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Acronyms and Abbreviations _____.

African Charter	African Charter on Human and Peoples' Rights
ACHPR	African Commission on Human and Peoples' Rights
AIDS	Acquired Immune Deficiency Syndrome
CEDAW	Convention on the Elimination of all Forms of Discrimination Against Women
CEDAW Committee	Committee on the Elimination of Discrimination Against Women
CRC	Convention on the Rights of the Child
ECtHR	European Court of Human Rights
FIDA U	<i>Federecion Internacional De Abogadas</i> or International Federation of Women Lawyers – Uganda
FSL	Feminist strategic litigation
HIV	Human Immuno-Deficiency Virus
HRPC	Human rights in patient care framework
IACHR	Inter-American Commission on Human Rights
ISLA	Initiative for Strategic Litigation in Africa
ICW –Kenya	International Community of Women living with HIV Kenya Chapter
KELIN-Kenya	The Kenya Legal & Ethical Issues Network on HIV and AIDS
NGO	Non-governmental organisation
OSIEA	Open Society Initiative for Eastern Africa
SRHR	Sexual and reproductive health rights
UDHR	Universal Declaration of Human Rights
UGANET	Uganda Network on Law, Ethics and HIV/AIDS
UNAIDS	Joint United Nations programme on HIV/AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
WHO	World Health Organization
WLC	Women's Legal Centre

Foreword

Across the globe, forced sterilisation is performed on vulnerable and marginalised groups, particularly young girls and women with disabilities or persons living with HIV for various purposes, including eugenics, population control, menstrual management and personal care, and pregnancy prevention (including pregnancy that results from sexual abuse). International and regional human rights bodies as well as professional organisations have expressed great concerns regarding forced sterilisation as a human rights violation. There is a consensus that forced sterilisation undermines the rights to dignity, right to found a family, health and reproductive care, non-discrimination, freedom to be free from torture, inhumane and degrading treatment autonomy, liberty and life. In addition to being a violation of human rights, any form of forced or forced sterilisation violates ethical principles, including respect for autonomy and physical integrity, beneficence and non-maleficence.

Historically, forced sterilisation was adopted for eugenics purposes, however, over the years, the practice has been used for various purposes including population control and as a means of regulating women's reproductive autonomy. From experience people that are susceptible to forced sterilisation include:

- Women
- Persons with disabilities (especially persons with mental disabilities)
- People living with HIV
- Poor and uneducated women
- People from minority groups
- Transgender and intersex persons

Studies have shown that forced sterilisation is practiced across different regions of Africa including Kenya, Namibia, South Africa, Malawi and Uganda. International and regional human rights bodies have condemned this practice noting that it violates various human rights guaranteed in international and regional human rights instruments. Moreover, these bodies have emphasised that states have the obligation to ensure that no individual is subjected to sterilisation without due regard to human rights norms and standards. It has further been noted that failure to prevent forced sterilisation of vulnerable and marginalised groups would amount not only to discrimination but also to an act of violence.

One of the important ways to hold a state accountable for its obligations to prevent forced sterilisation is through strategic litigation. Litigation can provide a powerful tool for redressing human rights violations in the context of forced sterilisation. More importantly, feminist litigation can create powerful precedence that can have multiplier effects in addressing the negative implications of forced sterilisation on women. In this regard, this document serves as an important resource material for lawyers and other

activists interested in strategic litigation to address the perennial challenges posed by forced sterilisation on our continent.

Beyond providing very useful information on human rights consequences of forced sterilisation, it equally contains detailed information on the strategies that can be applied towards overcoming the barriers to forced sterilisation. While it seems to be targeted at lawyers and other persons interested in strategic litigation in the context of forced sterilisation, it also serves as a useful resource material for anyone interested in understanding the nature and consequences of forced sterilisation. I have no doubt that this document will be useful to researchers, students, civil society groups, policy makers, international institutions and regional human rights bodies.

Ebenezer Durojaye

Head Socio-Economic Rights Project

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1. Introduction

1.1. Project Overview

This INSIGHTS is developed as part of the Initiative for Strategic Litigation in Africa's (ISLA) mandate to strengthen the capacity of feminist litigators and non-governmental organisations (NGOs) in the African continent to conduct strategic litigation and to create domestic and regional jurisprudence in the ambit of women's human and sexual rights. ISLA aims to expand jurisprudence to establish a cumulative and progressive interpretation of women's human rights resulting in meaningful change in the lives of women. INSIGHTS document our learnings as we do strategic litigation work. This publication specifically examines barriers and opportunities related to forced sterilisation in Africa.¹

Forced sterilisation, a medical procedure in which an individual's ability to bear children is removed without the patient's informed consent,² is prohibited under both international and domestic human rights instruments due to its lack of bodily autonomy, and the often physical, emotional and cultural consequences that flow thereon. Notwithstanding this, however, occurrences of forced sterilisation has been reported in several countries across the globe.³

While there have been some judicial interventions in respect of forced sterilisation in Africa, the situation remains dire due to procedural, substantive and cultural barriers, including, prescription requirements, social stigma and a sustained culture of unredressed women's rights violations before the courts.⁴ Against this background, and as part of its thematic areas, ISLA has run a series of capacity building interventions aimed at interrogating and generating knowledge on the issue of strategic litigation on forced sterilisation. This publication is one of the outputs of these initiatives.

Drawing inspiration from experiences detailed in ISLA-convened meetings on forced sterilisation coupled with desktop analysis, the publication seeks to, first, explore legal and policy frameworks on forced sterilisation in Africa and comparative jurisdictions and

¹ While this publication favours the more comprehensive term 'forced sterilisation', many of the texts quoted in this work also use the term 'forced or coercive sterilisation'. Therefore, in this research, these terms shall be used interchangeably.

² K Bakare & S Gentz 'Experiences of Forced Sterilization and coercion to Sterilize among Women Living with HIV (WLHIV) in Namibia: An Analysis of the Psychological and Socio-Cultural effects' (2020) 28(1) Sexual and Reproductive Health Matters, Article 1758439 <<https://doi.org/10.1080/26410397.2020.1758439>>.

³ Ibid. These countries include China, Democratic Republic of Congo, Dominican Republic, El Salvador, Fiji, Honduras, India, Indonesia, Kenya, Malawi, Mexico, Mozambique, Namibia, Nepal, Nicaragua, Pakistan, Philippines, South Africa, Sri Lanka, Swaziland, Tanzania, Thailand, Uganda, Ukraine, Venezuela, Vietnam and Zambia.

⁴ P Patel 'Forced Sterilization of Women as Discrimination' (2017) 38 Public Health Reviews 15 DOI 10.1186/s40985-017-0060-9.

second, to identify existing barriers and opportunities on feminist strategic litigation (FSL) for forced sterilisation, and in that way, make credible contributions to the existing body of knowledge on this subject.

It is intended to provide substantive and procedural understandings for legal practitioners who intend to commence or are in the midst of litigation on defending women who have undergone forced sterilisation. Further to this, this publication is also intended to serve as an important guide to other stakeholders, including judicial actors on existing barriers and possible opportunities to reimagine the existing order.

1.2. Factual Background and Structure of the Project

In January 2017, ISLA hosted a strategy consultation meeting on forced sterilisation whose aim was to provide technical legal assistance to participants interested in, or already undertaking, strategic litigation on forced sterilisation. Reflections gathered in this meeting were further expounded on in a follow up in-depth seminar convened in August 2018.⁵ Attendees were drawn from, among others, Kenya Legal & Ethical Issues Network on HIV and AIDS (KELIN), Centre for Reproductive Rights, Uganda Network on Law, Ethics and HIV/AIDS, Namibian Women's Health Network and the Joint United Nations Programme on HIV/AIDS (UNAIDS).

In both meetings, participants were invited to, among others, discuss the substantive and procedural barriers that exist in litigating cases of forced sterilisation with the view of providing technical legal assistance to participants interested in, or already undertaking, strategic litigation on forced sterilisation and determine ways in which ISLA and its partner organisations can work together on similar cases of forced sterilisation.

More specifically, in the 2018 meeting, representatives from KELIN-Kenya made presentations on two cases which they had filed before the High Court of Kenya on forced sterilisation of HIV+ women.⁶ Discussions also involved proposals to enhance ongoing collaborations between partner organisations and adopting holistic approaches to forced sterilisation cases.⁷

Reflections from these meetings ranged from the utility of the Maputo Protocol⁸ on initiating litigation cases on forced sterilisation to enhancing collaboration among stakeholders. These themes form the main thrust of this paper as they provide an important roadmap in achieving the first aim of this project by highlighting prescient

⁵ Information was obtained from the Meeting Reports from the Strategic Consultation Meetings on Forced Sterilisation held on January 2017 and August 2018.

⁶ LAW & 2 others v Marura Maternity & Nursing Home & 3 Others (Petition 606 of 2014).

⁷ ISLA partners for the Strategy Consultation on Forced Sterilisation meeting held in Mombasa, Kenya from 25 to 27 January 2017 were KELIN; FIDA U; Dullah Omar Institute; GEM; UGANET; Namibian Women's Health Network; UNAIDS; Women and Law in Southern Africa Research Trust; ICW –Kenya; ERRC; WLC; Leteipan and Associates; ICW- Global and OSIEA.

⁸ Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (adopted 1 July 2003, entered into force 25 November 2005) (Maputo Protocol).

barriers in litigating against forced sterilisation in Africa. Desktop research was used to inform the first aim of the research, that is, to provide a comprehensive review of the existing situation in respect of forced sterilisation.

In addition to the meeting reports, other important sources include laws, policies, treaties and practices in order to identify barriers to litigating forced sterilisation. This data from the literature review was analysed using a pan African, feminist and human rights lens and included an analysis of gendered power hierarchies with a view to interrogating how social, political and economic systems perpetuate discriminatory laws and practices that marginalise women.

To that end, this publication is divided into the following sections. The first section expounds on the objectives, background, methodology and approach taken in developing the publication. Section two provides a norms and standards context on forced sterilisation in Africa, including utilising a FSL in analysing the normative framework on forced sterilisation in Africa.

Section three discusses the cases identified and discussed in the 2017 and 2018 meetings and emerging themes that were highlighted in the said meetings while Section four reflects on the findings that emerged from the relevant 2017 and 2018 ISLA convenings to highlight barriers and opportunities that feminist strategic litigators face in taking cases on forced sterilisation, including procedural and structural barriers.

This publication concludes with suggestions and opportunities for reform.

2. Norms and Standards: Feminist Strategic Litigation and Forced Sterilisation_____.

2.1. Meaning and Approaches to Feminist Strategic Litigation

FSL employs feminism in an effort to litigate around women's lived realities. Feminism, that is, 'movement to end sexism, sexist exploitation, and oppression',⁹ is closely linked to the concept of patriarchy or the structural and institutionalised sexism which privileges men over women.¹⁰ As Tamale aptly notes, 'A common thread that runs through all feminist movements in Africa is the struggle to extend human rights to the female citizens of the continent'.¹¹ Put differently, feminism seeks to question the legitimacy of the structures that keep women in the continent subjugated and develop tools for transformative analysis and action.¹²

FSL uses the law to challenge women's subordination by placing patriarchal social relations, structures and systems in which oppression is embedded at the centre of its analysis.¹³ The FSL strategy involves looking beyond textual laws to their impact in the social, political and economic systems and their contributions in entrenching discriminatory laws and practices that marginalise women.

FSL utilises several approaches, including provision of arguments in court that are grounded in feminist theory; analysis of power issues; presentation of a variety of voices to help shape a case, a reflection on a broad array of experiences and expertise; listening to the client's story and bringing it to the attention of the court and drawing on the expertise and experience of lawyers to help guide the litigation.¹⁴

ISLA's theory of change centres on FSL as a tool for social change on the African continent.¹⁵ In actualising this theory, ISLA works as advisors to counsel to network lawyers and other lawyers who approach the organisation for technical legal support.¹⁶

⁹ B Hooks *Feminism is for Everybody: Passionate Politics* (2000) viii.

¹⁰ Ibid.

¹¹ S Tamale 'The Right to Culture and the Culture of Rights: A Critical Perspective on Women's Sexual Rights in Africa' (2019) <<https://www.fahamu.org/mbbc/wp-content/uploads/2011/09/Tamale-2007-Right-to-Culture.pdf>>.

¹² African Feminist Forum 'Charter of Feminist Principles for African Feminists' (2016) <<https://awdf.org/wp-content/uploads/AFF-Feminist-Charter-Digital-%C3%A2%C2%80%C2%93-English.pdf>>.

¹³ Ibid.

¹⁴ Ibid.

¹⁵ ISLA 'Litigation for Social Change' <<https://www.the-isla.org/priority-areas/litigation-for-social-change/>>.

¹⁶ Ibid.

Additionally, ISLA submits amicus curiae briefs and provide legal representation by acting as co-counsel before regional and international bodies.¹⁷

ISLA also provides assistance on case strategy development, strategic litigation plan development, comparative and international law research and legal brief commentary. Some of the cases in which ISLA conducted/assisted in strategic litigation include *Limbani Sibande v Bright Mwale & Attorney General of Malawi (Defence Forces)*¹⁸ where the petitioner, a transgender woman, was brutally attacked by members of Malawi Armed Forces; and *Pamela Adie v Corporate Affairs Commission*,¹⁹ where the applicant, Pamela Adie, challenged the Corporate Affairs Commission (CAC) of Nigeria's refusal to reserve the name 'Lesbian Equality and Empowerment Initiative' and consequently the refusal to register the organisation.

2.2. Contextualising Forced Sterilisation in Law and Practice

Sterilisation remains one of the most widely used forms of contraception in the world.²⁰ If done in adherence to the right clinical standards and informed consent, sterilisation methods such as vasectomy and tubal ligation are noted as safe and effective means of permanently controlling fertility.²¹ However, when conducted against the will of the patient, it is considered to be a human rights violation.²²

Although all childbearing women are vulnerable to forced sterilisation, the World Health Organization (WHO) has noted that people belonging to certain population groups, including people living with HIV, persons with disabilities, indigenous peoples, ethnic minorities transgender and intersex persons are at a greater risk of being sterilised without their full, free and informed consent due to the multiplicity of vulnerabilities that they face.²³

It is also important to note that while both men and women are subject to such practices, women and girls continue to be disproportionately impacted.²⁴ Across the globe, forced sterilisation is performed on young girls and women with disabilities for a number of reasons including eugenics-based practices of population control, menstrual management and personal care, and pregnancy prevention (including pregnancy that results from sexual abuse).²⁵

¹⁷ Ibid.

¹⁸ *Limbani Sibande v Bright Mwale & Attorney General of Malawi (Defence Forces)* Civil Cause 126 of 2021.

¹⁹ *Pamela Adie v Corporate Affairs Commission* Suit No: FHC/ABJ/CS/827/2018 Federal High Court of Nigeria, Abuja Judicial Division.

²⁰ Ibid.

²¹ WHO 'Eliminating forced, coercive and otherwise forced sterilization. An interagency statement, OHCHR, UN Women, UNAIDS, UNDP, UNFPA, UNICEF & WHO' (2014) <https://www.unaids.org/sites/default/files/media_asset/201405_sterilization_en.pdf>.

²² The American College of Gynecologists and Obstetricians (n 45)

²³ WHO (n 47).

²⁴ Ibid.

²⁵ Human Rights Watch.

Forced and coerced sterilisation have long-lasting physical, psychological and social effects, including severe mental pain, suffering and extreme psychological trauma. For women with disabilities, the issue of forced sterilisation encompasses much broader issues of reproductive health, including support for choices and services in menstrual management, contraception, abortion, sexual health management and screening, pregnancy, birth, parenting, menopause, sexuality, violence and sexual assault prevention.²⁶

In addition, forced sterilisation may result in social stigma, especially for women who are living with HIV. As du Toit notes, in addition to the vulnerability and stigmatisation that women experience due to their HIV-status, they are also subjected to stigma regarding their fertility.²⁷

2.3. Normative Human Rights Framework on Forced Sterilisation

2.3.1. International Human Rights Framework

All major international and regional human rights instruments provide for protections against forced sterilisation by codifying rights to privacy, equality and protection from torture and inhuman degrading treatment.²⁸

Prohibition of forced sterilisation has been specifically given by varied United Nations (UN) human rights special mechanisms. In interpreting art 25 of the Convention of Persons with Disabilities, for example, the UN Committee on the Rights of Persons with Disabilities recommended the abolition of surgery and treatment without the full and informed consent of the patient.²⁹ Additionally, the UN Committee on Economic, Social and Cultural Rights has emphasised that forced sterilisation of girls and women with disabilities is a breach of art 10 of the International Covenant on Economic, Social and Cultural Rights.³⁰

Furthermore, the UN Committee Against Torture has recommended that states take urgent measures to investigate promptly, impartially, thoroughly and effectively all allegations of forced sterilisation of women, prosecute and punish the perpetrators, and

²⁶ C Fromahder (n 42)

²⁷ M du Toit 'Forced sterilization of HIV-positive women in South Africa: A current legal perspective' (2018) 11(2) *SAJ of Bioethics Law* 80 DOI:10.7196/SAJBL.2018.v11i2.64.

²⁸ See, for example, Universal Declaration of Human Rights (adopted 10 December 1948) UNGA Res 217 A(III) (UDHR); International Covenant on Civil and Political Rights (adopted 16 December 1966, entered into force 23 March 1976) 999 UNTS 171; International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, entered into force 3 January 1976) 993 UNTS 3 (ICESCR); Convention on the Elimination of All Forms of Discrimination Against Women (adopted 18 December 1979, entered into force 3 September 1981) 1249 UNTS 13 (CEDAW); Convention on the Rights of Persons with Disabilities (adopted 13 December 2006, entered into force 3 May 2008) 2515 UNTS 3 (CRPD).

²⁹ UN Committee on the Rights of Persons with Disabilities (CRPD Committee) 'Concluding Observations on Tunisia' (2011) UN Doc CRPD/C/TUN/CO/1 para 29.

³⁰ UN Committee on Economic, Social and Cultural Rights (CESCR Committee) 'General Comment No. 5: Persons with Disabilities' (1994) para 31.

provide the victims with fair and adequate compensation.³¹ The UN Committee on the Rights of the Child has identified forced sterilisation of girls with disabilities as a form of violence and noted that state parties to the Convention on the Rights of the Child³² are expected to prohibit by law the forced sterilisation of children with disabilities.³³

Meanwhile, the UN Committee on the Elimination of Discrimination against Women (CEDAW Committee) has held forced sterilisation to be a violation of a woman's right to informed consent, infringing on her right to human dignity and physical and mental integrity.³⁴ The Committee further clarified that except where there is a serious threat to life or health, the practice of sterilisation of girls, regardless of whether they have a disability, and of adult women with disabilities in the absence of their fully informed and free consent, should be prohibited by law.³⁵

The Human Rights Committee has also pointed out that the prohibition of torture or cruel, inhuman or degrading treatment stated in art 7 of the International Covenant on Civil and Political Rights has special application to patients in medical institutions presumably because they are under the care and authority of state actors.³⁶

The WHO has also noted that sterilisation without full, free and informed consent is forced, 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 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.³⁷

Forced sterilisation is also viewed as a violation of the right to be free from torture and other cruel, inhuman or degrading treatment or punishment.³⁸ Its interpretation as a human rights violation is aggravated by the fact that this operation is often performed on vulnerable and marginalised groups, especially young girls and women with disabilities or living with HIV,³⁹ people diagnosed with a mental illness, persons with disabilities, racial minorities, poor women and people living with specific illnesses, such as epilepsy.⁴⁰ These inhuman operations are often framed within traditional social attitudes that

³¹ UN Committee Against Torture (CAT Committee) 'Concluding observations of the Committee against Torture. Slovakia' (2009) UN Doc CAT/C/SVK/CO/2 para 14; CAT Committee 'Concluding observations of the Committee against Torture. Czech Republic' (2004) UN Doc CAT/C/CR/32/2 para 6(n).

³² Convention on the Rights of the Child (adopted 20 November 1989, entered into force 2 September 1990) 1577 UNTS 3 (CRC).

³³ UN Committee on the Rights of the Child (CRC Committee) 'General comment No. 13 (2011) The right of the child to freedom from all forms of violence' (2011) UN Doc CRC/C/GC/13 paras 16, 21.

³⁴ Committee on the Elimination of Discrimination Against Women (CEDAW Committee) 'General recommendation 24' in 'Report of the Committee on the Elimination of Discrimination against Women' (1999) UN Doc A/54/38/Rev.1 chap I para 22.

³⁵ Ibid.

³⁶ Ibid.

³⁷ WHO (see note 32).

³⁸ As above.

³⁹ ISLA Consultations Report (unpublished).

⁴⁰ Patel (note 4 above).

characterise disability as a personal tragedy or a matter for medical management and rehabilitation.⁴¹

This point has also been enunciated by the Special Rapporteur on Violence against Women, its Causes and Consequences who has categorised forced sterilisation as a form of violence against women.⁴² Also, the UN Special Rapporteur on torture has emphasised that forced sterilisation of women with disabilities may constitute torture or cruel or inhuman treatment and that forced sterilisation constitutes a crime against humanity when committed as part of a widespread or systematic attack directed against any civilian population.

Additionally, in two of its General Comments, the Committee on the Rights of the Child has expressly noted that forced sterilisation of girls with disabilities constitutes a form of violence.⁴³

2.3.2. Forced Sterilisation in the African Human Rights System

Forced sterilisation is generally prohibited under the African Charter on Human and Peoples' Rights (the African Charter),⁴⁴ the African Charter on the Rights and Welfare of the Child⁴⁵ and the Maputo Protocol.⁴⁶

However, it is art 14 of the Maputo Protocol that makes specific reference to forced sterilisation by providing, in part, that women have the right to control their fertility, the right to decide whether to have children, the number of children and the spacing of children and the right to choose any method of contraception.⁴⁷ This position was further clarified by the African Commission in its adopted Resolution 260 on Forced Sterilisation, where it noted that all medical procedures, including sterilisation, must be provided with the free and informed consent of the individual concerned and within international standards.⁴⁸

General Comment No. 2 on art 14 of the Maputo Protocol further underscores this point by noting in part that: 'State parties should ensure that the necessary legislative measures, administrative policies and procedures are taken to ensure that no woman

⁴¹ Human Rights Watch (note 25 above).

⁴² Economic and Social Council 'Report of the Special Rapporteur on violence against women, its causes and consequences, Ms. Radhika Coomaraswamy, in accordance with Commission on Human Rights resolution 1997/44' (1999) UN Doc E/CN.4/1999/68/Add.4.

⁴³ CRC Committee 'General Comment No. 9 (2006): The rights of children with disabilities' (2007) UN Doc CRC/C/GC/9 2007; CRC Committee 'General comment No. 13 (2011): The right of the child to freedom from all forms of violence' (2011) CRC/C/GC/13.

⁴⁴ Organization of African Unity (OAU) African Charter on Human and Peoples' Rights (adopted 27 June 1981, entered into force 21 October 1986) OAU Doc CAB/LEG/67/3 rev 5 21 ILM 58 (1982) (Banjul Charter) art 4.

⁴⁵ OAU African Charter on the Rights and Welfare of the Child (adopted 1 July 1990, entered into force 29 November 1999) OAU Doc CAB/LEG/24.9/49 art 4.

⁴⁶ Maputo Protocol art 7.

⁴⁷ Ibid art 14.

⁴⁸ Ibid.

is forced because of her HIV status, disability, ethnicity or any other situation, to use specific contraceptive methods or undergo sterilization or abortion'.⁴⁹

Forced sterilisation is also categorised as a form of sexual and gender-based violence in General Comment No. 4 on the Maputo Protocol.⁵⁰ To that end, the African Union Commission provided specific state obligations, including legislative and policy measures to enact its prohibition against all women, with particular emphasis to women living with HIV/AIDS.⁵¹

Furthermore, the Niamey Guidelines to Combat Sexual Violence And Its Consequences In Africa lists 'forced sterilization' as a form of sexual and gender-based violence and mandates state parties to, among others, 'adopt legislative, administrative, judicial and all other necessary measures to implement these Guidelines'.⁵²

2.3.3. Judicial Approach to Forced Sterilisation

Judicial decisions in both domestic and regional spheres have also given important insight on forced sterilisation. In *Government of the Republic of Namibia v LM and Others*,⁵³ three women, living with HIV alleged that they had been sterilised without their informed consent. In all three cases, the women signed consent forms but argued that they were coerced into signing the said forms.

In holding for the petitioners, the Supreme Court emphasised that the decision of whether or not to be sterilised is of great personal importance and must be made with informed consent. Merely securing signatures to consent documents is not sufficient as women need to understand and appreciate the risks, consequences and available alternatives before opting for sterilisation.⁵⁴

To this end, the Supreme Court underscored that the woman must be in a position to comprehend the nature and consequences of the operation to be performed on her and concluded that consent for sterilisation cannot be obtained when women are in labour or in pain by stating in part:

⁴⁹ African Commission on Human and Peoples' Rights 'General Comment No. 2 on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa' (2015) <https://uniteforreproprights.org/wp-content/uploads/2018/01/achpr_instr_general_comment2_rights_of_women_in_africa_eng.pdf>.

⁵⁰ ACHPR 'General Comment No. 4 on the African Charter on Human and Peoples' Rights: The Right to Redress for Victims of Torture and Other Cruel, Inhuman or Degrading Punishment or Treatment (Article 5)' (2017) <<https://www.achpr.org/legalinstruments/detail?id=60>>.

⁵¹ Ibid.

⁵² ACHPR 'Guidelines on Combating Sexual Violence and its Consequences in Africa' (2017) (Niamey Guidelines).

⁵³ *Government of the Republic of Namibia v LM and Others* SA 49/2012 [2014] NASC 19.

⁵⁴ Ibid.

In the case before us, it is crucial to determine whether the respondents had the intellectual and emotional capacity to give their informed consent in the light of the peculiar circumstances in which they found themselves when signing the consent forms ... The records of all three respondents do not indicate what information was conveyed to the respondents when their written consent was obtained ... The principles of individual autonomy and self-determination are the overriding principles towards which our jurisprudence should move in this area of the law. These principles require that in deciding whether or not to undergo an elective procedure, the patient must have the final word.⁵⁵

In *V.C. v Slovakia*,⁵⁶ the applicant (a Roma woman) was sterilised in a public hospital without her informed consent after she had her second child. Finding in favour of the applicant, the European Court of Human Rights (ECtHR) found that sterilisation was carried out in gross disregard of her right to autonomy and choice as a patient, and held, in part:

Sterilisation constituted a major interference with a person's reproductive health status and bore upon many aspects of the individual's personal integrity including his or her physical and mental well-being and emotional, spiritual and family life. Without the consent of a mentally competent adult patient, it was incompatible with the requirement of respect for human freedom and dignity. Moreover, generally recognised international standards laid down that sterilisation may be carried out only subject to prior informed consent, save for exceptional emergency situations.

The ECtHR further listed situations in which sterilisation may be legitimately performed at the request of the person concerned. In the court's opinion, sterilisation may either be performed as a method of contraception or for therapeutic purposes where the medical necessity has been convincingly established. Whatever the case, the ECtHR was categorical that in both situations, informed consent must be secured.

Other important ongoing cases in the regional sphere include *FS v Chile*,⁵⁷ where two advocacy groups, *Vivo Positivo* and *Center for Reproductive Rights*, sued the Chilean government before the Inter-American Court on behalf of a 27-year-old HIV-positive woman who was sterilised during a caesarean section without her knowledge.

Following several years of unsuccessful litigation, the advocacy groups filed a complaint with the Inter-American Commission on Human Rights (IACHR) in 2009. Four years later, the IACHR announced that it would hear the case. This happens to be the first case it had admitted relating to HIV-positive women's sexual and reproductive health rights (SRHR). The decision in the case is still pending.

⁵⁵ Ibid.

⁵⁶ *VC v Slovakia* App No. 18968/07 (2007).

⁵⁷ *FS v Chile* (2009).

In *Andrea Szijjarto v Hungary*,⁵⁸ where a Hungarian Romani woman was subjected to coerced sterilisation by medical staff at the public hospital in Fehérgyarmat without her knowledge or consent, the CEDAW Committee found that the 'failure of the State party, through the hospital personnel, to provide appropriate information and advice on family planning' constituted a violation of the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW).

To that end, the CEDAW Committee found that the State of Hungary was responsible for the hospital's failure to obtain informed consent and the deprivation of the woman's right to decide the number and spacing of her children in violation of the CEDAW. Thus, the CEDAW Committee held the State of Hungary responsible for the forced sterilisation procedure performed in one of its public hospitals.⁵⁹

2.3.4. Justification for Prohibition of Forced Sterilisation

The prohibition of forced sterilisation is justified on several grounds, some of which are highlighted below.

First, forced sterilisation is considered to be a form of gender discrimination. While we acknowledge that both men and women may be subjected to forced sterilisation, statistical evidence shows that women are disproportionately affected by this practice.⁶⁰ Thus, forced sterilisation is inherently discriminatory against women since its intent is to 'deny specific populations the ability to procreate due to a perception that they are less than ideal members of society'. This discrimination is often intersectional as it is often conducted on women experiencing double vulnerabilities, such as women living with HIV or women living with disabilities.⁶¹

Additionally, as noted above, forced sterilisation may also be understood as a form of violence against women.⁶² In its General Comment No. 4, the African Commission asserted that forced sterilisation is an act of sexual or gender-based violence that may amount to torture or inhuman treatment.⁶³ Human Rights Watch has also noted 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.⁶⁴

⁵⁸ CEDAW Committee 'Communication No. 4/2004' (14 August 2006) UN Doc A/61/38.

⁵⁹ R Sifris 'Conceptualising Involuntary Sterilisation as "Severe Pain or Suffering" for the Purposes of Torture Discourse' (2010) 28(4) *Netherlands Quarterly of Human Rights* 523.

⁶⁰ *Ibid.*

⁶¹ du Toit (note 27 above).

⁶² International Justice Resource Center (n 82).

⁶³ ACHPR 'General Comment No. 4' (note 50 above).

⁶⁴ Human Rights Watch (note 25 above).

In a study conducted in Namibia among women that had been subjected to forced sterilisation, all participants reported discrimination or victimisation.⁶⁵ They further testified that they had received poor healthcare services because once healthcare providers discovered that they were sterilised, they were not examined and treated properly.⁶⁶

Third, forced sterilisation is also found to be a violation of the woman's right to health due to its adverse effect on acknowledged standards of the patient care framework. The human rights in patient care framework (HRPC) refers to the application of human rights principles to the context of patient care. It brings together the rights of both patients and providers and focuses on systemic issues and the role of the state.⁶⁷ HRPC is a useful framework for understanding the nature of forced and coerced sterilisation and thus how best to address it to ensure that the practice ends, and victims are properly provided with redress.⁶⁸

In sum, therefore, the HRPC framework applies human rights guaranteed under international treaties to patient care. The most relevant of these rights relates to right to health.

Health is the state of 'complete physical, mental and social well-being and not merely the absence of disease, or infirmity'.⁶⁹ Both the 1994 International Conference on Population and Development (the ICPD Conference) and the 1995 Fourth World Conference of Women held in Beijing (the Beijing Conference)⁷⁰ defined reproductive health as implying that people are able to have a satisfying and safe sex life, have the capability to reproduce and the freedom to decide if, when, and how often to do so, and the information and means for doing so, and furthermore that they have the right of access to appropriate health care services that will enable women to go safely through pregnancy and child birth and provide couples with the best chance of having a health infant.⁷¹

Intrinsic in this right to health is the requirement for individuals to provide free, full and informed consent to any medical procedure they undergo. Prevailing medical ethics and human rights standards require individuals to give free, prior and informed consent (also

⁶⁵ Bakare & Gentz (note 2 above).

⁶⁶ Ibid.

⁶⁷ J Cohen & T Ezer 'Human rights in patient care: A theoretical and practical framework' (2013) 15(2) *Health and Human Rights Journal* 7.

⁶⁸ Ibid.

⁶⁹ Preamble to the Constitution of the WHO (adopted by the International Health Conference, New York 19-22 June 1946, signed on 22 July 1946 by the representatives of 61 states and entered into force on 7 April 1948).

⁷⁰ R Copelon 'Introduction: Bringing Beijing Home' (2017) 21 Brooklyn J of Int Law 599 who notes in part that: 'These two conferences marked significant developments in reproductive health as they led to the adoption of consensus documents in which women's reproductive health rights, encompassing both autonomy and enabling social and economic conditions were highlighted as human rights concerns'.

⁷¹ Programme of Action of the International Conference on Population and Development (1994) UN Doc A/CONF.171/13 para 7.2; Beijing Declaration and Platform of Action (1995) UN Doc A/CONF.177/20/ADD.1 para 94.

sometimes referred to as meaningful consent) to any medical procedure, treatment or test they undergo.⁷²

Therefore, like any other contraceptive method, sterilisation should only be provided with the full, free and informed consent of the individual.⁷³ In some countries including Namibia and Kenya, women living with HIV, persons with disabilities, indigenous peoples, ethnic minorities, transgender and intersex persons are among the highest risk of persons who may be sterilised without their full, free and informed consent.⁷⁴

This lack of consent takes various forms:

- *The women's consent was obtained under duress.* In such cases, women are asked to sign consent forms while in labour or on their way to the operating theatre or are told or given the impression that to obtain another medical procedure such as an abortion or caesarean section, they had to consent to sterilisation.
- The consent was invalid because women were asked to sign a consent form for sterilisation without being provided with *full and accurate information* regarding the sterilisation procedure.
- *The women's consent was not obtained.* In such cases, women have never been asked if they want to be sterilised but are informed of their sterilisation after undergoing a caesarean section. In some instances, women are unaware they had been sterilised until they try to access contraceptives, only to be informed that they have been sterilised.⁷⁵

While forced and coerced sterilisation occurs in different settings, we can draw some commonalities. First, women most affected are from marginalised populations in their societies. Second, forced sterilisation often occurs in hospitals and governments facilities with weak or non-existent informed consent policies and procedures to protect patients' rights. It also occurs where there is little accountability for medical personnel which, therefore, normalises the practice of forced sterilisation.⁷⁶

The fourth justification on prohibition of forced sterilisation is that this action also violates the victim's right to information. This right enables people to make informed decisions and choices regarding their sexual and reproductive health situations. Censoring, withholding or intentionally misrepresenting information about sterilisation can put health and basic human rights in jeopardy.⁷⁷

⁷² Amnesty International, European Institutions Office 'Note to the attention of the Parliamentary Assembly Committee on Social, Health and Family Affairs Committee, in relation to the draft report on "Putting an end to coercive sterilisations and castrations"' (2011) <<https://www.amnesty.org/en/documents/IOR61/014/2011/en/>>.

⁷³ Ibid.

⁷⁴ Ibid.

⁷⁵ Patel (note 4 above).

⁷⁶ Open Society Foundations 'Against Her Will: Forced and Coerced Sterilization of Women Worldwide' (2011).

⁷⁷ WHO (n 135).

Sterilisation practices face two main threats in respect of right to information, that is, some women who wanted to reproduce being sterilised without their knowledge or consent or, in other cases, women who wanted sterilisation to limit their family size lacked access to reliable information about it.⁷⁸

Inability to access full and comprehensive information may also be considered a violation of one's dignity as it prevents an opportunity for an individual to make autonomous reproductive choices.⁷⁹ The principle of autonomy, expressed through full, free and informed decision-making, is a central theme in medical ethics and is embodied in human rights law.⁸⁰

Additionally, forced sterilisation has been described as a violation of the freedom of cruel, degrading and inhuman treatment.⁸¹ To that end, the UN Special Rapporteur on Torture has found, in part, that:

Forced interventions [including forced sterilization], often wrongfully justified by theories of incapacity and therapeutic necessity inconsistent with the Convention on the Rights of Persons with Disabilities, are legitimized under national laws, and may enjoy wide public support as being in the alleged 'best interest' of the person concerned ... Nevertheless, to the extent that they inflict severe pain and suffering, they violate the absolute prohibition of torture and cruel, inhuman and degrading treatment.⁸²

Forced fertilisation is also a violation to one's right to privacy. This right entails the right not to arbitrarily interfere with one's privacy, family, home or correspondence.⁸³ International human rights law has expanded the right to privacy to encompass a wide range of areas including prohibition of phone tapping and protection of a person's intimacy, identity, name, gender, honour, dignity, appearance, feelings and sexual orientation.⁸⁴

Subjection of women to forced sterilisation unjustifiably limits the right to privacy since it undermines the autonomy of women to make informed decisions on their reproductive functions.⁸⁵ Put differently, forced sterilisation deprives women of their fundamental right to privacy as it inhibits a woman to control her own reproductive behaviour.⁸⁶

⁷⁸ The American College of Gynecologists and Obstetricians (n 58).

⁷⁹ WHO (n 135).

⁸⁰ Ibid.

⁸¹ Bakare & Gentz (note 2 above).

⁸² Ibid.

⁸³ UDHR.

⁸⁴ Icelandic Human Rights Center 'The Right to Privacy and Family Life' <<https://www.humanrights.is/en/human-rights-education-project/human-rights-concepts-ideas-and-fora/substantive-human-rights/the-right-to-privacy-and-family-life>>.

⁸⁵ E Mulligan & M Ripper 'Reproductive Ethics: Perspectives on Contraception and Abortion' *International Encyclopedia of Public Health* (2017).

⁸⁶ R Kundnani 'Protecting the Right to Procreate for Mentally Ill Women' (2013) 23(1) *Review of Law and Social Justice* 59.

3. Emerging Cases and Themes on Forced Sterilisation in Africa_____.

3.1. Spotlight on Potential/Ongoing Cases from Africa

In the ISLA-convened meeting in August 2018, participants from KELIN-Kenya and Uganda Network on Law, Ethics and HIV/AIDS (UGANET) made workshop presentations on two cases on forced sterilisation that they had filed on behalf of the victims.

In Kenya, KELIN on HIV and Africa Gender and Media Initiative Trust, together with five women living with HIV, have filed two petitions in the High Court of Kenya in Nairobi.⁸⁷ These cases, filed under Petitions No. 605 and 606 of 2014 list Medecines Sans Frontieres, Pumwani Maternity Hospital, Marie Stopes International, Marura Maternity and Nursing Home, The County Executive Committee member in charge of Health Services, and Cabinet Secretary, Ministry of Health as respondents.

In these cases, the petitioners alleged that they were forcibly sterilised in different health facilities in Nairobi which occurred under the following circumstances: threatening to withhold food portions and baby formula milk from the women; inducement through promising to cover these women's medical expenses; failure to provide the necessary information to women to enable them make informed decisions; and failure to explain to these women the various family planning methods and options at their disposal.⁸⁸

The petitioners allege that the forced sterilisation violated constitutional rights of the victims, including the right to life, right to equality and freedom from non-discrimination, right to human dignity and freedom and security of the person. In light of this, the petitioners' cases seek, among others, a declaration of the violation of rights and an order directing respondents to put in place guidelines, measures and training for health care providers and social workers regarding informed consent. In addition, the petitioners request orders directing the introduction of a seven-day waiting period between the obtaining of consent and the commencement of the procedure and the issuance of a circular by the Ministry of Health that this practice of forced sterilisation is not government policy.⁸⁹

The cases were significantly delayed due to inordinate court delays and other difficulties occasioned by the COVID-19 pandemic. However, a judgement was delivered on 16 December 2022 in favour of the petitioners. In reaching this conclusion, the High Court held that a healthcare provider has a duty to ensure that patients who present themselves for treatment at health facilities must be informed of medical procedures that are to be

⁸⁷ *SWK and 5 others v Attorney General* Petitions 605 and 606 of 2014.

⁸⁸ *Ibid.*

⁸⁹ *Ibid.*

conducted on them, including the possible outcomes. In addition, the Court also noted the intersection of vulnerabilities faced by women living with HIV and found that due to their HIV status, these women are often compelled to make the wrong decisions on reproductive health due to stigma and fear.⁹⁰

In Uganda, UGANET are in the initial stages of developing a litigation strategy for cases relating to forced sterilisation. These cases concern the forced sterilisation of four HIV-positive women. The third petitioner underwent a caesarean section that resulted in a still birth. However, when she later tried to conceive again, the petitioner underwent a medical examination where she found out that she had been forcibly sterilised without her consent, as the doctor who performed the caesarean section allegedly deemed her unfit to have children because of her HIV-positive status.⁹¹

3.2. Themes Emerging from Potential Cases

Read jointly, both 2017 and 2018 meetings revealed three main general themes and inherent challenges in respect of developing a successful litigation case on forced sterilisation.

First of these themes is the extent, meaning and utility of art 14 of the Maputo Protocol. While recognised as an important entry point in litigating against forced sterilisation, art 14 is not without conceptual and drafting challenges. Firstly, these provisions pertain to reproductive autonomy, rather than sexual autonomy. Additionally, the wording of these provisions reveal an overemphasis of medical interpretation rather than human rights focus. While this may be remedied through a holistic reading of the Protocol (including arts 2, 3 and 4), drafting art 14 by way of medical understandings leaves potential victims legally exposed in making their claims.

A second emerging theme is the need for a holistic approach in developing effective strategic litigation suits on forced sterilisation. As noted in the ISLA-convened 2018 meeting, one of the reasons behind the successful decision in *Government of the Republic of Namibia v LM and Others* was due to the pre-trial research detailing the lived experiences of the women victims which mobilised civil society and embedded the issue within the wider society.

Effective post-case strategies have numerous benefits. Firstly, they are a helpful buffer against litigation fatigue since they catalyse mobilisation among the civic society and public engagement through media traction. Additionally, these strategies are able to facilitate and maintain continued donor support throughout the lengthy process of litigation.

The third emerging theme is the need for collaboration among stakeholders. In the

⁹⁰ Kelin Kenya, 'Press Release' (16 December 2022) <https://www.kelinkenya.org/after-an-8-year-wait-for-the-first-time-ever-the-court-rules-that-the-forced-sterilization-of-a-woman-living-with-hiv-is-discriminatory/>

⁹¹ ISLA Meeting Report (2017) (note 5 above).

August 2018 meeting, participants proposed the need for a collaborative space to provide support for legal and medical research; have access to available practical support in cases (for instance, intervention as amicus); and to encourage continental action on tackling the practice of forced sterilisation.

4. Barriers to Litigating Forced Sterilisation in Africa

Despite its obvious utility, FSL is often hampered by a number of substantive and procedural barriers, including poor access to information about court cases; limitations regarding who can institute a case before court ('standing' issues); short time-limits for instituting court cases; inhibitive costs and financial risk involved in litigation and the limited culture of using public interest litigation.⁹²

Some of these procedural and substantive barriers are discussed in more detail below. It is important to note from the onset that these findings were drawn from an in-depth seminar conducted by ISLA in 2017 and 2018 and which included participation from feminist litigators from Africa.

4.1. Legal Hurdles

4.1.1. Standing and Content of Suits

Standing in legal proceedings pertains to who can bring a legal challenge in court for purposes of public interest litigation.⁹³ In this context, standing may only be given where 'the person must be directly affected by the matter; which means that the petitioner must have a reasonable concern or be able to express such a concern "genuinely" on the part of a section of the public which he seeks to represent'.⁹⁴

However, more promisingly, other jurisdictions have expanded this test to include a class of people whose rights would have been prejudiced by the impugned actions. In *Open Door and Dublin Well Woman v Ireland*,⁹⁵ the ECtHR accepted that the victim status was met by individual women challenging an injunction because they belonged to a class of women which risked being directly prejudiced by it, even though in the circumstances they were not affected by it. Additionally, shifting positions on standing may cause substantial challenges for possible intervention by NGOs as part of strategic

⁹² S Bukani 'Feminist Strategic Litigation as a Tool for Confronting Gendered Exclusion and Sentencing' (2021) <<https://africanfeminism.com/feminist-strategic-litigation-as-a-tool-for-confronting-%e2%80%8b%e2%80%8bgendered-exclusion-and-silencing/>>.

⁹³ L Chidzuza & PN Makiwane 'Strengthening Locus Standi in Human Rights Litigation in Zimbabwe: An analysis of the Provisions in the New Zimbabwean Constitution' (2016) 19 PER / PELJ 1 DOI <http://dx.doi.org/10.17159/1727-3781/2016/v19i0a742/>

⁹⁴ For more discussion, see C Petricca-Riding 'When demonstrating sufficient interest makes legal standing meet capacity' (2020) *The Estates Gazette*.

⁹⁵ *Open Door and Dublin Well Woman v Ireland* [1992] ECHR 68.

litigation. Similar positions have been adopted in selected African jurisdictions such as in art 258 of the Constitution of Kenya, 2010.⁹⁶

Additionally, some jurisdictions lack clear laws guiding public Interest litigation. Survivors of forced sterilisation are therefore often torn between settling for acceptable but less effective procedures to addressing violations on the one hand and approaches that would most likely result in more client-centred remedies on the other.⁹⁷

4.1.2. Client Management

Litigants may sometimes participate in cases based on unmanageable expectations. In its 2017 capacity-building meeting with feminist litigators on forced sterilisation in Africa, ISLA collated views from its participants who noted, among others, the difficulty in managing the needs and expectations of complainants: threats on the right to privacy; fear of state reprisals; backlash and lack of commitment from both victims and lawyers; fear of cross-examination and having personal lives interrogated.

Other challenges include fear of exposure that comes with litigation; fear from reprisals from the state, the police in particular; the perception of the law as elitist and removed from every day people's lived realities; concerns around what happens when the family or community rejects you post litigation; a misunderstanding of the process of strategic litigation; the issue of liability for costs and damages; clients' interests v litigators' interests; the benefits that accrue to the client; system failure; and backlog of cases.

4.1.3. Inadequate Laws to support the framing of rights violations

The participants at the said ISLA capacity-building session further indicated that some African jurisdictions lack comprehensive laws on human rights framing before the courts.

In Uganda, for example, it was noted that failure of the Ugandan Constitution, which is the supreme law of the land, to provide for SRHR perpetuates legal challenges on grounds of justiciability, with lawyers having to have recourse to international and regional instruments to litigate on issues of forced sterilisation.

In some instances, lawyers have had to rely on other rights including the right to protection from inhumane and degrading treating under art 24 of the Ugandan Constitution⁹⁸ and the right to privacy under art 27 to enforce SRHR.⁹⁹

This lack of express provision in the Constitution has undermined enforcement of these rights because there is no guarantee of direct application of international treaties due to the nature of dualism in Ugandan justice system, which requires domestication of treaties before they can be considered as part of Ugandan laws.

⁹⁶ Constitution of Kenya (2010).

⁹⁷ du Toit (note 27 above).

⁹⁸ Constitution of the Republic of Uganda (1995) art 24.

⁹⁹ Ibid art 27.

4.1.4. Restrictive Legal Time Limits for Commencement of Action

The legal time limit for making a claim or appealing a decision varies depending on area of law. In the context of public Interest litigation, the applicable time limits pose challenges to judicial enforcement of rights. Intervening is equally subject to time constraints, with organisations which are desirous of intervening unable to act if they are barred by time.

In most jurisdictions, a three-month period is prescribed for judicial review proceedings.¹⁰⁰ The challenge must be brought within three months of the decision or omission being made. This short deadline means that it is very difficult for organisations, communities or individuals who wish to challenge a public decision to obtain a legal opinion, organise legal action, raise funds or obtain legal aid in time.

4.1.5. Framing Remedies

In some instances, lawyers are not equipped with the skills relevant to determine and frame the remedies responsive to cases of forced sterilisation. For example, the mode of calculation of damages and the nature of documents to support claims for damages are often not well-thought out. This impacts negatively on the quantifications of damages for victims of forced sterilisation.

Applicable rules remain unclear on whether out-of-court amicable settlements and other interim measures are available and are appropriate remedies as most jurisdictions do not provide such remedies in national laws.

Public interest litigation lawyers are also often torn between following judicial precedent regarding appropriate remedies and breaking the barriers of precedent to explore remedies that are more responsive to the needs of survivors of forced sterilisation. Thus, determining what qualifies as an appropriate remedy becomes a taxing issue for public interest litigation lawyers, especially in cases where a proposed remedy may not align with the immediate needs of the client.

4.1.6. Costs and Financial Risk

This is one of the most pronounced hindrances to public interest litigation.¹⁰¹ Many litigants shy away from instituting cases due to the exorbitant legal costs attached to the process. Some of these costs include court fees and the costs of preparing and printing documents for the court; full or partial liability for the other parties' expenses, depending on whether expenses are capped by the court; fees for legal advice and representation; and the internal resources required for an organisation to take a case

¹⁰⁰ See, for example, Promotion of Administrative Justice Act 3 of 2000 (South Africa); Fair Administrative Action Act, 2015 (Kenya).

¹⁰¹ M Snowden & J Cormack (n 10).

(such as research, victim support, liaison with legal representatives, communications and policy work).

Even in cases where legal aid has been enunciated in the law, more often than not, this legal aid is confined to solely criminal cases. government legal aid service provisions have not yet extended to public interest litigation cases. In addition to these costs, organisations must also weigh the risk of liability for the expenses of the other party in the event that the case is unsuccessful.

4.2. Contextual Hurdles

4.2.1. Patriarchal Court System and Social Norms

Public interest litigation on women's rights is also hampered by rigid social norms that influence how society, including courts and litigants, perceive women's rights issues. In contexts where some acts of violence against women are normalised, tolerated and generally accepted, effective judicial enforcement of women's rights remains difficult.

In analysing the limitations placed by a male court, male constructed social norms and male-conceived judicial standards in litigating sexual and reproductive health issues including forced sterilisation, Fudge notes that situations of a male dominated judiciary and society perpetuate substantial stereotypes against women, which, in turn, obscures the dangers of paternalism such as acceptance of decision making on behalf of seemingly helpless women to protect them from having children.¹⁰²

4.2.2. Documentation and Record Keeping

Due to length of time between the impugned incident and institution of a case on forced sterilisation (up to seven years or more),¹⁰³ it is sometimes difficult to collate all the necessary documentation required to institute a suit.¹⁰⁴ Lack of documentation invariably affects the collection of evidence to adduce in court in order to pass the set test of sufficient evidence for the issues under consideration.

¹⁰² Fudge (n 11).

¹⁰³ *SWK and 5 others v Attorney General* (note 87 above).

¹⁰⁴ Tamale (note 11 above).

5. Opportunities and Recommendations

FSL in the context of forced sterilisation remains a pressing issue among feminist advocates in the continent. While being cognizant of these challenges, we nonetheless propose the following recommendations.

5.1. Organisational Structuring

5.1.1. Preparatory Steps

In instituting an FSL strategy, an organisation must take note of several critical areas, including, how do we prove that the violations occurred? what is the legal test for each of the rights allegedly violated? e.g., discrimination, torture, privacy etc; what are the legal arguments? what kind of evidence should we adduce? (the language in the constitution may be different, but advocates have to think creatively around the provisions to apply to each case. International human rights instruments, even when not domesticated, can offer clarity on the scope and meaning of rights as provided for in the various national constitutions).

5.1.2. Documentation and Client Selection

In addition, one must take note of the documentation at hand. Documentation is an important and necessary element in the overall struggle of any social movement. It captures the complexity of historical process and social change, and it is based on thorough documentation that people and movements can reflect and learn.¹⁰⁵

Since poor documentation hampers feminist activism in general,¹⁰⁶ it is important to consider what we document and how we do it to build evidence demonstrating states' failure to adhere to their duties/obligations. It is critical to create a parallel system that will help us in instances where the state systems fail to systematically document dates, times and incidences of violation.

It is also important to identify and work with clients who are committed to the process of litigation. Clients should be committed to the case and prepared to see it through; willing to take on the challenge of what is at stake; have locus standi to institute action and voluntarily participate in the case.

¹⁰⁵ Ibid.

¹⁰⁶ Ibid.

5.2. Increased Collaboration Through a Sexual and Reproductive Health Network

One of the key recommendations emerging from the 2018 meeting was the formation of a SRHR network comprising stakeholders working in this context. This proposed network has several benefits. Firstly, this network can provide support for legal and medical research and can intervene as amicus while fostering continent-wide advocacy efforts in tackling the practice of forced sterilisation.

Additionally, a network of lawyers' working on SRHR cases would also strengthen ways in which to identify potential clients which would hopefully result in an increase of legal claims in respect of forced sterilisation. Since then ISLA has implemented this recommendation by working with its partners to develop an online collaborations platform Let Us Collaborate(LuC) <https://letuscollaborate.org/> This is a platform designed to support collaborations, coalitions, networks and collectives that work on women's rights and sexual rights in Africa.

Tied to the above is the need to identify peers from whom an organisation can draw collaborative efforts. There are various ways that organisations can contribute to public interest litigation without being party to a case. Getting a case to court often involves a collaborative effort and vital work by organisations. This entails informing rights-holders of their rights so they are able to identify breaches, identifying the available remedies at the disposal of survivors, recognising systemic issues and identifying potential test cases, research and evidence gathering, providing support to an individual instituting a case, providing a witness statement or affidavit to a party to a case and contributing financially to the litigation process.

Further to this, it is important for parties involved in the cause of addressing forced sterilisation to facilitate peer support and learning on issues of public interest litigation. This may encompass facilitating support, training and providing information/resources on aspects of effective public interest litigation. Particular aspects in this regard may include managing publicity and communications and advocating for changes to legislation, policy and practice.

5.3. Capacity-Building and Judicial Decision-Making

Feminist legal scholars must also take advantage of the growing paradigm shift in most jurisdictions towards integration of human rights perspectives in varied judicial proceedings, as in, Malawi, where Sikwese observes that:

The Industrial Relations Court has been able to improve court access to court by disadvantaged persons, including women, by considering cases from a human rights perspective and maintaining the supremacy of substance/facts over technicality. A case should not fail because of a technicality, it is the substance of

the matter which is critical. Judges ought to prioritise facts and not make decisions in a vacuum when issues of human dignity are at stake.¹⁰⁷

Collated efforts must also be made to engage feminist lawyers in training workshops on filing and sustaining strategic litigation suits. Good practices may be drawn from the bi-annual Feminist Litigation Institute convened by ISLA.

5.4. Conclusion

Forced sterilisation raises serious human rights concerns, particularly regarding the right to bodily integrity, health, privacy, family life and non-discrimination.¹⁰⁸ The WHO has aptly emphasised in its guidelines on Medical Eligibility Criteria for Contraceptive Use that '[g]iven that sterilisation is a surgical procedure that is intended to be permanent, special care must be taken to assure that every client makes a voluntary informed choice of the method'.¹⁰⁹

Public interest litigation is a core element of any democratic society based on the rule of law which aims to recognise and protect human rights. It is an essential tool in keeping public decision-making in check, guaranteeing the enforcement of human rights in our society and ensuring that those whose voice might otherwise not be heard have access to justice.¹¹⁰ While public interest litigation efforts in respect of sexual and reproductive health is relatively new, legal advocacy for women-friendly legislation goes back several decades in post-independent Africa.

However, the use of strategic action litigation is relatively new and faces practical, cultural and resource-related barriers.¹¹¹ It is important that African feminists continue to deepen and enhance their knowledge and skills on the use of law to challenge the historically disadvantaged positions in which women find themselves.

It is these disadvantaged positions that render women vulnerable to acts of violence including forced sterilisation. FSL is by far one of the most important legal innovations in the advancement of women's rights and social justice.

Throughout this text, we have attempted to contribute to the existing body of knowledge on the legal framework galvanizing claims against forced sterilisation as an atrocious and unacceptable violation of women's rights and an act that debases and erodes the bodily integrity of women.

In the final part of this paper, we wish to reiterate that while legal avenues are not a panacea for gender inequality, the law remains a central plank in this struggle as it acts

¹⁰⁷ Sikwese (n 37).

¹⁰⁸ Amnesty International, European Institutions Office (note 72 above).

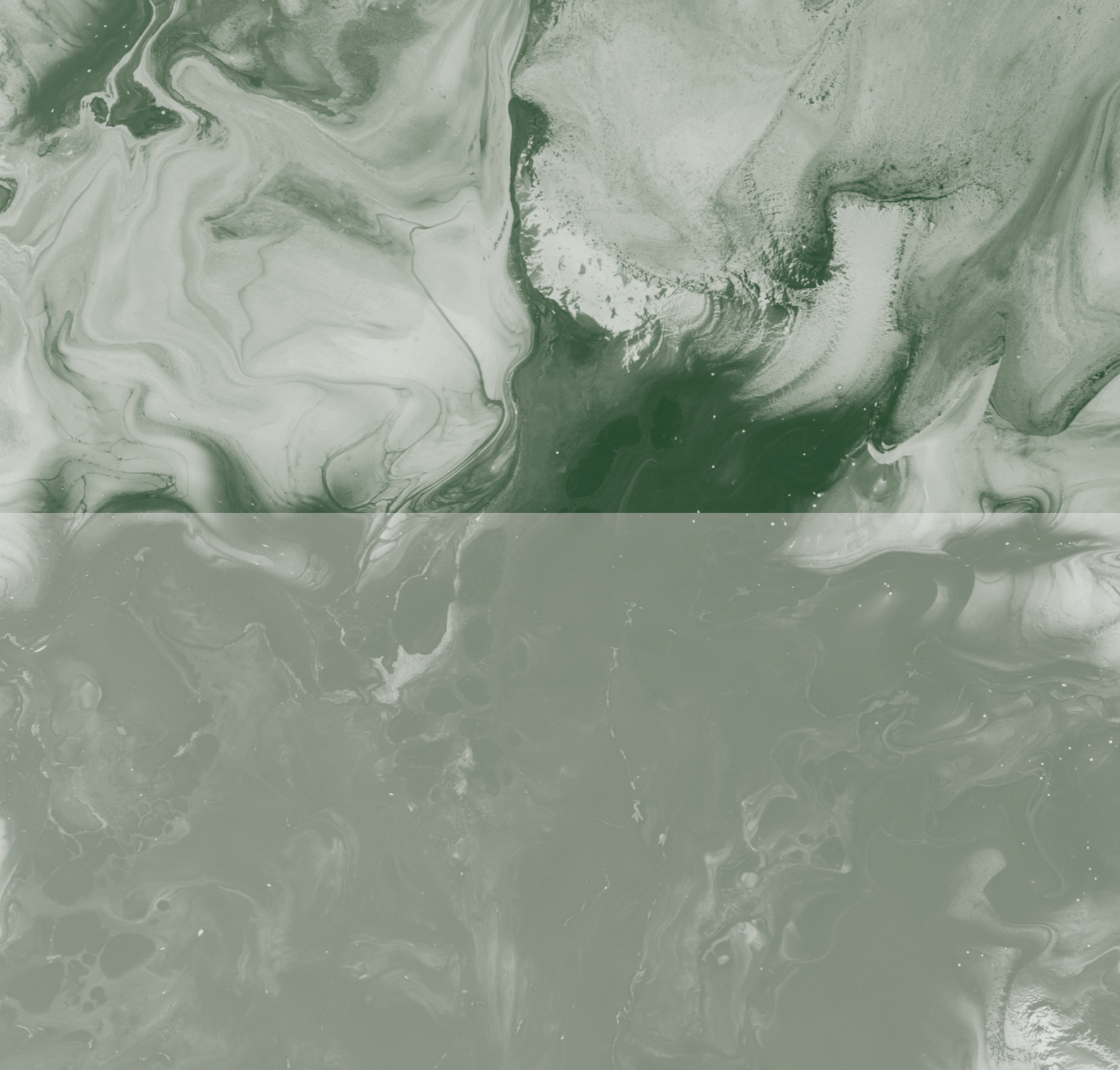
¹⁰⁹ WHO 'Medical eligibility criteria for contraceptive use' (2015) <<https://www.who.int/publications/i/item/WHO-RHR-15.07>>.

¹¹⁰ Snowden & Cormack (note 100 above).

¹¹¹ Tamale (note 11 above).

both as a shield and sword. It is a shield in the sense that it protects women against discrimination and the violation of their fundamental rights. As a sword, it challenges and overturns unjust sexist practices which results in fundamental changes to the status quo. It is to be conceded that law is far from being a magic bullet. Nonetheless, it can be a critical game changer in the gender political landscape.¹¹²

¹¹² Ibid.



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