



**UNIVERSITY OF PRETORIA - CENTRE FOR HUMAN RIGHTS**

**Helen Kanzira Lecture**

*“Valuing Women as Autonomous Beings:*

*Women’s Sexual and Reproductive Health Rights”*

**Lecture**

**by**

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**United Nations High Commissioner for Human Rights**

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Vice-Chancellor, Professor De la Rey,  
Director of the Human Rights Centre, Professor Viljoen,  
Distinguished Faculty,  
Dear Students,  
Ladies and Gentlemen,

I am honoured and pleased to deliver this annual lecture in honour of Helen Kanzira. As you will know, Helen was a graduate member of the Centre's first master in laws programme on human rights and democratization in Africa which was offered in 2000. Sadly, she died in 2007 at the very early age of 39 as a result of complications arising from giving birth to a baby girl. During her short life, she had gained the admiration of many. In the legal profession she was a force to reckon with and a person known for her honesty and compassion. To her family and friends Helen was a shining light extinguished too soon.

Helen's memory inspires women and men in Africa to focus on the individual and collective value of each and every woman and work to ensure that they can enjoy healthy and productive lives and give

birth to new life in freedom of choice and without fear of discrimination.

Freedom, equality and dignity are core human rights principles which are enshrined in article 1 of the Universal Declaration of Human Rights. When we defend human rights, we defend each person's right to make decisions about their life, about what they believe or do not believe. We defend each person's right to realize their full potential and live a life of dignity.

Much progress has been made in the realization of the enjoyment by women of their human rights since the adoption of the Universal Declaration of Human Rights in 1948. Yet, it is undeniable that women continue to experience a multitude of human rights violations. These range from gender-based violence, to harmful practices, to denial of women's legal capacity, to lack of equality with men in public and political life, work and within the family.

Violations of women's human rights are often linked to their sexuality and reproductive role. Women are frequently treated as property: they are sold into marriage, into trafficking, into sexual slavery. Violence against women frequently takes the form of sexual violence. Victims of such violence are often accused of promiscuity and held responsible for their fate, while infertile women are rejected by husbands, families and communities. In many countries, married women may not refuse to have sexual relations with their husbands, and often have no say in whether they use contraception. Lesbian women, are frequently shunned for not conforming with the dominant norm of heterosexuality, and sometimes face what has been disturbingly called "corrective" rape. Women's bodies are the site of human rights violations at work: they may face sexual harassment and violence; they may lose their jobs if they become pregnant – indeed, job loss based on sex discrimination is a reality in many countries, developed or developing. Women, especially those living in poverty or affected by armed conflict may be forced to provide sexual favours to gain access to housing, food, and social benefits. Across the globe, women lack access to life saving health services. Some of these

services are required only by women because of their reproductive functions. These are often under-prioritized and under-funded which translates into fatal consequences.

Ensuring that women have full autonomy over their bodies is the first crucial step towards achieving substantive equality between women and men. Personal issues – such as when, how and with whom they choose to have sex, and when, how and with whom they choose to have children - are at the heart of living a life in dignity. If we can tackle the stereotypes and assumptions that lead to denial of women's control over their bodies - stereotypes and assumptions which are deeply rooted in all societies - We will see a full acceptance of women as autonomous, free-thinking individuals, entitled to the full enjoyment of all human rights.

## **International Human Rights Law and Sexual and Reproductive Health Rights**

Women's sexual and reproductive health rights are grounded in rights guaranteed in human rights treaties. These include the rights to life, to be free from discrimination, to be free from torture and ill-treatment, to health, the right to privacy, and to information. The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), accepted by 187 States, protects the right of women to non-discriminatory health care services. It is also the first human rights treaty explicitly to require States to ensure access by women to family planning. CEDAW guarantees women the right, on a basis of equality with men "to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights." The CEDAW Committee, which oversees implementation of the Convention, takes the view that denying access to health services that are required by women, but not men constitutes discrimination

against women. Similarly, the Committee on Economic, Social and Cultural Rights, which oversees implementation of the International Covenant of the same name, interprets the right to health to include women's sexual and reproductive health rights, concluding that women have the right to sexual and reproductive health services and goods which are accessible, available, affordable, acceptable and of good quality.

The political agreements reached at the United Nations World Conferences also support women's sexual and reproductive health rights. The Cairo Programme of Action, adopted by the International Conference on Population and Development in 1994 reaffirms the rights 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." The Fourth World Conference on Women held in Beijing in 1995 reaffirmed these rights, and also recognized women's right to have control over their

sexuality. The Platform for Action adopted by the Conference states that “the human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence.”

Despite these agreements, reaffirmed by the reviews of these conferences, sexual and reproductive health rights continue to be debated in international discussions, as well as in many national contexts. This is a result of a variety of factors, including strongly held beliefs about the family and women’s role in society. These beliefs vary from culture to culture, but they have common underpinnings. These include stereotyped attitudes relating to the roles of women and men in society which portray women as mothers and homemakers and men as breadwinners and agents in the public sphere. Stereotypes also portray women as passive in matters of sexuality and men as sexually aggressive - legitimatizing and normalizing violence against women, including sexual violence within and outside of marriage. Stereotypes



of women as irrational beings continue to be widespread, justifying practices which deny women agency and capacity to make critical decisions about their lives and bodies. Prejudice, stereotypes and ideas about the inferiority or superiority of either of the sexes are recognized in article 5 of CEDAW as factors which support and perpetuate discrimination against women and denial of their human rights. States parties to the Convention bind themselves to take all appropriate measures to dismantle them.

Colleagues and friends,

Since 2009, my Office has been working to define maternal mortality and morbidity as matters of human rights. In 2010, I presented a report to the Human Rights Council on this topic explaining that whether women live, die or are disabled during childbirth is not a matter of public health alone: it is also a direct product of discrimination against women and denial of other human rights. Maternal death and injury are largely preventable, yet WHO reports that every day approximately 1000 women die from

preventable causes related to pregnancy and childbirth, with 99% of these deaths occurring in developing countries. Further, although there has been good progress, Goal 5 of the Millennium Development Goals on reducing maternal mortality and morbidity is still the most off track of the Millennium Development Goals.

My report makes clear that international human rights law requires States to refrain from actions which would negatively affect women's rights in the context of maternal mortality and morbidity, implement measures to protect women's rights from violation by non-State actors, and take legislative, administrative and judicial action to prevent maternal mortality and morbidity. CEDAW requires States parties to ensure that women receive appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary. Failure to meet these obligations can be fatal, but quality maternal health services are frequently unavailable as they are under-prioritized and under-funded. Even where there are such services, women may not have effective

access to them because of distance, cost, shame, or lack of knowledge about when to seek medical assistance.

Discrimination against women also heightens the risk that women and girls will experience maternal mortality and morbidity. Early marriage, which disproportionately affects girls, is frequently accompanied by early childbirth. This can amount to a death sentence for the young woman – the risk of maternal mortality is highest amongst girls under 15, with pregnancy related complications being the leading cause of death among adolescent girls in most developing countries. Violence against women and female genital mutilation also increase the risk of complications in pregnancy. Women from minority groups, indigenous women, women living with HIV/AIDS, and women facing multiple forms of discrimination are at greater risk of experiencing life threatening pregnancies. Some groups of women face discrimination and undignified care when they seek help at health facilities. This discourages them from returning to such providers and thus compromises their lives and health.

Approaching maternal mortality as a matter of human rights moves us from fatalistic notions that death in childbirth is an inevitable tragedy to a culture of accountability for these preventable deaths. Accountability is a means to address grievances, but its broader purpose is to address wider system failures. It is not a finger-pointing exercise, but a means by which we can identify gaps in policy design and implementation, and devise corrective solutions. Ensuring accountability for preventable maternal mortality and morbidity requires collection of accurate and disaggregated data. It also requires mechanisms to examine that data and other information in order to draw conclusions as to whether obligations have been met, and remedial action on the individual and system levels has been taken.

Ensuring that women have the opportunity to participate in decision-making, which affects their lives, especially in relation to their sexual and reproductive rights, is a central aspect of a human rights approach to maternal mortality and morbidity. Creating

opportunities for women to participate in policy design, implementation and monitoring often requires special efforts to seek their views and perspectives. Integrally linked to women's participation is raising women's awareness of their human rights. I congratulate the Centre for being at the forefront of this quest. Greater awareness of their human rights will generate increased demand by women for services, such as family planning, antenatal care, and safe delivery of their babies, as well as ensure that they know about available redress mechanisms when their rights have been violated. A human rights-based approach requires that women are seen as agents who have control and decision-making power over their own health, as entitlements, rather than as passive recipients of a charitable service.

There has been significant progress in the recognition of maternal mortality and morbidity as matters of human rights. In 2011, the Committee on the Elimination of Discrimination against Women found a violation of the CEDAW Convention in a case of a woman

who died as a result of pregnancy complications. The case, against Brazil, revealed a series of failures by health authorities including a failure to diagnose accurately a serious complication with the pregnancy, delays in referring the victim to a facility with appropriate capacities, and delays in treating her when she arrived there. The Committee found that the State had failed to ensure access for the victim to appropriate health care services. The victim was Afro-Brazilian, and, the Committee acknowledged that intersecting discrimination, based on sex and ethnicity, underpinned the denial of her human rights. The right to a remedy was also found to be violated. This case, the first on maternal mortality and morbidity decided by a human rights treaty body adds to the growing body of women's human rights jurisprudence and is a sound precedent for international, regional and domestic courts.

In September this year, my Office will present technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable

maternal mortality and morbidity to the Human Rights Council. This guidance marks a critical step forward in operationalizing women's rights to survive childbirth without injury.

Friends and colleagues,

Tackling maternal mortality and morbidity through a human rights approach requires us to examine the whole spectrum of women's rights, including the decision about whether and when to become pregnant, free from coercion and violence. Women, including young women, have a right to information in this context which is evidence-based – rather than ideologically-driven. This means that women and girls should be informed about the availability of modern methods of contraception, and their use should not depend upon the consent of others. It means that young people should have access to comprehensive sex education, so as to enable them to make informed choices.

Ensuring women's full enjoyment of sexual and reproductive health rights also requires us to address issues related to sexual orientation. Women's sexual orientation is central to their right to make decisions on matters related to their sexuality, including decisions about with whom they may choose to be intimate. Yet, women are punished, often with extreme violence, when they transgress norms of heterosexuality. South Africa is one of the few nations in the world that explicitly prohibit discrimination based on sexual orientation in their constitution. Despite this instances where lesbian women have been raped, based on the disturbing notion that this will 'cure' them of their sexual orientation have occurred in this country and elsewhere. I recently presented a report to the Human Rights Council on the many ways lesbian, gay, bisexual and transgender people suffer human rights violations in countries in all regions of the world solely because of their sexual orientation or gender identity. In that report, I called upon Member States to respond urgently to these unacceptable violations.



My Office's work on maternal mortality has highlighted the fact that unsafe abortion is the second leading cause of maternal mortality in the world. Part of a State's obligations to protect and promote women's and girls' rights to life and health is to ensure that they do not have to resort to unsafe abortion. Human rights mechanisms, including the CEDAW and Human Rights Committees have pointed out that States can take several measures to achieve this: reform laws that criminalize procedures, such as abortion, only needed by women; review laws on abortion to eliminate punitive provisions for women that undergo this procedure, or against health professionals who offer the service; make access to abortion services available at least in cases of rape, incest and in order to protect the life and health of the woman. Where abortion is legal, States should put in place clear regulations on timely and safe access. Women's rights to life and health also demand that post-abortion services, regardless of whether abortion is legal or banned, are accessible, affordable and safe.

The CEDAW Committee addressed several of these aspects recently in *LC v. Peru*. Here a 13 year old girl who had been sexually abused became pregnant, and attempted suicide by jumping off a building. She survived, but suffered severe injuries requiring urgent spinal surgery. Doctors discovered her pregnancy, and refused to perform this surgery, despite the fact she requested that her pregnancy be terminated in accordance with Peruvian legislation which allows abortion where the life of the woman is at risk or in order to prevent serious harm to her health. She ultimately miscarried, and the spinal surgery was performed, but three months after it was determined to be necessary. Sadly, she is now paralyzed from the neck down.

The Committee held that as abortion was legal in certain instances, including those of the victim, Peru was obliged to “establish an appropriate legal framework that allows women to exercise their right.” In particular, women and health professionals must have legal protection in accessing or performing these services, and there must be a mechanism for rapid decision-making and a right of appeal. The

Committee also considered that the failure of the State to ensure access to abortion in cases of sexual abuse and rape to be a factor contributing to the harm to the victim, who became pregnant as a minor because she was sexually abused.

Claims to sexual and reproductive health rights are sometimes countered with claims by medical and other professionals to their rights to freedom of thought and conscience, by which they do not agree to provide such services. Human rights law also protects the rights of medical practitioners to not engage in practices with which they disagree. Accordingly, a doctor may refuse to provide contraception or abortion if that offends her conscience, but this does not give that doctor the right to impart inaccurate information or mischaracterize reproductive health services on the basis of her personal beliefs. Equally important, conscientious objection cannot be exercised by an institution. The State is obliged to ensure that conscientious objection by individual practitioners does not interfere with women's ability to access to reproductive health services - for

instance by ensuring that alternatives are presented to the woman seeking care.

Friends and colleagues,

Realizing the enjoyment of human rights requires us to recognize the autonomy of the individual to make decisions, to pursue her or his rights, and live a life of freedom and dignity. Women must enjoy all human rights equally with men, free from discrimination. This requires immediate actions to guarantee access to essential services such as family planning and safe motherhood. Longer term action and dialogue to counter deep-seated stereotypes which perpetuate women's lack of enjoyment of sexual and reproductive health rights are also urgently needed. These issues are private, and deeply personal. And it is precisely because of the private and personal nature of women's sexual and reproductive health rights that we must ensure their protection under the human rights framework.

I would like to end my address by paying tribute to Helen Kanzira. She has been described to me as a hard-working, loyal, and intelligent African woman who was a generous friend to many. With a LLM in human rights from this University, she was playing the critical role of spreading the word about human rights in her own country, Uganda. We should live up to her example: continue to defend human rights, and educate others about human rights. In particular, we must step up our efforts to define maternal mortality as a human rights concern so that the women and girls do not die from preventable causes while giving life.

Thank you.