Developing norms and standards on maternal mortality in Africa: lessons from UN human rights bodies

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ABSTRACT: The African Charter on Human and Peoples' Rights and the Protocol to the African Charter Human and Peoples' Rights on the Rights of Women in Africa (African Women's Rights Protocol) contain useful provisions for addressing maternal mortality as a human rights violation. In addition, the African Union and its organs have recognised maternal mortality as a violation of the rights of women in Africa through initiatives such as the Campaign on Accelerated Reduction of Maternal Mortality in Africa; the African Commission on Human and Peoples' Rights (African Commission) Resolution 135 on Maternal Mortality in Africa; as well as the African Commission's General Comment on the Right to Life. Both the African Court on Human and Peoples' Rights and the African Commission are now set to apply these frameworks in their jurisprudence and engagements with States. However, despite these developments, a significant number of African women die every year due to complications arising from pregnancy or childbirth. These deaths are avoidable if African governments have lived up to their obligations under international and regional human rights instruments. This article addresses pertinent experiences from the United Nations human rights system and analyses the key lessons learned from their approaches to addressing maternal mortality as a human rights issue, to strengthen the African system's jurisprudence and legal frameworks.

TITRE ET RÉSUMÉ EN FRANÇAIS:

Le développement de normes et standards relatifs à la mortalité maternelle en Afrique: leçons apprises des organes des droits de l'homme des Nations Unies

RÉSUMÉ: La Charte africaine des droits de l'homme et des peuples et le Protocole à la Charte africaine des droits de l'homme et des peuples relatif aux droits des femmes en Afrique (Protocole relatif aux droits des femmes en afrique) contiennent des dispositions utiles pour traiter la mortalité maternelle comme une violation des droits humains. En outre, l'Union africaine et ses organes ont reconnu la mortalité maternelle comme une violation des droits des femmes en Afrique à travers des initiatives telles que la Campagne pour la réduction accélérée de la mortalité maternelle en Afrique; la Résolution 135 de la Commission africaine des droits de l'homme et des peuples (Commission africaine) sur la mortalité maternelle en Afrique; ainsi que l'Observation générale de la Commission africaine sur le droit à la vie. La Cour africaine des droits de l'homme et des peuples et la Commission africaine peuvent désormais appliquer ces normes dans leur jurisprudence et dans leurs relations avec les Etats. Cependant, malgré ces développements, un nombre important de femmes africaines meurent chaque année en raison de complications

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liées à la grossesse ou à l'accouchement. Ces décès sont évitables si les gouvernements africains respectent leurs obligations en vertu des instruments internationaux et régionaux relatifs aux droits de l'homme. Le présent article traite des expériences pertinentes du système des droits de l'homme des Nations Unies et analyse les principaux enseignements tirés des approches par lesquelles ce système traite la mortalité maternelle en tant que question de droits de l'homme pour renforcer la jurisprudence et les cadres juridiques du système africain.

KEY WORDS: African Commission on Human and Peoples' Rights, African Court on Human and Peoples' Rights, maternal mortality, maternal morbidity, resolutions on maternal mortality, United Nations human rights system

CONTENT:

1 INTRODUCTION AND RATE OF MATERNAL MORTALITY IN AFRICA

The African Commission's Resolution on Maternal Mortality in Africa in 2008, resolution 135, signalled one of the earliest coordinated regional efforts focused solely on addressing the significantly high levels of maternal deaths in African countries.[1] Prior to the adoption of resolution 135, the regional commitments to reducing maternal mortality were encapsulated in the 2003 Protocol to the African Charter Human and Peoples' Rights on the Rights of Women in Africa (African Women's Rights Protocol), the 2005 African Union's Policy Framework for the promotion of Sexual and Reproductive Health and Rights in Africa and the 2006 African Women's Rights Plan of Action. At the time of its adoption, the world experienced approximately 358 000 maternal deaths,[2] with 355 000 (99 per cent) of them occurring in

[1] African Commission on Human and Peoples' Rights, Resolution 135 available at http://www.achpr.org/sessions/44th/resolutions/135/ (accessed 14 July 2017).

[2] WHO *et al*, *Trends in maternal mortality: 1990 to 2008* http://apps.who.int/iris/bitstream/10665/44423/1/9789241500265_eng.pdf (accessed 14 July 2017).

developing countries.[3] Six of the eleven countries that accounted for 65 per cent of maternal deaths worldwide were African countries.[4] The adult lifetime risk of maternal death[5] in 2008 was highest in sub-Saharan Africa at 1 in 31 while in developed regions the lifetime risk was 1–1 in 4300.[6]

Accordingly, resolution 135 was timely, in that the African Commission on Human and Peoples' Rights (African Commission) recognised that African countries had both a regional and international obligation, under the African Women's Rights Protocol and the United Nations Millennium Development Goals (MDGs), to improve maternal health.[7] It expressed concern that no progress had been made towards reducing maternal mortality and declared preventable maternal mortality in Africa a violation of the rights to life, dignity, equality and non-discrimination.[8] It concluded by urging African governments to individually and collectively implement its specified recommendations, discussed in the section below, in order to reduce maternal deaths in the continent.[9]

The African Commission's resolution's call for a collective effort to address maternal mortality materialised in 2009 when the Campaign for the Accelerated Reduction of Maternal Mortality in Africa (CARMMA), a joint initiative of the African Union Commission and United Nations Population Fund (UNFPA), was launched.[10] Its core objective was to generate amplified action towards improving maternal health by expanding the availability and use of universally accessible health services, including those pertaining to sexual and reproductive health, which are critical for reducing maternal mortality, and ensuring accountability.[11] Currently, out of the 55 African Union (AU) member states, 46 have already launched CARMMA while 6 more are taking steps towards doing so.[12] Despite these regional commitments, a majority of African countries did not make adequate progress to meet MDG 5 which required the reduction of maternal mortality ratio (MMR) by three quarters (75 per cent) between 1990 and 2015.[13]

Indeed, the MDGs deadline coincided with the release of the latest statistics on the world's maternal mortality trend by the World Health Organization *et al* and yielded some insight into why most African countries were categorised as having made inadequate progress to meet

3 As above 1.

4 Democratic Republic of Congo, Ethiopia, Kenya, Nigeria, Sudan, United Republic of Tanzania WHO *et al* (n 2 above) 1.

5 The probability that a 15-year old female will die eventually from a maternal cause. As above.

6 As above.

7 African Commission (n 1 above).

8 As above.

9 As above.

10 http://www.carmma.org/ (accessed 19 October 2017).

11 As above.

12 http://www.carmma.org/scorecards.

13 United Nations Economic Commission for Africa *et al*, 'MDG Report 2015: Assessing Progress in Africa Toward the Millennium Development Goals' (2015).

MDG 5. The data showed that while the annual number of maternal deaths decreased by 43per cent from 532 000 in 1990 to approximately 303 000 in 2015, developing regions remained responsible for about 99 per cent of these deaths with sub-Saharan Africa accounting for 66 per cent in 2015.[14] Country-focused data also indicated that Nigeria alone accounted for 19 per cent of the world's maternal deaths with approximately 58 000 deaths while Sierra Leone and Chad were the two countries with the highest estimated lifetime risk of maternal death at 1 in 17 and 1 in 18 respectively.[15]

With the end of the MDGs timeline in 2015, the global community's unified shift from MDG 5 to the adoption of the United Nations Sustainable Development Goals (SDGs) 3 and 5, whose targets are to reduce the global MMR to less than 70 per 100 000 live births by 2030, and achieve gender equality and empower all women and girls,[16] provide an exceptional second chance. It offers opportunity to intensify African governments' efforts to reduce maternal mortality, with the assurance of international assistance and cooperation. To this end, this article analyses specific developments within the United Nations system that occurred within the same timeline as the African regional efforts, and which successfully catalysed the strengthening of norms and their practical application to reduce preventable maternal mortality, and draws key lessons from these approaches.

2 MATERNAL HEALTH AS A HUMAN RIGHTS ISSUE: THE NORMATIVE FRAMEWORK

Deaths during pregnancy and childbirth are avoidable and therefore should be viewed not only as a social injustice issue but also as human rights violations. Indeed, various human rights provisions in international and regional human rights instruments, such as the rights to life, health, information, education, personal liberty, freedom from discrimination, and freedom from torture, cruel, inhuman and degrading treatment, have been interpreted as relevant to addressing preventable maternal mortality and morbidity. This section of the paper considers some of these rights.

2.1 The right to health

The enjoyment of the right to the highest attainable standard of physical and mental health encompasses access to maternal health care services. This right, often referred to as the right to health, has been recognised in numerous international and regional human rights instruments with the most widely-recognised of these instruments

14 WHO (n 2 above).

15 As above.

16 United Nations Sustainable Development Goals, available at http://www.un.org/sustainabledevelopment/sustainable-development-goals/ (accessed 14 August 2017).

being the International Covenant on Economic, Social and Cultural Rights (ICESCR).[17] Article 12(1) of the ICESCR recognises the right of every one to the enjoyment of the highest attainable standard of health, whereas article 12(2) recognises the underlying determinants of health including maternal health care. Also, article 12 of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) recognises the right of all women on an equal basis with men to the enjoyment of the right to health.[18] More importantly, article 12(2) of CEDAW enjoins states to realise the right to health care services to all pregnant women.

Both the Committee on Economic Social and Cultural Rights (ICESCR Committee) and Committee on the Elimination of Discrimination against Women (CEDAW Committee), expert bodies charged with interpreting ICESCR and CEDAW, have issued relevant general comments or recommendations touching on the right to health in general and on women's health in particular.[19] For instance, in its General Comment 14, the ICESCR Committee noted that states must ensure four key principles of the right to health: availability, accessibility, acceptability and quality of health services for everyone, including pregnant women.[20] These principles are explained in detail below. Moreover, the ICESCR Committee has emphasised that states must give priority to the right to health of vulnerable groups, including women and children. Also, the CEDAW Committee in General Recommendation 24 has noted that states must ensure access to health care services peculiar to women's needs.[21] More importantly, the CEDAW Committee has noted that states must ensure the allocation of adequate resources to facilitate access to health care services needed by women and girls. It further notes that article 12 of the Convention requires governments to respect, protect and fulfil women's right to health.[22]

The United Nations Human Rights Council (UNHRC) for the first time in 2009 adopted a resolution on maternal mortality in which it calls on states to take steps and measures to address maternal mortality across the world.[23] According to the UNHRC, maternal mortality constitutes a gross violation of women's fundamental rights, including the rights to life, health, dignity and non-discrimination.[24] Thus, it

[17] International Covenant on Economic, Social and Cultural Rights, adopted 16 December 1966; GA Res 2200 (XXI), UN Doc A/6316 (1966) 993 UNTS 3 (entered into force 3 January 1976).

[18] Convention on the Elimination of All Forms of Discrimination Against Women GA Res 54/180 UN GAOR 34th Session Supp No 46 UN Doc A/34/46 1980.

[19] The Committee on ESCR and CEDAW Committee are the expert bodies tasked with ensuring compliance with the ICESCR and CEDAW.

[20] Committee on ESCR *The Right to the Highest Attainable Standard of Health; General Comment No 14*, UN Doc E/C/12/2000/4 para 12.

[21] CEDAW Committee *General Recommendation 24 on Women and Health* UN GAOR 1999, Doc A/54/38 Rev para 11.

[22] As above, paras 14-16.

[23] Human Rights Council *Preventable maternal mortality and morbidity and human rights* A/HRC/11/L.16/Rev 1, 16 June 2009.

[24] As above para 2.

urges states to take appropriate measures to prevent women from dying during pregnancy or childbirth. The UNHRC has also adopted a Technical Guidance on maternal mortality, where it urges states to adopt appropriate laws and policies to ensure safe motherhood and prevent women dying during childbirth and pregnancy.[25]

At the regional level, all the three major human rights instruments; the African Charter on Human and Peoples' Rights (African Charter),[26] the African Charter on the Rights and Welfare of the Child (African Children's Rights Charter)[27] and the African Women's Rights Protocol, contain provisions on the right to health, including access to maternal health care services. Article 14 of the African Women's Rights Protocol guarantees women's rights to health care, including sexual and reproductive health care. More importantly, article 14(2) enjoins states to

> (a) provide adequate, affordable and accessible health services, including information, education and communication programmes to women especially those in rural areas;
>
> (b) establish and strengthen existing pre-natal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breast-feeding.

The relevance of this provision to addressing maternal deaths in the region is discussed below.

According to Hunt and de Mesquita, maternal health care services must be understood broadly as an entitlement to an available, accessible, adequate, effective, well-resourced, culturally acceptable and integrated health system.[28] They further reasoned that some of the critical services that must be accessible to women in this integrated health system so as to prevent maternal deaths include: emergency obstetric care, a skilled birth attendant, education and information on sexual and reproductive health, safe and legal abortion services, and other sexual and reproductive health care services, such as family planning or contraceptive services.

Hunt and de Mesquita have further examined how the elements of the right to health as developed by the ICESCR Committee can be applicable specifically to maternal mortality and noted that availability requires states to ensure sufficient number of qualified health care

[25] Human Rights Council, Practices in adopting a human rights-based approach to eliminate preventable maternal mortality and human rights. 18th Session A/HRC/18/27; 8 July 2011.

[26] African Charter on Human and Peoples' Rights OAU Doc CAB/LEG/67/3/Rev 5, adopted by the Organisation of African Unity, 27 June 1981, entered into force 21 October 1986.

[27] African Charter on the Rights and Welfare of the Child, OAU Doc CAB/LEG/24.0/49 (1990) (entered into force 29 November 1999).

[28] P Hunt & JB de Mesquita *Reducing maternal mortality: the contribution of the right to the highest attainable standard of health* (2010) 6.

providers to provide maternal health care services to pregnant women.[29] Accessibility is made up of four elements-physical, economic, non-discrimination and information. This will require states to provide maternal health care services that are physically and financially accessible to all pregnant women, especially those in rural areas. It will also require states to address discriminatory laws, policies, practices and gender inequalities in health care and in society that prevent women and adolescent girls from accessing good quality services, including maternal care services. Information accessibility requires states to ensure that women and adolescents enjoy access to sexual and reproductive health information. This will require states to remove legal and policy as well as socio-cultural barriers to information on sexual and reproductive health. Acceptability requires that services must be respectful of the culture of individuals, minorities, peoples and communities and sensitive to gender and life-cycle requirements.[30] States must ensure that maternal services are sensitive to the rights, cultures and needs of pregnant women, including those from indigenous peoples and other minority groups. Moreover, States are expected to ensure that maternal health care services are medically appropriate and of good quality.

2.2 The right to life

The right to life is often regarded as one of the most fundamental of all human rights.[31] It is guaranteed in international and regional human rights instruments and national law including articles 6 of the International Covenant on Civil and Political Rights (ICCPR)[32] and 5 of the African Charter. As affirmed at the Vienna Programme of Action, all human rights (whether civil and political or socioeconomic rights), are indivisible, interrelated and interdependent.[33] Consequently, the violation of the right to health may result in the violation of the right to life.[34] This is even more pertinent with regard to maternal injuries and deaths, as deaths during pregnancy are largely avoidable. Previously, the right to life had been construed narrowly to impose negative obligations on the state to refrain from taking life. However, decisions of regional human rights bodies and national courts have affirmed that

29 As above 7.

30 As above.

31 See General Comment 6 of the Human Rights Committee on article 6 of the ICCPR.

32 International Covenant on Civil and Political Rights, adopted in 1966 entered into force on 23 March 1976.

33 Adopted by the World Conference on Human Rights in Vienna on 25 June 1993.

34 See for instance, Committee on ESCR General Comment No 14: The Right to the Highest Attainable Standard of Health, UN Doc E/C/12/2000/4 para 3. See also AE Yamin `Not just a tragedy: access to medication as a right under international law' (2003) 21 *Boston University International Law Journal* 370.

the right to life imposes positive obligations on states to prevent loss of life.[35] For example, in *Laxmi Mandal v Deen Dayal Haringar Hospital*; and *Jaitun v Maternity Home,* an Indian High Court found that death occasioned by lack of access to maternal health care services amounted to a violation of the right to life guaranteed in the Constitution.[36]

This approach would seem to reaffirm the positive nature of the duty imposed by the right to life as well as reinstate the indivisibility and interrelatedness of all rights including the rights to health and life. It is consistent with the reasoning of some United Nations treaty monitoring bodies (UNTMBs) who have emphasised that deaths arising from poor or lack of access to maternal health care services will amount to the violation of the right to life.

For instance, the Human Rights Committee in its General Comment 6 has explained that the right to life should not be construed narrowly but that it intersects with other rights such as housing, food and health care.[37] The Human Rights Committee has equally noted in its Concluding Observations that lack of access to reproductive health care services, including emergency obstetric care and services related to contraception for women, is a violation of their right to life.[38] In particular, the Committee has consistently expressed grave concern over high rates of maternal mortality, framing it as a violation of women's right to life.[39]

The broad interpretation of states' obligation to guarantee the right to life in instances of preventable maternal deaths has also been explicitly recognised by the African Commission in its concluding observations, and most recently in its General Comment 3 on the Right to Life.[40] The African Commission specifically noted that states have a responsibility to address chronic but pervasive threats to life such as preventable maternal deaths by establishing functioning health systems and eliminating discriminatory laws and practices that restrict access to healthcare services.[41]

35 See *Pachim Banga Khet Majoor Samity v State of West Bengal* (1996) 4 SCC 37. The Court held that failure on the part of a government hospital to provide emergency treatment to a citizen amounted to a violation of the right to life guaranteed under article 21 of the Indian Constitution

36 *Laxmi Mandal v Deen Dayal Haringar Hospital*; and *Jaitun v Maternity Home, MCD*, MANU/DE/1268/2010, cases WP(C) 8853/2008 and 10700/2009 (High Court of Delhi) judgment on 04.06.2010.

37 HRC *General Comment 6: The Right to Life* UN GAOR Human Rights Committee 37th session Supp No 40 para 6.

38 See HRC *Concluding Observation: Chile* 30/3/99 UN Doc CCPR/79/Ad. 104,para 15.

39 See for instance HRC *Concluding Observations: Bolivia* 01/04/97 UN Doc. CCPR/ 79/Ad. 74, 22; Concluding Observation: Guatemala 27/08/2001 UN Doc CCPR/CO/ 72GTM, para 19.

40 African Commission on Human and Peoples' Rights *General Comment 3: the right to life* Paras 3 and 42 available at http://www.achpr.org/files/instruments/general-comments-right-to-life/general_comment_no_3_english.pdf (accessed 14 July 2017).

41 As above.

2.3 The right to dignity and to be free from torture, cruel, inhuman or degrading treatment

Another important right and freedom relating to maternal death is the right to dignity and the freedom from torture, cruel, inhuman and degrading treatment, guaranteed in most human rights instruments. The preamble to the Universal Declaration of Rights (Universal Declaration) provides that 'the recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family, is the foundation of freedom, justice and peace in the world.'[42] Article 1 of the Universal Declaration further provides that all human beings are born free and equal in dignity.

While provisions of corresponding international human rights instruments do not explicitly guarantee the right to dignity, the equivalent of this right is expressed in provisions relating to the right to be free from torture, cruel, inhuman and degrading treatment. For instance, article 7 of the ICCPR provides as follows:

> No one shall be subjected to torture or cruel and inhuman or degrading treatment or punishment. In particular no one shall be subjected without his free consent to medical or scientific experimentation.[43]

Regional instruments contain explicit guarantees of both the right to dignity and freedom from torture and inhuman treatment. Article 5 of the African Charter recognises an individual's right to dignity. It provides that '[e]very individual shall have the right to the respect of the dignity inherent in a human being and to the recognition of his legal status'. It further prohibits all forms of cruel, inhuman and degrading treatment against any human being. This is complemented by article 3 of the African Women's Rights Protocol, which guarantees women's rights to dignity. It provides that 'every woman shall have the right to dignity inherent in a human being and to the recognition and protection of her human and legal rights'. Article 3 further provides that 'every woman shall have the right to respect as a person and to the free development of her personality'.

The right to dignity and freedom from torture and inhuman treatment has often been interpreted to ensure that prisoners are treated in humane ways. However national, regional and human rights mechanisms are increasingly recognising its application beyond prisons and other traditional settings where torture may occur to non-traditional settings such as healthcare institutions, as discussed below. National-level jurisprudence in Kenya and the UN Special Rapporteur on Torture have recognised that denial of care to, humiliation, mistreatment or detention of pregnant women seeking maternal care

42 Universal Declaration of Human Rights, GA Res 217 A (III), UN Doc A/810 (10 December 1948).

43 International Covenant on Civil and Political Rights adopted in 1966 entered into force 23 March 1976 999 UNTS 171 and 1057 UNTS 407 / [1980] ATS 23 / 6 ILM.

services will undermine their right to dignity and freedom from torture, cruel, inhuman or degrading treatment.[44]

Indeed, the recent General Comment of the African Commission on Redress for Torture expressly addressed torture, cruel, inhuman or degrading treatment in healthcare facilities and urged states to be mindful of the gendered nature of torture and other ill-treatment and ensure adequate protective measures are put in place.[45]

Consequently, where a state fails to ensure quality maternal health care services to pregnant women free of mistreatment, abuse and neglect, this will result in the violation of their right to dignity and freedom from cruel and inhuman treatment.

2.4 The right to equality and non-discrimination

The link between low status of women and high maternal deaths has been firmly established.[46] Indeed, as stated in the introduction, high maternal mortality rates are common among women in developing countries compared to developed countries as well as among vulnerable and marginalised women within a country. This perhaps is the most profound evidence of the injustice this avoidable situation represents. It also raises the issue of non-discrimination and violation of the right to equality. Article 12 of the CEDAW requires states to ensure access to health care services to women on a non-discriminatory basis.

The rights to equality and non-discrimination are essential to maternal mortality, particularly where poor, disadvantaged and vulnerable women in rural areas or indigenous communities are concerned. This was unequivocally confirmed by the CEDAW Committee in a ground breaking decision in *Alyne da Silva Pimentel v Brazil,* which is discussed in detail in the next section.[47]

Likewise, the African Women's Rights Protocol requires states to eliminate every form of discrimination against women including by undertaking measures to address the social and cultural patterns that perpetuate discrimination against women and girls.[48] It further obligates state parties to enact and implement appropriate measures prohibiting and curbing all forms of discrimination particularly those

44 *Millicent Awuor Maimuna & Another v Attorney General of Kenya & Others* (2012) Petition No 562. Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, *Report of the Special Rapporteur on torture and other cruel inhuman or degrading treatment or punishment,* Human Rights Council, para. 47, UN Doc. A/HRC/22/53 (1 February 2013) (Juan E Mendez).

45 African Commission on Human and Peoples' Rights, *General Comment No.3 on the Right to Life,* paras 19 and 30, available at http://www.achpr.org/files/instruments/general-comment-right-to-redress/achpr_general_comment_no._4_english.pdf (accessed 15 July 2017).

46 See R Cook *et al Reproductive health and human rights: integrating medicine, ethics, and law* (2003).

47 Communication 17/2008, *Alyne da Silva Pimentel v Brazil* CEDAW Committee CEDAW/C/49/D/17/ 2008. Decision of 25 July, 2011.

48 Article 2 of the African Women's Rights Protocol.

harmful practices which endanger the health and general well-being of women.[49]

Given the high maternal deaths in many African countries and the failure of governments to address this situation, African governments can be held accountable for the violation of the rights to equality and non-discrimination of women.

2.5 The right to information

Access to comprehensive sexual and reproductive health information is crucial to preventing ill-health and ensuring the well-being of all individuals. More importantly, access to sexual and reproductive health information can help in preventing unplanned pregnancies, unsafe abortion and minimising incidence of maternal deaths and morbidities. The ICESCR Committee has noted that the enjoyment of the right to health includes access to health facilities and information.[50] The right to information is guaranteed in most international human rights instruments. Article 19 of the ICCPR provides for the right to information, while articles 10(h) and 16(1)(e) of CEDAW guarantee women, including those in rural areas, access to family planning information. The right is equally guaranteed in regional instruments such as the African Women's Rights Protocol, particularly article 14(2)(a), which tasks states with providing adequate, affordable, and accessible health-related information, particularly for women in rural areas.[51]

These provisions impose both positive and negative obligations on states to ensure access to sexual and reproductive health information and to refrain from interfering with the enjoyment of this right.[52] Yet, in many parts of Africa, vulnerable women, including young women and women in rural areas, often lack access to adequate information to prevent unplanned pregnancies and other risks associated with pregnancy.

3 INITIATIVES AND JURISPRUDENCE OF UN HUMAN RIGHTS BODIES ON MATERNAL MORTALITY

As illustrated in the section above, UN institutions, including treaty monitoring bodies have had the opportunity to address maternal mortality as a human rights concern. This section considers the

49 Article 2(1)(b) of the African Women's Rights Protocol

50 UN CESCR General Comment 14 (n 20 above).

51 African Women's Rights Protocol, http://www.achpr.org/instruments/women-protocol/#14 (accessed 14 July 2017).

52 See S Coliver 'The right to information necessary for reproductive health and choice under international law' (1995) 44 *American University Law Review* 1279.

clarification and elaboration provided under the UN human rights system with regard to maternal mortality.

3.1 Resolution 11/8 and the first report of the Office of the High Commissioner for Human Rights regarding maternal mortality and morbidity

As noted above, despite the fact that regional and international instruments guarantee rights, which are applicable to preventable maternal deaths and injuries, these deaths have persisted in high levels. Concerted advocacy by stakeholders, and particularly non-governmental organisations (NGOs), at the regional and global levels eventually yielded extraordinary results at the United Nations. In June 2009, a year after the African Commission's resolution on maternal mortality and the same year that CARRMA was launched, the UN Human Rights Council adopted resolution 11/8 which ultimately became its first of a series of resolutions on preventable maternal mortality and morbidity and human rights to advance and set standards on maternal health.[53]

Recalling states' obligations under CEDAW, ICCPR and CESCR among others, the 2009 resolution recognised the need for increased political will, cooperation and technical assistance at the international and national levels to effectively reduce preventable maternal deaths and injuries.[54] Resolution 11/8 recognised that these deaths and injuries are aggravated by poverty, gender inequality and discrimination and other factors including inadequate access to health facilities and lack of infrastructure.[55] It further recognised that a majority of maternal deaths and injuries are preventable and should be addressed through protecting the rights of women and girls, especially their rights to life, dignity, education, health, information, non-discrimination and to enjoy the benefits of scientific progress.[56] The resolution urged states to fulfil and implement their human rights commitments under several instruments including by allocating sufficient resources to health systems.[57] It provided specific recommendations to states which included both honouring existing commitments and making new ones, swapping effective practices and technical assistance to reinforce their capacities, and integrating a human rights perspective into all of their efforts by addressing the link between discrimination against women and maternal mortality and morbidity.[58]

53 A/HRC/11/L.16 http://ap.ohchr.org/documents/E/HRC/resolutions/A_HRC_RES_11_8.pdf (accessed 14 July 2017).

54 As above.

55 As above.

56 As above, para 2.

57 As above, para 3.

58 As above, para 4.

Resolution 11/8 went beyond addressing states to urging other stakeholders, including national human rights institutions (NHRIs) and non-governmental organisations (NGOs), to prioritise the issue of preventable maternal mortality and morbidity in their work with the UN human rights system including the treaty monitoring bodies, special procedures, and the universal periodic review process.[59] It also tasked the UN High Commissioner for Human Rights (UNHCHR) with preparing a thematic study on the issue within one year, with the input of states, relevant UN agencies, and stakeholders.[60] The study would specifically identify the human rights dimensions of preventable maternal deaths and injuries in the existing international legal framework and offer suggestions for improving how the UN system had so far been addressing those human rights dimensions.[61] The resolution concluded with the Human Rights Council obliging itself to review the thematic study during its fourteenth session, in June 2010, to hold an interactive dialogue on the study, and take further action as needed.[62]

Indeed, the African Commission's resolution equally called on civil society, including NGOs, to advocate accountability and monitor the implementation of government programs to reduce maternal mortality.[63] It further provided specific recommendations to states such as to fulfil their obligations to allocate 15 per cent of their national budgets to the health sector, adopt a human rights framework in maternal health programs and strategies, and provide updates on policy, institutional and other national efforts aimed at decreasing maternal deaths and injuries, during periodic review sessions. However, it did not contain any time-specific deliverables which would have encouraged urgent action and assured accountability. The Commission neither had nor did the resolution call for the establishment of a mechanism equivalent to the UNHCHR, to coordinate the regional human rights system's and states' efforts and provide tailored technical guidance to states to promote compliance.

In contrast, the concrete mandates and time-specific provisions in the Human Rights Council's resolution, as well as the express inclusion of the contribution of other stakeholders beyond states, lent urgency to the issue, gave legitimacy to various stakeholders, and galvanised action. For instance, by April 2010, the Office of the High Commissioner for Human Rights (OHCHR) developed a thematic study, with the input of states, NGOs, and external experts, along with its key findings, serving as a game changer for how the United Nations system had previously worked to address maternal mortality and morbidity. The study clarified the conceptual framework for understanding the connection between maternal mortality and human rights. It confirmed the linkages between gender inequality and

59 As above, para 5.
60 As above, para 6.
61 As above.
62 As above, para 7.
63 African Commission (n 1 above) para 8.

discrimination against women and girls and maternal deaths and injuries and stressed the importance of ensuring women's human rights, including sexual and reproductive rights.[64] The study, in delineating an overview of the United Nations system's efforts to reduce preventable maternal deaths and injuries, determined that a significant initiatives were in existence and ranged from development of norms and policies to service provision and accountability measures.[65]

However, it further determined that these efforts sometimes lacked coherence and frequently needed greater action to ensure expected results,[66] and offered recommendations on what the Human Rights Council could do to strengthen these existing efforts.[67] For instance, the study urged governments to scale up technical interventions which are affordable, acceptable and culturally sensitive.[68] It noted that reducing maternal deaths would include much more than guaranteeing access to health care services and would entail addressing the underlying socio-cultural, political and economic determinants of health such as ensuring access to information on sexual and reproductive health, education, and promoting gender equality.[69] The OHCHR study further provided an analysis of what a human rights-based approach to reducing maternal mortality requires including the application of seven human rights principles.[70] These principles which are accountability,[71] non-discrimination, participation[72] and transparency,[73] empowerment,[74] sustainability,[75] as well as international assistance and cooperation,[76] must be integrated in all policies and programmes.

The effective application of these core principles to all of the efforts undertaken at a regional or country level in the African region would take the continent closer to its objective of effectively reducing preventable maternal mortality and morbidity. For instance, entrenching accountability in ongoing maternal mortality initiatives or campaigns in Africa such as CARMMA and 'Africa cares: no woman should die while giving life' must require all governments to not only ensure adequate redress is given to victims of preventable maternal

64 Report of the Office of the United Nations High Commissioner for Human Rights on preventable maternal mortality and morbidity and human rights; http://www2.ohchr.org/english/bodies/hrcouncil/docs/14session/A.HRC.14.39_AEV-2.pdf (accessed 14 July 2017).

65 As above, 22.

66 As above.

67 As above.

68 As above, 16-17.

69 As above.

70 As above, 18.

71 As above, 18-20.

72 As above, 20.

73 As above, 20-21.

74 As above, 21.

75 As above.

76 As above, 22.

injuries and death but to simultaneously prevent future occurrences through health system-wide reforms.[77] Ensuring redress for victims requires investigating violations, prosecuting perpetrators and providing reparation including compensation.[78] Though there are recent and ongoing efforts to secure this type of accountability for maternal deaths and injuries through the judicial system in a few African countries,[79] successful implementation of systemic changes to the health systems of African countries, a second component of what it means to ensure accountability, is yet to be attained.

3.2 Resolution 15/17 and the second report of the OHCHR

The findings and recommendations in the OHCHR study directly contributed to the adoption of a second resolution which sustained the momentum that was generated by the first. In 2010, the Human Rights Council adopted resolution 15/17, a second resolution on maternal mortality, in which it reaffirmed resolution 11/8 and welcomed recent maternal mortality-reduction initiatives, including in Africa.[80] These initiatives include the convening of the summit of the African Union in Kampala in July 2010 on 'Maternal, infant and child health and development in Africa', the launch of CARMMA and the 'Africa cares: no woman should die while giving life' campaign.[81] The Human Rights Council urged states to adopt the recommendations in the OHCHR study, discussed above, including collecting disaggregated data,[82] redoubling efforts to fulfil relevant rights obligations, and allocating adequate resources to the health sector.[83]

In the resolution, the Council also mandated OHCHR to invite states, UN and regional bodies, NHRIs, civil society organisations and other stakeholders to submit information on instances of good or effective practices that exemplify the adoption of a human rights-based approach to eliminating avoidable maternal deaths and injuries.[84] It

77 As above, 18.

78 As above, 18-20.

79 For a detailed discussion on this see O, Afulukwe-Eruchalu 'Accountability for non-fulfilment of human rights obligations: a key strategy for reducing maternal mortality and morbidity in sub-Saharan Africa; in C Ngwena and E Durojaye (eds) *Strengthening the protection of sexual and reproductive health and rights in the African region through human rights* (2014) 119-151; see also O Afulukwe-Eruchalu 'Accountability for maternal healthcare services in Nigeria' (2017) 137 *International Journal of Gynecology and Obstetrics* 220-226.

80 Preventable maternal mortality and morbidity and human rights: follow-up to Council resolution 11/8. A/HRC/15/L.27 https://documents-dds-ny.un.org/doc/UNDOC/GEN/G10/167/35/PDF/G1016735.pdf?OpenElement (accessed 14 July 2017).

81 As above.

82 As above, para 3.

83 As above, para 5. For a detailed discussion of the role of NGOs and NHRIs in addressing preventable maternal mortality and morbidity see Afulukwe-Eruchal (n 79 above).

84 As above, para 9.

was tasked with developing a second study that would represent an analytical compilation of its results.[85]

The Council, like it did with the first resolution, expressly called for the cooperation of NGOs and other stakeholders,[86] and included a provision in the resolution committing itself to be prepared to take additional action to reduce preventable maternal deaths and injuries during its next session.[87] This consistent and deliberate setting aside of time and space on the Council's agenda during a specified upcoming session to address ongoing efforts to reduce preventable maternal deaths also served as evidence of political will and ensured that preventable maternal mortality remained visible within the United Nations system.

Complying with the Council's request, the UNHCHR engaged a wide range of stakeholders, including 14 NGOs and five NHRIs, in developing an analytical report.[88] This second report identified good or effective practices in adopting a human rights-based approach to eliminating preventable maternal mortality and morbidity. It outlined how such initiatives embodied a human rights-based approach and which aspects succeeded in achieving a reduction in maternal mortality and morbidity through a human rights-based approach. These aspects included those that enhanced the status of women; strengthened health systems; addressed unsafe abortion; expanded access to sexual and reproductive rights; and improved monitoring and evaluation of states' accountability measures.[89] The report further provided concrete examples of ways in which similar initiatives could give effect more fully to a human rights-based approach in Africa,[90] and other regions.

A thorough review of these examples by African countries, and their application in existing regional initiatives on maternal mortality, could strengthen their chances of successfully reducing preventable maternal deaths.

85 As above, para 10.

86 As above, para 7.

87 As above, para 11.

88 A/HRC/18/27, para 1, available http://www2.ohchr.org/english/issues/women/docs/WRGS/A-HRC-18-27_en.pdf (accessed 14 July 2017).

89 As above, para 5.

90 As above, paras 35-50.

3.3 Resolution 18/2 and the OHCHR's 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

The Human Rights Council subsequently adopted a third resolution in 2011 which urged states and other stakeholders to pay heightened attention to the inter-linkages between maternal deaths and injuries and root causes such as gender inequality, lack of access to adequate health care services, and violence against women and girls.[91] It further mandated the UNHCHR to prepare a third report which would be a concise 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.[92] Resolution 18/2 raised the bar that had been set by the previous two resolutions by going beyond requesting a study that would give a theoretical explanation of a human rights-based approach to addressing preventable maternal deaths and injuries, including the 7 principles discussed above, to requesting one that would also lay out what it would mean to apply this approach in practice.[93]

In 2012, the OHCHR released the technical guidance[94] which served to operationalise the previous reports by providing concrete step-by-step information on what it would mean to apply a human rights-based approach in developing policies and programs to address preventable maternal deaths and injuries.

3.4 Resolution 33/18 and a unified focus on the Sustainable Development Goals

Since the release of the OHCHR's technical guidance, states have been encouraged to provide information on how they are applying the technical guidance. Civil society organisations and all other stakeholders also have periodic opportunities to submit information on how states are implementing the practical examples in the technical guidance in their programming and policies on maternal health.

91 A/HRC/RES/18/2, para 3, available at http://www.legal-tools.org/doc/1a2b4c/pdf/ (accessed 14 July 2017).

92 As above, para 5.

93 A/HRC/RES/18/2, para 3, available at http://www.legal-tools.org/doc/1a2b4c/pdf/ (accessed July 14 2017).

94 (A/HRC/21/22), available at http://www2.ohchr.org/english/issues/women/docs/A.HRC.21.22_en.pdf (accessed 14 July 2017).

In 2016, the HRC adopted a resolution on maternal mortality. Resolution 33/18, represents the latest instalment of these ground-breaking resolutions which continue to raise the bar on United Nations-led initiatives to address preventable maternal deaths.[95] In keeping with the global focus on meeting the targets set under the SDGs, the resolution has also recognised the importance of identifying, within the SDGs framework, appropriate national indicators in reducing maternal mortality and morbidity. It urges states to assess, reform and establish accountability mechanisms to ensure access to justice for women and girls, and to continue to apply the OHCHR's technical guidance.

Like the previous resolutions, it has retained the use of time-specific deliverables including by committing to convening a panel discussion on the connections between SDGs 3 and 5 and preventable maternal deaths and injuries, and sexual and reproductive health and rights. In doing so, the Council continues to send a strong message that its focus on maternal health will remain a priority and its deliberations, and perhaps resolutions, will not cease till preventable maternal deaths and injuries become a thing of the past. The African human rights system could benefit from this approach in developing and rolling out initiatives including resolutions, studies, and technical guidance which are especially designed to account for Africa's unique challenges and prospects.

3.5 Jurisprudence: CEDAW Committee decision in *Alyne v Brazil*

Aided by the adoption of the maternal mortality resolutions, the development and findings of the OHCHR's studies, and the work of NGOs, the CEDAW Committee, charged with interpreting and ensuring states' compliance with CEDAW, categorically confirmed states' obligations to address preventable maternal deaths and ensure to women adequate access to maternal health services, as a fundamental right, in its seminal decision of August 2011 in the case of *Alyne v Brazil*.[96]

On 11 November 2002, Alyne, a Brazilian woman of African descent who was then six months pregnant with her second child, went to a local health centre due to vomiting and severe abdominal pain.[97] The doctor did not perform any tests before sending her home with vitamins and medicine. She came back two days later, still complaining that she had severe pain, and only then did the doctors admit her and establish the absence of a foetal heartbeat.[98] Alyne had a stillbirth but, against prevailing medical standards which prescribe that surgery should be

95 A/HRC/RES/33/18 available at http://ap.ohchr.org/documents/dpage_e.aspx?si=A/HRC/RES/33/18 (accessed 15 July 2017).

96 Communication 17/2008, *Alyne da Silva Pimentel v Brazil*, CEDAW Committee 10 August 2011 UN Doc CEDAW/C/49/D/17/2008.

97 *Alyne da Silva Pimentel* (n 96 above) paras 2.1-2.14.

98 As above, paras 2.3-2.4.

performed urgently to ward off any bleeding or infection, she did not receive surgery for over 14 hours.[99]

After surgery, she had severe haemorrhaging and low blood pressure, but the doctors did not transfer her to a hospital with better-equipped facilities until her condition had worsened.[100] When they tried to transfer her, a municipal hospital was the only one that had space.[101] The local health centre did not own an ambulance and though the municipal hospital owned only one, it was reluctant to use it to facilitate the transfer, so Alyne's family attempted but was unable to arrange for a private ambulance.[102] During the resulting eight-hour delay in getting her to the municipal hospital, she fell into a coma.[103] When she was eventually transported to the municipal hospital, her medical records were not sent along.[104] Ultimately, Alyne was left in the hallway of an emergency room in the municipal hospital until she died 21 hours later,[105] on 16 November 2002, leaving behind a five year old daughter.[106]

Due to the undue delays in obtaining a remedy in Brazil, substantiated by evidence that women who belong to vulnerable groups in Brazil, such as those who are poor and those who are of African descent, are unlikely to obtain a remedy in the courts,[107] the case was initiated before the CEDAW Committee in 2007. The main claims were that the government of Brazil had violated Alyne's rights to life, health and legal redress, guaranteed by its Constitution as well as international human rights treaties, including CEDAW.[108] The claims highlighted the poor quality of care at an inadequately-equipped health centre, the delay in recommending a referral, the lack of space at better-equipped hospitals, the lack of reliable transportation to effect the transfer, the failure to transfer her medical records along with her to ensure appropriate and timely care, and the lack of access to emergency obstetric care as the main factors that caused her death.

The CEDAW Committee determined that Alyne's death was due to low-quality care.[109] It also found that Brazil had violated Alyne's right to health under article 12 of the Convention. It determined that the government's assertion that it could not be held responsible for the actions of a private health institution was invalid, emphasising that governments could not relinquish their responsibilities by outsourcing

99 As above, para 2.6.
100 As above, paras 2.6-2.8.
101 As above, para 2.8.
102 As above.
103 As above.
104 As above, para 2.10.
105 As above, paras 2.12 & 3.6.
106 As above, para 3.14.
107 As above, para 5.3.
108 Paras 3.1-3.15; see articles 1, 2 & 12 of the CEDAW.
109 As above, paras 7.3-7.5.

medical services. Instead, they must supervise and regulate the health practices and policies of private health facilities.[110] It also found that Brazil had violated Alyne's right to access to justice guaranteed in article 2(c), due to the delays and ultimate lack of redress. It further determined that the government had failed in its obligation to exercise due diligence in ensuring that private healthcare providers deliver sufficient care as provided for in article 2(e) of the Convention.[111] It also held that Alyne's right to non-discrimination, defined under article 1, had been violated.[112]

The Committee issued both individual and broader remedies aimed at addressing structural shortcomings. It mandated individual remedies such as reparation to Alyne's family, including financial compensation.[113] It also required the government to ensure maternal healthcare was affordable to all women,[114] and to train healthcare providers about women's reproductive rights including quality care during pregnancy and timely emergency obstetric care.[115] The Committee asked the government to provide effective remedies for violations of women's reproductive rights,[116] to make certain that health centres respect reproductive healthcare standards,[117] to punish providers who violate women's reproductive rights,[118] and to implement a national law to reduce maternal mortality and morbidity.[119]

The case also established state responsibility for private healthcare facilities, and can offer the African Court on Human and Peoples' Rights (African Court) crucial insights on the role it could play to develop and strengthen standards and ensure accountability for preventable maternal mortality and morbidity.

4 POTENTIAL OF THE AFRICAN COURT AND COMMISSION TO DEVELOP NORMS ON MATERNAL MORTALITY

As noted above, all the three major human rights instruments in the region – the African Charter, the African Children's Rights Charter and the African Women's Rights Protocol – contain important provisions relevant in addressing maternal mortality as a human rights violation. Furthermore, both the African Court and the African Commission have

110 As above, para 7.5.
111 As above, para 8.
112 As above.
113 As above, para 8.1.
114 As above, para 8.2(a).
115 As above, para 8.2(b).
116 As above, para 8.2(c).
117 As above, para 8.2(d).
118 As above, para 8.2(e).
119 As above, para 8.2(f).

important roles to play in developing norms and standards on maternal mortality. The Court can develop important jurisprudence on maternal health to hold states accountable in this regard. Equally, the African Commission through its promotional and protective mandate can develop norms and standards to address maternal mortality in the region. So far, the African Court is yet to decide any case relating to maternal mortality. Most of the cases that the Court has dealt with relate to civil and political rights. This may be due to the fact that only 8 countries have entered a declaration as envisaged under article 36(4) of the Protocol to the African Charter establishing the Court. It might be necessary for the Court to consider experiences from other jurisdictions in this regard.

While the Commission and Courts are yet to issue any decision specifically relating to maternal mortality, some important standards have been developed relevant to addressing this issue in the region. As noted earlier, as far back as 2008, the Commission adopted a resolution relating to maternal mortality as a human rights challenge. In that resolution, the Commission declared maternal mortality a state of emergency in Africa and called on African governments to wake up to their obligations to address preventable maternal deaths in the region. The Commission reasoned that maternal deaths in the region constituted a violation of women's rights to dignity, life, health and non-discrimination.

In its first General Comment on article 14 of the African Women's Rights Protocol, the Commission had called on African governments to create an enabling environment where legal and policy frameworks respect the rights of persons living with or affected by HIV.[120] The Commission noted that

> States Parties should also ensure that health workers are not allowed, on the basis of religion or conscience, to deny access to sexual and reproductive health services to women as highlighted in this document.[121]

It further expressed deep concerns about lack of access to sexual and reproductive health services for women in the region. Moreover, the Commission urged African governments to adopt a holistic approach towards addressing norms that perpetuate the low status of women in societies and improve access to sexual and reproductive health services for women.[122] This statement is not only crucial to addressing the high prevalence of HIV among women, but also important in mitigating some of the factors that aggravate maternal mortality in the region. Studies have shown correlation between high HIV prevalence and maternal mortality in the region.[123]

[120] African Commission on Human and Peoples' Rights General Comments on article 14(1)(d) and (e) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa adopted during the 52nd Ordinary Session in Côte d'Ivoire 9-22 October 2012.

[121] As above, para 31.

[122] As above.

[123] See for instance L Say *et al* 'Global causes of maternal death: A WHO systematic analysis' (2014) *Lancet* e323-e333.

Furthermore, in its General Comment 2 on other provisions of article 14 of the African Women's Rights Protocol, the Commission called on African governments to ensure universal access to sexual and reproductive health in order to address unsafe abortion and mortalities among women and girls.[124] Although the General Comment did not specifically focus on maternal mortality, some of the standards developed by the Commission are relevant in addressing high maternal mortality in the region. For instance, the Commission calls on African governments to ensure availability of contraceptive services, family planning services and sexuality education in order to advance the sexual and reproductive health of women in the region.[125] Given that low uptake of contraception and lack of access to family planning services often lead to unplanned pregnancies, this statement by the Commission is germane in addressing maternal mortality in the region.[126]

Also, in its General Comment 3 the Commission adopted a similar progressive approach as the HRC in its General Comment 6 to interpreting the right to life guaranteed under the African Charter by noting that states do not only have negative obligations to refrain from taking lives but also positive obligations to prevent loss of life.[127] The Commission specifically notes that the right to life includes preventing maternal deaths. This is also consistent with the approach of the other United Nations bodies such as the CEDAW Committee, Committee on the Rights of the Child, and the CESCR in its General Comment 14, where it noted that the enjoyment of the right to health is dependent on other rights such as life, dignity, privacy and non-discrimination.[128]

The Commission's stance is also an acknowledgment of the interdependence and interrelatedness of all human rights. The Commission has affirmed this approach in some of its jurisprudence. For instance, in the *SERAC* case, the Commission had reasoned that the pollution of water and land of the Ogoni people not only violated the right to health but also undermined the rights to life, dignity, food and non-discrimination.[129] Also, in *International Pen* case, the Commission noted that a denial of access to health care services to a prisoner would undermine the right to life guaranteed in the African

[124] African Commission on Humana and Peoples' Rights General Comment 2 on article 14(1)(a), (b), (c) and (f) and article 14(2)(a) and (c) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa adopted during the 55th Ordinary Session in Angola 28 April -12 May 2014.

[125] As above.

[126] For a detailed analysis of this General Comment see C Ngwena *et al* 'Human rights advances in women's reproductive health in Africa' (2014) 129 *International Journal of Gynaecology and Obstetrics* 184-187.

[127] African Commission on Human and Peoples' Rights General Comment No. 3 On the African Charter on Human and Peoples' Rights: The Right to Life (Article 4) adopted during its 57th Ordinary Session, held in Banjul, The Gambia, in November 2015.

[128] General Comment 14 (n 15 above).

[129] *Social and Economic Rights Action Centre (SERAC) and another v Nigeria* (2001) AHRLR 60 (ACHPR 2001).

Charter.[130] This approach provides an opportunity for the Commission in future to address maternal mortality as not only a violation of women's rights to health and reproductive well-being, but also the rights to life, dignity and non-discrimination.[131]

Although the Commission is yet to clearly outline the nature of states' obligations in relation to the right to health under the Charter or the African Women's Rights Protocol, it has, however, noted as follows:

> Enjoyment of the human right to health as it is widely known is vital to all aspects of a person's life and well-being, and is crucial to the realisation of all the other fundamental human rights and freedoms. This right includes the right to health facilities, access to goods and services to be guaranteed to all without discrimination of any kind ... The African Commission would however like to state that it is aware that millions of people in Africa are not enjoying the right to health maximally because African countries are generally faced with the problem of poverty which renders them incapable to provide the necessary amenities, infrastructure and resources that facilitate the full enjoyment of this right. Therefore, having due regard to this depressing but real state of affairs, the African Commission would like to read into article 16 the obligation on part of states party to the African Charter to take concrete and targeted steps, while taking full advantage of its available resources, to ensure that the right to health is fully realised in all its aspects without discrimination of any kind.[132]

This statement would seem to suggest that the realisation of the right to health under the Charter must be interpreted broadly to cover not only physical access but also health facilities and goods. Implicit in this is that states must ensure access to comprehensive maternal health care including availability of skilled health care providers, emergency medical care and access to transportation services for women in rural areas. In addition, it would require African governments to ensure access to quality, affordable maternal health medicines such as oxytocin and misoprostol to prevent post-partum haemorrhage and magnesium sulphate for the treatment of pre-eclampsia and eclampsia. A report has noted that more than 80 million out of 136 million women (majority of whom are in developing countries, including Africa) that give birth annually suffer from excessive bleeding (known medically as postpartum haemorrhage (PPH)) after childbirth.[133] It further notes that pre-eclampsia and eclampsia claim the lives of an estimated 63,000 women (majority in developing countries) each year.[134] It is noted that the odds of a woman dying as a result of these conditions in developing countries are about 300 times higher than that of developed countries.[135] This unacceptable and tragic waste of human lives requires the urgent attention of African governments.

[130] *International Pen and Others (on behalf of Ken SaroWiwa) v Nigeria* (2000) AHLR 212 (ACHPR 1998).

[131] For a detailed discussion of this approach see E Durojaye 'The approaches of the African Commission to the right to health under the African Charter' (2013) 17 *Law Democracy and Development* 393.

[132] See *Purohit and Another v The Gambia* (2003) AHRLR 96 (ACHPR 2003) paras 80-84.

[133] R Wilson *et al Key data and findings: medicines for maternal health* (2012).

[134] As above.

[135] As above.

In some of its concluding observations to states reports, the Commission has expressed concerns about the unacceptably high maternal deaths in some countries. For instance, in its concluding observations to the government of Nigeria the Commission noted with concern the high maternal mortality in the country and urged the government to take adequate steps and measures to address the situation.[136] Similarly, in its Concluding Observations to the report of the government of Malawi, the Commission expressed concerns about the inability of women to access health care services, including reproductive health care, due mainly to shortages of skilled health care providers and distance to health care facilities.[137] According to the Commission, this situation impacted more negatively on women in rural areas than in other parts of the country. The Commission, thus, called on the government of Malawi to strengthen all initiatives aimed at reducing maternal deaths and increase budgetary allocation to the health sector to at least 15 per cent in line with the Abuja Declaration.[138] More importantly, the Commission enjoined the government to:

> [e]nhance the availability and accessibility of maternity services, including post-natal services, including by: increasing the number of healthcare facilities that are fully equipped to provide comprehensive maternal healthcare; increasing the number and training of skilled health personnel and utilization of skilled health personnel during pregnancy, childbirth and postnatal period at all levels of the health system; and building and improving facilities in rural areas and access to skilled medical birth attendants to reduce labour complications.[139]

This admonition of the Commission to the government of Malawi resonates with the approach of human rights bodies such as the ICESCR Committee in its General Comment 14, the Human Rights Council and the CEDAW Committee.[140] It is also consistent with the reasoning of the Commission in some of its interpretative documents such as the resolution on maternal mortality and the Principles and Guidelines on the Implementation of Socio-economic Rights under the African Charter.[141] An important conclusion to be drawn from this is that while the Commission has not yet issued a decision on a communication on maternal mortality, the existing interpretative guidance and the experiences from international human rights bodies provide it with ample arsenal to issue a decision on this issue in future.

[136] African Commission, Concluding Observations and Recommendations on the 5th Periodic Report of the Federal Republic of Nigeria on the Implementation of the African Charter on Human and Peoples' Rights (2011 - 2014) adopted during the 57th Ordinary Session 4 - 18 November 2015, Banjul, The Gambia.

[137] African Commission, Concluding Observations and Recommendations on the Initial and Combined Periodic Report of the Republic of Malawi on the Implementation of the African Charter on Human and Peoples' Rights (1995-2013) adopted during the 57th Ordinary Session held from 4-18 November 2015 Banjul, The Gambia.

[138] As above, 77.

[139] As above, 105.

[140] HRC General Comment 6 of the HRC on article 6 and General Recommendation 24 of the CEDAW Committee.

[141] African Commission, Principles and Guidelines on the Implementation of Economic, Social and Cultural Rights in the African Charter on Human and Peoples' Rights adopted in 2010.

5 CONCLUSION

The African human rights system continues to play a crucial role in efforts to reduce preventable maternal mortality and morbidity in Africa. Its laws, policies, and programmes have set standards and clarified the obligations of states to uphold human rights guarantees that apply to maternal health. Existing and new standards and initiatives on this issue could benefit from the approaches and lessons learned from the United Nations human rights system. The unified global focus on the SDGs, including the goal to reduce maternal mortality worldwide, and the availability of international cooperation and assistance, and technical guidance offer African governments' timely opportunities to amplify efforts to address the significant level of preventable pregnancy-related injuries and death. The African Commission and Court's mandates to promote and protect human rights, and interpret human rights laws and standards, put them in unique positions to identify, operationalise, and ensure the implementation of human rights-based approaches to successfully reduce preventable maternal deaths and injuries in the region. Both the Commission and Court will benefit from the establishment of a special mechanism on human rights in Africa, equivalent to the UNHCHR, to coordinate and operationalise the regional human rights bodies' and states' efforts to address preventable maternal mortality and morbidity and other human rights violations.