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**"At the Hospital There are No Human Rights":
Reproductive and Sexual Rights Violations of
Women Living with HIV in Namibia**

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“At the hospital there are no human rights”:

Reproductive and sexual rights violations of women living with HIV in Namibia

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EXECUTIVE SUMMARY

“At the hospital there are no human rights.”
– Anonymous, Rehoboth, Namibia, April 15, 2010

This report documents the ongoing stigma and discrimination of women living with HIV in Namibia, building on prior findings and investigations on the subject, such as the 2008 research conducted by the International Community of Women Living with HIV/AIDS (ICW) and the Namibian Women’s Health Network (NWHN). The report, based upon both desk research and a field mission, examines the human rights situation related to sexual and reproductive health of women living with HIV, including the gravity and ongoing nature of forced and coerced sterilizations in Namibia. The report also provides evidence of violations of informed consent in the context of HIV testing, breaches of patient confidentiality, and denial of information to HIV-positive patients. It further considers how persistent stereotypes and gender-based violence contribute to stigma and discrimination in this context. Finally, the report explores how all these issues are interrelated and mutually reinforce the prevention of equal treatment of women living with HIV in Namibia.

The report first outlines the general scope of the HIV epidemic and its feminized nature, as well as how the Government of Namibia has addressed the disease through its health and justice sectors. Next, the report documents incidents of human rights violations experienced by women living with HIV when they attempt to access sexual and reproductive health services. Special attention is paid to HIV testing, discrimination within health treatment facilities, and forced sterilizations. The report further explores the systemic cultural and structural challenges to the enjoyment of human rights faced by women living with HIV. Finally, the report analyzes these issues in light of national and international human rights obligations and concludes with remedial recommendations.

International and National Human Rights Legal Analysis and Key Findings

Access to reproductive and sexual health information and services is a central component of women’s human rights protection, as women bear the burden of reproduction. Decisions related to reproduction and sexual activity directly affect women’s and girls’ bodies, and therefore their lives and health, including their ability to finish school, hold jobs, and participate in public life. This gendered burden of reproduction can have social consequences: the value of women and girls is tied to their sexual availability to men and their caretaking and child-rearing role in families. Furthermore, domestic and gender-based violence is often used to maintain gender hierarchy.

International human rights law recognizes the centrality of sexual and reproductive health to women’s rights. It provides support for women and girls to access needed health care and make independent decisions by protecting of a series of rights, including health, life, nondiscrimination, equality, liberty, physical integrity, privacy, and the right to decide freely on the number and spacing of children.

This report indicates a need for further investigation of human rights violations arising from the Government of Namibia’s actions. Under international law, the Government is required to respect, protect, and fulfill its human rights obligations. Through Namibian law and policies and international human rights instruments, the Government is bound to uphold these human rights.

1. Stigma and Discrimination in the Context of Sexual and Reproductive Rights

Participants reported that women living with HIV who attempt to access sexual and reproductive health care in Namibia find their rights violated in two key ways with respect to stigma and discrimination.

Segregation

Participants emphasized that hospital delivery facilities have been designed to segregate those living with HIV from those who are not. The segregation of HIV-positive and HIV-negative patients has often led to mistreatment or lack of treatment by hospital staff.

Neglect

HIV-positive participants reported that medical personnel have systematically neglected their care needs, particularly during childbirth. Rather than assisting in the birthing process as they do with HIV-negative women, medical personnel have ignored requests for assistance and in some cases women living with HIV have been forced to deliver without medical assistance, even in health care settings.

International and regional human rights treaties prohibit discrimination on grounds such as race, sex, or “other status,” which has been authoritatively interpreted to include HIV. Other international human rights documents, such as the U.N. General Assembly Declaration of Commitment on HIV/AIDS and the U.N. International Guidelines on HIV/AIDS and Human Rights, provide detailed guidance on how to ensure the promotion and protection of privacy, nondiscrimination, and equality rights of people living with HIV.

2. Violations of Informed Consent

HIV Testing

Participants recounted that women tested for HIV in Namibia have not been provided beforehand with sufficient counseling or information to allow for informed consent. Medical personnel in Namibia’s public health care facilities often do not speak the same language as their patients, and translation was reported to be rarely available, complicating the ability to counsel and receive consent. Women spoke of many incidents of miscommunication and misunderstanding. Such circumstances do not afford women the opportunity to make an informed choice regarding HIV testing. Many participants indicated that women can feel pressured into getting tested, for example by the implicit or explicit power differential communicated by a nurse’s command, and the women may not fully understand the reasons behind the test or the potential consequences of a positive or negative outcome.

Forced and Coerced Sterilization

Forced and coerced sterilization have been in Namibian news since the 2008 investigation conducted by ICW and NWHN. However, this public spotlight has provided neither sufficient impetus for Namibian doctors to stop forcibly and coercively sterilizing women living with HIV nor sufficient pressure for the Namibian Government to intervene to stop or punish those who perform such illegal sterilizations. Nearly every focus group led by the International Human Rights Clinic at Harvard Law School (IHRC) and NWHN in April 2010 uncovered an

undocumented case involving forced or coerced sterilization.

The rights to liberty and security of person, as well as to be free from medical experimentation, have been foundational to the modern human rights movement. These rights are rooted in many international human rights treaties, including the International Covenant on Civil and Political Rights (ICCPR), to which Namibia is a party. The Government has an obligation to ensure that choices surrounding medical procedures are informed, and that individuals can exercise autonomous decision-making in their private lives, such as decisions surrounding the number and timing of children. Moreover, the ICCPR requires States Parties to “ensure . . . an effective remedy” when such rights are violated. This report notes that a court of first instance has allowed for the filing of a few lawsuits against the Government for forced and coerced sterilization, but they have languished for several years, with no decision rendered as of July 2012.

3. Lack of Confidentiality

Participants reported a complete disregard for patient confidentiality, exacerbating discrimination in Namibian public health care facilities. Facilities and/or facility staff segregate HIV-positive patients from those who are HIV-negative, and the medical passports, which patients are required to carry, broadcast the HIV status of the bearer.

International human rights treaties to which Namibia is a party, such as the International Covenant on Economic, Social and Cultural Rights (ICESCR), Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), and Convention on the Rights of the Child (CRC), have established the right to health. This places obligations on the Government — such as ensuring the availability, accessibility, acceptability, and quality of health services, including those for sexual and reproductive matters, without discrimination or coercion. Confidentiality is an aspect of acceptability and quality of the right to health, particularly in guaranteeing that information about individual health status does not circulate beyond those health professionals who need to know it. Confidentiality is paramount in mitigating discrimination and stigma for people living with HIV.

4. Denial of Information

IHRC and NWHN found evidence through their field research to suggest that women living with HIV are routinely denied information while seeking medical care. Participants reported being handed consent forms and test results in languages unknown to them, or at times (such as the onset of labor) when they would be unable to read them properly regardless of language. In verbal exchanges, medical personnel have reportedly been dismissive of HIV-positive women’s concerns or understanding of their care. Additionally, caregivers were often described as unable or unwilling to explain procedures and processes to women living with HIV. These female patients have commonly been without necessary information to make informed choices and decisions about their own health and well-being.

The right to seek, receive, and impart information forms part of the interdependent and interrelated corpus of human rights, and is found in many international and regional treaties ratified by the Government of Namibia. Information is a key component of the right to health as well. Accurate information must be available and accessible, both in terms of content and language.

5. Cultural Barriers: Gender-Based Violence and Persistence of Stereotypes

Research and discussions with participants also suggest that gender-based violence, such as intergenerational transactional sexual relationships and intimate partner violence, may contribute to the risk of HIV transmission and the violation of the rights of women living with HIV in Namibia. Pervasive gender-based stereotypes limit opportunities for everyone; these attitudes give men and boys license to use violence and coerce sex acts from women and girls, which many women and girls resign themselves to accept.

International and regional human rights law and national laws and policies make clear that violence against women and girls is a form of gender-based discrimination that governments must, using due diligence, eliminate. Gender-based violence contributes to maintaining women and girls in subordinate roles. In such situations, the Government of Namibia is obligated to increase efforts to educate the public and create a society where women, girls, men, and boys are respected, not ascribed to stereotypical roles in the family and community. The Government must ensure that rights are respected, protected, and fulfilled equally and on a basis of nondiscrimination.

Key Recommendations

This report makes the following recommendations to redress the sexual and reproductive rights violations perpetrated upon women living with HIV and to help ensure that such violations no longer occur in Namibia:

Government of Namibia

Stigma and Discrimination in the Context of Sexual and Reproductive Health Care

- Remove all barriers to women's access to comprehensive sexual and reproductive health services, education, and information.
- Monitor the provision of health services to women by public, nongovernmental, and private organizations, to ensure equal access and quality of care.
- Require all health services to be consistent with the human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent, and choice.
- Ensure that the training curricula of health workers include comprehensive, mandatory, gender-sensitive courses on women's health and human rights.

Informed Consent: Forced and Coerced Sterilization

- Immediately take action to stop ongoing forced and coerced sterilization, including holding accountable those who have committed such acts and taking steps to ensure better surveillance and reporting mechanisms are implemented in health care facilities to prevent future violations.
- Involve women and girls living with HIV in each stage of policy and law design and implementation.
- Develop and implement a system to provide an effective and fair remedy to all women who have been subject to forced or coerced sterilization.
- Create a system that allows individuals to report violations of rights related to sexual and reproductive health care and that monitors responses from the Government.
- Provide long-term assistance to individuals and their families who have suffered forced or coerced sterilization.

Informed Consent: HIV Testing and Discrimination

- Immediately modify any segregated public health care facilities, such that patients are not physically sorted by HIV status either as policy or by hospital staff.
- Ensure that medical passports maintain privacy and are not used in a manner that violates patient confidentiality.
- Train staff and providers in health care facilities on human rights and associated approaches, in order to reduce stigma and discrimination of HIV-positive individuals.
- Build upon HIV education programs that have already proven successful, and institute programs designed to promote gender equality, human rights, and sexual and reproductive rights in particular.

Confidentiality

- Ensure that laws, policies, and regulations appropriately penalize any breach of confidentiality by health professionals regarding the private, health-related data of their patients.
- Establish and monitor the material facilities (locked file cabinets, secure databases, private consultation areas) as well as procedures to maintain the confidentiality of patient information.
- Train staff and providers in health care facilities on maintaining confidentiality.
- Educate patients on their rights to confidentiality and on the redress mechanisms available to them should their rights be violated.

Information

- Ensure that health professionals provide complete, medically accurate sexual and reproductive health information in a manner consistent with U.N. CESCR General Comment 14 in terms of accessibility, acceptability, and quality.
- Establish oversight and redress mechanisms to ensure that such information is provided to patients.
- Train staff and providers to provide such information.
- Educate patients on their rights to information.

Cultural Barriers: Gender-Based Violence and Persistence of Stereotypes

- Eliminate gender-based violence by implementing Namibian and international laws and policies sanctioning such behavior.
- Educate community and youth leaders on gender equality.
- Provide educational and income generation opportunities to youth, men, and women in order to create alternative life choices, other than those based on gender-based stereotypes.

Donors

Stigma and Discrimination in the Context of Sexual and Reproductive Health Care

- Support programming that integrates rights related to sexual and reproductive health care and HIV to ensure a full range of continuous care for women living with HIV.
- Support the training of hospital staff to decrease stigma and discrimination.
- Support grassroots efforts, especially organizations of women living with HIV, in advocating for and monitoring change.

Informed Consent: Forced and Coerced Sterilization

- Support funding that investigates instances of forced or coerced sterilization and takes an active role in holding doctors and providers accountable for rights violations.
- Fund ongoing documentation of rights violations, legal services, and the litigation process.

Informed Consent: HIV Testing and Discrimination

- Provide technical and financial assistance to the Government of Namibia, its schools, and professional associations of medicine, nursing, midwifery, public health, and law, as well as civil society (especially nongovernmental organizations (NGOs) of and for people living with HIV) to ensure that rights related to informed consent are respected, protected, and fulfilled.

Confidentiality

- Provide technical and financial assistance to the Government of Namibia, its schools, and professional associations of medicine, nursing, midwifery, public health, and law, as well as civil society (especially NGOs of and for people living with HIV) to ensure that rights related to confidentiality are respected, protected, and fulfilled.

Information

- Provide technical and financial assistance to the Government of Namibia, its schools, and professional associations of medicine, nursing, midwifery, public health, and law, as well as civil society (especially NGOs of and for people living with HIV) to ensure that rights related to information (in the context of health) are respected, protected, and fulfilled.

Cultural Barriers: Gender-Based Violence and Persistence of Stereotypes

- Ensure that women living with HIV play a leadership role in programs.
- Prioritize funding for HIV-positive women's organizations and networks of HIV-positive people.
- Support programming that integrates a gender perspective with specific attention to gender-based violence.
- Fund educational programming that targets Namibian youth and aims to reduce HIV-related stigma in Namibian society through dialogue and education.

Namibian Civil Society

Stigma and Discrimination in the Context of Sexual and Reproductive Health Care

- Provide safe spaces for dialogue about sexual and reproductive health rights, as well as other challenges facing Namibian women and girls.
- Monitor the availability, accessibility, acceptability, and quality of the provision of sexual and reproductive health care and seek redress where appropriate.

Informed Consent: Forced and Coerced Sterilization

- Continue to build capacity to document discrimination against women living with HIV in Namibia, with a particular focus on recognizing and investigating violations of sexual and reproductive rights, especially forced and coerced sterilization.

Informed Consent: HIV Testing and Discrimination

- Continue to build capacity to document discrimination against women living with HIV in Namibia, with a particular focus on recognizing and investigating violations of sexual and reproductive rights, especially relating to HIV testing.

Confidentiality

- Continue to build capacity to document discrimination against women living with HIV in Namibia, with a particular focus on recognizing and investigating violations of sexual and reproductive rights, especially related to confidentiality.

Information

- Strengthen capacity to document discrimination against women living with HIV in Namibia, with a particular focus on violations of sexual and reproductive rights to information.

Cultural Barriers: Gender-Based Violence and Persistence of Stereotypes

- Build the leadership of women living with HIV in community-based organizations and NGOs.
- Design and implement new outreach measures to involve men in efforts to end discrimination against women living with HIV in Namibia.
- Continue to advocate for equal access to sexual and reproductive health services for women living with HIV.

I. INTRODUCTION

A. Background and Methodology

This report is based upon research conducted in 2009 and 2010, including a fact-finding mission in April 2010 by the International Human Rights Clinic at Harvard Law School (IHRC), in conjunction with the Namibian Women's Health Network (NWHN). Northeastern University School of Law assisted in the drafting of this report. This research builds upon findings from a 2008 fact-finding effort conducted by the International Community of Women Living with HIV/AIDS (ICW) and NWHN. The 2008 investigation launched a project focused on forced and coerced sterilization of women living with HIV. In the course of researching such sterilization, many broader issues of stigma and discrimination came to light. This report examines the multiple layers and forms of discrimination women living with HIV in Namibia have faced when they have sought access to sexual and reproductive health services.

In April 2010, IHRC and NWHN jointly conducted focus groups and individual interviews with approximately 90 women in four Namibian communities: Katatura; Havana (Hakahana); Rehoboth; and Dordabis. Focus groups consisted of a minimum of 20 participants each. A small number of men, fewer than 20 in all, also participated in the focus groups. Most participants were selected through their affiliation with HIV support groups in the identified communities. A small subset joined after independently contacting NWHN to express an interest in participating. More in-depth interviews were done with individuals drawn from the focus groups. These in-depth interviews are highlighted in the report and are consistent with previous accounts of violations of human rights, such as those referenced in the 2008 fact-finding report.

A number of additional interviews were held in Windhoek with UNAIDS, the Namibian Ministry of Justice, and the Ombudsman of Namibia. These interviews focused on the rights of, and potential remedies available to, Namibian women facing HIV-related discrimination during their pursuit of sexual and reproductive health care.

Further meetings with civil society organizations yielded information relevant to discrimination faced by the HIV-positive community in Namibia, with particular emphasis on sexual and reproductive health care, women, and children. Finally, IHRC also partnered with NWHN to lead a two-day training session in Windhoek for 20 female community leaders; the purpose of the training was to equip these community leaders with knowledge and skills to identify and document sexual and reproductive rights violations.

B. HIV/AIDS in Namibia: Scope of the Problem

Despite its relatively large geographic size, the population of Namibia is small at approximately 2,130,000.¹ While Namibia is one of the five countries considered most affected by HIV/AIDS,² the burden of the epidemic does not fall evenly across its population. Of the 150,000 adult

¹ World Statistics Pocketbook and United Nations Statistics Division, *Country Profile: Namibia*, UNdata, available at <http://data.un.org/CountryProfile.aspx?crName=Namibia>.

² See, e.g., *Namibia Country Grant Portfolio*, THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA, available at <http://portfolio.theglobalfund.org/Grant/Index/NMB-202-G01-H-00?lang=en> [hereinafter THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA].

Namibians whom UNAIDS calculates to be living with HIV, it estimates 95,000 are women.³ The most recent available data indicate that 17.8 percent of pregnant women in Namibia tested HIV-positive in 2008.⁴ While this figure represents progress from the 22 percent prevalence among pregnant women in 2002,⁵ it suggests the burden of HIV/AIDS in Namibia falls primarily on women.

Official data on HIV/AIDS treatment and care services in Namibia are inconsistent. In its 2010 submission to the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS, the Namibian Government estimated 83 percent of adults and 95 percent of children with advanced HIV infection received antiretroviral treatment (ART) in 2009.⁶ This data is in tension with the UNAIDS Report on the Global AIDS Epidemic for 2010, which states that only 76 percent of eligible Namibian adults received ART.⁷

On the other hand, Namibia's 2010 UNGASS submission indicates only 58 percent of pregnant women living with HIV received ART to reduce the risk of mother-to-child transmission in 2009,⁸ while both the UNAIDS Global Report for 2010 and the United States Centers for Disease Control and Prevention note that more than 80 percent of Namibian women "in need" received services geared toward prevention of mother-to-child HIV transmission (PMTCT).⁹ Meanwhile, the latest figures from the World Health Organization (WHO) indicate that as of 2008, Namibia reached an astonishing 91 percent ART coverage rate for pregnant women living with HIV.¹⁰ It would be ideal if the WHO data were the most accurate. However, IHRC-NWHN research casts doubt on the value of such figures due to our findings regarding the pervasive neglect and discrimination against women in Namibia, especially against those who are poor and HIV-positive.

C. Namibian Health Infrastructure

1. Health Sector Financing

Ensuring that the health system is adequately financed is one of the pillars of the right to health. While this report does not consider the adequacy of Namibia's overall health expenditures and

³ UN Joint Programme on HIV/AIDS (UNAIDS), GLOBAL REPORT: UNAIDS REPORT ON THE GLOBAL AIDS EPIDEMIC: 2010 181-82 (2010) [hereinafter UNAIDS, GLOBAL REPORT]. It is important to note that the USAID 2006-07 Demographic Health Survey data show, and recent IHRC research confirms that women are far more likely than men to be tested for HIV. See USAID, *Namibia Demographic and Health Survey 2006-07: Policy Brief, 2*, available at <http://www.healthnet.org.na/statistics/HIV%208-11.pdf>. As a result, this statistic may be skewed.

⁴ NAMIB. MINISTRY OF HEALTH AND SOCIAL SERVICES (MOHSS), UNITED NATIONS GENERAL ASSEMBLY SPECIAL SESSION COUNTRY REPORT: REPORTING PERIOD 2008-2009 8 (2010), available at http://data.unaids.org/pub/Report/2010/namibia_2010_country_progress_report_en. [hereinafter MOHSS, UNGASS Submission].

⁵ *Id.*

⁶ *Id.* at 4.

⁷ UNAIDS, GLOBAL REPORT, *supra* note 3, at 97, 213 (discussing the process by which UNAIDS consults with the World Health Organization, The Global Fund, The US President's Emergency Plan for AIDS Relief, and other groups to evaluate country-submitted data). The inconsistency between Namibian and UNAIDS data needs further investigation, as UNAIDS imposes an extensive verification process of country-submitted UNGASS data, crosschecking it with information available from other UN and independent agencies.

⁸ MOHSS, UNGASS Submission, *supra* note 4, at 4.

⁹ UNAIDS, GLOBAL REPORT, *supra* note 3, at 78; Centers for Disease Control and Prevention (CDC), Namibia Country Profile, Aug. 9, 2010, available at <http://www.cdc.gov/globalaids/Global-HIV-AIDS-at-CDC/countries/Namibia/>.

¹⁰ WHO, WORLD HEALTH STATISTICS 2010, 93 (2010) available at http://www.who.int/whosis/whostat/EN_WHS10_Full.pdf.

budget, it does suggest that there are unmet needs for reproductive and sexual health services for HIV-infected women (and likely the general population). Namibia's 2007 total health expenditure per capita was USD \$319, with the Namibian Government contributing roughly USD \$134 per capita.¹¹ External resources contribute 10.6 percent of Namibia's total health expenditure.¹² Notwithstanding donor and national financing, a major shortcoming of the Namibian health system is that it has not managed to keep abreast of the HIV/AIDS and tuberculosis (TB) epidemics and faces ongoing tension between building long-term capacity and responding to the more immediate demands of the AIDS and TB crises.¹³

HIV/AIDS prevention, treatment, care, and support programs in Namibia are funded and supported by a variety of multilateral, bilateral, and domestic funding mechanisms. These include significant grants from the U.S. President's Emergency Plan for AIDS Relief¹⁴ and the Global Fund to Fight AIDS, Tuberculosis, and Malaria.¹⁵ Between 2005 and 2007, total annual expenditure on HIV/AIDS in Namibia increased significantly from USD \$79.1 million to \$130.5 million. However, in its 2010 UNGASS submission, Namibia did not disclose HIV/AIDS expenditures for the 2008-2009 reporting period.¹⁶ HIV/AIDS-related services in Namibia are implemented by international and domestic governmental agencies, such as Namibia's Ministry of Health and Social Services (MOHSS) and the United States Agency for International Development (USAID),¹⁷ as well as domestic and international NGOs and faith-based service delivery mechanisms.

Overall, the Namibian Government has made strong efforts toward managing the AIDS epidemic. However, this report shows that in the face of continued discrimination, the Namibian Government's efforts to combat the AIDS epidemic fall short in protecting poor women living with HIV.

2. Private and Public Infrastructure

Access to health care is one aspect of enjoying the right to health and the Government of Namibia must provide such access through its health system. Namibia provides health services through both public and private institutions. The public sector makes up 95 percent of the overall health care sector. This sector is comprised of both state-run and faith-based institutions.¹⁸ There are 35 government-run hospitals and 305 additional facilities, including more than 250 health centers and clinics.¹⁹ Although the private sector accounts for only about 5 percent of health care provision in Namibia,²⁰ it employs twice as many doctors as the public sector.²¹ In other words,

¹¹ *Id.*

¹² *Id.*

¹³ See World Health Organization, *Country Strategy at a Glance: Namibia* (May 2010), available at http://www.who.int/countryfocus/cooperation_strategy/ccsbrief_nam_en.pdf; Willy McCourt & Magda Awases, *Addressing the Human Resources Crisis: A Case Study of the Namibian Health Service*, 5 HUMAN RESOURCES FOR HEALTH 1 (2007), available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1779804/>.

¹⁴ See USAID, *Africa: Namibia*, July 22, 2010, available at http://www.usaid.gov/locations/sub-saharan_africa/countries/namibia/ (stating "the United States provided nearly \$100 million to Namibia in 2009 through the U.S. President's Emergency Plan for AIDS Relief").

¹⁵ The Global Fund alone granted over USD 150 million to Namibia's Ministry of Health and Social Services for services related to HIV/AIDS. As of December 2010, 87 percent of the grant has been delivered and spent (roughly USD 120 million), with the grant set to close in 2013 (see THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA, *supra* note 2).

¹⁶ MOHSS, UNGASS Submission, *supra* note 4, at 4.

¹⁷ See USAID, *supra* note 14 (indicating "USAID's programs focus on ... reducing the spread of HIV").

¹⁸ MOHSS, UNGASS Submission, *supra* note 4, at 36.

¹⁹ *Id.*

²⁰ *Id.*

the private sector absorbs a disproportionate amount of human and financial resources, which raises basic concerns about equality and fairness in accessing health care services.²²

Evidence suggests that many turn to the private sector for health care services, straining their financial wherewithal due to the expense. A 2008 peer-reviewed study shows middle-income households resort to selling assets or borrowing money to pay for their care more than twice as often as the highest income families do.²³

3. Affordability

A critical aspect of access to health care services is affordability. Namibia imposes “user fees” on those who access the public health care system, although there is an exemption policy for indigent patients.²⁴ In addition, the Government of Namibia reports that out-of-pocket spending for Namibian households stands at 6 percent of total health expenditures, a level that rivals industrialized economies.²⁵ However, the majority of Namibia’s population does not earn what most residents of industrialized countries do; more than 50 percent of Namibians live below the international poverty line.²⁶ This 6 percent (comprising “user fees” and other out-of-pocket costs) therefore unfairly burdens the majority of Namibians who are poor. For an individual woman living with HIV, her entire household budget could be absorbed by such costs, and be a barrier to accessing health services and medication.

In the context of maternal health, the requirement of a user fee can serve to prevent or deter women from seeking and obtaining the health care services they require.²⁷ This results from a variety of factors, including the timing at which the fees are imposed (at the time of provision of services), lack of alternative means of payment (no room for payment on credit), and pre-existing discriminatory tendencies against women on a societal and familial level.²⁸ In practice, even the presence of exemptions on the basis of need does not suffice to ensure that health care is available to those who require it. These exemptions may not operate effectively for a number of reasons: unequal provision of such exemptions; a lack of sufficient socioeconomic information, which leads to under-inclusion of individuals who would otherwise qualify for such exemptions;

²¹ MOHSS, ANNUAL REP. 2007/2008 11-12 (2008), available at http://www.healthnet.org.na/documents/annual_reports/Annual%20Report%202007-2008.pdf [hereinafter MOHSS, Annual Report].

²² For example, as of 2007, the Namibian Government’s expenditure accounted for only 42.1 percent of Namibia’s total health expenditure, a drop from the 70 percent of total expenditure for which it used to be responsible. See WHO, *supra* note 12, at 134.

²³ Adam Leive & Ke Xu, *Coping with Out-of-Pocket Health Payments: Empirical Evidence from 15 African Countries*, 86 BULL. WORLD HEALTH ORG. 849C, 851-52C (2008), available at <http://www.scielosp.org/pdf/bwho/v86n11/a14v8611.pdf>. This study did not explicitly discuss traditional healers (who are classified as “private” care providers and are sought after in rural communities.)

²⁴ See REPUBLIC OF NAMIBIA, MINISTRY OF HEALTH AND SOCIAL SERVICES, Health Facility Census 2009(2011) 70 available at <http://www.measuredhs.com/pubs/pdf/SPA16/SPA16.pdf>.

²⁵ See MOHSS, *supra* note 21; See also REPUBLIC OF NAMIBIA, MINISTRY OF HEALTH AND SOCIAL SERVICES, HEALTH AND HIV/AIDS RESOURCE TRACKING: 2007/08 & 2008/09, 40 (Dec. 2011) available at http://www.who.int/nha/country/nam/nha_namibia_2009.pdf

²⁶ CIA World Factbook, *Namibia* (2011) available at <https://www.cia.gov/library/publications/the-world-factbook/geos/wa.html> (based on UNDP 2005 poverty estimates). The World Bank also states that “Namibia’s income distribution is among the most unequal in the world, with a Gini coefficient estimated at 0.58 by the latest (2009/10) household survey. Namibia is ranked 120 out of 187 countries surveyed in the 2011 Human Development Report.” See World Bank National Country Brief, available at <http://tinyurl.com/7povs5q>.

²⁷ See Margaux J. Hall, Aziza Ahmed and Stephanie E. Swanson, *Answering the Millennium Call for the Right to Maternal Health: The Need to Eliminate User Fees*, 12 YALE HUM. RTS. & DEV. L. J 62.

²⁸ *Id.* at 82.

and a lack of awareness among the women of the availability of the exemptions.²⁹

4. Physical Accessibility

The proximity of health facilities to populations is one important element of health care access. Seven of Namibia's 13 regions do not have private hospitals, thus limiting availability of basic and/or emergency services.³⁰ A recent study found the "Caprivi, Ohangwena and Omusati regions as being the most deprived" in terms of access to health care.³¹ The same study found unequal access of rich and poor populations to health care to be reflective of both the great wealth disparity between the richest and poorest segments of Namibian society and the apartheid-era system of fund allocation.³² Even in rural areas that have public hospitals, those hospitals are located at a great distance from rural populations.

Transportation to distant hospitals can be difficult to find and very costly to hire. About 70 percent of the population lives in rural areas. Of these, the poorest are households headed by women (approximately 43 percent of all households) in rural areas. Female-led households are particularly disadvantaged with decreased access to resources, less secure employment opportunities, limited control over earnings, and a heavier burden of physical labor.

As a result, traditional healers are often the most geographically accessible private-care option for rural populations. Additionally, Namibia's MOHSS observes that the concentration of private-care facilities in wealthier areas "also affects the geographic distribution of health professionals and contributes to the relatively lower access to health services in rural areas."³³ This evidence all suggests that socioeconomic status is a key determinant of Namibians' ability to access medical care.

These physical barriers to access coupled with the barriers imposed by administrative requirements such as user fees are indicative of some of the key features of the health care system that fail to meet the requirements of successful health care delivery (namely, availability, accessibility, acceptability, and quality³⁴). As a result, HIV-positive women in Namibia are not receiving the full extent of health care to which they are legally entitled. This in turn raises the question of what means of recourse are available to these women to address such deprivations.

D. Namibian Legal Infrastructure

The enjoyment of the right to health requires oversight and accountability to ensure, for example, nondiscrimination in access to health services. It is in this context that access to justice, the judicial system, and all other accountability mechanisms becomes most salient. Formal accountability mechanisms include courts, Ombudsman offices, and professional licensing boards; informal ones include customary dispute resolution mechanisms.

²⁹ *Id.* at 85-87.

³⁰ MOHSS, Annual Report, *supra* note 21, at 14.

³¹ Eyob Zere et al., *Equity in Health Care in Namibia: Developing a Needs-based Resource Allocation Formula Using Principal Components Analysis*, 6 INT'L J. FOR EQUITY HEALTH (2007), available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1851011/>.

³² *Id.*

³³ MOHSS, Annual Report, *supra* note 21, at 12.

³⁴ U.N. Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14*, ¶ 38, U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000).

1. Legal and Policy Bases for Judicial Enforcement of Rights Related to Sexual and Reproductive Health Care

Namibian courts rely on a variety of sources to guide decisions on health. First, the Namibian Constitution (the Constitution) enumerates and protects numerous rights relevant to violations related to the delivery of health care service generally, and sexual and reproductive health of women living with HIV specifically. Among these, the Constitution protects the right to found a family,³⁵ as well as the rights to: life;³⁶ human dignity;³⁷ freedom from cruel, inhuman, and degrading treatment;³⁸ equality;³⁹ and freedom from discrimination.⁴⁰ The explicit grounds that the Constitution protects from discrimination are “sex, race, colour, ethnic origin, religion, creed or social or economic status,” thereby not expressly encompassing discrimination based on HIV status.⁴¹

Further, the Constitution provides that treaties Namibia is party to and the “general rules of public international law and international agreements” are constituent parts of the applicable law in Namibia. Courts have interpreted this to mean that treaties to which Namibia is a party have been incorporated automatically into the country’s domestic law.⁴² Individual provisions of ratified international instruments are “binding upon the state” and government officials must give effect to those instruments just as they must give effect to any other legislative act of Parliament.⁴³ Some of the relevant international agreements to which Namibia is a party include the International Covenant on Economic, Social, and Cultural Rights (ICESCR);⁴⁴ the International Covenant on Civil and Political Rights (ICCPR);⁴⁵ the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW);⁴⁶ the Convention Against Torture (CAT);⁴⁷ and the Convention on the Rights of the Child (CRC).⁴⁸

³⁵ NAMIB. CONST. art. 14, § 1 includes the right of “men and women . . . to marry and to found a family”, and further notes each partner “shall be entitled to equal rights as to marriage, during marriage, and its dissolution.”

³⁶ Art. 6 states, in relevant part, “The right to life shall be respected and protected.” *Id.*

³⁷ Art. 8, § 1 notes “the dignity of all persons shall be inviolable.” *Id.*

³⁸ Art. 8, § 2(b) prohibits “cruel, inhuman or degrading treatment or punishment.” *Id.*

³⁹ Art. 10, § 1 states, “All persons shall be equal before the law.” *Id.*

⁴⁰ Art. 10, § 2. *Id.*

⁴¹ *Id.* However, its ratification of the International Covenant on Economic, Social, and Cultural Rights would impute HIV status as a protected ground. *See* U.N. Committee on Economic, Social, and Cultural Rights, *General Comment 20*, ¶ 33, U.N. Doc. E/C.12/GC/20 (July 2, 2009) (discussed in text).

⁴² *See, e.g., Government of the Republic of Namibia and Others v. Mwilima & all other accused in the Caprivi treason trial*, 2002 NR 235, 259 (SC) (ICCPR was ratified in accordance with art. 63 and therefore is domestic law by virtue of art. 144).

⁴³ *See Mwilima*, 2002 NR at 260 (director of Legal Aid must ensure that State provides legal assistance to persons “as justice requires” as stipulated in the ICCPR).

⁴⁴ Namibia became a state party on Feb. 28, 1995. *Status of the International Covenant on Economic, Social, and Cultural Rights*, UNITED NATIONS TREATY COLLECTION, available at http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-3&chapter=4&lang=en.

⁴⁵ Namibia became a state party on Nov. 28, 1994. *Status of the International Covenant on Civil and Political Rights*, UNITED NATIONS TREATY COLLECTION, available at http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-3&chapter=4&lang=en.

⁴⁶ Namibia became a state party on Nov. 23, 1992. *Status of the Convention on the Elimination of All Forms of Discrimination against Women*, UNITED NATIONS TREATY COLLECTION, available at http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-8&chapter=4&lang=en.

⁴⁷ Namibia became a state party on Nov. 28, 1994. *Status of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, UNITED NATIONS TREATY COLLECTION, available at http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-9&chapter=4&lang=en.

⁴⁸ Namibia became a state party on Sept. 30, 1990. *Status of the Convention on the Rights of the Child*, UNITED NATIONS TREATY COLLECTION, http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-11&chapter=4&lang=en (last visited Aug. 24, 2011).

Additionally, Namibia is a party to regional human rights treaties, including the African Charter on Human and Peoples' Rights (the African Charter)⁴⁹ and the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (African Protocol on the Rights of Women).⁵⁰

The Namibian Government consented to documents negotiated at U.N. conferences that address the right to accessible and appropriate reproductive health care. These documents interpret the legally binding international human rights treaties, and permit more meaningful implementation. Such conferences include the 1994 International Conference on Population and Development (ICPD)⁵¹ and its regional and periodic reviews, as well as the 1995 Fourth World Conference on Women and its regional and periodic reviews. At the ICPD, the international community established and reaffirmed the 1994 ICPD Programme of Action (POA).⁵² The Fourth World Conference on Women also marked the creation of the Beijing Declaration and Platform for Action (PFA), a document regarded as the most comprehensive "articulation of international commitments related to women's rights."⁵³ The Beijing PFA and ICPD POA embody the international community's recognition that human rights, including sexual and reproductive rights, are at the core of efforts to achieve gender equality.⁵⁴ Finally, at the United Nations General Assembly Special Session on HIV/AIDS in 2001, Namibia pledged "to eliminate gender inequalities [and] gender-based abuse" with respect to HIV/AIDS.⁵⁵

The National HIV/AIDS Policy of 2007 ("the Policy") identifies human rights as a driving force behind its text⁵⁶ and articulates standards for health in the context of HIV/AIDS. In its first section, the Policy recognizes that "an effective response to HIV/AIDS requires respect for, protection and fulfillment of all human, civil, political, economic, social and cultural rights."⁵⁷ At the outset of the Policy, the Government concedes that people living with HIV/AIDS are "discriminated against and marginalized"⁵⁸ and recognizes the "unequal position of girls and women in society."⁵⁹

Furthermore, in two key points, the Policy states: "(1) [t]he rights and dignity of people living with or affected by HIV/AIDS shall be respected, protected, and fulfilled; [and] (2) a conducive legal, political, economic, social, and cultural environment in which the rights of people living with HIV/AIDS are respected, protected, and fulfilled shall be created."⁶⁰

⁴⁹ Namibia became a state party on July 30, 1992. *List of Countries Who Have Signed, Ratified/Adhered to the African Charter On Human And Peoples' Rights*, available at UNIVERSITY OF MINNESOTA HUMAN RIGHTS LIBRARY, <http://www1.umn.edu/humanrts/instree/ratz1afchr.htm>.

⁵⁰ Namibia became a state party on 23 Nov. 1992. *Status of Treaties, Conventions, Protocols, and Charters*, AFRICAN UNION, available at <http://www.africa-union.org/root/au/documents/treaties/treaties.htm>.

⁵¹ *Programme of Action of the International Conference on Population and Development* (ICPD), Cairo, Egypt, Sept. 5-13, 1994, U.D. Doc. A/CONF.171/13.Rev.1 (1995).

⁵² Center for Reproductive Rights (CRR), "Beijing +15," 2009, available at <http://reproductiverights.org/sites/crr.civicactions.net/files/documents/beijing+15%20factsheet.pdf>.

⁵³ *Beijing Declaration and Platform for Action*, adopted at the Fourth World Conference on Women, Beijing, China, 27 October 1995, available at <http://www.unhcr.org/refworld/docid/3dde04324.html> [hereinafter Beijing PFA].

⁵⁴ CRR, *supra* note 52.

⁵⁵ Declaration of Commitment on HIV/AIDS, G.A. Res. S-26/2, U.N. Doc. A/RES/s-26/2 (June 27, 2001).

⁵⁶ Republic of Namibia, NATIONAL POLICY ON HIV/AIDS § 2.2 (2007), available at http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/legaldocument/wcms_140589.pdf [hereinafter NATIONAL POLICY ON HIV/AIDS].

⁵⁷ *Id.* § 1.1.

⁵⁸ *Id.*

⁵⁹ *Id.*

⁶⁰ *Id.*, § 2.2.

The Policy makes explicit gender-conscious provisions, promising that “women and girls, including women living with HIV/AIDS . . . shall have equal access to appropriate, sound HIV-related information and education programmes [as well as] prevention and health services.”⁶¹ The Policy stresses that the latter services must include “sexual and reproductive health services” that are “women and youth friendly.”⁶²

With respect to the prevention of mother-to-child transmission (PMTCT) of HIV/AIDS, the Policy provides clear guidance regarding women living with HIV who wish to bear children:

Couples, in which one or both partners are HIV-positive, wanting to have a child should be provided with adequate information on the risk of mother-to-child transmission as well as the risk of re-infecting each other so that they can make an informed decision as to whether or not to have a child.⁶³

The government has further pledged to “provide free access to safe obstetric care and antiretroviral treatment to all HIV-positive pregnant women to prevent HIV transmission from mother to child.”⁶⁴

MOHSS also issued Guidelines for Voluntary Counseling and Testing in 2006. These guidelines articulate the need to respect the human rights of HIV-positive individuals as well as those of the community at large.⁶⁵

2. Formal Courts

In terms of structure, Namibia’s judiciary consists of three tiers: the Supreme Court, the High Court, and the Lower Courts.⁶⁶ The Supreme Court is the highest court of appeal⁶⁷ and “functions both as a court of last resort over disputes in all areas of the law as well as an equivalent of a constitutional court.”⁶⁸ The High Court has “original jurisdiction to hear and adjudicate upon all civil disputes and criminal prosecutions, including cases which involve the interpretation, implementation and upholding of [the] Constitution.”⁶⁹ The High Court also hears appeals from decisions of the Lower Courts.⁷⁰ Acts of Parliament created the Lower Courts, which include the magistrate courts, labor courts, and customary/traditional courts.⁷¹ Magistrate courts address more cases than any other type of court in the system.⁷² Their decisions are not

⁶¹ *Id.* § 2.3.1.

⁶² *Id.*

⁶³ *Id.* § 3.5.3.

⁶⁴ *Id.* § 3.5.6.

⁶⁵ Republic of Namibia Ministry of Health and Social Services, GUIDELINES FOR VOLUNTARY COUNSELLING AND TESTING, (2006) § 1.2.

⁶⁶ See NAMIB. CONST. art. 78, § 1(a)-(c).

⁶⁷ NAMIB. CONST. art. 79, § 2 (noting the Supreme Court “shall hear and adjudicate upon appeals emanating from the High Court”).

⁶⁸ Welcoming Message by the Chief Justice of the Republic of Namibia, the Honourable Mr. Justice Peter Shivute, SUPREME COURT OF NAMIBIA, available at <http://www.superiorcourts.org.na/supreme/default.asp>.

⁶⁹ NAMIB. CONST. art. 80, § 2.

⁷⁰ *Id.*

⁷¹ These include NAMIB. MAGISTRATES COURT ACT (1944), NAMIB. MAGISTRATES ACT (2003), NAMIB. LABOUR ACT (1992), and NAMIB. COMMUNITY COURTS ACT (2003).

⁷² Geraldine Mwanza Geraldo and Isabella Skeffers, *Researching Namibian Law and the Namibian Legal System*, in GLOBALEX, Hauser Global Law School Program, N.Y.U School of Law (2007), available at <http://www.nyulawglobal.org/Globalex/Namibia.htm>.

formally recorded in law reports, but rather are documented in case of appeal to the High Court.⁷³

Although the judicial system is formally independent from the other branches of government, international observers consider corruption to be a significant problem⁷⁴ and note that the “lack of capacity” of the judicial system has resulted in “substantial trial delays . . . especially at lower levels.”⁷⁵ Three key consequences of “a lack of resources” within the judicial system are: (1) an insufficient number of “qualified magistrates and other court officials”; (2) “slow or incomplete police investigations”; and (3) “a serious backlog of criminal cases and delays of years between arrest and trial.”⁷⁶ Furthermore, a 2006 Freedom House report discussed the “deplorable physical conditions at most Lower Courts,” which it found “contributed to a substandard system of administration of justice.”⁷⁷ Observers stress that “[e]conomic and geographic barriers [and] a shortage of public defenders” make access to justice more difficult, particularly for rural Namibians.⁷⁸ Some ethnic groups in Namibia have also alleged that the government “favors the majority Ovambo [ethnic group] in allocating funding and services.”⁷⁹

Thus, while in theory aggrieved individuals have the right to sue, in practice access to courts is quite difficult. There are material difficulties: shortage of lawyers, distance to courthouses, costs of litigation, and so on; there are also conceptual and cultural barriers including recourse to state courts to settle disputes and linguistic difficulties, etc. As to the material barriers, there is an identified shortage of lawyers and judges in Namibia.⁸⁰ High and multiple fees are also a problem; while the Law Society of Namibia has set benchmark tariffs that can be charged by practitioners for non-litigious, conveyancing and trademark-related matters, no similar guidance is set for litigious actions.⁸¹ The Professional Standards of the Law Society mandate that practitioners should not charge a fee that is “unreasonably high, having regard to the circumstances of the matter.”⁸²

While this would appear to include litigious matters within its scope, the ability of the Council of the Law Society to meaningfully engage in the exercise of determining what are “unreasonably high” fees in the absence of any benchmarks for tariffs in the context of litigious matters is questionable. Further, given the challenges in achieving gender equality in Namibian society,⁸³ it cannot be assumed that all women are sufficiently empowered to utilize legal or administrative mechanisms to rectify failings in the delivery of health care services.

⁷³ *Id.*

⁷⁴ See U.S. DEPARTMENT OF STATE, BUREAU OF DEMOCRACY, HUMAN RIGHTS, AND LABOR, 2009 HUMAN RIGHTS REPORT: NAMIBIA (March 11, 2010), available at <http://www.state.gov/g/drl/rls/hrrpt/2009/af/135968.htm> (noting legislative steps to address corruption have not halted its occurrence) [hereinafter US State Dept.].

⁷⁵ FREEDOM HOUSE, FREEDOM IN THE WORLD 2010 – NAMIBIA (2010), available at <http://www.freedomhouse.org/template.cfm?page=22&year=2010&country=7883>.

⁷⁶ U.S. STATE DEPT., *supra* note 74.

⁷⁷ NATIONAL SOCIETY FOR HUMAN RIGHTS (NAMIBIA), SHADOW REPORT: U.N. CONVENTION ON THE ELIMINATION OF ALL FORMS OF DISCRIMINATION AGAINST WOMEN: NGO COMMENTS ON COUNTRY REPORT, 34 (December 9, 2006), available at http://www.iwraw-ap.org/resources/shadow_reports.htm.

⁷⁸ FREEDOM HOUSE, *supra* note 75.

⁷⁹ *Id.*

⁸⁰ Office of the Prime Minister, Namibia, *A DECADE OF PEACE, DEMOCRACY AND PROSPERITY 1990 – 2000: MINISTRY OF JUSTICE* (2000).

⁸¹ Non-Litigious Tariffs 2010-2011, Conveyancing Fees and Trademarks Tariffs, pursuant to Rule 23 of Rules of the Law Society (2002), available at http://www.lawsocietynamibia.org/index.php?option=com_content&view=article&id=93&Itemid=126.

⁸² *Id.* at Rule 21(L)(ii).

⁸³ See UNICEF, NAMIBIA’S WOMEN AND GIRLS: REAPING THE BENEFITS OF GENDER EQUALITY? (2007)

Despite these obstacles, women living with HIV/AIDS have been able to bring court challenges against the Namibian Government for violations of their reproductive rights, assisted by the Legal Assistance Centre (LAC) AIDS Law Unit, which focuses on assisting individuals whose HIV status is the cause of violations of their rights. Such legal assistance is quite costly, and the organization is dependent upon international donor funding and other voluntary contributions. It is unclear how long these cases can be sustained or how they will be resolved.

Litigation

In 2007, ICW, NWHN, and other NGOs began to hear reports indicating that Namibian women living with HIV who had sought medical care via public health services had been forcibly sterilized. These organizations contacted the media and publicized the issue of forced and coerced sterilization.⁸⁴ Since early 2008, the LAC has worked in conjunction with ICW and NWHN to document for the purposes of litigation more than 15 cases of women who have allegedly been coerced into sterilization.⁸⁵ However, many more cases of forced sterilization have been documented in the country.

LAC and ICW have filed cases from the Katutura State, Windhoek Central, and Oshakati hospitals against MOHSS on behalf of sterilized women who are seeking monetary compensation for harm suffered.⁸⁶ In all of the cases filed to date, the key issue before the court is the meaning of “consent.”⁸⁷ The Namibian Government contends that the sterilized women provided written consent for their procedures and that the mechanisms for ascertaining informed consent were adequate.⁸⁸ MOHSS has stated that the Government insists sterilizations occurred with consent because they “have the medical files and consent forms to prove it.”⁸⁹ In response, LAC and other advocacy groups have asserted language barriers and illiteracy to discredit the consent forms as sufficient evidence and questioned the ability of the forms to provide women living with HIV with accurate information.⁹⁰ At the writing of this report, the cases have been heard and the opinion is forthcoming.

3. Other State Accountability Mechanisms

In addition to courts, there are extrajudicial accountability mechanisms that can be used to vindicate health-related rights violations. The Office of the Ombudsman plays a role in seeking accountability for the provision of health care. The Ombudsman is mandated to receive and investigate complaints relating to violations of human rights, and this would include the right to health.⁹¹ In this regard, it bears noting that the MOHSS developed a Patient’s Charter in 2002

⁸⁴ End Forced Sterilization!, *Fact Sheet: Women Living with HIV Have Allegedly Been Sterilised without Their Informed Consent*, ¶¶ 2-3, available at <http://endforcedsterilisation.wordpress.com/about/fact-sheet/>.

⁸⁵ *Id.* at ¶ 4.

⁸⁶ E.g., Wezi Tjaronda, *Namibia: Sterilisation Cases Headed for Courts*, NEW ERA, Apr. 7, 2008, available at <http://allafrica.com/stories/200804070421.html>; *Women Living with HIV Allegedly Sterilized Without Their Informed Consent*, LEGAL ASSISTANCE CENTRE, available at <http://www.lac.org.na/projects/alu/sterilisation.html>.

⁸⁷ Priti Patel, *Agenda 75: How Did We Get Here and Where to Now? The Coerced Sterilisation of HIV-positive Women in Namibia*, <http://endforcedsterilisation.wordpress.com/about/background/>.

⁸⁸ Denver Isaacs, *Forced Sterilisation Claims in Court Soon*, NAMIBIAN, June 24, 2009, available at [http://www.namibian.com.na/index.php?id=28&tx_ttnews\[tt_news\]=56663&no_cache=1](http://www.namibian.com.na/index.php?id=28&tx_ttnews[tt_news]=56663&no_cache=1).

⁸⁹ Tjaronda, *supra* note 86.

⁹⁰ See generally Pooja Nair, *Litigating against the forced sterilization of HIV-positive women: Recent developments in Chile and Namibia*, 23 HARV. HUM. RTS. J. 223-231 (2010).

⁹¹ *Mandate of the Office of the Ombudsman*, OMBUDSMAN NAMIBIA, available at <http://www.ombudsman.org.na/index.php/about-us/51-mandates-of-the-office-of-the-ombudsman.html?start=1>.

that sets out the rights of patients and the standard of care that they are entitled to receive.⁹² The elucidation of such standards aids in serving as a benchmark against which patients are able to assess the delivery of health care services and seek recourse as necessary when the standards are not met.

There are, however, limitations on the extent to which the Ombudsman is able to provide the necessary support in procuring accountability in health care delivery. Due to limited resources, the Ombudsman's office claims it is unable to effectively utilize all the powers that it has available.⁹³

The medical profession itself is self-regulating in nature. The Namibian Medical and Dental Council has the power to investigate formal complaints through the institution of a disciplinary committee.⁹⁴ In the absence of an actual complainant, the council may appoint a pro-forma complainant to investigate allegations.⁹⁵ In accordance with the findings of the disciplinary hearing, the Namibian Medical and Dental Council has the power to choose among sanctions ranging from a reprimand to removal of the practitioner's name from the register.⁹⁶ Additionally, 60 other types of health professionals are subject to the powers of the Allied Health Professions Council of Namibia, which has similar powers to investigate complaints through disciplinary hearings.⁹⁷

4. Customary/Traditional Court System

Under the Namibian Constitution, customary courts apply customary law and operate in parallel to the formal justice system.⁹⁸ Customary law is flexible, is not based on precedent, and decisions are not formally reported.⁹⁹ The interactions of "[m]ost rural citizens" with the law take place within the traditional/customary courts, which "hear[] most [of the] civil and petty criminal cases in rural areas."¹⁰⁰ Many rural Namibians reportedly consider it more culturally appropriate to resolve disputes within the family or with mediation from members of the immediate community than to do so within the formal court system.¹⁰¹ Customary courts often seem to Namibians to be more accessible and efficient than the formal court system, especially given the incomplete development of the formal courts in rural areas.¹⁰²

Although Namibian law "provides that customary law is invalid if it is inconsistent with the [Namibian] constitution,"¹⁰³ observers emphasize that "[t]raditional courts in rural areas have often ignored constitutional procedures."¹⁰⁴ These observers do concede that the Government is in the process of implementing legislation that attempts "to create greater uniformity in

⁹² PRIMARY HEALTH CARE & NURSING SERVICES DIRECTORATE, MINISTRY OF HEALTH AND SOCIAL SERVICES, THE PATIENT CHARTER OF NAMIBIA (July 1998), available at <http://www.healthnet.org.na/documents.html>.

⁹³ Ombudsman, Windhoek, 19 April 2010.

⁹⁴ See NAMIB, MEDICAL AND DENTAL ACT (2004), art. 38 § 1(a)-(b). & art. 46 § 1.

⁹⁵ *Id.*

⁹⁶ *Id.* at art. 42, § 1.

⁹⁷ See NAMIB. ALLIED HEALTH PROFESSIONS ACT (2004), art. 18, art. 37 § 1 & art. 41 § 1.

⁹⁸ See, e.g., NAMIB. CONST. art. 66, § 1.

⁹⁹ Geraldo and Skeffers, *supra* note 72.

¹⁰⁰ US STATE DEPT., *supra* note 74.

¹⁰¹ Manfred O. Hinz & Frank Thomas Gatter, GLOBAL RESPONSIBILITY - LOCAL AGENDA: THE LEGITIMACY OF MODERN SELF-DETERMINATION AND AFRICAN TRADITIONAL AUTHORITY 42-3 (2006).

¹⁰² Felicity Thomas, *Global Rights, Local Realities: Negotiating Gender Equality and Sexual Rights in the Caprivi Region, Namibia*, 9 CULTURE, HEALTH & SEXUALITY 599, 611 (2007).

¹⁰³ US STATE DEPT., *supra* note 74.

¹⁰⁴ FREEDOM HOUSE, *supra* note 75.

traditional court operations and better connect them to the formal judicial system.”¹⁰⁵

Despite reforms undertaken by the Government, women “continue to face discrimination in customary law and other traditional societal practices.”¹⁰⁶ Even with some new legal safeguards in place, “[l]ack of awareness of legal rights as well as informal practices have undermined the success of [those] changes.”¹⁰⁷ In 2008, the U.N. Committee on the Elimination of Racial Discrimination “remain[ed] concerned about aspects of customary laws of certain ethnic groups on personal status that discriminate against women and girls.”¹⁰⁸ The Committee suggested that Namibia “consider introducing a system which allows individuals a choice between customary law systems and the national law while ensuring that the discriminatory aspects of customary laws are not applied.”¹⁰⁹ A recent study of the Traditional Authority of Uukwambi in northern Namibia explored the activities that the authority undertook “to combat the severe gender imbalance inherent within its system of customary justice and administration.”¹¹⁰ The study found that “older women in particular still believe that only men can make sound decisions” and tended to “remain quiet during court proceedings.”¹¹¹ Men continue to constitute the majority of the “higher levels of the court hierarchy . . . due to the still skewed number of men compared to women traditional leaders.”¹¹² Indeed, “[m]ale dominance is visible” in “leadership, dispute settlement, and normative content” of the traditional court system.¹¹³ A 2006 Freedom House submission to the Committee on the Elimination of Discrimination Against Women (the CEDAW Committee) described the justice system as “unable to help combat the high incidence of [violence against women] and effectively deal with other legal problems afflicting women.”¹¹⁴

Traditional justice clearly plays a vital role in Namibian society. The Government’s attempt to ensure uniformity in the traditional justice system through legislation (the Community Courts Act) represents an acknowledgment that these mechanisms will continue to remain significant in the future. In the context of access to justice, traditional justice serves as a much easier port of call than the formal legal framework. Nevertheless, access in form does not necessarily translate into substantive accountability. As highlighted above, there remains a gender imbalance in traditional justice mechanisms and this serves to entrench existing gender biases (in contrast to a formal legal system, which has an express commitment toward nondiscrimination on the basis of gender). While the two systems can be viewed as complementary processes, the possibility that they may lead to the promotion of contradictory values ought to be borne in mind as a potential pitfall.

The applicable laws identified above demonstrate that the basis for substantive protections with respect to rights related to sexual and reproductive health care is clearly established in Namibia. Although the institutional mechanisms may be imperfect, they are still a means for enforcing the

¹⁰⁵ *Id.*

¹⁰⁶ *Id.*

¹⁰⁷ *Id.*

¹⁰⁸ Committee on the Elimination of Racial Discrimination, *Concluding Observations: Namibia*, ¶11, U.N. Doc. CERD/C/NAM/CO/12 (Sept. 22, 2008).

¹⁰⁹ *Id.*

¹¹⁰ Janine Ubink, *Gender Equality on the Horizon? The case of Uukwambi Traditional Authority, Northern Namibia* 2 (Int’l Dev. Law Org., Enhancing Legal Empowerment through Engagement with Customary Justice Systems, Working Paper Series, Paper No. 4, 2010), available at <http://www.idlo.int/english/WhatWeDo/Research/LegalEmpowerment/Pages/Customary1.aspx>.

¹¹¹ *Id.* at 18.

¹¹² *Id.*

¹¹³ *Id.* at 24.

¹¹⁴ NATIONAL SOCIETY FOR HUMAN RIGHTS (NAMIBIA), *supra* note 77.

existing legal protections for these rights.

As the ratifications of numerous international human rights treaties would suggest, Namibia has endorsed international political goals closely associated with human rights. However, the reality that women living with HIV encounter when they try to access public sexual and reproductive health care services appears to differ drastically from the standards that the Namibian Government articulates in these documents.

II. RIGHTS VIOLATIONS OF WOMEN LIVING WITH HIV IN NAMIBIA IN ACCESSING SEXUAL AND REPRODUCTIVE HEALTH SERVICES

A. Violations Relating to and Arising from HIV Testing

*Testing is key to the prevention of HIV, as well as to the effective care, support, and treatment of those living with HIV/AIDS. When women know their positive status, they can avoid re-infection by another strain of the virus and take precautions to protect their sexual partners. In cases of pregnancy, HIV-positive women can dramatically decrease the chances of spreading HIV to their children by accessing PMTCT, which they would only be able to do were they aware of their HIV status at an early stage in the pregnancy.*¹¹⁵

*According to UNAIDS, “3 C’s” should guide HIV testing: (1) informed consent; (2) confidentiality; and (3) counseling.*¹¹⁶ *In this regard, the Voluntary Counseling and Testing (VCT) model, which involves providing information on the implications of the test results and obtaining the patient’s consent, has been considered the best way to strike the balance between health-related goals and protection of the rights of the individual tested.*¹¹⁷

The official Government data point to improvements in access to VCT services in Namibia, especially for antenatal treatment.¹¹⁸ IHRC-NWHN interviews suggest that the statistics on those who received antenatal care and pre-testing and post-testing counseling should be treated with a dose of caution, as it is unclear whether the quality of the services provided or the continuity of the services was accounted for in the statistics provided. Rather, the interviews would suggest various instances in which national and international standards on HIV and human rights that are prerequisites to testing are not met.

One HIV-infected woman related a discussion she had with a nurse at an antenatal clinic, explaining the prerogatives nurses took: “I told [the nurses]: ‘You can’t force them to get tested.’ But before, the clinic would say: ‘We as nurses must know.’ So the woman must be tested.”¹¹⁹ The lack of information, as explained by one interviewee, leads women to follow the health workers’ views and authority and makes women feel unable to refuse a test when recommended

¹¹⁵ UNAIDS, *Fast Facts about HIV Testing and Counseling*, in FAST FACTS ABOUT HIV 1 (2011), available at http://www.unaids.org/en/media/unaids/contentassets/dataimport/pub/factsheet/2008/20080527_fastfacts_testing_en.pdf.

¹¹⁶ UNAIDS/WHO, *Policy Statement on HIV Testing* 1 (2004), available at <http://www.who.int/hiv/pub/vct/en/hivtestingpolicy04.pdf> (noting that this guideline has been “advocated since the HIV test became available in 1985”).

¹¹⁷ Amnesty Int’l, *South Africa: ‘I am at the lowest end of all’. Rural Women Living with HIV Face Human Rights Abuses in South Africa*, 63, AI Index AFR AFR53/001/2008, March 18, 2008.

¹¹⁸ MOHSS, UNGASS Submission, *supra* note 4, at 27-8 (the State recognizes that when same day test results are not provided, the vast distances in the country constitute a challenge for HIV testing). In this regard, see also MOHSS, UNGASS Submission, *supra* note 4, at 22.

¹¹⁹ Anonymous, Dordabis, Namibia, April 16, 2010.

by these professionals. Similarly, lack of informed consent was rampant across health facilities. One woman observed that:

In 2003, I became pregnant, but I did not know my status. I ignored people telling me to get tested. Then I got maternity service. The doctor knew I was HIV positive, but he did not tell me. I had my baby. I breast fed for 8 months. When my baby got diarrhea, I found out my baby was HIV positive.¹²⁰

The quotation illustrates the necessity of providing pregnant women who are seeking antenatal care with information as to the importance and consequences of being tested for HIV. These statements also evince a disturbing pattern in the conduct of health care workers — a tendency not to treat pregnant women who are in their care as adults who are capable of making their own decisions. The decision to coerce testing and the withholding of information about the HIV status of a patient from the patient demonstrate a lack of respect of the inherent dignity of the person involved. These decisions deprive women of the benefit of making significant medical decisions relating to their health, lives, and bodily integrity on their own accord. Another interviewee expressed a similar sentiment when recounting her experiences, “Because I did not know my HIV status, I got sick and went for a test. The nurses did not say anything. They took my blood but they did not tell me the results.”¹²¹

Further, interviewees indicated that women often do not have access to clear, accurate, and detailed information on essential issues related to HIV testing, such as the advantages of knowing their HIV status; the possible test results and their consequences; the available treatment for those who tested positive, including PMTCT; and their right to freely choose to take the test in the first place. It would also appear that health care workers lack sensitivity and alarm women in a very counterproductive way. One woman stated:

Sometimes . . . the nurses come during antenatal . . . and tell pregnant women everyone should be tested. They say the reason is to protect children who are born to HIV mother. But you go to the counseling room, and the women come out crying. So you think: I am not going to get tested. Or they say they will go but not come back for result. So it’s scary for people. They are scared of the result.¹²²

The importance of ensuring that appropriate counseling (both during the decision-making process and subsequent to the release of the test result) is provided to the pregnant women who are encouraged to be tested cannot be understated. As highlighted in the discussion on discrimination and stigma in section B below, pregnancy is an emotionally challenging experience. Given that the nature of the test result carries the potential to significantly alter the woman’s life and the life of her unborn child, the role that counseling can play in preparing the pregnant women is significant. However, reality suggests a disregard for the significance of counseling. Our interviews conducted support ICW findings: women who are HIV tested during pregnancy may have a more traumatic experience due to the lack of adequate counseling.¹²³ One woman said of her testing experience, “At the hospital there are no human rights.”¹²⁴

¹²⁰ Anonymous, Okuryangava, Namibia, April 13, 2010

¹²¹ Anonymous, Okuryangava, Namibia, April 16, 2010

¹²² Anonymous, Okuryangava, Namibia, April 16, 2010.

¹²³ THE INTERNATIONAL COMMUNITY OF WOMEN LIVING WITH HIV/AIDS (ICW), THE FORCED AND COERCED STERILIZATION OF HIV POSITIVE WOMEN IN NAMIBIA 11 (March 2009). The report notes that a pregnant woman who did not receive counseling attempted suicide after learning she was HIV-positive.

¹²⁴ Anonymous, Rehoboth, Namibia, April 15, 2010.

IHRC-NWHC researchers observed a difficulty with respect to procuring effective counseling and ensuring informed consent: the language barrier. Our observation corroborates ICW's previous report on women living with HIV in Namibia. Many doctors cannot communicate in the respective dialect of their patients and there is often no translation available. These obstacles resulted in misinformation and miscommunication, and ultimately contribute to patients' lack of informed consent and prevent them from being able to obtain effective counseling.¹²⁵

The challenges presented by the language barrier extend further in time to the stage where the test results are presented to the women. One of the interviewees recounted receiving her test: "The letter was in English, but I couldn't read the letter and I couldn't read it because I was bleeding."¹²⁶ The inability to explain what an HIV diagnosis, prognosis, and treatment plan means simply compounds the failure to procure informed consent in the first place.

A similarly callous attitude was encountered by another woman:

He said, 'You are HIV-positive. You [have] to go to Katatura hospital to get your positive test results.' I went to that room, I knocked; they said I need a medical passport, I went and got a medical passport, the man is talk, talk, talk. He said, 'Do you know what HIV is?' I said, 'Yes, it kills,' and he said, 'Well you have HIV.' I walked out and threw away the card.¹²⁷

Very few HIV-positive women who were interviewed reported having received a thorough consultation from a medical provider wherein the causes, effects, and available courses of treatment for HIV/AIDS were explained to their satisfaction and understanding. The lack of counseling undermines the intended value of encouraging testing — prevention of re-transmission and providing appropriate medical care to the diagnosed individuals.

Another problem that occurs during testing is the failure to respect the right of confidentiality of the individuals who are tested. Confidentiality is routinely breached, as this interviewee expressed:

At the health center, HIV section is where HIV-positive people go. [It's] mixed at reception, but after you go to the HIV section. Even if you go for any illness—even with a dentist—people will know [your status] when they see the passport.¹²⁸

This interviewee's account brings home the lack of protection for the privacy and confidentiality of an HIV-positive individual who is seeking treatment.¹²⁹ Many IHRC-NWHN interviewees described that Namibian medical facilities generally have two waiting rooms, one for HIV-positive patients, and one for those who are HIV-negative. These positive and negative zones are clearly marked, and reception staff direct patients to one or the other upon registration based on a patient's HIV status. Individuals must disclose HIV status to the clinic staff at the reception so as

¹²⁵ ICW, THE FORCED AND COERCED STERILIZATION OF HIV POSITIVE WOMEN IN NAMIBIA, *supra* note 123, at 11.

¹²⁶ Anonymous, Namibia, April 15, 2010.

¹²⁷ Anonymous, Namibia, April 15, 2010.

¹²⁸ Anonymous, Havana, Namibia, April 13, 2010.

¹²⁹ As defined by UNAIDS, "Confidentiality relates to the right of individuals to protection of their data during storage, transfer, and use, in order to prevent unauthorized disclosure of that information to third parties." *Guidelines on Protecting the Confidentiality and Security of HIV Information: Proceedings from a Workshop 15-17 May 2006, Geneva, Switzerland*, "Interim Guidelines," May 15, 2007, at 2 (emphasis in original).

to be directed to the appropriate waiting room. Simply by their presence in a given room, they are automatically branded with their HIV status for all to see — employees of the clinic, fellow patients, and all passers-by. Aside from lacking any medical basis, the policy of physically separating HIV-positive patients from those who are not destroys any illusion of confidentiality that may be desired by those with an HIV-positive status.

The disregard of patient confidentiality by the health care service providers begins from the moment that individuals enter the health care facility. IHRC-NWHN researchers heard repeatedly about the medical passport system in Namibia and how HIV status is prominently displayed on each person's passport: "First you go to reception to pay, that is where it starts with a big number on your passport and paper in passport that says HIV patient on top of passport."¹³⁰ Patients must present their medical passports in order to receive *any* sort of medical care. Thus, a Namibian woman must disclose her HIV status regardless of the health care she is seeking. Similar to the physical separation policy, the branding of one's HIV status on the medical passport and the requirement that it be brandished at any and every medical-related transaction clearly vitiates any possibility of HIV-status confidentiality for Namibian women. As one of the interviewees stated, "Everyone that is looking at you and can see your card knows that you are an HIV-positive patient."¹³¹

B. Stigma and Discrimination in Sexual and Reproductive Health Services¹³²

*HIV-related stigma and discrimination have long been recognized as globally pervasive phenomena and as significant barriers to an effective response to the HIV epidemic.*¹³³ *The UN General Assembly's 2001 Declaration of Commitment on HIV/AIDS notes stigma and discrimination "undermine prevention, care and treatment efforts . . . and must be addressed."*¹³⁴ *Stigma and discrimination not only increase the burden on those who are HIV-positive, but also on their families and those close to them.*¹³⁵ *The UNAIDS Programme Coordinating Board states that "[s]tigma and discrimination associated with HIV can be as devastating as the illness itself."*¹³⁶

In many cases, either or both factors can lead to devastating effects for HIV-positive individuals such as job and property loss, abandonment by one's family, denial of medical services, and

¹³⁰ Anonymous HIV-positive man, Havanah, Namibia, April 13, 2010.

¹³¹ Anonymous, Okuryangava, Namibia, April 13, 2010.

¹³² The legal framework provides that discrimination on the basis of HIV status is prohibited. However, traditionally, the human rights community has treated stigma and discrimination as related factors, which together constitute discrimination that violates legally provided protections to affected individuals. For present purposes, the UNAIDS approach to discrimination and stigma is of guidance — both components are viewed as part of "a 'process of devaluation' of people either living with or associated with HIV and AIDS. . . . Discrimination follows stigma and is the unfair and unjust treatment of an individual based on his or her real or perceived HIV status": UNAIDS, REDUCING HIV STIGMA AND DISCRIMINATION: A CRITICAL PART OF NATIONAL AIDS PROGRAMMES — A RESOURCE FOR NATIONAL STAKEHOLDERS IN THE HIV RESPONSE, 9 (2007).

¹³³ UNAIDS, Reducing HIV Stigma and Discrimination: A Critical Part of National AIDS Programmes, at 7 [hereinafter UNAIDS, Reducing HIV Stigma].

¹³⁴ Declaration of Commitment on HIV/AIDS, *supra* note 55, at ¶13.

¹³⁵ UNAIDS, HIV-RELATED STIGMA, DISCRIMINATION AND HUMAN RIGHTS VIOLATIONS: CASE STUDIES OF SUCCESSFUL PROGRAMMES 12 (2005), available at http://data.unaids.org/publications/irc-pub06/jc999-humrightsviol_en.pdf.

¹³⁶ UNAIDS PCB, 26th Meeting, *Non-Discrimination in HIV Responses* (3 May 2010), UNAIDS/PCB(26)/10.3, ¶ 5, available at http://www.unaids.org/en/media/unaids/contentassets/documents/priorities/20100526_non_discrimination_in_hiv_en.pdf.

verbal and physical abuse.¹³⁷ Although there are conflicting studies, several suggest that “women experience HIV-related stigma and discrimination more than men, are more likely to experience the harshest and most damaging forms, and have fewer resources for coping with it.”¹³⁸

The need to address stigma and discrimination in Namibia has been acknowledged in successive versions of the country’s National Policy on HIV/AIDS.¹³⁹ However, interviews with women in four Namibian communities revealed to IHRC and NWHN that stigma and discrimination continue to be prevalent, particularly in the context of sexual and reproductive health services. One HIV-positive woman, for example in describing her birthing experience, told us “No one wanted to touch me.”¹⁴⁰

While undergoing one of the most challenging experiences of any woman’s life, women living with HIV (who are already plagued with greater stress over their health and the health of their child) are singled out and discriminated against throughout their pregnancy, including during labor. Along with bearing the emotional weight of such conduct, HIV-positive pregnant women also find themselves at increased (yet avoidable) health risks and their babies face great (and once again, avoidable) risk of contracting HIV.¹⁴¹ A participant articulated one common experience at a clinic:

[The] first time I went to the clinic was in 2005 for antenatal care because I wanted to find out if I was pregnant. I already knew I was HIV-positive. That is why I went for antenatal care. During the visit, the nurse in charge said, ‘How can you get pregnant? You know you are HIV-positive; you are spreading the disease. How will you afford this child? Why didn’t you use a condom when you know you are HIV-positive?’¹⁴²

Rather than providing information on how this woman living with HIV could minimize the risk of mother-to-child transmission, the nurse in this instance criticized the patient seeking antenatal care.

In IHRC-NWHN focus groups, women living with HIV demonstrated fear of accessing reproductive health services. One participant articulated a story reflective of the fear faced by many other HIV-positive women:

I was on ARVs since 2005 and have a boyfriend and have been sexually active without a condom and got pregnant. I was afraid to tell the nurses I was pregnant when I went to the ARV clinic. I aborted at home.¹⁴³

Aware of the trends of discrimination of HIV-positive pregnant women by health care workers, others in a similar position have been loathe to reveal their status to nurses. The woman quoted chose to self-abort at home rather than face what she feared would be harsh judgment by the

¹³⁷ *Id.*

¹³⁸ *Id.* at ¶ 14.

¹³⁹ See, e.g., NATIONAL POLICY ON HIV/AIDS, *supra* note 56, at 7; NATIONAL STRATEGIC PLAN ON HIV/AIDS: THIRD MEDIUM TERM PLAN, at 33 (2004–2009); NATIONAL STRATEGIC PLAN ON HIV/AIDS: MEDIUM TERM PLAN II, 9 (1998–2004).

¹⁴⁰ Anonymous, Rehoboth, Namibia, April 15, 2010.

¹⁴¹ *Id.*

¹⁴² Anonymous, Dorabis, Namibia, April 17, 2010.

¹⁴³ Anonymous, Rehoboth, April 15, 2010.

nurses at the ARV treatment clinic. This fear of stigma not only creates a climate where women living with HIV hesitate to seek out adequate prenatal care, but also places their immediate physical health in danger when they seek out solutions for themselves.

Further, the accounts to IHRC and NWHN researchers reveal continued discrimination during labor and child delivery. For example, one participant stated:

The nurses in the maternity ward are not helpful to the pregnant women, especially [those working] the night shift. They just sit in office; you keep calling them, but they do not come. Sometimes they come when the baby is already out. Sometimes the babies are dying because the nurse is late. The women don't know what is happening. The nurses don't want to come close to the women. They always come after the baby is already out.¹⁴⁴

Maternity ward health care providers would reportedly avoid interacting with women living with HIV for fear of exposure to HIV. Participants noted that segregation of HIV-positive from HIV-negative women in the maternity ward contributed to a system that both enabled discrimination by health care workers and further stigmatized the women living with HIV.

C. Forced and Coerced Sterilization

Women living with HIV have been targets of forced and coerced sterilization procedures. Those who are poor are even more at risk for such unwanted medical intervention because they are considered “unable” or “unworthy” of bearing and rearing children. Medical doctors violate their own ethics, and violate the rights of women when they subject them to such abusive interventions. Forced and coerced sterilization, in many societies, can cause women to be isolated, ostracized, and cast out from their families, as they no longer can bear children. The UNAIDS Reference Group on HIV and Human Rights has called upon governments and nongovernmental actors alike to “stop paying lip service to the rights of women and girls, and invest in tangible programs that empower women and girls to assert their sexual and reproductive autonomy and rights, including freedom from violence and coercion.”¹⁴⁵ The Reference Group statement stresses specifically that women living with HIV must be protected from “forced and coerced sterilization.”¹⁴⁶

IHRC-NWHN research confirms and elaborates on the findings in the ICW's 2008 report, which represents the range of detailed instances where women described their experiences of forced and coerced sterilization. These include situations wherein medical personnel violated their reproductive and sexual rights in the following ways: failed to obtain consent; failed to communicate with patients due to language barriers; obtained consent under duress and/or based on misinformation; demanded consent to sterilization in order for a female patient to access other necessary services including abortion and child delivery; demanded and/or obtained consent for sterilization without providing information about sterilization or other contraceptive options; recorded misinformation on medical passports; and denied women access to medical records.¹⁴⁷

¹⁴⁴ Anonymous, Okuryangava, Namibia, April 16, 2010.

¹⁴⁵ UNAIDS Reference Group on HIV and Human Rights, *Stay the Rights Course: Statement to the 2011 United Nations High Level Meeting on AIDS*, available at http://www.stoptortureinhealthcare.org/sites/default/files/stay-the-rights-course_0.pdf.

¹⁴⁶ *Id.*

¹⁴⁷ ICW, THE FORCED AND COERCED STERILIZATION OF HIV POSITIVE WOMEN IN NAMIBIA, *supra* note 123, at 10-12.

Our investigations revealed that the majority of reported cases of forced and coerced sterilization involve the failure of medical personnel to obtain informed consent in part by failing to provide HIV-positive women with a description of the nature of the sterilization procedure, as well as its effects, consequences, and risks. Women living with HIV continuously revealed this pattern to IHRC-NWHN researchers throughout the focus groups and during one-on-one interviews held in April 2010. The entrenched practice of disregarding informed consent and subjecting women to unwanted sterilizations has provoked outrage, as one participant lamented, “You are a person living positive; how can you have rights and have your doctor without your signature or your family[’s permission] sterilize you?”¹⁴⁸

Interviews indicated that significant numbers of women living with HIV have been coerced or forced into sterilization procedures by hospital personnel without being properly advised on the medical realities of having children as an HIV-positive woman:

I did not get information that a person living positive can have babies. They just told me I must go for sterilization, so I went for it. It was not my idea. They said, ‘If you go for sterilization, it’s for your health and so you don’t want to spread the disease.’ I did not want to have a positive baby.¹⁴⁹

Accounts of women being urged toward sterilization or being sterilized were common in the focus group discussions. Many of the stories explicitly spoke to misinformation and intimidation on the part of health care providers and hospital staff:

Before the surgery they said I have a soft hormone and we will see what we can do about it. The other doctor who came in said, “Oh! You are sterilized! . . . I started crying but no one can help me.”¹⁵⁰

As this quote illustrates, this woman was not provided with any information she could use to make an informed medical decision. Rather, reference was made to a “soft hormone,” and she found herself in an operating room, receiving a procedure that had not been previously discussed. Many women experienced paternalistic attitudes from medical providers. One woman reported a physician saying: “[Y]ou have enough kids, you are unemployed, and no money, you have to get sterilized.”¹⁵¹

The violation of these women’s human rights is not an exercise in abstraction — it takes a physical and emotional toll. Said one of the focus group’s participants, “What also hurts is that I wasn’t allowed to sign. You should have someone’s consent before you sterilize them.”¹⁵² Motherhood and fertility are prized in Namibia and the documented cases probably only scratch the surface of the true problem.¹⁵³ Many women find that having the ability to have children “stripped from them makes it even harder . . . to negotiate already treacherous personal relationships.”¹⁵⁴ Some men have abandoned their partners upon learning they had been sterilized.¹⁵⁵ Other women have reportedly decided not to inform their partners out of fear of

¹⁴⁸ Anonymous, Rehoboth, April 15, 2010.

¹⁴⁹ Anonymous, Dordabis, Namibia, April 17, 2010.

¹⁵⁰ Anonymous HIV-positive woman, Havanah, Namibia, April 15, 2010.

¹⁵¹ Anonymous, Rehoboth, Namibia, April 15, 2010.

¹⁵² Anonymous, Rehoboth, Namibia, April 15, 2010.

¹⁵³ Priti Patel & Brett Davidson, *Namibian Women Face Forced Sterilization*, HUFFINGTON POST, Nov. 12, 2009, available at http://www.huffingtonpost.com/priti-patel/namibia-women-face-forced_b_356245.html.

¹⁵⁴ *Id.*

¹⁵⁵ *Id.*

such abandonment and alienation.¹⁵⁶

III. CULTURAL BARRIERS

When considering the access to justice, traditional and otherwise, IHRC-NWHN observed that the pervasive stereotyping and gender bias against women and girls acts as a barrier to justice within these formal frameworks, which are the function of patriarchy. This is but one dimension in which the prevailing cultural attitudes in a society shape the enforcement and provisions of human rights.

Addressing rights related to the sexual and reproductive health of women is a fundamental measure of respect for the equality of women and girls. Any long-term sustainable change led by the Government will only take root if there are concurrent efforts to alter the attitudes prevalent in society at large. To that end, IHRC-NWHN highlight some aspects that act to restrict any meaningful enforcement and protections for women's sexual and reproductive health rights in Namibia.

A. Structural Obstacles and Intergenerational Transactional Sex

Namibia's unemployment rate is reported to be as high as 51 percent.¹⁵⁷ In rural communities like Havana, Rehoboth, and Dordabis, there is ongoing frustration with the lack of employment. The IHRC-NWHN team's discussion with the community in Dordabis suggests many teenage girls in the area consider transactional sex relationships with migrant workers to be their only opportunity for money, entertainment, or fun. Although teenage girls cite boredom as a reason for engaging in such conduct, it is likely that this high-risk behavior results from a climate of poverty and a perception of the lack of any other feasible options. As one interviewee told us, "Many men come here for construction work. They are always new to the community. Young females drop out of school and hook up with them in exchange for money or entertainment and drinks."¹⁵⁸

There is evidence that relationships based upon intergenerational transactional sex, or "sugar daddy" relationships, contribute to the spread of HIV across Southern Africa. Numerous studies have documented the serious effects such relationships have on HIV transmission in the region.¹⁵⁹

¹⁵⁶ *Id.*

¹⁵⁷ Though the CIA's World Factbook offers a wildly improbable 2008 estimate of 5 percent for Namibia's unemployment rate (see <https://www.cia.gov/library/publications/the-world-factbook/geos/wa.html>), and Namibia's Ministry of Trade and Industry claims 30 percent (see <http://www.mti.gov.na/subpage.php?linkNo=53>), one Namibian paper places it around 51 percent based on unofficial statistics (see Charles Tjatidini, *President Exhorts Nation to Fight Unemployment*, S. TIMES, April 30, 2010, <http://www.southerntimesafrica.com/article.php?title=President%20exhorts%20nation%20to%20fight%20unemployment&id=4034&sid=454590aefd73ae1efd6ebf8817d87fc9>). This is in line with what the IHRC team heard in Windhoek.

¹⁵⁸ Anonymous, Dordabis, Namibia, April 16, 2010.

¹⁵⁹ See, e.g., Suzanne Leclerc-Madlala, *Age-disparate and Intergenerational Sex in Southern Africa: The Dynamics of Hypervulnerability*, 22 AIDS S17 (2008).

While there is a law criminalizing sexual activity with a person under the age of 16,¹⁶⁰ focus group participants told IHRC and NWHN that some Namibian girls as young as 10 enter into transactional sexual relationships with much older adults.¹⁶¹ Both IHRC-NWHN findings and United Nations Children’s Fund (UNICEF) data support that assertion.¹⁶²

Anecdotal evidence collected from four areas and focus group participants suggests that both male and female children take part in intergenerational sexual relationships in exchange for compensation such as cellphones, alcohol, and cash.¹⁶³ One told us:

They [young people] go to the *shebeen* (local bar), and they start drinking because there is nothing to do. No work, no job, nothing. So they drink there and they end up sleeping with someone who has money. Someone buys them alcohol and they end up in bed.¹⁶⁴

Most IHRC-NWHN focus group participants reported knowing of “sugar mommies” in their communities, as well as “sugar daddies.”¹⁶⁵ However, no quantifiable data comparing the incidence of “sugar daddies” to that of “sugar mommies” are available; anecdotal evidence and recent UNICEF findings suggest that the traditional “young female with much older male partner” model of intergenerational transactional sex relationships is still the most common variation.¹⁶⁶ The IHRC-NWHN team heard reports of Namibian men seeking out young, uneducated women and girls when passing through rural areas looking for work.¹⁶⁷ A feature of participation in such relationships was to engage in high-risk sex, and young women faced difficulties negotiating safe sex given economic disenfranchisement.¹⁶⁸

Factors identified as a reason for engaging in such relationships are boredom and a lack of other opportunities. One participant commented, “This would stop if there were work . . .”¹⁶⁹ In the rural community of Dordabis, the local school only goes up to grade seven. As one interviewee explained, “To go to high school, young people must travel, and no one has the money for that.”¹⁷⁰ Unable to continue their education, young people in Dordabis reportedly remain in their isolated, impoverished community with very little to do. TV and radio signals do not reach the area, and community members report that “there is only a church choir” to provide entertainment.¹⁷¹ As one resident put it, “The youth here have nothing . . . they drop out at grade

¹⁶⁰ Combating of Immoral Practices Act of 1980. Originally, the statute referred only to girls, the 2000 revision changed it to be gender neutral. For discussion, see Legal Assistance Centre, *Rape in Namibia: An Assessment of the Operation of the Combating of Rape Act, 2006*, at 135 (discussing the Combating of Immoral Practices Act Amendment Act 7 of 2000) available at www.lac.org.na/projects/grap/Pdf/rapefull.pdf. [hereinafter LAC Rape Paper].

¹⁶¹ Anonymous young woman, Windhoek, Namibia April 12, 2010.

¹⁶² UNICEF, *NAMIBIA’S WOMEN AND GIRLS: REAPING THE BENEFITS OF GENDER EQUALITY?* 3 (2007) (citing a survey finding 42 percent of females aged 10-14 “had their first sexual encounter through forced sex” as well as numerous rape/sexual offences cases involving complainants aged 5-10).

¹⁶³ Discussion with groups in Windhoek, Havana, Dordabis, and Rehoboth showed this trend.

¹⁶⁴ Interview with group leader, April 17, 2010.

¹⁶⁵ Groups in Windhoek, Havana, Dordabis, and Rehoboth showed this trend. The IHRC team did not hear accounts in this trip of homosexual young male-“sugar daddy” relationships, but this is likely due to the team’s methodology and focus on women-centered issues. It should not be considered as a suggestion that such relationships do not occur.

¹⁶⁶ See UNICEF, *NAMIBIA’S WOMEN AND GIRLS: REAPING THE BENEFITS OF GENDER EQUALITY?*, *supra* note 162.

¹⁶⁷ Anonymous, Windhoek, Namibia, April 12, 2010.

¹⁶⁸ Anonymous, Dordabis, Namibia, April 16, 2010.

¹⁶⁹ Anonymous, Dordabis, Namibia, April 16, 2010.

¹⁷⁰ Anonymous, Dordabis, Namibia, April 16, 2010.

¹⁷¹ *Id.*

seven and have babies. The babies drop out after grade seven and have babies. It's a cycle."¹⁷²

B. Intimate Partner Violence

The IHRC-NWHN team's conversations with Namibian women suggest that women who attempt to assert their right to safe sex frequently face severe consequences, as one interviewee commented:

There is a fight every day in each house. The beatings of the woman. The woman is scared to say, 'My husband or boyfriend beat me because I say I want to use a condom.' In some cases women just commit suicide because they are scared. Maybe my husband is beating me because I want to use a condom. If I tell anyone, they say, 'How can you tell your husband to use a condom?'¹⁷³

In Havana, every member of the focus group had heard of women being beaten for asking their partners to use condoms.¹⁷⁴ This reported prevalence of violence and the community's awareness of it likely has considerable detrimental effect on the condom-related behavior of women in the area. Focus group participants report that cultural norms in Havana dictate that women have no right to ask their partners to use condoms. One woman interviewed observed, "Sometimes there is a fight. He leaves you in the house, and he goes to another woman. You cry, what am I going to do? So next time, all you can say is, "It's OK not to use a condom."¹⁷⁵ The success of educational efforts to promote the use of condoms is undermined by intimate partner violence.¹⁷⁶ One participant offered:

Some people end up divorcing [their] wife just because of the condoms. They break relationships up. Or the woman is beaten just for asking to use a condom. He says all along you have been having sex without condoms, now you must be cheating and that's where you learned about condoms.¹⁷⁷

HIV prevention programs targeting community education enjoy wide sponsorship in Namibia. Evidence suggests that women are far more likely than men to attend HIV workshops and learn about condom use.¹⁷⁸ Indeed, UNAIDS reports express concern that "[d]espite evidence that beneficial behaviour change can be achieved, few HIV programmes engage men and boys."¹⁷⁹ For education to be effective, those who acquire knowledge must be empowered to act on it. Put simply, women who assert their right to safe sex must be free from violence. As a participant put it, "Women's workshops are good — but [women] go home to men."¹⁸⁰

Although Namibia has recently reformed its legal policy with respect to intimate partner

¹⁷² *Id.*

¹⁷³ Anonymous, Havana, Namibia, April 16, 2010.

¹⁷⁴ Havana and Okuryangava, Namibia, April 16, 2010

¹⁷⁵ Anonymous, Namibia, April 16, 2010.

¹⁷⁶ For further evidence of the efficacy of educational efforts directed toward young women in Namibia, see WHO, *supra* note 10, at 33 (showing for the indicator "Females aged 15–24 years with comprehensive correct knowledge of HIV/AIDS (%)," Namibia leads the field of countries that submitted data with 65 percent of Namibian young women having such knowledge).

¹⁷⁷ Anonymous HIV-positive man, Okuryangava, Namibia, April 16, 2010.

¹⁷⁸ This was apparent to the IHRC team based on interviews with community members as well as with NGO workers in Namibia.

¹⁷⁹ UNAIDS, GLOBAL REPORT, *supra* note 3, at 121.

¹⁸⁰ NGO Worker, Windhoek, Namibia, April 15, 2010.

violence,¹⁸¹ this legislative shift seems to have had little effect thus far on the lives of many Namibian women. In some communities, there is no visible government infrastructure to provide the necessary recourse for abandoned or abused women. Women who are “chased away” by their partners and families report that they are “made [to] sleep outside” with “nowhere to go and no way to get food.”¹⁸²

IV. LEGAL ANALYSIS AND FINDINGS: OBLIGATIONS UNDER INTERNATIONAL AND NATIONAL LAW AND POLICY

A. Stigma and Discrimination in Sexual and Reproductive Health Services

1. National Law and Policy

Namibia’s national laws and policies establish clear norms regarding stigma and discrimination against people living with HIV/AIDS. The Policy states :(1) “People living with HIV/AIDS shall not be discriminated against in access to health care and related services”, and (2) “HIV/AIDS shall not be used as a reason for denying an individual access to social services, including health care.”¹⁸³ The Policy also reflects recognition of the interlinked relationship between gender-based discrimination and discrimination based on HIV status. It provides that all women, including those living with HIV, are to be granted equal access to HIV-related information and health services, including women-friendly sexual and reproductive health services.¹⁸⁴ Women also “have the right to have control over, and to decide responsibly, free of coercion, discrimination and violence, on matters related to their sexuality and reproductive health.”¹⁸⁵

Namibia’s Guidelines for the Prevention of Mother-to-Child Transmission of HIV acknowledge the need to train health care workers so that they do not discriminate against women living with HIV during labor. These guidelines note that rather than isolating these women, health professionals should take universal precautions—such as wearing gloves and plastic aprons—for all women who are in labor, regardless of HIV status.¹⁸⁶ In addition, they acknowledge that “[e]motional support during labour is important for all women, and may be even more crucial for an HIV-positive woman who is concerned about her condition and the risk of transmission to the child.”¹⁸⁷

The Government of Namibia has indicated its willingness to implement legal reforms to address stigma and discrimination against people living with HIV with respect to other areas of life. For example, the Labour Act of 2007 includes a provision that prohibits workplace discrimination against people based on their HIV status.¹⁸⁸ In July 2010, Namibia amended its Immigration Control Act to lift travel restrictions on people living with HIV.¹⁸⁹ The Third Medium Term Plan, which encompassed the implementation of the Policy from 2007-2009,¹⁹⁰ emphasized the

¹⁸¹ See NAMIB. COMBATING OF DOMESTIC VIOLENCE ACT NO. 4 OF 2003.

¹⁸² Anonymous, Rehoboth, Namibia, April 15, 2010.

¹⁸³ NATIONAL POLICY ON HIV/AIDS, *supra* note 56, at 7.

¹⁸⁴ *Id.* at 8.

¹⁸⁵ *Id.*

¹⁸⁶ NAMIB. MINISTRY OF HEALTH AND SOCIAL SERVICES, GUIDELINES FOR THE PREVENTION OF MOTHER-TO CHILD TRANSMISSION OF HIV 13 (2008).

¹⁸⁷ *Id.*

¹⁸⁸ NAMIB. LABOUR ACT § 5(2) (2007).

¹⁸⁹ *Press Release: Namibia lifts travel ban for people living with HIV*, UNAIDS (July 8, 2010), available at <http://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2010/july/20100708prnamibia/>.

¹⁹⁰ NATIONAL POLICY ON HIV/AIDS, *supra* note 56, at 34.

need for policy development and law reform in order to “create an enabling environment that effectively addresses stigma and discrimination.”¹⁹¹

While these steps are encouraging, to date Namibia has no general statutory or constitutional prohibition on discrimination based on HIV status. This precludes a clear legal basis in domestic law to ensure that there be no discrimination against people living with HIV. On the whole, Namibia’s domestic legal and policy frameworks (with the exception of a statutory or constitutional prohibition on discrimination on the basis of HIV status) conform to the standards required internationally. What the accounts of the Namibian women render clear, however, is that these are not being implemented and translated into substantive protections for the affected community.

2. International Human Rights Implications

International and regional human rights treaties prohibit discrimination based on various grounds, including gender, disability, and “other status” (which has been interpreted to include actual or presumed HIV status, as discussed below). Based on the experiences recounted by women living with HIV who attempt to access sexual and reproductive health services, it is clear that the various types of discriminations are inextricably linked. The effects of any one type of discrimination are necessarily compounded by that of another type of discrimination: the stigma associated with an HIV-positive status is compounded for a woman who is structurally perceived by society as being inferior and not meriting equal treatment. Other factors that exacerbate the lived experience of discrimination include residing in a rural area and being young.

a. *Discrimination on the Basis of HIV Status*

As a starting point, the ICCPR prohibits any discrimination on the basis of a variety of enumerated grounds as well as on the basis of “other status.”¹⁹² The U.N. Commission on Human Rights has determined that “the term ‘or other status’ in nondiscrimination provisions in international human rights texts can be interpreted to cover health status, including HIV/AIDS.”¹⁹³ The Commission also has found that “existing international human rights standards” prohibit “Discrimination on the basis of AIDS or HIV status, actual or presumed.”¹⁹⁴

A similar approach has been taken with respect to the International Covenant on Economic, Social, and Cultural Rights (ICESCR) by the Committee on Economic, Social and Cultural Rights (CESCR). The CESCR has cited “health status” as an example of a category that would fall within the “other status” provision in the prohibition on discrimination in the ICESCR.¹⁹⁵ Furthermore, the CESCR notes the “widespread stigmatisation of persons on the basis of their health status . . . often undermines the ability of individuals to enjoy fully their Covenant rights.”¹⁹⁶ The CESCR has underscored the importance of adopting a holistic approach to fighting discrimination, as opposed to one that is formal and technical, and recognized that States

¹⁹¹ NATIONAL STRATEGIC PLAN ON HIV/AIDS: THIRD MEDIUM TERM PLAN, *supra* note 139, at 33.

¹⁹² International Covenant on Civil and Political Rights, Dec. 16, 1966, 999 U.N.T.S. 171, art. 26 [hereinafter ICCPR].

¹⁹³ Comm’n on Human Rights Res. 995/44, ¶ 1, U.N. Doc. E/CN.4/1995/176 (3 Mar. 1995). Examples of treaties which prohibit discrimination on the basis of “other status” include, ICCPR, *supra* note 192, art. 26; International Covenant on Economic, Social, and Cultural Rights, Dec. 16, 1966, 999 U.N.T.S. 3, art. 2(2) [hereinafter ICESCR]. The African Charter on Human and People’s Rights likewise prohibits discrimination based on “other status.” African Union, African Charter on Human and People’s Rights, June 27, 1981, 21 I.L.M. 58, art. 2. (1982) [hereinafter African Charter].

¹⁹⁴ *Id.*

¹⁹⁵ Committee on Economic, Social, and Cultural Rights (CESCR), *General Comment 20*, ¶ 33, U.N. Doc. E/C.12/GC/20 (July 2, 2009).

¹⁹⁶ *Id.*

Parties must “immediately adopt the necessary measures to prevent, diminish and eliminate the conditions and attitudes which cause or perpetuate substantive or de facto discrimination” so as to fulfill their treaty obligations.¹⁹⁷

The spirit of these treaty commitments toward prohibiting discrimination on the basis of health status has also manifested in various international policy documents. First, at the UNGASS on HIV/AIDS in 2001, states reiterated their commitment to eliminate discrimination against people living with HIV¹⁹⁸ and agreed to “develop strategies to combat stigma and social exclusion connected with the epidemic” and ensure access to health care and health services for HIV-positive individuals.¹⁹⁹ Second, the 2006 *International Guidelines on HIV/AIDS and Human Rights*, which act as a roadmap for states on the intersection between international human rights norms and HIV,²⁰⁰ underscore the necessity of legal protections for people living with HIV.²⁰¹

Despite these legal protections in form, the reality for women living with HIV in Namibia is starkly different. As noted in section IV (A) above, there is no provision for domestic legal remedies for discrimination on the explicit basis of HIV status (due to an absence of a statutory or constitutional prohibition to this effect). From an international law point of view, the absence of such a provision in Namibian domestic law places Namibia in violation of its obligation to adopt legal prohibitions on discrimination under numerous of the treaties discussed above (for example, Article 26 of the ICCPR). Based on IHRC-NWHN observations, the Namibian Government has failed to guarantee to women living with HIV their rights to equality and nondiscrimination in breach of the ICESCR,²⁰² especially as related to the provision of health care services.²⁰³

b. Discrimination on the Basis of Sex (and other status)

The burden of discrimination borne by women living with HIV in Namibia is compounded by systemic gender-based discrimination.²⁰⁴ Discrimination against women on the basis of their sex is prohibited by various international human rights treaties, those already cited (the ICCPR²⁰⁵ and ICESCR²⁰⁶) as well as the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW),²⁰⁷ the African Charter on Human and People’s Rights,²⁰⁸ and the African Protocol on the Rights of Women.²⁰⁹

¹⁹⁷ *Id.*

¹⁹⁸ Declaration of Commitment on HIV/AIDS, *supra* note 55, at ¶ 58.

¹⁹⁹ *Id.*

²⁰⁰ Office of the United Nations High Commissioner for Human Rights and the Joint United Nations Programme on HIV/AIDS, *International Guidelines on HIV/AIDS and Human Rights* (2006 Consolidated Version), ¶¶ 107-109, U.N. Doc. HR/PUB/06/9 (July 2006) [hereinafter *International Guidelines*].

²⁰¹ *Id.* at ¶ 22(f).

²⁰² ICESCR, *supra* note 193, at arts. 2, 3.

²⁰³ ICESCR, *supra* note 193, at art. 12.

²⁰⁴ Joint United Nations Programme on HIV/AIDS and Office of the High Commissioner of Human Rights, *Handbook on HIV and Human Rights for National Human Rights Institutions*, ¶ 110, U.N. Doc. HR/PUB/07/3 (2007) [hereinafter *Handbook on HIV and Human Rights*].

²⁰⁵ ICCPR, *supra* note 192, at art. 3.

²⁰⁶ ICESCR, *supra* note 193, at art. 2(2).

²⁰⁷ Convention on the Elimination of All Forms of Discrimination against Women, Dec. 18, 1979, 1249 U.N.T.S. 13, art. 2 [hereinafter CEDAW].

²⁰⁸ African Charter, *supra* note 193, at art. 2.

²⁰⁹ African Union, Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa, July 11, 2003, art. 2 [hereinafter African Protocol on the Rights of Women].

These treaties echo a call for the prohibition of discrimination on the basis of sex — for example, the African Charter prohibits discrimination on the basis of sex,²¹⁰ and calls on all States Parties to “eliminate every discrimination against women and to ensure the protection of the rights of women as stipulated in international declarations and conventions.”²¹¹ The African Protocol on the Rights of Women commits States Parties to “combat all forms of discrimination against women through appropriate legislative, institutional and other measures.”²¹²

As many of the women in our focus group revealed, girls (under 18 years old) are vulnerable to the same kinds of gender-based discrimination and HIV infection. The Convention on the Rights of the Child (CRC) prohibits discrimination “of any kind” against a child.²¹³ This is to be irrespective of whether the child is in fact HIV-positive, and Article 24 explicitly addresses obligations to promote and protect a child’s health.²¹⁴ The CRC’s General Comments 3 (on HIV) and 4 (on adolescent health) elaborate the range of equality and nondiscrimination measures that states must take. However, it would appear that, in Namibia, no explicit legal protections are in place for the girl to be free of discrimination.

B. Testing

1. National Law and Policy

The Namibian Constitution provides for the right to dignity²¹⁵ and the rights to equality and freedom from discrimination,²¹⁶ rights that would entitle women to voluntary counseling and testing.

The Policy recognizes that patients should be entitled to these rights, emphasizing that “[t]esting for HIV should always be voluntary, save as may be provided for in applicable legislation.”²¹⁷ The Policy also holds that HIV testing must only be done with the informed consent of the patient, such consent being obtained by “adequate information about the nature of an HIV test, including the potential implications of a positive and negative result.”²¹⁸ It is incumbent on medical personnel to “ensure that the informed consent of the patient is obtained prior to HIV testing for the purposes of differential diagnosis, [and] that such testing is accompanied by pre and post test counseling.”²¹⁹ This approach is an articulation of the Government’s intention to “promote a routine offer of voluntary counseling and testing for couples planning to have a child, all pregnant women and all children exposed to HIV infection in accordance with national PMTCT guidelines.”²²⁰

Nevertheless, it is clear that there remain Namibian women who are coerced into receiving an

²¹⁰ African Charter, *supra* note 193, at art. 3.

²¹¹ *Id.* at art. 18.

²¹² African Protocol on the Rights of Women, *supra* note 209, at art. 2(1).

²¹³ Convention on the Rights of the Child, Nov. 20, 1989, 1577 U.N.T.S. 3, art. 2(1) [hereinafter CRC].

²¹⁴ *Id.*

²¹⁵ NAMIB. CONST. art. 8, § 1.

²¹⁶ *Id.* art. 10, § 1-2.

²¹⁷ NATIONAL POLICY ON HIV/AIDS, *supra* note 56, at 18 (emphasis in original). Provisions on voluntary testing and counseling can be found in other instruments, such as: NAMIB. MINISTRY OF LABOUR, GUIDELINES FOR IMPLEMENTATION OF NATIONAL CODE ON HIV/AIDS IN EMPLOYMENT §§6.3, 6.5 (1998); NAMIB. MINISTRY OF HEALTH AND SOCIAL SERVICES, NATIONAL POLICY ON INFANT AND YOUNG CHILD FEEDING §3.4 (2003); NAMIB. HIV/AIDS CHARTER OF RIGHTS §4 (2004); and THE PATIENT CHARTER OF NAMIBIA, *supra* note 92, at 3,5,7 and 9.

²¹⁸ NATIONAL POLICY ON HIV/AIDS, *supra* note 56, at 18.

²¹⁹ *Id.* at 24-5.

²²⁰ *Id.* at 20.

HIV test as part of their antenatal care and are left in doubt of either the results of the test or the implications of HIV status, which is in violation of and contradiction to these legal protections and policy commitments.

2. International Human Rights Implications

a. *Discrimination*

As discussed previously, major international human rights treaties including the ICCPR, the ICESCR, CEDAW, the African Charter, and the African Protocol on the Rights of Women prohibit discrimination against women. The impact of compulsory HIV testing on women found by IHRC-NWHN research has also inflicted mental suffering, and is a violation of these general prohibitions against discrimination on the basis of sex. Further, these effects also violate Namibia's specific duty to provide health care that is free from discrimination, as required under Article 12 of CEDAW. It is thus incumbent on the Namibian Government to take "all appropriate measures" to eliminate this discrimination.²²¹ Some possible steps Namibia could take include enacting or strengthening "anti-discrimination and other protective laws that protect vulnerable groups . . . from discrimination in both the public and private sectors," particularly vulnerable, pregnant women.²²²

In addition to exacerbating stigma and discrimination, the lack of status confidentiality for HIV-positive Namibians is tantamount to discrimination on the basis of HIV status. Such state-sponsored discrimination at Namibian health care facilities constitutes a violation of Namibia's international treaty obligations to ensure the right to equality and nondiscrimination as defined in the ICCPR and the ICESCR.

b. *Rights to Privacy, Information, and Health*

Article 17(1) of the ICCPR prohibits "arbitrary or unlawful interference" with individual privacy. This right encompasses "information concerning a person's private life"²²³ as well as a woman's "reproductive functions."²²⁴ A failure to provide the requisite information so that a pregnant woman is able to meaningfully consent to or decline HIV testing is clearly a violation of these privacy protections.

The CESCR has interpreted the right to health in the ICESCR to incorporate "access to health-related education and information, including on sexual and reproductive health."²²⁵ This right involves "information accessibility," which is "the right to seek, receive and impart information and ideas concerning health issues" in a manner that does not "impair the right to have personal health data treated with confidentiality."²²⁶ To meet this obligation, states must provide patients with appropriate HIV-related information, education, and support, as well as access to voluntary counseling and testing.²²⁷ The broader ability to access information related to HIV/AIDS,

²²¹ CEDAW, *supra* note 207, at art 2.

²²² *International Guidelines*, *supra* note 200, ¶ 9 (Guideline 5).

²²³ Human Rights Committee (HRC), *General Comment 16: Article 17: The Right to Respect of Privacy, Family, Home and Correspondence, and Protection of Honour and Reputation*, ¶ 10, U.N. Doc. A/43/40 (32nd Sess., 1988) [hereinafter *HRC General Comment 16*].

²²⁴ HRC, *General Comment 28: Equality of Rights between Men and Women*, ¶ 20, U.N. Doc. CCPR/C/21/Rev.1/Add.10, (68th Sess., 2000) [hereinafter *HRC General Comment 28*].

²²⁵ CESCR, *General Comment No. 14*, *supra* note 34, at ¶ 8.

²²⁶ *Id.* at ¶ 12(b).

²²⁷ *Handbook on HIV and Human Rights*, *supra* note 204, at 6.

especially with respect to prevention and treatment, is key as well.²²⁸

The requirements to protect a pregnant woman's rights to dignity, to make an informed choice, and to confidentiality are also implicated under a state's obligation under Article 12 of CEDAW to ensure "access to quality health-care services."²²⁹ Further, insofar as girls are concerned, the CRC mandates that states must provide "appropriate pre-natal and post-natal health care" for mothers.²³⁰

CEDAW imposes a specific obligation on States Parties to ensure that women are not discriminated against in the provision of health care.²³¹ In the context of testing (and in sterilization as discussed below), the failure to provide information or to obtain informed consent undermines women's (and girls with reference to the CRC) right to health. We have found the Namibian Government is in violation of CEDAW because it has not taken "all appropriate measures" to eliminate this discrimination against women living with HIV, particularly discrimination in health care services.²³² As the International Guidelines on HIV/AIDS and Human Rights recognize and stress, "[d]iscrimination against women, de facto and de jure, renders them disproportionately vulnerable to HIV and AIDS" and "[s]ystematic discrimination based on gender also impairs women's ability to deal with the consequences of their own infection and/or infection in the family, in social, economic, and personal terms."²³³

Regional treaties contain similar provisions protecting an individual's right to receive information as a constituent part of health care.²³⁴ The African Protocol on the Rights of Women requires States Parties to ensure that individuals are given "the right to be informed on one's health status and on the health status of one's partner, particularly if affected with sexually transmitted infections, including HIV/AIDS, in accordance with internationally recognised standards and best practices."²³⁵

In addition to the violations of the right to informed consent and counseling, the right to privacy and confidentiality have been also violated in the context of Namibian health care workers' treatment of HIV status. Under the International Guidelines on HIV/AIDS, a state should enact legislation to ensure that information about HIV status of an individual is protected against "use or disclosure in the health-care and other settings."²³⁶

In Namibia, there is no legislation in place that explicitly protects privacy, confidentiality, and information in health care settings. IHRC-NWHN findings suggest that existing policies serve to broadcast, rather than conceal, the HIV status of Namibian citizens. The failure to afford citizens confidentiality with respect to HIV status represents a significant weakness in Namibian

²²⁸ See Office of the High Commissioner on Human Rights and the World Health Organization, *The Right to Health Fact Sheet No. 31*, (June 2008), 21, available at <http://www.unhcr.org/refworld/docid/48625a742.html> (noting "it is important to ensure the availability of medicines and strengthen HIV prevention by, for instance, providing condoms and HIV-related information and education, and preventing mother-to-child transmission) [hereinafter *The Right to Health Fact Sheet*].

²²⁹ CEDAW Committee, *General Recommendation 24*, ¶ 22., U.N. Doc. A/54/38 (1999).

²³⁰ CRC, Nov. 20, 1989, 1577 U.N.T.S. 3, Art 24(2)(d).

²³¹ CEDAW, *supra* note 207, at art. 12.

²³² See CEDAW, *supra* note 207, at art. 2.

²³³ *International Guidelines*, *supra* note 200, at ¶110.

²³⁴ African Charter, *supra* note 193, at art. 9 (articulates that "[e]very individual shall have the right to receive information").

²³⁵ African Protocol on the Rights of Women, *supra* note 209, at art. 14(1)(e).

²³⁶ *International Guidelines*, *supra* note 200, at ¶ 21(a).

HIV/AIDS policy that actively contributes to discrimination against HIV-positive individuals. The use of medical passports with prominent HIV-status indicators and separate physical waiting areas also erects barriers to adequate care for women living with HIV.

Furthermore, these policies violate “the right to have personal health data treated with confidentiality” inherent in the right to health as incorporated in the ICESCR²³⁷ and implicate the right to privacy in the ICCPR. They also deter the achievement of “[u]niversal access to care and treatment [that] is also an important component of the right to health for persons living with HIV/AIDS.”²³⁸

As far as political commitments (which further support interpretations of the duties of States Parties under international human rights law), Namibia and other states recognized the right of men and women “to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice” in the Beijing PFA.²³⁹ In the Political Declaration on HIV/AIDS, which the U.N. General Assembly endorsed in 2006, States Parties made a commitment to promote “a wide range of prevention programmes that take account of local circumstances, ethics and cultural values, . . . including information, education, and communication, in languages most understood by communities and respectful of cultures.”²⁴⁰ In the Declaration of Commitment on HIV/AIDS, states also committed to providing voluntary and confidential counseling and testing to HIV-infected women and access to effective treatment to reduce mother-to-child transmission of HIV.²⁴¹ Finally, the International Guidelines on HIV/AIDS and Human Rights emphasize that women in prenatal treatment “should be provided with accurate information about the risk of prenatal transmission to support them in making voluntary and informed choices about reproduction.”²⁴²

C. Forced Sterilization

1. National Law and Policy

The Namibian Constitution recognizes the rights to life;²⁴³ dignity;²⁴⁴ equality;²⁴⁵ to found a family;²⁴⁶ freedom from cruel, inhuman, and degrading treatment;²⁴⁷ and freedom from discrimination.²⁴⁸ The Namibian National Policy on HIV/AIDS echoes rights found in the Namibian Constitution.²⁴⁹ It articulates that “women and girls, including women living with HIV/AIDS . . . shall have equal access to appropriate, sound HIV-related information” and women-friendly health services.²⁵⁰ The Policy also recognizes the need for information, stating that “couples, in which one or both partners are HIV-positive, wanting to have a child should be provided with adequate information on the risk of mother-to-child transmission as well as the risk of re-infecting each other so that they can make an informed decision as to whether or not to

²³⁷ CESCR, *General Comment No. 14*, *supra* note 34, at ¶ 12(b).

²³⁸ *The Right to Health Fact Sheet*, *supra* note 228, at 21.

²³⁹ *Beijing PFA*, *supra* note 53, ¶94.

²⁴⁰ Political Declaration on HIV/AIDS, G.A. Res. 60/262, ¶ 22, U.N. Doc. A/RES/60/262 (June 2, 2006).

²⁴¹ Declaration of Commitment on HIV/AIDS, *supra* note 55, at ¶ 54.

²⁴² *Id.*

²⁴³ NAMIB. CONST. art. 6.

²⁴⁴ *Id.* art. 8, §§ 1-2(b).

²⁴⁵ *Id.* art. 10, §§ 1-2.

²⁴⁶ *Id.* art. 14, §.1.

²⁴⁷ *Id.* art. 8, §§ 1-2(b).

²⁴⁸ *Id.* at art. 10, §§ 1-2.

²⁴⁹ NATIONAL POLICY ON HIV/AIDS, *supra* note 56, pmb1.

²⁵⁰ *Id.* at Chapter 2.3.1

have a child.”²⁵¹ With regard to medical personnel, the “government shall provide free access to safe obstetric care and ARV treatment to all HIV-positive pregnant women to prevent HIV transmission from mother to child. PMTCT programmes shall provide for treatment, care, and support for both parents.”²⁵²

Despite the rights articulated in the Namibian Constitution and the Policy, the experiences of women living with HIV who have been forced or coerced into sterilization in the health sector indicate that efforts have not been taken to ensure that these protections are meaningfully enforced by the health care sector.

2. International Human Rights Implications

a. *Violation of the Right to Bodily Integrity*

Article 7 of the ICCPR explicitly provides that “no one shall be subjected without his free consent to medical or scientific experimentation.”²⁵³ This article, which applies to all “medical institutions,”²⁵⁴ encapsulates protection for the dignity and integrity of an individual²⁵⁵ and covers acts that cause physical and mental pain and suffering.²⁵⁶ States must prevent forced sterilizations in order to comply with their obligations under Article 7.²⁵⁷

The ICESCR recognizes the right “of everyone to the enjoyment of the highest attainable standard of physical and mental health.”²⁵⁸ As interpreted by the CESCR in its General Comment 14, the right to health encompasses “the right to control one’s health and body including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from . . . non consensual medical treatment.”²⁵⁹

Article 16 of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT) also requires States Parties to prevent acts of cruel, inhuman, or degrading treatment.²⁶⁰ Its treaty monitoring committee, the CAT Committee, has also expressed concerns regarding allegations of involuntary sterilization of women within the jurisdiction of States Parties.²⁶¹

The African Charter asserts that all human beings are entitled to respect for life, integrity, and dignity of person.²⁶² The African Protocol on the Rights of Women recognizes that “every woman” is entitled to respect for her life, integrity, and security and prohibits “all forms of exploitation” and “cruel, inhuman or degrading” treatment.²⁶³

²⁵¹ *Id.* at Chapter 3.5.3-3.5.6.

²⁵² *Id.*

²⁵³ ICCPR, *supra* note 192, art. 7.

²⁵⁴ Human Rights Committee (HRC), *General Comment 20, Article 7, Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, ¶ 5, U.N. Doc. HRI/GEN/1/Rev. 1 (1994).

²⁵⁵ *Id.* at ¶ 2.

²⁵⁶ *Id.* at ¶ 5.

²⁵⁷ HRC, *General Comment 28: Equality of Rights Between Men and Women (Art. 3)*, *supra* note 224, at ¶ 11.

²⁵⁸ ICESCR, *supra* note 193, at art. 12(1).

²⁵⁹ CESCR, *General Comment No. 14*, *supra* note 34, at ¶ 8.

²⁶⁰ Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Dec. 10, 1984, 1465 U.N.T.S. 85 [hereinafter CAT].

²⁶¹ See Committee Against Torture (CAT Committee), *Concluding Observations: Czech Republic*, ¶¶ 85-87, U.N. Doc. A/59/44 (2004).

²⁶² African Charter, *supra* note 193, at arts. 4, 5.

²⁶³ African Protocol on the Rights of Women, *supra* note 209, at art. 4(1).

Finally, the International Guidelines on HIV/AIDS and Human Rights specifically articulate that forced sterilization of women living with HIV is a violation of “the right to liberty and integrity of the person.”²⁶⁴ Reports given to IHRC-NWHN reveal that sterilization of women living with HIV in Namibia has occurred without their “free consent,”²⁶⁵ inflicts mental and physical suffering, and offends “the dignity and the physical and mental integrity of the individual.”²⁶⁶ Sterilization without a woman’s free consent is an affront to her bodily integrity and constitutes cruel, inhuman, and degrading treatment in violation of the ICCPR, the CAT, the African Charter, and the African Protocol on the Rights of Women.

Although the Namibian Constitution prohibits cruel, inhuman, and degrading treatment,²⁶⁷ “it is not sufficient for the implementation of [international human rights obligations] to prohibit such treatment . . . or to make it a crime.”²⁶⁸ Namibia must take “legislative, administrative, judicial, and other measures . . . to prevent and punish” these acts of nonconsensual sterilization.²⁶⁹ Domestic law must recognize “the right to lodge complaints against maltreatment” and these complaints “must be investigated promptly and impartially by competent authorities so as to make the remedy effective.”²⁷⁰

Finally, professional ethics of physicians and nurses also require a much more considerate standard of care than the one IHRC-NWHN documented. For example, the International Federation of Gynecology and Obstetrics’ Ethical Considerations on Sterilization states that “the process of informed choice must precede informed consent to surgical sterilization.”²⁷¹ The physician must provide information regarding “recognized available alternatives, especially reversible forms of family planning which may be equally effective.”²⁷² The physician must ensure that the patient “has been properly counseled concerning the risks and benefits of the procedure and of its alternatives” prior to commencing the procedure.²⁷³ IHRC-NWHN research demonstrates that there was no “free and informed consent” prior to sterilization, nor did the physician and patient engage in a process of “informed choice” with information regarding “risks and benefits of the procedure” and “recognized available alternatives, especially reversible forms of family planning.”²⁷⁴

b. Violation of the Right to Found a Family

The Universal Declaration of Human Rights recognizes the right of “men and women of full age . . . to found a family”²⁷⁵ and describes the family as “the natural and fundamental group unit of society” that is “entitled to protection by society and the State.”²⁷⁶ The ICCPR also recognizes

²⁶⁴ *International Guidelines*, *supra* note 200, at ¶ 118.

²⁶⁵ ICCPR, *supra* note 192, art. 7.

²⁶⁶ HRC, *General Comment 20*, *supra* note 254, at ¶ 2.

²⁶⁷ NAMIB. CONST. art. 8, § 1-2(b).

²⁶⁸ HRC, *General Comment 20*, *supra* note 254, at ¶ 8.

²⁶⁹ *Id.*

²⁷⁰ *Id.* at ¶ 14.

²⁷¹ INTERNATIONAL FEDERATION OF GYNECOLOGY AND OBSTETRICS (FIGO), RECOMMENDATIONS ON ETHICAL ISSUES IN OBSTETRICS AND GYNECOLOGY BY THE FIGO COMMITTEE FOR THE ETHICAL ASPECTS OF HUMAN REPRODUCTION AND WOMEN’S HEALTH, 93, (October 2009), *available at* <http://www.figo.org/docs/Ethics%20Guidelines%20%20English%20version%202006%20-2009.pdf> [hereinafter FIGO, *Recommendations on Ethical Issues*].

²⁷² *Id.*

²⁷³ *Id.*

²⁷⁴ *Id.* at 93.

²⁷⁵ Universal Declaration of Human Rights (UDHR), G.A. Res. 217A (III), *adopted* 10 December 1948, art. 16(1), U.N. Doc A/810.

²⁷⁶ *Id.* at art. 16(3).

the right to found a family,²⁷⁷ and the Human Rights Committee has held that this right “implies . . . the possibility to procreate.”²⁷⁸ In conjunction with this right, “family planning policies . . . should be compatible with the provisions of the Covenant and should in particular not be discriminatory or compulsory.”²⁷⁹

CEDAW encompasses the right “to decide freely and responsibly on the number and spacing of . . . children.”²⁸⁰ The CEDAW Committee has held that because “compulsory sterilization or abortion adversely affects women’s physical and mental health,” the practice violates women’s right to freely choose to have children.²⁸¹ In *A.S. v Hungary*, the CEDAW Committee held that a sterilization procedure performed “without [the woman’s] full and informed consent . . . permanently deprived her of her natural reproductive capacity” and therefore violated her right to freely choose the number and spacing of her children.²⁸² The hospital’s decision not to provide “detailed information about the sterilization, including the risks involved and the consequences of the surgery, alternative procedures, or contraceptive methods” at a “stressful” time violated the state’s obligation to fulfill the right to information.²⁸³

The African Protocol on the Rights of Women provides that States Parties must “ensure that the right to health of women, including sexual and reproductive health, is respected and promoted.”²⁸⁴ This right includes “a) the right to control their fertility; b) the right to decide whether to have children, the number of children and the spacing of children; [and] c) the right to choose any method of contraception.”²⁸⁵ This right is also interlinked with the right to information, which requires that proper information relating to the medical risks associated with pregnancy for HIV-positive women be provided to those women.

In Namibia, some health care workers deem women who are HIV-positive unable to understand the information that is necessary for them to render a meaningful decision about serious medical issues including HIV testing and sterilization. This medical culture of paternalism toward HIV-positive women who seek treatment and/or are pregnant has the consequence of violating the core of women’s reproductive rights — the right to have a child and a family at the time of and in a manner of their own choosing.

The International Guidelines on HIV and Human Rights specifically articulate that forced abortions and sterilization of women living with HIV “violate the human right to found a family.”²⁸⁶ Women should be “provided with full and accurate information about the risk of perinatal transmission to support them in making voluntary, informed choices about reproduction.” This information must include education about prevention of mother-to-child transmission.²⁸⁷

²⁷⁷ ICCPR, *supra* note 192, art. 23(2).

²⁷⁸ HRC, *CCPR General Comment No. 19: Article 23, Protection of the Family, the Right to Marriage and Equality of the Spouses*, 27 July 1990, ¶ 5 [hereinafter HRC, *General Comment 19*].

²⁷⁹ *Id.*

²⁸⁰ CEDAW, *supra* note 207, at art. 16(1)(e).

²⁸¹ CEDAW Committee, *General Recommendation 19*, ¶ 22, U.N. Doc. No. A/47/38 (11th Sess. 1992).

²⁸² *A.S. v Hungary*, Communication No. 4/2004, Committee on the Elimination of Discrimination against Women, ¶ 11.4, U.N. Doc. CEDAW/C/36/D/4/2004 (2006).

²⁸³ *Id.*

²⁸⁴ African Protocol on the Rights of Women, *supra* note 209, at art. 14(1).

²⁸⁵ *Id.*

²⁸⁶ *International Guidelines*, *supra* note 200, at ¶ 118.

²⁸⁷ *Id.*

c. Discrimination on the Basis of Sex and HIV Status

Forced and coerced sterilization in Namibia appears to occur disproportionately to women living with HIV and is based solely on these women's HIV-positive status and ability as women to bear children. Such sterilization constitutes a discriminatory act on the basis of HIV status in violation of the Namibian Government's obligations to not discriminate on the basis of sex or HIV status under Article 3 of the ICCPR, Article 2(2) of the ICESCR, Articles 2(e) and 8 of CEDAW, and Article 18 of the African Charter. This practice also constitutes a discriminatory act inflicting "physical, mental or sexual harm or suffering" on the basis of sex, in violation of Namibia's CEDAW obligations.²⁸⁸

d. Violation of the Right to Information

Attendant in a violation of the right to bodily integrity in the context of forced sterilization is the absence of provision of complete information as to the nature of the procedure, its effects, consequences, and risks associated with it. The lack of adequate information regarding sterilization violates the right to be informed regarding health status "in accordance with internationally recognized standards and best practices" under the African Protocol on the Rights of Women.²⁸⁹

At this juncture, the right to health in the context of the state's "specific and continuing obligation to move as expeditiously and effectively as possible towards the full realization" of the right to health²⁹⁰ ought to be borne in mind. While international human rights law accounts for a State Party's limited resources by allowing for "progressive realization" of the right to health, this does not deprive the obligation of having any immediate effect.²⁹¹ Some specific obligations identified in CESCR General Comment 14 that Namibia should be seeking to enforce with immediate effect include: (a) to not apply coercive medical treatments (save in exceptional circumstances as provided);²⁹² (b) to refrain from "censoring, withholding or intentionally misrepresenting health-related information;"²⁹³ and (c) to adopt legislation "ensuring equal access to health care and health-related services provided by third parties."²⁹⁴ The failure of Namibia to have taken these measures, in addition to the failure to prevent or rectify the conduct discussed in the preceding sections (which violate the sexual and reproductive health rights of HIV-positive women) needs to be countered immediately.

As has been discussed with respect to the various legal breaches above, an overall framework of applicable law is presently available in Namibia — both in the form of domestic law and policy and international human rights treaty obligations. What is absent, however, is enforcement of these rights and protections in order to bring an end to the continuing violations of the rights of women living with HIV.

D. Cultural Barriers: International Human Rights Implications

Namibia has the responsibility under the ICESCR to promote "social determinants of good health, such as environmental safety, education, economic development and gender equity."²⁹⁵

²⁸⁸ CEDAW Committee, *General Recommendation 19*, *supra* note 281, ¶ 6.

²⁸⁹ African Protocol on the Rights of Women, *supra* note 209, at art. 14(1).

²⁹⁰ CESCR, *General Comment No. 14*, *supra* note 34, at ¶ 31.

²⁹¹ *Id.* at ¶ 31.

²⁹² *Id.* at ¶ 34.

²⁹³ *Id.* at ¶ 34.

²⁹⁴ *Id.* at ¶ 35.

²⁹⁵ CESCR, *General Comment No. 14*, *supra* note 34, at ¶ 16.

Under CEDAW and the CEDAW Committee's General Recommendation 19, Namibia must "modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices that are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women."²⁹⁶ Regional treaties, such as the African Protocol on the Rights of Women (Articles 4 and 5), erect similar frameworks for addressing violence against women and gender-based stereotypes.²⁹⁷ IHRC-NWHN research demonstrates that several aspects of the cultural and structural environment in Namibia have contributed to the previously discussed violations of HIV-positive women's human rights.

1. Intergenerational Transactional Sex

CEDAW has noted that "as a consequence of unequal power relations based on gender, women and adolescent girls are often unable to refuse sex or insist on safe and responsible sex practices."²⁹⁸ The CEDAW Committee has recognized the constrained choices of women and girls due to poverty and unemployment, where sex stereotypes are prevalent.²⁹⁹

In addition, Article 34 of the CRC requires States Parties to "protect the child from all forms of sexual exploitation and sexual abuse" and take measures to prevent "[t]he inducement or coercion of a child to engage in any unlawful sexual activity [and] [t]he exploitative use of children in prostitution or other unlawful sexual practices."³⁰⁰ Additionally, under Article 19 of the CRC, States Parties must "take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse ... [and] maltreatment or exploitation, including sexual abuse."³⁰¹ These measures include the "establishment of social programmes to provide necessary support for the child" and "other forms of prevention and for identification, reporting, referral, investigation, treatment and follow-up of instances of child maltreatment."³⁰²

The CRC's Committee on the Rights of the Child addresses the needs of adolescents specifically, stating that "adolescents who are sexually exploited, including in prostitution . . . are exposed to significant health risks, including. . . HIV/AIDS, . . . violence, and psychological distress."³⁰³ In order to prevent the spread of HIV/AIDS, states should target environmental factors through programs that provide information to adolescents, programs that ensure adolescents have access to "preventative measures" (such as condoms), and programs "aimed at changing cultural views."³⁰⁴ Further, states should make efforts to reintegrate affected children in an environment that "fosters health, self-respect and dignity."³⁰⁵

2. Intimate Partner Violence

The ICESCR recognizes the equality of men and women³⁰⁶ and also protects the family.³⁰⁷ The

²⁹⁶ CEDAW, *supra* note 207, at art. 5.

²⁹⁷ African Protocol on the Rights of Women, *supra* note 209.

²⁹⁸ CEDAW Committee, *General Recommendation 24*, *supra* note 229, at ¶ 18.

²⁹⁹ CEDAW Committee, *General Recommendation 19*, *supra* note 281, at ¶ 15.

³⁰⁰ CRC, *supra* note 230.

³⁰¹ *Id.*

³⁰² *Id.* at art. 19(2).

³⁰³ CRC, *General Comment 4: Adolescent Health and Development in the Context of the Convention on the Rights of the Child*, ¶ 37, U.N. Doc. A/59/41 (33rd Sess., 2004).

³⁰⁴ *Id.* at ¶ 30.

³⁰⁵ *Id.* at ¶ 37.

³⁰⁶ ICESCR, *supra* note 193, at art. 3.

³⁰⁷ ICESCR, *supra* note 193, at art. 10(1).

CESCR has recognized that “gender-based violence is a form of discrimination that inhibits the ability to enjoy rights and freedoms, including economic, social, and cultural rights, on a basis of equality.”³⁰⁸ Consequently, States Parties must provide “victims of domestic violence . . . with access to safe housing, [and] remedies and redress for physical, mental and emotional damage.”³⁰⁹

The CEDAW Committee has determined that gender-based violence “which impairs or nullifies the enjoyment by women of human rights and fundamental freedoms ... is discrimination within the meaning of Article 1 of the Convention.”³¹⁰ According to the CEDAW Committee, “commercial exploitation of women . . . contributes to gender-based violence.”³¹¹ However, other societal factors also contribute to violence against women, including the fact that in many societies, women are “regarded as subordinate to men or as having stereotyped roles.”³¹² Such “traditional attitudes” perpetuate violence against women, particularly “within family relationships.”³¹³ The violence that results contributes to a cycle in which “gender-based violence help[s] to maintain women in subordinate roles and contribute[s] to their low level of political participation and to their lower level of education, skills and work opportunities.”³¹⁴

The relevant standard of conduct for a state with regard to these international obligations is the due diligence standard.³¹⁵ In the context of intimate partner violence as it falls within the scope of gender-based violence, the due diligence obligation requires the state to take all measures necessary to prevent and investigate gender-based violence, as well as to ratify international treaties, develop national legislation to implement treaty obligations, provide support services, and educate to increase awareness about discriminatory practices.³¹⁶

E. Conclusion

Lack of availability of crucial information is often cited as an underlying cause of the global HIV/AIDS crisis. A recent article condensed analyses of relevant U.N. agencies and nongovernmental human rights groups and concluded that “[f]ulfilling the fundamental human right to information is essential in the prevention and ultimately the eradication of HIV/AIDS.”³¹⁷ At the basis of this claim are studies demonstrating that in countries where people do not have access to information about the risks of HIV/AIDS, prevention efforts will inevitably fail.³¹⁸ The violation of one’s human right to receive information needed to protect one’s health, “as set forth in international human rights covenants,” is pervasive.³¹⁹

³⁰⁸ Committee on Economic, Social, and Cultural Rights, *General Comment No. 16: The equal right of men and women to the enjoyment of all economic, social and cultural rights*, ¶ 27, U.N. Doc. E/C.12/2005/4 (11 August 2005).

³⁰⁹ *Id.*

³¹⁰ CEDAW Committee, *General Recommendation 19*, *supra* note 281, at ¶ 7.

³¹¹ *Id.* at ¶ 12.

³¹² *Id.* at ¶ 11.

³¹³ *Id.* at ¶ 23.

³¹⁴ *Id.* at ¶ 11.

³¹⁵ This standard was established in *Velasquez Rodriguez Case*, Inter-Am. Ct. H.R. (Ser. C) No.4 (1988)

³¹⁶ Yakin Erturk, *Report of the Special Rapporteur on violence against women, its causes and consequences*, U.N. Doc. E/CN.4/2006/61 (2006)

³¹⁷ Kalah Macedo, *Global HIV/AIDS Pandemic is a Result of Human Rights Violations*, WORLD POVERTY AND HUMAN RIGHTS ONLINE (Mar. 28, 2010), <http://wphr.org/2010/kalah/global-hiv-aids-pandemic-is-a-result-of-human-rights-violations>.

³¹⁸ *Id.* (citing studies conducted by UNDP and Human Rights Watch).

³¹⁹ *Id.*

V. RECOMMENDATIONS

IHRC and NWHN make the following recommendations to redress the sexual and reproductive rights violations perpetrated upon women living with HIV and to help ensure that such violations no longer occur:

Government of Namibia

Stigma and Discrimination in the Context of Sexual and Reproductive Health Care

- Remove all barriers to women's access to comprehensive sexual and reproductive health services, education, and information.
- Monitor the provision of health services to women by public, nongovernmental, and private organizations, to ensure equal access and quality of care.
- Require all health services to be consistent with the human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent, and choice.
- Ensure that the training curricula of health workers include comprehensive, mandatory, gender-sensitive courses on women's health and human rights.

Informed Consent: Forced and Coerced Sterilization

- Immediately take action to stop ongoing forced and coerced sterilization, including holding accountable those who have committed such acts and taking steps to ensure better surveillance and reporting mechanisms are implemented in health care facilities to prevent future violations.
- Involve women and girls living with HIV in each stage of policy and law design and implementation.
- Develop and implement a system to provide an effective and fair remedy to all women who have been subject to forced or coerced sterilization.
- Create a system that allows individuals to report violations of rights related to sexual and reproductive health care and that monitors responses from the Government.
- Provide long-term assistance to individuals and their families who have suffered forced or coerced sterilization.

Informed Consent: HIV Testing and Discrimination

- Immediately modify any segregated public health care facilities, such that patients are not physically sorted by HIV status either as policy or by hospital staff.
- Ensure that medical passports maintain privacy and are not used in a manner that violates patient confidentiality.
- Train staff and providers in health care facilities on human rights and associated approaches, in order to reduce stigma and discrimination of HIV-positive individuals.
- Build upon HIV education programs that have already proven successful, and institute programs designed to promote gender equality, human rights, and sexual and reproductive rights in particular.

Confidentiality

- Ensure that laws, policies, and regulations appropriately penalize any breach of confidentiality by health professionals regarding the private, health-related data of their patients.
- Establish and monitor the material facilities (locked file cabinets, secure databases, private consultation areas) as well as procedures to maintain the confidentiality of patient information.

- Train staff and providers in health care facilities on maintaining confidentiality.
- Educate patients on their rights to confidentiality and on the redress mechanisms available to them should their rights be violated.

Information

- Ensure that health professionals provide complete, medically accurate sexual and reproductive health information in a manner consistent with U.N. CESCRC General Comment 14 in terms of accessibility, acceptability, and quality.
- Establish oversight and redress mechanisms to ensure that such information is provided to patients.
- Train staff and providers to provide such information.
- Educate patients on their rights to information.

Cultural Barriers: Gender-Based Violence and Persistence of Stereotypes

- Eliminate gender-based violence by implementing Namibian and international laws and policies sanctioning such behavior.
- Educate community and youth leaders on gender equality.
- Provide educational and income generation opportunities to youth, men, and women in order to create alternative life choices, other than those based on gender-based stereotypes.

Donors

Stigma and Discrimination in the Context of Sexual and Reproductive Health Care

- Support programming that integrates rights related to sexual and reproductive health care and HIV to ensure a full range of continuous care for women living with HIV.
- Support the training of hospital staff to decrease stigma and discrimination.
- Support grassroots efforts, especially organizations of women living with HIV, in advocating for and monitoring change.

Informed Consent: Forced and Coerced Sterilization

- Support funding that investigates instances of forced or coerced sterilization and takes an active role in holding doctors and providers accountable for rights violations.
- Fund ongoing documentation of rights violations, legal services, and the litigation process.

Informed Consent: HIV Testing and Discrimination

- Provide technical and financial assistance to the Government of Namibia, its schools, and professional associations of medicine, nursing, midwifery, public health, and law, as well as civil society (especially nongovernmental organizations (NGOs) of and for people living with HIV) to ensure that rights related to informed consent are respected, protected, and fulfilled.

Confidentiality

- Provide technical and financial assistance to the Government of Namibia, its schools, and professional associations of medicine, nursing, midwifery, public health, and law, as well as civil society (especially NGOs of and for people living with HIV) to ensure that rights related to confidentiality are respected, protected, and fulfilled.

Information

- Provide technical and financial assistance to the Government of Namibia, its schools, and professional associations of medicine, nursing, midwifery, public health, and law, as well as civil society (especially NGOs of and for people living with HIV) to ensure that rights related to information (in the context of health) are respected, protected, and fulfilled.

Cultural Barriers: Gender-Based Violence and Persistence of Stereotypes

- Ensure that women living with HIV play a leadership role in programs.
- Prioritize funding for HIV-positive women's organizations and networks of HIV-positive people.
- Support programming that integrates a gender perspective with specific attention to gender-based violence.
- Fund educational programming that targets Namibian youth and aims to reduce HIV-related stigma in Namibian society through dialogue and education.

Namibian Civil Society

Stigma and Discrimination in the Context of Sexual and Reproductive Health Care

- Provide safe spaces for dialogue about sexual and reproductive health rights, as well as other challenges facing Namibian women and girls.
- Monitor the availability, accessibility, acceptability, and quality of the provision of sexual and reproductive health care and seek redress where appropriate.

Informed Consent: Forced and Coerced Sterilization

- Continue to build capacity to document discrimination against women living with HIV in Namibia, with a particular focus on recognizing and investigating violations of sexual and reproductive rights, especially forced and coerced sterilization.

Informed Consent: HIV Testing and Discrimination

- Continue to build capacity to document discrimination against women living with HIV in Namibia, with a particular focus on recognizing and investigating violations of sexual and reproductive rights, especially relating to HIV testing.

Confidentiality

- Continue to build capacity to document discrimination against women living with HIV in Namibia, with a particular focus on recognizing and investigating violations of sexual and reproductive rights, especially related to confidentiality.

Information

- Strengthen capacity to document discrimination against women living with HIV in Namibia, with a particular focus on violations of sexual and reproductive rights to information.

Cultural Barriers: Gender-Based Violence and Persistence of Stereotypes

- Build the leadership of women living with HIV in community-based organizations and NGOs.
- Design and implement new outreach measures to involve men in efforts to end discrimination against women living with HIV in Namibia.
- Continue to advocate for equal access to sexual and reproductive health services for women living with HIV.