader context of stigma and discrimination of people living with HIV it is argued that this ought to be sufficient to show prima facie evidence of HIV discrimination.

The advantages of using the criminal law as a remedy is that there are no legal costs attached to the use of this remedy. The women will be represented by the State and therefore the use of a legal representative is not required. The issue of prescription will not be a challenge in this instance as the complainant has a period of twenty years from the date of the sterilisation to lay a complaint against a medical practitioner.[287] There are however, drawbacks in using the criminal justice system which cannot be dismissed. Where a medical practitioner faces a charge of assault, intention must be proved. It is submitted that the State may encounter difficulties with this element of the crime if there is a signed consent form. With regards to contravention of the Sterilisation Act,[288] it is submitted that the Act[289] is silent on whether proof of negligent or intentional conduct on the part of the medical practitioner will suffice to secure a conviction. Thus far, there has been no successful prosecution of a medical practitioner for assault or alternatively the contravention of the Sterilisation Act.[290] It is submitted that public policy issues may deter the State from prosecuting or in the event of there being a prosecution, imposing a custodial sentence on a medical practitioner who has been charged with crimes arising out of sterilising HIV positive women without their informed consent.

It appears from a review of the other sterilisation cases discussed in chapter 2, and the South African legal remedies discussed above, with this type of issue, which is broad based in nature there is a greater possibility of success if a legal response is driven by an NGO. In terms of the remedies described above an NGO may appoint a legal representative to lead a civil claim on behalf of the plaintiff and they are able to undertake a watching brief in any of the other remedies proposed. NGOs undertaking litigation of a human rights nature will be able to make the litigation simply one element of a larger strategic intervention to address the underlying issues. In this case we submit that the coerced or forced sterilisation of HIV positive women was founded on discriminatory attitudes and the law cannot on its own change such views. We argue that this broader concept of justice was particularly successful in Namibia as it has brought about systemic change. The *Sithole* case

[285] *Government of the Republic of Namibia v LM and Others* (SA 49/2012) [2014] NASC 19 (3 November 2014).
[286] Strode et al '''She made up a choice for me'': 22 HIV-positive women's experiences of involuntary sterilization in two South African provinces' (2012) 20 (39S) *Reproductive Health Matters* 1-9.
[287] See discussion at 5.5.1 in Chapter 5.
[288] 44 of 1998.
[289] Ibid.
[290] Ibid.

demonstrates that the NGO could litigate even on the basis of a single claimant. There is no need to show that the practice is systemic. The advantages of the civil, criminal and administrative remedies are discussed further chapter 6.

**5.6 Conclusion**

In South Africa there is a constitutional right to have any legal dispute ventilated in Court, tribunal or another forum.[291] In furtherance of this guaranteed right South Africa has a broad range of legal remedies. There are three possible legal avenues which HIV positive women can use in order to obtain legal relief. They may invoke the civil law or criminal law which would involve litigation. They also have the option of approaching the three Chapter 9 institutions and the professional bodies for medical practitioners and nurses which is non-litigious in nature. All of these avenues have advantages and disadvantages attached to them. It is submitted, that where the cause of action is a failure to obtain informed consent, all three avenues can be pursued. However, where discrimination is the cause of action the criminal law remedy can only be used in terms of the crime of crimen iniuria. In such a case the victim would need to be able to show her dignity was violated intentionally through the discriminatory conduct. A criminal charge of assault, crimen iniuria or contravention of the Sterilisation Act and complaints to the South African Human Rights Commission, Commission for Gender Equality, Public Protector and the Health Professional Bodies can run parallel to the civil claim.

This thesis has adopted a broad definition of access to justice that evaluates legal and administrative remedies on the basis of a range of factors. It is submitted that given the range of options, women are able to identify what would be appropriate relief in their individual capacity or as part of advocacy by a Non-Governmental Organisation.

[291] Section 34 of the Constitution of the Republic of South Africa, 1996.

# Chapter 6

# Achieving access to justice for HIV positive women alleging forced or coerced sterilisation

## 6.1 Introduction

This chapter critically discusses the facilitators and barriers to access to justice. It breaks down the concept of access to justice into five factors which are measured against the lived experiences of HIV positive women who desire legal and other redress. This chapter starts with a discussion on the law on prescription as this is a fundamental legal bar to any civil matter and will apply regardless of the merits of the matter. It concludes with an evaluation of the extent to which sterilised HIV positive women could access the legal remedies described in chapter 5.

## 6.2 Prescription

Time bars and legislation that have the effect of limiting the time within which legal action may be instituted are referred to as prescription.[1] Prescription has been defined as occurring when various types of obligations may be extinguished or rendered unenforceable by the effluxion of time.[2] Failure to institute legal action timeously, ultimately equates to the interests of justice being compromised with the prolonged delays leading to uncertainty in the affairs of those concerned.[3] Prescription is a particularly significant issue for the South African women who participated in the Strode et al study.[4] In this research there was only one participant whose case had not prescribed which effectively indicated that it was highly unlikely that any of the others could utilise any of the civil law remedies.

Case law has provided us with an array of convincing reasons which cannot easily be disregarded, regarding the purpose of having prescriptive periods in our law. In *Mohlomi's* case Judge Didcott held that in instances where witnesses are available their recollection of events may be unreliable.[5] In addition, prescription serves the purpose to protect a debtor

[1] *Road Accident Fund and Another v Mdeyide* (CCT 10/10) [2010] ZACC 18; 2011 (1) BCLR 1 (CC); 2011 (2) SA 26 (CC) (30 September 2010) at para 101.
[2] J S Saner *The Law of South Africa* (21) (2010) 2 ed at 103.
[3] *Mohlomi v Minister of Defence* (CCT41/95) [1996] ZACC 20; 1996 (12) BCLR 1559; 1997 (1) SA 124 (26 September 1996) at para 11 and JS Saner 'Prescription' in *The Law of South Africa* 2 ed (2010) at 103.
[4] A Strode et al '''She made up a choice for me'': 22 HIV-positive women's experiences of involuntary sterilization in two South African provinces' (2012) 20 (39S) *Reproductive Health Matters* 1-9.
[5] Ibid. Similar sentiments have been expressed in the case of *Road Accident Fund and Another v Mdeyide* (CCT 10/10) [2010] ZACC 18; 2011 (1) BCLR 1 (CC) ; 2011 (2) SA 26 (CC) (30 September 2010) at para 8 where Van der Westhuizen J stated that ''the quality of adjudication by courts is likely to suffer as time passes, because evidence may have become lost, witnesses may no longer be available to testify, or their recollection of events may have faded. The quality of adjudication is central to the rule of law. For the law to be respected, decisions of courts must be given as soon as possible after the events giving rise to disputes and must follow from sound reasoning, based on the best available evidence.''

from old claims against which it cannot effectively defend itself because of a loss of records or witnesses caused by the lapse of time.[6] In essence, the rules of prescription prevent procrastination and the harmful consequences of it which cannot convincingly be ignored.[7] In *Links v MEC, Department of Health, Northern Cape Province*, the court held that the other side of this principle is that if it is applied too strictly it can violate a litigant's rights in terms of section 34 of the Constitution.[8] This point is of particular importantance in the context of forced or coerced sterilisations where most plaintiffs are likely to be poor and unaware of their rights and the need to institute legal action within certain time periods.

Prescription applies across all areas of our civil and criminal law. The prescription period for criminal offences is 20 years.[9] The prescription periods that relate to civil claims are listed in the Prescription Act 68 of 1969. The periods described in this Act would apply to any delictual claim or any claim in terms of PEPUDA. The table below sets out the various periods.

**Table 6.1: Extinctive prescription periods as set out in the Prescription Act 68 of 1969**

| **Prescription Period** | **30 Years** | **15 Years** | **6 Years** | **3 Years** |
|---|---|---|---|---|
| **Nature Of The Claim** | -For a debt secured by a mortgage bond;<br>-Any judgment debt;<br>-Any debt in respect of a taxation;<br>-Any debt owed to the state in respect of claims relating | -Any debt owed to the state in respect of claims relating to the advance of money or sale or lease of land. | -In respect of a debt arising from a negotiable instrument or notarial contract. | -In respect of any other debt. |

[6] *Uitenhage Municipality v Molloy* 1998 2 SA 735 (SCA).
[7] *Mohlomi v Minister of Defence* (CCT41/95) [1996] ZACC 20; 1996 (12) BCLR 1559 (CC); 1997 (1) SA 124 (CC) (26 September 1996) at para 11.
[8] *Links v Member of the Executive Council, Department of Health, Northern Cape Province* (CCT 29/15) [2016] ZACC 10; 2016 (5) BCLR 656 (CC); 2016 (4) SA 414 (CC) (30 March 2016) at para 22.
[9] Section 18 of the Criminal Procedure Act 51 of 1977 states that the right to institute a prosecution for any offence will prescribe after a period of 20 years from the date on which the offence was committed unless it is an offence of murder, treason, robbery with aggravated circumstances, kidnapping, rape, the crime of genocide; crimes against humanity and war crimes and human trafficking for sexual purposes.

| | | | | |
|---|---|---|---|---|
| | to the mining of minerals. | | | |

A departure from the prescriptive periods contained in the Prescription Act[10] is permissible in certain instances. In these deserving instances, the Court will grant condonation which will then have the effect of allowing the litigant access to justice.[11] For the purposes of this dissertation the three year period is of relevance to us which in effect means that women who have been sterilised either without their informed consent or coercively, have a period of three years to institute action for a claim for damages. The crucial question is then when does prescription begin to run, taking into account the provisions of section 12 (3) of the Prescription Act 68 of 1969. Section 12 (3) provides ''A debt shall not be deemed to be due until the creditor has knowledge of the identity of the debtor and of the facts from which the debt arises: Provided that a creditor shall be deemed to have such knowledge if he could have acquired it by exercising reasonable care.''

With the advent of the Constitution, and more especially section 39 (2)[12] it is now mandatory for Courts when interpreting legislative provisions to do so through the prism of the Constitution.[13] This mandatory interpretation is activated when the legislative provision concerned affects a right or rights in the Bill of Rights.[14] For our purposes, the right being affected is the right to access to the Courts in terms of section 34.[15] In such instances, the Court will be duty bound to promote the object, spirit and purport of the Bill of Rights.[16] According to Jafta J ''the objects of the Bill of Rights are promoted by, where the provision is capable of more than one meaning, adopting a meaning that does not limit a right in the Bill of Rights.''[17]

It is trite that section 10 (1) read with sections 11 and 12 of the Prescription Act has the effect of limiting a litigant's right to access the courts which has been guaranteed by the Constitution.[18] However, section 39 (2) mandates courts to invoke this section when discharging their judicial function of interpreting legislation which involves a right in the Bill

[10] 68 of 1969.
[11] *Road Accident Fund and Another v Mdeyide* (CCT 10/10) [2010] ZACC 18; 2011 (1) BCLR 1 (CC); 2011 (2) SA 26 (CC) (30 September 2010) at para 103.
[12] This section makes it mandatory for a Court, tribunal or forum when interpreting legislation; and when developing the common law or customary law, to promote the spirit, purport and objects of the Bill of Rights. Constitution of the Republic of South Africa, 1996.
[13] *Makate v Vodacom (Pty) Ltd* (CCT52/15) [2016] ZACC 13; 2016 (6) BCLR 709 (CC); 2016 (4) SA 121 (CC) (26 April 2016) at para 87.
[14] Ibid at para 88.
[15] Constitution of the Republic of South Africa, 1996.
[16] *Makate v Vodacom (Pty) Ltd* (CCT52/15) [2016] ZACC 13; 2016 (6) BCLR 709 (CC); 2016 (4) SA 121 (CC) (26 April 2016) at para 88.
[17] Ibid at para 89.
[18] Ibid at para 90.

of Rights.[19] Therefore, on the authority of *Makate*[20] an interpretation of the word debt that must be preferred is the one that has the least intrusive effect on the right of access to courts.[21] The learned Judge stated that:

Constitutional rights conferred without express limitation should not be cut down by reading implicit limitations onto them, and when legislature provisions limits or intrudes upon those rights they should be interpreted in a manner least restrictive of the right if the text is reasonably capable of bearing that meaning.[22]

The Prescription Act is silent on the definition of debt. In order to seek out the true meaning of debt turning to recent case law for assistance would be helpful. The narrow definition of debt as set out in the *ESCOM*[23] case has come to be accepted in the Constitutional Court case of *Off-Beat Holiday Club*,[24] as opposed to the broad definition of debt as set out in the *Desai* case.[25] The debate on whether to accept the broad or narrow definition of debt was settled in the *Makate* case.[26] The *ESCOM* case held that a debt is ''that which is owed or due; anything (as money, goods or services) which one person is under obligation to pay or render to another.''[27]

It is important at this point to examine what is meant by a 'debt' being due. In the Supreme Court of Appeal case of *Truter v Deysel,*[28] Van Heerden JA stated that:

> For the purposes of the Act, the term 'debt due' means a debt, including a delictual debt, which is owing and payable. A debt is due in this sense when the creditor acquires a complete cause of action for the recovery of the debt, that is, when the entire set of facts which the creditor must prove in order to succeed with his or her claim against the debtor is in place or, in other words, when everything has happened which would entitle the creditor to institute action and to pursue his or her claim.[29]

The concept of cause of action was expounded in the case of *Evins v Shield Insurance Co Ltd*[30] where it was held that ''every fact which it would be necessary for the plaintiff to

---

[19] Ibid.
[20] *Makate v Vodacom (Pty) Ltd* (CCT52/15) [2016] ZACC 13; 2016 (6) BCLR 709 (CC); 2016 (4) SA 121 (CC) (26 April 2016).
[21] Ibid at para 91.
[22] Ibid.
[23] *Electricity Supply Commission V Stewarts and Lloyds of SA (Pty) Ltd* 1981 (3) SA 340 (A).
[24] *Off-Beat Holiday Club and Another v Sanbonani Holiday Spa Shareblock Limited and Others* (CCT106/16) [2017] ZACC 15; 2017 (7) BCLR 916 (CC) (23 May 2017).
[25] The term debt was held to mean ''a wide and general meaning, and includes an obligation to do something or refrain from doing something.'' *Desai NO v Desai NNO and Others* (718/93) [1995] ZASCA 113; 1996 (1) SA 141 (SCA); (22 September 1995) 9.
[26] *Makate v Vodacom (Pty) Ltd* (CCT52/15) [2016] ZACC 13; 2016 (6) BCLR 709 (CC); 2016 (4) SA 121 (CC) (26 April 2016).
[27] *Electricity Supply Commission v Stewarts and Lloyds of SA* (Pty) Ltd 1981 (3) SA 340 (A) 344.
[28] 2006 (4) SA 168 (SCA).
[29] Ibid.
[30] 1980 (2) All SA 40 (A) 57.

prove, if traversed, in order to support his right to judgment of the Court. It does not comprise every piece of evidence which is necessary to prove each fact, but every fact which is necessary to be proved.''

In addition, the court stated that the proper legal meaning of the expression 'cause of action' is the entire set of facts which gives rise to an enforceable claim and includes every fact which is material to be proved to entitle a plaintiff to succeed in his claim. It includes all that a plaintiff must set out in his declaration in order to disclose a cause of action. Such cause of action does not 'arise' or 'accrue' until the occurrence of the last of such facts and consequently the last of such facts is sometimes loosely spoken of as the cause of action.[31]

In a unanimous judgment by the Constitutional Court in the case of *Links v MEC, Department of Health, Northern Cape Province*,[32] clarity was given on how the provisions of section 12 (3) of the Prescription Act[33] must be interpreted. The Court went on to state that this case concerns the constitutionally protected right to security of the person as entrenched in section 12 of the Constitution.[34]

The issue before the Court in this matter was whether the applicant's claim had prescribed by the 6 August 2009 when the summons was served on the respondent.[35] In such a matter, the onus rests on the respondent to prove that a period of three years had elapsed

---

[31] Ibid.

[32] *Links v Member of the Executive Council, Department of Health, Northern Cape Province* (CCT 29/15) [2016] ZACC 10; 2016 (5) BCLR 656 (CC); 2016 (4) SA 414 (CC) (30 March 2016). The salient facts of the case are that the applicant Mr Links, sought medical treatment on the 26 June 2006 at the Kimberley Hospital for a dislocated thumb on his left hand. A plaster of Paris cast was put on the applicant's left hand and forearm. The applicant was sent home and was asked to return after 10 days in order to have the cast removed. Around the 30 June 2006 the applicant went back to the hospital complaining of severe pain and discomfort in his left hand. The applicant was then given pain medication and requested to return in five days. The applicant returned to the hospital before the expiry of the five days and on the 5 July 2006 he was operated on and his left thumb was amputated. The applicant had to then undergo further operations for the removal of dead, damaged and infected tissue. In November 2006 the applicant approached a private firm of attorneys to establish why he had lost the use of his left hand and why his thumb had been amputated. The applicant being indigent, approached the Legal Aid Board in Kimberley for assistance in December 2006. The Legal Aid Board neglected to institute action against the respondent on behalf of the applicant for almost three years. Prior to the expiry of the three year period the applicant was referred to his attorneys of record for assistance. Within a matter of days the applicant sent out a section 3 notice to the respondent as required by the Institution of Legal Proceedings against Certain Organs of State Act 40 of 2000. This was followed through with the issue of summons against the respondent. The summons was served on the respondent on the 6 August 2009. Upon receipt of the summons two special pleas were raised by the respondent. The first special plea was that the section 3 notice failed to comply with the provisions of the Act and the second being that the applicant's claim had prescribed because the summons was served after the lapse of the three year period from the date on which the applicant's thumb was amputated namely the 5 July 2006. The full bench of the Northern Cape High Court pronounced that the applicant's claim had prescribed and therefore could not condone his failure to give notice as contemplated in section 3 of the Institution of Legal Proceedings against Certain Organs of State Act 40 of 2000.

[33] 68 of 1969.

[34] *Links v Member of the Executive Council, Department of Health, Northern Cape Province* (CCT 29/15) [2016] ZACC 10; 2016 (5) BCLR 656 (CC); 2016 (4) SA 414 (CC) (30 March 2016) at para 22.

[35] Ibid at para 24.

from the date the debt became due and in addition the respondent must show what facts the applicant was required to know before prescription could commence running.[36] In this case, the respondent had to show that the applicant had full knowledge of those facts on or before the 5 August 2006.[37] Judge Zondo stated that:

> The provisions of section 12 seek to strike a fair balance between, on the one hand, the need for a cut-off point beyond which a person who has a claim to pursue against another may not do so after the lapse of a certain period of time if he or she has failed to act diligently and on the other the need to ensure fairness in those cases in which a rigid application of prescription legislation would result in injustice. As already stated, in interpreting section 12(3) the injunction in section 39(2) of the Constitution must be borne in mind. In this matter the focus is on the right entrenched in section 34 of the Constitution.[38]

The applicant's contention remained that he did not have the requisite knowledge on or before the 5 August 2006 which, would place him in good stead to institute a claim against the respondent.[39] The Court further stated that:

> In cases of this type, involving professional negligence, the party relying on prescription must at least show that the plaintiff was in possession of sufficient facts to cause them on reasonable grounds to think that the injuries were due to the fault of the medical staff. Until there are reasonable grounds for suspecting fault so as to cause the plaintiff to seek further advice, the claimant cannot be said to have knowledge of the facts from which the debt arises.[40]

The provisions of section 12 (3) of the Prescription Act[41] were then examined by the court. The respondents in discharging the onus placed on them stated that ''the applicant's cause of action arose on 26 June 2006 and the applicant had knowledge of all the relevant facts on that day."[42] To this averment, the Court stated that ''in a claim for delictual liability based on the Aquilian action, negligence and causation are essential elements of the cause of action. Negligence, and, as this Court has held, causation have both factual and legal elements. Until the applicant had knowledge of facts that would have led him to think that possibly there had been negligence and that this had caused his disability, he lacked knowledge of the necessary facts contemplated in section 12(3).

[36] Ibid.
[37] Ibid
[38] Ibid at para 26.
[39] Ibid at para 28.
[40] Ibid at para 42.
[41] Act 68 of 1969.
[42] *Links v Member of the Executive Council, Department of Health, Northern Cape Province* (CCT 29/15) [2016] ZACC 10; 2016 (5) BCLR 656 (CC); 2016 (4) SA 414 (CC) (30 March 2016) at para 44.

The Court unequivocally pronounced that the applicant had no knowledge of what had caused his left hand thumb to be amputated as at the 5 August 2006.[43] In explaining why such a finding was made the Court stated that:

> The opinion given by Dr Reyneke was that the amputation of the applicant's thumb and loss of function of the left hand "was most probably due to the plaster of paris that was too tight, and not removed soon enough . . .when ischemia occurred". That opinion was given years after the events in issue. Without advice at the time from a professional or expert in the medical profession, the applicant could not have known what had caused his condition. It seems to me that it would be unrealistic for the law to expect a litigant who has no knowledge of medicine to have knowledge of what caused his condition without having first had an opportunity of consulting a relevant medical professional or specialist for advice. That in turn requires that the litigant is in possession of sufficient facts to cause a reasonable person to suspect that something has gone wrong and to seek advice.[44]

The Constitutional Court appears to have departed from the Supreme Court of Appeal's position in *Truter* in that, rather than finding that prescription runs from the point from which there is knowledge of the debt, Zondo J held that the creditor / litigant must be aware of some wrongdoing on the part of the debtor. In this context of sterilisation abuse this more liberal approach would mean that the cause of action is not the date of the sterilisation per se but rather the date that a woman became aware that her rights had been violated. However, it is submitted that this generous interpretation of section 12 (3) of the Prescription Act would only apply when it is alleged that a debt arises from the violation of a constitutional right. This means that potential litigants would have to rely on for example a violation of the right to bodily integrity, dignity and equality in terms of section 12 of the Constitution.

This dissertation focuses on women who have been sterilised either without their informed consent or coercively in public hospitals. In essence this means that action must be instituted against the Minister of Health who is vicariously liable for the actions of the doctor who performed the sterilisation and the health professional who failed to take the informed consent. Instituting action against an organ of state is governed by the Institution of Legal Proceedings Against Certain Organs of State Act 40 of 2002. Section 3 of the Act[45] provides for the giving of notice to an organ of state from which a debt is claimed, prior to the institution of proceedings. In essence, the requirement is now that written notice must be given within six months from the date on which the debt became due.[46] The notice is peremptory and legal proceedings cannot be instituted prior to such notice being given subject to the provisions of section 3 (4) of the Act.[47] The notice requires that the facts

[43] Ibid at para 46.
[44] Ibid at para 47.
[45] Section 3 of the Institution of Legal Proceedings against Certain Organs of State Act 40 of 2002.
[46] Ibid.
[47] 40 of 2002.

giving rise to the debt and the particulars of the debt that are within the knowledge of the creditor must be set out.[48]

Failure to serve notice timeously may be condoned, on application to a court, if the court is satisfied that the debt has not already been extinguished by prescription,[49] if good cause exists for the failure to serve notice timeously and if the organ of state was not unreasonably prejudiced by the failure.[50]

This procedural requirement which only applies to claims made against an organ of state appears to be out of line with the constitutional court's focus on ensuring that litigants are not denied their constitutional rights to have their disputes settled by a competent court. For example, in the *Sithole* coerced sterilisation matter, the sterilisation was performed on the 4 June 2009. The date on which Sithole became aware of the material facts giving rise to her claim was on the 17 November 2011. Thereafter, *Sithole's* legal representatives despatched the required notice in terms of section 3 (1)(a) of the Institution of Legal Proceedings Against Certain Organs of State Act on the 21 December 2011 to the MEC for Health and Social Development, two medical practitioners and the nurse involved in the sterilisation. Summons was then served on the 30 May 2012. The defendants raised a special plea[51] pleading that the debt became due on the 4 June 2009 and the notice required in terms of the Act should have been sent to the defendants within six months from that date. In response, *Sithole's* legal representatives made an application for condonation for the non-compliance of sections 3 (1 ) (*a*) and 3 (2) (*a*) of the Act. In *Sithole's* case, the defendants initially opposed the application but at a later stage acceded to the coerced sterilisation matter and condonation was granted for the late filing of the required notice.

There is no on-going evidence of the continued sterilisation of HIV positive women. This may be due to the State's roll out of antiretroviral medication and the longer life expectancy of persons living with HIV. As stated above the data in the Strode et al study showed that most of the cases were more than three years old. These would all be cases against the Ministry of Health and there are stricter time limits that apply in this regard. It is submitted that the only argument that could be made in a condonation application would be that the women did not know that their sterilisation was without informed consent, for a

[48] Section 3 (2) (*b*) (i) and (ii) of Act 40 of 2002.
[49] For our purposes section 11 (*d*) of the Prescription Act 68 of 1969 is applicable.
[50] Section 3 (4) (*b*) (i), (ii) and (iii).
[51] A special plea is a plea that raises a special defence regarding a legal problem in the plaintiff's case. It does not concern itself with the merits of the plaintiff's case. A special plea that is raised successfully can have the effect of bringing the plaintiff's case to an end regardless of the merits of the case. It can also have the effect of delaying the plaintiff's cause of action. A special plea of extinctive prescription is raised when a plaintiff institutes action against the defendant after the prescriptive period for a particular type of claim has lapsed. In instances, where a Court upholds a special plea of prescription the defendant will no longer be legally liable to the plaintiff. S Pete & D Hulme et al *Civil Procedure: A Practical Guide* 3 ed (2017) 211, 213.

discriminatory reason and was wrongful. Based on the *Links*[52] case above it is argued that they could show that they only became aware of it on the date that they first heard of the forced or coerced sterilisations being wrongful.

### 6.3 Strengths and weaknesses of the legal framework for sterilisations

South Africa has an extensive legal framework dealing with sexual and reproductive rights. The Constitution sets the landscape for women to have autonomy over the decisions relating to their reproductive choices.[53] Although there is a statutory framework which is based on the Constitutional principles, there are a number of gaps and weaknesses in this framework. The section below highlights the strengths within the current law and then identifies some key weaknesses.

The strengths and weaknesses of the South African legal framework have been evaluated on the basis of 5 core principles; the functionality of the justice system, affordability of legal services, accessibility of legal remedies and their acceptability to the complainants and whether the legal remedies hold individuals and the State accountable for wrongdoing.[54]

#### 6.3.1 Functionality of the justice system

In order to have a legal system that facilitates access to justice rather than the individual resolution of disputes there must be a functioning legal system in place. In South Africa, the State provides for a system of courts to adjudicate both on civil and criminal matters. In criminal matters the State takes an active role in investigating, prosecuting and adjudicating cases, whilst in civil matters which are private in nature the State simply provides access to adjudication services. The State regulates the actions of health professionals through the creation of a number of statutory bodies, and one of the core functions of such professional bodies is the resolution of disputes. Finally, in the constitutional era the Constitution has created the Chapter 9 institutions. These are all State funded statutory bodies which have wide ranging powers to investigate complaints, report on their findings and make recommendations for the resolution of the dispute. The advantage of the way in which the South African legal framework is structured is that complainants have a wide range of options available to them in resolving disputes. For example, our Chief Justice has always gone to great lengths to promote access to justice for the poor in South Africa and has taken the opportunity by stating that:

> Litigation is prohibitively expensive and therefore not an easily exercisable constitutional option for an average citizen. For this reason, the fathers and mothers of our

[52] *Links v Member of the Executive Council, Department of Health, Northern Cape Province* (CCT 29/15) [2016] ZACC 10; 2016 (5) BCLR 656 (CC); 2016 (4) SA 414 (CC) (30 March 2016) at para 44.
[53] Section 12 (2) (*a*) of the Constitution of the Republic of South Africa, 1996.
[54] *Economic Freedom Fighters v Speaker of the National Assembly and Others; Democratic Alliance v Speaker of the National Assembly and Others* (CCT 143/15; CCT 171/15) [2016] ZACC 11; 2016 (5) BCLR 618 (CC); 2016 (3) SA 580 (CC) (31 March 2016).

> Constitution conceived of a way to give even to the poor and marginalised a voice, and teeth that would bite corruption and abuse excruciatingly. And that is the Public Protector. She is the embodiment of a biblical David, that the public is, who fights the most powerful and very well-resourced Goliath, that impropriety and corruption by government officials are. The Public Protector is one of the true crusaders and champions of anti-corruption and clean governance.[55]

This quote shows that even if funds are an obstacle to pursuing a matter there are a number of statutory bodies that could be utilised to resolve the matter. In this regard, the South African framework is unique as the remedies do not focus only on punishment and redress only, as in certain circumstances the remedies allow for the ordering of transformative change. For example in the *TAC*[56] case the Court ordered the Department of Health to roll out the prevention of mother to child transmission programme across the country.

Many of the issues that relate to whether the legal system is functioning in a way that promotes access to justice are procedural in nature. The first procedural hurdle that is required to be overcome by the litigant before instituting action against the Health Ministry and its servants is to send a legal notice to the possible defendants in terms of the Institution of Legal Proceedings against Certain Organs of State Act.[57] The Act[58] requires that such notice must be sent within six months of the debt becoming due. This is a significant hurdle for many potential litigants who have faced sterilisation abuse, as the literature has revealed that many of the women only become aware of their rights many years later.

It is possible to argue that the date on which the cause of action arose will be the date on which the material facts from which the claim arose becomes known to the claimant. This means that prescription would run from the date of knowledge of wrongfulness and not the date of sterilisation. If this argument is accepted it may well be possible for some of the women to institute civil claims against the Ministry of Health. It is possible that the Health Ministry's legal representative would oppose the approach and argue that the matter prescribed if they were not notified of a possible claim six months after the date on which the sterilisation was performed. In the *Sithole*[59] case, the date of the sterilisation was the 4th June 2009 and the date on which Sithole became aware that her rights had been violated was on the 17 November 2011. This was almost two and a half years after the date of the sterilisation.

Once a period of thirty days expires and there is no response from the defendants, the plaintiff's legal representative will proceed with the issuing of a summons. Presumably, a

---

[55] Ibid para 52.
[56] (CCT8/02) [2002] ZACC 15; 2002 (5) SA 721; 2002 (10) BCLR 1033 (5 July 2002).
[57] 40 of 2002.
[58] Ibid.
[59] *Sithole v The MEC for Health and Social Development & 3 Others* – unreported case no. 19744/2012 – High Court of South Africa, Gauteng Local Division, Johannesburg.

notice of intention to defend the action will be filed by the defendants, as a failure to do so will result in default judgment being taken against the defendants. The next procedural step that may be taken by the defendants would be to file their plea. Before pleading on the merits of the case, the defendants may in all likelihood raise a special plea of prescription alleging that the claim has prescribed because of the late filing of the notice as required in terms of section 3 of the Act.[60] This procedural step was taken in *Sithole's*[61] case by the defendants. At this stage the plaintiff will have to make an application for condonation for the late filing of the notice. This can be a setback for the plaintiff should the court not grant the application for condonation as it has the effect of dismissing the plaintiff's claim. Where a woman becomes aware of her rights three years after the date of the sterilisation she would have to apply for condonation for the late filing of the notice. The defendant may raise a special plea of prescription which would in all probability be opposed by the plaintiff as she will raise as her defence the date on which she became aware of the material facts giving rise to her claim. It is of concern that all of the violations occurred in State hospitals and the six month rule applies. It is argued that section 3 of the Institution of Legal Proceedings against Certain Organs of State Act[62] is in conflict with section 12 (3) of the Prescription Act[63] and in our instance only serves to place an onerous burden on the plaintiff. The rationale for this observation is that claims against the State are treated differently to claims against individuals or juristic persons which is not justifiable. In our case the protection of the State against late claims adds an additional onerous burden on poor women, who are often illiterate and do not have access to legal advice.

After pleadings have been exchanged and the close of pleadings is reached, the parties will apply for a trial date and commence with pre-trial preparations. Pre-trial notices will be filed, medical examinations will take place and this will culminate in a pre-trial conference being held. The filing of pleadings and notices are governed by strict time limits in terms of the Uniform Rules of Court.[64] Preparation for trial will then take place and it is at this point that the plaintiff's legal representative must consider who bears the burden of proof and what evidentiary burden must be satisfied to be successful with their claim.

The substantive law will govern on whom the burden of proof rests depending on the nature of the claim. In our case, the burden of proof will rest on the plaintiff since what is being alleged is negligence and the legal consequences of negligence are being attached to a fact.[65] With regards to the discrimination allegation, the plaintiff will be relying on the

[60] 40 of 2002.
[61] *Sithole v The MEC for Health and Social Development & 3 Others* – unreported case no. 19744/2012 – High Court of South Africa, Gauteng Local Division, Johannesburg.
[62] 40 of 2002.
[63] 68 of 1969.
[64] Available at http://www.justice.gov.za/legislation/rules/UniformRulesCourt[26jun2009].pdf accessed on 1 January 2018.
[65] P J Schwikkard & S E Van Der Merwe *Principles of Evidence* 4ed (2016) at 617.

ground of HIV which does not feature as a listed ground in the Constitution.[66] The burden will be on the plaintiff once again to show that the discrimination was unfair. The evidential burden refers to the duty of the plaintiff to make out a triable case and for the defendant to adduce evidence to rebut the case made out by the plaintiff.[67] The plaintiff will therefore have to adduce evidence to the effect that either (a) even though she signed the consent form this was not done voluntarily or (b) the procedure was done without her written consent. This evidence will be adduced orally at trial by the plaintiff herself and any other witnesses that she may call to support her allegations. The plaintiff will have to give oral testimony regarding the actions of the health care practitioners or other hospital staff towards her whether it was verbal or non-verbal in nature to make out a case for lack of informed consent and discrimination. Whilst having a functional legal system is important, such a system has to be based on a series of procedural rules based both in the civil and criminal law to ensure that all parties are treated fairly. These procedural rules are open to manipulation by the defendant and this can result in a high level of frustration by plaintiff's who feel that justice is being delayed.[68] This is illustrated by the *Madida*[69] case where the Department of Health was able to delay the matter by failing to comply with procedural timelines. The loss of hospital records by the defendants could also have the effect of impacting on the functionality of the court system. It may impact on the patient's ability to prove their case as the onus rests on them to prove negligence on the part of the doctors and health care workers. In the absence of vital records of the patient, this task would be significantly more onerous.[70]

Based on the discussion above it is submitted that we have a functional court system. The functionality of the court system may however, be open for manipulation by defendants. In this instance the women would have to proceed against a well-resourced Ministry of Health who in some instances may have little regard for procedural time lines.[71] This once again contributes to the disadvantage suffered by individual women to obtain redress for their unlawful sterilisation. The Strode et al study indicated that many women wanted reversals done as part of their relief. In such cases, time delays would make such processes less likely to succeed.

[66] Section 9 (3) of Act 18 of 1996.
[67] Schwikkard & Van Der Merwe *Principles of Evidence* 4ed (2016) at 622-623.
[68] *Madida obo M v Mec for Health for the Province of Kwa-Zulu Natal* (14275/2014) [2016] ZAKZPHC 27 (14 March 2016) at para 23.
[69] Ibid.
[70] *Khoza v Member of the Executive Council for Health And Social Development of the Gauteng Provincial Government* (2012/20087) [2015] ZAGPJHC 15; 2015 (3) SA 266 (GJ); [2015] 2 All SA 598 (GJ) (6 February 2015) at para 47 and 70.
[71] Ibid at para 42.

### 6.3.2 Affordability

Affordability is a key element to access to justice because if there is no State funding for legal services it means that the poor are excluded from these dispute resolution mechanisms. The narratives of HIV positive women and other women who have been sterilised for other discriminatory reasons is clearly woven together by the underlying thread of poverty.[72] One of the ripple effects of poverty is that it poses a significant barrier to access to justice as the possibility of hiring a legal representative is non-existent. There is only one instance in which our Constitution merits payment of legal costs for civil litigation by the State. These are instances where a child is concerned. Section 28 (1) (*h*) makes provision for a state appointed legal practitioner to assist a child in civil proceedings in cases where a substantial injustice would arise.[73] Section 28 (1) (*h*)[74] is unlikely to assist in this instance as a child may not be sterilised and in the narratives referred to above the youngest participant was 19 years old.[75]

Legal Aid South Africa will provide free legal assistance for a limited category of civil matters to litigants who cannot afford legal representation. These are confined to family matters, evictions, employment issues, contract matters and impact litigation.[76] The envisaged outcome of impact litigation matters litigated by Legal Aid South Africa must have the effect of providing relief to a large group of persons or a broader community.[77] In this instance it means that the only way HIV positive women who claim to be victims of sterilisation abuse could apply for legal aid is to lodge a civil claim where the anticipated outcome would have an impact on way the HIV positive women are treated during child birth. It is argued that it would be hard to make a case for this issue to be dealt with by Legal Aid South Africa as there is no evidence of it having been carried out in terms of a policy and it is unlikely that it is continuing.

The cost of civil litigation is governed by a tariff which dictates how a client will be billed for work done. There are different tariffs for the superior and inferior courts.[78] For an HIV

---

[72] As reflected in studies conducted in South Africa, Kenya and Namibia.

[73] D McQuoid-Mason 'Access to justice in South Africa: Are there enough lawyers?' (2013) 3 (3) *Oñati Socio-Legal Series* 561 at 565. Another instance where free legal representation is provided at the expense of the State is to an accused in a criminal matter. This is catered for in terms of section 35 (3) (*g*) of the Constitution.

[74] Constitution of the Republic of South Africa, 1996.

[75] Essack & Strode 'I feel like half a women all the time: The impacts of coerced and forced sterilisations on HIV-positive women in South Africa' (2012) 26 (2) *Agenda* 24.

[76] Available at http://www.legal-aid.co.za/ accessed on 29 September 2017.

[77] Available at http://www.legal-aid.co.za/?p=929 accessed on 29 September 2017. According to McQuoid-Mason the types of cases that are most likely to be taken on are those that involve child-headed households, AIDS orphans women, the rural poor, the landless, farmworkers and matters concerned with the socio-economic rights of the poor. McQuoid-Mason 'Access to justice in South Africa: Are there enough lawyers?' (2013) 3 (3) *Oñati Socio-Legal Series* 561 at 567.

[78] See 'Magistrates' courts: Amendment of the rules of court; GNR 33, GG 38399, p 50ff, 23 January 2015, available at http://www.justice.gov.za/legislation/notices/2015/20150123-gg38399_rg10349_gon33-RulesBoard.pdf accessed on 29 September 2017 for the Magistrate's Court tariff and 'Amendment of the rules regulating the conduct of the proceedings of the several provincial and local divisions of the high court of

positive woman who has been sterilised without her informed consent it is most likely that she will have to access private legal representation. Therefore, it can be safely assumed that an HIV positive woman who has been sterilised without her informed consent, will utilise the High Court to obtain redress. This will be done to claim damages and/or for an order for specific performance as the jurisdictional limit for claims is above four hundred thousand rand. Should a reversal of the sterilisation be sought as relief, this would be regarded as an order for specific performance and this type of claim must be heard in the High Court.[79] This in turn means that she will be responsible for legal costs at a higher rate. In addition to the exorbitant legal fees that will certainly be an obstacle in the path to accessing justice, there are other costs that must be taken into consideration. A prudent attorney will not discount the possibility of a cost order being granted against an HIV positive woman who is not successful at trial. Further, the cost of travelling to the legal practitioner for consultations, the possibility of losing income as a result of not being at work whilst attending consultations or medical examinations and the cost of consulting with medical experts cannot be ignored.

It is undeniable that the issue of legal representation is linked intrinsically to affordability. According to McQuoid-Mason most attorneys and advocates practise in urban areas which serve the more affluent communities.[80] The converse of this is that litigants from indigent communities struggle to secure competent free legal representation in civil matters of this nature. Even though a matter can be brought before the Equality Court and High Court without legal representation and the plaintiff may act in their own capacity it will be argued that this is far from being ideal. The complexities of litigation for an unrepresented litigant will only serve to compromise their case or alternatively having it dismissed by the Court. The women in all the cases discussed thus far, dealing with the forced or coerced sterilisation for a discriminatory reason were represented by non-governmental organisations. The Women's Legal Centre represented *Sithole*;[81] in the Namibian case of *LM & Others*[82] the women were represented by the Legal Assistance Centre; The Centre for Civil and Human Rights represented the Romani women with their litigation in Slovakia; and in Kenya the ongoing litigation is being driven by Kenya Legal & Ethical Issues Network on HIV and AIDS (KELIN).[83]

---

South Africa'; GNR 31, GG 38399, p 18ff, 23 January 2015, available at 'http://www.justice.gov.za/legislation/notices/2015/20150123-gg38399_rg10349_gon31-RulesBoard.pdf accessed on 29 September 2017 for the High Court tariff.

[79] A claim for specific performance cannot be heard in the Magistrate's Court if it is not accompanied by an alternative claim for damages in terms of section 46 (2) (*c*) of the Magistrate's Court Act 32 of 1944.

[80] McQuoid-Mason 'Access to justice in South Africa' (1999) 230 (17) *Windsor Y.B Access to Justice* 1.

[81] *Sithole v The MEC for Health and Social Development & 3 Others* – unreported case no. 19744/2012 – High Court of South Africa, Gauteng Local Division, Johannesburg.

[82] *LM and others v The Government of the Republic of Namibia* case no 1603/2008, available at http://www.saflii.org/na/cases/NAHC/2012/211.html accessed on 1 July 2015.

[83] *SWK and others v Médecins Sans Frontières and others* Petition No. 605 of 2014, In the High Court of Kenya at Nairobi Constitutional and Human Rights Division.

Given that there will be limited access to state legal aid unless the sterilisation matter is classified as a form of impact litigation there will be no state funding for it. In this context it means that HIV positive women would have to fund the matter themselves or seek the services of a pro bono lawyer or NGO to assist them if they wish to use the civil law as a remedy.

### 6.3.3 Accessibility

The key issues which relate to the accessibility to legal remedies is knowledge of legal rights by the plaintiffs/complainants and the geographic access to courts.

For our purposes, the awareness of the right to bodily and psychological integrity, the right to equality and dignity are key as they form the foundation of the HIV positive women's cause of action. It is awareness of these constitutionally protected rights that women who are sterilised without their informed consent for discriminatory reasons must be aware of before instituting legal action. Apart from having knowledge of the protection afforded by various domestic laws women must also have knowledge of protection afforded by regional and international legal instruments. Thus far, all the impact litigation around the forced and coerced sterilisation of women for a discriminatory reason, stemmed from findings conducted by human rights organisations. In Namibia, the International Community of Women Living with HIV/AIDS raised awareness about the gross sexual reproductive health and human rights violations suffered by HIV positive women. In the Slovakian cases, the women became aware of their rights after a fact finding mission was conducted around the reproductive health rights of Romani women. In Kenya, The Africa Gender and Media Initiative Trust (GEM) uncovered sexual reproductive health and human rights violations after a study was conducted that had the exclusive focus on HIV positive women. In the South African case of *Sithole*,[84] she only became aware that her sexual reproductive and human rights had been violated after being interviewed as part of a study being conducted by Her Rights Initiative. It is therefore indisputable that timeous knowledge of rights is a prerequisite to access to justice.[85]

Apart from knowledge of the laws conferring rights on HIV positive women, they are also required to have knowledge of institutions that offer ancillary relief apart from relief that can be offered by the courts. These institutions are the Health Professions Council of South Africa, South African Nursing Council, South African Human Rights Commission, Commission for Gender Equality and the Public Protector.

The lack of knowledge of laws and rights or alternatively becoming aware of these laws and rights after an effluxion of time will result in procedural hurdles being encountered by the

[84] *Sithole v The MEC for Health and Social Development & 3 Others* – unreported case no. 19744/2012 – High Court of South Africa, Gauteng Local Division, Johannesburg.
[85] M Nyenti 'Access to justice in the South African social security system: Towards a conceptual approach' (2013) 46 (4) *De Jure* 901 at 914.

litigant. In this particular instance, there has been a lack of awareness around the issue of forced or coerced sterilisations of HIV positive women, as a human rights issue. It is submitted that this issue has to compete with many other key issues that impact on women's well-being either directly or indirectly. Some of these issues are domestic violence, maintenance for their children, health related matters and other socio-economic rights issues such as access to housing or social grants. These issues seem to command more awareness. This lack of knowledge around the forced or coerced sterilisations results in a low number of women coming forward to access impact litigation services.

The physical location of courts may have the effect of restricting access to justice. There are fourteen High Courts in South Africa all of which are situated in the major cities. The amount of money being claimed by a plaintiff is one of the factors that dictate at which Court legal proceedings will be instituted. In all likelihood, the amount that will be claimed for damages relating to the coerced or forced sterilisation of HIV positive women would require that action be instituted in a High Court.

It is submitted that there is limited accessibility to the legal system by HIV positive women who have been sterilised without their consent. This is illustrated by the fact that there has only been one matter that has been brought before a South African court even though the latest stigma index study in South Africa showed that at least one hundred HIV positive women felt that they had been victims of sterilisation abuse.[86] It appears that the key reason that women are not coming forward for legal assistance is because of their lack of knowledge of their rights.

### 6.3.4 Acceptability

There are a number of factors that impact on whether plaintiffs or complainants feel that justice has been done. These include amongst others the time it takes to resolve the matter, the associated costs (discussed above) and achieving their desired outcome.

The law's delays have been the subject of complaints from litigants for many centuries, and it behoves all courts to make proper efforts to ensure that the quality of justice is not adversely affected by delays in dealing with cases which are brought before them, whether in bringing them on for hearing or in issuing decisions when they have been heard.[87] This observation, by our Chief Justice Judge Mogoeng Mogoeng captures the effect that time delays have on litigants. Time delays in litigation cannot lay at the feet of one role-player alone. Delays on the part of the parties, legal representatives and the court system contribute to lengthy delays. Too few courts and presiding officers are often the causes of

[86] LL Gonzalez 'Almost 10 percent of HIV-positive women report forced sterilisation – study', 10 June 2015, available at https://www.health-e.org.za/2015/06/10/ almost-10-percent-of-hiv-positive-women-report-forced-sterilisation-study/ accessed on 25 May 2018.

[87] 'Speech by the Chief Justice of the Republic of South Africa Chief Justice Mogoeng Mogoeng at the opening of the provincial case flow management workshop at Port Alfred, 19 July 2012',2, available at http://www.judiciary.org.za/doc/Speech-CJ_19-July-2012_EL.pdf accessed on 8 October 2017.

postponements. The approximate time it takes to obtain a trial date is between six months and two years in the KwaZulu-Natal High Courts.[88] Unfortunately, the rules of the Court offer endless opportunity for the shrewd litigant or legal representative to drag out a matter almost endlessly.[89] The results of inordinate delays in civil litigation proceedings have the effect of increasing the already high cost of civil litigation.[90] Long periods of delays in having matters heard may contribute significantly to the poor quality of evidence that will be given by witnesses.[91] Poor litigants who are often unemployed and who do not have the funds to make phone calls to their lawyers or to see them may be further prejudiced by the long and lengthy delays.[92] The overall result will be that the justice system will be held in a low esteem by litigants.[93]

This difficulty is being addressed by the introduction of an initiative by the Office of the Chief Justice in the form of a case flow management system. The introduction of the judicial case flow management in civil matters is as a result of the ''ongoing criticisms related to excessive delays in the finalisation of cases that are experienced in courts around the country.''[94] This new concept to the judiciary has been described as the process ''through which courts move cases from inception to ultimate conclusion.'' [95] The aim in civil litigation is to reduce the time delays from the issuing of a summons to the delivery of judgment, and hence effectively ensuring that the pace of the litigation is not controlled by the parties and their legal representatives.[96] This is a move away from litigant driven litigation towards judicial management of cases where judicial officers are expected to set and enforce procedural time limits.[97]

It is hard to state unequivocally whether HIV positive women are satisfied with the justice system because this issue has not been researched. Nevertheless, it appears from other literature that there is dissatisfaction with the time delays as it places an extra financial burden on poor litigants. It was beyond the scope of this dissertation to assess the extent to which the system is effective.

---

[88] Pete & Hulme et al *Civil Procedure: A Practical Guide* 3ed (2017) at 263.
[89] 'Speech by the Chief Justice of the Republic of South Africa Chief Justice Mogoeng Mogoeng at the opening of the provincial case flow management workshop at Port Alfred, 19 July 2012', 10, available at http://www.judiciary.org.za/doc/Speech-CJ_19-July-2012_EL.pdf accessed on 8 October 2017.
[90] Ibid at
[91] Ibid.
[92] Ibid.
[93] Ibid.
[94] N Manyathe-Jele 'Progress on judicial case-flow management' 2014 *De Rebus*, available at http://www.saflii.org/za/journals/DEREBUS/2014/65.pdf.
http://www.saflii.org/za/journals/DEREBUS/2014/65.pdf
[95] 'Speech by the Chief Justice of the Republic of South Africa Chief Justice Mogoeng Mogoeng at the opening of the provincial case flow management workshop at Port Alfred, 19 July 2012', 5, available at http://www.judiciary.org.za/doc/Speech-CJ_19-July-2012_EL.pdf accessed on 8 October 2017.
[96] Ibid.
[97] Ibid at 6.

### 6.3.5 Accountability

There is only access to justice if the legal system is able to hold those liable for the alleged wrongdoings accountable. In South Africa the civil law can be used to hold health care practitioners individually accountable and their employers vicariously liable. The civil law can order payment of damages and specific performance such as in vitro fertilisation treatment. In terms of the criminal law, health care practitioners could also be held individually accountable for their unlawful actions. The criminal law can hold individuals accountable through imposing a range of sentences such as imprisonment or a fine. The criminal law cannot hold the institution where the abuse occurred liable. Finally, the administrative remedies can impose individual or collective accountability. It can also order systemic changes to be implemented.

It is submitted that there is the possibility of HIV positive women holding the medical practitioners, their employees and the Ministry of Health accountable. This is evidenced by the range of different sanctions that could be imposed.

## 6.4 Conclusion

South Africa has emerged from a fragmented past that has moved from denying the majority of its citizens the franchise, separate public health care facilities, different education systems, demarcated recreational facilities and different laws many of which promoted segregation like the Immorality Act of 1957 and Group Areas Act of 1950. Further, under apartheid, access to justice was not a principle that featured strongly in its legal system. We have however, bravely navigated our country into being a constitutional state where access to justice is a fundamental right for all of its people. In addition, the creation of specialist courts has also played a role in ensuring access to justice for all. A good example of these are the Equality Courts. It is insufficient to declare that we have a functional system of courts without taking into account factors that may actually lead to a conclusion that access to justice is a distant reality for poor, illiterate, vulnerable, HIV positive women. The concept of access to justice in this thesis is measured against the ability of this class of women to obtain legal relief that suits their individual needs. The potential causes of action that have been identified are violations of equality, dignity and bodily and psychological integrity. The equality violation may be ventilated in the Equality Court. Although this forum requires no legal representation it may be argued that it would be extremely difficult for illiterate women to approach this forum, institute and understand the nature of legal proceedings without the assistance of an NGO. The remaining two causes of action are best suited to be canvassed in a High Court. In this instance, the challenge would be to secure competent free legal representation. It cannot be ignored that all the litigation that was instituted on behalf of HIV positive women who were sterilised without informed consent nationally and regionally was not undertaken by private legal practitioners. Further, NGOs may be well equipped to deal with this human rights

violation but a drawback for the women is actually finding out about them and their services.

This dissertation has used a matrix of five factors to assess the extent to which HIV positive women could obtain justice when pursuing legal claims for sterilisation abuse. However, it is accepted that there are other factors that may impact on their ability to obtain the relief they desire. These include for example whether they have competent legal representation. Further, whilst the outcome of a matter may not necessarily be the most important issue for an NGO, for individual women looking for financial compensation a successful outcome may be the only way that they would measure access to justice.

It is paramount that the factors, barriers, strengths and weaknesses of each of these remedies need to be assessed in a context specific manner as the challenges experienced by HIV positive women who have been sterilised without their full and informed consent is unique to them. This also rings true for other women who have been sterilised for other discriminatory reasons.[98] The common denominator that characterises this group of women is that they are poor, illiterate, they desire more children and they have the need to be accepted by their partners, families and communities. These serve to make them a vulnerable and marginalised group in society and therefore deserving of the utmost protection of the law. Although, an adequate legal framework exists to protect the rights of women who been sterilised for a discriminatory reason, this does not equate to them obtaining justice. This chapter has shown that five enablers are needed in order to ensure that justice is achieved. Unfortunately, in the South African context, state legal services are granted in very limited instances outside of the criminal justice system. This means that access to courts and affordability of legal practitioners will always be an issue for the poor. Further, the acceptability of legal remedies to the women can be best described as a double-edged sword. Apart from the women receiving financial compensation they strongly desire to be placed in the same situation they were in prior to the sterilisation, which may not become a reality for many of them. Holding health care workers and doctors accountable is possible in a range of ways however, it appears to be underutilised thereby having limited effect on dealing with the root cause of the problem. Therefore, it is submitted that all five enablers need to be connected to each other before HIV positive women who have been sterilised can access justice successfully.

[98] 'Case of V.C. v Slovakia'; application no. 18968/07 European Court of Human Rights available at http://www.menschenrechte.ac.at/orig/11_6/V.C.pdf accessed on 1 July 2015.

# Chapter 7

# Conclusion

## 7.1 Introduction

This chapter provides a summary of the study and examines the key findings of this dissertation on the forced or coerced sterilisation of HIV positive women for discriminatory reasons, in South Africa in particular. It then deals with the complexities associated with these findings and concludes by setting out recommendations to address some of these complexities and issues.

The interest in the topic arose largely out of research undertaken by Strode, Mthembu and Essack who, in 2011, documented the experiences of South African women who had been subjected to forced or coerced sterilisations. Whilst forced sterilisations happen globally, sterilisations in the context of women living with HIV is still a relatively new area of research. It is important in our context as South Africa has one of the highest HIV rates in the world. Whilst various types of legal and administrative remedies are available, there are relatively few instances of these remedies being used to address sterilisation abuse in South Africa. This may be due to the complexities surrounding the use of the law to resolve discriminatory practices which are often based on differing value systems. The research problem addressed in this thesis is that there are complexities associated with applying the civil, criminal and administrative law remedies to address the coerced and forced sterilisation of women living with HIV. These complexities may impact on the ability of the women to access justice. This was undertaken by measuring each of the various remedies against a matrix of factors which were identified from the *Economic Freedom Fighters*[1] case as being the central pillars underpinning the concept of access to justice.

The main research question that was derived from the research problem is:

Are the legal and other remedies to address the forced or coerced sterilisation in South Africa adequate to ensure access to justice for the affected women as described in the case study by Strode, Mthembu and Essack?

The associated sub questions were:

i) Which of the existing legal remedies are most appropriate to address the rights violations within this context?

ii) What are the strengths, weaknesses and gaps within the current legal framework, which are exposed by this particular rights violation?

[1] (CCT 143/15; CCT 171/15) [2016] ZACC 11; 2016 (5) BCLR 618 (CC); 2016 (3) SA 580 (CC) (31 March 2016).

iii) Is the law on informed consent flowing from bodily and psychological integrity adequate to address the coerced and forced sterilisation of HIV positive women?

iv) Is it possible to prove that individuals or classes of women are being discriminated against on the basis of their HIV status when they are coerced or forced into being sterilised? and

v) Is law reform needed to comprehensively address this rights violation?

In order to answer these questions this study undertook a critical examination of the relevant legal framework in South Africa and referred to cases from Slovakia, Namibia and Kenya where remedies were/are being sought which not only highlight the availability of and access to remedies but also show the complexities of such actions and associated problems. Secondary source material was also consulted to provide analysis and insights.

Chapter 1 provided background to the topic, definitions of the terms such as forced and coerced sterilisation, key legislation, the research problem and questions and methodology. Chapter 2 critically examined the experiences of Slovakian women who have used a wide range of advocacy and legal remedies to address the forced and coerced sterilisation of Romani women. They ultimately used the regional human rights system by approaching the European Court of Human Rights. The chapter also discussed a key case currently before the courts in Kenya and two cases in Namibia and South Africa.

Chapter 3 discussed the issues around informed consent and right to bodily and psychological integrity with reference to international, regional and South African instruments and legislation. Chapter 4 focussed on the rights to equality and dignity in terms of international, national and regional law. It set out in detail the relevant South African constitutional provisions and cases as well as describing the Promotion of Equality and Prevention of Unfair Discrimination Act. Chapter 5 considered the various types of remedies in detail. Chapter 6 looked at access to justice and the extent to which each of these remedies used in this context would facilitate or hinder access to justice.

## 7.2 Findings

### *(i) Documentary evidence shows that the forced and coerced sterilisation of women living with HIV existed*

The forced and coerced sterilisation of women with HIV has occurred in South Africa. However, the extent of the problem and whether it is continuing is unclear. It is argued that it is deeply ingrained by stereotypes of intersectional discrimination based on race, sex and HIV which devalues these human characteristics and aims at discouraging this group from reproducing.

### *(ii) There is no state sanctioned policy requiring HIV positive women to be sterilised*

The sterilisation of HIV positive women either forcibly or coercively was not based on a policy. In fact the 2012 National Contraceptive Guidelines expressly state that no one should be sterilised for a discriminatory reason. In this context it is clear, given the research and litigation, that these sterilisations can be regarded as a practice based on prejudices and stereotypes. It remains unclear whether this practice is continuing.

### *(iii) The practice of forced or coerced sterilisation of HIV positive women appears to have occurred because of discriminatory attitudes of health care workers*

It is submitted, that this practice has deeply embedded roots in past and present prejudices and stereotypes. In South Africa, it has its roots in race, gender and class discrimination as all case studies from Sub-Saharan Africa show that only African women, using Public Health care facilities, have been forcibly or coercively sterilised with their HIV positive status being a catalyst in the process. The nature of the problem is evidenced by the two studies conducted in South Africa.

### *(iv) The forced or coerced sterilisation of HIV positive women violates a number of rights*

The forced or coerced sterilisation of women with HIV involves two key human rights issues. These have crystallised through the recent civil litigation in Namibia, Kenya and South Africa. These issues are the violation of two rights namely (i) the right to bodily and psychological integrity (informed consent) and (ii) the rights to equality and dignity (not to be discriminated against on the basis of a person's HIV status).

### *(v) Local research indicates that affected women desire a range of legal and other forms of redress*

The studies conducted in South Africa reveal that the affected women want legal redress for the fact that their bodies were violated and that they are no longer able to have children.[2] Fortunately, the right to access the courts and claim compensation is protected in our legal framework.[3]

### *(vi) There are three broad categories of redress that could be used to address the forced or coerced sterilisation of women living with HIV*

There are three broad categories of remedies available to address the issue of the forced or coerced sterilisation of HIV positive women. They can been clustered into civil, criminal and administrative remedies. None of these are specific to the issue at hand but they are broad enough to accommodate claims of forced or coerced sterilisation of women living with HIV.

---

[2] A Strode et al '"She made up a choice for me'': 22 HIV-positive women's experiences of involuntary sterilization in two South African provinces' (2012) 20 (39S) *Reproductive Health Matters* 1-9.
[3] Section 34 of the Constitution of the Republic of South Africa, 1996.

In order to obtain such redress, reliance will have to be placed on the rights contained in the Constitution[4], Sterilisation Act[5], National Health Act[6] and PEPUDA[7] to drive litigation of this nature.

### *(vii) The use of civil litigation to redress this violation of rights appears to be the most appropriate way in which justice can be achieved*

Civil litigation stemming from one of the studies and driven by the Women's Legal Centre Trust was successful and resulted in an out of court settlement.[8] As indicated, this practice is not confined to the shores of South Africa and cases of forced or coerced sterilisation of HIV positive women have been reported in other African countries. Presently, civil litigation is underway in Kenya to highlight this gross human rights violation and obtain compensation through the justice system for the affected women.[9] Litigation was recently concluded in Namibia where the Supreme Court found that the Ministry of Health must be held liable for the damages incurred when three HIV positive women were coerced into being sterilised against their will.[10]

Based on the above, it is submitted that the most suitable legal remedy in South Africa for HIV positive women who have been sterilised either forcibly or through coercion is the use of the civil law. It has thus far been used once in South Africa where a successful out of court settlement was reached.[11] The basis of the claim hinged on the lack of informed consent which was supported by the Sterilisation Act[12] and the Constitution.[13] It was further submitted that the documented informed consent obtained could not be considered as being reflective of Sithole's wishes since her HIV status was used to coerce her into

[4] Constitution of the Republic of South Africa, 1996.
[5] Act 44 of 1998.
[6] Act 61 of 2003.
[7] Act 4 of 2000.
[8] These are the studies conducted by Strode, Mthembu and Essack which is documented in Strode et al '"She made up a choice for me'': 22 HIV-positive women's experiences of involuntary sterilization in two South African provinces' (2012) 20 (39S) *Reproductive Health Matters* 1-9 and the Human Sciences Research Council report 'The people living with HIV stigma index: South Africa 2014' (2015), available at http://www.stigmaindex.org/sites/default/files/reports/Summary-Booklet-on-Stigma-Index-Survey%20South%20Africa.pdf accessed on 18 December 2017.
[9] African Gender and Media Initiative 'Robbed of choice: Forced and coerced sterilization experiences of women living with HIV in Kenya' (2012), available at http://kelinkenya.org/wp-content/uploads/2010/10/Report-on-Robbed-Of-Choice-Forced-and-Coerced-Sterilization-Experiences-of-Women-Living-with-HIV-in-Kenya.pdf accessed on 1 July 2015.
[10] *LM and Others v The Government of the Republic of Namibia* case no 1603/2008 available at http://www.saflii.org/na/cases/NAHC/2012/211.html accessed on 1 July 2015.
[11] *Sithole v The MEC for Health and Social Development & 3 Others* – unreported case no. 19744/2012 – High Court of South Africa, Gauteng Local Division, Johannesburg.
[12] Act 44 of 1998.
[13] Constitution of the Republic of South Africa, 1996.

signing the consent form.[14] Similarly, in the Namibian case of *LM*,[15] the women's claims were pegged on the lack of informed consent and discrimination based on their HIV positive status. In both jurisdictions it was accepted that the women's signed informed consent forms was not free from any coercion.

### *(viii) Most civil litigation challenging the failure of health care workers to obtain informed consent has been successful*

It is clear from the litigation in Slovakia, Namibia and South Africa that the courts will be sympathetic to civil claims regarding the failure of health care workers to obtain proper informed consent to a sterilisation procedure. These cases have even been successful where there has been documentary evidence of signed consent forms. The courts have made it clear that consent to a sterilisation can only be given in circumstances in which women are informed and are able to act voluntarily.

### *(ix) Legal action addressing equality only will require strategic decision-making in the most appropriate forum*

The dilemma that faces women who have been sterilised forcibly or coercively for a discriminatory reason is whether to litigate in the Equality Court or High Court. The Equality Court has a distinct advantage over the High Court because using the Equality Court firmly places the issue in the context of stigma and discrimination. Discrimination on the ground of HIV would also be easier to prove as HIV is listed as one of the prohibited grounds of discrimination in terms of the PEPUDA.[16] The onus of proof in this instance shifts to the Department of Health or the individual health care worker to prove that the discrimination is fair. The use of this Court would however mean that claiming a violation of the right to informed consent would not be possible in the action, as the Equality Court's domain is exclusively for claims based on harassment, discrimination and hate speech.[17] A further consideration to note is that our procedural law does not allow for the splitting of one cause of action into separate claims. This effectively means that only the discrimination leg of the claim can be brought before the Equality Court.

The High Court is equipped to hear a claim premised both on informed consent and equality. There appears to be no difficulty with the high courts making a finding of the absence of full and free informed consent. Litigants in this regard may rely on the common law, Constitution, Sterilisation Act and National Health Act to advance this type of claim. The courts have awarded monetary compensation for this violation in three jurisdictions which is in line with one of the findings namely that women seek legal redress. In addition,

---

[14] *Sithole v The MEC for Health and Social Development & 3 Others* – unreported case no. 19744/2012 – High Court of South Africa, Gauteng Local Division, Johannesburg.
[15] *LM and others v The Government of the Republic of Namibia* case no 1603/2008 available at http://www.saflii.org/na/cases/NAHC/2012/211.html accessed on 1 July 2015.
[16] Act 4 of 2000.
[17] Ibid.

the High Court is the only competent court of first instance that can grant an order for specific performance. In certain cases it may be ordered that the Department of Health reverse the sterilisation procedure.

Although we have good laws in the Constitution and PEPUDA[18] to support a claim based on equality, section 9 (3) of our Constitution does not list HIV as a prohibited ground of discrimination.[19] When relying on an unlisted ground to prove discrimination the onus will rest on the HIV positive women to show on a balance of probabilities that the discrimination was unfair.[20] It is this onus that women who have been forcibly or coercively sterilised for a discriminatory reason, failed to discharge in two matters that have come before the courts.[21] The courts in both instances have not given any indication in their judgments of what further evidence would be required to be adduced, to enable a finding of discrimination to be made.

### (*x) The criminal law is not a viable legal remedy to address the forced or coerced sterilisation of women living with HIV*

Although it is theoretically possible to charge a health care worker with assault or the contravention of the Sterilisation Act,[22] this is not practically feasible or acceptable to the victims. Proving intention to deliberately violate a woman's body will be virtually impossible and it is unlikely that a conviction will be seen as addressing the redress concerns of affected women.

### *(xi) A strength of the framework is that there are a range of administrative remedies which may be useful if combined with civil litigation*

The administrative remedies are a useful tool to highlight the practice of forced or coerced sterilisation of women living with HIV. In addition, the institutions concerned can engage robustly in raising awareness around legal literacy and medical ethics.

---

[18] Ibid.
[19] Constitution of the Republic of South Africa, 1996. Whilst HIV remains as an unlisted ground of discrimination in terms of our Constitution there is progress, in that it now features as a listed ground in PEPUDA.
[20] W Freedman 'Understanding the right to equality' (1998) 115 (2) *South African Law Journal* 243-251 at 246.
[21] *LM and others v The Government of the Republic of Namibia* case no 1603/2008, available at http://www.saflii.org/na/cases/NAHC/2012/211.html accessed on 1 July 2015 and *V. C. v Slovakia* Application no. 18968/07 European Court of Human Rights, available at http://www.menschenrechte.ac.at/ orig/ 11_6/ V.C..pdf accessed on 1 July 2015.
[22] Act 44 of 1998.

### *(xii) There are many complexities to the legal and administrative remedies that may act as barriers or weaknesses in the legal framework*

Addressing the issue of the forced and coerced sterilisation of women living with HIV is a complex legal problem. Accessing justice through litigation is just one of a number of different ways that it should be tackled:

(aa) The element of legal literacy is key to instituting legal proceedings. In our instance, knowledge of the two main human rights are required before a woman realises that it is unlawful and wrongful to be sterilised without her full and informed consent because she is HIV positive. Without being aware that a rights violation of protected rights has taken place, women will not be in a position to seek legal advice and obtain legal relief.

(bb) The issue of prescription is a real challenge as a civil claim must be instituted within three years of a woman being sterilised. The two South African studies have shown that due to a lack of legal literacy of their human rights and the trauma that may be accompanied by the life changing procedure performed on them, many women do not seek legal advice in time resulting in their claims prescribing.[23] Prescribed claims, even though they may have merit in them, have limited means of redress and can largely only be resolved through either the criminal or administrative remedies. Both criminal law and administrative law remedies have limitations, see below.

(cc) The difficulty that arises when women become aware of their rights after a significant lapse of time after the sterilisation is accessing medical records in order to initiate litigation. Missing hospital files are a common problem and the difficulties associated with this has the effect of preventing litigation from even commencing hence extinguishing any legitimate claim that this group of women may have.[24]

(dd) There has been no finding of discrimination either in the *LM*[25] case or the international case of *V.C*[26] where discrimination was alleged on the ground of ethnicity. In as much as it is cause for concern for a number of reasons as elucidated by Patel, we have not been given any guidance from the courts on what needs to be proved on a balance of probabilities for a finding of discrimination to be made.[27] Patel is of the view that a finding in support of the prohibition of discrimination is important for the following reasons. Firstly, a finding that the forced or coerced sterilisation of the litigants took place because they were HIV positive

---

[23] 'SA's forced sterilisation shame' *News24*, 6 August 2014, available at https://www.news24.com/Archives/City-Press/SAs-forced-sterilisation-shame-20150429 accessed on 7 January 2018.
[24] 'SA's forced sterilisation shame' *News24*, 6 August 2014, available at https://www.news24.com/Archives/City-Press/SAs-forced-sterilisation-shame-20150429 accessed on 7 January 2018.
[25] *LM and others v The Government of the Republic of Namibia* case no 1603/2008, available at http://www.saflii.org/na/cases/NAHC/2012/211.html accessed on 1 July 2015.
[26] *V. C. v Slovakia* Application no. 18968/07 European Court of Human Rights, available at http://www.menschenrechte.ac.at/orig/11_6/V.C..pdf accessed on 1 July 2015.
[27] P Patel 'Forced sterilization of women as discrimination' (2017) 38 (15) *Public Health Reviews* 1-12.

and deserving of non-discrimination protection by the court, recognises the existence of such practice.[28] Secondly, a judgment finding that the forced or coerced sterilisation of HIV positive women took place and violated their right to equality is important to highlight the marginalisation of this specific group of women in society.[29] Thirdly, a finding of discrimination by the courts will assist in addressing the hidden reasons for the practice so that it may be addressed effectively.[30] Lastly, the failure to investigate this discriminatory practice indicates that there is a misunderstanding by the judiciary regarding the core nature of forced or coerced sterilisation which is inherently a discriminatory practice.[31] The courts must accept that the motivating reason behind the forced or coerced sterilisation of HIV positive women is to ''deny them the ability to procreate due to a perception that they are less than ideal members of our society.''[32] It is further submitted, that future civil cases ought to be pleaded under the actio iniuriarum as a violation of a person's dignity.

(ee) The criminal law has never been successfully used in any jurisdiction either nationally or internationally, to prosecute health care practitioners who have sterilised women without obtaining their full, free and informed consent. There are two main impediments that stand in the way of achieving successful criminal convictions when using the common law crime of assault or the violation of the provisions of the Sterilisation Act[33] respectively. The first is the requirement that the element of intention must be proved to secure a conviction of assault. This requirement will be easily defeated by the presence of a ''signed'' consent form. The Sterilisation Act,[34] makes it possible for a criminal prosecution to be instituted presumably in instances where consent was not obtained freely, voluntarily and in writing after the nature of the procedure had been explained to the patient. The second difficulty, is establishing whether negligence or intention on the part of the person responsible for recording the consent is required in terms of the Act.[35] It is unclear whether a court would accept that the offence of failing to obtain consent in terms of the Sterilisation Act could be met if the health care worker's actions were negligent rather than deliberate.

(ff) The downside to using the administrative remedies although accessible and free, is that they do not fulfil the needs of the women who have expressed their desire to claim monetary compensation.[36]

[28] Ibid at 7.
[29] Ibid at 8.
[30] Ibid.
[31] Ibid at 9.
[32] Ibid.
[33] Act 44 of 1998.
[34] Ibid.
[35] Ibid.
[36] Strode et al '''She made up a choice for me'': 22 HIV-positive women's experiences of involuntary sterilization in two South African provinces' (2012) 20 (39S) *Reproductive Health Matters* 1-9.

### *(xiii) Five factors can be used to evaluate whether remedies will provide access to justice for this group of women*

This thesis argues that the five broad categories are: functionality of the justice system, affordability of legal services, accessibility of legal remedies, their acceptability to the complainants and whether the remedies hold individuals or the State accountable, can be used as benchmarks for accessing justice

### *(xiv) Law reform is needed to address gaps in the legal framework*

South Africa has a good legal framework which facilitates redress of these types of human rights violations. However, there are two significant gaps that emerge from the Sterilisation Act.[37] These are that the Act is silent on the issue of discrimination and on whom the responsibility rests to obtain the voluntary and written informed consent.[38]

### *(xv) Programmes to address the root causes of stigma, discrimination and violations of dignity are needed*

The role of health care workers cannot be underestimated in contributing to the decrease in the vertical transmission of the human immunodeficiency virus to a new born baby.[39] Some health care providers may allow their strong personal views regarding HIV positive women conceiving to impact heavily on the type of care and advice that they dispense to them.[40] In instances where these health care providers feel that HIV positive women should not be sexually active, counselling on issues of reproduction and contraception may be neglected.[41] Sterilisations and abortions may be heavily promoted without adequate attention being paid to the woman's own personal desires.[42]

HIV positive pregnant mothers have been at the receiving end of disparaging and judgemental remarks from health care practitioners as is evidenced by the narratives of women in the Strode et al study. One woman said that her obstetrician/gynaecologist told her that ''*she should be careful when having sex and that she should not even think about getting pregnant*.''[43] Upon becoming pregnant, the obstetrician/gynaecologist was not

[37] Act 44 of 1998.

[38] This issue was discussed at length in the *Pandie v Isaacs* (A135/2013, 1221/2007) [2013] ZAWCHC 123 (4 September 2013) case. Unfortunately, the Court did not make a finding on whether it was the responsibility of the gynaecologist or nursing staff to procure informed consent.

[39] V Paiva et al 'The right to love: The desire for parenthood among men living with HIV' (2003) 11 (22) *Reproductive Health Matters* 91-100 at 91.

[40] L Meyer et al 'Focus on women: Linking HIV care and treatment with reproductive health services in the MTCT-Plus Initiative' (2005) 13 (25) *Reproductive Health Matters* 136-146 at 137.

[41] Ibid.

[42] Ibid.

[43] MG van Dijk et al 'Health care experiences of HIV-infected women with fertility desires in Mexico: A qualitative study' (2014) 25 (3) *Journal of the Association of Nurses in Aids Care* 1-9 at 6.

willing to deliver her baby and told her that ''*he refused to bring children with AIDS to the world*.''[44] Another woman lamented that ''*I had to put up with the judgemental attitude of the health care staff, including their disbelief that a woman with HIV would get pregnant.*''[45] Other disapproving comments made to HIV positive expectant mothers by health care providers were that ''*there is no need to have a child when you know that you are HIV positive…They told me I should abort.*''[46]

Judgemental attitudes towards HIV positive pregnant women are not confined to the exclusive domain of health care workers and health care practitioners, they extend to government officials and auxiliary hospital staff.[47] This is highlighted by the utterance of ex-President Thabo Mbeki's spokesman Parks Mankahlana who stated: ''*the mother is going to die and that HIV negative child will be an orphan. That child must be brought up, who is going to bring that child up? It's the state. That's, resources you see?*''[48] This attitude highlights the view that children orphaned by HIV are a burden to the State. In *Sithole's* case, a cleaner in the ward where she was, made degrading remarks about her perceived sexual proclivity.[49] The cleaner obtained knowledge of Sithole's HIV status from a ward nurse who discussed this openly in the presence of other patients as well.[50]

Apart from trying to weed out discriminatory attitudes and stereotypes that health care providers have, another challenge is to transport their mind set from a curative care services approach to a more preventative approach which is required for sexual and reproductive health care.[51] The type of care that HIV positive women require is long term continuous care which assists in the fostering of long term relationships between patients and health care providers which aids in facilitating desirable health outcomes.[52] The expectation is that there is early detection of symptoms by health care workers, strict regimen of taking medication by patients and a strict commitment to obtaining continuous care by patients.[53]

---

[44] Ibid.
[45] A Ramkissoon et al 'Options for HIV-positive women' (2006) 1 *South African Health Review* 315 – 332 at 317.
[46] D Cooper et al 'Life is still going on: Reproductive intentions among HIV-positive women and men in South Africa' (2007) 65 *Social Science and Medicine* 274-283 at 280.
[47] D Cooper 'In pursuit of social development goals and HIV-infected women's reproductive rights – South Africa as a case study' (2008) 75 *Agenda* 4 at 8 and E Bell et al 'Sexual and reproductive health services and HIV testing: Perspectives and experiences of women and men living with HIV and Aids' (2007) 15 (29) *Reproductive Health Matters* 113-135 at 124.
[48] C McGreal 'The shame of the new South Africa' *The Guardian* 1 November 2012, available at https://www.theguardian.com/world/2002/nov/01/aids.southafrica accessed on 17 November 2017
[49] *Sithole v The MEC for Health and Social Development & 3 Others* – unreported case no. 19744/2012 – High Court of South Africa, Gauteng Local Division, Johannesburg para 17.8.2 of plaintiff's amended particulars of claim.
[50] *Sithole v The MEC for Health and Social Development & 3 Others* – unreported case no. 19744/2012 – High Court of South Africa, Gauteng Local Division, Johannesburg para 17.10 of plaintiff's amended particulars of claim.
[51] Meyer et al 'Focus on women: Linking HIV care and treatment with reproductive health services in the MTCT-Plus Initiative' (2005) 13 (25) *Reproductive Health Matters* 136-146 at 138.
[52] Ibid 137.
[53] Ibid.

A major contributory factor to the abusive manner in which birthing mothers are treated is the conduct of health care workers towards them. This does not exist in isolation but is supported by other negative factors like the over-burdened and under-resourced public health care facilities.[54] This is further intensified by the huge power differential that exists between poor, often illiterate women and nurses in particular.[55] The study conducted by Jewkes et al found that the dominant thread of the narratives of birthing mothers reflected the high levels of abuse and neglect inflicted on them by the nurses.[56] A matter for concern is that even though the narratives report abuse and poor treatment, women do not feel empowered to complain about the conduct of nurses and therefore this leaves little room for their conduct to be sanctioned, improved or reformed.[57] Women have indicated that they are afraid to complain as they fear that they may be ostracised on future visits to the health care centres and that they have been told that the treatment is beneficial to them.[58] Freedman and Kruk submit that the presence of physical or psychological abuse in a health care setting is indicative of a health system in crisis where, quality and accountability are compromised.[59] The end result of health systems that tolerate this abuse devalues women which has negative consequences for their health.[60]

It is submitted that an effective way to deal with this festering issue is to (i) acknowledge the existence of this unethical conduct on the part of nurses by being guided by the lived experiences of birthing mothers;[61] (ii) recognise that there is a broader need for change, with management leading the dialogue by insisting on acceptable staff patient interactions; (iii) fortify their efforts by reporting errant behaviour of nurses to the South African Nursing Council;[62] (iv) hold the Department of Health accountable for the conduct of nurses through vicarious liability;[63] (v) sensitise, train and conduct educational campaigns on patient's rights for nurses[64] and (vi) improve working conditions and provide staff support for nurses.[65] In addition, many of the suggestions made by Pickles[66] can be mirrored in order to improve the experience of birthing mothers in public health care institutions. Amongst these are a call

[54] R Jewkes, N Abrahams and Z Mvo 'Why do nurses abuse patients? Reflections from South African Obstetric Services' (1998) 47 (11) *Social Science and Medicine* 1781 – 1795 at 1781.
[55] Ibid.
[56] Ibid at 1785.
[57] Ibid at 1792.
[58] Ibid at 1785 and 1792.
[59] LP Freedman and ME Kruk 'Disrespect and abuse of women in childbirth: challenging the global quality and accountability agendas' (2014) 384 *The Lancet* e 42 – e 44 at e43.
[60] Ibid.
[61] Ibid.
[62] Jewkes, Abrahams and Mvo 'Why do nurses abuse patients? Reflections from South African Obstetric Services' (1998) 47 (11) *Social Science and Medicine* 1781 – 1795 at 1793.
[63] C Pickles Eliminating abusive 'care' A criminal law response to obstetric violence in South Africa' (2015) 54 *SA Crime Quarterly* 5 – 16 at 10.
[64] Ibid at 11.
[65] Ibid.
[66] C Pickles 'Lived experiences of the Choice on Termination of Pregnancy Act 92 of 1996: Bridging the gap for women in need' (2013) 29 *The South African Journal on Human Rights* 515 – 535 at 535.

for the Department of Health to adopt a leading role by ''providing clear direction concerning policy implementation plans'' and to hold ''values-clarification workshops'' that probe the systemic nature of the problem.[67] An initiative that is in existence in the Cape Town Metro District Health Services may also be simulated at other health care facilities around the country to promote respectful maternity care of birthing mothers.[68] The Patient-Centred Maternity Care Code in the Cape Metro was introduced in response to the disrespectful behaviour by maternity staff and the poor quality of care that birthing mothers were subjected to.[69] The code has a zero tolerance for abusive and disrespectful behaviour and most importantly addresses health system problems that may contribute to such behaviour by nurses.[70] The objectives of the code are that every birthing mother (i) has the right to be treated with dignity and respect;[71] (ii) has the right to receive information about obstetric care and pregnancy;[72] (iii) has the right to have a personal companion present for emotional support whilst in labour[73] and (iv) has the right to maternity facilities that are responsive to their needs.[74]

The forced or coerced sterilisation of women living with HIV carries a double burden for them. Coming forward to institute legal proceedings against the wrongdoers may be a sensitive matter as they will now be identified by their families and communities as being barren and HIV positive. This may have the effect of deterring women from accessing justice for a grave human rights violation.

The stigma and discrimination that HIV positive women face comes from many sectors. This has the potential to prevent them from coming forward to access legal advice for fear of being victimised as many of the women will rely on the same hospital for future medical care.[75] The health care sector carries it owns set of stereotypes against HIV positive women who wish to become mothers. Studies have shown that in many instances the personal negative views of health care practitioners come into play when dealing with this group of affected women regarding their reproductive health rights.[76] Families and communities who mistreat and ostracise women who have been sterilised also play a vital role in discouraging women from accessing legal assistance.

---

[67] Ibid.
[68] S Honikman 'Abuse in South African maternity settings is a disgrace: Potential solutions to the problem' (2015) 105 (4) *South African Medical Journal* 284-286 at 284-285.
[69] Ibid 284.
[70] Ibid.
[71] Ibid.
[72] Ibid.
[73] Ibid.
[74] Ibid.
[75] C Pickles 'Lived experiences of the Choice on Termination of Pregnancy Act 92 of 1996: Bridging the gap for women in need' (2013) 29 *The South African Journal on Human Rights* 515 – 535 at 535.
[76] Strode et al '''She made up a choice for me'': 22 HIV-positive women's experiences of involuntary sterilization in two South African provinces' (2012) 20 (39S) *Reproductive Health Matters* 1-9.

## 7.3 Conclusions

On the basis of the findings above this thesis concludes:

### *(i) The forced and coerced sterilisation of women living with HIV has been shown to be a significant human rights issue*

At least 100 women in South Africa have reported that they were sterilised because they were HIV positive. This indicates that this practice is a significant human rights issue which needs to (a) be comprehensively addressed by the Department of Health, (b) further facilitate access to justice for women who qualify to institute civil claims and (c) further investigation into whether any other form of compensation should be paid in situations where civil claims have prescribed. This particular issue forms part of a broader set of rights violations that has been documented in many jurisdictions and is referred to as obstetric violence.

### *(ii) South Africa has a well-established legal framework*

There is dedicated legislation dealing with sterilisations which protects women from involuntary sterilisations. There is also dedicated legislation dealing with equality. There are also well developed legal remedies in the legislation mentioned as well as in the civil and criminal law. This is complimented by a range of administrative remedies.

### *(iii) Civil claims are the most appropriate legal remedy to address the forced or coerced sterilisation of women living with HIV in South Africa*

Based on the research conducted by Strode, Mthembu and Essack and the assessment of the advantages and disadvantages of each of the three major remedies, this thesis finds that that a claim for damages using the civil law is the most appropriate form of legal redress. Despite the difficulty that we are presently faced with regarding proving discrimination, instituting a civil claim appears to be the most effective way of obtaining legal relief which meets the needs of the affected population. However, such claims can only proceed if the courts accept that prescription runs from the moment that the plaintiff became aware of the cause of action and not the date of the sterilisation.

### *(iv) A well-established legal framework is insufficient to ensure access to justice*

Access to justice is a broad concept that aims at ensuring individuals or classes of litigants are able to use the legal system to resolve their disputes. This thesis has used five factors as a benchmark for reviewing the extent to which these external factors impact on the ability of HIV positive women who allege sterilisation abuse are able to access the justice system. This review has shown that firstly the five factors identified are indicators of whether access to justice is achievable. It is argued that these factors are broad enough to be applied to other human rights litigation involving marginalised groups. Secondly, that although a wide

range of legal remedies exist and are available, HIV positive women will face a number of hurdles in attempts to vindicate their rights and hold those responsible accountable.

### (*v) Limited law reform and extensive value based training is needed to improve access to justice for HIV positive women who have been forcibly or coercively sterilised*

Minor changes to the Sterilisation Act[77] could significantly improve patient protections and potentially facilitate the holding of health care workers accountable through the civil or criminal law. More extensive work is needed to ensure that the values of health care workers mirror those in the Constitution[78] to ensure that all patients are treated with dignity but especially those in childbirth.

## 7.4 Recommendations

Based on the findings and conclusions of this dissertation, the following recommendations are made. These aim at:

### *(i) Law reform*

In order to strengthen the legal framework and ensure that coerced or forced sterilisations do not occur in the future, the following changes are needed to the Sterilisation Act,[79] that is by whom the consent must be taken and that it should not be done for a discriminatory reason. These changes will be broadly beneficial as they will protect all persons considering sterilisation as a form of birth control. They will also strengthen the current provisions in the Act dealing with consent. Finally, through the insertion of discrimination in the South African Sterilisation Act, this Act will be unique as it will clearly re-inforce the constitutional principle on equality thus sending a strong message that the forced or coerced sterilisation of men or women because of their race, gender, ethnicity, HIV status or any other arbitrary ground will be unlawful. In this regard, the proposed recommendations are additions to sections 2 and 4 of the Sterilisation Act[80]:

**Persons capable of consenting**

2. (1) No person is prohibited from having sterilisation performed on him or her if he

or she is—

(a) capable of consenting;

(b) 18 years or above and

(2) A person capable of consenting may not be sterilised without his or her consent.

[77] 44 of 1998.
[78] Constitution of the Republic of South Africa, 1996.
[79] Act 44 of 1998.
[80] Ibid.

(3) (a) Sterilisation may not be performed on a person who is under the age of 18

years except where failure to do so would jeopardize the person's life or seriously impair

his or her physical health.

(4) No person may be asked to consent to a sterilisation procedure based on a discriminatory reason.[81]

(b) Section 3 (1) (*a*) and (2) will apply with the necessary changes

**Consent**

4. For the purposes of this Act, ''consent'' means consent given freely and voluntarily

without any inducement and may only be given if the person giving it has—

(a) been given a clear explanation and adequate description of the—

(i) proposed plan of the procedure; and

(ii) consequences, risks and the reversible or irreversible nature of the sterilisation procedure;

(b) been given advice that the consent may be withdrawn any time before the

treatment; **[and][82]**

(c) signed the prescribed consent form <u>and</u>

(d) written consent may only be obtained before the onset of labour by a surgeon or gynaecologist performing the procedure.[83]

***(ii) Undertake research***

Further research is needed to (i) document other cases and establish whether the practice is continuing and (ii) inquiring into some of the reasons that health care workers think are behind this practice.

[81] The underlined words indicate the insertion to the Sterilisation Act, 44 of 1998.
[82] This is an omission from the Sterilisation Act, 44 of 1998.
[83] The underlined words indicate the insertion to the Sterilisation Act, 44 of 1998.

### *(iii) Support legal literacy*

Further research and litigation will not be possible unless HIV positive women are aware of their rights. Legal literacy is needed to ensure that health care workers are aware that this practice is illegal and women understand that their rights may have been violated.

# Bibliography

**Secondary Sources**

**Journal Articles**


1. Albertyn, C & Goldblatt, B 'Facing the challenge of transformation: Difficulties in the development of an indigenous jurisprudence of equality' (1998) 14 *SAJHR* 248-276.
2. Albertyn, C and Fredman, S 'Equality beyond dignity: Multi-dimensional equality and Justice Langa's judgments' (2015) 1 *Acta Juridica* 430 – 455.
3. Appelbaum, P S 'Assessment of patients' competence to consent to treatment' (2007) *The New England Journal of Medicine* 1834 -1840.
4. Badul, CJ & Strode, A '*LM and others v The Government of the Republic of Namibia*: The first sub-Saharan African case dealing with coerced sterilisation of HIV-positive women – *Quo vadis'* (2013) 13 *African Human Rights Law Journal* 214-228.
5. Badul, CJ, Strode, A & Singh, PP 'Obtaining informed consent for a sterilisation in the light of recent case law' (2018) 108 (7) *South African Medical Journal* 557-558.
6. Bell, E ... et al 'Sexual and reproductive health services and HIV testing: Perspectives and experiences of women and men living with HIV and Aids' (2007) 15(29) *Reproductive Health Matters* 113-135.
7. Bohler-Muller, N 'The promise of equality courts' (2006) 22 *SAJHR* 380-404.
8. Borges, MTR 'A violent birth: Reframing coerced procedures during childbirth as obstetric violence' (2018) 67 *Duke Law Journal* 827 – 862.
9. Cameron, E 'Legal and human rights responses to the HIV/AIDS epidemic' (2006) 1 *Stellenbosch Law Review* 47-90.
10. Chaskalson, A 'From wickedness to equality: The moral transformation of South African law' (2003) 1(4) *International Journal of Constitutional Law* 590 -609.
11. Chaskalson, A 'Human dignity as a foundational value of our constitutional order' (2000) 16 (2) *The South African Journal on Human Rights* 193-205.
12. Cook, R J and Dickens, BM 'Voluntary and involuntary sterilisation: denials and abuses of rights' (2000) 68 *International Journal of Gynaecology and Obstetrics* 61-67.
13. Cooper, D 'In pursuit of social development goals and HIV-infected women's reproductive rights – South Africa as a case study' (2008) 75 *Agenda* 4-15.

14. Cowen, S 'Can dignity guide South Africa's equality jurisprudence?' 2001 17 (1) *The South African Journal on Human Rights* 34 – 58.
15. De Vos, WLR 'Is a class action a ''classy act" to implement outside the ambit of the constitution' (2012) 4 *TSAR* 737-757.
16. De Waal, J 'Equality and the Constitutional Court' (2002) 14 *SA Mercantile Law Journal* 141-156.
17. Dhai, A 'Informed consent – 2008' (2008) 1(1) *South African Journal of Bio-ethics and the Law* 27-30.
18. Dickens, BM & Cook, RJ 'The legal effects of fetal monitoring guidelines' (2010) 108 *International Journal of Gynecology and Obstetrics* 170-173.
19. Du Plessis, L 'Subsidiarity: What's in the name for Constitutional Interpretation and djudication?' (2006) 2 *Stellenbosch Law Review* 207-231.
20. Durojaye, E 'Involuntary sterilisation as a form of violence against women in Africa' (2017) 53(5) *Journal of Asian and African Studies* 1-12.
21. Essack, Z & Strode, A 'I Feel Like Half a Women All the Time: The Impacts of coerced and forced sterilisations on HIV-positive Women in South Africa' (2012) 26 (2) *Agenda* 24-34.
22. Farlane, L 'HIV-positive women have family planning needs too' (2008) 75 *Agenda* 31-37.
23. Freedman, LP and Kruk, ME 'Disrespect and abuse of women in childbirth: challenging the global quality and accountability agendas' (2014) 384 *The Lancet* e 42 – e 44.
24. Freedman, W 'Understanding the right to equality' (1998) 115(2) *South African Law Journal* 243-251.
25. Giesen, D 'From Paternalism to Self-determination to shared Decision making' (1988) 1 *Acta Juridica* 107-127.
26. Giesen, D 'From paternalism to self-determination to shared decision making' (1988) (1) *Acta Juridica* 107-127.
27. Godia, J 'Dialogue with women living with HIV and AIDS: a case for reproductive and sexual health rights' (2008) 75 *Agenda* 46-52.
28. Govender, K 'Equality, Sexuality and Taking Rights Seriously' (2008) 29 (1) *Obiter* 1-18.

29. Gruskin, S ... et al 'Ensuring sexual and reproductive health for people living with HIV: An overview of key human rights, policy and health systems issues' (2007) 15(29) *Reproductive Health Matters* 4-26.
30. Handmaker, J 'Public Interest Litigation for Refugees in South Africa and the Potential for Structural Change' (2011) 27 (1) *South African Journal on Human Rights* 65-81.
31. Honikman, S 'Abuse in South African maternity settings is a disgrace: Potential solutions to the problem' (2015) 105 (4) *South African Medical Journal* 284-286.
32. Hurter, E 'Seeking truth or seeking justice: Reflections on the changing face of the adversarial process in civil litigation' (2007) 2 *TSAR* 240-262.
33. Hurter, E 'The Draft Legislation concerning Public Interest Actions and Class Actions: The Answer to all Class Ills?' (1997) *Comparative and International Law Journal of Southern Africa* 304-324.
34. Jagwanth, S 'Expanding equality' (2005) *Acta Juridica* 131-148.
35. Jewkes, R and Penn-Kekana, L 'Mistreatment of women in childbirth: Time for action on this important dimension of violence against women' 2015 12 (6) *PLOS Medicine* 1-4.
36. Jewkes, R, Abrahams, N and Mvo, Z 'Why do nurses abuse patients? Reflections from South African Obstetric Services' (1998) 47 (11) *Social Science and Medicine* 1781–1795.
37. Kruger, R 'Equality and unfair discrimination: Refining the Harksen test' (2011) *South African Law Journal* 479-512.
38. Lawrence, J 'The Indian Health Service and the sterilization of native American women' (2000) 24(3) *The American Indian Quarterly* 400-419.
39. Liebenberg, S 'South Africa's evolving jurisprudence on socio-economic rights: an effective tool in challenging poverty' (2002) 6 (2) *Law, Democracy and Development* 159 –191.
40. Loenen, T 'The Equality Clause in the South African Constitution: Some remarks from a comparative perspective' (1997) *South African Journal on Human Rights* 401-429.
41. Malherbe, R 'Some thoughts on unity, diversity and human dignity in the new South Africa' (2007) 1 *Tydskrif vir die Suid-Afrikaanse Reg* 127 – 133.

42. Mantell, JE ... *et al* 'The right to choose parenthood among HIV-infected women and men' (2009) 30(4) *J Public Health Policy* 367-378.
43. Mbiada, CJT 'The Public Protector as a mechanism of political accountability: The extent of its contribution to the realisation of the right to access adequate housing in South Africa' (2017) 20 *PER / PELJ* 1-34.
44. McGregor, M & Germishuys, W 'The Taxonomy of an ''Unspecified'' Ground in Discrimination Law' (2014) 35 (1) *Obiter* 94-107.
45. McLaughlin, LC 'The price of failure of informed consent law: coercive sterilizations of HIV positive women in South Africa' *Law and Inequality: A Journal of Theory and Practice* (2014) 32(1) 69 -93.
46. McQuoid-Mason, D 'Access to justice in South Africa: Are there enough lawyers?' (2013) 3(3) *Oñati Socio-Legal Series* 561-579.
47. McQuoid-Mason, D 'Access to justice in South Africa' (1999) 230(17) *Windsor Y.B Access to Justice* 1-16.
48. McQuoid-Mason, D 'What constitutes medical negligence?' (2010) 7(4) *SA Heart* 248-251.
49. Meyer, L ... et al 'Focus on women: Linking HIV care and treatment with reproductive health services in the MTCT-Plus Initiative' (2005) 13(25) *Reproductive Health Matters* 136-146.
50. Murray, C 'The Human Rights Commission et al: What is the Role of South Africa's Chapter 9 Institutions?' (2006) 9(2) *Potchefstroom Electronic Law Journal* 122-147.
51. Nyenti, M 'Access to justice in the South African social security system: Towards a conceptual approach' (2013) *De Jure* 901-916.
52. Paiva, V ... *et al* 'The right to love: The desire for parenthood among men living with HIV' (2003) 11(22) *Reproductive Health Matters* 91-100.
53. Patel, P 'Forced sterilization of women as discrimination' (2017) 38(15) *Public Health Reviews* 1-12.
54. Pickles, C 'Eliminating abusive 'care' A criminal law response to obstetric violence in South Africa' (2015) 54 *SA Crime Quarterly* 5 – 16.
55. Pickles, C 'Involuntary contraceptive sterilisation of women in South Africa and the criminal law' (2016) 29(2) *South African Journal on Criminal Justice* 89-115.

56. Pickles, C 'Lived experiences of the Choice on Termination of Pregnancy Act 92 of 1996: Bridging the gap for women in need' (2013) 29 *The South African Journal on Human Rights* 515 – 535.
57. Pickles, C 'Sounding the alarm: *Government of the Republic of Namibia v LM* and women's rights during childbirth in South Africa' (2018) 21 *PER/PELJ* 1-34.
58. Pieterse, M 'The interdependence of rights to health and autonomy in South Africa' (2008) 125 (3) *The South African Law Journal* 553-572.
59. Pityana, B 'Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000' (2002) XLIV (1) *Codicillus* 2-9.
60. Ramkissoon, A ... *et al* 'Options for HIV-Positive Women' (2006) 1 *South African Health Review* 315 – 332.
61. SALC 'Report on the Recognition of class actions and public interest litigation in South Africa' (1998) (v)-104.
62. Schachter, O 'Human dignity as a normative concept' (1983) 77 (4) *The American Journal of International Law* 848-854.
63. Sifris, R 'The voluntary sterilisation of marginalised women: power, discrimination, and intersectionality' (2016) 25 (1) *Griffith Law Review* 45-70.
64. Strode, A ... et al '''She made up a choice for me'': 22 HIV-positive women's experiences of involuntary sterilization in two South African provinces' (2012) 20 (39Supp) *Reproductive Health Matters* 1-9.
65. Strode, A et al '''She made up a choice for me'': 22 HIV-positive women's experiences of involuntary sterilization in two South African provinces' (2012) 20(39S) *Reproductive Health Matters* 1-9.
66. Swart, GJ 'An outcomes-based approach to the interpretation of the right to equality' (1998) 13 *SA Public Law* 217-233.
67. Tan, N H S S 'Deconstructing paternalism- What serves the patient best? (2002) 43 (3) *Singapore Medical Journal* 148-151.
68. Van der Walt, A & Kituri, P 'The Equality Court's View on Affirmative Action and Unfair Discrimination' (2006) 27 (3) *Obiter*.
69. Van Dijk, MG ... et al 'Health care experiences of HIV-infected women with fertility desires in Mexico: A qualitative study' 2013 *Journal of the Association of Nurses in Aids Care* 1-9.

70. Van Loggerenberg, A 'An alternative approach to informed consent' (2018) 135 (1) *The South African Law Journal* 55-72.
71. Van Oosten, FFW '*Castell v De Greef* and the Doctrine of Informed Consent: Medical Paternalism ousted in favour of Patient Autonomy' (1995) (1) *De Jure* 164-179.
72. Van Reenen, TP 'Equality, discrimination and affirmative action: an analysis of section 9 of the Constitution of the Republic of South Africa' (1997) 12 *SA Public Law* 151-165.
73. Wood, A 'Human dignity, right and the realm of ends' (2008) 1 *Acta Juridica* 47 – 65.

**Books**

1. Albertyn, C, Goldblatt, B & C Roederer *Introduction to the Promotion of Equality and Prevention of Unfair Discrimination Act* Johannesburg: Witwatersrand University Press, (2001).
2. Bishop, M and Woolman, S 'Freedom and security of the person' in S Woolman and M Bishop (eds) *Constitutional Law of South Africa* 2 ed Cape Town: Oxford University Press, (2008).
3. Burchell, J *Principles of Criminal Law* 5 ed Cape Town: Juta (2016).
4. Cameron, E *Justice* Cape Town: Tafelberg (2014).
5. Carstens, P & Pearmain, D *Foundational Principles of South African Medical Law* Cape Town: Lexis Nexis, (2007).
6. Currie, I & De Waal, J *The Bill of Rights Handbook* 6 ed Cape Town: Juta, (2016).
7. De Vos, P & Freedman, W *South African Constitutional Law in Context* Cape Town: Oxford University Press, (2014).
8. Dhai, A, McQuoid-Mason, DJ *Bioethics, Human Rights and Health Law Principles and Practice* Cape Town: Juta, (2011).
9. Falnigan, J 'Obstetric autonomy and informed consent' (2016) *Ethical Theory Moral Pract* 225-244.
10. Faris, JA & Hurter, E *Student Handbook for Civil Procedure* 7ed Cape Town: Lexis Nexis, (2015).
11. Govindjee, A *Introduction to Human Rights Law* Cape Town: Lexis Nexis, (2009).
12. Jones & Buckle, *The Civil Practice of the Magistrates' Courts in South Africa* 10 ed Cape Town: Juta (2012).

13. Joubert JA 'Patrimonial Loss' in A Kanjan (ed) *The Law of South Africa* 3 ed Durban: Lexis Nexis, Vol 3 (2013).
14. Kemp, G … et al *Criminal Law in South Africa* 2 ed Cape Town: Oxford University Press, (2015).
15. Midgley, MM & Loubser, JR *The Law of Delict in South Africa* 3 ed Cape Town: Oxford University Press, (2017).
16. Midgley, R & Loubser, M *The Law of Delict in South Africa* 2 ed Cape Town: Oxford University Press, (2012).
17. Neethling, J & Potgieter, JM *Law of Delict* 7 ed Cape Town: Lexis Nexis, (2015).
18. O' Sullivan, M 'Reproductive rights' in S Woolman and M Bishop (eds) *Constitutional Law of South Africa* 2 ed Cape Town: Oxford University Press, (2008).
19. Pete, S & Hulme, D … et al *Civil Procedure: A Practical Guide* 3ed Cape Town: Oxford University Press, (2017).
20. Pickles, C *Pregnancy Law in South Africa: Between Reproductive Autonomy and Foetal Interests* Cape Town: Juta, (2017).
21. Rycroft, A *Race and the Law in South Africa* Cape Town: Juta, (1987).
22. Saner, JS 'Prescription' *The Law of South Africa* 2 ed Durban: Lexis Nexis. Vol 21 (2010) 103.
23. Schwikkard, PJ & Van Der Merwe, SE *Principles of Evidence* Cape Town: Juta,4ed (2016).
24. Snyman, CR *Criminal Law* 6 ed Cape Town: Lexis Nexis, (2014).
25. Strauss, SA *Doctor, patient and the law* 3 ed Pretoria: J L van Schaik (1991).
26. Woolman, S 'Dignity' in S Woolman & M Bishop (eds) *Constitutional Law of South Africa* 2 ed Cape Town: Juta, (2008).

**Dissertations**

1. Robertson, KM *An Analysis of the Class Action in South Africa* (Unpublished LLM thesis, University of Pretoria, 2015).
2. Van Oosten, FF *Doctrine of Informed Consent in Medical Law* (Unpublished LLD thesis, UNISA, 1989).

**Websites**

1. 'African (Banjul) Charter on the Human and Peoples' Rights, 27 June 1981' available at *http://www.achpr.org/instruments/achpr/*, accessed on 1 July 2015.
2. 'Convention on the Elimination of All Forms of Discrimination against Women, 18 December 1979' available at *http://www.un.org/womenwatch/daw/cedaw/text/econvention.htm*, accessed on 1 July 2015.
3. 'International Covenant on Civil and Political Rights, 16 December 1966' available at *http://www.ohchr.org/Documents/ProfessionalInterest/ccpr.pdf*, accessed on 1 July 2015.
4. 'Recommendation of the Commissioner for Human Rights concerning certain aspects of law and practice relating to sterilization of women in the Slovak Republic' available at *http://www.coe. int/en/web/commissioner/country-report/slovak- republic*, accessed on 21 January 2017.
5. 'SA's forced sterilisation shame' *News24*, 6 August 2014 available at *https://www.news 24.com/Archives/City-Press/SAs-forced-sterilisation-shame-20150429*, accessed on 7 January 2018.
6. 'Speech by the Chief Justice of the Republic of South Africa Chief Justice Mogoeng Mogoeng at the opening of the provincial case flow management workshop at Port Alfred, 19 July 2012' available *at http://www.judiciary.org.za/doc/Speech-CJ 19-July-2012 EL.pdf*, accessed on 8 October 2017.
7. 'The General Assembly Resolution 48/134 of 20 December 1993' available at *http://www.ohchr.org/*, accessed on 20 November 2015.
8. African Charter on Human and Peoples Rights available at http://www.achpr.org/instruments/achpr/, accessed on 16 July 2018.
9. African Commission on Human and Peoples' Rights '260: Resolution on Involuntary Sterilisation and the Protection of Human Rights in Access to HIV Services' available at http://www.achpr.org/sessions/ 54th/resolutions/260/ accessed on 25 May 2018.
10. African Gender and Media Initiative 'Robbed of choice: Forced and coerced sterilization experiences of women living with HIV in Kenya', (2012) available at *http://kelinkenya.or g/wp-content/uploads/2010/10/Report-on-Robbed-Of-Choice-Forced-and-Coerced- Sterilization-Experiences-of-Women-Living-with-HIV-in-Kenya.pdf*, accessed on 1 July 2015.

11. AIDS Foundation South Africa 'Why is the South African HIV/AIDS prevalence so high?' available at *https://www.aids.org.za/hivaids-in-south-africa,* accessed on 5 January 2018.
12. Bantu Education Act available *at https://en.wikipedia.org/wiki/BantuEducationAct,1953*, accessed on 7 April 2017.
13. Beijing Declaration and Platform for Action -The Fourth World Conference on Women, available at http://www.un.org/womenwatch/daw/beijing/pdf/BDPfA%20E.pdf accessed on 8 June 2018.
14. Carstens, PA 'Informed consent in South African medical law with reference to legislative developments' available at *http://new.samls.co.za/node/407,*accessed on 11 April 2015.
15. Chamberlain, G 'UK aid helps to fund forced sterilization of India's poor' *The Guardian,* 15 April 2012 available at *https://www.theguardian.com/world/ 2012/apr/15/uk-aid-forced-sterilisation-india,* accessed on 2 November 2017.
16. Chamberlain, G 'UK aid helps to fund forced sterilisation of India's poor' *The Observer,* 14 April 2012 available at *https://www.theguardian.com/world/2012/apr/15/uk-aid-forced-sterilisation-India,* accessed on 1 December 2014.
17. Department of Health 'National contraception clinical guidelines', (2012) available at *https://www.mm3admin.co.za/documents/docmanager/3c53e82b-24f2-49e1-b997-5a35803be10a/00037761.pdf,* accessed on 17 February 2015.
18. Department of Justice 'Judicial Matters Amendment Act 8 of 2017, Government Gazette, No 41018' available at *http://www.justice.gov.za/legislation/acts/2017-008.pdf*, accessed on 8 October 2017.
19. Follow-up report on the Slovak Republic (2001 – 2005) 'Assessment of the progress made in implementing the recommendations of the Council of Europe Commissioner for Human Rights' available at *https://wcd.coe.int/ViewDoc.jsp?id=983969&Site=COE*, accessed on 21 January 2017.
20. General Recommendations Adopted by the Committee on the Elimination of Discrimination Against Women available at http://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/ 1_Global/ INT_CEDAW_GEC_3731_E.pdf accessed on 8 June 2018.

21. Global Commission on HIV and the Law 'Overview of the Africa regional dialogue', [2011] available at *https://hivlawcommission.org/dialogues/africa/,* accessed on 1 July 2015.
22. Gonzalez, LL 'Almost 10 percent of HIV-positive women report forced sterilisation – study', 10 June 2015, available at https://www.health-e.org.za/2015/06/10/ almost-10-percent-of-hiv-positive-women-report-forced-sterilisation-study/ accessed on 25 May 2018.
23. Hahn, JJ 'Your guide to the South African equality courts: A step by step process to empower paralegals, community leaders and human rights educators', (2015) available at *http://www.legal-aid.co.za/wp-content/uploads/2015/11/Equality-Court-Handbook-2015.pdf,* accessed on 26 December 2017.
24. Health Professions Council of South Africa available at http://www.hpcsa.co.za /conduct/Complaints, accessed on 17 February 2015.
25. Health Professions Council of South Africa Guidelines for Good Practice in the Health Care Professions 'Seeking Patient's Informed Consent: The Ethical Considerations' 2 ed (2008) Booklet 9 available at *http://www.hpcsa.co.za/Conduct/Complaints*, accessed on 1 July 2015.
26. High Court tariff GG 38399, GNR 31, 23 January 2015 available *at http://www.justice.gov.za/legislation/notices/2015/20150123-gg38399_rg10349_gon31-RulesBoard.pdf,* accessed on 29 September 2017.
27. HPCSA 'Guidelines for good practice in the health care professions: General ethical guidelines for reproductive health' 2ed, (2007) available at http://www.hpcsa.co.za/downloads/conductethics/rules/generalethicalguideline reproductive_health.pdf, accessed on 26 December 2017.
28. *https://www.google.co.za /search?q=v+c+v+slovakia &oq= v+c++v+slovakia& aqs=chrome..69i57.18021j0j7&sourceid=chrome&ie=UTF-8#q=v+c+v+ slovakia+ olga +lenczewska,* accessed on 26 December 2016.
29. Human Rights Watch 'Sterilization of Women and Girls with Disabilities: A Briefing Paper' available at https://www.hrw.org/news/2011/11/10/sterilization-women-and-girls-disabilities accessed on 8 June 2018.

30. Human Sciences Research Council and South African AIDS Council 'The people living *http://www.stigmaindex.org/sites/default/files/reports/Summary-Booklet-on-Stigma-Index-Survey%20South%20Africa.pdf*, accessed on 2 January 2018.
31. Kelin available at http://www.kelinkenya.org/ accessed on 5 October 2018.
32. Keller, J 'Effective rights-based responses...? The NSP response to gender violence', (2012) available at *file:///C:/Users/badulc/Downloads/ALQ_March_April_2012.pdf*, accessed on 26 December 2017.
33. *KR against Lanarkshire Health Board*, available at https://www.scotcourts.gov.uk/search-judgments/judgment?id=615d1ea7-8980-69d2-b500-ff0000d74aa7 accessed on 25 May 2018.
34. *Law v Canada (Minister of Employment and Immigration*) [1999] 1 RCS 497, available at https://scc-csc.lexum.com/scc-csc/scc-csc/en/1691/1/document.do accessed on 16 July 2018.
35. Lenczewska, O 'The fine line between the 'medically necessary' and the degrading: A Study of the Case of *V.C. v. Slovakia*' available at
36. Magistrate's Court tariff GG 38399, GNR 33, 23 January 2015 available *at http://www.justice.gov.za/legislation/notices/2015/20150123-_gg38399_rg10349_gon33-RulesBoard.pdf*, accessed on 29 September 2017.
37. Manyathe-Jele, N 'Progress on judicial case-flow management' 2014 *De Rebus* available at *http://www.saflii.org/za/journals/DEREBUS/2014/65.pdf*, accessed on 8 October 2017.
38. McGreal, C 'The shame of the new South Africa' The Guardian, 1 November 2012 available at *https://www.theguardian.com/world/2002/nov/01/aids.southafrica*, accessed on 17 November 2017.
39. Mulheron, R 'The Class Action in Common Law Legal Systems: A Comparative Perspective', (2004) available at *https://books.google.co.za/books?id=rq3bBAAAQBAJ&printsec=frontcover&dq=The+Class+Action+in+Common+Law+Legal+Systems:+A+Comparative+Perspective&hl=en&a=X&ved=0ahUKEwjJw763kofYAhXPhRoKHV54CSwQ6AEIKDAA#v=onepage&q=The%20Class%20Action%20in%20Common%20Law%20Legal%20Systems%3A%20A%20Comparative%20Perspective&f=false*, accessed on 7 December 2017.

40. National Contraceptive Clinical Guidelines of 2012, available at https://www.gov.za/sites/default/files/ Contraception_Clinical_Guidelines_28jan2013-2.pdf accessed on 25 May 2018.
41. Open Society Foundations 'Against her will: forced and coerced sterilization of women worldwide' available at *https://www.opensocietyfoundations.org/sites/default/files/against-her-will-20111003.pdf*, accessed on 2 November 2017.
42. Pehe, J 'The Split of Czechoslovakia: A Defeat or a victory?' available at *http://www.pehe.cz/prednasky/ 2004/ the-split-of-czechoslovakia-a-defeat-or-a-victory*, accessed on 25 September 2017.
43. Ratcliffe, H 'Women and forced sterilisation' (2012) *A Global Voice for Women* – Soroptimist International available at *http://www.soroptimistinternational.org/assets/med*, accessed on 1 December 2014.
44. South African History Online 'The June 16 Soweto Uprising' available at *http://www.sahistory.org.za/topic/june-16-soweto-youth-uprising*, accessed on 7 April 2017.
45. South African Human Rights Commission available at *http://sahrc.org/home/index/php?ipkContentID=1*, accessed on 17 February 2015.
46. South African Nursing Council available at *http://www.sanc.co.za/complain-misconduct.htn*, accessed on 17 February 2015.
47. Stats SA 'Mid-year population estimates 2017' available at *http://www.statssa.gov.za/ publications/P0302/P03022017.pdf*, accessed on 5 January 2018.
48. The Convention on Human Rights and Biomedicine available at *https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId =090000168007cf98*, accessed on 26 December 2016.
49. *The Government of the Republic of Namibia v LM and Others* case no 49/2012 available at *http://www.saflii.org/na/cases/NASC/2014/19.html*, accessed on1 July 2015.
50. The Human Sciences Research Council Report 'The people living with HIV stigma index: South Africa 2014', (2015) available at *http://www.stigmaindex.org/sites/default/files /reports/Summary-Booklet-on- Stigma-Index-Survey%20South%20Africa.pdf*, accessed on 18 December 2017.

51. The International Covenant on Civil and Political Rights available at https://www.ohchr.org/en/professionalinterest/pages/ccpr.aspx, accessed on 16 July 2018.
52. The Universal Declaration of Human Rights available at *http://www.echr.coe.int/pages/home.aspx?p=basictexts,* accessed on the 26 December 2016.
53. UNAIDS 'South Africa: Overview', [2018] available at *http://www.unaids.org/en/regionscountries/countries/southafrica,* accessed on 5 January 2018.
54. UNAIDS 'UNAIDS data 2017', (2017) available at *http://www.unaids.org/sites/ default /files/media_asset/20170720_Data_book_2017_en.pdf,* accessed on 5 January 2018.
55. UNFRA 'Programme of action adopted at the International Conference on Population and Development' Cairo, 5-13 September 1994, (2004) (Cairo Declaration) available at *https://www.unfpa.org/sites/default/files/event-pdf/PoA_en.pdf,* accessed on 1 November 2017.
56. United Nations 'History of the document' available at *http://www.un.org/en/documents/udhr/history.shtml*., accessed on 1 July 2015.
57. Universal Declaration of Human Rights available at http://www.un.org/en/documents/udhr/history.shtml, accessed on 16 July 2018.
58. Women's Legal Centre 'Press release: The South African government must do more to prevent coerced sterilisations in public hospitals', [2015] available at *http://wlce.co.za/wp-content/uploads/2017/02/WLC-_Media-Release_Coerced-Sterilisation_141116.pdf,* accessed on 28 December 2017.
59. Zampas, C 'Body and Soul Report: Forced sterilization and other assaults on Roma reproductive freedom in Slovakia' available at *https:// www.reproductiverights.org/sites/default/files/documents/bo_slov__part1.pdf*, accessed on 23 December 2016.

**Primary Sources**

**National Cases**

1. *AB and Another v Minister of Social Development* (CCT155/15) [2016] ZACC 43; 2017 (3) BCLR 267 (CC); 2017 (3) SA 570 (CC) (29 November 2016).

2. *ANC v Sparrow* (01/16) [2016] ZAEQC 1.
3. *Barkhuizen v Napier* (CCT72/05) [2007] ZACC 5; 2007 (5) SA 323 (CC); 2007 (7) BCLR 691 (CC) (4 April 2007).
4. *Bato Star Fishing (Pty) Ltd v Minister of Environmental Affairs and Tourism and Others* (CCT 27/03) [2004] ZACC 15; 2004 (4) SA 490 (CC); 2004 (7) BCLR 687 (CC).
5. *Brink v Kitshoff* (CCT15/95) [1996] ZACC 9; 1996 (4) SA 197; 1996 (6) BCLR 752.
6. *Broude v McIntosh & another* 1998 (2) All SA 555 (A).
7. *C v Minister of Correctional Services* 1996 (4) SA 292 T.
8. *Castell v de Greef* 1993 (3) SA 501 (C) 505.
9. *Castell v De Greef* 1994 (4) SA 408 (C).
10. *Christian Lawyers Association v Minister of Health and Others (Reproductive Health Alliance as Amicus Curiae*) 2005 (1) SA 509 T.
11. *Dadoo Ltd and Others v Krugersdorp Municipal Council* 1920 AD 530.
12. *Dawood and Another v Minister of Home Affairs and Others; Shalabi and Another v Minister of Home Affairs and Others; Thomas and Another v Minister of Home Affairs and Others* (CCT35/99) [2000] ZACC 8; 2000 (3) SA 936; 2000 (8) BCLR 837 (7 June 2000).
13. *De Reuck v Director of Public Prosecutions (Witwatersrand Local Division) and Others* (CCT5/03) [2003] ZACC 19; 2004 (1) SA 406 (CC); 2003 (12) BCLR 1333 (CC) (15 October 2003).
14. *DE v RH* (CCT 182/14) [2015] ZACC 18; 2015 (5) SA 83 (CC); 2015 (9) BCLR 1003 (CC).
15. *Desai NO v Desai NNO and Others* (718/93) [1995] ZASCA 113; 1996 (1) SA 141 (SCA).
16. *Du Preez v Minister of Justice and Constitutional Development and Others* 2006 (5) SA 592 (EqC).
17. *Duncanmec (Pty) Limited v Gaylard NO and Others* (CCT284/17) [2018] ZACC 29 (13 September 2018).
18. *Economic Freedom Fighters v Speaker of the National Assembly and Others; Democratic Alliance v Speaker of the National Assembly and Others* (CCT 143/15; CCT 171/15) [2016] ZACC 11; 2016 (5) BCLR 618 (CC); 2016 (3) SA 580 (CC) (31 March 2016).
19. *Electricity Supply Commission V Stewarts and Lloyds of SA (Pty) Ltd* 1981 (3) SA 340 (A).
20. *Esterhuizen v Adminstrator, Transvaal* 1957 (3) SA 710 (T).
21. *Evins v Shield Insurance Co Ltd* 1980 2 All SA 40 (A).

22. *Ex Parte Chairperson of the Constitutional Assembly: In Re-Certification of the Amended Text of the Constitution of the Republic of South Africa*1996 (4) SA 744 (CC).
23. *Ferreira v Levin NO and Others; Vryenhoek and Others v Powell NO and Others* (CCT5/95) [1995] ZACC 13; 1996 (1) SA 984 (CC); 1996 (1) BCLR 1 (6 December 1995).
24. *Fraser v Children's Court Pretoria North and Others* (CCT31/96) [1997] ZACC 1; 1997 (2) SA 261 (CC); 1997 (2) BCLR 153 (CC).
25. *Government of the Republic of South Africa and Others v Grootboom and Others* (CCT11/00) [2000] ZACC 19; 2001 (1) SA 46; 2000 (11) BCLR 1169 (4 October 2000).
26. *Harksen v Lane NO* (CCT9/97) [1997] ZACC 12; 1997 (11) BCLR 1489; 1998 (1) SA.
27. *HMBMP Properties (Pty) Ltd v King*1981 (1) SA 906 (N).
28. *Hoffmann v South African Airways* (CCT17/00) [2000] ZACC 17; 2001 (1) SA 1; 2000 (11) BCLR 1211; [2000] 12 BLLR 1365 (CC).
29. *In re Dube* 1979 (3) 820 N 821.
30. *Isaacs v Pandie* (12217/07) [2012] ZAWCHC 121 (CC); 2004 (11) BCLR 1125 (CC); [2004] 12 BLLR 1181 (CC).
31. *Kruger v Coetzee* 1966 2 SA 428 (A).
32. *Larbi-Odam and Others v Member of the Executive Council for Education (North-West Province) and Another* (CCT2/97) [1997] ZACC 16; 1997 (12) BCLR 1655; 1998 (1) SA 745.
33. *Lee v Minister of Correctional Services* (CCT 20/12) [2012] ZACC 30; 2013 (2) BCLR 129 (CC); 2013 (2) SA 144 (CC); 2013 (1) SACR 213 (CC).
34. *Links v Member of the Executive Council, Department of Health, Northern Cape Province* (CCT 29/15) [2016] ZACC 10; 2016 (5) BCLR 656 (CC); 2016 (4) SA 414 (CC).
35. *Louwrens v Oldwage* 2006 (2) SA 161 (SCA).
36. *Lymbery v Jefferies* 1925 AD 236.
37. *Makate v Vodacom (Pty) Ltd* (CCT52/15) [2016] ZACC 13; 2016 (6) BCLR 709 (CC); 2016 (4) SA 121 (CC).
38. *Mashongwa v PRASA* (CCT03/15) [2015] ZACC 36; 2016 (2) BCLR 204 (CC); 2016 (3) SA 528 (CC) (26 November 2015).
39. *Mayelane v Ngwenyama and Another* (CCT 57/12) [2013] ZACC 14; 2013 (4) SA 415 (CC); 2013 (8) BCLR 918 (CC) (30 May 2013).
40. *McDonald v Wroe* 2006 (3) All SA 565 (C).

41. *MEC for Education: KwaZulu-Natal and Others v Pillay* (CCT 51/06) [2007] ZACC 21; 2008 (1) SA 474 (CC); 2008 (2) BCLR 99 (CC) (5 October 2007).
42. *Minister of Finance and Other v Van Heerden* (CCT 63/03) [2004] ZACC 3; 2004 (6) SA
43. *Minister of Finance and Others v Gore NO* (230/06) [2006] ZASCA 98; [2007] 1 All SA 309 (SCA); 2007 (1) SA 111 (SCA).
44. *Minister of Health and Others v Treatment Action Campaign and Others (No 2)* (CCT8/02) [2002] ZACC 15; 2002 (5) SA 721; 2002 (10) BCLR 1033 (5 July 2002).
45. *Minister of Home Affairs and Another v Fourie and Another* (CCT 60/04) [2005] ZACC 19; 2006 (3) BCLR 355 (CC); 2006 (1) SA 524 (CC) (1 December 2005).
46. *Mohlomi v Minister of Defence* (CCT41/95) [1996] ZACC 20; 1996 (12) BCLR 1559; 1997 (1) SA 124.
47. *Moseneke and Others v Master of the High Court* (CCT51/00) [2000] ZACC 27; 2001 (2) BCLR 103; 2001 (2) SA 18.
48. *National Coalition for Gay and Lesbian Equality and Others v Minister of Home Affairs and Others* (CCT10/99) [1999] ZACC 17; 2000 (2) SA 1; 2000 (1) BCLR 39.
49. *NM and Others v Smith and Others* (CCT69/05) [2007] ZACC 6; 2007 (5) SA 250 (CC); 2007 (7) BCLR 751 (CC) (4 April 2007).
50. *Off-Beat Holiday Club and Another v Sanbonani Holiday Spa Shareblock Limited and Others* (CCT106/16) [2017] ZACC 15; 2017 (7) BCLR 916 (CC).
51. *Pandie v Isaacs* (A135/2013, 1221/2007) [2013] ZAWCHC 123.
52. *Petersen v Maintenance Officer and Others* 6541/03) [2003] ZAWCHC 61; [2004] 1 All SA 117 (C) (11 November 2003).
53. *President of the Republic of South Africa and Another v Hugo* (CCT11/96) [1997] ZACC 4; 1997 (6) BCLR 708; 1997 (4) SA 1.
54. *R v Lusu* 1953 (2) SA 484 (A).
55. *Rex v Abdurahman*1950 (3) SA 136 (A).
56. *Richter and Another v Estate Hamman* 1976 (3) SA 226 (C).
57. *Rikhoto v East Rand Administration Board and Another* 1983 (4) SA 278.
58. *Road Accident Fund and Another v Mdeyide* (CCT 10/10) [2010] ZACC 18; 2011 (1) BCLR 1 (CC); 2011 (2) SA 26 (CC).
59. *Rompel v Botha* 1957 (3) SA 710 (T) 719.
60. *S v Dodo* (CCT 1/01) [2001] ZACC 16; 2001 (3) SA 382 (CC); 2001 (5) BCLR 423 (CC) (5 April 2001).

61. *S v Makwanyane* (CCT3/94) [1995] ZACC 3; 1995 (6) BCLR 665; 1995 (3) SA 391; [1996] 2 CHRLD 164; 1995 (2) SACR 1 (6 June 1995).
62. *S v Williams and Others* (CCT20/94) [1995] ZACC 6; 1995 (3) SA 632 ; 1995 (7) BCLR 861 (CC) (9 June 1995).
63. *SABC v DA* 1997 (2) SA 97 (CC).
64. *Santam Insurance Co Ltd v Vorster*
65. *Sibisi No v Maitin* 2014 (6) SA 533 (SCA).
66. *Sibisi NO v Maitin* 2014 (6) SA 533 (SCA).
67. *Sithole v The MEC for Health and Social Development & 3 Others* – unreported case no. 19744/2012 – High Court of South Africa, Gauteng Local Division, Johannesburg.
68. *Steenkamp NO v Provincial Tender Board, Eastern Cape* 2006 (3) SA 151 (SCA).
69. *Stoffberg v Elliot* 1923 CPD 148.
70. *The Master v IL Black & Co Ltd* and *Others* 1983 (1) SA 986 (A).
71. *Truter v Deysel* 2006 (4) SA 168 SCA.
72. *Uitenhage Municipality v Molloy* 1998 2 SA 735 SCA.
73. *Van Duivenboden* 1990 (1) SA 680 A.
74. *Waring & Gillow Ltd v Sherborne* 1904 (TS) 340.
75. *Western Cape Provincial Government and Others In Re DVB Behuising (Pty) Limited v North West Provincial Government and the Registrar of Deeds* (CCT22/99) [2000] ZACC 2; 2000 (4) BCLR 347; 2001 (1) SA 500 (CC).

**National Legislation**

1. The Bantu Education Act of 1953.
2. The Bantu (Urban Areas) Consolidation Act 25 of 1945.
3. The Black Administration Act 38 of 1927.
4. The Children's Act 38 of 2008.
5. The Choice on Termination of Pregnancy Act 92 of 1996.
6. The Commission on Gender Equality Act 39 of 1996.

   s 11 (1) (a) (i-iii).

   s 11 (1) (b).

   s 11 (1) (e) (i).

s 11 (1) (e) (ii) A.

s 11 (1) (e) (ii) B.

s 11 (1) (h).

s 12 (3) (e) (ii) B.

s 12 (4) (b).

s 13 (1) and (5).

7. The Constitution of the Republic of South Africa, Act 200 of 1993 (interim Constitution).

s 6.

s 98 (2) (c).

s 8 (1).

s 8 (2).

s 33 (1).

8. The Constitution of the Republic of South Africa, Act 108 of 1996.

s 1(1).

s 1 (1) (xxii) (b) (i)-(iii).

s 7(1).

s 9.

s 9 (2).

s 9 (3).

s 9 (4).

s 10.

s 10 (1).

s 11.

s 12.

s 12 (2) (a).

s 12 (2) (b).

s 14.

s 27.

s 27 (1) (a).

s 34.

s 35 (3) (g).

s 39 (2).

s 39 (1) (b).

s 167 (6).

s 172(1) (a).

s 181 (1) (b).

s 181 (2).

s 181 (3).

s 182 (1) (b).

s 182 (1) (c).

s 183.

s 184 (1) (a).

s 184 (1) (b).

s 184 (1) (c).

s 181 (1) (d).

s 187 (1).

s 187 (2).

9. The Criminal Procedure Act 51 of 1977.

s 18.

10. The Employment Equity Act 55 of 1998.

11. The Health Professions Act 56 of 1974.

12. The Human Rights Commission Act 40 of 2013.

s 13 (1) (b) (vi).

s 13 (3) (a).

13. The National Health Act 61 of 2003.

s 6.

s 6 (1) (b).

s 6 (1) (c).

s 6 (2).

s 7.

s 55.

s 71.

s 167 (6).

14. The Native Administration Act 38 of 1927.

15. The Native Urban Areas Act of 1954.

s 10.

16. The Institution of Legal Proceedings Against Certain Organs of State Act 40 of 2000.

s 3.

s 3 (1) (a).

s 3 (4).

17. The Judicial Matters Amendment Act 8 of 2017.

18. The Magistrate's Court Act 32 of 1944.

s 46 (2) (c).

19. The Prescription Act 68 of 1969.

s 11.

s 12 (3).

20. The Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000.

s 1.

s 1 (a) and (b).

s 2 (a).

s 3 (2)(b) (i) (ii).

s 3 (4) (b) (i) (ii) (iii).

s 5(1).

s 6.

s 9.

s 13.

s 13 (2) (a).

s 14 (2).

s 14 (2) (c).

s 14(3).

s 14 (3) (a).

s 14 (3) (a) – (e).

s 14 (3)(b).

s 14 (3) (i) (i) and (ii).

s 14 (3) (f).

s 14 (3) (f) to (i).

s 14 (3) (h).

s 16.

s 16 (1) (a) and (c) (i).

s 20.

s 20 (1) (c).

s 20 (1) (f).

s 20 (c).

s 21 (2) (j).

s 21 (2) (k).

s 21 (2) (l).

s 21 (2) (d).

s 21(2) (0).

s 23 (1).

s 23 (3).

s 28 (1).

21. The Public Health Act.

22. The Public Protector Act 23 of 1994.

s 6 (4) (a).

23. The Railways and Harbours Regulation, Control and Management Act 22 of 1916.

24. The Sterilisation Act 44 of 1998.

s 2 (1) (a) and 4 (c).
s 2(2).
s 3.
s 4.
s 4 (a) (i).
s 4 (a) (ii).
s 4 (c).
s 4 (b).
s 9.
s 12.

**International Cases**

1. *I.G. and others v. Slovakia*, Application no. 15966/04, Council of Europe: European Court of Human Rights.
2. *LM and Others v Government of the Republic of Namibia* (I 1603/2008, I 3518/2008,/ 3007/2008) [2012] NAHC 211 (30 July 2012).
3. *N.B. v Slovakia,* Application no. 29518/10, Council of Europe: European Court of Human Rights.
4. *Rogers v Whitaker* [1992] HCA 58.
5. *SWK and others v Médecins Sans Frontières and others* Petition No. 605 of 2014, In the High Court of Kenya at Nairobi Constitutional and Human Rights Division.
6. *The Government of the Republic of Namibia v LM and Others* (SA 49/2012) [2014] NASC 19 (3 November 2014).
7. *V. C. v Slovakia* Application no. 18968/07 European Court of Human Rights.

**International Legislation**

1. The Health Care Act 1994.
   s 13 (1).
2. The Constitution of the Republic of Kenya, 2010.
   Article 2 (5) – (6).
   Article 26 (1) and (3).
   Article 27 (1) – (8).
   Article 28.
   Article 29 (d) (f).
   Article 31 (a).
   Article 33 (1).
   Article 35 (1) (b).
   Article 43 (1) (a).
   Article 46 (1) (a) – (c).
   Article 43 (1) (a).
3. The Sterilisation Regulation.
   s 2 (a).
   s 2 (b).

**Conventions**

1. ACHPR

   Article 2.

   Article 3.

   Article 5.

Article 6.

Article 9 (1).

Article 16.

Article 18 (3).

2. CAT
3. CEDAW

   Article 1.

   Article 10(h).

   Article 12.

   Article 14 (1)(b).

   Article 16(1) (e).

4. Discrimination (Employment and Occupation) Convention, 158.
5. ECHR

   Article 3.

   Article 8 (1).

   Article 12.

   Article 13.

   Article 14.

6. ICCPR

   Article 7.

   Article 9.

   Article 10.

   Article 17(1).

   Article 19(2).

   Article 26.

7. ICESCR

   Article 10(1).

   Article 12 (1).

   Article 12 (2).

   Article 16

8. The International Convention on the Elimination of All Forms of Racial Discrimination

   Article 2 (d).

9. The Protocol to the ACHPR on the Rights of Women in Africa (Maputo Protocol)

   Articles 1 (b), (c) and (g).

   Article 2.

   Article 2 (a).

   Article 3.

   Article 4 (1).

   Article 14.

   Article 14 (1) (b).

10. The United Nations Fourth World Conference on Women

    Article 29.

11. UDHR

    Article 1.

    Article 2.

    Article 3.

    Article 5.

    Article 12.

    Article 19.

    Article 25.