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Involuntary sterilisation as a form of violence against women in Africa

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Abstract

This article examines the meaning and nature of sterilisation. It equally discusses the historical context of involuntary sterilisation and its likely human rights implications. More importantly, it discusses the decision of the Namibian Supreme Court in *Government of Namibia v LM* and argues that the court fails to consider involuntary sterilisation as a form of human rights violation, particularly violence against women. The article contends that given the attendant mental, physical and emotional trauma a woman may suffer upon undergoing forced sterilisation, this would amount to an act of violence against women as recognised under international human rights law.

Introduction

In recent times, documented evidence across Africa shows that women living with human immunodeficiency virus (HIV) have been made to undergo sterilisation without their knowledge or consent. Studies in some African countries including Namibia, Botswana, South Africa and Kenya have revealed that incidences of involuntary sterilisation are often initiated by health care providers without proper counselling or informed consent of women living with HIV (African Gender and Media Initiative, 2012; Essack and Strode, 2012; Gatsi et al., 2010). In many African countries, people living with HIV still encounter discriminatory practices on a daily basis. The situation is worse for women living with HIV who are erroneously believed to be incapable of exercising their sexual and reproductive desires, including raising a family. Consequently, women living with HIV have been subjected to forced or coerced sterilisation. This has raised both legal and ethical concerns in those countries. Sterilisation done with the informed consent of an individual is recognised as a form of birth control. However, when it is carried out without informed consent or knowledge of an individual this may resort in violation of human rights. Experience has shown that vulnerable and marginalised women, particularly those living with HIV or disabilities tend to be targets of involuntary sterilisation. Some of these women are poor with little education and as such are sometimes unable to challenge the violation of their rights. This raises concerns about the lawfulness of this act. It should be noted that sterilisation is an irreversible process which may have lasting mental and psychological effects on a woman.

Against this background, this article examines the meaning and types of sterilisation. It equally discusses the historical context of involuntary sterilisation and its likely human rights implications. More importantly, the article discusses the decision of the Namibian Supreme Court in the *Government of Namibia v LM* and argues that it was a missed

opportunity for the court not to consider involuntary sterilisation as a form of human rights violation, particularly violence against women. The article contends that given the attendant mental, physical and emotional trauma a woman may suffer upon undergoing forced sterilisation, this would amount to an act of violence against women as recognised under international human rights law. It argues that African governments are obligated under international law to respect, protect and fulfil the rights of women in the context of involuntary sterilisation. Consequently, it enjoins African governments to take necessary measures in line with their obligations under international law to prevent women from all forms of violence, including forced or coerced sterilisation.

Types of sterilisation

Sterilisation is defined as "a process or act that renders an individual incapable of sexual reproduction' (OHCHR et al., 2014). It is an irreversible procedure with profound physical and psychological effects. It is recognised as an important option for individuals and couples to control their fertility. Indeed, it is one of the most widely used forms of contraception across the world. OHCHR et al., (2014), have noted that when performed according to appropriate clinical standards with informed consent, sterilisation methods such as vasectomy and tubal ligation are safe and effective means of permanently controlling fertility. As a form of contraception, sterilisation must only be performed with the free, full and informed consent of an individual. When it is performed with the full and informed consent of the individual it is regarded as voluntary sterilisation.

On the other hand, sterilisation is said to be involuntary when it is performed forcibly or with coercion. Forced sterilisation will occur when a person is sterilized after expressly refusing the procedure, without her knowledge or is not given an opportunity to provide consent (Human Rights Watch, 2011). Coerced sterilisation occurs when financial or other incentives, misinformation, or intimidation tactics are used to compel an individual to undergo the procedure (Human Rights Watch, 2011).

During the 20th century some countries in Asia resorted to offering incentives to families in order to encourage them to undergo sterilisation as a form of population control (OSF, 2011). A good example is the one-child policy of the Chinese government, which offered incentives to families to undergo sterilisation in order to control population growth in the country (Zubrin, 2012). This approach was criticised as a coerced form of population control capable of under-mining the sexual and reproductive autonomy of families in general and that of women in particular. Sterilisation without full, free and informed consent has been variously described by international, regional and national human rights bodies as involuntary, coercive and/or forced practice, and as a violation of fundamental human rights, including: the right to health; the right to information; the right to dignity; the right to bodily integrity; the right to privacy; the right to decide on the number and spacing of children; the right to found a family; and the right to be free from discrimination. The human rights implications of involuntary sterilisation are further explored below.

Historical context of involuntary sterilisation

Between 1870 and 1945, during the period of eugenics, involuntary sterilisation, originally used as a tool for improving the genetic constitution of human, later became an instrument of population and public health control (Kerr and Shakespeare, 2002; Kevles, 1998). Thus, the early part of 20th century witnessed the enactment of laws permitting and encouraging involuntary or coercive sterilisation in countries such as Germany, Japan and United States. These laws affected a significant number of vulnerable and disadvantaged groups including, persons with disabilities, ethnic or religious minorities, who were forcibly sterilised without their consent (Burleigh, 1994; Kevles, 1998).

One of the earliest cases in this regard was the American case of *Buck v Bell* decided in 1927. In that case, Carrie Buck (the plaintiff) a person with mental disabilities was operated upon, receiving a compulsory salpingectomy (a form of tubal ligation) in accordance with the legislation of the State of Virginia. She had challenged her forcible sterilisation as a violation of her right to equality and due process under the Fourteenth Amendment of the American Constitution. The American Supreme Court held that a state statute permitting compulsory sterilisation of the unfit, including the intellectually disabled 'for the protection and health of the state' did not contravene the Due Process provision of the Fourteenth Amendment. This decision of the court would seem insensitive to the plight of vulnerable and marginalised groups. It would also seem that the court turned a blind eye to the gender dimension raised by this case. Indeed, the case would seem to sacrifice fundamental rights of disadvantaged groups on the altar of state policy. Such an approach is inconsistent with the principles of the rule of law and constitutionalism.

After the Second World War, many countries embarked on reforms of laws and practices relating to eugenics and sterilisation. Thus, more emphasis was placed on informed consent of individuals. The period between the 1960s and 1990s witnessed forced sterilisation being employed as an instrument of population control in some parts of Asia, Europe and Latin America, with total disregard to the rights of individuals (Brown, 1984; Petchesky and Judd, 1998). In some of these countries, a wide-range of tactics or coercive measures, including offer of money, food, land and housing, or threats, fines or punishments, together with misleading information, were employed to secure sterilisation of some members of the population (OHCHR et al., 2014). Some of these countries offered rewards to health providers who met sterilisation targets, while others who failed to meet targets were at risk of losing their jobs (Cook and Dickens, 2000; Kumar, 1999: 1251). It should be noted that the forced sterilisation policy of some of the governments was targeted at vulnerable groups such as people living in poverty, persons with disabilities, indigenous peoples and ethnic minorities. In recent times, transgender, people living HIV and intersex have become targets of forced sterilisation (OHCHR et al., 2014). In most cases, little or no information is provided and informed consent may not be obtained. This has elicited both legal and ethical concerns regarding this process. Given the invasive nature of this procedure and its attendant consequences, it becomes very crucial that full, free and informed consent is sought before it is performed. Failure to do so may encroach on the fundamental rights of the affected person as guaranteed under international, regional and national laws.

Involuntary sterilisation as a human rights violation in Africa

While it remains uncertain how long forced sterilisation has been practiced in Africa, the incidence of forced sterilisation increased in recent times particularly in relation to women living with HIV. Africa has remained the epicentre of the epidemic with about 27 million people living with HIV in 2015 and an estimated 800,000 HIV-related deaths in the region (UNAIDS, 2016). While significant progress has been made regarding access to life-saving medications for those in need, stigma and discrimination continues to undermine efforts at addressing the epidemic in the region. In almost all facets of human endeavour, people living with HIV, particularly women, continue to encounter discriminatory practices. Thus, people living with HIV are sometimes denied services or opportunities including access to health care, housing or employment (UNAIDS, 2016). More importantly, women living with HIV are sometimes denied access to medical services unless they consent to sterilisation. This is often due to mistaken and discriminatory beliefs that HIV positive women are not supposed to be mothers. Studies have shown that health care providers in South Africa have denied access to health care services for HIV positive women unless they agree to be sterilised (De Bruyn, 2006; Open Society Initiative for Southern Africa, 2010). In Namibia and South Africa, women report being pushed to sign consent forms without explanation while they were already in labour and being wheeled to the operating theatre (Gatsi et al., 2010). This is not peculiar to Africa; in Chile, women have reportedly been sterilised during routine caesarean sections without their informed consent (Center for Reproductive Rights and Vivo Positivo, 2010). All of these women found out that they had been sterilised after the procedure was completed.

In 2008, 230 women living with HIV were interviewed in Namibia about sterilisation. Forty of the women (17%) stated that they had been coerced or forced into sterilisation (International Community of Women Living with HIV/AIDS, 2009).

As noted above, involuntary sterilisation can undermine individuals' rights enshrined in numerous international and regional human rights instruments. Some of these rights include the right to found a family, the right to autonomy, privacy, liberty, security of person, non-discrimination and the right to be free from cruel, inhumane and degrading treatment. These rights are guaranteed in major UN human rights instruments such as the Universal Declaration on Human Rights,[1] the International Covenant on Civil and Political Rights (ICCPR),[2] the International Covenant on Economic, Social and Cultural Rights (ICESCR),[3] the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW),[4] the Convention on the Rights of the Child[5] and the Convention on the Rights of Persons with Disabilities.[6] Most of the treaty bodies responsible for monitoring the implementation of these instruments, and special mechanisms of the United Nations, have addressed the issue of involuntary sterilisation in their work. For instance, the Committee on Economic, Social and Cultural Rights (CESCR) in its General Comment 5 has noted that forced sterilisation of girls and women constitutes a breach of article 10 of the International Covenant on Economic, Social and Cultural Rights dealing with the right to protect the family.[7] Also, the Human Rights Committee has explained that forced

sterilisation amounts to violations of article 7 of the ICCPR, which prohibits torture, cruel, inhumane or degrading treatment as well as article 17 on the right to privacy.[8] The International Federation of Gynaecology and Obstetrics' Guidelines on Female Contraceptive Sterilization provide that:[9]

Only women themselves can give ethically valid consent to their own sterilization. Family members including husbands, parents, legal guardians, medical practitioners and, for instance, government or other public officers, cannot consent on any woman's or girl's behalf.

Women's consent to sterilization should not be made a condition of access to medical care, such as HIV/ AIDS treatment, natural or caesarean delivery, or abortion, or of any benefit such as medical insurance, social assistance, employment or release from an institution. In addition, consent to sterilization should not be requested when women may be vulnerable, such as when requesting termination of pregnancy, going into labour or in the aftermath of delivery.

Regional human rights instruments such as the African Charter on Human and Peoples' Rights,[10] the African Charter on the Rights and Welfare of the Child[11] and the Protocol to the African Charter the African Charter on the Rights and Welfare of the Child[11] and the Protocol to the African Charter on the Rights of Women (Maputo Protocol)[12] all contain relevant provisions that can be used to address incidences of involuntary or forced sterilisation in the region. Some of these provisions relate to the rights to equality and non-discrimination, dignity, health and reproductive health care, freedom from cruel, inhumane and degrading treatment, and liberty. In 2013, concerned by the prevalence of involuntary or forced sterilisation in Africa, the African Commission decided to deal with the situation in a very direct way when it adopted Resolution 260 on Involuntary Sterilisation.[13] This was a landmark resolution that condemns involuntary sterilisation as a gross human rights violation. The African Commission notes that while sterilisation is an acceptable form of birth control, which should be made accessible to every individual who so chooses, including women living with HIV, it must only be carried out with full and free consent of the individual. In particular, the African Commission affirms that all forms of involuntary sterilisation violate the rights to equality and non-discrimination, dignity, liberty and security of person, freedom from torture, cruel, inhuman and degrading treatment, and the right to the best attainable state of physical and mental health, as enshrined in the regional and international human rights instruments, particularly the African Charter and the Maputo Protocol. It therefore, enjoins African governments to put in place mechanisms to ensure that women living with HIV are not subjected to coercion, pressure or undue inducement by healthcare providers and/or institutions in order to secure consent for sterilisation or other medical procedures. It also urges African governments to ensure the regular training of health care providers on the protection of human rights in the context of health care, including the principles of informed consent and non-discrimination. The Commission further requires African governments to put in place complaint mechanisms, legal assistance, and reparation for women living with HIV who are victims of involuntary

sterilisation. This resolution is a welcome development as it will go a long way in drawing the attention of African governments to the perennial challenge in the region.

While the African Commission or the African Court is yet to decide on any case relating to involuntary sterilisation, lessons can be drawn from other jurisdictions where this issue has been addressed. For instance, the European Court of Human Rights has addressed the issue of involuntary/forced sterilisation in the context of Roma women. In some of these cases, the court has affirmed that involuntary or forced sterilisation of Roma women constitutes the violation of their rights to be free from cruel, inhumane and degrading treatment and to private family life guaranteed in articles 3 and 8 of the European Convention. In *V.C v Slovakia* (2007), the applicant of Roma ethnic origin, was sterilised in a public hospital without her full and informed consent, following the birth of her second child. The European Court found that the sterilisation was carried out with gross disregard to her right to autonomy and choice as a patient in violation of articles 3 (prohibition of inhuman and degrading treatment) and 8 (right to family life) of the European Convention. The Court has reached a similar position in other cases involving forced sterilisation of Roma women (*I.G, M.K and R.H v Slovakia* 2004; *N.B v Slovakia* 2010).

Similarly, the CEDAW Committee in *AS v Hungary* (2004) has held that forced sterilisation of a woman without her informed consent by a Hungarian hospital during an emergency caesarean section procedure constitutes a violation of her rights to access to information (article 10), health (article 12) and to decide the number and spacing of her children (article 16) under the Convention. These decisions affirm that involuntary or forced sterilisation undermines women's fundamental rights.

Judicial response to involuntary sterilisation – *Government of the Republic of Namibia v LM and others* (2014)[14]

This case was brought by three HIV positive women who claimed that they were made to undergo sterilisation (bilateral tubal ligations) without their knowledge or consent. They also claimed that they were targeted for sterilisation because of their HIV status. Consequently, they alleged that their rights to life (article 6), liberty of person (article 7), dignity (article 8), equality and freedom to be free from discrimination (article 10) and to found a family (article 14) all guaranteed under the Namibian Constitution have been violated or infringed upon. The women further alleged that the sterilisation procedures were performed as part of a wrongful and unlawful practice of discrimination against them on account of their HIV positive status. The women based their action broadly on two main issues (Kanguade, 2017):

(1) Informed consent:

(a) Whether the Namibian government state hospital medical practitioners performed sterilisation procedures without obtaining informed consent from the plaintiffs.

(b) Whether the failure to obtain informed consent from the plaintiffs by the medical practitioners infringed the following constitutional rights:

(i) The right to life

(ii) The right to liberty
(iii) The right to human dignity
(iv) The right to found a family
(2) Discrimination on the basis of HIV-positive status
(a) Whether the forced sterilisation was in fact due to the HIV positive status of the women and therefore constituted discriminatory practice
(b) Whether the following constitutional rights were infringed:
(i) The rights mentioned in issue (1) (b) above
(ii) The right to equality and freedom from discrimination.

At the High Court, it was held that the government failed to establish that the women had given their informed consent to the sterilisation procedures. With regard to the issue of discrimination, the court found that there was no evidence to support the assertion that the women were targeted for sterilisation due to their HIV status. On appeal to the Supreme Court, the High Court decision to dismiss the claim of discrimination was upheld. With regard to the issue of informed consent, the Supreme Court affirmed the decision of the High Court by holding that informed consent of the women had not been properly obtained. It was noted further that the mere fact that the women purportedly signed a consent form is not a *prima facie* evidence of consenting to the procedure. Rather, the circumstances surrounding the signing of a consent form must be taken into consideration. According to the court, the fact that the women could not understand what they were signing because they were pressurised to do so would seem to vitiate the consent purported to have been given. In the court's view this action of the health care providers 'smacks of medical paternalism' and must not be condoned.[15] Relying on the statement of Innes CJ in *Waring & Gillow Ltd v Sherborne* (1904), the court identified the essential elements of informed consent to include knowledge, appreciation and consent.

This case is significant in many respects. First, it establishes the fact that forced or coerced sterilisation undermines the right to consent or autonomy of women. Second, it condemns medical paternalism by noting that such an act will no longer be tolerated. Third, it reinstates the essential elements of informed consent (knowledge, appreciation and consent) and clarified that mere signing of a consent form is not equivalent to giving full, free and informed consent for invasive medical procedures such as sterilisation.

Perhaps a major shortcoming of this case is that the court was so engrossed with the issue of informed consent that it failed to address the human rights concerns raised by this case. The Supreme Court missed a great opportunity to consider the human rights implications of forced sterilisation on the three women who initiated the case. The women had alleged at the High Court that by virtue of being coerced to undergo sterilisation and given its irreversible effects, their rights to dignity, liberty, life and non-discrimination had been violated. Rather than addressing the issue of discrimination raised in this case, the court turned a blind eye to the intersectionality of gender, social status and HIV raised by this case. The three women plaintiffs had to contend with the fact that they were coerced to undergo sterilisation because of their HIV status, gender and low social status. Intersectional discrimination relates to multiple

factors or grounds intermingling with one another such that they create a peculiar risk or burden of discrimination (Cook, 2013). According to Cook (2013: 109):

Intersectionality is associated with two features. First, the grounds or factors are analytically inseparable such that the experience of discrimination cannot be disaggregated into distinct grounds. The experience is transformed by the interaction. Second, intersectionality is associated with a qualitatively different experience, 'creat[ing] consequences for those affected in ways which are *different* from consequences suffered by those who are subject to one form of discrimination only.'

Had the court considered this intersectionality, it could perhaps have come to a different conclusion regarding the claim for non-discrimination. Perhaps the fault should not be laid at the court's doorsteps, but rather on the lawyers who drafted the court papers. It would seem that the focus of the lawyers was to secure a remedy for the plaintiffs through tortious liability. Thus, little attention was paid to the human rights dimension of the case. This would account for the inability of the court to properly engage with human rights violations raised by this case.

More importantly, taking into consideration the circumstances leading to the coerced sterilisation of the three HIV positive women, a case for gender-based violence should have been canvassed. Unfortunately, this was never considered in the pleadings of the women at the High Court. One of the doctors that testified in this case had noted that sterilisation could be a harrowing experience for women accompanied by social–medical consequences. This will obviously fall under the definition of violence as envisaged in international human rights instruments. This aspect of the paper is considered in greater detail below.

It should be noted that an organisation known as Kenya Legal and Ethical Issues Network on HIV & AIDS (KELIN) has instituted a legal action on behalf of some women living with HIV who were coerced to undergo sterilisation in Kenya. The five HIV positive women were suing the Kenyan government for violations of their health and human rights.[16] This case is still before the High Court in Kenya and it is hoped that the court will take a more progressive approach to the human rights issues raised by involuntary sterilisation. More importantly, it is hoped that the case will focus on the violence dimension of forced sterilisation.

Nexus between involuntary sterilisation and violence against women

Involuntary sterilisation can also be regarded as violence against women. Article 1 of the Maputo Protocol, drawing inspiration from the CEDAW, defines violence against women broadly to include any form of act that may result in physical, mental, emotional or physiological harm to women. According to the Protocol, violence against women means:

[A]ll acts perpetrated against women which cause or could cause them physical, sexual, psychological, and economic harm, including the threat to take such acts; or to undertake

the imposition of arbitrary restrictions on or deprivation of fundamental freedoms in private or public life in peace time and during situations of armed conflicts or of war.[17]

It further provides in article 4 the detailed steps and measures African governments should adopt to address violence against women. This ranges from enacting law to prevent violence against women, punishing perpetrators of violence against women to rehabilitating victims of violence. Also, in article 5 (d), the Protocol calls for protection of women from violence, abuse and intolerance. This can be interpreted to include a right to protection from sexual violence or such violence as hampers women's enjoyment of their sexual rights and freedom (Durojaye and Murungi, 2014). Clearly, from this broad definition provided by the Maputo Protocol, involuntary or forced sterilisation will amount to an act of violence against women.

It should be noted that the provisions of articles 4 and 5 of the Protocol must be read together with article 14, which contains elaborate provision on sexual and reproductive rights of women. It explicitly affirms women's right to sexual and reproductive health, including protection from sexually transmitted infections such as HIV. Violence against women not only undermines their physical wellbeing but may also compromise their sexual and reproductive well-being.

Studies have documented how HIV positive women, have been coerced to undergo sterilisation against their will in the region. Many of these women continue to lament the psychological and mental trauma this has caused them (Essack and Strode, 2012). Some of the women lament that given the irreversible nature of the practice, they are forever haunted by the fact that they will not be able to give birth again. In essence, the after-effects of involuntary sterilisation have continued to result in anguish for the affected women. This is more so given that in many African societies motherhood is often celebrated as the norm (African Gender and Media Initiative, 2012; Rochon, 2008). Thus, inability to bear children as a result of coerced sterilisation would seem to put these women at risk of negative attitudes such as isolation, stigma and discrimination as well as physical or verbal abuse.

Essack and Strode (2012) have documented the experiences of HIV positive women who were coerced to undergo sterilisation. Some of the women narrated the emotional, psychological and physical distress they daily experience. While some of them lamented how they were jeered at and ridiculed, others shared how they were deserted or sent packing by their partners due to their inability to conceive again (Essack and Strode, 2012: 28). One of the participants who had experienced forced sterilisation expressed her frustration in this manner:

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.

Due to real or perceived acts of violence and negative reactions that they may experience, many of the women did not inform their partners about their situation. For instance, a woman from a Kenyan study lamented that "When I told him about the sterilization, he picked a machete and threatened to cut me into pieces" (African Gender and Media Initiative, 2012: 26). A study notes that violation of sexual and reproductive rights in the context of forced sterilisation only serves to 'severely undermine government's public health initiatives on HIV and reproductive health' (Gatsi et al., 2010: 12).

Therefore, the governments of countries where these forced sterilisations took place should be held accountable. This is in line with the African Commission's decision in *Zimbabwe NGO Forum v Zimbabwe* (2006) where the Commission reinstated the doctrine of due diligence in sexual violence by noting that "[a] state can be held complicit where it fails systematically to provide protection of violations from private actors who deprive any person of his/her human rights." The Commission further notes that the Zimbabwean government has failed to demonstrate due diligence in preventing politically motivated acts of violence, which have led to murder and rape in the country. This position was reiterated in *Egyptian Initiative for Personal Rights & INTERIGHTS v Egypt* (2011), where the African Commission noted that acts of sexual violence against women constitute a violation of the right to equality and non-discrimination guaranteed in the African Charter and the Maputo Protocol.

The CEDAW Committee in General Recommendation 19 on violence against women has explained:

The Convention in article 1 defines discrimination against women. The definition of discrimination 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. Gender-based violence may breach specific provisions of the Convention, regardless of whether those provisions expressly mention violence.[18]

The Committee notes further that 'Compulsory sterilization or abortion adversely affects women's physical and mental health, and infringes the right of women to decide on the number and spacing of their children.'[19] It concludes that this not only impairs on women's right to enjoy their fundamental rights and freedoms, but also amounts to discrimination as envisaged in the Convention. According to the Committee, states must take adequate measures to address all forms of violence against women whether in public or private.

In two of its General Comments – General Comments 9 and 13 – the Committee on the Rights of the Child has addressed forced sterilisation of children with disabilities. According to the Committee, involuntary sterilisation of girls with disabilities constitutes a form of violence. [20]

Also, the former UN Special Rapporteur on Violence against Women, Radhika Coomaraswamy[21] has asserted that forced sterilisation is a method of medical control of a woman's fertility. It violates a woman's physical integrity and security and constitutes violence against women. A similar view is shared by the United Nations Special Rapporteur on torture, when he notes that forced sterilisation of women with disabilities may constitute torture, cruel or inhuman treatment. He further notes that 'forced sterilisation constitutes a crime against humanity when committed as part of a widespread or systematic attack directed against any civilian population'.[22]

At the Fourth World Conference on Women in Beijing (FCWC), the international community identified what constitute acts of violence against women and reaffirmed the rights of women, including women with disabilities, to found and maintain a family, to attain the highest standard of sexual and reproductive health, and to make decisions concerning reproduction free from discrimination, coercion, and violence.[23]

Human rights organisations have condemned forced sterilisation as a form of violence against women. For instance, Human Rights Watch (2011) has explained that forced sterilisation is an act of violence, a form of social control, and a violation of the right to be free from torture and other cruel, inhuman or degrading treatment or punishment.

From the foregoing, it is clear that African governments have the obligations to respect, protect and fulfil women's rights in the context of involuntary sterilisation. The obligation to respect would imply that governments must ensure that laws and policies do not endorse or condone forced sterilisation of women. The obligation to protect implies that governments must ensure that third parties, such as health care providers do not pressurise women to undergo sterilisation without free and informed consent. On the other hand, the obligation to fulfil will require governments to take administrative, judicial and budgetary measures to address involuntary sterilisation. This will include ensuring the training of health care providers on ethical and human rights issues relating to involuntary sterilisation and repealing laws or policies that condone involuntary sterilisation. It also means empowering women through training to know their rights in the context of involuntary sterilisation. More importantly, it will include ensuring access to justice for women who have experienced forced sterilisation.

It should be noted that in 2015 the Nigerian government enacted the Violence against Persons (Prohibition) Act (VAPP). Section 3 of the Act criminalises the act of coercing another to engage in any act to the detriment of that person's physical or psychological well-being. Although the section does not specifically mention sterilisation, it can be invoked to address involuntary sterilisation in the country. No doubt this is a positive development which should be emulated by other African countries. There is need for more countries in the region to adopt laws and policies that will address involuntary sterilisation as a form of violence against women.

Conclusion

Women in Africa have continued to experience involuntary sterilisation. Most of these women are coerced to undergo sterilisation due to their HIV status or because of their disabilities. While sterilisation is recognised as a form of fertility control when it is done with the full, free and informed consent of a woman, it becomes a human rights violation when it is coerced or forced. Involuntary sterilisation undermines a woman's rights to autonomy, dignity, liberty, to found a family, health and non-discrimination. In response to the incidence of forced sterilisation in some parts of Africa, the CEDAW Committee has noted as follows:[24]

States must adopt legislative and policy measures that clearly define the requirement of free, prior and informed consent with regard to sterilizations, in accordance with relevant international standards, including by prescribing an appropriate reflection period after a woman has been informed about the nature of the sterilization, its permanent consequences, potential risks and available alternatives, and the woman's expression of her free, prior and informed consent to undergo the procedure.

More importantly, forced sterilisation constitutes an act of violence against women given its invasive nature and the attendant physical, mental and psychological consequences that follow the procedure. Resolution 260 of the African Commission, which condemns involuntary sterilisation as a human rights violation provides a great opportunity for African governments to address this practice within their jurisdictions. Consequently, African governments must exhibit more political will to enact appropriate laws to address involuntary sterilisation and ensure their implementation. Also, legislation that permits forced sterilisation must be repealed with immediate effect. African governments would need to embark on training of health providers to ensure that they promote and protect the rights of all women, especially HIV positive women to decision-making in the context of sterilisation.

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Notes

1. Universal Declaration of Human Rights, GA Res 217 A (III), UN Doc A/810 (10 December 1948).
2. International Covenant on Civil and Political Rights adopted in 1966 entered into force 23 March 1976 999 UNTS 171 and 1057 UNTS 407 / [1980] ATS 23 / 6 ILM.
3. International Covenant on Economic, Social and Cultural Rights, adopted 16 December 1966; GA Res 2200 (XXI), UN Doc A/6316 (1966) 993 UNTS 3 (entered into force 3 January 1976).
4. Convention on the Elimination of All Forms of Discrimination Against Women GA Res 54/180 UN GAOR 34th Session Supp No 46 UN Doc A/34/46 1980.
5. Convention on the Rights of the Child GA Res 25 (XLIV), UN GAOR Supp No 49 UN Doc A/RES/44/25 1989.

6. The Convention on the Rights of Persons with Disabilities and its Optional Protocol (A/RES/61/106) was adopted on 13 December 2006.
7. See General Comment 5 para 31.
8. See *General Comment No. 28*: Equality of rights between men and women paras 11 and 20
9. *International Federation of Gynaecology and Obstetrics*. (2011). *Guidelines* for *Female Contraceptive Sterilization*.
10. African Charter on the Rights and Welfare of the Child, OAU Doc. CAB/LEG/24.0/49 (1990) (*entered into force* Nov. 29, 1999).
11. African Charter on the Rights and Welfare of the Child, OAU Doc CAB/LEG/24.0/49 (1990) (entered into force 29 November 1999).
12. Adopted by the 2nd Ordinary Session of the African Union General Assembly in 2003 in Maputo CAB/ LEG/66.6 (2003) entered into force 25 November, 2005, particularly article 14 of the Protocol.
13. Adopted by the African Commission on Human and Peoples' Rights at its 54th Ordinary Session held from 22 October to 5 November 2013, in Banjul, The Gambia.
14. 14. (SA 49/2012) [2014] NASC 19 (3 November 2014).
15. (SA 49/2012) [2014] NASC 19 (3 November 2014), para 104.
16. *SWK & Others Vs. MSF France & Others* Petition 605 of 2014.
17. Article 1 of the Maputo Protocol.
18. UN Committee on Committee on the Elimination of Discrimination against Women (CEDAW) (1992), General recommendation No. 19: Violence against women, 29 January 1992, A/47/38 [paras. 22, 24m, 24n].
19. UN Committee on Committee on the Elimination of Discrimination against Women (CEDAW) (1992), General recommendation No. 19: Violence against women, 29 January 1992, A/47/38 [para 22].
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