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CONSTITUTIONAL
HUMAN RIGHTS

REPUBLIC OF KENYA
IN THE HIGH COURT OF KENYA AT NAIROBI
CONSTITUTIONAL AND HUMAN RIGHTS DIVISION
PETITION NO. 606 OF 2014

IN THE MATTER OF THE ENFORCEMENT OF THE BILL OF RIGHTS UNDER ARTICLE 22(1) OF THE CONSTITUTION OF KENYA (2010)

AND

IN THE MATTER OF ALLEGED CONTRAVENTION OF FUNDAMENTAL RIGHTS AND OF ARTICLES 19, 20, 21, 22, 25, 27, 28, 29, 31, 33, 35, 43, 45 AND 46 OF THE CONSTITUTION OF KENYA

BETWEEN

L.A.W...1ST PETITIONER
KENYA LEGAL & ETHICAL ISSUES
NETWORK ON HIV & AIDS (KELIN)..2ND PETITIONER
AFRICAN GENDER & MEDIA
INITIATIVE TRUST (GEM)...3RD PETITIONER

VERSUS

MARURA MATERNITY NURSING HOME................................1ST RESPONDENT
COUNTY EXECUTIVE COMMITTEE
MEMBER INCHARGE OF HEALTH SERVICES
(NAIROBI COUNTY)...2ND RESPONDENT
CABINET SECRETARY MINISTRY OF HEALTH..........................3RD RESPONDENT

AND

SECRETARIAT OF THE JOINT UNITED NATIONS
PROGRAMME ON HIV/AIDS (UNAIDS SECRETARIAT)...............AMICUS CURIAE

EMEA 104111578

AMICUS CURIAE SUBMISSIONS

The Joint United Nations Programme on HIV/AIDS ("**UNAIDS**") is an innovative partnership comprising the UNAIDS Secretariat and eleven United Nations ("**UN**") system organisations (the "**UNAIDS Co-sponsors**").[1] It was established in 1994 under UN Economic and Social Council Resolution 1994/24, which, *inter alia*, tasks UNAIDS with the following objectives:

a) To provide global leadership in response to the HIV/AIDS epidemic;

b) To achieve and promote global consensus on policy and programmatic approaches;

c) To strengthen the capacity of the UN System to monitor trends and ensure that appropriate and effective policies and strategies are implemented at the country level;

d) To strengthen the capacity of national governments to develop comprehensive national strategies and implement effective HIV/AIDS activities at the country level;

e) To promote broad-based political and social mobilization to prevent and respond to HIV/AIDS within countries, ensuring that national response involves a wide range of sectors and institutions; and

f) To advocate greater political commitment in responding to the epidemic at the global and country levels, including the mobilization and allocation of adequate resources for HIV/AIDS related activities.

The UNAIDS Secretariat is a global expert on the HIV epidemic and the response to it. It benefits from the expertise and resources of its Cosponsors, as well as that of a wide range of government, civil society and private sector advisors, academics, professionals and practitioners from across the globe with experience and interest in the fields of HIV, public health and human rights. UNAIDS aims to lead and inspire the world in achieving universal access to HIV prevention, treatment, care and support. The vision of UNAIDS is "Zero new HIV infections, Zero discrimination and Zero AIDS-related deaths".[2]

The UNAIDS Secretariat has gathered considerable information on effective HIV prevention policies and programmes, emphasizing in particular human rights and

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[1] The eleven UNAIDS Cosponsors are: the Office of the United Nations High Commissioner for Refugees ("UNHCR"); the United Nations Children's Fund ("UNICEF"); the World Food Programme ("WFP"); the United Nations Development Programme ("UNDP"); the United Nations Population Fund ("UNFPA"); the United Nations Office on Drugs and Crime ("UNODC"); the United Nations Entity for Gender Equality and the Empowerment of Women ("UN Women"); the International Labour Organization ("ILO)"; the United Nations Educational, Scientific and Cultural Organization (UNESCO); the World Health Organization ("WHO"); and the World Bank. The present submission is made solely on behalf of the UNAIDS Secretariat.

[2] UNAIDS. *UNAIDS 2016-2021 Strategy. On the Fast-Tack to end AIDS*. Geneva, 2015.

public health norms relating to non-discrimination, security, privacy, autonomy and informed consent as critical to the response to HIV, including in the context of efforts to address mother to child transmission of HIV.

The UNAIDS Secretariat takes no position regarding the outcome of these proceedings. The exclusive purpose of the present *amicus curiae* submission is to ensure that the Court is fully appraised of:

a) The international human rights standards and public health guidance regarding access to HIV and sexual and reproductive health services for women living with HIV;

b) The significance of informed consent as a fundamental international human rights standard and public health recommendation; and

c) The importance of rights-based approaches and enabling environments (including, in particular, effective protection of informed consent) in supporting access to and uptake of HIV prevention, treatment and care services.

The UNAIDS Secretariat's position is as follows:

a) First, international public health and human rights standards are relevant to the proceedings. It is thus of importance that the court is fully appraised of the relevant standards. Kenya has committed itself to international human rights obligations which are critical to the present proceedings. Kenya and other UN Member States have also committed themselves to respect, protect and fulfil the human rights of those living with, at risk of, and affected by HIV, including women living with HIV. UNAIDS' recommendations relating to critical HIV-related legal and human rights issues, such as informed consent to HIV prevention and treatment services, provide normative guidance to support all countries, including Kenya, in fulfilling their human rights obligations in the context of HIV.

b) Second, involuntary sterilisation violates basic human rights, guaranteed under several relevant human rights treaties. It is contrary to best available and evidence-informed public health recommendations for responding to the HIV epidemic.

c) Third, rights-based approaches based, among others, on the protection of autonomy and informed consent to HIV prevention and treatment services are most effective in advancing women and children's health in the context of HIV.

I. ARGUMENT

A. INTERNATIONAL PUBLIC HEALTH AND HUMAN RIGHTS STANDARDS ARE RELEVANT TO THE PROCEEDINGS

I) The applicability of international human rights law to the proceedings

The applicability of international law in the domestic legal system of Kenya is outlined in the Constitution of Kenya (2010) (the "**Constitution**") under articles 2(5) and 2(6). Article 2(5) of the Constitution states: "The general rules of international law shall form part of the law of Kenya." Article 2(6) states: "Any treaty or convention ratified by Kenya shall form part of the law of Kenya under this Constitution".

Under the Constitution, courts have held that international law forms an integral part of Kenyan law and can be invoked in legal disputes in Kenya. The High Court in *Wanjiku & Another v the Attorney General & Others* held that articles 2(5) and 2(6) of the Constitution left no doubt "that international law is applicable in Kenya."[3] **In *Barasa v the Cabinet Secretary Ministry of Interior and National Coordinator and Others***, the High Court stated: "It is beyond argument that Kenya, being a member of the United Nations and in its co-existence with others in the comity of nations, recognizes international laws, treaties and conventions, particularly those that have been ratified by her."[4]

The courts of Kenya have explicitly ruled that international human rights norms guaranteed under Kenya's international legal obligations are justiciable to the extent that they do not directly conflict with the Constitution. The High Court in *Wanjiku & Another v the Attorney General & Others* stated that:

> I would also draw on the authority of Article 19(3) which is part of the Bill of Rights that recognizes other rights other than those protected by the Bill of Rights provided they are not inconsistent with the Constitution. These rights would be founded not only on specific statutes but also international treaties and conventions.[5]

Rights-based and evidence-informed policies and recommendations provided by international organisations, such as UNAIDS and the World Health Organisation ("**WHO**"), constitute normative guidance that assist UN Member States, including Kenya, in fulfilling their international human rights obligations. UNAIDS' guidance to countries are based on nearly 40 years of experience and practice in supporting the

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[3] *Wanjiku & Another v the Attorney General & Others*, Petition No. 190 of 2011, High Court at Nairobi, [2012] eKLR, para 18.
[4] *Barasa v the Cabinet Secretary Ministry of Interior and National Coordinator and Others*, Constitutional Petition No. 488 of 2013, High Court at Nairobi, [2014] eKLR, para 44.
[5] *Wanjiku & Another v the Attorney General & Others*, Petition No. 190 of 2011, High Court at Nairobi, [2012] eKLR, para 21.

development of the most effective responses to addressing the HIV epidemic. This experience has demonstrated that for HIV responses to be effective, they must be grounded in the respect of human rights. As stated in the *International Guidelines on HIV/AIDS and Human Rights*:

> The protection of human rights is essential to safeguard human dignity in the context of HIV and to ensure an effective, rights-based response to HIV and AIDS. An effective response requires the implementation of all human rights, civil and political, economic, social and cultural, and fundamental freedoms of all people, in accordance with existing international human rights standards.[6]

The importance of human rights to effective HIV responses was reiterated in the *2016 Political Declaration on HIV and AIDS* adopted by all UN Member States including Kenya in June this year:

> the promotion and protection of, and respect for, the human rights and fundamental freedoms of all, including the right to development, which are universal, indivisible, interdependent and interrelated, should be mainstreamed into all HIV and AIDS policies and programmes.[7]

II) Involuntary sterilisation violates human rights norms

Human rights norms are particularly relevant to the proceedings, notably the rights to non-discrimination, privacy, security, dignity, freedom from torture, cruel, inhuman and degrading treatment, and to health. These human rights norms are provided under global and regional treaties to which Kenya is a party. Involuntary sterilisation has been shown to violate these global and regional treaties.

Involuntary sterilisation violates the right to health

Several international and regional human rights treaties guarantee the right to health, including the International Covenant on Economic, Social and Cultural Rights, which guarantees "the enjoyment of the highest attainable standard of physical and mental health." [8] The U.N. Committee on Economic, Social and Cultural Rights,

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[6] International guidelines. page 16, http://www.ohchr.org/Documents/Publications/HIVAIDSGuidelinesen.pdf

[7] Political declaration on AIDS 2016, para 5, available at http://www.unaids.org/sites/default/files/media_asset/2016-political-declaration-HIV-AIDS_en.pdf

[8] International Covenant on Economic, Social and Cultural Rights art. 12(1), Dec. 16, 1966, 993 U.N.T.S. 3; Convention on the Rights of the Child art. 24(1). Nov. 20. 1989, 1577 U.N.T.S. 3, *See also* Convention on the Elimination of All Forms of Discrimination Against Women arts. 11(1)(f). 12. Dec. 18. 1979, 1249 U.N.T.S. 13; G.A. Res. 217 (III) A, Universal Declaration of Human Rights art. 25(1) (Dec. 10. 1948)]: European Social Charter art. 11. Oct. 18. 1961. 529 U.N.T.S. 89: Convention on the Elimination of Racial Discrimination art. 5(e)(iv). Dec. 21. 1965. 660 U.N.T.S. 195: African Charter on Human and Peoples' Rights art. 16. June 27. 1981. 1520 U.N.T.S. 217: Additional Protocol to the American Convention on Human Rights in the Area of Economic. Social and Cultural Rights ("Protocol of San Salvador") art. 10. Nov. 17. 1988. OAS Doc. OAS/Ser.L/V/I.4 rev. 13; Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa art. 14, Sept. 13, 2000. OAU Doc. CAB/LEG/66.6; Convention on the Rights of Persons with Disabilities art. 25. March 30, 2007. 2515 U.N.T.S. 3.

which monitors state compliance with the International Covenant on Economic, Social and Cultural Rights, has explained that the right to reproductive health is "an integral part of the right to health" and includes "the right to make free and responsible decisions and choices, free of violence, coercion and discrimination, over matters concerning one's body and sexual and reproductive health."[9]

Article 16 of the African Charter on Human and Peoples' Rights ("**ACHPR**"), which covers the right to the highest attainable standard of health, protects every person's right to receive appropriate health care services.[10] In addition, Article 14 of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa adopted in Maputo, Mozambique in 2000 (the "**Maputo Protocol**") stipulates that: "States Parties shall ensure that women's right to health, including sexual and reproductive health is respected and promoted".[11]

General Comment No. 2 of the African Commission on Human and Peoples' Rights on the Maputo Protocol sets forth that "the training of health workers should include non-discrimination, confidentiality, respect for the autonomy and free and informed consent of women and girls"[12] and that:

> State parties should take all appropriate measures, through policies, sensitization and civic education programs, to remove all obstacles to the enjoyment by women of their rights to sexual and reproductive health. Specific efforts should especially be made to address gender disparities, patriarchal attitudes, harmful traditional practices, prejudices of health care providers, discriminatory laws and policies, in accordance with Articles 2 and 5 of the Protocol."[13]

Women's rights to health include the right to control their fertility and the right to choose any method of contraception. Article 14 of the Maputo Protocol, as well as the Convention on the Elimination of All Forms of Discrimination Against Women ("**CEDAW**"), emphasizes the rights of women to make informed decisions about their reproductive health and it especially stresses the right to retain their fertility.[14] This includes the right to provide or withhold informed consent to medical treatment.

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[9] Comm. on Economic, Social and Cultural Rights General Comment No. 22, para. 1, 5, U.N. Doc. E/C.12/GC/22 (Advanced Unedited Version) (March 4, 2016).

[10] African (Banjul) Charter on Human and People's Rights, (OAU Doc. CAB/LEG/67/3 rev. 5, 21 I.L.M. 58), adopted 27 June 1981, 1982, entered into force 21 October 1986, Article 16.

[11] Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, (CAB/LEG/66.6), adopted by the 2nd Ordinary Session of the Assembly of the Union, Maputo, 2000, reprinted in 1 Afr. Hum. Rts. L.J. 40, entered into force Nov. 25, 2005, Article 14.

[12] Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, (CAB/LEG/66.6), adopted by the 2nd Ordinary Session of the Assembly of the Union, Maputo, 2000, reprinted in 1 Afr. Hum. Rts. L.J. 40, entered into force Nov. 25, 2005, article 14, para 58.

[13] The Protocol to the African Charter of Human and Peoples' Rights on the Rights of Women in Africa, "General Comment No. 2 on Article 14 .1 (a) (b) (c) and (f), and Article 14. 2 (a) and (c)", 2014.

[14] Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, (CAB/LEG/66.6), adopted by the 2nd Ordinary Session of the Assembly of the Union, Maputo, 2000, reprinted

Human Rights law mandates that informed consent is a prerequisite for *any* medical intervention. The essential elements of informed consent are reflected in health care laws and standards, in ethical codes, and in human rights law. The right of access to health-related information is an essential component of the right to health and a component of the right to informed decision-making.[15] The UN Committee on Economic, Social and Cultural Rights has emphasized that health-related information, like all other health services, must be available, accessible, acceptable, and of good quality.[16] The CEDAW Committee similarly recognizes the importance of health-related information for women, especially in the reproductive health context.[17] Under CEDAW Article 16(1)(e), states must ensure that women and men alike have "the same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights".[18]

The CEDAW Committee, in interpreting the right to health in its General Recommendation 24, provides basic elements to informed consent; it notes that states should ensure women's "right to be fully informed, by properly trained personnel, of their options in agreeing to treatment or research, including likely benefits and potential adverse effects of proposed procedures and available alternatives."[19] CEDAW has noted in its General Recommendation 24 that "acceptable services are those that are delivered in a way that ensures that a woman gives her fully informed consent, respects her dignity, guarantees her confidentiality and is sensitive to her needs and perspectives. State parties should not permit forms of coercion, such as non-consensual sterilization, that violate women's rights to informed consent and dignity"[20]

General Comment 22 on sexual and reproductive health to the CESČR adopted by the UN Committee on Economic, Social and Cultural Rights repeatedly condemns practices of forced and coerced sterilisation, including against women and girls belonging to vulnerable populations, and calls on states to take legal and policy

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in 1 Afr. Hum. Rts. L.J. 40, entered into force Nov. 25, 2005. Article 14; CEDAW Convention, articles 10(h), 12, 16. Convention on the Elimination of all forms of Discrimination Against Women, General Recommendation No. 24, para. 28, U.N. Doc. A/54/38/Rev.1 (1999) (interpreting art. 12).

[15] Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, H.R. Council, para. 40, U.N. Doc. A/HRC/7/11 (Jan. 31, 2008) (by Paul Hunt); *see also* Comm. on Economic, Social and Cultural Rights General Comment No. 14, *supra* note 10, para. 1.

[16] Comm. on Economic, Social and Cultural Rights General Comment No. 14.

[17] *See* CEDAW, art. 16(1)(e) (guaranteeing women the right to access to information in order to "decide freely and responsibly on the number and spacing of their children") & art. 10(h); Comm. on the Elimination of Discrimination Against Women, General Recommendation No. 24, para. 28, U.N. Doc. A/54/38/Rev.1 (1999) (interpreting art. 12).

[18] CEDAW, art. 16(1)(e).

[19] Comm. on the Elimination of Discrimination Against Women, General Recommendation No. 24, para. 20 (interpreting art. 12).

[20] Comm. on the Elimination of Discrimination Against Women, General Recommendation No. 24, para. 22, U.N. Doc. A/54/38/Rev.1 (1999) (interpreting art. 12).

measures to end such practices.[21] In a recent concluding observation issued on the State report presented by Namibia in relation to lack of informed consent in the context of sterilisation of HIV positive women, the Committee recommended the state party to: "implement measures for clearly defining the requirement of free, prior and informed consent with regard to sterilisation" and to "raise awareness among medical personnel of that requirement".[22]

In *A.S. v. Hungary*, the CEDAW Committee found a violation of the right to health, the right to information and to be free from discrimination where a woman was sterilized without her informed consent. The CEDAW Committee, in finding the violations, noted that the woman had a right "to specific information on sterilization and alternative procedures for family planning in order to guard against such an intervention being carried out without her having made a fully informed choice."[23]

UN human rights bodies have issued numerous concluding observations on forced or coerced sterilisation, including in the context of sterilisation of HIV positive women.[24] General Comment 2 of the African Commission on Human and Peoples' Rights on Article 14 of the Maputo Protocol notes that states have specific obligations to eliminate involuntary sterilisation, including against HIV positive women:

> State parties should ensure that the necessary legislative measures, administrative policies and procedures are taken to ensure that no woman is forced because of her HIV status, disability, ethnicity or any other situation, to use specific contraceptive methods or undergo sterilization or abortion. The use of family planning/contraception and safe abortion services by women should be done with their own informed and voluntary consent. [25]

Involuntary sterilisation violates the rights to privacy, and the right to physical integrity and personal autonomy and decision-making in health care

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[21] CESCR, GC No.22 (2016), E/C.12/GC/22. 4 March 2016, paras 30, 57-59

[22] CESCR, to Namibia 2016, E/C.12/NAM/CO/1, 23 March 2016, paras 67-68

[23] The Committee also called attention to A.S.'s "state of health on arrival at the hospital and observe[d] that any counselling that she received must have been given under stressful and most inappropriate conditions." A.S. v. Hungary, Comm. on the Elimination of Discrimination Against Women, Communication No. 4/2004, para. 11.2. U.N. Doc. CEDAW/C/36/D/4/2004 (Aug. 29, 2006). Taking all of this into consideration, the CEDAW Committee found "a failure of the State party, through the hospital personnel, to provide appropriate information and advice on family planning" in violation of women's equal right to health-related information under article 10(h) of the Convention. *Id.*

[24] CEDAW to Namibia. Concluding observations (2015) CEDAW/C/NAM/CO/4-5. HRC to Namibia. Concluding observations (2016) CCPR/C/NAM/CO/2: HRC to Namibia Concluding observations (2015) CEDAW/C/NAM/CO/4-5: CESCR to Namibia. Concluding observations (2016) CCPR/C/NAM/CO/2; Concluding observations (2016) E/C.12/NAM/CO/1: CAT to Kenya CAT/C/KEN/CO/2 (2013). para. 27.

[25] ACHPR, GC 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. para 47.

The right to autonomy over reproductive health decisions is an essential aspect not only of the right to health but also of the right to privacy. The right to privacy is protected by numerous international and regional human rights treaties. Article 17 of the International Covenant on Civil and Political Rights prohibits arbitrary or unlawful interference with a person's privacy, family, home, as well as unlawful attacks on a person's honour and reputation.[26] The right to respect for privacy includes the right to personal autonomy as well as the right to physical and psychological integrity. Article 6 of ACHPR on the right to liberty and security of the person, protects every person from acts that constitute unlawful invasions of their physical integrity.[27]

Both the Inter-American Court of Human Rights and the European Court of Human Rights have established that "the rights to private life and to personal integrity are directly and immediately linked to health care,"[28] which is "violated when the means by which a woman can exercise the right to control her fertility are restricted."[29] These regional human rights courts have specifically affirmed that the protection of private life includes "respect for the decisions both to become a mother or a father, and a couple's decision to become genetic parents."[30] The European Court of Human Rights has also long held that the right to respect for private life includes the right to personal autonomy as well as the right to physical and psychological integrity.[31]

The UN Human Rights Committee has issued several concluding observations condemning the practice of involuntary sterilisation as implicating the right to privacy amongst other rights.[32] The U.N. Special Rapporteur on the right to health has explained that women have "the right to freely consent to or refuse services (including sterilisation services) that are non-coercive and respectful of autonomy, privacy and confidentiality and information provided by properly trained personnel."[33]

The European Court of Human Rights has heard several individual cases concerning involuntary sterilisation. In each case it has decided that, regardless of the circumstances of each matter, the practice of involuntary sterilisation is a violation of the right to private life as protected under the European Convention on Human

[26] International Covenant on Civil and Political Rights, adopted by the General Assembly resolution 2200A (XXI) of 16 December 1966, entered into force on 23 March 1976, Article 17.
[27] African (Banjul) Charter on Human and People's Rights, (OAU Doc. CAB/LEG/67/3 rev. 5, 21 I.L.M. 58), adopted 27 June 1981, 1982, entered into force 21 October 1986, Article 6.
[28] Artavia Murillo et al v. Costa Rica, Merits, Reparations, and Costs, Judgment, Inter-Am. Ct. H.R. (ser. C) No. 257, para. 146-147 (Nov. 28, 2012); See also, European Court of Human Rights, *NB v Slovakia Application No. 29518/10 (2012)., VC v. Slovakia Application No. 18968/07* (2011).
[29] Artavia Murillo et al v. Costa Rica *Para 146*
[30] *Id.*
[31] *See, e.g.*, Tysiaç v. Poland, App. No. 5410/03, para. 107, Eur. Ct. H.R. (2007).
[32] HRC to Czech Republic, Concluding Observation to Czech Republic, CCPR/C/CZE/CO/2 , 2007, para 10; HRC to Slovakia, Concluding Observation to Slovakia CCPR/CO/78/SVK (2003) para. 12.
[33] Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, H.R. Council, para. 45, U.N. Doc. A/64/272 (Aug. 10, 2009), para 57.

Rights.[34] The Court has noted that it "attaches weight to the existence of prior consent in the context of a patient's right to respect for his or her physical integrity. Any disregard by the medical personnel of a patient's right to be duly informed can trigger the State's responsibility in the matter."[35]

The European Court of Human Rights stated that "sterilisation constitutes a major interference with a person's reproductive health status. As it concerns one of the essential bodily functions of human beings, it bears on manifold aspects of the individual's personal integrity including his or her physical and mental well-being and emotional, spiritual and family life." The European Court of Human Rights has affirmed that imposition of medical treatment without informed consent is "incompatible with the requirement of respect for human freedom and dignity, one of the fundamental principles on which the Convention is based"[36] Sterilisation in the absence informed consent "violated the applicant's physical integrity and was grossly disrespectful of her human dignity."[37]

The resolution of the African Commission on Human and People's rights on involuntary sterilisation and the protection of human rights in access to HIV services, places a particular focus on involuntary sterilisation practices against HIV positive women.[38] The Commission has articulated the practice as a violation of numerous rights protected by the African Charter and other international human rights treaties and to particularly to the principle of autonomy. It recommends that State Parties put in place mechanisms to ensure that HIV positive women are not subject to coercion, pressure, duress or undue inducement by healthcare providers or institutions when they sign the consent for sterilisation.[39] It requires State Parties to monitor that women living with HIV are provided with all necessary information on HIV and reproductive health services in a language that they could easily understand.[40] The ACHPR also calls on states to take measures to end the practice, ensure respect in law and practice for informed consent in line with international

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[34] European Court of Human Rights. *FC v Slovakia.* Application No. 18968/07 (2011) *IG v Slovakia, and others v Slovakia.* Application no. 15966/04. (2012). *NB v Slovakia Application No. 29518/10 (2012).*

[35] *Csoma v. Romania.* App. No. 8759/05. para. 42. Eur. Ct. H.R. (Jan. 15, 2013)."[T]he Court has underlined that it is important for individuals facing risks to their health to have access to information enabling them to assess those risks." As a result "[T]he Contracting States are bound . . . to adopt the necessary regulatory measures to ensure that doctors consider the foreseeable consequences of a planned medical procedure on their patients' physical integrity and to inform patients of these consequences beforehand, in such a way that the latter are able to give informed consent." Moreover. "if a foreseeable risk of this nature materialises without the patient having been duly informed in advance by doctors. the State Party concerned may be directly liable under Article 8 for this lack of information[.]"

[36] *FC v Slovakia* Application No. 18968/07. European Court of Human Rights (August 2011)

[37] *NB v Slovakia.* Application No. 29518/10. European Court of Human Rights (December 2012)

[38] Resolution 260 on Involuntary Sterilization and the Protection of Human Rights in Access to HIV Services. adopted in Banjul. the Gambia. 2013. http://www.achpr.org/sessions/54th/resolutions/260/.

[39] *Id.*

[40] *Id.*

human rights obligations, ensure training to health care providers on the issue, and ensure accountability where violations have occurred. [41]

Six U.N. agencies—the World Health Organization, Office of the High Commissioner on Human Rights, UNAIDS, UNDP, UNICEF, UN Women, and UNFPA—issued a statement (the "**Interagency Statement**") specifically providing guiding principles for the provision and regulation of sterilisation services, so as to prevent involuntary sterilisation, including against HIV positive women. These agencies recognize the critical importance of the right to privacy and autonomy in reproductive health care decision-making, particularly in the context of sterilisation:

> *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. People should be able to choose and to refuse sterilization. Respecting autonomy requires that any counselling, advice or information given by health-care providers or other support staff or family members should be non-directive, enabling individuals to make decisions that are best for themselves, with the knowledge that sterilization is a permanent procedure and that other, non-permanent methods of fertility control are available.* [42]

The statement sets forth the components of informed consent in the context of sterilisation, including concerning HIV positive women. It is anchored in international human rights norms, and has stressed autonomous decision-making as one of its guiding principles. [43]
It notes that

> the information provided to people so that they can make an informed choice about sterilization procedures should emphasize the advantages and disadvantages, the health benefits, risks and side-effects, and it should enable comparison of various contraceptive methods. Counselling on sterilization should include the following points:
>
> - the procedure is considered to be permanent;
> - persons who may want to have a child in the future should choose a different method of contraception;
> - provision of information on alternatives, including long and short term temporary methods of contraception;
> - sterilization is a surgical intervention, and as such may entail minimum risks;
> - the person can change their mind at any time;
> - information on side effects and follow-up;
> - sterilization does not protect from HIV, other STIs or abuse; and

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[41] *Id.*
[42] World Health Organization, *Eliminating Forced, Coercive and Otherwise Involuntary Sterilization: An Interagency Statement* 9 (2014)
[43] *Ibid*, page 9

- that the decision to undergo contraceptive sterilization is a decision belonging to the individual only.[44]

The Interagency Statement specifically recommends the following to ensure autonomy and privacy:

> In obtaining informed consent, take measures to ensure that an individual's decision to undergo sterilization is not subject to inappropriate incentives, misinformation, threats or pressure. Ensure that consent to sterilization is not made a condition for access to medical care (such as HIV or AIDS treatment, ...) or for any other benefit (such as medical insurance, social assistance,...).
>
> Where women face contraindications to pregnancy, offer sterilization as one possible method from the full range of contraceptive options available. There are no legitimate medical or social indications for contraceptive sterilization.
>
> As sterilization for the prevention of future pregnancy is not a matter of medical emergency, ensure that the procedure is not undertaken, and consent is not sought, when women may be vulnerable and unable to make a fully informed decision, such as when requesting termination of pregnancy, or during labour, or in the immediate aftermath of delivery.[45]

The Interagency Statement specifically addresses the practice of involuntary sterilisation against HIV positive women, condemning the practice as a violation of human rights and medical, health and ethical standards. Noting that women living with HIV have a right to contraception and other reproductive health services on the same grounds as all other women.[46]

Involuntary Sterilisation violates the right to be from torture and cruel, inhuman or degrading treatment

The right to be free from torture and cruel, inhuman or degrading treatment is protected in many international and regional human rights treaties.[47] The UN

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[44] *Ibid*, page 11.

[45] World Health Organization, *Eliminating Forced, Coercive and Otherwise Involuntary Sterilization: An Interagency Statement* 9 (2014), page 14.

[46] World Health Organization, *Eliminating Forced, Coercive and Otherwise Involuntary Sterilization: An Interagency Statement* 9 (2014) pages 3-4.

[47] *See, e.g.*, Universal Declaration of Human Rights, *supra* note 1, art. 5 ("No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment."); International Covenant on Civil and Political Rights art. 7, G.A. Res. 2200a (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, U.N. Doc. A/6316 (1966) (entered into force Mar. 23, 1976) ("No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment."); Convention on the Rights of the Child, *supra* note 1, art. 37 ("No child shall be subjected to torture or other cruel, inhuman or degrading treatment or punishment"); European Convention for the Protection of Human Rights and Fundamental Freedoms art. 3, *adopted* Nov. 4, 1950, 213 U.N.T.S. 222 (entered into force Sept. 3, 1953) ("No one shall be subjected to torture or to inhuman or degrading treatment or punishment."); African Charter on Human and Peoples' Rights, *supra* note 8, art. 5 ("All forms of exploitation and degradation of man particularly slavery, slave trade, torture, cruel, inhuman or degrading punishment and treatment shall be prohibited."); Convention against Torture and Other Cruel, Inhuman and Degrading Treatment arts. 2, 16,

Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment ("Convention Against Torture") defines torture as "any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purpose as [...] for any reason based on discrimination of any kind [...]"[48] Article 5 of ACHPR stipulates that every individual "shall have the right to the respect of the dignity inherent in a human being". It also states that all forms of exploitation particularly cruel, inhuman or degrading punishment and treatment shall be prohibited.[49]

Similar to the ACHPR, Article 4 of the Maputo Protocol addresses the rights to life, integrity, liberty and security of every woman. [50] Article 4 sets out that:

> Every woman shall be entitled to respect for her life and the integrity and security of her person. All forms of exploitation, cruel, inhuman or degrading punishment and treatment shall be prohibited.[51]

The Committee Against Torture, which monitors state compliance with the Convention Against Torture noted in its General Comment No. 2 about the enhanced risk of torture and ill-treatment in the context of reproductive health care:

> [G]ender is a key factor. Being female intersects with other identifying characteristics or status of the person, such as race, nationality,... immigrant status etc. to determine the ways that women and girls are subject to or at risk of torture or ill-treatment and the consequences thereof. The contexts in which females are at risk include deprivation of liberty, [and] *medical treatment, particularly involving reproductive decisions* . . . .(emphasis added).[52]

The U.N. Special Rapporteur on torture has similarly stated:

> [W]omen seeking maternal health care face a high risk of ill-treatment, particularly before and after childbirth. . . . Such mistreatment is often motivated by stereotypes regarding women's childbearing roles and

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adopted Dec. 10. 1984. G.A. Res. 39/46. U.N. GAOR. 39th Sess.. Supp. No. 51. U.N. Doc. A/39/51. at 197 (1984) (entered into force June 26. 1987): Inter-American Convention on the Prevention. Punishment and Eradication of Violence Against Women art. 4(d). *adopted* June 9. 1994. 33 I.L.M. 1534 (entered into force Mar. 5. 1995); (stating that women have "[t]he right not to be subjected to torture"): Inter-American Convention to Prevent and Punish Torture. *adopted* Dec. 9. 1985. O.A.S.T.S. No. 67 (entered into force Feb. 28. 1987).

[48] Convention against Torture and Other Cruel. Inhumane or Degrading Treatment or Punishment. adopted by the General Assembly resolution 39/46 of 10 December 1984. entry into force 26 June 1987. Article 1.

[49] African (Banjul) Charter on Human and People's Rights. (OAU Doc. CAB/LEG/67/3 rev. 5. 21 I.L.M. 58). adopted 27 June 1981. 1982. entered into force 21 October 1986. Article 5.

[50] Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa. (CAB/LEG/66.6). adopted by the 2nd Ordinary Session of the Assembly of the Union, Maputo. 2000, reprinted in 1 Afr. Hum. Rts. L.J. 40, entered into force Nov. 25, 2005, Article 4.

[51] Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa. (CAB/LEG/66.6), adopted by the 2nd Ordinary Session of the Assembly of the Union, Maputo, 2000, reprinted in 1 Afr. Hum. Rts. L.J. 40. entered into force Nov. 25, 2005. Article 4.

[52] CAT Comm. General Comment No. 2, para. 22, U.N. Doc. CAT/C/GC/2CRP.1/Rev. 4 (Nov. 23, 2007) (emphasis added).

inflicts physical and psychological suffering that can amount to ill-treatment.[53]

International and regional human rights bodies have repeatedly affirmed that sterilisation without informed consent violates the right to be free from torture and cruel, inhuman or degrading treatment. These bodies include the European Court of Human Rights,[54] the African Commission on Human and Peoples' Rights,[55] the UN Committee Against Torture,[56] and the UN Human Rights Committee.[57] For example, the UN Committee against Torture in its latest review of Kenya's compliance with the Convention against Torture has raised concern over the involuntary sterilisation of HIV positive women in Kenya.[58]

In every judgment concerning involuntary sterilisation, the European Court of Human Rights has found a violation of Article 3 of the Convention, the right to be free from torture and other ill-treatment. Importantly, the European Court of Human Rights made clear that involuntary sterilisation is a violation of this right even if that was not the specific intent of the medical provider. The Court found that although there was no proof that the medical staff concerned had intended to ill-treat the women who were sterilized, they had acted with "gross disregard for her right to autonomy and choice as a patient", in violation of Article 3.[59]

The UN Special Rapporteur on Torture in his report to the UN Human Rights Council on Torture in health settings (2013), noted that "the administration of non-consensual medication or involuntary sterilization is often claimed as being a necessary treatment for the so-called best interest of the person concerned."[60] He

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[53] Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, *Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, H.R. Council, para. 47, U.N. Doc. A/HRC/31/57 (Jan. 5, 2016).

[54] I.G. and Others v. Slovakia, App. No. 15966/04, Eur. Ct. H.R. (Nov. 13, 2012); N.B. v. Slovakia, App. No. 29518/10, Eur. Ct. H.R. (June 12, 2012); V.C. v. Slovakia, App. No. 18968/07, para. 119, Eur. Ct. H.R. (Nov. 8, 2011) (finding that the woman's forced sterilization "attained the threshold of severity required to bring it within the scope of Article 3.").

[55] African Commission on Human and Peoples' Rights, *260: Resolution on Involuntary Sterilisation* (November 5, 2013), http://www.achpr.org/sessions/54th/resolutions/260 (declaring that involuntary sterilisation violates the right to freedom from torture and cruel, inhuman, and degrading treatment).

[56] *See, e.g.*, CAT Comm., Concluding Observagtions: Kenya, 2013, CAT Comm., Concluding Observations: Czech Republic, para. 12, U.N. Doc. CAT/C/CZE/CO/4–5 (2012); CAT Comm., Concluding Observations: Slovakia, para. 14, U.N. Doc CAT/C/SVK/CO/2 (2009).

[57] Human Rights Comm., Concluding Observations: Czech Republic, para. 9, U.N. Doc. CCPR/C/CZE/CO/2 (2007); Human Rights Comm., Concluding Observations: Slovakia, para. 12, U.N. Doc. CCPR/CO/78/SVK (2003).

[58] Convention against torture and other cruel and degrading treatment or punishment, *Concluding observations on the second periodic report of Kenya, adopted by the Committee at its fiftieth session* CAT/C/KEN/CO/2 para. 27 (2013).

[59] *VC v Slovakia*, Application No. 18968/07, European Court of Human Rights (August 2011) . at para 101. See also NB v Slovakia Application No. 29518/10, European Court of Human Rights (December 2012).

[60] Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, *Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, H.R. Council, U.N. Doc A/HRC/22/53 (Feb. 1, 2013), para 32.

references the International Federation of Gynaecology and Obstetrics (the "**FIGO Committee**"), which emphasize in their ethical guidelines that "sterilization for the prevention of future pregnancy cannot be ethically justified on grounds of medical emergency. Even if a future pregnancy may endanger a woman's life or health, she must be given the time she needs to consider her choice. Her informed decision must be respected, even if it is considered liable to be harmful to her health."[61] The Special Rapporteur noted that "The doctrine of medical necessity continues to be an obstacle to protection from arbitrary abuses in health-care settings [...]" The Rapporteur has noted that informed consent is "not mere acceptance of a medical intervention, but a voluntary and sufficiently informed decision."[62]

Involuntary sterilisations violates the right to non-discrimination

Historically, women have been disproportionately subjected to involuntary sterilisation due to their reproductive capacities and to strong social and cultural beliefs and stereotypes about sexuality, pregnancy and motherhood. The CEDAW Committee and other treaty bodies have recognized that sterilisation is a form of discrimination against women.[63]

This is particularly present in the health care field, because of the hierarchies found in the health care settings between providers and patients. The UN Special Rapporteur on Health has recognized this power imbalance generally, noting that states must protect the right to autonomy over medical decision as a counterweight to "the imbalance of power, experience and trust inherently present in the doctor-patient relationship."[64] General Comment 2 to the Maputo Protocol notes that efforts to eliminate gender stereotyping be especially made to address patriarchal attitudes as well as the prejudices of health care providers. [65] As referenced above, the Committee Against Torture has noted the enhanced risk of torture and ill-treatment in the context of reproductive health care, based on gender and intersecting factors.[66]

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[61] Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, *Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, H.R. Council, U.N. Doc A/HRC/22/53 (Feb. 1, 2013), para 33.

[62] Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, *Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, H.R. Council, 28, U.N. Doc A/HRC/22/53 (Feb. 1, 2013), P. 7.

[63] See, for example, A.S. v. Hungary, Comm. on the Elimination of Discrimination Against Women, Communication No. 4/2004, ¶ 11.2, U.N. Doc. CEDAW/C/36/D/4/2004 (Aug. 29, 2006).

[64] Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, H.R. Council, ¶ 45, U.N. Doc. A/64/272 (Aug. 10, 2009), para 45.

[65] ACHPR, GC 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, para 60

[66] CAT Comm. General Comment No. 2, para. 22, U.N. Doc. CAT/C/GC/2CRP.1/Rev. 4 (Nov. 23, 2007)

The UN Committee on Economic, Social and Cultural Rights in its General Comment 22 recognizes that "[t]he realization of women's rights and gender equality, both in law and in practice, requires repealing or reforming the discriminatory laws, policies and practices in the area of sexual and reproductive health. Removal of all barriers interfering with women's access to comprehensive sexual and reproductive health services, goods, education and information is required."[67]

Additionally, women often face discrimination and coercion on multiple and intersecting grounds, because they are women, live with disability or HIV and/or belong to indigenous populations or ethnic minorities.[68] The discriminatory nature of sterilisation without informed consent can thus be compounded by the intersection of gender with race, socioeconomic status, or disability, or HIV status. The UN Committee on Economic, Social and Cultural Rights General Comment 22 notes:

> "[i]ndividuals belonging to particular groups may be disproportionately affected by intersectional discrimination in the context of sexual and reproductive health. As identified by the Committee,[69] groups such as, but not limited to, poor women, persons with disabilities, migrants, indigenous or other ethnic minorities, adolescents, LGBTI persons, and people living with HIV/AIDS are more likely to experience multiple discrimination.... Measures to guarantee non-discrimination and substantive equality should be cognizant of and seek to overcome the often exacerbated impact that intersectional discrimination has on the realization of the right to sexual and reproductive health". [70]

Human rights standards recognize that women living with HIV have a right to contraception and other reproductive health services on the same grounds as all other women. For example, the Human Rights Committee, in its most recent concluding observation to a state party on the issue of involuntary sterilisation against HIV positive women, has noted the practice as a principle of area of concern for the protection of the right to non-discrimination under the ICCPR:

> 11. The Committee is concerned about the persistence of discriminatory stereotypes and deep-rooted patriarchal attitudes regarding the roles and responsibilities of women, which furthermore constitute a major cause of violence against women. It also notes with concern that: ...

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[67] Committee on Economic, Social and Cultural Rights, "General Comment No. 22", (U.N. Doc. E/C.12/GC/22), Advanced Unedited Version, March 4, 2016, para 28

[68] World Health Organization, *Eliminating Forced, Coercive and Otherwise Involuntary Sterilization: An Interagency Statement* 9 (2014)

[69] Including race and colour, sex, language, religion, political or other opinion, national or social origin, property, birth, or other status including ethnicity, age, nationality, marital and family status, disability, sexual orientation and gender identity, intersex status, health status, place of residence, economic and social situation, other status, and those facing multiple forms of discrimination, see CESCR *General Comment No. 20*.

[70] Committee on Economic, Social and Cultural Rights, "General Comment No. 22", (U.N. Doc. E/C.12/GC/22), Advanced Unedited Version, March 4, 2016, para 30.

(b) Reparation has not been granted to all women who have been subjected to forced or coerced sterilization owing to their HIV-positive status;

12 The State party should take comprehensive measures to eliminate stereotypical conceptions of gender roles, involving and targeting traditional leaders and the public at large. It should also: ...

(b) Ensure that women subjected to forced or coerced sterilization have access to reparation as well as to sterilization reversal where possible, and adopt formal guidelines to ensure that the fully informed consent of a woman undergoing sterilization is systematically sought by medical personnel.[71]

The UN Inter agency Statement on involuntary sterilisation referenced above, notes that guiding principle for the provision of sterilisation services is non-discrimination. It notes that laws, policies and practices should aim at eliminating stereotypes and discriminator attitudes that lead to the practice and should guarantee non-discrimination on all grounds. [72]

B. INVOLUNTARY STERILISATION COMPROMISES EFFECTIVE PUBLIC HEALTH AND HIV RESPONSES

Nearly forty years of global efforts to address the HIV epidemic have shown that punitive approaches that violate human rights, including forced sterilisation, compromise rather than supporting effective responses to HIV. As noted by the International Guidelines on HIV/AIDS and Human Rights:

> One aspect of the interdependence of human rights and public health is demonstrated by studies showing that HIV prevention and care programmes with coercive or punitive features result in reduced participation and increased alienation of those at risk of infection. In particular, people will not seek HIV-related counselling, testing, treatment and support if this would mean facing discrimination, lack of confidentiality and other negative consequences. Therefore, it is evident that coercive public health measures drive away the people most in need of such services and fail to achieve their public health goals of prevention through behavioural change, care and health support.[73]

Involuntary sterilisation is among the most concerning form of coercive approaches because it compromises public health and HIV responses and targets women often from the most vulnerable communities and populations. Coercive approaches,

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[71] HRC to Namibia. Concluding Observation to Namibia. 22 April 2016. CCPR/C/NAM/CO/2, paras 11 and 12.

[72] World Health Organization. *Eliminating Forced. Coercive and Otherwise Involuntary Sterilization: An Interagency Statement* 9 (2014). page 10.

[73] UNAIDS and Office of the UN High Commissioner for Human Rights (OHCHR). *International Guidelines on HIV/AIDS and Human Rights*, 2006 Consolidated Version, (HR/PUB/06/09), Geneva, 2006 para 96. page 78

including forced sterilisation, are misguided and ineffective responses that can never be justified in the context of efforts to end mother-to-child transmission of HIV. As noted by the An Interagency Statement on Eliminating Forced, Coercive and Otherwise Involuntary Sterilization:

> The provision of high-quality contraceptive and family planning information to women living with HIV is often undermined by pervasive misconceptions among policy-makers and healthcare providers regarding HIV transmission. Often the information provided about prevention of vertical transmission, or regarding the ability of women living with HIV to care for their children, is inaccurate. This can lead to stigmatization, violence and discrimination, including coercive sterilization practices, despite the evidence, which shows that a combination of safer infant feeding practices and antiretroviral treatments taken by women prenatally and during labour and breastfeeding can significantly reduce the chances of transmission of HIV to their babies. When such interventions are being effectively provided, rates of transmission of HIV from mothers to children can be reduced to less than 5%.[74]

Studies conducted in various regions and countries of the world, including in Kenya, have shown that the practice of involuntary sterilisation lead to women living with HIV losing trust in health care service and medical personnel and being more reluctant to seek health and HIV services.[75] Stigma and discrimination in health care settings, including fear of involuntary sterilisation serve as disincentives for patients, particularly women living with HIV to seek out services and providers to treat patients equally. For instance, the power dynamics, discrimination and lack of full information within the health services, discourage HIV positive women from seeking medical services and drive them underground. The fear of procedures without consent or consultation also lead to loss to follow up as negative experiences in health care setting mean that many women do not return to health care facilities.[76]

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[74] World Health Organization, *Eliminating Forced, Coercive and Otherwise Involuntary Sterilization: An Interagency Statement* 9 (2014).

[75] See, among others, International Community of Women Living with HIV (ICW) The forced and coerced sterilisation of HIV-positive women in Namibia, 2009, available at: http://www.icw.org/files/The%20forced%20and%20coerced%20sterilization%20of%20HIV%20positive%20women%20in%20Namibia%2009.pdf; Vivo Positivo and Center for Reproductive Rights Dignity denied. Violations of the rights of HIV-positive women in Chilean health facilities, 2010, available at: http://reproductiverights.org/sites/crr.civicactions.net/files/documents/chilereport_FINAL_singlepages.pdf; Asia Pacific Network of People Living with HIV (APN+) "Positive and pregnant: How dare you" A study on access to reproductive and maternal health care for women living with HIV in Asia. Findings from six countries: Bangladesh, Cambodia, India, Indonesia, Nepal and Viet Nam, 2012, available at http://aidsdatahub.org/dmdocuments/positive_and_pregnant_2012.pdf; and Kenya National Commission on Human Rights Realising sexual and reproductive health rights in Kenya: A myth or reality? 2012, available at http://www.knchr.org/Portals/0/Reports/Reproductive%20health%20report.pdf.

[76] S Gruskin et al "Ensuring sexual and reproductive health for people living with HIV: An overview of key human rights, policy and health systems issues" Reproductive Health Matters 2007, 15 (29 Supplement), pp 4-26.

In recognition of the public health harms of involuntary sterilisation and the human rights violations that it involves, UN Member States unanimously called for ending this practice in the Political Declaration on HIV and AIDS adopted by the UN General Assembly in June 2016.[77]

Several global medical, public health, HIV institutions and bodies have taken clear positions against involuntary sterilisation. For instance, the FIGO Committee the International Federation of Gynaecology and Obstetrics ("**the FIGO Committee**") stresses that the obligation to obtain the informed consent of a woman before any medical intervention is undertaken on her derives from respect for her fundamental human rights. The FIGO Committee has endorsed the following definition of informed consent, for the Study of Ethical Aspects of Human Reproduction and Women's Health, which flows from basic human rights:

> Informed consent is a consent obtained freely, without threats or improper inducements, after appropriate disclosure to the patient of adequate and understandable information in a form and language understood by the patient on
>
> a) the diagnostic assessment;
>
> b) the purpose, method, likely duration and expected benefit of the proposed treatment;
>
> c) alternative modes of treatment, including those less intrusive, and
>
> d) possible pain or discomfort, risks and side effects of the proposed treatment." [78]

Similarly, The World Medical Association (the "**WMA**") has equally adopted a statement in October 2012, which stresses that no person regardless of sex, gender, medical condition, or disability should be subject to coerced or forced permanent sterilisation.[79] The statement highlights that sterilisation as any other medical treatment should be performed only after a competent patient gave his or her full, free and informed consent, and should be free from any material or social incentives.[80]

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[77] UN General Assembly Resolution, *Politcal Declaration on HIV AIDS: On the Fast-Track to End AIDS in the age of Sustainable Development 2016-2021*para 61(h). available at: "http://www.unaids.org/sites/default/files/media_asset/20151027_UNAIDS_PCB37_15_18_EN_rev1.pdf."

[78] The FIGO Committee for the Study of Ethical Aspects of Human Reproduction and Women's Health, *Ethical Issues in Obstetrics and Gynecology*, October 2012, p.14.

[79] WMA General Assembly, 63rd. Statement on Forced and Coerced Sterilization, Bangkok, Thailand, October 2012. Accessed at: "www.wma.net_en_30publicqtions_10policies_s21_index.html".

[80] WMA General Assembly, 63rd. Statement on Forced and Coerced Sterilization. Bangkok. Thailand. October 2012. Accessed at: "www.wma.net_en_30publicqtions_10policies_s21_index.html".

Following an 18-month investigation into the impact of the law in the context of HIV, the Global Commission on HIV and the Law, an independent body of expert and leaders convened by UNDP and UNAIDS, released a comprehensive report on HIV, the law and human rights in 2012 which emphasises the importance of ending punitive laws, stigma and discrimination to support effective HIV responses.[81] In its report, the Global Commission noted that:

> Coercive and discriminatory practices in health care settings are rife, including forced HIV testing, breaches of confidentiality and the denial of health care services, as well as forced sterilisations and abortions. Since 2001, when forced and coerced sterilization and abortion among HIV-positive women were first documented, reports have emerged from Chile, Venezuela, Mexico, Dominican Republic, Indonesia, Kenya, Namibia, South Africa, Tanzania, Thailand, Uganda and Zambia. Some women report being denied access to HIV and health services unless they agree to abortion or sterilization.[82]

In light of these findings, the Global Commission on HIV and the Law made the following comprehensive recommendations to countries to prevent and address involuntary sterilisation in the context of HIV:

> 4.2. Countries must prohibit and governments must take measures to stop the practice of forced abortion and coerced sterilisation of HIV-positive women and girls, as well as all other forms of violence against women and girls in health care settings.
>
> 4.3. Countries must remove legal barriers that impede women's access to sexual and reproductive health services. They must ensure that:
>
> 4.3.1 Health care workers provide women with full information on sexual and reproductive options and ensure that women can provide informed consent in all matters relating to their health. The law must ensure access to safe contraception and support women in deciding freely whether and when to have children, including the number, spacing and methods of their children's births.
>
> 4.3.2 Health care workers are trained on informed consent, confidentiality and non-discrimination.

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[81] Global Commission on HIV and the Law, HIV and the Law: Risks, Rights and Health, July 2012, available at: http://www.hivlawcommission.org/resources/report/FinalReport-Risks,Rights&Health-EN.pdf.

[82] Global Commission on HIV and the Law, HIV and the Law: Risks, Rights and Health, July 2012, pp 65-66, available at: http://www.hivlawcommission.org/resources/report/FinalReport-Risks,Rights&Health-EN.pdf

4.3.3 Accessible complaints and redress mechanisms are available in health care settings.[83]

C. RIGHTS-BASED APPROACHES TO PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV ARE NECESSARY TO ENDING THE AIDS EPIDEMIC

Rights-based approaches are critical to all aspects of effective HIV responses, including for the elimination of mother to child transmission of HIV. UNAIDS affirms the universality, inalienability and interdependence of human rights and reiterate their importance in the context of HIV. As provided under the International Guidelines on HIV/AIDS and Human Rights:

> The protection of human rights is essential to safeguard human dignity in the context of HIV and to ensure an effective, rights-based response to HIV and AIDS. An effective response requires the implementation of all human rights, civil and political, economic, social and cultural, and fundamental freedoms of all people, in accordance with existing international human rights standards.[84]

Global efforts to end the AIDS epidemic as a public health threat by 2030 are grounded in human rights and require breaking down prejudice, exclusion, criminalisation and discrimination. As the Executive Director of UNAIDS, Michel Sidibé, has stated:

> Through the realization of their rights, people being left behind will move ahead, to the very forefront of the journey to end the AIDS epidemic – informed and empowered, mobilized and engaged.[85]

The failure to meet public health goals represents a serious threat to the human rights of HIV positive women. A rights-based approach not only meets public health goals, it is also critical to improve women's perception about the benefits of HIV testing and counselling and has a direct impact on the utilization of such services.[86]

In recent years, efforts to accelerate access to services for women and their infants to end vertical transmission of HIV and to keep mothers alive have been yielding

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[83] Global Commission on HIV and the Law, HIV and the Law: Risks, Rights and Health, July 2012, p 69, available at: http://www.hivlawcommission.org/resources/report/FinalReport-Risks,Rights&Health-EN.pdf.

[84] UNAIDS and Office of the UN High Commissioner for Human Rights (OHCHR), *International Guidelines on HIV/AIDS and Human Rights*. 2006 Consolidated Version, (HR/PUB/06/09), Geneva, 2006, p.16.

[85] UNAIDS, Press Statement Message from the executive director of UNAIDS on human rights, 10 December 2015, available at: "www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2015/december/20151210_EXD_HRD".

[86] World Health Organization, HIV/AIDS Policy, advocacy and stakeholder mobilization, *Promoting a rights-based approach to HIV testing and counseling*, available at: "www.who.int/hiv/topics/vct/toolkit/components/policy/introduction/en/index4.html".

important results.[87] In 2011, UNAIDS and its partners launched a Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive ("Global Plan"). The Global plan prioritises 22 countries with the highest number of pregnant women living with HIV in need of services globally, including Kenya. Through the acceleration of evidence-informed and rights-based approaches, the number of new HIV infections among children in the 21 Global Plan priority countries in sub-Saharan Africa dropped to under 200 000 for the first time since the 1990s.[88] This represents a 43% decline in the number of new HIV infections among children in these 21 countries since 2009.[89] In 2013, twice as many (68%) pregnant women living with HIV in the priority countries had access to antiretroviral medicines to reduce the risk of HIV transmission to their children as in 2009 (33%).[90]

These successes are based on evidence-informed and rights based approaches that involve a combination of safer infant feeding practices and antiretroviral treatments taken by women prenatally and during labour and breastfeeding can significantly reduce vertical transmission from mother to child. When such interventions are being effectively provided, rates of transmission can be reduced to less than 5%.[91] In some countries, efforts to expand effective and rights-based services to address mother-to-child transmission of HIV involves establishing formal links between health care service points and community-based organisations ("**CBOs**"), including networks of women living with HIV. CBOs can perform the functions of spreading information about the services in the community, mobilising people to come forward for services, helping with appointments, providing information on patients' rights, conducting exit interviews, supporting patients to come back to the services, and providing feedback to service providers. Such CBOs can help empower both patients and health care providers to avoid human rights abuses and to address stigma and discrimination in the context of programme to end vertical transmission of HIV.

It is therefore evident that an effective HIV response is interrelated and interdependent to upholding universal human rights. Defending the rights of HIV positive women is critical to ensuring access to life-saving services since violations of women's rights continue to render women and girls more vulnerable to HIV and prevent them from accessing services and care.[92]

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[87] UNAIDS, *2014 Progress Report on the Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive*, 2014, pp 7-8.

[88] UNAIDS, *2014 Progress Report on the Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive*, 2014, pp 7-8.

[89] UNAIDS, *2014 Progress Report on the Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive*, 2014, pp 7-8.

[90] UNAIDS, *2014 Progress Report on the Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive*, 2014, pp 7-8.

[91] OHCHR, UN Women, UNAIDS, UNDP, UNFPA, UNICEF and WHO, *Eliminating Forced, Coercive and Otherwise Involuntary Sterilization. An Interagency Statement*, World Health Organization, 2014, p. 3.

[92] UNAIDS, *On the Fast-Track to end AIDS Strategy 2016-2021*, p. 3 and 14, available at: "http://www.unaids.org/ sites/default/files/media_asset/20151027_UNAIDS_PCB37_15_18_EN_rev1.pdf."

A rights-based approach to effective HIV responses means that counselling, testing and treatment must be treated as a voluntary health-care continuum. As stressed by the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, the protection of autonomy and informed consent is central to the realisation of the right to health and other related rights. Consequently, the Special Rapporteur provides the following recommendations to States in relation to informed consent:

a) States must meet their obligations to safeguard informed consent through legislative, political and administrative mechanisms;

b) health-care providers are cognizant that, according to their duty to act in the best interests of the patient, they are key players in protecting informed consent; and

c) national and international bodies emphasize the importance of informed consent as a fundamental aspect of the right to health in relevant policy and practice.[93]

A rights-based approach to HIV is thus critical to effective HIV responses in the context of HIV positive women and informed consent. As stated by UNAIDS Executive Director, Michel Sidibé:

> Countries must investigate and address all reports of forced sterilisation and other coerced practices against women, including women living with HIV. We will not reach our common goals for the AIDS response if people lose trust in the health care system because of fear of coercion.[94]

D. UNAIDS' RECOMMENDATIONS

It is UNAIDS' view that involuntary sterilisation of women living with HIV and the lack of informed consent for sterilisation procedures infringe upon human rights, undermine the effectiveness of HIV programmes and deter women living with HIV from seeking and receiving HIV services for their own health and for the prevention of HV transmission to their babies. UNAIDS stresses that the protection of human rights, including the rights to autonomy and informed consent in the context of HIV services and programmes to end mother to child transmission of HIV, is essential to effective responses.

Protecting the legal and ethical requirement of informed consent is not only intrinsically right, it is also a public health imperative. An enabling environment that prioritizes informed consent in the clinical setting is vital in yielding the greatest

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[93] General Assembly resolution, *Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, (A/64/272), 10 August 2009, p. 4.

[94] UNAIDS, *Women everywhere have the right to informed consent*, 2012, available at "www.unaids.org/en/resources/presscentre/featurestories/2012/august/20120808women.

individual and public health benefits owing to the direct correlation between patient trust and medical efficacy.

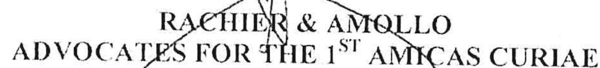
Coerced and forced sterilisation is counterproductive, as it prevents women from seeking necessary medical treatment. Countries should instead use a full range of rights-based and evidence informed HIV prevention methods to reduce the risk of HIV transmission including vertical HIV transmission to reach the end of AIDS by 2030.

II. CONCLUSION

1. The UNAIDS Secretariat respectfully submits to this Court the above standards and recommendations, which have been developed over the past three decades of HIV epidemic and pertain to effective, rights-based, evidence-informed, public-health responses in the context of HIV. These evidence and recommendations do not support involuntary sterilisation in the context of HIV.

2. The UNAIDS Secretariat hopes that its recommendations regarding the human rights and public health rationales for ending involuntary sterilisation will assist this Court as it makes its decision in this important case, a decision that will affect the health and human rights of people throughout Kenya and beyond.

DATED at Nairobi this 21st day of July 2016



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