

## ***LM and Others v Government of the Republic of Namibia: The first sub-Saharan African case dealing with coerced sterilisations of HIV-positive women – Quo vadis?***

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### **Summary**

*It has been argued that three factors characterise the HIV epidemic in sub-Saharan Africa – its female face; the implications it poses for sexual and reproductive health services (particularly those provided to women); and the pervasive discrimination following those who are infected. These factors also form the context within which there have been an increasing number of reports of HIV-positive women being coerced or forced into being permanently sterilised in order to prevent future pregnancies. The recent decision in LM and Others v Government of the Republic of Namibia deals with the alleged discriminatory and coerced sterilisation of three women living with HIV. This article describes and critiques the LM judgment. It concludes with brief comments on the way forward for similar litigation in other Southern African countries.*

### **1 Introduction**

Globally, sub-Saharan Africa is the region most profoundly affected by HIV/AIDS, as it is home to more than two-thirds of all people living

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with HIV.<sup>1</sup> Women are disproportionately affected by the virus, with almost 60 per cent of all HIV infections being in women of reproductive age.<sup>2</sup> Furthermore, the epidemic continues to be characterised by high levels of stigma and discrimination against people living with HIV.<sup>3</sup> It has been argued that three factors characterise the epidemic in sub-Saharan Africa – its female face; the implications it poses for sexual and reproductive health services (particularly those provided to women); and the pervasive discrimination following those who are infected.<sup>4</sup> These factors also form the context within which there have been an increasing number of reports of HIV-positive women being coerced<sup>5</sup> or forced<sup>6</sup> into

1 WHO, UNAIDS & UNICEF *Global HIV/AIDS response: Epidemic update and health sector progress towards universal access report* (2011) 24 [http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/20111130\\_u\\_a\\_report\\_en.pdf](http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/20111130_u_a_report_en.pdf) (accessed 8 March 2013).

2 As above.

3 E Cameron 'Legal and human rights responses to the HIV/AIDS epidemic' (2006) 1 *Stellenbosch Law Review* 37 38; United Nations Development Programme *Global Commission on HIV and the law: Risks, rights and health* (2012) 65 <http://www.hivlawcommission.org/index.php/report> (accessed 7 February 2013).

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) 92 *Agenda* 24-25. The authors refer to four ways in which HIV impacts on adult women. Firstly, most women become infected during the years in which they may choose to reproduce; secondly, without medical interventions, vertical transmission of HIV is possible; thirdly, HIV can negatively affect the fertility of HIV-positive women, making reproduction difficult; and, fourthly, multiple pregnancies which are closely spaced may impact negatively on a woman's health.

5 This article uses the term 'coerced sterilisation' to refer to a situation where incentives, misinformation or intimidation tactics are used to compel a woman to consent to undergo a surgical procedure to permanently end her ability to reproduce (see Essack & Strode (n 4 above) 27). Eg, at the 2011 African Regional Dialogue, facilitated by the Global Commission, one participant described her experience of coerced sterilisation as follows: 'Women with HIV are not expected to fall pregnant. One day I could tell my doctor was angry. I had broken his trust when I said I was pregnant. He was disappointed. I had failed my doctor, I felt irresponsible and guilty. He said, "I don't want you to go through this again", so I was sterilised. I was the bad woman. I was HIV positive. I compromised my health' (civil society participant, Swaziland); *HIV and the law* (n 3 above) 65.

6 This article uses the term 'forced sterilisations' to refer to a situation in which a woman is surgically sterilised without her knowledge, or the opportunity to provide consent to the procedure (see Essack & Strode (n 4 above) 27). Accordingly, she only discovers that she has been sterilised after the procedure has taken place. Eg, in a South African study, one of the participants described her experience as follows: 'I was going for a Caesarean section. That was the only thing I had signed for. I don't know the rest, I found that out later when I had gone to [a] gynaecologist. I had asked if it is possible for me to have a baby. He said, "No, you were closed up." "In which way, is my womb there?" He said, "No, the womb is there, you did a tubal ligation" (participant 4). A Strode *et al* "'She made up a choice for me": Twenty-two HIV-positive women's experiences of involuntary sterilisation in two South African provinces' (2012) 20 *Reproductive Health Matters* 1 6.

being permanently sterilised in order to prevent future pregnancies.<sup>7</sup> The Global Commission on HIV and the Law found this to be a global human rights' issue, noting that<sup>8</sup>

the reproductive medical clinic is not a welcoming place for many HIV-positive women. Coercive and discriminatory practices in health care settings are rife, including forced HIV testing, breaches of confidentiality and the denial of health care services, as well as forced sterilisations and abortions.

Likewise, the literature reveals widespread allegations of coerced or forced sterilisation of women living with HIV in, *inter alia*, Chile, Venezuela, South Africa, Tanzania, Thailand, Uganda and Zambia.<sup>9</sup>

Limited research has been undertaken on why HIV-positive women would be targeted for sterilisations. However, in a recent South African study, participants reported that health care workers gave them one of four reasons for this 'practice': Firstly, they were HIV positive and therefore should not have more children. Secondly, sterilisations would prevent more babies being born with HIV. Thirdly, this would lower the number of children left as orphans. Fourthly, as pregnancies could have a negative impact on an HIV-positive woman's health, she should be stopped from harming herself.<sup>10</sup>

Although litigation is underway in several countries,<sup>11</sup> there has been no reported African judgments on this issue, than the *LM and Others v the Government of the Republic of Namibia* case.<sup>12</sup> This recent decision of the Namibian High Court deals directly with the alleged discriminatory and coerced sterilisation of three women living with HIV.<sup>13</sup> The case is significant, not only because it is the first of its kind in sub-Saharan Africa, but also as there is a possibility of similar litigation in a number of other countries.<sup>14</sup>

7 See, generally, P Patel 'The coerced sterilisation of HIV-positive women in Namibia' (2009) 75 *Agenda* 38-44; P Nair 'Litigating against the forced sterilisation of HIV-positive women: Recent developments in Chile and Namibia' (2010) 23 *Harvard Human Rights Journal* 223-231.

8 *HIV and the law* (n 3 above) 65.

9 As above. Open Society Initiative *Against her will: Coerced and forced sterilisation of women worldwide* (2011) <http://www.opensocietyfoundations.org/publications/against-her-will-forced-and-coerced-sterilization-women-worldwide> (accessed 7 February 2013).

10 As above.

11 *HIV and the law* (n 3 above) 65.

12 Case 1603/2008.

13 As above.

14 The Women's Legal Centre in Cape Town, South Africa, have recently lodged a claim for damages, on behalf of a woman living with HIV who alleges that she was wrongfully and unlawfully coerced into being sterilised (personal communication, Ms Sonja Bornman, 1 November 2012). In Kenya it has been reported that more than 40 women living with HIV will approach the courts for redress regarding their alleged coerced sterilisation. *The Star* 23 August 2012 <http://allafrica.com/stories/201208240201.html> (accessed 7 February 2013). See also F Kasiva *Robbed of choice: Forced and coerced experiences of women living with HIV in Kenya* (2012) African Gender and Media Initiative, Nairobi.

This article describes and critiques the *LM* judgment. It concludes with brief comments on the way forward for similar litigation in other Southern African countries.

## 2 *LM and Others v Government of the Republic of Namibia*

### 2.1 Facts

The three plaintiffs were all HIV-positive women, who alleged that they had been sterilised without their informed consent. They further alleged that the reason that they had been coerced into being sterilised was because they were HIV positive.<sup>15</sup>

The first plaintiff, LM, was 26 years old at the time of the sterilisation. She was in hospital to deliver her third child (her first was stillborn).<sup>16</sup> On 13 June 2005, she signed a form giving consent to an operation. This form stated that she was to undergo a Caesarean section and bilateral tubal ligation.<sup>17</sup> The consent document was a single form for both procedures.<sup>18</sup> LM had been in labour for 14 to 15 hours before she was given the consent form to sign,<sup>19</sup> and she signed it whilst on a stretcher outside the theatre.<sup>20</sup> The hospital records did not indicate the type of information that was given to her as part of the consent process prior to the bilateral tubal ligation procedure.<sup>21</sup> These same records also do not reflect whether she was given information on any alternative methods of contraception.<sup>22</sup> LM testified that a nurse told her that she was to be sterilised since all women who are HIV positive go through that procedure.<sup>23</sup> According to expert testimony for the plaintiff by Dr Kimberg, the prognosis for reversal of her sterilisation procedure was poor.<sup>24</sup>

The second plaintiff, MI, had previously given birth to two children.<sup>25</sup> She signed a standard consent form for an operation on 8 December 2007.<sup>26</sup> MI also signed the form at the height of her labour.<sup>27</sup> On the form it indicated that she was giving her consent for a 'Caesar + BTL due to previous Caesar'.<sup>28</sup> She also signed a second,

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15 *LM* case (n 12 above) para 2.

16 Para 10.

17 As above.

18 Para 16.

19 Para 18.

20 Para 16.

21 Para 10.

22 As above.

23 Para 16.

24 Para 10.

25 Para 20.

26 Para 10.

27 Para 36.

28 Para 10.

separate consent form for the sterilisation (the BTL).<sup>29</sup> The form that she signed included a place on it 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.<sup>30</sup> However, in her particular file, this part of the form had been left unsigned by the surgeon.<sup>31</sup> There were no hospital records to indicate that MI was counseled on the proposed sterilisation, or on whether she had been informed of other alternative methods of contraception.<sup>32</sup> MI testified that she was not asked by the doctor whether she wanted to be sterilised, but rather was told that she was going to be sterilised whether she liked it or not.<sup>33</sup> Furthermore, it was her evidence that the hospital staff had made it clear that there was a policy in place that all women living with HIV should be sterilised.<sup>34</sup> An expert witness testified that MI's prognosis for reversal of her sterilisation procedure was very poor.<sup>35</sup>

The third plaintiff, NH, was 46 years old and had seven children.<sup>36</sup> 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.<sup>37</sup> NH signed the forms after having been in labour for a prolonged period.<sup>38</sup> Like LM, she signed the forms whilst on a stretcher waiting to go into the theatre.<sup>39</sup> 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.<sup>40</sup> 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.<sup>41</sup> An expert witness testified that from a surgical point of view, the prognosis for reversing her sterilisation was good, but the chance of another pregnancy was low due to the advanced age of the plaintiff.<sup>42</sup>

In summary, as is shown in Table 1 below, all three plaintiffs were sterilised immediately after or during a Caesarian section. They all had children from previous pregnancies. One plaintiff was under the age of 30. They signed consent forms whilst in active labour, and immediately prior to the birth of their children. Two of the three

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29 Para 11.

30 As above.

31 As above.

32 As above.

33 Para 20.

34 Para 21.

35 Para 10.

36 Para 11.

37 As above.

38 Para 25.

39 As above.

40 Para 33.

41 Para 28.

42 Para 11.

plaintiffs signed an additional consent form which dealt specifically with the sterilisation. In all three cases, their hospital records did not reflect any documentation of the process of obtaining their consent to the sterilisation, or of whether the women had been told that alternative, non-permanent forms of birth control were available to them.

**Table 1: Summary of circumstances under which the plaintiffs 'consented' to sterilisation**

	FIRST PLAINTIFF	SECOND PLAINTIFF	THIRD PLAINTIFF
<b>Age</b>	26	-	46
<b>Number of children previously born alive</b>	1	3	6
<b>Situation at time of signing informed consent form</b>	In labour for 14–15 hours	At height of labour	Prolonged labour
<b>Nature of forms signed</b>	(1) form consenting to a C/S + BTL	(1) form consenting to a C/S + BTL (2) form for a BTL – surgeon did not sign this, confirming the procedure had been explained	(1) form consenting to a C/S + BTL (2) form for a BTL
<b>Place where informed consent form was signed</b>	On a stretcher outside the theatre	-	On a stretcher outside the theatre
<b>Offered alternative forms of contraception?</b>	No information on this in hospital record	No information on this in hospital record Health passport indicated that she wished to be sterilised	Health passport indicated that she wished to be sterilised
<b>Reason for sterilisation</b>	Informed that all HIV-positive women are sterilised	Informed that there was a policy to sterilise all HIV-positive women	-

The plaintiffs instituted two civil actions against the government of the Republic of Namibia for the unlawful sterilisation procedures that were performed on them. These were:

- (i) a claim for damages, grounded in the civil law, that the surgical procedures were unlawful as they were performed without the plaintiff's consent, or alternatively that they were unlawful as the medical practitioners had breached their duty of care that they owed to the three plaintiffs;<sup>43</sup>

<sup>43</sup> Para 1.

- (ii) a claim based on the Constitution of the Republic of Namibia, that the sterilisations were done as part of a wrongful and discriminatory practice of discrimination based on the women's HIV status. This amounted to a breach of their basic human rights, as guaranteed by the Constitution.<sup>44</sup>

## 2.2 Issues

Based on the evidence before it, the Namibian High Court held that it was required to decide on two issues: firstly, whether the three plaintiffs had given their informed consent to the sterilisation procedures and, secondly, whether they were discriminated against due to their HIV status.

## 2.3 Judgment

### 2.3.1 Consent to the sterilisation

With regard to the first claim, the Namibian government raised the defence of *volenti non fit injuria* (to one consenting no harm is done),<sup>45</sup> arguing that all three plaintiffs had signed consent forms indicating that they had agreed to their sterilisations.<sup>46</sup> The Court held that if a defendant relies on this defence, there is an onus on them to establish that all its elements existed.<sup>47</sup> The core of informed consent is knowledge, appreciation and agreement to all aspects of the transaction, including its consequences.<sup>48</sup> Furthermore, any consent provided 'must be given freely and voluntarily and should not have been induced by fear, fraud or force'.<sup>49</sup> The Court held that this resulted in a factual rather than a legal inquiry by the Court, which must establish whether consent was properly and voluntarily obtained in the particular circumstances.<sup>50</sup>

The judgment shows that two issues relating to this defence emerged through the evidence. Firstly, was adequate information provided to the patients in order for their consent to the sterilisation to be informed? Secondly, was consent provided in circumstances which facilitated the plaintiffs' making a voluntary decision regarding their sterilisation?

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44 Para 2.

45 Para 9.

46 As above.

47 Paras 27 & 13.

48 As above.

49 Para 14.

50 Para 28.

Each of these issues is now considered:

**(i) Information**

The Court held that, to assess whether the patient has given informed consent to the procedure, it must be established whether they have been provided with adequate information to make an informed choice.<sup>51</sup> This is not an absolute right, and in some circumstances the doctor is not required to disclose specific details if, for example, the patient is already aware of the information.<sup>52</sup> From the facts it appears that in Namibia, contraceptive choices are a topic covered in the antenatal classes offered to pregnant women. Clinic staff facilitates group counselling sessions at which pregnant women are told about various contraceptive options for use after their current pregnancy, and they may at this point elect sterilisation as one of these choices.<sup>53</sup> If they elect an option such as sterilisation, this is noted on their health passport, which is taken with them to hospital when they go for the delivery of their baby.<sup>54</sup>

The Court held that the Namibian government was not able to prove that they had provided the plaintiffs with sufficient information to make an informed choice on whether or not to be sterilised. There appeared to be three rationales for this. Firstly, the notes made in the three hospital files did not document the nature of the information that had been provided to the plaintiffs;<sup>55</sup> there was also no record of whether they had been told of alternatives to sterilisation.<sup>56</sup> Secondly, two of the consent forms were an inadequate reflection of the women's agreement to the sterilisation, as the first plaintiff did not sign a separate consent form for the sterilisation, and the second plaintiff's form giving consent to be sterilised was not completed by the surgeon. 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.<sup>57</sup>

**(ii) Voluntariness**

The Court held that any consent provided 'must be given freely and voluntarily and should not have been induced by fear, fraud or force'.<sup>58</sup> *In casu*, all three women were asked to give consent and sign

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51 Para 16.

52 FF van Oosten, quoted in P Carstens & D Permaine *Foundational principles of South African medical law* (2007) 458 para 26. Constitution of the Republic of South Africa, 1996.

53 *LM case* (n 12 above) para 28.

54 Paras 44 & 52.

55 Paras 20-23.

56 As above.

57 Paras 56 & 65.

58 Para 14.



the required forms whilst they were in active labour. The defendant's own witness conceded that this was 'highly undesirable'.<sup>59</sup> The Court held that consent should not be obtained in these circumstances – not only because it impacted on voluntariness, but also because it made the consent process hurried.<sup>60</sup>

It should be noted that the Court did not make a finding on the *quantum* of damages owed in respect of this first claim that their informed consent had not been obtained for the sterilisations, given that the parties had agreed that this issue be held over for adjudication at a later stage.<sup>61</sup>

### 2.3.2 Unfair discrimination

With regard 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.<sup>62</sup> No further reasons were given for dismissing this claim.

## 2.4 Critique of the judgment

This discussion on the judgment is divided into two parts. These are the implications that it has for (i) the law of informed consent; and (ii) the outlawing of the alleged discriminatory practice of forced or coerced sterilisation of women living with HIV.

### 2.4.1 Implications of judgment for the law of informed consent to medical treatment

In Namibian law, it is a well-established principle that consent will only be valid if it is based on knowledge concerning the nature and effect of the act being consented to.<sup>63</sup> The *LM* case adds to this body of law, by requiring – for the first time – the documenting of what information has been provided to the patient. This places an additional burden on medical practitioners who must make notes on the nature of the information they have provided to the patient, in order to facilitate rational decision making. This is a break with the past, when simply recording the patient's decision was generally regarded as sufficient proof that they met the standard of advising the patient of any material risk in the procedure.<sup>64</sup> In this way, the *LM*

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59 Para 35.

60 Para 69.

61 Para 8.

62 Para 83.

63 In paragraph 10 of the judgment, the Court held that the South African case of *Castel v De Greef* 1994 4 SA 408 (C) 421 426B is the leading judgment on informed consent

64 As above.

case was a victory for patients' rights, and adds to the existing patient protections during the consent process.

The Court did not, however, address the issue of what information is required to be provided to a woman before a sterilisation, despite international standards being available on this point.<sup>65</sup> For example, the World Health Organisation (WHO) has identified six key pieces of information that every patient should be informed of, before a sterilisation.<sup>66</sup>

- 1 Sterilisation is a surgical procedure.
- 2 It has both risks and benefits.
- 3 The procedure will prevent future pregnancies.
- 4 Sterilisation is considered a permanent procedure.
- 5 Refusing to be sterilised will not result in the loss of any benefits.
- 6 Non-permanent forms of contraceptive alternatives are available.

In this instance, it appears that there was only evidence that the women were told that the procedure was a surgical one, as they all signed consent to surgery forms.<sup>67</sup> It is possible that the second and third plaintiffs had some information on the nature and implications of sterilisations, as they had elected this form of contraception during their antenatal classes. However, there was no evidence to confirm the nature of this information. Accordingly, it could be argued that the summation of evidence does not indicate that any of the other five WHO standards were met during the consent process.

With regard to the standard of information that should be provided before a sterilisation, the Court did, however, comment that patients should at a minimum be informed of both the advantages and disadvantages of sterilisation, as well as of alternative contraception methods.<sup>68</sup> It also noted:<sup>69</sup>

Even though individual counselling may be an ideal situation in which to do proper and skilled counselling, one should not close one's eyes (figuratively speaking) to the realities encountered at state hospitals. I can see no reason why group counselling cannot be adequate and sufficient, provided that skilled counsellors are engaged and information is conveyed in languages which are understood by the patients requiring such counselling.

The *LM* case is also important from a patients' rights perspective, as it adds to our understanding of voluntariness. The Court found that obtaining consent during labour did not promote autonomous

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65 WHO *Medical eligibility criteria for contraceptive use* (2010) [http://whqlibdoc.who.int/publications/2010/9789241563888\\_eng.pdf](http://whqlibdoc.who.int/publications/2010/9789241563888_eng.pdf) (accessed 9 February 2013).

66 As above.

67 WHO (n 65 above) paras 10-11.

68 Para 70.

69 Para 79.

decision making, particularly as it made the procedure rushed.<sup>70</sup> This is an important finding, as other studies have found that many women felt coerced into being sterilised when they were asked to make this decision, whilst in labour and enduring great pain.<sup>71</sup> This finding has implications for the way in which hospitals obtain consent for a sterilisation, and it seems to imply that although it may be convenient and cost-effective for a sterilisation to be undertaken at the same time as a Caesarean section, consent to the sterilisation should be obtained before the onset of active labour. It may also mean that in the longer term, there ought to be law reform in Namibia to ensure that there are special protections for women undergoing a sterilisation. In this context, Strode, Mthembu and Essack – writing about the situation in South Africa – argue for amendments to the Sterilisation Act,<sup>72</sup> to place an obligation on hospital authorities to counsel women before a sterilisation, and to require a specific time period between the date of providing consent and the execution of the procedure.<sup>73</sup> These authors submit that this will enhance voluntary decision making.<sup>74</sup>

#### 2.4.2 Implications of judgment for outlawing of coerced or forced sterilisation of women living with HIV

Sadly, the judgment does not take forward the issue of forced or coerced sterilisation of women living with HIV. It is difficult to understand Hoff J's cursory dismissal of the second claim on discrimination. In essence, the Court held that the plaintiffs had not discharged their onus of showing that the discrimination had occurred.<sup>75</sup>

Herbstein and Van Winsen submit that the phrase 'burden of proof' refers to the onus which rests on a litigant to establish the factual basis for a claim or defence.<sup>76</sup> In this instance, the plaintiffs had alleged that<sup>77</sup>

the sterilisations were done as part of a wrongful practice of discrimination against them based on their HIV status and that this amounts to a breach of their basic human rights as guaranteed by the provisions of the Constitution of the Republic of Namibia.

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70 Para 34.

71 Eg, Strode *et al* (n 6 above) 5 set out the following two quotes from participants in their study, who were asked to consent whilst in labour: 'They made me sign this paper after I had collapsed in the toilet' (participant 1); 'I was under an emergency of getting a child. They should not have operated on me during the time of distress when I was in labour' (participant 17). Also see the International Community of Women Living with HIV/AIDS (ICW) *The forced and coerced sterilisation of women living with HIV in Namibia* (2009).

72 Act 44 of 1998.

73 Strode *et al* (n 6 above) 7.

74 As above.

75 *LM* case (n 12 above) para 2.

76 AC Cilliers *et al* Herbstein & Van Winsen (2009) 891.

77 *LM* case (n 12 above) para 2.

Accordingly, *in casu*, it is submitted that the onus of proof rested on them to prove that the health care workers acted in a discriminatory way when coercing them into being sterilised because they were HIV positive. It is assumed that, to meet this burden of proof, the plaintiffs would need to show that the health care workers treated them in a discriminatory manner, and this could be done through their own evidence of the events, other corroborating facts, or witness testimony and/or the submission of documentary proof.

*In casu*, there is no official state policy which recommends the sterilisation of women living with HIV in Namibia, and no evidence of a discriminatory reason for the sterilisation in the women's files. Thus, it appears that there was no documentary proof which could be put forward to support their allegations. However, it is assumed that the plaintiffs gave their own evidence on why they perceived the actions of the health care workers to be discriminatory in order to discharge the onus. It is therefore of concern that their evidence is not described in any detail in the judgment. A brief reference is made to the versions of the first and second plaintiff's evidence, with Hoff J noting that the first plaintiff testified that before she was taken to the theatre, a nurse came into the delivery room and told her that she would be sterilised, since 'all women who are HIV positive go through that procedure'.<sup>78</sup> The judgment states further that the second plaintiff testified that she was made to understand that there was a policy in place that women who are HIV positive should be sterilised.<sup>79</sup> It is argued that these averments make out a *prima facie* case of a violation of article 10 of the Constitution of the Republic of Namibia (the equality clause). However, this is ignored by the judgment, as there is no mention of whether the plaintiffs' evidence was subject to cross-examination and found to be plausible or unreliable.

Furthermore, it is of concern that the judge did not address the issue of the inferences that could have been drawn to corroborate the plaintiffs' evidence in this regard. It is clear from the summary of evidence that some of the proven facts corroborated the versions of the first and second plaintiffs. These facts include (i) that all the health care workers involved in the sterilisations were aware of the plaintiffs' HIV status, as it was noted in their files that they were on anti-retroviral treatment;<sup>80</sup> and (ii) that the sterilisations were undertaken as though it was an emergency, with consent being hurriedly obtained outside the theatre, and whilst the women were in labour, despite this being contrary to international guidance regarding sterilisations.<sup>81</sup> The sterilisation of the first plaintiff was particularly problematic as she did not indicate a desire to be sterilised during antenatal classes, was below the age of 30 (which WHO sets as a

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78 Para 33.

79 Para 21.

80 Paras 17, 20 & 25.

81 WHO *Medical eligibility criteria* (n 65 above).

threshold for sterilisations),<sup>82</sup> and was only giving birth to her second child. In this context, it is unclear why the Court did not draw any adverse inferences from these proven facts.

In the case of *AA Onderlinge Assuransie Bpk v De Beer*,<sup>83</sup> it was held that it is not necessary for a plaintiff in a civil claim to prove that the inference which he or she asks the court to make is the only reasonable inference possible in the circumstances. Instead, the Court held that the plaintiff will discharge the onus which rests on him or her if they can convince the Court that the inference being advocated is the most readily, apparent and acceptable inference from a number of possible inferences. In this instance, it is argued that HIV-related discrimination and a desire to ensure that HIV-positive women do not reproduce is the most readily, apparent and acceptable inference in the circumstances.

It is argued that the Court's failure to consider why three HIV-positive women – delivering babies at different times – all believed that they had been coerced into being sterilised simply because they were HIV positive is a key weakness in the judgment. This leaves this issue unaddressed, despite the fact that the Namibian courts have in the past recognised that treating persons with HIV arbitrarily is a form of unfair discrimination. For example, in *Nanditume v Minister of Defence*, the Labour Court held that 'no person may be excluded from enlistment into the Namibian Defence Force solely on the basis of such person's HIV status where such person is otherwise fit and healthy'.<sup>84</sup>

Finally, although there is limited international jurisprudence on discriminatory sterilisations, the recent dissenting opinion by one of the judges of the European Court of Human Rights in *VC v Slovakia*, which found the sterilisation of Roma women in Czechoslovakia to be a discriminatory practice, gives hope for further development in this area.<sup>85</sup> In this case, the dissenting judgment found that the sterilisation of VC violated article 14 – the right to equality – in the European Convention on Human Rights,<sup>86</sup> as she had been coerced into being sterilised as a direct result of her 'ethnic origin'.<sup>87</sup>

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82 As above.

83 1982 2 SA 604 (A).

84 (2002) AHRLR 119 (NaLC 2000) para 40.

85 *VC v Slovakia* (Slovakia) application 18968/07. In this matter, the applicant was a woman of Roma ethnic origin, who was sterilised during the delivery of her second child via Caesarean section. The applicant had been in labour for several hours when she was asked whether she wanted to have more children. She responded positively, but was told by the medical personnel that if she had more children, either she or the baby would die. Accordingly, she told the medical personnel 'Do what you want to do.' She then signed a note indicating that she had requested sterilisation.

86 This article prohibits discrimination on any ground, including sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.

87 *VC v Slovakia* (n 85 above), dissenting opinion of Judge Mijovic.

### 3 Litigation in other parts of Southern Africa

The *LM* case was a clear victory for patients' rights, as the Court held that the mere existence of signed consent forms for a sterilisation were insufficient, and that there was an onus on health care workers to document the information that they had provided to the patient, and that they had to ensure that consent was obtained in circumstances that promoted voluntariness. Nevertheless, the judgment failed to address the issue of the forced or coerced sterilisation of women living with HIV as a form of unfair discrimination. It is submitted that the failure of the Court to recognise that this 'practice' of coerced sterilisation of women living with HIV as a form of systemic discrimination requires further reflection. This also has implications for pending litigation in other countries. The following are preliminary suggestions on what is needed to strengthen claims of unfair discrimination in other cases:

- 1 *Research*. In *VC v Slovakia*, the applicant relied on a large-scale study showing that, although Roma women made up only 7 per cent of the population, they accounted for 60 per cent of all sterilisations undertaken. This clearly indicated a discriminatory bias in the health system towards sterilising Roma women.<sup>88</sup> It is submitted that this type of 'evidence' is clearly compelling and further research is required in Southern Africa, to build a similar quantitative evidence base through hospital record reviews that show a that disproportionate number of HIV-positive women are being sterilised. Alternatively, even if it is not possible to show that HIV-positive women are being disproportionately sterilised, at least research should be undertaken to show that the cohort of women being sterilised is younger and more likely to be HIV infected.<sup>89</sup>
- 2 *Amici curiae*. Organisations working with women living with HIV may be used to join the proceedings as *amici curiae*, and present evidence or existing research documenting the experiences of HIV-positive women, and why they perceive the actions of health care workers to be discriminatory.
- 3 *Alternative legal strategies*. In the *LM* case the plaintiffs argued that their constitutional rights to equality had been violated. However, it may in future matters be worth considering using the equality provisions in HIV-specific laws rather than the civil law in order to challenge the practice. For example, Angola, Madagascar, Mauritius, Mozambique and Tanzania all have HIV laws which outlaw unfair discrimination on the basis of a person's HIV

<sup>88</sup> *VC v Slovakia* (n 85 above) para 45.

<sup>89</sup> There have already been a number of studies documenting the experiences of women living with HIV (eg Essack & Strode (n 4 above); Strode *et al* (n 6 above); International Coalition of Women Living with HIV (n 71 above); and Kasiva (n 14 above)). There do not appear to have been any quantitative studies on the extent of forced sterilisations that have taken place in Southern Africa.

status.<sup>90</sup> It is possible that, as such provisions are HIV-specific, the remedies created in such laws may provide more effective relief.

#### 4 Conclusion

The *LM* judgment is a significant one from a patient rights' perspective, as it recognises consent as a process rather than an outcome. However, it failed to advance the campaign against coerced or forced sterilisations of women living with HIV. It appears that, worldwide, courts are being slow to accept this form of discrimination as unlawful. The most recent majority decision by the European Court of Human Rights on a similar issue also avoided a finding of unfair discrimination when the Court held that it was unnecessary to examine article 14 (the prohibition of discrimination) when deciding whether the applicant had been sterilised without her consent.<sup>91</sup> In contrast, the dissenting judgment held that a finding on this issue was important as it would send a strong message that governments can no longer use racial stereotypes to defend abuse masquerading as medicine.<sup>92</sup>

*Quo vadis?* It appears clear that more evidence will have to be put before a court to support an allegation of unfair discrimination relating to HIV-positive women in the future. Alternatively, different legal strategies may need to be investigated.

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90 A Storde *et al* 'Are there laws and policies protecting people infected and affected by HIV/AIDS in Southern Africa? An update of a review of the extent to which countries within the South African Development (SADC) region have implemented the HIV/AIDS and Human Rights International Guidelines' (2010) *Obiter* 58 62.

91 VC case (n 85 above).

92 As above.