Make it *everybody's* business...

Lessons Learned from Addressing the Coerced Sterilisation of Women Living with HIV in Namibia:

A Best Practice Model

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executive summary

Make it everybody's business to know that we as HIV positive women, we have rights and you have to recognise those rights and you shouldn't be any different from any other woman.[1]

The coerced sterilisation of women living with HIV is an ongoing, and largely invisible, human rights violation in Namibia, and globally, with documented incidents from South Africa to Chile. In order to develop a ***best practice model*** for other countries to use and adapt as a tool to document and address the coerced sterilisation of positive women in Namibia – within the framework of advancing the sexual and reproductive health and rights of positive women – the following report:

- Documents and analyses the approaches used to highlight the practice of coerced sterilisation of young women living with HIV, including the strategies used to build an evidence base;
- Documents and analyses the advocacy responses to this practice;
- Documents and analyses the litigation processes pertaining to coerced sterilisation of women living with HIV from a community perspective;
- Identifies the lessons learned, both successes and challenges; and,

- Outlines '*best practice*' as a tool for other countries in the region to share experiences and adapt to national contexts.

The analysis of lessons learned to date in addressing the coerced sterilisation of positive women in Namibia is part of a broader initiative to advance the sexual and reproductive health and rights of women living with HIV, including the right to safe, healthy motherhood and to true reproductive choices. The broader initiative entails a mapping of emerging trends and neglected issues at the intersection of sexual and reproductive rights and health and HIV; the development of human rights frameworks, policy briefs, and fact sheets; the use of human rights mechanisms, including the Special Rapporteur; capacity building; and community mobilisation.

This report reviews the multi-pronged strategy that has been utilised in the Namibian context. Through this multi-pronged strategy, the Namibian experience demonstrates how documentation, advocacy, and litigation processes can all work together to address rights violations, hold the government accountable for what is taking place in its public hospitals, and afford redress to women who have been violated. Further, the report highlights how an issue that is both invisible and contentious can be made visible and be brought to mainstream audiences through community-led documentation and alliance building spearheaded by women living with HIV. Examining the experiences of the Namibia Women's Health Network and her partners, the report seeks to tell a narrative of empowerment and accountability where, in part, the empowerment comes from seeking accountability.

METHODOLOGY

The report is based on the documentation and analysis of various advocacy approaches and responses used in the Namibian context to address the coerced sterilisation of positive women. During the documentation process, information was gathered by various means, such as in-depth interviews with key NGO partners and affected community stakeholders, including women whose experiences of coerced sterilisation are currently being litigated in Namibia; and a series of dialogues and community meetings with positive women in various regions of Namibia, where incidents of coerced sterilisation have been documented, to assess women's experiences of, and expectations for, the campaign against coerced sterilisation, as well as the litigation process. Furthermore, the court proceedings and related advocacy activities in Namibia have been documented. Lastly, the authors undertook a desk review of relevant reports, correspondence, and media coverage.

overview and context[2]

One doctor…she came to me in the morning time to tell me, 'You know you cannot have anymore babies… They closed you'. I say, 'No, I did not sign, because I am a married woman, I cannot sign to not getting a baby.' They say, 'No, we cannot do anything more, because they already closed you.'[3]

The coerced sterilisation of women living with HIV is a grievous and ongoing human rights violation in Namibia, which is occurring within the context of both HIV care, specifically the prevention of vertical transmission programmes (more commonly known as PMTCT, prevention of mother to child transmission), and general obstetric care. More than 40 cases of coerced sterilisation have been documented since 2008 by the International Community of Women Living with HIV (ICW) and the Namibia Women's Health Network[4], with 15 of these cases taken forward for litigation by the Legal Assistance Centre of Namibia, after additional research and physician exams[5]. Six of these fifteen cases, which were closest to the time of prescription, were lodged with the courts in October 2009, with three cases given court dates in June 2010. These three cases have been heard in June 2010 before the High Court of Namibia, and have subsequently been postponed to September 2010.

Women living with HIV are being sterilised without consent, including without their full knowledge of what sterilisation entails. As one positive woman respondent reported, '*Most of the people, we don't know. If you just say come and sign here, but you don't say* [why]... *I come to sign, but I don't know* [what I am signing for].'[6] In some instances, '*consent*' to sterilisation has become a prerequisite for access to maternity care, and in other instances, 'consent' is obtained under duress while a woman is in active labour. The experience of another positive woman interviewed, and as narrated in a community dialogue, provides a compelling example of how this can occur:

> *On 16 June 2004, something that changed her life forever happened when she went to Katutura to give birth and was told that the child is too big and therefore she was to deliver the baby through c-section. She was told that for the doctor to perform the c-section she has to sign, and she was told to sign papers that were not explained to her.*
>
> *She was taken to the theatre for c-section and without her knowledge was sterilised. She spent two weeks in the hospital; no one explained to her what had happened. After being discharged and spending two weeks at home, she went back to the same hospital to access family planning. To her surprise, she was told by the nurse that she will not be given family planning, because she is already sterilised. She asked the nurse why, and she was told that was done, because of the fact that 'she is HIV positive and people who are HIV positive are not supposed to have children... This has been upsetting to her, because now she feels...she is not a complete woman according to her culture.*[7]

Defining concepts

'*Coerced sterilisation*' is generally defined as the use of coercion in obtaining the necessary informed consent for the sterilisation procedure. '*Forced sterilisation*' refers to the instance when a woman is unaware that she would be undergoing a sterilisation procedure at the time of the surgery and only learns of the sterilisation after the fact[8]. Evidence suggests that both practices are widespread in Namibia.

Informed decision-making and consent are essential rights elements of all medical procedures, and arguably particularly vital when permanent procedures are being performed. However, in all of the cases documented, the right to informed consent was violated. In at least six cases, consent was obtained by medical personnel in situations of duress. Women were asked to sign consent forms, while in labour or on their way to the operating theatre, or were told or given the impression that they had to consent to sterilisation in order to obtain another medical procedure, such as an abortion or caesarean section. In other instances, women were asked to sign a consent form for sterilisation, without being informed of the form's contents. In all of these cases, medical personnel failed to provide the women with a full description of the nature of the procedure, its effects, consequences, and risks. No medical personnel informed the women of the procedure's irreversibility, or provided information on alternative forms of birth control and family planning. In addition, no information was provided on the potential side-effects of sterilisation.[9]

These practices directly contradict the informed consent guidelines issued by the International Federation of Gynecology and Obstetrics (FIGO).

The guidelines emphasise that:

> *The process of informed choice must precede informed consent to surgical sterilisation. Recognised available alternatives, especially reversible forms of family planning which may be equally effective, must be given due consideration. The physician performing sterilization has the responsibility of ensuring that the person has been properly counselled concerning the risks and benefits of the procedure and of its alternatives.*[10]

The FIGO guidelines also specifically note that the difficulty or time-consuming nature of providing the necessary information for a woman's informed consent does not absolve medical providers from striving to fulfil these criteria for informed consent. They also emphasise that '*informed consent is not a signature but a process of communication and interaction*'.[11]

Namibia's neighbour, South Africa, has legislation mandating that consent be obtained prior to any medical procedure, including sterilisation, and that consent must be '*given freely and voluntarily without any inducement*'.[12] Although no specific legislation affording the right to informed consent currently exists in Namibia, the practice of forced or coerced sterilisation violates numerous rights as guaranteed in the Namibian Constitution, as well as in various human rights treaties ratified by Namibia, including the right to be free from cruel, inhuman, and degrading treatment; the right to liberty and security of a person; the right to health and family planning; the right to privacy; and the right to equality and to be free from discrimination.[13]

Impact and responses

The impact of involuntary sterilisation can be devastating, affecting a woman's mental and physical health and her relationship with her partner, her family, and society at large. For some women who have been sterilised, they find that their '*family don't want to be with them again, some were married women* [and] *the husband or boyfriend leave them because they cannot…give birth anymore*'.[14] Socio-cultural expectations of womanhood and motherhood also greatly impact on the extent to which women are in the position to cope with the implications of sterilisation after returning to their communities.

> *And our culture…it looks down on women who cannot have children… So how is this woman going to live in the community? She is going to be depressed, she is going to be stigmatised, she is going to be discriminated…and she might even think of killing herself.*[15]

The impact of sterilisation without consent on women's overall well-being and health status also has serious implications for the healthcare system as a whole; as the fear of discrimination and mistreatment can discourage women from seeking healthcare services, and can severely undermine the government's public health initiatives around HIV and reproductive health.

Although these egregious violations have been repeatedly brought to the attention of the Government of Namibia since 2008, the Government has yet to take actions to halt ongoing violations. With representation from the Namibian Legal Assistance Centre, six of the women subjected to coerced or forced sterilisation have filed cases before the High Court, alleging violations

of their right to life, human dignity, and equality and the right to be free from cruel, inhuman, and degrading treatment. Court dates have been continuously delayed from October and November 2009, to June 2010, and now until September 2010.

In 2008, documentation of 13 cases was submitted by the Namibia Women's Health Network, the International Community of Women Living with HIV/AIDS (ICW), the Legal Assistance Centre, and the Southern Africa Litigation Centre to the Deputy Minister of Health and Social Services, Petrina Haingura. At this time, the Deputy Minister said that the Ministry would issue circulars to the health facilities stating that if forced and coerced sterilisations were occurring at hospitals, they should be halted. Follow-up investigations conducted by the Namibia Women's Health Network revealed that the circulars were not distributed to healthcare facilities. The Minister of Health, Richard Kamwi, through a ministerial statement in Parliament in March of 2009, denied that involuntary sterilisations of women living with HIV is a pattern in Namibia or have taken place in Namibian hospitals. In addition to stating that the Ministry of Health investigation established that all women who had undergone sterilisation had signed the relevant consent forms, Minister Kwami is further cited as stating that '*Our findings did not indicate any specific trend with regard to bilateral tubal ligation performed on HIV-positive women*'.[16]

As a result of the Ministry's denial and inaction, violations are ongoing and women living with HIV continue to come forward with their health passports stating that they have been sterilised, or recommended for sterilisation.

The to date documented forced and coerced sterilisations of women living

with HIV occurred at public hospitals – Katutura State Hospital, Central State Hospital, and Oshakati State Hospital. However, the full extent of the incidence is yet to be established, with new cases continuously becoming known from different regions and hospitals in Namibia. Responding to the practice of sterilisation without consent, the Legal Assistance Centre is litigating several of these cases, arguing that the coerced sterilisation of positive women at public hospitals violates these women's rights under the Namibian Constitution, while at the same time national and regional campaigns to end the forced sterilisation of HIV positive women in Southern Africa have been launched.

making coercive sterilisation visible

COMMUNITY LED DOCUMENTATION: BUILDING AN EVIDENCE BASE

> *Nowadays…Namibia is really becoming a role model because Namibia is doing the PMTCT so well that they are now at 97% of children being born by positive mothers, they are not having HIV, so why sterilise now? Why sterilise a young girl if she falls pregnant and it's her first pregnancy…when we know that you can have children even if you are living with HIV?*[17]

Beginning in 2005, the Center for Reproductive Rights, ATHENA, and ICW identified coerced sterilisation as a pervasive, yet unrecognised, human rights violation facing positive women necessitated further documentation and possible litigation. Against the backdrop of regional and global advocacy to raise the visibility of coerced sterilisation, as well as to advance the sexual and reproductive rights of women living with HIV, ICW and the Namibia Women's Health Network convened a five-day Young Women's Dialogue in January 2008 in Windhoek to discuss issues relevant to young women living with HIV in Namibia. During the course of the workshop, three young, positive women stepped forward to share their experiences of forced or coerced sterilisation at public hospitals that occurred in the context of HIV care.

The Namibia Women's Health Network

> *…decided to get involved and take up the issue, as we realised that it was another form of discrimination and abuse of positive women…* [and a violation of] *rights to motherhood. We were also concerned about the negative effects on women accessing PMTCT.*[18]

The Namibia Women's Health Network and the Legal Assistance Centre undertook the initial documentation, and met with nine different groups in Katutura. Additional documentation was conducted by ICW and the Namibia Women's Health Network through April 2008 in three different regions of Namibia, namely in Khomas, Oshana and Otjiwarongo. Forty cases of coerced or forced sterilisation were identified from interviews with around 200 women. The majority of cases of sterilisation without consent occurred at the Katutura Hospital, where representatives from the Namibia Women's Health Network and the Legal Assistance Centre met with the Customer Care Officer in 2008. The Officer stated that she would investigate the allegations, given the information coming from positive women. However, no response has been received to date. A submission of the documentation was also made by ICW to the Deputy Minister of Health in August 2008 with no response, and again by the Legal Assistance Centre in January 2009 with a response in June of 2009 from the Ministry, stating that no such sterilisations were taking place.

The documentation process took place in tandem with capacity building of positive women in human rights documentation, as well as on sexual and reproductive health and rights in the context of HIV and AIDS. The intent of this approach was to catalyse a positive woman-led response, that in itself

would be empowering, and a form of redress for women whose rights had been violated. The approach engaged women as fact-finders and evidence gatherers, and facilitated a process whereby women could understand and identify the violations, as well as seek accountability through documentation and advocacy.

Methods to document cases and build an evidence base included community dialogues with positive women, in-depth interviews with affected women and service providers, as well as a review of health passports and health records where available. This process has been, and still is, filled with challenges, including:

- Lack of knowledge and understanding among community members of what sterilisation is, such that many potentially affected women do not know whether or not they have been sterilised;

- Issue of validity of health passports, and outstanding questions as to whether or not sterilisation was accurately recorded in all cases, with evidence suggesting that sterilisation was not recorded in all instances;

- Inaccessibility and/or denial of access to health records in public hospitals, which are considered property of the government;

- Burden and cost of definitive proof of performed sterilisation through physical exam;

- Denial of and resistance to identifying coerced sterilisation as a '*legitimate*' and '*real*' human rights violation facing positive women by

service providers and key allies in the broader HIV, human rights, and sexual and reproductive health and rights communities;

- Lack of dedicated funding for documentation and redress; and,

- Tension between community-led documentation and '*technical expertise*' in human rights documentation, including a lack of resources and capacity in both areas.

Lessons learned

The experiences in Namibia underscore the many ways in which coerced sterilisation is a challenging human rights violation to evidence, address – and afford redress. The documentation gathered to date suggests that the practice of coerced sterilisation builds as much from power differentials between service provider and patient/client, and provider's failure to provide information to patients about their care, as from patients' general lack of knowledge about their rights and available redress mechanisms as and when rights violations occur. As one of the women living with HIV shared:

> *Even if you go to the antenatal [clinic], sometimes the nurse will do an observation, booking, or sonar, but they will never tell you what they are really checking… They will not tell you if it is a boy or a girl, normal or not normal. You don't see anything; the nurse is just doing her observations, that's it, and you go home. Maybe if you ask… but sometimes they will just say 'why do you want to know?'*[19]

Women are generally not in conversation with their providers about their care, and limited information is shared between providers and patients

as a matter of routine. Further compounding these dynamics is the issue of language.

> *Now I can speak a bit of English, I can understand a bit of English. And when the doctor tells me that I challenge him, before when I was not talking and understanding* [English] *I was scared but now I can understand and talk back. I can ask the doctor, I can challenge him.*[20]

Many of the women who have been subjected to coerced sterilisation speak a regional dialect and, as such, have even more limited means by which to ask questions of their service providers or ability to understand the information provided in materials or on forms they may receive.

Documentation gathered to date also suggests that positive women who are coercively sterilised lack information and awareness about their bodies, as well as their rights, underscoring the importance of an approach to building an evidence base that is empowering, and not extractive. The experience of the Namibia Women's Health Network demonstrates how a positive woman-led and empowerment-based process can be built. Despite limited resources to pursue the issue of coerced sterilisation of positive women in Namibia, ICW and Namibia Women's Health Network initiated documentation by and with positive women in conjunction with capacity building among positive women. As such, the documentation process was largely based on positive women interviewing other positive women about potential violations in healthcare settings, including sterilisation without consent. This was combined with awareness raising and capacity building on sexual and reproductive health and rights in the context of HIV and

AIDS, led by and with positive women. Therefore, the process of building an evidence base was both participatory and transformative.

Despite the tireless efforts of the Namibia Women's Health Network, ICW, the Legal Assistance Centre, ARASA, and other national and regional partners (including global allies, such as the Center for Reproductive Rights and ATHENA) to identify coerced sterilisation as a pressing human rights violation facing positive women, it took years and constant '*noise*' (such as linkages to journalists and resulting newspaper articles) to have the issue gain the momentum it has currently achieved. Some members of the mainstream human rights community initially dismissed claims that this was a problem, due to an absence of comprehensive, multi-country evidence, as documented by '*technical experts*'. Some members of the sexual and reproductive health and rights community were initially hesitant to embrace the issue as it fell outside the strict purview of core issues, such as access to family planning or access to safe, legal abortion. Some positive networks were also slow to embrace the issue, as the sexual and reproductive health and rights of women living with HIV is a relatively recent component of HIV activism. Even today the issue of coerced sterilisation has not been taken up by people living with HIV broadly at the national level in Namibia. Lastly, some mainstream women's organisations have remained quiet on the issue, possibly because of the stigma associated with HIV and AIDS.

Overarching all of this remains a perceived '*reality*' that the general public views the sterilisation of positive women as a '*common-sense*' HIV prevention strategy, largely based on discriminatory attitudes that positive women should not be allowed to engage in sex and/or bear children.

Something you have to say is that it's not right, it is a big deal, you are not doing anybody a favour… The public who doesn't know any better would think, it is a good thing you are sterilised, you are not going to get pregnant being HIV positive…so they feel like it is stopping the spread of the virus so they probably think it's a solution to their problem… You are not going to pass it on to another generation.[21]

When the Namibia Women's Health Network reached out to and met with the Legal Assistance Centre to see whether or not redress through the courts was a possible strategy, the issue of sterilisation of positive women without consent began to build even more momentum. Once the issue of coerced sterilisation was determined to be an issue ready for litigation by legal advocates in Namibia, and a number of legal cases were solidified, the practice of coerced sterilisation of positive women began to gather greater visibility, and perceived legitimacy as a pressing human rights violation.

The research around the issue of coerced and forced sterilisation of positive women also illustrated that this human rights violation has occurred – and continues to occur – as a result of significant stigma and discrimination against women living with HIV.

This is not an isolated case, the case of women being sterilised in the healthcare sector... I think it is a society-wide element that is manifesting in the healthcare sector, and I was particularly alarmed when speaking to lay people about the cases... Everybody says why it should be happening, why should they not be sterilised, they should not have children. And it shows that it is engrained in the way that Namibian society views people living with HIV.[22]

This stigma and discrimination both result from, and perpetuate a reality in which women have limited knowledge of their rights and of the health issues impacting their lives, and in which women are not in the position to (and have historically not been able to) challenge authority figures, particularly those of the opposite sex. These are very real barriers to addressing many sexual and reproductive health and rights issues facing positive women, and they create an environment in which such violations thrive and have long occurred without being addressed.

BRINGING IN THE LEGAL AND HUMAN RIGHTS COMMUNITY: BUILDING COURT CASES

> *In my language we always say that a child who doesn't cry when it's on its mother's back, it will die. So it is the same with us, if we don't talk up, stand up, speak out, nothing will improve. And you are not supposed to be scared to speak out because you are protected by the Constitution of Namibia. You are protected by knowing that you have got people like us Namibia Women's Health Network, and we have got people from outside Namibia…who will be behind us so don't be scared. If you speak out, and they see you are protected by all these people, you will see good things coming to your community. But we need to talk, to say the things which are happening there.*[23]

In early 2008, the Namibia Women's Health Network brought the documentation of positive women who had been coercively sterilised to the Legal Assistance Centre to seek redress for the women who had been

violated, as well as to generate more momentum around, and attention to, the practice of coercive sterilisation of positive women in Namibia. As of April 2008, the Legal Assistance Centre filed cases on behalf of fifteen positive women who had been sterilised in public hospitals alleging violations of their constitutional rights to be free from discrimination and cruel, inhuman, and degrading treatment, as well as positive rights to found a family and to dignity.[24]

The seemingly systemic practice of sterilisation as an HIV prevention strategy directed toward women living with HIV, as shared by a woman who was sterilised, '*the doctor said yes we sterilised you because of your HIV status'*,[25] directly contravenes the Namibian Constitution and rights-based HIV policies. The National HIV/AIDS Policy adopted in 2007 states that '*an effective response to HIV/AIDS requires respect for, protection and fulfilment of all human, civil, political, economic, social and cultural rights*'.[26] The policy statement on the prevention of vertical transmission of HIV (commonly identified as prevention of mother-to-child transmission) also underscores the importance of comprehensive, health-advancing and rights-fulfilling approaches, with the commitment that:

> *...government shall provide free access to safe obstetric care and antiretroviral 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.*[27]

The policy also specifically recognises that:

> *...women and girls, including women living with HIV/AIDS...shall have equal access to appropriate, sound HIV-related information, prevention*

and education programmes…[and] *women and youth-friendly sexual and reproductive health services.* [28]

While the violation of coerced and forced sterilisation may be clear in principle, it is far more challenging to prove it as a matter of legal fact. Despite ongoing reports of coerced sterilisation, it has taken considerable effort and investment by the Legal Assistance Centre to solidify and substantiate the fifteen cases. Each case that the Legal Assistance Centre has litigated, had to be recent and thoroughly researched, including physician exams of the plaintiffs, to confirm sterilisation. Further, the Legal Assistance Centre undertook this work with limited staff and no dedicated funding.

The court cases have raised the profile of coerced sterilisation as a pressing human rights violation, and have garnered a much broader response than the initial documentation alone was able to generate. The identification of court cases served as the foundation for a related national, and now regional, campaign to end forced sterilisation, and also brought media attention. All these factors combined gave '*weight*' and '*importance*' to the issue, such that more national, regional, and global partners have joined in the advocacy to address the practice of coerced sterilisation of positive women, and are now looking to the experiences of Namibia as a model for documentation, litigation, and advocacy responses in their respective countries. More partners are also now looking to join with the Namibia Women's Health Network, the Legal Assistance Centre, the AIDS and Rights Alliance of Southern Africa (ARASA), and others, to document and advocate around positive women's sexual and reproductive health and rights, particularly to address coerced sterilisation – an issue that a few years ago

very few would listen to and engage with now holds a vastly larger audience and support base.

From a community perspective, tremendous expectation has been placed on the litigation and the development of court cases. The positive women interviewed are seeking a sense of restored wholeness and justice through the process. As one positive woman shared, '*I want only to tell those doctors they cannot close anymore people, because even if you are HIV positive, you are normal.*'[29] The core responses we heard to the question of what positive women are expecting from the litigation, across women who are plaintiffs and women who are not, focused on the payment of damages and the possibility of reversing the sterilisation.

The cost has been identified first and foremost as economic security – and the redress women seek is compensation. As noted by the Legal Assistance Centre, '*In some cases, women would obviously claim damages and there is an amount of one million that has been claimed*'.[30] The inability to have a child, or additional children, can jeopardise a woman's long term financial security of who will care for the woman when she is old, while women also face the immediate cost of losing one's partner, or being rejected by one's community, due to the perception that a woman's value is closely linked to her ability to have children. '*The problem I have now* [is] *my boyfriend he doesn't want me. He says you are closed, then what can I do with a woman who cannot have a baby?*'[31] Therefore, just as women seek compensation, they also seek for the procedure to be reversed, or to receive other kinds of assisted reproductive technology that may enable them to have another child. In the context of seeking redress, women also indicated preferential access to adoption as

a possible form of redress, especially in situations where the sterilisation cannot be reversed.

At the same time, being visible as litigant, or as a woman who has been sterilised, greatly impacted on the day-to-day reality of living in one's community, or of seeking healthcare. '*You find that people now think that just admitting that you have been sterilised is synonymous with admitting that you are HIV positive*.'[32] By speaking up publicly as a woman who was sterilised without consent, women fear seeking services at the hospital, as one of the plaintiffs expressed:

> *But now the problem is* [getting] *help. If I go into the hospital, they will see my name, ah, not good. They say yah you are sterilised, you are the people in the story for the New Era… I am now afraid to go* [to the hospital]*, and I don't know what I can do.*[33]

Litigation also takes a toll on the plaintiffs. Legal proceedings are slow, time consuming, and complicated. Litigation can prove unsuccessful, and the experience of being a '*test case*' has the potential to inflict more damage upon a person who has already faced serious violations of their rights and of their dignity. For women who are part of the court cases, they have had to tell and re-tell their stories many times. They have potentially had to undergo physical exams to prove the facts of their case, and they have now entered a system of language that is unfamiliar to those who have not been trained in law, to processes that are slow and complex, and to hearings that can be postponed without notice. Women also potentially face the risk of having their credibility questioned in the process of court proceedings; a not so uncommon side-effect of language, systems and processes unfamiliar and,

at times, difficult to follow for women testifying in this case. These women have become the visible face of a conflict between the perceived general belief that positive women should not have children, the rights of all women, and the social roles that define a woman's value based on her ability to have children.

Lessons learned

Building from community documentation of a human rights violation to a legal court case has transformed the response to the issue of sterilisation without consent nationally, regionally, and globally. While much can be ascribed to the launch of a national and regional campaign, identifying women who have been coercively sterilised as plaintiffs has transformed the situation in Namibia from one where the issue was summarily dismissed by NGO partners or government officials to a landscape where the coerced sterilisation of positive women is now viewed as a matter of pressing urgency by more allies.

The lack of sufficient funding, technical expertise, and dedicated human resources has limited the reach of the litigation, and the continuous engagement of plaintiffs in it. Building court cases is a lengthy and detailed process, as one unsubstantiated claim could undermine all of the cases being brought forward. In addition, conclusively evidencing sterilisation without consent is a difficult task. Compounding the challenges faced by the lawyers is the burden placed on the women plaintiffs, and the challenge of creating untenable expectations among community members. All of the women who have experienced coerced or forced sterilisation will not have their day in court, and the women who do – may not attain the outcomes they wish.

The women who have their cases prescribed still have to be helped and

> *also from conversations with these women, it comes out very clear that the women need certainty. Although their cases will never go into the court of law…somehow they need to find out their real* [sterilisation] *status…I was on the operation table and that's all I know.*[34]

Recognising these challenges, it is crucial to ensure continuous communication with both women who are plaintiffs in the case and women who have been sterilised, but are not part of the litigation process, due to prescription and other reasons. Similarly, it is critical to acknowledge that the women who appeared as plaintiffs may require continued counselling and support, due to the impact of being questioned and telling their stories publicly during the court proceedings. There is great need to develop strategies for seeking redress for women whose cases have prescribed and will not be heard in court, and for managing the tensions that may potentially arise when some sterilised women receive compensation for the occurred abuse and violation, while others, who have had the same experience, are not entitled to receive such compensation.

Although, affording redress to every woman who has been sterilised without her consent is beyond the scope of strategic litigation and this particular court case, transparency of court case proceedings, as well as processes surrounding the actual court case, are vital to the potential '*success*' and '*impact*' of the court case for all women who have been violated. Further, it is the impact of the litigation on not only ending the sterilisation of positive women in Namibia, but also changing the public opinion on this practice, which arguably defines whether or not the litigation has been successful.

Since bringing the cases to court is just the first step in a very long process, an essential part of litigation as an advocacy tool is ensuring that women are prepared for litigation, that they understand that they will be asked very difficult, personal questions, and that their credibility can be called into question. In the situation where cases are extended or delayed, it is also important to make sure that women are prepared to deal with social circumstances that may arise as a result of their cases being discussed in the media, which may have repercussions for women within their communities. Even though the names of plaintiffs are not to be disclosed by journalists, the communities in which the plaintiffs live are often small, and it can become difficult to maintain the confidentiality of the plaintiffs.

FORGING ALLIANCES: LAUNCHING A CAMPAIGN

> *As Women's Solidarity, we have to join so that not only the affected women, but the rest of the other women, potential women that might fall prey to it and the other women who have already fallen prey to it but still live on not knowing their condition, need to be informed.*[35]

The ongoing community documentation of the violations, led by the Namibia Women's Health Network, and the development of court cases by the Legal Assistance Centre together formed the core around which a national campaign developed. The alliance that the Namibia Women's Health Network has achieved spans the gender, HIV, human rights, and sexual and reproductive health and rights communities, and Namibia Women's Health Network views this mobilisation of partnerships nationally, regionally, and internationally as one of

the biggest successes of the efforts to address coerced sterilisation to date. This strong partnership has not only enabled the success of this particular campaign, but will also foster potential collaboration on other human rights efforts, particularly addressing positive women's sexual and reproductive health and rights, at a regional and international level in the future.

National partners, such as Sister Namibia, sought to support the issue of coerced sterilisation exactly because it was outside the '*male-stream*' and as a feminist organisation, they '*try to look for the core issues which nobody talks about and this is one such issue*'.[36] Namibian Planned Parenthood Association (NAPPA) joined the campaign because it

> *…falls squarely in our mandate. We are here to protect and promote sexual and reproductive health and rights… We are increasingly looking at sexual/gender-based violence, and this particular area is falling at an interesting intersection. It doesn't qualify as your usual domestic violence/rape within marriage…however this is a form of gender-based violence we believe.*[37]

Women's Solidarity Network took up the issue and joined the campaign, because

> *…first of all, it was a big question around the rights of women in general, but specifically women who are HIV positive – the right to know when you are treated medically and also the right to have a voice around your reproductive and family planning… The second question was…if it is a concern of being HIV positive, what is the whole outcry about the preventive programmes that the government is putting in place that the government has decided to sterilise in secret. Then the third reason why*

we went in was to use this tool as a tool to bring out the education around the reproductive and sexual health of our women.[38]

Over the years, the Namibia Women's Health Network and partners have been engaged with various advocacy activities aimed at raising awareness on, and highlighting the occurrence of, human rights abuses positive women are faced with within the context of sexual and reproductive health, as well as addressing the practice of coerced sterilisation of positive women. With the increasing momentum and public interest, as well as the inception of the national campaign to end forced sterilisation in 2009, campaign activities have mainly focused on and around the court case dates and received support not only from women and women's groups, but also from the broader civil society community in Namibia and the region. Organisations that are part of the national campaign include the AIDS and Rights Alliance for Southern Africa (ARASA), Legal Assistance Centre, Namibia Women's Health Network, Namibian Planned Parenthood Association, Open Society Initiative for Southern Africa (OSISA), Sister Namibia, Southern Africa Litigation Centre (SALC), Women's Leadership Centre, and Women's Solidarity Namibia.

Campaign activities linked to the June 2010 court proceedings included a march from Katutura to the Ministry of Health and Social Development, and the handing over of a petition with over 1000 signatories from Namibia and around the world to the Ministry of Health and Social Services, demanding, amongst other things, that a circular be issued to both the public and private health facilities explicitly prohibiting the practice of sterilisation without informed consent. The campaign also issued a media statement on 01 June 2010, the first date of the court case at the High Court of Namibia in Windhoek. Sit-ins

at the maternity wards of the Katatura State Hospital and the Onandjokwe Lutheran Hospital also took place for the duration of the court case from 01 to 03 June 2010.

The court case and its related advocacy activities has sparked great media interest and coverage, highlighting once again that the sterilisation of positive women without their informed consent has now reached a certain momentum and level of support – momentum and support it should have received since 2007, when the first cases of coerced sterilisation of positive women became known.

The national '*End Forced Sterilisation*' campaign has evolved as a seemingly natural process to the increasing advocacy demands leading up to the first appearance of this case in court in October 2009. With this joining of resources, the voice collaboratively calling to end the sterilisation of positive women without their consent in Namibia has become louder, and will not easily be '*silenced*' again. However, with the ongoing delay in the court case, there are challenges in sustaining the momentum, and ensuring that the issue, as well as the public interest and support, will not '*disappear*' until the next court date in September 2010.

Although supported by allies within and beyond Namibia, the campaign is still a fairly new campaign with limited resources and capacity, raising questions of how to sustain the momentum and support, how to maintain the energy, focus and excitement despite the delays in court proceedings, and how to ensure that plaintiffs receive the necessary support and remain prepared for their next appearance in September 2010.

Part of the challenge sustaining the momentum and gathering broad community support for the campaign also seems to be expanding the focus of campaign activities from court dates to communities and the '*community aspect of sterilisation*'. As expressed by ARASA:

> *I think that one of our shortages or shortcomings of our work as a campaign that I realise more and more is working with communities… raising awareness within the communities and looking at the community aspect of sterilisation.*[39]

Lessons learned

Forging alliances, launching a campaign, and gathering broader support has raised the visibility of both the occurrence of, and the need to seek redress for, coerced sterilisation of positive women in Namibia. The public interest and support has grown, and expectations have risen as to the potential outcome and impact of the campaign and the litigation process with far-reaching implications for the protection of women's sexual and reproductive rights. As expressed by one of the campaign partners, an '*ideal*' outcome would be to:

> *…put women's reproductive rights back on the table, and have them now put laws in place that allow women to have more autonomy over decisions that are made with their bodies, whether they be around sterilisation or abortion, or anything else.*[40]

There is also the hope that the court case and its related advocacy responses will assist in establishing trust in, and thus greater access to, the legal system.

> *I think it will be unifying for other women knowing that the legal system*

does work for them and that you can take legal recourse and it will be to your benefit if it's for a legitimate cause. That will be inspiring for women who may be trying to access laws, other laws around gender-based violence.[41]

The campaign has also been a great success in that it garnered incredible media attention from regional, national and international media outlets (print, online, radio, and television). While this, in and of itself, is a positive factor and increases the visibility of the cases and the broader issues of rights violations against women living with HIV, the media attention has, in some cases, negative impacts on individual women. In more than one case journalists printed inaccurate facts about the cases, as well as about individual women's stories, and this misinformation caused communities to discriminate against the women profiled.[42] To ensure that women who come forward and speak out are not further violated and victimised by agreeing to make their experiences public, it is crucial to train media spokespersons about the imperative to clarify facts with the media before stories are printed, and to also ensure that women participating in media activities understand the potential repercussions of making their stories public.

The delays and postponements in the court case has however also raised the question as to the sustainability of these gains, due to a lack of sufficient resources and capacity to keep the momentum, maintain the energy, and ensure that the voices calling to end forced sterilisation are kept aloud until the next court appearance.

looking to the future and lessons learned

What can only be a best thing for the citizens of the country is that the government comes out and says we are sorry, we have done things on behalf of the Ministry for Health, and we are promising and committing towards real health for all. We are committing towards patient/doctor relations improvement, committing ourselves towards putting in mechanisms that enable a patient not to be discriminated but treated with dignity and be consulted when this happens.[43]

Looking forward, what are the key issues that have emerged and lessons to apply in efforts to address the coerced sterilisation of women living with HIV in Namibia and elsewhere?

Importance of dialogue and of 'breaking the silence'

As campaign partner Sister Namibia has underscored, the fundamental first step is '*to get these women that have been sterilised unknowingly to come together and talk about it, because usually silence is the first thing that prevents any kind of progress*'.[44] The issue of coerced sterilisation was first recognised in a dialogue with young women living with HIV, and the community led response to it has resulted from the ongoing work of the Namibia Women's Health Network to bring positive women into conversation about their experiences, and the ongoing rights violations they are subjected to. At the core

of these conversations has been, and continues to be, positive women's right to bodily autonomy, including the right to make free and informed sexual and reproductive decisions.

Importance of information

Expanding upon this point of '*breaking the silence*' is the importance of sharing information among women, who are facing or have undergone coerced sterilisation, about their bodies and their rights; and to also raise awareness among the broader community of allies and stakeholders about HIV, reproductive health, and human rights.

The other aspect of this information flow is to ensure that developments that occur at a national level feedback to women at a community level, just as experiences at a community level need to inform efforts at the national level. As one respondent framed it:

> *The other thing is information, because some women just really don't know what's going on, and a lot of things happen on a higher level that are affecting women on the grassroots level; and you find that women on the grassroots level only get titbits of information.*[45]

Need for dedicated resources

Funding and human resource challenges have limited the scope, reach, and momentum of the work to date. There has been insufficient funding to conclusively document all of the allegations of coerced sterilisation in Namibia, and to assess the extent to which the violation is occurring. The pace of the litigation and the number of cases that have been brought forward by the Legal Assistance Centre has also been impacted by a lack

of dedicated resources. The national campaign to end forced sterilisation has achieved tremendous success in raising the visibility of, and awareness around, the sterilisation of positive women without informed consent. However, the lack of a dedicated, salaried coordinator and adequate funding could potentially affect both the future impact and sustainability of the campaign.

Importance of ongoing engagement and support for affected women

> *I think there is a need for holistic, psychological treatment.*[46]

As a first step towards supporting women who have been sterilised and engaging with communities where coerced sterilisation has been identified as a pattern, all of the partners involved in the campaign and in the litigation process need to continuously and consistently interact with one another. Information needs to be shared across all partners and stakeholders, and the approaches taken should be led by and with affected women.

Further, multiple partners in the campaign identified the need for attention to the lived experience of coerced sterilisation and to the community impact.

> *There is a big need for psychosocial support and information around the implications of what happened, and dealing with that in the societies and communities that they live in.*[47]

To date, campaign initiatives have largely focused on the court cases and have not had the ability to adequately meet the individual needs of affected women.

Addressing stigma and discrimination

> *Women living with HIV being discriminated against in the healthcare sector, particularly in the SHR services sector, is not an isolated case…I think it is a society wide element that is manifesting itself in the healthcare sector.*[48]

The advocacy to date has illuminated how the sterilisation of positive women without their informed consent not only forms part of a larger social fabric, but also manifests the prevailing stigma and discrimination against people living with HIV. Women who have been sterilised often face an additional layer of stigma and discrimination, partly based on socio-cultural expectations of motherhood and the importance placed on women's ability to bear children. It is not uncommon for women who are no longer able to have children to be ostracised by their families and communities, and/or abandoned by their partners. In addition to the serious socio-economic implications, these violations also impact on women's general well-being and overall health.

There is also the challenge of limited or no support structures assisting women with these and other consequences of making their experiences public. In some cases women have come forward with their stories, expecting to be supported by their communities and/or support groups, only to find that many of their peers believe that women living with HIV should not have the right to have children. Recognising these realities, it is crucial to ensure sufficient and ongoing support when working with women who decide to speak out about their experiences and the violations of rights they have been subjected to.

Addressing the stigma and discrimination that both underline, and perpetuate the occurrence of coerced sterilisation of positive women is paramount to ensure not only the halt of this practice, but also a more adequate access to redress as and when positive women's rights to free and informed sexual and reproductive choice have been violated.

Involving healthcare professionals

> *There is the important aspect of the healthcare professionals themselves being involved... First teach them, educate them, inform them about their duties as healthcare professionals, and then tell them that if you do still feel that you want to go ahead and do the wrong thing...you will be jailed, your medical license will be taken away, and so on.*[49]

The work around coerced sterilisation has highlighted a general lack of knowledge about patients' rights, particularly positive women's rights, as well as the urgent need to work with healthcare professionals at all levels, to educate them about both the healthcare professional's responsibilities and the rights of the patient, including consequences of mistreating patients. As many healthcare settings lack the necessary infrastructure, including the capacity and human resources, to manage patients and provide quality care, determining what kind of support structures healthcare professionals need should be part of the engagement. Capacity building of healthcare providers about HIV, sexual and reproductive health, and rights is an important step towards ensuring that patients are in the position to make free and informed decisions about their bodies and their health.

Further, in the vein of looking forward, there is a need for community advocates and healthcare providers to be in dialogue, to share concerns, to collectively seek to overcome stigma and fear, and to identify solutions, which are mutually beneficial, rights-based, and facilitate positive women's access to quality sexual and reproductive healthcare.

> *I think there is need also for these health professionals to have a dialogue with the women themselves, living with HIV, so that they can hear from women and understand from the positive women's perspective.*[50]

Importance of a broader sexual and reproductive health and rights framework

> *The thing with this campaign is that it's not just limited to sterilisation, it's the whole gamut of things, abortion, etc.*[51]

A key success of the advocacy and work to date has been the alliance-building between women living with HIV and the broader gender, human rights, and sexual and reproductive health and rights communities. Coerced sterilisation has been one '*wedge*' that has brought different stakeholders together in addressing a wide range of issues at the intersection of sexual and reproductive health and rights and HIV, including positive women's rights to make free and informed sexual and reproductive choices. These partnerships are fundamental to the efforts to advance sexual and reproductive health and rights of women, and to focus specifically on the implications of these efforts for women living with HIV.

Forced and coerced sterilisation is but one of the many issues positive women are dealing with in regards to their sexual and reproductive health and rights, especially as it relates to their status as a woman living with HIV. Positive women are often denied access to care and/or '*forced*' into treatment or procedures; given inaccurate information; and are seldom in the position to claim their right to make informed decisions about their bodies and health, including their sexual and reproductive health, free from fear and coercion.

Addressing the sterilisation of women without informed consent within a broader sexual and reproductive health and rights framework also affords the opportunity to raise awareness about women's sexual and reproductive rights in the context of HIV, and to advance women's rights to autonomy and bodily integrity, to be free from all forms of violence, and to equality and non-discrimination. The recognition, advancement and protection of a woman's right to make sexual choices; to decide whether or not to have children, with whom and how many; to have access to safe and legal abortion; and to have control over decisions regarding her life and health, is paramount to end forced sterilisation of positive women and to guarantee the right of safe and healthy motherhood for positive women.

identifying 'best practice'[52]

You are also a human being, and you also have that right to have kids.[53]

1) ***Positive woman led processes and meaningful community involvement at every level***: The leadership of women living with HIV has been fundamental to the success of the advocacy to date in Namibia, as well as the process of seeking accountability, which in itself has been empowering and transformative.

2) ***Investment in positive women's organisations and initiatives***: The leadership of positive women is not possible without funding for the institutional platforms and the organisational capacity to support and enable leadership.

3) ***Training of positive women in sexual and reproductive health and rights***: Ongoing training has advanced women's empowerment and agency through expanding their knowledge of their bodies and of their rights.

4) ***Expanding capacity and expertise in human rights documentation***: Investing in community led documentation and related advocacy has built a new cadre of human rights advocates

and has enabled positive women to engage directly as fact-finders and evidence gatherers.

5) ***Engagement of human rights partners with litigation expertise and the capacity to litigate***: Bringing on partners with litigation expertise has provided new avenues for redress and technical support to community partners.

6) ***Use of traditional and new social media***: The use of media allowed for outreach to large audiences in and outside Namibia, and for more women to learn of the violations and related advocacy, as well as to step forward and share their experiences.

7) ***Dedicated resources to***:

   a. Undertake detailed and far-reaching documentation;
   b. Support litigation; and,
   c. Facilitate awareness raising, mobilisation, and campaigning, including to support a dedicated co-ordinator of these efforts, are all essential to building a solid evidence base, sustaining advocacy, and ensuring that the occurrence of violations is halted.

8) ***Building a national movement and engaging in grassroots activism***: Building alliances between women living with HIV and other gender, sexual and reproductive health and rights, and human rights advocates fostered new platforms for affected women to have a voice.

9) ***Engaging international, regional, and national human rights mechanisms***: Partners used the mechanisms of the Special Rapporteurs, the African Commission on Human and Peoples' Rights, and the Ombudsman's Office to raise the profile and visibility of coerced sterilisation.

10) ***Tapping into the women's global sexual and reproductive health and rights movement***: Building alliances with global movements brought broader support, awareness, and momentum, as well as expertise, strengthening the visibility of the advocacy and campaign efforts.

about

NAMIBIA WOMEN'S HEALTH NETWORK

The Namibia Women's Health Network (NWHN) is the first national network of positive women in Namibia. NWHN aims to provide information, education, skills and capacity building to improve the health of Namibian women and youth infected and affected by HIV, and to empower them to become leaders on sexual and reproductive health and rights at the local and national level.

NWHN seeks to mobilise and engage positive women, particularly young women, around HIV and AIDS and sexual and reproductive health policy setting and programme development in Namibia. NWHN has worked actively to address the sexual and reproductive health and rights of positive women, and has focused on addressing violations of these rights. In particular, NWHN has addressed, documented, and provided education around the issues of coercive sterilisation of positive women, unsafe abortion, discrimination of positive individuals, and other critical issues. NWHN is represented on parliamentary decision-making bodies and has taken an active role nationally to generate more visibility of, and attention to, the priorities and perspectives of women living with and affected by HIV and AIDS.

AIDS LEGAL NETWORK

The AIDS Legal Network (ALN), based in Cape Town, South Africa, is a human

rights organisation committed to the promotion, protection and realisation of fundamental rights and freedoms of people living with, and affected by, HIV and AIDS. The ALN focuses primarily on the promotion and advancement of the principles of equality, non-discrimination, human dignity and equal enjoyment of all rights and freedoms. A main goal of the ALN is to address discriminatory practices and attitudes, to promote behavioural change, and to facilitate a holistic human rights-based approach to HIV and AIDS.

The AIDS Legal Network (ALN) is engaging in numerous activities aiming to address prevailing stigma and discrimination based on, and in the context of, HIV and AIDS; and to promote behavioural change, so as to facilitate equal access to, and realisation of, fundamental rights and freedoms. It is our principled understanding that addressing the gendered societal context, as well as prevailing discriminatory attitudes, beliefs and practices in all spheres of society, including healthcare service provision; and creating an enabling and supportive environment, are essential steps towards enhancing the adequacy and efficiency of the response to HIV and AIDS, and ensuring that everyone is equally in the position to access, and benefit from, available HIV prevention, testing, treatment, support and care services and programmes, irrespective of a person's sex, gender, sexual orientation and/or HIV status. It is within this context that our main programme areas focus on capacity building and awareness raising, human rights education and training, policy research, as well as advocacy and lobbying.

ATHENA NETWORK

The ATHENA Network was created to advance gender equity and human

rights in the global response to HIV and AIDS. Because gender inequity fuels HIV and HIV fuels gender inequity, it is imperative that women and girls – particularly those living with HIV – speak out, set priorities for action, and lead the response. The ***Barcelona Bill of Rights***, promulgated by partners at the 2002 International AIDS Conference, is our framework for action. ATHENA's mission is to:

- Advance the recognition, protection, and fulfilment of women's and girls' human rights, comprehensively and inclusively, as a fundamental component of the response to HIV and AIDS.

- Ensure gender equity in HIV-related research, prevention, diagnosis, treatment, care, and development interventions based on a gendered analysis.

- Promote and facilitate the leadership of women and girls, especially those living with HIV, in all aspects of the response to HIV and AIDS.

- Bridge the communities around the world that are addressing gender, human rights, sexual and reproductive health and rights, and HIV.

PROJECT BACKGROUND

Since 2007, as part of a multi-prong strategy, the Namibia Women's Health Network, AIDS Legal Network, and ATHENA have partnered to address the sexual and reproductive health and rights of HIV positive women, with a particular focus on forced and coerced sterilisation.

Select highlights of our work to date have included:

- Advocacy around the XVII International AIDS Conference in Mexico City in 2008 on various issues at the intersection of women, HIV and sexual and reproductive health and rights;
- Consultations with the United Nations Special Rapporteur on the Right to Health, Anand Grover, on the sexual and reproductive health and rights of HIV positive women;
- Collaboration on the *'Bridging the Gap*' publication series in 2009, addressing the emerging and neglected issues at the intersection of HIV and sexual and reproductive health and rights;
- A pilot documentation project in 2009 by HIV positive women on the human rights violations HIV positive women face when accessing sexual and reproductive health services;
- Collaborative statements at the Commission on the Status of Women and the African Commission on Human and Peoples' Rights in 2009; and,
- A roundtable discussion '*Bridging the Gap: Cross-cutting strategies to address the Intersection of HIV and sexual violence from the perspective of HIV positive women*' at the Sexual Violence Research Initiative Forum in July 2009.

We wish to continue to build from this strong foundation by:

- Empowerment through the continued training and capacity building of

positive women on issues of sexual and reproductive health and rights, including ongoing involvement in advocacy initiatives and monitoring of these efforts;

- Expanded documentation of human rights violations experienced by positive women, with a focus on coerced sterilisation in Namibia and regionally;
- Support for legal action and the continued monitoring of case progression through the legal system;
- Continued and expanded visibility of sexual and reproductive health and rights issues nationally, regionally, and globally;
- Continued and expanded use of human rights mechanisms, such as the Special Rapporteur, to highlight and halt ongoing human rights violations in the context of women and HIV;
- Engagement of policy-makers and parliamentarians to ensure adequate policy and legislative frameworks, as well as budgets, to ensure adequate and appropriate sexual and reproductive health and rights services;
- Reaching out to, and collaborating with, other countries in the Southern African region to build a broader body of evidence around coerced sterilisation, and other coercive practices in sexual and reproductive health and rights in healthcare settings; and,
- Launching a '*best practice*' model at the XVIII International AIDS Conference in Vienna in July 2010.

endnotes

1. Interview with Sister Namibia, 26 March 2010.
2. Parts of the introduction are an updated excerpt from prior petitions and statements developed by project partners, with authorship by Elisa Slattery of the Center for Reproductive Rights.
3. Interview with positive woman 1, transcript on file with authors, 14 May 2010.
4. For more information see: ICW. 2009. *The Forced and Coerced Sterilization of HIV Positive Women in Namibia*. [www.icw.org/files/The%20forced%20 and%20coerced%20sterilization%20of%20HIV%20positive%20women%20in%20 Namibia%2009.pdf]
5. Many of the other cases were already prescribed and thus, could not be included in litigation.
6. Interview with positive woman 2, transcript on file with authors, 14 May 2010.
7. Interview with positive woman 3, transcript on file with authors, 14 May 2010.
8. Center for Reproductive Rights. 2003. *Body and Soul: Forced Sterilization and Other Assaults on Roma Reproductive Freedom in Slovakia* . [http://reproductiverights. org/sites/crr.civicactions.net/files/documents/bo_slov_part2_0.pdf]
9. ICW. 2009. *The Forced and Coerced Sterilization of HIV Positive Women in Namibia*. [www.icw.org/files/The%20forced%20and%20coerced%20sterilization%20of%20 HIV%20positive%20women%20in%20Namibia%2009.pdf]
10. International Federation of Gynecology and Obstetrics, Ethical Issues in Obstetrics and Gynecology 74 (Nov. 2006), [www.figo.org/files/figo-corp/Ethical%20Issues%20 -%20English.pdf] [hereinafter Ethical Issues in Obstetrics and Gynaecology]
11. Ethical Issues in Obstetrics and Gynaecology, 14.
12. *Ibid.*
13. For more in-depth analysis of relevant legal frameworks see: ICW. 2009. The Forced and Coerced Sterilization of HIV Positive Women in Namibia. [www.icw.org/files/ The%20forced%20and%20coerced%20sterilization%20of%20HIV%20positive%20 women%20in%20Namibia%2009.pdf], and also ???. 2009. Developing a Human Rights Framework to Address Coerced Sterilization and Abortion. Bridging the Gap. Athena Network. [www.athenanetwork.org/docs/HEAL_Policy_Brief.pdf.]
14. Katutura Dialogue, 23 March 2010.
15. Jennifer Gatsi, 24 March 2010.
16. 'No Coerced Sterilization of Positive Women: Kamwi'. In: *The Namibian*. [www. namibian.com.na/index.php?id=28&tx_ttnews[tt_news]=57040&no_cache=1.]
17. Jennifer Gatsi, 24 March 2010.
18. Interview with Namibia Women's Health Network, March 2010.
19. Katutura dialogue, 23 March 2010.

20. Katutura dialogue, 23 March 2010.
21. Interview with Sister Namibia, 26 March 2010.
22. Interview with ARASA, 25 March 2010.
23. Jennifer Gatsi, 24 March 2010.
24. LAC Communication to partners, on file with author.
25. Katutura dialogue, 23 March 2010.
26. Republic of Namibia National Policy on HIV/AIDS 2007.
27. *Ibid*.
28. *Ibid*.
29. Interview with positive woman 1, transcript on file with author, 14 May 2010.
30. Interview with Legal Assistance Centre, 25 March 2010.
31. Interview with positive woman 2, transcript on file with author, 14 May 2010.
32. Interview with Sister Namibia, 26 March 2010.
33. Interview with positive woman 2, transcript on file with author, 14 May 2010.
34. Interview with Women's Solidarity Network, 24 March 2010.
35. *Ibid*.
36. Interview with Sister Namibia, 26 March 2010.
37. Interview with NAPPA, 25 March 2010.
38. Interview with Women's Solidarity Network, 24 March 2010.
39. Interview with ARASA, 25 March 2010.
40. Interview with Sister Namibia, 26 March 2010.
41. *Ibid*.
42. In one case *The Namibian* misquoted Victoria Noa, one of the campaign spokespeople and a woman who has herself been sterilized. The misreporting led Victoria's family and community to shun her, and had negative implications on her work environment as well. The journalist printed an apology and correction one week later, but much of the damage had already been done.
43. Interview with Women's Solidarity Network, 24 March 2010.
44. Interview with Sister Namibia, 26 March 2010.
45. *Ibid*.
46. Interview with Women's Solidarity Network, 24 March 2010.
47. Interview with ARASA, 25 March 2010.
48. *Ibid*.
49. Interview with Sister Namibia, 26 March 2010.
50. Jennifer Gatsi, 26 March 2010.
51. Interview with Sister Namibia, 26 March 2010.
52. With many thanks to Aziza Ahmed for her inputs to this framework based on her work with ICW and the Namibia Women's Health Network from 2008 to the present.
53. Dordabis dialogue, 24 March 2010.

notes

Namibia Women's
Health Network

ATHENA