ADDRESS BY JUSTICE MAYA
PRESIDENT OF THE SUPREME COURT OF APPEAL:
HELEN KANZIRA MEMORIAL LECTURE
UNIVERSITY OF VENDA
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Ladies and Gentlemen

I must begin by tendering my unreserved and most humble apology that this event takes place only today when it was originally arranged for a date during a more fitting period, August, which is Women's month. But life's exigencies have a way of intruding at the most inconvenient of times. But here we are and I am really happy to be among you this morning.

I must also express my deep pride for being associated with this institution. We have been watching with growing delight as the University of Venda took its rightful place among its peers; becoming an important player in the South African higher education

landscape and contributing meaningfully to the development of the human resources and other needs of the country and region. This institution values and unabashedly celebrates its Africanness and it is no mean feat that it is the only centre of higher learning, as I am told, that offers the Bachelor of Indigenous Knowledge Systems programme in South Africa; this in an age when we are lamenting the degradation of our precious indigenous languages and cultures. This is true leadership by example and one hopes that our other institutions of learning will follow suit.

I am humbled by the invitation to give this year's public lecture in honour of an illustrious woman, an icon of women's universal struggles, after whom the lecture is named. And the opportunity is especially gratifying because the subject issue is one of such gravity that it should occupy the collective mind and will of all mankind until the problem is eradicated. This is so because women bear the burden of child bearing and keeping the human species alive. I cannot think of a more important human task. The subject is also very close to my heart. I too am a mother who has suffered from some of the life threatening afflictions associated with pregnancy and childbirth. When I fell pregnant with my first child as a young woman, I suffered from pre-eclampsia ie hypertension induced by pregnancy, which has persisted throughout my adult life. And five years later, I gave birth to my middle child and almost died from excessive bleeding and anaesthetic complications. But because I had a good job which earned me a good income, a good healthcare plan and easy access to good healthcare facilities, my life was saved.

Regrettably, Helen Kanzira was not as lucky. And like many other women in the developing countries who do not enjoy these advantages, she died needlessly, from childbirth complications, in the 21st century. Thankfully, her death has not been in vain as it has inspired this movement that provides a platform on which the gross violations to women's health, sexual, reproductive rights and just the basic right to determine their lives can be highlighted. And as we honour her legacy today we are particularly reminded to step up our efforts to define maternal mortality as a human rights issue,

so that women and girls do not die from avoidable causes while performing the most natural, life giving act that benefits all of humankind.

Reproductive health and rights is a wide-ranging topic. For purposes of this presentation, I will cover the normative legal framework pertaining to the right to health care in the international context, in broad strokes, and then bring the focus to South Africa and what has been done in the country since we attained democracy to address the challenges arising from maternal health issues and give effect to the right to reproductive health that is entrenched in our Constitution.

Primary causes of death

The main conditions that have been identified as contributing to maternal death are non-pregnancy-related-infections such as HIV-AIDS, tuberculosis, pneumonia, meningitis and malaria (with HIV-AIDS reportedly constituting 95% mortality in this group); obstetric haemorrhage ie excessive bleeding, hypertension, medical and surgical disorders attributable to poor access to care, lack of appropriately trained and experienced doctors and nurses; and an inadequately resourced health system. According to relevant experts, the majority of these deaths are entirely preventable.

Case studies conducted by the National Committee for Confidential Enquiry into Maternal Deaths in South Africa (NCCEMD), which has been operational since 1998, maternal deaths almost doubled between 1990 and 2008. And according to the statistics of the World Health Organisation in 2013 South Africa was ranked in the top forty worst maternal health countries in the world alongside smaller, poor countries such as Haiti, Niger, Ethiopia and Liberia.

It is universally recognised that maternal health is an indicator of the strength of a country's health system which provides early warnings of wider health system problems. But more importantly, maternal mortality severely impacts the development

of a country. Healthy mothers enable a country to maximise its human capital, reduce poverty, hunger and child mortality and improve universal primary education. It is partly in recognition of these facts and to enhance these societal benefits that the international community has developed various policies and legal instruments to address maternal mortality.

International Law, Agreements and Treaty Monitoring Bodies

Women's sexual and reproductive health rights are founded in a number of rights guaranteed in various international human rights laws and treaties. These include the rights to life, to equality, to health, to privacy, to information and not to be subjected to discrimination, torture and ill-treatment.

The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), 1979, signed by 187 nations, is the foremost human rights treaty. It provides extensive measures for the elimination of discrimination against women in the field of health care, inter alia, access to health care which includes access to family planning (article 12(1)), appropriate services in relation to pregnancy, confinement and the postnatal period which must be provided free of charge where necessary (article 12(2)), a special recognition of the additional burdens faced by rural women in vindicating these rights (article 14), and the equal right of women to decide freely and responsibly the number and spacing of their children and have access to information, education and the means to exercise these rights (article 16(e)).

Similar protections are stipulated in other instruments including

- the International Covenant on Economic, Social and Cultural Rights, 1966, which guarantees '[t]he right to the highest attainable standard of physical and mental health' (article 12);

- the International Covenant on Civil and Political Rights, 1966 which guarantees '[e]quality between men and women' (article 3) and requires the law to protect all against discrimination (article 26);
- the Programme of Action of the International Conference on Population and Development, Cairo, 1994 which sets out the internationally accepted, wide definitions of 'reproductive health' and 'reproductive rights', respectively, as the 'state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes', and '… the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health ... includ[ing] the right of all to make decisions concerning reproduction free of discrimination, coercion and violence';
- the African Union Campaign; and
- the SADEC Gender Policy and the ECOWAS Protocol, 2013.

In addition to these instruments, there are the political agreements reached at the United Nations World Conferences which also support women's sexual and reproductive health rights. There are then the three Treaty Monitoring Bodies

- the Committee on Economic Social and Cultural Rights, which spells out the comprehensive rights and freedoms contained in the right to health (para 8) and enjoins States to provide functioning, accessible, acceptable and quality health facilities, goods and services (General Comment No. 14 of 2000 titled 'The Rights to the Highest Attainable Standard of Health' (Article 12 ICESCR) paras 8 and 12. respectively);

- the Committee on CEDAW which decrees it discriminatory for a member State to refuse to legally provide for the performance of (certain) reproductive health services for women and makes it the duty of the member States to ensure women's rights to safe motherhood and emergency obstetric services (General Recommendation No. 24 of 1999 "Women and Health" (Article 12 The Right to Health, Non-Discrimination and Choice)); and
- the Human Rights Committee (General Comment No.28 of 2000 "Equality of Rights Between Men and Women" (Article 3 ICCPR)).

Quite apart from these measures, the United Nations (UN), following its Millennium Summit in 2000, established the Millennium Development Goals. These were in the form of eight international development goals which were intended to be achieved by 2015. The member States, which include South Africa, committed to eight key objectives – the eradication of extreme poverty and hunger; the achievement of universal primary education; the promotion of gender equality and empowerment women; the reduction of child mortality; the improvement of maternal health and combating HIV/AIDS and other diseases. When these goals were not achieved within the anticipated time frames, the UN launched the Sustainable Development Goals, which have the same objectives, to transform the world by 2030. The key goals which impact women's sexual and reproductive rights in the new compendium are ensuring healthy lives and promoting well-being for all, ensuring inclusive and quality education for all and achieving gender equality and empowering all women and girls.

But the women's lot has not improved much despite this plethora of measures which enjoin member States to provide their citizens with adequate health care that addresses the different needs, roles and responsibilities of women in relation to

pregnancy and family planning and implement measures that will create gender quality so that women are empowered to access the services that are available.

Position in South Africa

The Constitution of the Republic of South Africa, Act 108 of 1996, entrenches the achievement of equality as a founding value and the full and equal enjoyment of all fundamental rights and freedoms by all (s 9). Thus, it embodies gender equality and its attainment as an essential part of the creation of a just society. In s 27(1) , the Constitution grants 'everyone … the right to have access to … health care services, including reproductive health care'. And in s 27(2) it enjoins the 'state to take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of … these rights'.

The courts, led by the Constitutional Court, have pertinently interpreted s 27(1) and (2). And although they have declined to recognise the minimum core of the rights in question that must be immediately provided for by government, they have held that the sections must be read in conjunction and mean that the State must take reasonable steps to progressively realize the rights they provide. Accordingly, in *Minister of Health v Treatment Action Campaign (No 2)* [2002] ZACC 15; 2002 (5) 721; 2002 (10) BCLR 1033 (CC), the Court dealt with the issue whether the government was meeting its obligation with respect to enforceable socioeconomic rights based on existing policies to provide access to health services for HIV-positive mothers and their new-born babies. It held that these provisions required the Government to devise and implement, within its available resources, a comprehensive and co-ordinated programme to progressively realize the right of pregnant women and their new-born children to access health services to combat mother-to-child transmission of HIV, such a program to include reasonable measures for counselling and testing of pregnant

women for HIV, counselling HIV-positive pregnant women on the options open to them to reduce the risk of mother-to-child transmission of HIV and ensuring that appropriate treatment was available to women for such purposes (see also *Lungisile Ntsele v MEC for Health, Gauteng Provincial Government* SGHC Case No 2009/52394 delivered on 24 October 2012; *Vuyisile Lushaba v The MEC for Health, Gauteng* SGHC Case No 17077/2012 delivered on 16 October 2014; *Khoza N obo minor child Z v MEC for Health & Social Development, Gauteng Provincial Government* Case No 2012/20087 delivered on 6 February 2015).

Pursuant to these provisions, the Choice on Termination of Pregnancy Act, 1996, (the Abortion Act) which governs abortion, was promulgated. Significantly, this statute has since survived two legal challenges. In *Christian Lawyers Association v Minister of Health*, the plaintiff sought the striking down of the entire Act on the ground that it violated the constitutionally guaranteed right to life of the foetus. However, the Constitutional Court determined that the word 'everyone' in s 1 of the Constitution, which guarantees that '[e]veryone has the right to life', could not include an unborn child. In *Christian Lawyers Association v National Minister of Health*, the plaintiff applied for an order declaring unconstitutional the provisions that permitted a minor with the capacity to consent to terminate a pregnancy without parental consent or control. The court ruled that abortion rights (without parental involvement) could apply to adolescents with the capacity to give informed consent.

So, everyone is guaranteed the right to make decisions concerning their reproduction, and to security in and control over their bodies. The Constitution, domestic legislation, policies and protocols and the jurisprudence of the courts unambiguously oblige the government to support the protection of women's sexual and reproductive health as a fundamental human right.

In addition to the Abortion Act, the government introduced other important policies in the sphere of reproductive health. In 1994 it introduced free health care for pregnant women and children under 6 years. In 1998 maternal deaths were rendered notifiable by law and the NCCEMD which monitors the process of notification and conduct independent assessment of maternal deaths, predominantly in public health care facilities.

This committee reports that since 2011, following the implementation of the policy on the introduction of an improved HIV testing and the provision of ARV-treatment to all HIV-positive pregnant women from 2009, there has been a marked decline of maternal deaths in hospitals. And the Abortion Act has made safe abortions more accessible, thereby reducing incidences of unsafe abortions and maternal mortality and morbidity related to abortion significantly since its promulgation. There has also been a decline in deaths caused by obstetric haemorrhage although deaths owing to complications of hypertension remain high. South Africa now compares favourably among other sub-Saharan countries in terms of its key maternal health interventions.

But there is still a lot of work to be done. According to the NCCEMD mentioned above, a trifling percentage, a mere 4,6% of the Gross Domestic Products accounts for our health budget and there is need for intensified efforts focussed on improving the health system holistically to reduce the death owing to haemorrhage and hypertension – proper training of doctors, nurses and allied health workers and improvement of obstetric care and facilities, bringing properly resourced health care facilities to all, especially the many poor and rural black women in far flung rural areas who do not access the health system early enough or at all by reason of their location, ensuring efficient emergency transport between facilities so women do not die waiting for

ambulances or being carted in wheelbarrows to far health centres by desperate relatives, keeping the focus on HIV-AIDS testing so that people know their status, destigmatising the syndrome, improving screening systems, prevention and treatment measures, ensuring safe caesarean section births as this has been found to cause a three times higher mortality rate than normal deliveries, careful monitoring and treatment of hypertensive patients, promotion of family planning services especially to the young and older mothers to prevent pregnancy in these particularly vulnerable groups, eradicating child marriages which place young girls at risk, health worker training and. There is still great need for more health workers to receive training in the termination of pregnancy. Safe abortion services are also limited by the low use of medical abortion in public facilities. The lack of adequate public facilities to provide safe abortion care services also translates into the poor implementation of the guidelines.

I cannot conclude the presentation without alluding to the other incidents of systemic gender discrimination and gross violations of their rights which women face daily which result in deaths and for those who survive, render it impossible for them to live and function in a dignified way. We see in court case statistics and media reports that women continue to be victims of extremely high levels of rape and domestic violence in South Africa. Society, sometimes including the very judicial officers adjudicating cases involving sexual violence against women, blames the women victims for their own sexual assault by questioning their physical appearance, sense of dress and their presence at the places where they were attacked. Women continue to be treated as sexual objects who may never hold any valuable opinions or have a voice and who exist solely for the benefit of others, usually men. They are assumed to be intellectually inferior to men and less capable than them in any sphere of life. And on top of these disadvantages, women carry an unequal burden of home care and child rearing.

Poverty, which mostly affects women and girls, is another dire challenge. We live in a country where it is still an unaffordable luxury for many young girls to even access sanitary towels. And this of course has an extremely negative effect on their lives because when that time of the month arrives they must stay at home. So they lose valuable school time as they miss classes and some of them end up being so discouraged that they simply do not return to school. Poverty invariably translates to less chances of getting an education and more chances of suffering ill health, early marriage and / or pregnancy, abuse and exploitation. And these women are then sunk even deeper into the poverty trap.

The major cog of the solution lies in empowering all women and girls, mainly by investing in their education and development and creating and enhancing existing social safety nets that will ensure that they remain in school, and do not, in addition to missing out on valuable school hours because they are having their periods and cannot afford sanitary pads and end up not returning to school, have to stay at home to care for younger siblings because they were orphaned by HIV-Aids and have no one to raise them, or are abducted or handed over by their families and forced into early marriages with much older men for lobola because their families are poor and need the money, and all the other risks to which vulnerable women are susceptible. These are realities of many girls and young women in South Africa and elsewhere. A good education increases the chances of becoming informed and are aware of what is going on in the world around one, capable, articulate, self-sufficient and independent.

Thank you.