**Call for submissions**

***Women’s and girls’ sexual and reproductive health and rights in situations of crisis***

The Working Group on discrimination against women and girls will present a thematic report on women’s and girls’ sexual and reproductive health and rights[[1]](#footnote-1) (SRHR) in situations of crisis to the 47th session of the Human Rights Council in June 2021. The report will examine women’s and girls’ SRHR within an overarching framework of reasserting gender equality and countering roll-backs.

The Working Group will take a broad approach to crisis.In doing so, it intends not only to look at humanitarian crises, typically understood as encompassing international and non-international conflicts and occupied territories, natural disasters, man-made disasters, famine and pandemics, but it will also examine long-standing situations of crisis resulting from structural discrimination deeply embedded in histories of patriarchy, colonization, conquest and marginalization (such as in the case, for example, of indigenous women, Roma women and women of African descent), as well as other types of crisis based on the lived experiences of women, such as those induced by environmental factors, including the toxification of the planet, land grabbing, political, social and economic crises, including the impact of austerity measures, refugee and migrant crises, displacement crises, and gang-related violence, among others. The Working Group will examine how existing laws, policies, and practices can contribute to negative reproductive health outcomes for women and girls in situations of crisis and restrictions on their autonomy during their life-cycle, using an intersectional approach.

In order to inform the preparation of this report and in line with its mandate to maintain a constructive dialogue with States and other stakeholders to address discrimination against women and girls, the Working Group would like to seek inputs from all stakeholders. Submissions should be sent **by 31 August 2020** to [wgdiscriminationwomen@ohchr.org](mailto:wgdiscriminationwomen@ohchr.org) and will be made public on the Working Group's web page, unless otherwise requested. The Working Group is particularly interested in receiving information about challenges faced in ensuring that women’s and girls’ sexual and reproductive rights are respected, protected and fulfilled in times of crisis, and are adequately prioritized, as well as examples of good practices.

**Questionnaire**

Concept/definition of crisis

1. **Please provide information on the legal and policy framework used by your State to manage situations of crisis and on how the concept of “crisis” has been defined or framed**.

South African society is marked by gross social inequalities, manifesting themselves mainly along racial, class, and gender lines. It is arguable that racial inequities (in the form of apartheid) have most significantly shaped the social profile and consequently health and health care of South Africa. Under the Population Registration Act of 1950, all South Africans were classified into a "population group" at birth and assigned a racial category, namely White, Indian, Coloured, and African. Although this act was repealed in 1991, its social and economic effects will remain present for a long time to come.

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. In terms of the Promotion of Equality and Prevention of Unfair Discrimination Act of 2000 , 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 anyperson 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.

Violence Against women and HIV infections are at crisis level in South Africa , particular VAW that is perpetrated by the state on HIV Positive Women who have been forced and coerced into Sterilisation since early 2000s. Despite existing regulations and laws protecting women’s reproductive choice in South Africa (deBruyn, 2004), coerced sterilisations are occurring (Gatsi, Kehler & Crone, 2010). This violence is not acknowledge by the State despite the recent publication of the Report by the Commission for Gender Equlaity[[2]](#footnote-2), consitituional body mandated by an Act of Parliament to promote and protect gender equality in South Africa. The actions of the state can be better explained by understanding the ideology of patriarchy also features prominently in the explanations of VAW in South Africa. This central feminist explanation of VAW suggests that the male-dominated power structure throughout institutionalised South Africa and in individual relationships forms the underlying bias that enables VAW. This bias enables the formation and entrenchment of norms and attitudes that disadvantage women and children, as the balance of social power is tilted to the advantage of men, their perspectives and their rights.[[3]](#footnote-3) In understanding VAW, and not just GBV, the shortcomings of the concept of patriarchy make it insufficient.[[4]](#footnote-4)( Sibanda- Moyo , Konje & Brobbery , 2017)

“Coerced sterilisation occurs when financial or other incentives, misinformation, orintimidation tactics are used to compel an individual to undergo the procedure. Additionally, sterilisation may be required as a condition of health services or employment. Forced sterilisation occurs when a person is sterilised without her knowledge or is not given an opportunity to provide consent” (Open Society Foundations, 2011, p. 2).

Research suggests that HIV-positive women in South Africa face widespread, persistent, and severe

stigma and discrimination, especially when accessing sexual and reproductive healthcare in public

hospitals. HIV-positive women may experience difficulty in accessing information on HIV and

pregnancy as well as information on available contraceptive options (de Bruyn, 2004). In addition, if

HIV-positive women decide to become pregnant, they may be subjected to intense negative

attitudes and discrimination from their own communities and from healthcare providers (de Bruyn,

2004).

Much of the literature focuses on the nature and types of choices that are made by women living

with HIV (Bedimo et al., 1998). Many factors have been identified which influence reproductive

choices including culture, the psycho-social and economic situation, the views of partners and

friends, and the attitudes of healthcare workers (Bedimo et al., 1998)

‘I Feel Like Half a Woman All the Time[[5]](#footnote-5)’:A qualitative report of HIV-positive women’s experiences of

coerced and forced sterilisations in South Africa details extensively the stories of Black HIV Positive women who were forced and coerced into sterilisation , takes you through their pain , stigma and injustice perpetrated by health care workers . “The report is based on 22 semi-structured interviews conducted with HIV-positive women in Gauteng and KwaZulu-Natal who were identified through a screening questionnaire as believing that they had undergone a coerced or forced sterilisation. Most women in this study reported that they were coerced into having a sterilisation. These women’s accounts indicate that their “consent” to sterilisation did not always meet the criteria of fully informed, voluntary and free from pressure and coercion. From their reports, it appears that the informational component of the informed consent process was not always satisfied, as the sterilisation procedure and its consequences were rarely explained. Most women described signing a consent form under very stressful circumstances, such as while they were in active labour or while being wheeled to the theatre. Others reported being coerced into accepting a sterilisation in order to receive another healthcare service like an abortion or caesarean section. Women reported that the provision of appropriate and accurate information about the sterilisation was inadequate and that they felt unable to make an independent and informed decision because they were often in distress. In most instances, healthcare providers equated the signing of consent forms with fully informed consent. Therefore, the “consent” obtained from these women may be invalid in most cases. As is clearly outlined in the International Federation of Gynaecology and Obstetrics’ (FIGO) Guidelines on Female Contraceptive (FIGO, 2011), a signature on paper does not, on its own, signify consent. It is the process under which the consent is sought that determines if it was fully informed, coerced or forced.”( Mthembu et al 2011)

The Human Sciences Research Council and South African AIDS Council ‘The people living with HIV stigma index: South Africa 2014’[[6]](#footnote-6) (2015). This study by HSRC and South African AIDS Council further indicated that more than 498 women living with HIV in South Africa were sterilised . 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. At the Fourth World Conference on Women in Beijing it was recognised that the forced sterilisation of women amounts to violence. 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.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

South Africa has the biggest HIV epidemic in the world, with 7.7 million people living with HIV.HIV prevalence among the general population is high at 20.4%. Prevalence is even higher among men who have sex with men, transgender women, sex workers and people who inject drugs.The country has the world’s largest ART programme, Women are disproportionately affected by HIV in South Africa. In 2017, 26% of women were estimated to be living with HIV, compared to around 15% of men.[[7]](#footnote-7) ( UNAIDS, South Africa)

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.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.

1. **Please list the type of situations that would fit the concept of “crisis” in your State and indicate what situations are excluded**.
   1. South Africa remains the epicenter of the HIV pandemic as the largest AIDS epidemic in the world—20 percent of all people living with HIV are in South Africa, and 20 percent of new HIV infections occur in South Africa and the numbers are alarming among Adolescent Girls and Young Women. Of the estimated 7.2 million South Africans living with HIV, nearly 60 percent are women over the age of 15. Women who were forced and coerced into sterilisation are not priority in the HIV National Strategic Plan[[8]](#footnote-8)
   2. In South Africa, a country scarred by the history of apartheid, violence against women (VAW) is endemic. Statistics on femicide, rape and domestic violence demonstrate unprecedented prevalence rates. According to South Africa’s 2016 Demographic and Health Survey, one in five women older than 18 has experienced physical violence. This figure is reportedly higher in the poorest households, where at least one in three women has reported physical violence The report Violence Against women in South Africa : A couuntry in Crisis (2017) details the forms of Violence Against Women but omits to mention Forced and Coerced sterilisation of HIV poistive Women as a form of VAW. This report calls on *Need for multifaceted approaches*: VAW is an intricate phenomenon requiring a multifaceted approach and should be understood as the outcome of multiple factors interlinked at the individual, family, community and societal levels. Workable approaches must take into account the individual-level factors of women’s socioeconomic realities (e.g., education, income and employment) as well as macro structural factors (e.g., patriarchal structures, social and economic policies) that shape women’s lives and experiences. The National Strategic Plan on GBVF[[9]](#footnote-9) does not priorities women living with HIV who were forced and coerced into sterilisation.
2. What institutional mechanisms are in place for managing a crisis and how are priorities determined?

The 1993 UN Declaration on the Elimination of Violence against Women provided the basis for the dominant understandings of VAW in development and academic discourses. The Declaration defines VAW as

…any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.[[10]](#footnote-10)

This definition employs the underpinnings of the human rights framework and other instruments which specifically address the human rights of women.[[11]](#footnote-11) These include the provisions in the UN Declaration on the Elimination of Violence against Women and its further expansion in the 1995 Beijing Platform for Action, as well as those in the Universal Declaration of Human Rights, and in the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW). This conceptualisation foregrounds a relationship between discrimination, violence and notions of power. VAW is understood as both feeding off and reinforcing discrimination against women, including discrimination based on race, ethnicity, sexuality, work, age, disability and other markers. This understanding of VAW implies that sociocultural ideas about men and women – gender ideology – in a particular context are important for the definitions of VAW.[[12]](#footnote-12) It also points to the responsibilities of state governments in their commitments to human rights and, as per the social contract, in their obligation to work towards social justice by preventing VAW, protecting women against it, investigating acts of violence and punishing perpetrators.

* The National Strategic Plan on TB, HIV and STIs (2017-2022) clearly lists the key and vulnerable populations to be targeted in reducing HIV related stigma and discrimination. Even though forced sterilisation of HIV positive women has been discussed by concerned members of civil society, this population did not make the list of key and vulnerable populations to be supported in eliminating HIV related stigma and discrimination in accessing health care.

**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. The most significant of these constitutional protections are found in the rights

to equality, human dignity, life,freedom and security of the person (bodily integrity) privacy, and health care, food, water and social security. Without derogating from the importance of the above rights, section 12(2)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.

**The Sterilisation Act 44 of 1998**

The Sterilisation Act is clearly in keeping with the human rights based approach adopted by the Constitution.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.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.

**The National Health Act 61 of 2003**

The National Health Act also lends its voice to the issue of informed consent. Section 6 (1) (b) and (c) 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.

**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. This important piece of legislation has recently included HIV as a prohibited ground of discrimination, and otherimportant grounds that have been recognised by the Act as being a prohibited ground of discrimination are the race group of a person and sex. The Equality Act enablescomplainants of unfair discrimination to approach the local Equality Courts for redress.

**Common law on informed consent**

There is a common law obligation on medical practitioners to obtain informed consent before treating or operating on patients. 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. The duty to obtain informed consent rests with the treating or operating medical practitioner or treating health care practitioner.

Challenges and good practices

1. Please highlight any challenges faced in the provision of SRH services and good practices in ensuring women’s and girls’ SRHR in situations of crisis, including, for example, measures concerning timely access to the the following types of services and aspects of care:
2. Access to essential medicines as prescribed by the WHO, equipment and technologies essential for the quality provision of sexual and reproductive health services;
3. Prevention of HIV transmission, post-exposure prophylaxis and treatment for HIV/AIDS as well as the prevention and treatment of sexually transmissible infections;
4. Pregnancy-related health services, including pre- and post-natal care, assistance during child-birth, and emergency obstetric care.
5. Prevention, investigation and punishment of all forms of gender-based violence, and access to timely and comprehensive medical interventions, mental health care, and psychosocial support for victims and survivors;
6. Measures to prevent and prohibit practices such as female genital mutilation and child, early and forced marriage;
7. Legal and policy safeguards against abuses and delays in the provision of SRH services for example in relation to confidentiality, referrals, informed consent, conscientious objection, and third party consent requirements;
8. The affordability of SRH services especially for those in situations of vulnerability; and
9. Other pertinent information that may affect the availability accessibility, affordability, acceptability and quality of SRH services and information.

The situation in South Africa has a myrad of challnges above and they contribute to the violation of Human rights experienced by women living with HIV who were forced and coerced into sterilisation by the state .

* PMCTCT is prescribed by WHO on managing the mother to child transmission of HIV and yet this is the entry point for VAW by the state in South Africa. When pregnant HIV + Women seek medical health they enter the sites of their violations .
* No measures have been taken by the state to address the issue of forced and coerced sterilisation
* The Constitution of the Republic of South Africa, 1996
* Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000, This important piece of legislation has recently included HIV as a prohibited ground of discrimination, and otherimportant grounds that have been recognised by the Act as being a prohibited ground of discrimination are the race group of a person and sex.
* The Sterilisation Act is clearly in keeping with the human rights based approach adopted by the Constitution.
* The National Health Act also lends its voice to the issue of informed consent.
* Common law on informed consent , there is a common law obligation on medical practitioners to obtain informed consent before treating or operating on patients
* The socioeconomic status of the Black HIV positive Women who were sterilised .
* Assumptions that violence drives HIV infections and HIV infections drive Violence Against Women, taking into consideration the loss associated with being unable to bear children . The loss and isolation is internal at individual level and external in the society as the patriarchal society does not value a women who is unable to bear children , this stigma gets exacerbated when the women in HIV positive. The lose their social standing and voice at home and in society .

**Experiences of crisis**

**5. Please list the situations of crisis experienced by your State in the last five years.**

**5.1. HIV:** Women in South Africa are at a high risk of being infected with HIV. Statistics indicate that women, particularly adolescent girls and young women, are the population that has the highest prevalence of HIV in the country.

Poverty, both at individual and societal levels, has been associated with HIV spread. Poor individuals, due to lack of alternatives to earning a livelihood, may be more likely to engage in sex work or other forms of transactional sex. It is reported that HIV prevalence is lower among higher socio-economic classes in the country. As a consequence of apartheid and the associated racial segregation and discrimination, many South African young women, especially black ones have relatively lower levels of education. Their earning potential within the job market is therefore compromised. South Africa has high rates of poverty and unemployment, and young women constitute the majority of this unemployed populations.

5.2. **Gender Based Violence and Femicide:** South Africa has been plagued by Violence Against Women and Femicide. Violence against women is an important contributor to ill-health of women, it affects their physical and emotional well-being and has particular consequences for their sexual and reproductive health. Women living in violent relationships are often constrained in making sexual and productive choices. This puts them at great risk of early and unwanted pregnancy and sexual and transmitted infections, including HIV and further violence.

Gender Based Violence and Femicide or Violence against women is widespread, with rates of physical and sexual intimate partners violence and non-partner sexual violence as very high in the country. Similarly, gender and sexual based violence in South Africa is widespread and a common problem which is increasingly normalised and underreported. Reported statistics on Gender Based Violence hardly include data on forced and coerced sterilisation of women living with HIV. It is therefore safe to say the levels of Gender Based Violence are even higher than accounted for.

1. What was the impact of those crises on women and girls? Please provide information in particular on the following aspects:
2. Which groups of women and girls were most affected and how, taking into account different factors, such as age, geographic location (including urban and rural areas), ethnic and social origin, disability, marital status, migratory status, citizenship status or other status?
3. What was the impact on their SRHR? Were any specific risk factors and needs identified? Do you have data and/or qualitative information disaggregated by the factors listed under question 6(a)? If not, please explain why.
4. What were the main obstacles encountered by the State, if any, in identifying and addressing the impact of the crisis on women’s and girls’ SRHR?
5. What measures were adopted during and after the crisis to ensure women and girls’ access to sexual and reproductive health services? Please indicate which SRHR services are recognized as essential services in the health policy or laws of your State and are funded through the health system. What steps were taken to ensure the continuity of services and access during the crisis?
6. What other protocols or systems were put in place to prevent adverse reproductive and sexual health outcomes due to the common risks triggered by crisis including, for example, gender-based violence and child marriage? Were any special measures adopted for specific groups of women and girls?
7. Were women’s rights organizations[[13]](#footnote-13) involved in the needs and impact assessments and the recovery policies? If not, please indicate why.
8. Which actors or institutions played a role in the provision of emergency responses? Please describe their role and explain what roles were played, if any, by national women’s rights or human rights mechanisms, or other similar bodies as well as civil society organisations.
9. How were the emergency responses funded and to what extent did they rely on foreign aid or assistance, if any? Please also indicate how in your State adequate financing of women’s sexual and reproductive health is ensured more generally on an ongoing basis.
10. What obstacles have civil society organisations encountered in their efforts to deliver sexual and reproductive services?

* Women living with HIV form part of a marginalised group facing intersectional discrimination in society. Women described being discriminated against by healthcare providers. It is argued that the sterilisation of HIV-positive women in South Africa is rooted in pervasive stigma and discrimination that these women should be prevented from having children. This discrimination manifests in different ways.
* Additionally, women who are forcibly or coercively sterilised face double the stigma because they are both HIV-positive and unable to bear children. Forced and coerced sterilisations have several negative personal and social consequences. These include, but are not limited to, emotional distress and social isolation, divorce or abandonment by partners, persistent mental and physical health problems and financial costs (often related to attempts to reverse the procedure). Many of these women (and their partners) still desired more children and our respondents reported that being sterilised has affected them profoundly, making them feel like less of a woman.
* To date no measures have been taken by the State to address this matter
* Her Rights Initiative has been involved in trying to get the state to acknowledge the practice and find ways to curb it , other several women’s organisation have supported these initiatives . Recently the Commission for Gender Equality published a report highlighting the gross violation of Human Rights and the extreme form of Violence Against Women , yet nothing has happened. Her Rights Initiative (HRI) together with the Health Economics AIDS Research Division(HEARD), University of KwaZulu-Natal, Justice and Women (JAW), Positive Women’s Network and the AIDS Legal Network (ALN) conducted a qualitative study to document HIV-positive women’s experiences of coerced or forced sterilisation in Gauteng and KwaZulu-Natal.

1. Could you identify any lessons learned? Please indicate if and how these lessons have been applied in preparedness strategies or in subsequent situations of crisis.
2. If your State has humanitarian aid programmes, please indicate whether SRHR are explicitly covered in the humanitarian aid strategy and how priorities on SRHR are set.

It is very common to observe that young people’s sexual and reproductive health needs are neglected in humanitarian settings. In South Africa, no evidence has been found on sexual and reproductive health and rights provisions in humanitarian settings. In cases of emergency and disaster management, such as the COVI19 period, sexual and reproductive health services were declared as one of the essential services. Experiences of women accessing health care during this period paint a picture of lack of access to SRHR services due to reprioritising resources to flattening the COVID19 curve.

1. Please indicate the main challenges, if any, encountered by women and girls to access justice and obtain reparations for violations of their SRHR, including any procedural barriers, and the types of assistance available to access legal and other remedies. Please also indicate the groups of women and girls most affected. Where applicable, please indicate the role played by a national truth and reconciliation commission (or a similar body) in ensuring the recognition of human rights violations in relation to women’s and girls’ SRHR and reparations.

* The CGE report has been released five years after the complaint was launched .
* During the investigation, it was observed that some of the hospital records were missing due to the ancient nature of the complaint. Some of these missing hospital records contained copies of informed consent.
* Lack of initial cooperation from the Department of Health. They indicated that they needed evidence before acting on the complaints tabled to them. This necessitated an investigation to generate the evidence, which took five years to produce.

Preparedness, recovery and resilience :

1. **Is there any preparedness or risk management strategy/plan/policy in your State? If so, please provide information on the following aspects:**

As it stands, there is no risk management strategy regarding forced sterilisation of women living with HIV. The overarching policy documents that address HIV and Gender Based Violence and Femicide are not explicit on addressing violations and discrimination experienced by women living with HIV in relation to forced sterilisation.

1. To what crisis does it apply? What situations are excluded?
2. Does it contain a definition of crisis? If so, please indicate the definition used.
3. Does it include measures concerning women and girls’ SRHR? If so, please describe the measures included and any special measures envisaged and/or adopted for specific groups of women and girls concerning both preparadeness and recovery.
4. How were the risks related to women and girls’ sexual and reproductive health and rights, in urban and rural areas, identified and assessed?
5. Were women’s rights organizations involved in: i) the development of the strategy/plan/policy; ii) assessment of the risks concerning SRHR; iii) the design of the measures implemented; and iv) the monitoring of the strategy/plan/policy? Please indicate the steps taken to ensure their participation and to include a gender-perspective in crisis preparedness, management and recovery.
6. Please indicate if the strategy/plan/policy has undergone any assessments to date. If so, what were the main findings and recommendations concerning women’s and girls’ SRHR?
7. **If your State does not have a plan that can immediately go into effect in a time of crisis, please explain why it is so.**

Although the Constitution is being widely regarded as a ‘beacon of hope’, the right to health that is non-discriminatory for HIV positive women has not yet been implemented in a more meaningful way, which would be beneficial to them. Even with the existence of institutional and legislative frameworks designed to transform the country based on its foundational principles of non-sexism and non-racialism, the realisation of women’s rights protection in relation to health is still far from being translated into substantive reality.

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 sterilisation by HIV positive women. This amounts to a blatant violation of women’s rights in terms of receiving comprehensive and accurate information about sterilisation, thus compromising their rights to providing full and informed consent to being sterilised.

Key to the realisation of protection of rights of women living with HIV is the implementation of the comprehensive laws that seek to enhance the quality of women’s lives. The Department of Health and Department of Women, Children and People with Disability are pivotal and adequate vessels for ensuring that this task is achieved. There is lack of enforcement of socio-economic rights for women in South Africa, particularly in relation to sexual and reproductive health rights. The government departments, whose mandate speaks to promotion and protection of women’s rights, have not been adequately accountable. Accountability is more than setting out abstract norms, but entails ensuring the implementation and evaluation of protection and promotion of women’s rights as well as the provision of remedies in the event of violations. Even though the Department of Health has been engaged by civil society on addressing forced sterilisation of women living with HIV, the response has been irresolute.

1. **Are there specific ways in which international human rights mechanisms can support States in their efforts to address a crisis?**

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. The International Covenant on Civil and Political Rights and the African Charter on Human and Peoples Rights describe dignity as a right accorded to every person. In South African Constitution, the right to dignity is given prominence by being placed as the second human right in the Bill of Rights directly after equality. The fact that dignity occupies such a central role in our Constitution signifies the constitutional commitment to asserting dignity and to preventing South African from returning to a system anchored on discrimination.

Even though South African government’s efforts largely promote equality among all South Africans, equality cannot be pursued in isolation from human dignity. This is particularly important for women living with HIV when discrimination on unlisted ground is alleged. Protecting dignity of women living with HIV who have been sterilised is viewed as the desired outcome of placing value on equality. Therefore, dignity and equality should not be viewed as competing values but rather as complimentary values. An infringement of one’s dignity is more easily ascertained when there exists an inequality of power and status between the violator and the victim. This rings true especially in the case of vulnerable women living with HIV who are pitted against well educated health care professionals. This elevated status and unequal power dynamic between health care practitioners and women living with HIV may impact on their ability to make highly personal decisions about their reproductive health.

South Africa ratified CEDAW in 1995. The Convention under its Article 12 mandates ‘state parties to the convention to take all appropriate measures to eliminate discrimination against women in the field of health care and ensure both men and women have equal access to health care services’. Furthermore, the CEDAW Committee in its General Recommendation No.19 on Violence against women stated that ‘compulsory sterilisation is a form of violence against women because it adversely affects women’s physical and mental health and infringes on the right of women to deiced on the number and spacing of their children’.

1. SRHR include women’s right to make free and responsible decisions and choices, free of violence, coercion and discrimination, regarding matters concerning one’s body and sexual and reproductive health, as well as entitlements to unhindered access to a whole range of health facilities, goods, services and information on sexual and reproductive health, such as maternal health, contraceptives, family planning, sexually transmitted infections, HIV prevention, safe abortion and post-abortion care, infertility and fertility options, and reproductive cancer. Women’s right to sexual and reproductive health further encompasses the “underlying determinants” of sexual and reproductive health, including access to safe and potable water, adequate sanitation, adequate food and nutrition, and adequate housing, among others, and effective protection from all forms of violence, torture and discrimination and other human rights violations that have a negative impact on the right to sexual and reproductive health. Moreover, it covers social determinants, notably social inequalities in society, poverty, unequal distribution of power based on gender, ethnic origin, age, disability and other factors, systemic discrimination, and marginalisation, which affect people’s patterns of sexual and reproductive health. [↑](#footnote-ref-1)
2. <http://www.cge.org.za/wp-content/uploads/2016/12/Forced-Sterilisation-of-Women-Living-with-HIV-and-Aids-in-South-Africa.pdf> [↑](#footnote-ref-2)
3. Namy, et al. (2017). Towards a feminist understanding of intersecting violence against women and children in the family. *Social Science & Medicine, 184*, 40–48*.* [↑](#footnote-ref-3)
4. Patil, V. (2013). From patriarchy to intersectionality: A transnational feminist assessment of how far we’ve really come. *Signs: Journal of Women in Culture and Society, 38*(4), 847–867; Sokoloff, N. J., & Dupont, I. (2005). Domestic violence at the intersections of race, class, and gender. *Violence against Women, 11*(1), 38–64. [↑](#footnote-ref-4)
5. Sethembiso Mthembu, Zaynab Essack and Ann Strode (2011)‘I Feel Like Half a Woman All the Time’:A qualitative report of HIV-positive women’s experiences of coerced and forced sterilisations in South Africa [↑](#footnote-ref-5)
6. The 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 [↑](#footnote-ref-6)
7. <https://www.unaids.org/en/regionscountries/countries/southafrica> [↑](#footnote-ref-7)
8. <https://sanac.org.za/the-national-strategic-plan/> [↑](#footnote-ref-8)
9. <https://justice.gov.za/vg/gbv/NSP-GBVF-FINAL-DOC-04-05.pdf> [↑](#footnote-ref-9)
10. ‘Declaration on the Elimination of Violence against Women’, UN Doc. A/RES/48/104 (20 December 1993), <http://www.un.org/documents/ga/res/48/a48r104.htm> (accessed August 2017), art. 1. [↑](#footnote-ref-10)
11. Amnesty International, ‘Gender, Sexuality, & Identity’, <http://www.amnestyusa.org/our-work/issues/women-s-rights/violence-against-women/violence-against-women-information> (accessed August 2017); CSVR, ‘Gender-Based Violence (GBV) in South Africa: A Brief Review’, 2016, [http://www.csvr.org.za/pdf/Gender%20Based%20Violence%20in%20South%20Africa%20-%20A%20Brief%20Review.pdf](http://www.csvr.org.za/pdf/Gender%2520Based%2520Violence%2520in%2520South%2520Africa%2520-%2520A%2520Brief%2520Review.pdf) (accessed August 2017). [↑](#footnote-ref-11)
12. Bollen, S., Artz, L., Vetten, L., & Louw, A. (1999). *Violence against Women in Metropolitan South Africa: A Study on Impact and Service Delivery*. Monograph 41. Pretoria: Institute for Security Studies. [↑](#footnote-ref-12)
13. The expression women’s rights organizations should be understood as encompassing organizations of women of different ages, backgrounds and identities. [↑](#footnote-ref-13)