HER RIGHTS INITIATIVE

TRANSFORMING POWER

National meeting on Forced Coerced Sterilization of women living with HIV

Her Rights Initiative

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Her Rights Initiative

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Abbreviations and acronyms

ANC	Anti Natal Clinic
APHA	Advocacy for the Prevention of HIV in Africa
CALS	Centre for Applied Legal Studies
CGE	Commission for Gender Equality
CSVR	Centre for the Study of Violence and Reconciliation
DoH	Department of Health
EC	Equality Court
FCS	Forced and Coerced Sterilization
GBVF	Gender Based Violence and Femicide
HIV	Human Immunodeficiency Virus
HPCSA	Health Professional Council of South Africa
HSRC	Human Science Research Council
HRI	Her Rights Initiative
NSP	National Strategic Plan
SRHR	Sexual and Reproductive Health Rights
SANAC	South African National AIDS Council
TLD	Tenofovir/lamivudine/dolutegravir
TRC	Treatment Action Campaign
UN	United Nations
WLC	Women's Legal Centre

Executive Summary

For about 12 years, a group of women living with HIV subjected to forced and coerced sterilization (FCS) have journeyed with the Her Rights Initiative (HRI) seeking redress for the injustices and human rights violations committed against them. HRI is a social impact organisation formed in 2009 to advocate for sexual and reproductive rights of women, and particularly women living with HIV. At the basis of the violations and the infringement on women's human rights is the vicious cycle of stigma and discrimination which has legitimized and justified the actions of many a healthcare worker in their prejudices towards women living with HIV.

Her Rights Initiative, in partnership with Heinrich Boll Foundation, held a 2-day meeting on forced and coerced sterilization of women living with HIV on the 15th and 16th of November 2020; co-facilitated by Prof Mzi Nduna and Oyama Tshona. There were 27 women living with HIV who were forcibly sterilized in the meeting.

Her Rights Initiative lodged the Complaint on Forced Sterilizations to the Commission for Gender Equality in 2015. This was because from HRI's perspective, the Department of Health was not addressing the issue as they had not followed up on the recommendations made, and did not see to all the joint advocacy work they had committed to conduct with HRI. The complaint was motivated by the fact that the violation was continuing. In the same year, a HIV/AIDS Stigma Index study commissioned by the South African National AIDS Council, led by the Human Sciences Research Council, and other collaborating partners, found that 498 women living with HIV (7.6% of women living with HIV) who participated in the study reported that they had been forced into sterilization. 37% of women in the same study reported that they had been forced into taking Depo Provera, a hormonal contraceptive. This confirmed HRI's suggestion that the practice was wide spread, and that there is a systematic effort to end fertility of poor Black HIV positive women. The CGE investigated the complaint over five years. The CGE released the report in February 2020. Prior to the release of the report some key United Nations agencies had issued a joint statement on the issue.

The purpose for convening was to hold a national dialogue and advocacy planning meeting on FCS to firstly, create a safe space for the women to share their experiences and explore coping strategies in order to determine short and long term mental health, psycho-social needs of the women; to inform a baseline for short term and long term mental health, psycho-social support needs of the women; to receive feedback and updates from the CGE on findings and recommendations of the Investigative Report on FCS; to engage and discuss advocacy, research and legal interventions for redress and ending FCS and its impact on women living with HIV in South Africa, and finally to map and draw key advocacy and research priorities for implementation.

Allyship organizations that were present at the meeting were South African National Aids Council (SANAC), The Women's Legal Centre (WLC), the Centre for the Study of Violence and Reconciliation (CSVR), Centre for Applied Legal Studies (CALS), ProBono.org, Dr Tlaleng Mofokeng: United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Advocacy for the Prevention of HIV in Africa (APHA), Ms Yvette Raphael: activist and advocate for the rights of women living with HIV, ACT Ubumbano: a network of Southern African and European organisations working for economic, gender and environmental justice, and Prof Eddie Mhlanga: Medical/Obstetrics doctor and women's health policy expert.

Findings from the meeting deliberations and discussions emphasized FCS as a gross human rights violation and inhumane systemic medical malpractice. The intersectionality suffered by women living with HIV victimized through FCS has affected their psychological well-being and their physical health as well, in the form of subsequent complications that may be linked to these procedures. Women cited medical complications and a need for medical health care services and further education and information sharing on FCS and other forms of family planning available to them. Education on human rights and the empowerment of women with the capacity to exercise them was also an expressed need.

Forced and coerced sterilization of women living with HIV took away the most relevant human rights principle of protecting the dignity of people living with HIV/AIDS and is thus framed as

violence against women against the background of gender inequality, as it manifests as the systematic oppression of women living with HIV and a violation of women's human rights; engrained in the health sector. The 26 violations and contraventions of a combination of laws against torture and inhumane treatment committed against women living with HIV through forced and coerced sterilization were summarized in the Commission for Gender Equality (CGE) report as follows: "*The complainants had their right to equality and freedom from discrimination violated; The Complainants' right to dignity, bodily integrity and freedom and security over their bodies, were violated; The right to the highest attainable standards of health including sexual and reproductive rights were violated; The Complainants were not provided with adequate knowledge on the sterilisation procedure before being asked to consent thus violating their right to information; The Complainants were not advised on other alternative methods of contraception; The Complainants were subjected to cruel, torturous or inhuman and degrading treatment; The medical staff breached their duty of care to the patients; While some files had consent forms, this cannot be equated to informed consent. The consent forms do not reflect the nature of the discussions that took place prior to such consent being given, and they are also not indicative of the language that was used to explain the procedure. This begs the question of whether the Complainants even understood the procedure at all; There is a lack of a uniform file management systems within the DOH and including electronic file management and backup; The Complainants could not reasonably be said to have consented to the procedure given the current structure of the consent forms and the alleged unethical process used to obtain consent. They were therefore forced and/or coerced into being sterilised."* This, linked to the legacy and remnants of the oppression of Black Women in South Africa, warrants inclusion in the National Strategic Plan to combat violence against women.

Allyship and access were also cited as important tools for advocating for redress as language and socioeconomic barriers hinder the affected women's ability to pursue justice, as the women are mostly poorer and unemployed or under employed Black South Africans, compounding their vulnerability. Health was one of the sites of gendered and racialised oppression and human rights violations in colonial and apartheid South Africa; yet, the politics

of health is silenced in post-apartheid South African discourse. This creates a conducive environment for racialised human rights abuse to continue in health services.

This report speaks to the need for the transformation of the healthcare sector, to account for mistreatment and to shift the culture of disregard for the lives and autonomy of Black South African women living with HIV. The South African government and the law ought to provide not only for the redress and compensation for the pain and suffering and for future medical expenses resulting from these injustices, but for legal remedies that will end and prevent FCS of women and the educating of the health sector on human rights abuses and violations and accountability for any and all infringements.

1. Introduction and background

'*Violations of women's human rights kill women alive. Taking a decision from women pains women, it is painful especially when it is done by health care workers: people who are trusted to care for women living HIV*' (participant, national Forced and Coerced Sterilization of Women Living with HIV meeting, Johannesburg)

Coerce is to pressure, intimidate, or force (someone) into doing something.

The Declaration of Commitment from the UN General Assembly Special Session on HIV/AIDS is a historical landmark in the fight against HIV/AIDS and includes respect for human rights and reduction of stigma associated with HIV/AIDS[1]. As far back as the early 2000s, the United National Joint Programme for HIV/AIDS warned that the lack of human rights protection in the response to the AIDS epidemic could become a matter of life and death[1]. South Africa as part of the UN is aware of the UN systems' human rights framework and approach that should be followed in the response to the HIVAIDS epidemic. Despite this, the South African government fails to put in place tools and protocols to promote, protect and defend women's human rights. South Africa, as a member of the UN knows that it is necessary to assess the epidemic in the context of human rights and make sure to bring into sharper relief some of the prerequisites for an effective response. These prerequisites include an integration of the principles, norms, and standards that are established in existing international human rights instruments[1]. The government's failure to do so, which resulted in their employees performing forced and coerced sterilization on women living with HIV, suggests that the UN should hold the South African government accountable for this. South Africa is bound to prioritise the principles of non-discrimination and integrate this into its HIV/AIDS response strategy to inter alia, prohibit any mandatory procedures including forced and coerced sterilization.

The UNAIDS further presaged that the HIV/AIDS epidemic would burrow deeper into the socioeconomic fault lines of communities and societies and widen

An **Epidemic** is the rapid spread of disease to a large number of people in a given population within a short period of time.

these fissures[1]. This is seen in the close examination of the women who form part of the Her Rights Initiative's collective who are claiming redress for human rights violations related to Forced and Coerced Sterilization (FCS). These women are Black, African, poorer and mostly unemployed or under employed. It is known to the government that the denial of basic rights limits people's options to defend their autonomy, to protect themselves and this leaves them even more vulnerable; government employees who performed these procedures took advantage of this. The government's delay to engage in processes that will offer redress also hinges on this.

Examples of Guiding Human rights instruments
1. The Constitution of the Republic of South Africa
2. The Universal Declaration on Human Rights
3. The Covenant on Economic, Social a Cultural Rights
4. The Covenant on Civil and Political Rights
5. The Convention of the Elimination of all forms of Discrimination against Women
6. The Convention on the Rights of the Child
7. The Maputo Protocol
8. The United Nations WOMEN
9. The United Nations Population Fund (UNFPA)

Table 1: Guiding Human Rights Instruments

The mandate of the United Nations Population Fund (UNFPA) is (1) to build the knowledge and the capacity to respond to needs in population and family planning; (2) to promote awareness in both developed and developing countries of population problems and possible strategies to deal with these problems; (3) to assist their population problems in the forms and means best suited to the individual countries' needs; and (4) to assume a leading role in the United Nations system in promoting population programmes, and to coordinate projects supported by the Fund. The joint statement by the OHCHR, UNWOMEN and UNFPA, and other UN bodies issued in 2014 placed the issue of FCS at the centre of women's rights and human rights [12],

particularly where their sexual and reproductive health rights are concerned. It is then evident that the mandate of the UNFPA was violated through the forced sterilization of these women living with HIV [13].

In the context of HIV/AIDS, the UN stresses that governments have an obligation to respect, protect and fulfill human rights[1]. Forced and coerced sterilization of women living with HIV took away the most relevant human rights principle of protecting the dignity of people living with HIV/AIDS. The UN stressed the protection of the rights of people living with HIV including the rights to marry and find a family[1]. Forced and Coerced sterilization is like giving people the right to vote and taking away the ballot papers.

In the South African society, children are at the center of a family[2] and the woman's inability to bear children attracts stigma, discrimination, violence, and distress. Forced and Coerced sterilization exerts further stress and risks for women. Women who cannot bear children may face abandonment by their partners, social stigma amongst friends, colleagues and family. Human rights of people living with HIV continue to be violated[3, 4]. "Forced sterilization" is a sterilization procedure, such as tubal ligation, performed without informed consent from the patient[5]. In forced and/or coerced sterilization, women's autonomy and the right to decision-making are undermined, there is lack of or manipulation of the information given about what sterilization entails, and there is also subtle or overt pressure to sign the consent form and sometimes with threats[6]. Forced and coerced sterilization further marginalizes these women, who already face stigma and discrimination due to HIV/AIDS[4, 5]. Forced and coerced sterilization is decried as an ethical and human rights problem[5]. Involuntary sterilization has devastating social and emotional impacts on women. This affects them emotionally, mentally, physically, and impacts their relationships with their partners, families and the wider community[4, 6]. Forced and coerced sterilization also has psychological effects as it affects women's perceptions of themselves as women[4].

Research was undertaken to provide evidence to the then minister of Health, Minister Aaron Motsoaledi, that indeed the violations did happen. This followed the Minister's rejection of self-presentation (through HRI) of anecdotal evidence for human rights violation. In an

attempt to buy time, the Minister sent HRI back to conduct a study. This happened although the government promises to adhere to Batho Pele principles, which could be interpreted to mean that if a minister catches word of violations, they should urgently respond by conducting an investigation to unearth the problem. The government chose not to do so, but instead sent a women's volunteer-based organization without scientific skill and without funding to go do research and return with evidence. HRI conducted the study in KwaZulu-Natal and Gauteng in 2010-2011, in partnership with the University of KwaZulu-Natal (UKZN) Health Economics and HIV Research Division (HEARD). The study provided the required scientific evidence and validated the occurrence of the violations and the need for addressing human rights violations in South African healthcare settings[4]. Further evidence of the occurrence of violations is apparent in light of the Gauteng case of a 32-year-old HIV positive woman that was forced to sign a form consenting to sterilization at a Johannesburg state hospital in 2009. The woman was part of the HRI group and was represented by the Women's Legal Centre. The Gauteng department of health made an out-of-court settlement to pay half-a-million rand for damages that caused pain and suffering she endured because of being coercively sterilised in a state hospital [11].

In the HSRC stigma index, about 498 women reported that they were sterilized without their consent. Though this was clearly a human rights violation and an unearthing of an adverse effect, the duty to report for the HSRC did not apply. To date, those victims have not been identified and no follow up has been done with them. This further indicated collusion between government agencies, and the HSRC as a national science council that reports to parliament, to erase and hide the matter. Forced and coerced sterilization violates local and international human rights frameworks[7]. The report to the investigations that were further conducted to provide evidence of the violations to the South African government was released in February 2020 by the Commission for Gender Equality[7].

The actions of the health staff who partook in these procedures undermine the efforts aimed at promoting bodily autonomy and decision-making for sexual and reproductive health (SRHR); it reverses the gains made by the primary health care services around family planning

and childcare. This therefore suggests that a bigger SRHR response is weakened by violations that appear to be about individual women. All of this is due to intolerance and social ostracism by prejudiced healthcare workers.

In the South African public health sector, Black African women who acquired HIV are made to bear the brunt of the epidemic; to feel guilty and to pay the price for having been infected. In what appears to be a clear act of social disapproval and an expression of societal discrimination, these women are treated with disdain, disrespect and their rights are dismissed. Just like sexual coercion, forced and coerced sterilization is a form of violence against women and therefore the National Strategic Plan to combat violence against women[8], cannot fight gender-based violence against women without a plan to address the plight of women who were forced and coerced into sterilization.

As demonstrated in ***figure 1*** below; stigma, discrimination and human rights violations form a vicious circle, legitimating and spurring each other. At the core of this are societal norms that differentiate women and men on biological, psychological and cultural norms[9]. Forced and Coerced Sterilization worsens the impact of living with an HIV infection.

Figure 1: Stigma, Discrimination and Human Rights Violations Cycle

3. Methodology

The meeting was co-facilitated by Prof Mzi Nduna and Oyama Tshona. The facilitators drafted a flexible agenda that changed during the meeting to respond to the needs of the participants and the meeting organizers. The various iterations of the draft agenda were shared and discussed with the meeting organizers (HRI) and this worked well. The agenda attached here as Appendix II contains a reflection of what was covered.

The approach used was participatory in nature and allowed for the participants to express themselves and use their ethnic languages. The multilingualism that existed in the meeting room allowed for this. The facilitators were also able to take into cognizance the education and literacy diversity that existed in the room and account for it in their facilitation. The participants shared a lot during the meeting as the meeting allowed a safe space for

connection. Women sharing their pain in stories and narrating their experiences of the forced and coerced sterilization was part of the healing process and such opportunities could continue. This resonated with the framework that the meeting organizers requested, as Sixolile Ngcobo from HRI said in her introductory remarks; that the process is aimed at taking "…*all parts of the participant as a total holistic person*…" and this, she emphasized was regardless of the person's title, position and/or roles outside of the room.

In the room there were co-founders of Her Rights Initiative (HRI) (Sixolile Ngcobo and Sethembiso Mthembu) who organised the meeting and were able to give a background to the work on forced and coerced sterilization. Their presence was affirming to the women who have lived with this experience over a decade. The women who are victims of Forced and Coerced Sterilization had journeyed with HRI on this issue for about 12 years. Participants were diverse in various ways – they were urban and rural; young and old; literate and illiterate – but most importantly they had a shared identity as Black South African women and living with HIV, who were forced and coerced into sterilization. They mostly travelled from KwaZulu Natal and Gauteng but may as well have been from elsewhere.

Allyship organizations that were present were: South African National Aids Council (SANAC), The Women's Legal Centre (WLC), ProBono.org, the Centre for the Study of Violence and Reconciliation (CSVR), Centre for Applied Legal Studies (CALS), Dr Tlaleng: United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Advocacy for the Prevention of HIV in Africa (APHA), Ms Yvette Raphael: activist and advocate for the rights of women living with HIV, ACT Ubumbano: a network of Southern African and European organisations working for economic gender and environmental justice; and Prof Eddie Mhlanga: Medical/ Obstetrics and Health Policy Expert. The attendance list with details of the rest of the participants for the two-day meeting was collected.

In café style facilitation, participants were asked to discuss in their tables and share their expectations for the meeting. The expectations, as expressed in the first session of the first day of the meeting are in Appendix I. The meeting invited presentations from partner

organizations such as the Women's Legal Centre, APHA, UN Special Rapporteur on the Right to Health, ProBono.org, and CALS. The Commission for Gender Equality also presented on the second day. There was unhappiness in the meeting about the focus of the presentation from CGE. The presentation was based on the report but not specifically focused on actions that the CGE has taken since the publication of the report. Also, the invitation to the CGE was directed at the senior management – Head of the Legal Department/ Chairperson/ CEO or their deputies). The disappointment in the room, that the CGE was represented by junior staff other than those invited led to a discussion about the way forward. The presenters were requested to contact the office to express to the office that this was unacceptable and that a meeting was still needed with the CGE senior officials.

Intersectionality as a methodology and framework

There was emphasis in the meeting that the women who found themselves in the room could be categorized as Black African, poorer (in the sense that they used public hospitals) and lived with HIV. These identities, all of them on their own are a source of marginalization and exclusion. And when they are experienced by one person the multiplicity of oppression is unimaginable. In a classed and racialized society like South Africa, being Black African and poorer allows for the government and others to treat that group with neglect knowing that they often do not have the facilities and means to access legal recourse for the gross and multiple violations that they experience.

An important aspect in the understanding and working with the intersectionality framework was that intersectionality should not be misconstrued as mainstreaming. That whilst struggles intersect, the struggle of women living with HIV who have been forcibly sterilized and/or coerced into sterilization is theirs, and affects them in a unique way that cannot be mainstreamed in other issues. It is for this reason that allyship was important but that the issue remains that which requires the victims themselves. There are, but few organizations that have come forth to pledge support to the issue of FCS. These include the funders of the meeting, Heinrich Böll Foundation, the Commission for Gender Equality which investigated the matter, UKZN HEARD which conducted a study to provide accepted evidence, APHA, the UN, CSVR,

CALS, ProBono.org, WLC and others. However, a lot of organizations that work in the field of social justice, GBV and HIV/AIDS are yet to show commitment to this issue; not even one of the these organisations issued a statement or a message of support when the CGE report was released. This lack of support and acknowledgement further marginalizes, silences and excludes women living with HIV from spaces that should rightfully address and share in concerns of their plight. The UN Bodies issued a statement decrying FCS but is yet to meet with HRI to discuss ways in which they can support the issue going forward. The listing of FCS as a human rights violation by the UN is welcome, but that should translate into actional support.

"With no real targets, the inclusion of women living with HIV in the NGBVF policy is mere tokenism" Sethembiso Mthembu, 15.11.2020

and co-option.

The GBVF strategy documents have no real commitment to the issue of FCS; no specific objectives to tackle the issue, no targets, and no Monitoring and Evaluation plan for it.

4. Deliberations, Findings and discussions

Medical and health violations and services

Forced and Coerced Sterilization (FCS) of women living with HIV is the worst form of medical malpractice, violence against women and violation of the rights of women. Nasreen Solomons from the Women' Legal Centre emphasized that sterilization and a decision to create a family is a very personal decision. This right includes the right to reproductive healthcare.

Eugenics is the practice or advocacy of improving the human species by selectively mating people with specific desirable hereditary traits. It aims to reduce human suffering by "breeding out" disease, disabilities and so-called undesirable characteristics from the human population.

In what seems to be eugenics, women in various hospitals were sterilized without their knowledge or consent. In these settings, women were infantilized and regarded as not able to make decisions for themselves: hence decisions are made for them. Prof Eddie Mhlanga added that there is a need for the South African society, advocates of no violence against women and people in the medical ethics field to follow up on this matter as it has bigger implications. His worry centered on lack of adherence to ethical practice, the principles of 'do not harm' and 'prevention of adverse effects'. In the context of obstetrics and gynaecology, Prof expressed a concern around the extent of medicalization of natural processes such as natural birth vs caesarian; episiotomy vs female genital mutilation.

One of the most urgent asks from the participants was medical support for women to whom Forced and Coerced Sterilization was performed. Whilst some of these women are known to the HRI, CGE and the government of South Africa, many women are in provinces where research to establish this is yet to be conducted and also need assistance. Some of these women are organized under HRI and others are possibly grouping, and the government needs to take care of their medical needs whilst they are pursuing their different processes for redress. The meeting deliberated on the approaches to healthcare and with relevance to medical procedures, consent and information sharing. Others live with disability(ies), this compounded the challenges that they experienced.

In the context of forced and coerced sterilization, women who experienced further medical complications and disorders in their cervix related this to the sterilization, though it could possibly be unrelated. Whilst some of their problems may, others may not be related to the procedure. However, with lack of information and education everything is lumped together. This suggests that there needs to be strengthened education for the general population and targeted interventions for these women to extend knowledge around sexual and reproductive health.

> Forced and coerced sterilization robs women of their motherhood and their grand motherhood and erases their lineage…"
>
> Sethembiso Mthembu,

Even with out of court settlements and compensations, the emotional scars that the violation caused women will never be erased. The efforts of the Sate to end the fertility of HIV+ women by whatever means possible is unacceptable.

Further medical concerns that seem to be shared by many in the room included excessive bleeding with no resolution even after several visits to the clinic and hospital.

Tenofovir/lamivudine/dolutegravir, simply known as TLD is a drug that is given to newly diagnosed HIV positive people. It is believed, by some women who were in the meeting that this drug may permanently damage women's ability to get pregnant.

Amendments to the sterilization Act and process

The collective built consensus on the need for HRI to join forces with health advocates, and advocated for amendments to the sterilization process so that any introduction of the proposals for sterilization as an option for a pregnant woman are introduced during the ante-natal (ANC) visits. This, according to the women, would allow women ample time to think through, read and find out more about sterilization; consult significant others in their lives and make an informed decision without any undue inducement to agree to the procedure. The women identified ANC clinic visits as a catchment opportunity but that is lost because in most hospitals a conversation about post-partum contraceptive use is introduced in the labour ward shortly after the woman has given birth. This, the women contended, bordered on unethical health practice as the healthcare workers attempt to get consent from a woman at a time when they should be focusing on their newborns and learning a lot about how to receive the baby and lactation. Following labour, some women experience postpartum depression, and this affects their health seeking and decision-making abilities.

Post sterilization psychological sequel

The post sterilization psychological sequel on discovering and/or realising that one will never have children again resulted in the women suffering emotionally and psychologically, and these manifested in physically unexplained symptomatology for some. The participants shared

health complaints that were seemingly unattended, and some were reported to the clinics and hospitals but left unattended. Some of the women had never received proper counseling and that addended to the burdens that they live with.

There is a challenge of lack of psycho-social and mental health support for victims and this was expressed by participants in the meeting expectations. This presents a limitation in the HRI's work with the women as a focus on the law and human rights alone does not fully address the impacts of FCS. Psychiatric evaluations and provisions of tools for coping mechanisms and support systems are imperative for victims of violence living with trauma. There was a sense too in the meeting that the women wanted to know and understand what exactly was done to their bodies in terms of the nature of the sterilization performed: tubal ligation, where the fallopian tubes are cut or sealed; or a hysterectomy, where the uterus is surgically removed, etc. This, a reasonable request, as it may assist the women in finding closure and so necessitates medical examinations to ascertain the procedures and their possible effects on their bodies for an improved quality of life.

Postpartum depression

Depression suffered by a mother following childbirth, typically arising from the combination of hormonal changes, psychological adjustment to motherhood, and fatigue; postnatal depression

Addressing gender in family planning

There are tensions in legal provisions for sterilization and this created a gap for abuse and coercion without anyone else knowing.

Considering this and the need to open opportunities for family planning in a gender equitable way; the collective also proposed that strong advocacy for male sterilization should be considered. Meeting participants were concerned about what they attributed to be carelessness on the side of the government in making sure that the rights of women who test positive are protected. A further concern was raised on the use of the TLD (drug/injection) which is given to people who have tested positive for HIV. The TLD is a three-in-one combination of tenofovir, lamivudine and dolutegravir in one pill. Participants were worried that there is some (anecdotal) evidence that this treatment may make women infertile in the

long run. Besides concerns about permanent infertility, there were also anxieties around the treatment stemming from the fact that if one was not infertile, they could give birth to children with a deformity or disability. Her Rights Initiative thus calls on the government to commission a study to bring forth evidence of safety of this drug/injection for women living with HIV.

HIV stigma

> *"only clean women should bear children"*
>
> Sethembiso Mthembu, 15.11.2020

Promise Sethembiso Mthembu contextualized violence against women in the health sector and offered that victims of forced and coerced sterilization are not "*unfortunate women*" but that they are targeted. In the same way that women victims of brutal forms of violations during apartheid were ignored and erased by the TRC[10], women victims of medical violence are ignored by the South African government. Sethembiso called on all participants to make sure that the political nature of this issue should not be lost. The reports on FCS all point to the pursuance of the "disease and danger" image of the black women's bodies that is structural in the healthcare system resulting in higher rates of mortality for women living with HIV. The hierarchy below presets what seems to be a strategy to deal with HIV+ women in the health sector (***see figure 2***).

It was alluded to, that the HSRC HIV stigma index reported on violations of HIV positive women. The Stigma Index is a UNAIDS initiative, its foreword signed off by the Deputy Minister of Justice who also chairs the SANAC Human Rights sector, yet there have been no actionable outcomes for eliminating FCS. This is true for other collaborating organisations such as the WITS Reproductive Health Institute (WRHI), NAPWA and TAC, among others. The extent that the issue of women forced and coerced into sterilization is undermined, is evident in that the executive report of the HIV/AIDS Stigma Index does not mention it. Participants at this meeting agreed that follow up is needed for the work on the HIV/AIDS stigma report that was published by the HSRC to understand its impact.

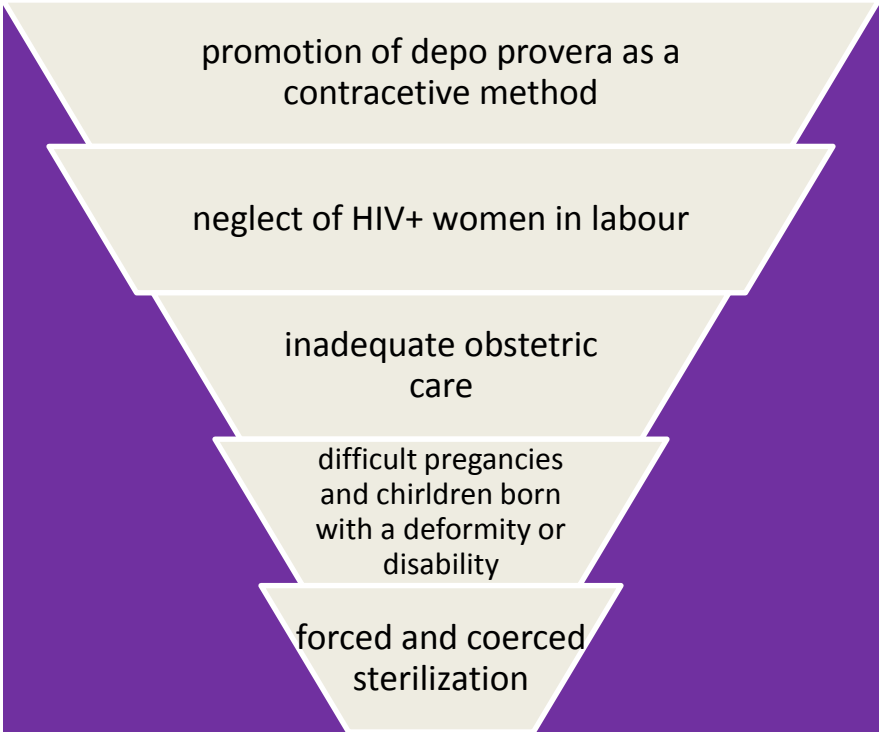


Figure 2: Suggested hierarchy presetting impressions for dealing with HIV+ Women in the Health Sector

Reaching out to men through their female partners was cited as one of the risks that a gender-blind intervention may out women at risk of domestic violence. This strategy, to reach at men through women, was reported to have been happening in some sites where women that tested positive for HIV were given a test kit and required to test their partner/s.

Education of healthcare workers

One of the main concerns that the attendees expressed was the lack of adequate information and knowledge by healthcare workers at local and district health facilities. On this, Prof Mhlanga decried the delays in getting cutting edge research findings to healthcare workers on the ground. The ivory tower that South African research is, continues to be a bother and a concern, especially given that some of these findings that remain ivory towers are from research that is supported through public funds. This information and knowledge gap needs to be closed by transforming science councils and institutions of higher learning where this research is based.

Participants encouraged that educating healthcare workers around human rights, gender inequality, HIV stigma and other related topics should be framed and aimed at values clarification. Considerations for holistic health are found wanting amongst health workers and hence blatant violations occur because they are systematic and difficult to break. The systematic barriers to access to health care that is free of violence were linked to the legacy and remnants of years and years of oppression of Black African South Africans.

> "it is not bad doctors who forcingly violated black bodies in this way, forced and coerced sterilization is not medical negligence" Sethembiso Mthembu, 15.11.2020

A healthcare sector which disregards, and disrespects Black African women needs to be revised and reconstructed so as to shift this culture and the government should be at the forefront of this transformation. This was echoed by the Women's Legal Centre in their presentation where they affirmed the cruciality of a feminist approach to this matter. The WLC stressed that FCS is rooted in the systematic context of racism, sexism and eugenics both in practice and policy. Sethembiso emphasized the obligation of the government in finding redress because it was not one Doctor who performed all these surgeries. This violence points to a planned and systemic roll out of a strategy from a ministry of health. State violence of Black women is a symptom and a sign of an incomplete liberation that does not address human rights violations. Hence the HRI calls on the government to compensate all the women who are victims of this brutality. Nasreen Solomons from the WLC shared the same sentiments and attributed the government's failure to implement redress for the victims to the fact that it is "…*because women's lives are not a priority for those in power*…" and this is something that needs consistent and constant fighting for. Healthcare workers need to be taught that a woman who is un/less educated may know more about life, can rightfully make their own decisions and their wishes should always be respected. To this end, the system has been oppressive to women in general and has treated these women in such a bad way that they may begin to doubt if they are not the reason that oppression happens to them. These five points sum up the sentiments in the meeting about the broken trust between nurses/doctors and

women living with HIV. Why should Black, African, Poorer, Women, living with HIV trust nurses and doctors when;

- They take away women's ability to make decisions about their bodies
- They perform unexplained procedures on women
- They judge women as unable to make decisions for themselves
- They sterilise women living with HIV without their consent
- They destroy their files in the hospitals

Gender-based violence against women

"…*compensation, by the government, for violated women is urgent*…"

Participants framed and contextualized their experiences of Forced and Coerced Sterilization within the background of gender inequality, gender-based violence and femicide. To sum it up, Prof Mhlanga suggested that the message communicated by obstetric violations, including FCS violations seems to suggest to women that "*if you want to reproduce; you will die. If you want to live; do not reproduce*". Prof Mhlanga further cautioned that healthcare workers should have the insight that it is inappropriate to seek consent for family planning from a woman in labour because they may not be in a state to comprehend and consent to the offer. To this end, the practitioners involved in the forced and coerced sterilization procedures should have known that they behaved unethically and in fact broke the laws related to women's human rights.

There was recognition in the room that gender-based violence against women is also systematic and engrained in the health and research sectors where "*everything seems to start and end with the women*" (participant at the national FSC meeting). This, according to the women who supported this complaint referred to clinical trials against HIV, family planning clinics, sterilization, etc. That all these services are centered around women as if women solely bear the responsibility for preventing unplanned pregnancies and HIV infections. To this end, there is a project in clinics that requires that women collect a test kit for their partners and family members to encourage them to know their HIV status. Women at the meeting

cautioned that this is risky for women. This suggests to their partners that they tested and are aware of their HIV positive status, and this may attract domestic violence. In the past, women living with HIV had had to bear the brunt for testing and bringing the news to their partners only to be met with rejection and violence. Women seem to be an easy target in the health system. To demonstrate that there is no sense in targeting women (and not men) Prof Mhlanga pointed out that it is senseless to not target men because "…*sterilizing a woman prevents one child being born in nine months; and sterilization of a men prevents nine children being born in one month*". It is therefore more effective to sterilize men than women but because of gender dynamics, men's reproductive capacities are considered prime and untouchable. Linking this to their experiences of FCS, participants expressed that "…*compensation, by the government, for violated women is urgent*…". This is a sentiment that resounded throughout the two-day meeting. There was a sentiment that the 'combos' such as 'test and treat' are the ones that package health services in a way that makes it impossible for users to delink their consent. So, consenting to give birth at a hospital is not and should not be construed as consenting to give the healthcare worker the right to sterilize without consent. But healthcare workers are being acculturated, accustomed, empowered to use the combo approaches in HIV/AIDS management. When A is presented as part of B; it becomes unclear to users if they can refuse B and still be entitled to A, and no one wants to be on the wrong side of a nurse or doctor because that may mean that they will not get the service that they need and may be confronted with a very negative attitude for disagreeing to take a 'good offer'.

The continued violation and murder of women living with HIV makes the world feel very unsafe for women like the ones who attended the meeting, one participant drew the attention of the meeting to the serial murder of women in Ugu: the killing of 32 women by a serial killer in KwaZulu-Natal. A constant factor in these killings seems to be the fact that all the women but two, were living with HIV and on treatment; it would appear that this was organized crime. It is believed that 30 of the 32 women were on HIV treatment and it is possible that this femicide was a crime against HIV positive women. The Ugu murderer committed suicide and this closed the case. Similarly, GuGu Dlamini, a woman from KwaManciza in the KZN province was stoned and stabbed to death after she admitted to being HIV positive on radio, on World AIDS Day

1998. From the reality of these cases, it is inferable that women living with HIV are killed because of their status, and that HIV infection increases women's risk of and exposure to violence; whilst their position in society makes it harder for them to address their experiences of GBV. Violence towards HIV positive women has not been acknowledged by HIV and GBVF policies and strategic plans; and because they are ostracized in society they are not an organized group, they are not funded and as such they do not make it to policy decision-making spaces such as the SANAC and GBVF meetings, to name a few. SANAC and GBVF programmes are not analysed from a broader societal perspective but rather by identities and organisations in the forefront; as such programmes are a collection of projects of organisations with existing access. This also owing to the limitation resulting from Statistics SA's exclusion of HIV infection as one of the indicators in recording femicide in the country, further alienating women living with HIV from the agendas of HIV and GBVF programmes.

Language and access

Language is a facilitator and a barrier to communication at different levels. In South Africa, access to business language is facilitated by education status. South Africa has eleven official languages but the predominant business language is English. Further to the language is the business jargon in which most of the research reports and other documents are written. This varies from science, developmental, health, welfare to legal human rights disciplines and their languages. To make knowledge accessible to all, it is necessary for information to be converted to simple and understandable English, and further to local languages so that it is prepared for consumption by the people who are affected: in this case the Black African, a poorer woman who uses public facilities and are affected by forced and coerced sterilization. The need to address language use in South Africa goes beyond provisions that need to be made in relation to Forced and Coerced Sterilization, but to the broader health sector. Her Rights Initiative collective joins forces with others to advocate for the realization of multilingualism in South Africa.

Legal aspects

The main purpose of the two-day meeting was to connect with 27 women living with HIV and subjected to Forced and Coerced Sterilization on the basis of their HIV status. These women, through the Her Rights Initiative collective, further submitted a complaint to the Commission for Gender Equality for the same. Eight months after the release of the report by the CGE that confirmed these violations, the women were yet to hear what the next steps were and what redress they should expect from the government. Participants emphasized that they would like to know from HRI, from the advocates who joined their struggles to advocate for change, from their legal representations and from the government, what were the possibilities for them as individual complainants to receive redress of some sort and what would this look like; women were asking for clarity on the three-year prescription Act. This was explained on the second day by the legal allies from CALS, ProBono.org, WLC and Advocates Dali Mpofu and Tembeka Ngcukaitobi.

There are limitations to seeking legal recourse for violations of this nature. One of these limitations is that the victim may know much later that they have been sterilized. There was a discussion at length about the Prescription Act and what this means for the victims whose cases date back a decade ago. Nonetheless, the work to seek redress remains important and this limitation will and should be addressed. For instance, the case could be brought to the Equality Court for it is the most accessible and approachable court to work through.

A few options such as opening a criminal case against specific and known practitioners, and lead evidence in a trial were explored as possible avenues for redress. If found guilty through a criminal case; the perpetrator will face jail time. The other option was to approach and work with Chapter 9 Institutions (CGE, HRC, etc.), approaching the Equality Court to seek redress and specifically compensation for the pain and suffering and for future medical expenses. Compensation that is awarded through courts, however, is awarded for an individual case(s). The UN could support HRI by demanding accountability from the government. As the employer of the doctors and nurses, the government needs to be held accountable. Dr Tlaleng impressed that women need to be mindful that there are good and bad laws; so, the focus on

advocacy and redress needs to be on justice. The training of healthcare workers, creation of safer spaces for women and provision of medical and psycho-social support for women victims of FCS are things that need to be prioritized. All these options are not easy, and women are going to need support to stay the course. As individuals and as a collective, the victims must think about what they want and are able to do. As violations such as forced and coerced sterilization ate structural; the court should compel the government to implement the recommendations of the Commission for Gender Equality.

The meeting resolved that Class Action Court Action should be instituted against the Department of Health. The Class Action will achieve amongst others, Constitutional Court pronouncement on prescription, clear articulation on monetary redress for damages, including Constitutional damages. Furthermore, a Class Action court case will secure remedies and redress for all HIV positive women who were subjected to forced sterilization in South Africa in the past, and the future. Legal organisations who participated in the meeting were given the mandate to set a framework for the Class Action Court Action

Research, monitoring and evaluation

There was also a discussion about anecdotal evidence vs scientific evidence. Women's lived experiences are the data and women's stories are the research, and so they should not be discounted in favour of science in developing countries like South Africa where access to science is skewed based on race and gender, with whites and men overrepresented in knowledge production. Research was highly valued by the participants, they, however, cautioned against overzealous researchers who pronounce study findings and their implications for policy and practice change, and promote a product without any replication studies conducted. Considerations for implementation of research findings needs to be carefully thought through and adequately planned for.

Challenges

Some of the challenges facing women in the space and being the targeted beneficiaries of interventions include the following:

Language. The language used to communicate information needs to be simple and accessible for most women.

Turnaround time. The length of the turnaround time for legal resource is long and may leave women exhausted, and some may give up on the process. Related to this was the question around the window period to apply for redress. There is also a problem with gatekeeping access and service delivery to communities by political representations; the endemic culture of violence in health institutions such as clinics and hospitals. This culture blocks access for many women and hinders them from complaining and they are often threatened. This is reported in scientific studies elsewhere.

5. Conclusions

The purpose for convening was to hold a national dialogue and advocacy planning meeting on FCS:

- To create a safe space for the women to share their experiences and explore coping strategies in order to determine short and long term mental health, psycho-social needs of the women;
- The experiences from the meeting will inform a baseline for short term and long term mental health, psycho-social support needs of the women;
- To receive feedback and updates from the CGE on findings and recommendations of the CGE Investigative report on forced sterilizations;
- To engage and discuss advocacy, research and legal interventions for redress; and reduction of impact of FCS on women and to end FCS of women living with HIV in South Africa; and
- To map and draw key advocacy and research priorities for implementation in the next six months to a year.

HIV positive women who participated in the meeting were from various communities and regions in KwaZulu-Natal and Gauteng. Her Rights Initiative lodged the Complaint on Forced

Sterilizations to the Commission for Gender Equality in 2015. The Complaint was on behalf of 48 women living with HIV who were forced and coerced into sterilization. The meeting sought to craft the way-forward on the implementation of recommendations of the CGE Investigative Report on Forced and Coerced Sterilizations in South Africa.

There was recognition from the meeting that the continued violations of women, and women of color (Black African, poor women), is indicative of the transformation that is needed in South Africa post 1994. Whist the Constitution's laws and polices change for the better in South Africa, practices are still backwards, and this goes unpoliced by the government. This is indicative of the fact that the laws and policies are not conceived from the feminists' perspectives which consider unique intersecting lived experiences of poor Black women in colonial and post-colonial society. This state of affairs was created, by amongst others, the rejection of feminists analysis of eugenics, reproductive crimes and humiliation of Black female bodies by the colonial and the apartheid South Africa. The government, as an employer bears the responsibility of the actions of its employees and in turn should hold its employees accountable. Furthermore, these human rights violations are systematic, and therefore require systematic and human rights redress and transformatory political interventions.

There is a need to explore possible strategies to change the systematic oppression, marginalization and discrimination against women at a macro level whilst simultaneously holding individual perpetrators (hospitals) of violations against women accountable. ProBono.org has some resources through the Global Fund to work on violations against Key and Vulnerable Populations. This could include the training of community (legal) advice offices, lawyers and strategic impact litigation with a focus on this matter. Community legal offices are in most district towns in South Africa and accessible to women for advice and information. Women would like to be able to understand and translate policy, for example, to hold officials accountable for the Batho Pole Principles; as well as other instruments such as the mandate of the UNFPA, UN WOMEN and OHCHR joint statement; and the Patient's Rights Charter. Women are keen to explore advocacy for women's issues around forced and coerced

sterilization. For this to be successful, there is a need to establish trust that those not affected, who consume the pain of the victims are accountable to the victims.

6. Recommendations

Below is a list of recommendations that were identified from the meeting. The main recommendation for the Commission for Gender Equality was that they reconvene the meeting with the same participants and support the organization with the logistics of the follow up meeting. At that meeting, some of the recommendations outlined below will be explore with the CGE.

For the UN agencies

1. The United nations should demonstrate its commitment to human rights as promoted in various international instruments that South Africa is a signatory to by beginning a process to hold the South African government accountable for its failure to promote and safeguard the rights of women living with HIV to bodily integrity autonomy, quality and non-discriminatory health care, and from forced and coerced sterilization.
2. The UN should hold the State to account and demand for redress from the SA government as far as contraventions of the UN agencies' issued interagency statement; as well as support women living with HIV in their efforts to demand redress from the government.
3. Partner with Her Rights Initiative to escalate the matter to the office of the Presidency for urgent attention.

For the collective/HRI

1. It is prudent that the HRI and the collective learn more about their legal partners and successes/success rate in defending similar cases so that they partner with an organization that is strong in human rights and in particular women human rights in the GBVF and HIV fields. The HRI could also learn more about cases of this nature in other countries, especially Asian, Australian and Latin American countries, which are lower-resourced countries with high HIV prevalence; but this to include seemingly resourced countries

where marginalised groups face similar marginalisation. The main focus should be to find out how the cases went, what worked and what did not work in addressing FCS legally. If there were any commissions of inquiry conducted to seek redress or mediatory processes carried out, the HRI should ascertain how these were done and the results thereof.

2. Together with the advocates for this case(s) and legal representation, an urgent need to work on a fast-tracked turnaround time was identified. To fast track this, a recommendation was made for HRI, CALS, ProBono.org and the WLC to meet with Advocates Dali Mpofu and Tembeka Ngcukaitobi as soon as it is possible.
3. That HRI creates a platform for open and up to date communication on the progress of the matter so that the affected parties do not feel neglected.
4. HRI, and partners, to also work and possibly partner with organisations such as Treatment Action Campaign, Right to Know, Foundation for Human Rights, Lawyers for Human Rights, Section 27, and AIDS Law Project so as to raise community awareness. These are organisations that may serve as allies in providing access to information: technical and legal information so that the women are kept well informed and engaged in processes that are about them.
5. Whilst counselling and support groups are set up in local clinics; they are not always functional and may not be resourced with counsellors who are knowledgeable and skilled to deal with the victims of forced and coerced sterilization. There is therefore a need to support the victims with a tailor-made intervention that will incorporate counselling, peer support and working in a multi-disciplinary fashion with other service providers. The need to identify an organization that can support women was identified as urgent so that the victims deal with the trauma and get themselves ready to journey together and with their allies in the process of pursuing redress. The CSVR may be explored as such an organisation.
6. HRI should mobilize allies and join forces in the fight against HIV stigma. This should include sectors such as the faith-based, traditional leaders and healers.
7. To advocate for the involvement of HIV+ women in all steps of the participation ladder to open spaces for self-representation and give voice to the victims. The participation and

inclusion should be in line with the intersectionality of Black African women who are under employed or unemployed, from poor backgrounds, and who are HIV positive and were subjected to FCS. The openness to safe spaces for women living with HIV should include access and representation in bodies such as SANAC, considering that there is currently no focus on their issues. SANAC is a mainstream body, so when the issues of women living with HIV are raised they get lost in the analysis and silenced by the dark side of democracy, amplifying the importance of self-representation.

8. In partnering with other institutions and private allies, HRI needs to assess the credibility, competency and effectiveness of the partner(s) so as to appropriately support the women without exerting further and unnecessary trauma on them. The HRI collective also needs to mobilise support from international partners both coontinentally and globally.
9. Explore the role and position of the HPCSA and the South African Nursing Council on this matter.

For the government

1. As per recommendations of the CGE report the NDOH needs to facilitate dialogue between themselves and the complainants in order for them to find ways of providing redress to the Complainants.
2. The DoH policy and practice pertaining offers for family planning, including sterilization for pregnant women needs to be revised so that it is part of the ANC care rather than a matter that is introduced during labour. At this point the woman is vulnerable and asking them for consent raises ethics tensions. The decision to undergo sterilization requires information and education to enable the patient/client to make an informed decision. This is a process, and not an incident; and it is never an immediately necessary operation.
3. The government initiate investigate a process to examine the Sterilization Act closely and make amendments to make it impossible for healthcare workers to unduly induce any women into 'making a decision' to have sterilization when in labour. This is also an advocacy issue.
4. There needs to be strengthened education for healthcare workers on human rights.

5. The government should put in place mechanisms to ensure that this and similar violations do not happen again and provide avenues for the debriefing of victims, their children and families and also address healthcare workers as some of them may have been negatively affected by the violations that happened under their watch and they could not stop it.
6. Ensure that Her Rights Initiative is represented in the GBVF Council structure because FCS is a systematic and systemic form of GBVF, by the government.
7. Mandate for the speedy implementation of the recommendations of the CGE report, in particular those related to redress. There needs to be a focus on implementation versus documenting human rights violations and not seeking redress for those violations; this strategy on its own, is silencing human rights violations.

For the health sector

1. There needs to be a national audit of health facilities to establish their compliance with national protocols and guidelines.
2. Medical ethics during training and during continued professional development to break the culture of generational transmission of professional brutality in the health sector.

Medical ethics vs human rights

1. Changes to the curriculums would break the generational transmission of a culture that violates women.
2. There is an incredible need for information and education on Human Rights. A Rights campaign is needed to educate about rights in the healthcare system, human rights and violations, and women's rights.

Research recommendations

1. It was suggested that the following studies need to be conducted to support the process and prevent similar human rights violations from happening:

A study to clear the suspicions that the TLD: three-in-one combination of Tenofovir, Lamivudine and Dolutegravir in one pill, which is given as part of the test and treat campaign may be dangerous for women.

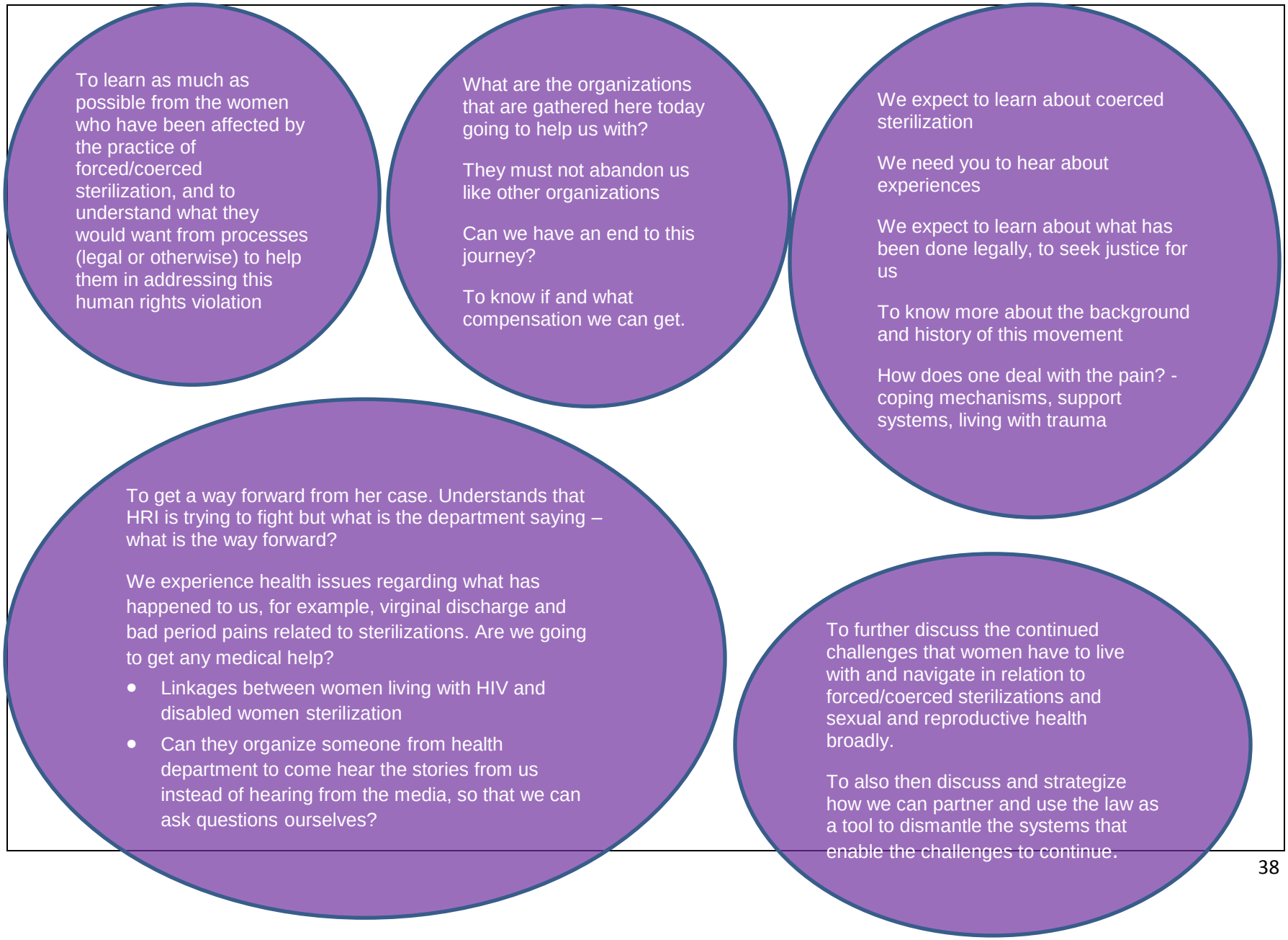
2. The second aspect was research on the extent and impact of FCS on women and their wellbeing (socio-economic, psychological, etc.) coupled with documentation of the women's stories for publication.

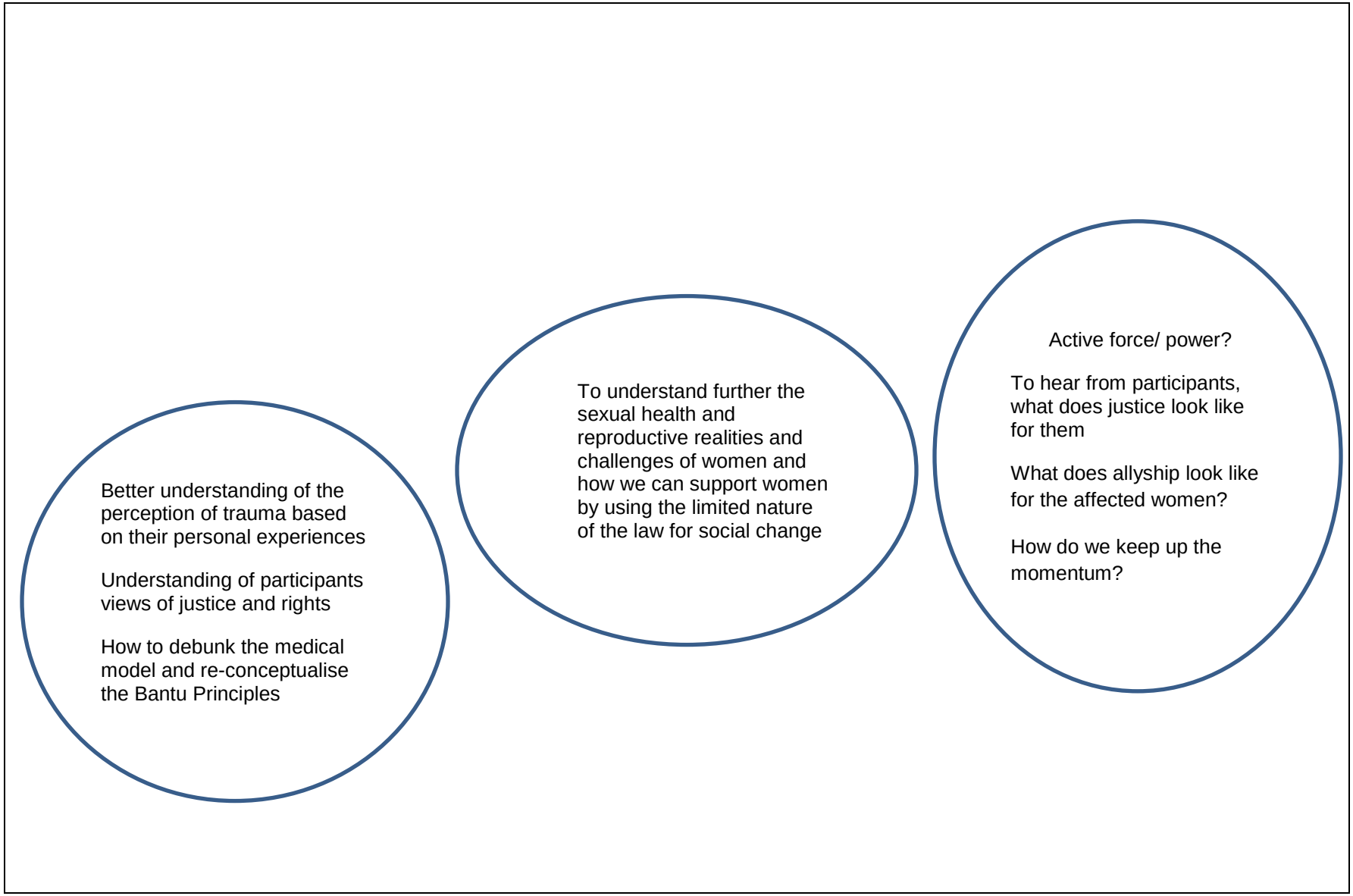
7. Appendices

Appendix I - Meeting expectations

Appendix II - Meeting agenda

Appendix I: Meeting expectations


To learn as much as possible from the women who have been affected by the practice of forced/coerced sterilization, and to understand what they would want from processes (legal or otherwise) to help them in addressing this human rights violation
What are the organizations that are gathered here today going to help us with?
They must not abandon us like other organizations
Can we have an end to this journey?
To know if and what compensation we can get.
We expect to learn about coerced sterilization
We need you to hear about experiences
We expect to learn about what has been done legally, to seek justice for us
To know more about the background and history of this movement
How does one deal with the pain? - coping mechanisms, support systems, living with trauma
To get a way forward from her case. Understands that HRI is trying to fight but what is the department saying – what is the way forward?
We experience health issues regarding what has happened to us, for example, virginal discharge and bad period pains related to sterilizations. Are we going to get any medical help?
Linkages between women living with HIV and disabled women sterilization
Can they organize someone from health department to come hear the stories from us instead of hearing from the media, so that we can ask questions ourselves?
To further discuss the continued challenges that women have to live with and navigate in relation to forced/coerced sterilizations and sexual and reproductive health broadly.
To also then discuss and strategize how we can partner and use the law as a tool to dismantle the systems that enable the challenges to continue.


Better understanding of the perception of trauma based on their personal experiences
Understanding of participants views of justice and rights
How to debunk the medical model and re-conceptualise the Bantu Principles
To understand further the sexual health and reproductive realities and challenges of women and how we can support women by using the limited nature of the law for social change
Active force/ power?
To hear from participants, what does justice look like for them
What does allyship look like for the affected women?
How do we keep up the momentum?

Appendix II: Meeting agenda

MEETING ON FORCED AND COERCED STERILIZATION OF WOMEN LIVING WITH HIV

15-16 NOVEMBER 2020

RADISSON-BLU HOTEL IN SANDTON, JOHANNESBURG

MEETING FACILITATORS: PROFESSOR MZIKAZI NDUNA, with Oyama Tshona

SESSION	ITEM	SPEAKER
08h30-08h40	Welcome Introductions	Her Rights Initiative: Sixolile Ngcobo Prof. Mzikazi Nduna/Oyama Tshona
	Opening Remarks	Heinrich Boll Foundation: Claudia Lopes
08h40-09h00	Unpack objectives and purpose of the meeting	Prof. Mzikazi Nduna /Oyama Tshona
09h00-10h30	**CONTEXT ANALYSIS:** Forced sterilizations advocacy journey 2008- 2020 Forced and coerced sterilizations of women living with HIV in South Africa: Historical, feminists legal and international human rights perspective	Her Rights Initiative: Sethembiso Promise Mthembu Nasreen Solomons: Women's Legal Centre
10h30-11h00	**MORNING TEA BREAK**	
11h00-13h00	Medical, obstetrics and women's health perspective Centering of forced and coerced sterilizations of women living with HIV from a global perspective	Prof. Ronald Mhlanga: Medical doctor and women's health policy expert Dr Tlaleng Mofokeng: United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health
	Discussions and reflections on presentations	Prof. Mzikazi Nduna/Oyama Tshona

	LUNCH BREAK	
14h00-15h30	The river of life/Loosing something/ A letter to my past self	Prof. Mzikazi Nduna/Oyama Tshona With psychosocial support by Amina Mwaikambo and Thembisile Masondo, Centre for the Study of Violence and Reconciliation (CSVR)
15h30-15h45	**AFTERNOON TEA BREAK**	
15h45-17h00	Reflections (partner organisations) listing key research, advocacy and support needs from the discussion)	Prof. Mzikazi Nduna/Oyama Tshona
17h00	Wrap up for the day and closure	Her Rights Initiative

DAY TWO

SESSION	**ITEM**	**SPEAKER**
09h00-10h30	Finish Day one: Psychosocial aspects	Prof. Mzikazi Nduna/Oyama Tshona
10h30-11h00	**MORNING TEA BREAK**	
11h30-13h00	Presentation of the findings of the CGE investigative report on forced and coerced sterilizations of women living with HIV *Reflexive discussion and (identifying key areas and interventions for litigation and advocacy)* Q&A: Discussions	Commission for Gender Equality (CGE)
13h00-14h00	**LUNCH BREAK**	
14h00-15h30	**Panel discussion:** *Responses to CGE Report*	WLC, CALS, ProBono
15h30-15h45	**AFTERNOON TEA BREAK**	
15h45-17h00	Consultations Responding to the meeting objectives	Amina Mwaikambo and Thembisile Masondo, Centre for the Study of Violence and Reconciliation (CSVR) Mzi and Oyama
	Rounding of and forward thinking: Research, Prioritisation and planning of advocacy, Human Rights Work, Psychosocial support Keeping in touch as a volunteer organisation	Her Rights Initiative

17h00	Way forward and closure	Her Rights Initiative, Heinrich Boll Foundation

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