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The Human Rights Council's Resolution on Maternal Mortality: Better late than never

*Ebenezer Durojaye**
Doctoral candidate, Department of Constitutional Law, University of the Free State, South Africa

Summary

The article examines data in relation to maternal mortality and the causes of death during pregnancy and childbirth. It analyses the United Nations Human Rights Council's Resolution on Maternal Mortality and its importance to the prevention of maternal deaths worldwide. The article argues that, although the Resolution of the Human Rights Council should have come sooner, nonetheless it remains a strong statement by a UN body to the international community, particularly poor regions such as Africa, to take adequate measures to address the causes of maternal deaths. The article concludes by commending the Human Rights Council for this Resolution and expresses the hope that greater attention will be given to the issue of maternal mortality by the international community in regions worst affected, such as Africa.

1 Introduction

The newly-constituted United Nations (UN) Human Rights Council (UNHRC), agreed to the Resolution on preventable maternal mortality and human rights at its 11th session, on 21 June 2009.[1] The Resolution could not have come at a better time. Maternal mortality has remained a great challenge, particularly in poorer countries. It is estimated that every day about 1 500 women die due to pregnancy-related complica-

* LLM (Free State); ebenezer1170@yahoo.com

1 Human Rights Council Preventable Maternal Mortality and Morbidity and Human Rights A/HRC/11/L.16/Rev 1, 16 June 2009.

tions, translating to about half a million deaths each year.[2] Moreover, it is believed that somewhere in the world a woman dies every minute during childbirth.[3] Maternal deaths among women of reproductive age are widespread in developing countries.[4] For every woman that dies during pregnancy, many more suffer a lifetime of disabilities or morbidities. Approximately 99 per cent of maternal deaths occur in poor regions such as Asia and Africa.[5] Sadly, pregnancy is therefore a very risky venture in developing countries, particularly in Africa.

Against this background, this article examines data on maternal mortality and the causes of deaths during pregnancy and childbirth. It analyses the UN Human Rights Council's Resolution on Maternal Mortality and comments on its importance in preventing maternal deaths worldwide. The article argues that, although the Resolution of the Human Rights Council may be a little late, nonetheless it remains a strong statement by a UN body to the international community, particularly poor regions such as Africa, that they should take adequate measures in order to address the causes of maternal deaths. The article concludes by commending the Human Rights Council for the Resolution and expressed the hope that greater attention will be given to the issue of maternal mortality by regions that are worst affected, among them Africa.

2 Maternal mortality as a health challenge

According to the World Health Organization (WHO), a maternal death is 'the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes'.[6] Deaths during pregnancy and childbirth are generally preventable and have almost been eliminated in developed countries. However, maternal mortality has remained one of the leading causes of death and morbidity among women in Africa.[7] The reasons why women die during pregnancy are well known, and include problems such as haemorrhages (25 per cent), unsafe abortions (13 per cent), eclampsia (12 per cent), infections (16 per cent) and obstructed labour and other

2 World Health Organization *Report of a meeting: Parliamentarians Take Action for Maternal and Newborn Health* (2009) 8.

3 As above.

4 A Glasier *et al* 'Sexual and reproductive health: A matter of life and death' (2006) 368 *Lancet* 1595-1607.

5 As above.

6 WHO *The tenth revision of the international classification of diseases* (1992).

7 See WHO *Maternal mortality in 2000*: *Estimates developed by WHO, UNICEF and UNFPA* (2004).

direct causes (16 per cent).[8] It should be noted that, while these are the general causes of maternal deaths, the reasons why women die during pregnancy may differ from country to country.[9] There are also indirect causes, such as HIV/AIDS, malaria, anaemia and hepatitis (20 per cent). These complications can be addressed through the provision of emergency obstetric care services. However, such services are generally unavailable in poorer regions. It is estimated that in developing countries, about 60 per cent of all deliveries take place outside health facilities[10] and only about 60 per cent of births are attended to by skilled health care providers.[11] In Africa, the percentage of deliveries attended to by skilled health care providers is even lower, at about 47 per cent.[12] Besides medical reasons, other reasons for deaths during pregnancy and childbirth include the so-called three delays: delays in reaching treatment; delays in identifying the problem; and delays in getting help. Also, the low status of women, early marriage and a general lack of respect for women's rights often aggravate deaths during pregnancy.

In 1987, the Safe Motherhood Initiative was launched in Kenya with a view to addressing the challenges posed by maternal deaths.[13] However, more than 20 years after the launching of this initiative, little or no progress has been made in preventing women from dying during pregnancy and childbirth. Despite the remarkable achievements man has recorded in science during the last century, it is scandalous that half a million women (99 per cent of them in Asia and Africa) still die each year during pregnancy and childbirth. As Fathalla *et al* rightly point out, the world lacks neither the resources nor the technologies to prevent women from dying during pregnancy and childbirth; what is lacking is the political will and commitment to take action.[14]

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8 WHO *The World Health Report 2005 – Make every mother and child count* (2005).

9 Eg, a report has shown that unsafe abortion constitutes about 30% to 40% of all maternal deaths in Kenya. See Center for Reproductive Rights *Failure to deliver: Violations of women's human rights in Kenyan facilities* (2007) 24. In Zimbabwe a study has shown that a lack of access to transportation is responsible for 28% of maternal deaths in rural areas. See Center for Reproductive Rights *Briefing paper: Surviving pregnancy and childbirth: An international human right* (2005), whereas in Ethiopia early marriage has been attributed as a major cause of maternal death in the country. See S Hailu *et al* 'Health facility-based maternal deaths audit in Tigray, Ethiopia' (2009) 23 *Ethiopia Journal of Health Development* 115-119.

10 WHO (n 8 above).

11 WHO 'Skilled attendant at birth — 2006 updates. Geneva: World Health Organization, 2006 http://www.who.int/reproductivehealth/ global_monitoring/skilled_attendant.html (accessed 23 December 2009).

12 WHO, UNICEF, UNFPA and World Bank *Maternal mortality in 2005* (2007)18.

13 The Safe Motherhood Initiative that was launched by the WHO, the World Bank, the United Nations Population Fund, the United Nations Children's Fund, the International Planned Parenthood Federation and the Population Council in 1987.

14 M Fathalla *et al* 'Sexual and reproductive health for all: A call for action' (2006) 368 *Lancet* 2095-2100.

The situation of African women is more precarious than that of other women. Africa accounts for more than half of the total number of women who die each year during pregnancy or childbirth.[15] It is estimated that in Africa, the average lifetime risk of a woman dying during or after pregnancy is one death in 16 live births, compared to a woman in Western Europe whose corresponding risk is about one in 2 800 live births.[16] In some countries, such as Sierra Leone, the risk of a woman dying during pregnancy is even higher, at one in eight, compared to her counterpart in Ireland whose corresponding risk is one in 48 000.[17] In actual fact, with the exception of Afghanistan, the 14 countries with the highest maternal mortality ratios in the world are in Africa.[18] For instance, the maternal mortality ratio in Nigeria is estimated at 1 100 deaths out of 100 000 live births, compared to just one death out of 100 000 live births in Ireland.[19] Also, it is estimated that about 117 000 women die yearly during childbirth in India, making it the country with the largest number of maternal deaths in the world.[20] It should be noted that the surviving children of a woman who dies as a result of pregnancy-related complications are at a great risk of dying themselves. There is also a wider and far-reaching negative impact on older siblings, families and neighbours as well as the entire community. Thus, each year maternal health complications contribute to the deaths of 1,5 million infants in the first week of life and 1,4 million stillborn babies.[21]

It should be borne in mind that under the African human rights system, the issue of maternal mortality has been addressed by the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (African Women's Protocol).[22] For instance, article 14 of the Protocol, which contains elaborate provisions on the sexual and reproductive rights of women, also addresses the issue of safe delivery and antenatal care for women. Specifically, article 14(2)(b) requires states to establish and strengthen existing prenatal, delivery and post natal health and nutritional services for women during pregnancy and while breastfeeding. Surely this provision is aimed at ensuring that women will go through pregnancy safely in the region.

15 WHO *et al* (n 12 above).

16 WHO *Global burden of disease 2000, Version 1 estimates* (2000).

17 WHO *et al* (n 12 above).

18 As above.

19 As above.

20 As above.

21 V Boama & S Arukumaran 'Childbirth: A rights-based approach' (2009) *International Federation of Gynaecology and Obstetrics* 125-127.

22 Adopted by the 2nd ordinary session of the AU General Assembly in 2003 in Maputo CAB/LEG/66.6 (2003), entered into force 25 November 2005.

Inspired by General Comment 14[23] of the Committee on Economic, Social and Cultural Rights (ESCR Committee), article 14(2)(a) of the African Women's Protocol requires African governments to provide adequate, affordable and accessible health care services to women, especially those in rural areas. The African Commission on Human and Peoples' Rights (African Commission) in one of its recent resolutions has affirmed maternal mortality as a human rights challenge in the region and called on African governments to redouble their efforts in preventing women from dying during pregnancy and childbirth.[24] Therefore, the Human Rights Council Resolution on maternal death is complementary to the African Commission's resolution and further affirms the need for urgency in addressing the issue of maternal mortality.

3 Maternal mortality and the Millennium Development Goals

Maternal mortality represents one of the most telling instances of inequality between rich and poor countries and between women in rural and urban areas. One of the eight Millennium Development Goals (MDGs) relates to reducing maternal deaths from 1990 rates, by 75 per cent by 2015.[25] In order to achieve this goal, certain indicators were agreed to. These include the maternal mortality ratio, contraceptive use, adolescents' birth rates, antenatal care coverage and universal access to sexual and reproductive health services.[26] However, a report has shown that the target may not be met by some countries in poor regions, particularly those in Africa.[27] This is because little or no progress has been made in these regions with regard to reducing the incidence of maternal deaths. In many developing countries, the maternal mortality ratio has remained very high, while contraceptive prevalence is very low and many deliveries are still being attended to by unskilled traditional birth attendants or family members.[28] It is therefore a welcome development that the highest UN body on human rights deems it fit to agree to a resolution on such an important issue.

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23 The Right to the Highest Attainable Standard of Health; ESCR Committee General Comment 14, UN Doc E/C/12/2000/4.

24 See the African Commission on Human and Peoples' Rights Resolution on Maternal Mortality in Africa Meeting at its 44th ordinary session held in Abuja, Nigeria, 10-24 November 2008, ACHPR/Res 135 XXXXIIII.

25 Goal 5 specifically relates to reducing maternal deaths by three-quarters by 2015. The MDGs are an outcome of the UN Millennium Declaration and Millennium Development Goals launched in 2000.

26 As above.

27 UN Department of Publication Information *Africa and the Millennium Goals 2007 update* (2007).

28 See WHO *et al* (n 12 above).

The next section examines the content of the Human Rights Council's Resolution and its relevance for the challenge of reducing maternal mortality. Given the fact that targets under goal 5 of the MDGs to reduce maternal deaths by three-quarters by 2015 seem to be proving almost impossible for countries in poor regions such as Africa, the importance of this Resolution to galvanise international commitment to prevent maternal deaths cannot be overemphasised. While it is noted that the Resolution is by no means binding on states, it nonetheless represents a strong statement by the UN on a very worrisome situation.

4 Analysis of the Human Rights Council's Resolution

The seven-paragraph Resolution begins with a Preamble which reiterates commitments made by states at consensus meetings, such as the International Conference on Population and Development,[29] the Fourth World Conference on Women (Beijing Platform for Action)[30] and the MDGs. At these meetings it was agreed that women would be assured good health throughout their lives and that they should be prevented from dying during pregnancy and childbirth. This is not the first time that the highest UN human rights body passed a resolution regarding a health issue. It would be recalled that in 2001 at the peak of the HIV/AIDS pandemic and in light of the difficulties facing infected persons in poor regions to get access to life-saving drugs, the then Human Rights Commission agreed to a Resolution on access to essential medicines as a fundamental right.[31] That Resolution was crucial in influencing the historic Doha Declaration agreed to by World Trade Organization (WTO) Ministers in November 2001.[32] However, the Resolution on Maternal Mortality by the newly-constituted Human Rights Council can be regarded as the body's first resolution specifically addressing an important health issue. The Council emphasises the need for increased political will and commitment, including co-operation and technical assistance at the international and national levels, in order to address the 'unacceptably high global rate of preventable maternal mortality and morbidity'.

4.1 Maternal mortality as a human rights challenge

The Human Rights Council reiterates the fact that maternal mortality is a human rights challenge which deserves urgent attention from

29 Report of the International Conference on Population and Development 7 UN Doc A/CONF 171/13 (1994).

30 Fourth World Conference on Women Beijing held on 15 September 1995, A/CONF 177/20.

31 See UN Commission on Human Rights adopted Resolution 2001/33 on Access to Medication in the Context of Pandemics such as HIV/AIDS, April 2001.

32 WTO Doha Ministerial Declaration on the TRIPS Agreement and Public Health, WTO Doc WT/MIN(01)/DEC/2 (2001).

governments across the world. In particular, the Resolution restates that death during pregnancy and childbirth violates women's rights to life, dignity, health and non-discrimination, all guaranteed in international and regional human rights instruments.[33] This is highly commendable and seems to coincide with the view of other commentators on the issue. For instance, Cook *et al*[34] note that the failure by governments to address maternal deaths and disability represents one of the greatest injustices of our times and constitutes gross violations of women's rights. Framing maternal mortality as a human rights violation underscores the importance of holding governments accountable for their failure to prevent maternal deaths.

As stated earlier, most deaths during pregnancy in developing countries are due to the low status of women and a lack of access to comprehensive health care to meet women's needs. In its General Recommendation 24, the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) Committee has enjoined states to 'ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation'.[35] The CEDAW Committee notes further that the failure by states to ensure access to health care services peculiar to women's needs constitutes an act of discrimination against women.[36] Equally, the Human Rights Committee, charged with monitoring the implementation of ICCPR, in some of its concluding observations on reports of states parties on what they have done to bring their laws, policies and practices into compliance with their treaty obligations, has framed maternal mortality as a violation of women's rights to life and survival.[37]

Applying a human rights-based approach to an issue such as maternal mortality is important in the sense that it reminds states of their obligations under international law to respect, protect and fulfil women's rights. It also emphasises the point that access to health care services for women should not be viewed as a privilege, but rather as an important entitlement. A human rights-based approach can also be used to hold states accountable for their failure to fulfil their obligations

33 n 31 above, para 2.

34 RI Cook *et al Advancing safe motherhood through human rights* (2002). See also A Yamin & D Maine 'Maternal mortality as a human rights issue: Measuring compliance with international treaty obligations' (1999) 21 *Human Rights Quarterly* 563-607; F Leeuwen & R Amollo 'A human rights-based approach to improving maternal health' (2009) 10 *ESR Review* 21-24.

35 CEDAW Committee General Recommendation 24 on Women and Health UN GAOR 1999 Doc A/54/38 Rev, para 8(2).

36 n 35 above, para 14.

37 See, eg, Concluding Observations to Democratic Republic of the Congo, para 14, UN Doc CCPR/C/COD/CO/3 (2006); see also Concluding Observations to Mali, para 14, UN Doc CCPR/CO/77/MLI (2003).

under international human rights law to prevent women from dying during pregnancy and childbirth. In this regard, states will need to take adequate measures to repeal laws that not only discriminate against women, but also hinder their access to sexual and reproductive health care services. Conversely, states will need to enact appropriate laws that will facilitate unhindered access to high-quality sexual and reproductive health services, and ensure non-discrimination and autonomy in reproductive decision making to women and girls in order to ensure safe pregnancy and childbirth.[38]

More importantly, a human rights-based approach can be used to remind the international community of commitments made at different consensus meetings and gatherings. For instance, during the International Conference on Population and Development it was agreed by the countries of the world that the reproductive health of women would be given priority and that all individuals shall have the right 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.[39] Furthermore, it was agreed that governments should remove all legal, medical and regulatory barriers to access to information and services on reproductive health for all women.[40] Thus, the human rights approach will remind states of the steps they have taken with regard to these promises and comments. Equally, at the African Ministers' meeting in Maputo in 2005, a continental sexual and reproductive health framework was drawn up. This framework aims at realising universal access to sexual and reproductive health care services, including services related to antenatal, childbirth and postnatal care.[41]

4.2 Resource allocation for maternal health

The Resolution laments the unacceptably high incidence of maternal deaths across the globe and enjoins states to[42]

> renew their political commitment to eliminating preventable maternal mortality and morbidity at the local, national, regional and international levels, and to redouble their efforts to ensure the full and effective implementation of their human rights obligations.

38 Center for Reproductive Rights *Briefing paper* (n 9 above).

39 n 29 above, para 7.3.

40 n 29 above, para 7.20.

41 Special Session: The African Union Conference of Ministers of Health, Universal Access to Comprehensive Sexual and Reproductive Health Services in Africa: Maputo Plan of Action for the Operationalisation of the Continental Policy Framework for Sexual and Reproductive Health and Rights 2007-2010 Sp/MIN/CAMH/5(1) September 2006.

42 n 31 above, para 3.

More importantly, the Human Rights Council calls on states to commit more of their resources to addressing maternal mortality.[43] This call is very important, given the recent development in the world where funds to address sexual and reproductive health issues have been diverted to HIV/AIDS. Fathalla *et al* have observed that funding for HIV/AIDS-related activities has increased greatly since 1995 compared to other sexual and reproductive heath issues.[44] For instance, HIV/AIDS-related funding has increased from 9 per cent of the sexual and reproductive health total to about 56 per cent in 2004.[45] On the other hand, funding for sexual and reproductive health services (including services for maternal health) grew slightly, from 18 per cent to 26 per cent, whereas funding for family planning, including maternity services, diminished greatly from 55 per cent to 9 per cent.[46] While it is no doubt important to sustain spending on reversing the impact of HIV/AIDS in the world, care must be taken not to do this at the expense of other important sexual and reproductive health issues, especially maternal mortality.

Most of the deaths arising during pregnancy and childbirth are preventable, but one of the problems is that many governments do not pay enough attention to the health needs of women. If the goal of reducing maternal deaths by 75 per cent by 2015 is to be realised, then governments in poor regions, particularly sub-Saharan Africa, will need to redouble their efforts to prevent maternal deaths in their countries. This will require allocating more resources than at present to the health sector to address family planning and maternal health. At present, African governments are spending too little on the health of their population. A report has shown that the *per capita* expenditure on the health sector by some African countries ranges from US $65 in Kenya, US $51 in Nigeria, US $29 in Tanzania to US $45 in Mozambique.[47] The only exception is South Africa whose *per capita* expenditure on health is about US $700. This scenario contrasts sharply with spending in some developed countries where, for instance, spending ranges from US $5 274 in the United States, US $3 446 in Switzerland to US $3 409 in Norway.[48]

At the Abuja Declaration in 2001,[49] African governments agreed to commit 15 per cent of their annual budget allocations to the health

43 n 31 above, para 4.

44 Fathalla *et al* (n 14 above).

45 As above.

46 As above.

47 N Master '*Per capita* total expenditure on health in international dollars by country' http//www.nationmaster.com/graph/hea_per_cap_tot_exp_on_hea_in_int_dol-capita-total-expenditure (accessed 11 June 2009).

48 As above.

49 African Summit on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases, Abuja, Nigeria, 24-27 April 2001, OAU/SPS/ABUJA/3.

sector. This position was reiterated at the Gaborone Declaration[50] and the Maputo Plan of Action.[51] Sadly, however, many countries in the region have not kept to this promise. Rather, a report has shown that African governments have continued to commit a greater part of their resources on acquiring arms and ammunition even when most of these countries are not at war or threatened by war. For instance, a report has shown that spending on the military by African governments has increased by about 51 per cent in the past ten years.[52] Ironically, millions of women have lost their lives and suffered life-time injuries due to childbirth during the same period. This is contrary to article 10(h) of the African Women's Protocol, which enjoins African governments to spend less on war and more on women's health and development. Therefore, it will be necessary, in line with article 2(1)(c) of the African Women's Protocol, for African governments to adopt gender-responsive budgeting in their respective countries.[53] This will ensure that the health needs of women in general, and maternal health in particular, are given adequate attention.

It is unacceptable that a woman should be allowed to die every minute from pregnancy-related complications. The Resolution thus reminds states of commitments made to reduce maternal mortality at important meetings, including the ICPD, the Beijing Platform and the MDGs. In essence, the international community should fulfil commitments made at these meetings and fora to address factors that contribute to maternal deaths. The Human Rights Council, unlike the Resolution of the African Commission on Maternal Mortality,[54] did not call for a state of emergency to be declared in countries where maternal mortality is highest. Considering the magnitude of loss of lives and slow progress to address maternal deaths in these countries, such a call for a declaration of emergency would not have been out of place. It will reinforce the urgency in addressing maternal mortality

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50 The 2nd ordinary session of the Conference of the African Ministers of Health CAMH/MIN/Draft/Decl (II), Gaborone, Botswana, 10-14 October 2005. At this Conference, AU countries committed themselves to the achievement of universal access to treatment and care for all and reiterated the need to allocate 15% of their national budgets to health in line with the Abuja Declaration.

51 Maputo Declaration on Malaria, HIV/AIDS, Tuberculosis and Other Related Diseases Assembly/AU/Decl 6(II) 2003.

52 See, eg, *The Guardian* 'Africa's military spending rises by 51 per cent' 10 June 2008 http://www.guardiannewsngr.com/news/article06 (accessed 10 October 2009).

53 Art 2(1)(c) provides that '[s]tate parties shall combat all forms of discrimination against women through appropriate legislative, institutional and other measures. In this regard, they shall: integrate a gender perspective in their policy decisions, legislation, development plans, programmes and activities and in all other spheres of life.'

54 See the African Commission Resolution (n 24 above). Para 4 of the Resolution provides: 'Consider the declaration on the state of maternal health in Africa as a continental emergency and to take appropriate regional actions.'

and the need for governments in developing countries to wake up to their responsibilities as regards women's health.

The Resolution, in the spirit of goal 8 of the MDGs, requests states to give increased attention to maternal mortality and morbidity initiatives in their development partnership and co-operation arrangements. This is an important point which should propel rich countries and donor agencies to give technical support to poorer countries in order to address the causes of maternal mortality. It is worthy of mention here that the Human Rights Council requires such initiatives to adhere to human rights principles and standards generally, particularly the impact of such initiatives on gender inequality. In other words, such initiatives must put women at the centre of the solution and must address gender inequality and other factors that predispose women to dying during pregnancy.

Moreover, there should be an increased and equitable allocation of resources to address health care services needed by women and such health care services must be culturally acceptable to women.[55] Most countries with high maternal mortality ratios are from Africa. Many of these countries are regarded as least-developed countries[56] and are unable to meet the health demands of their people due to a lack of resources. In this regard, the ESCR Committee in its General Comment 14 has called on rich nations to promote socio-economic rights in other countries. Particularly, the Committee has noted:[57]

> Depending on the availability of resources, states should facilitate access to essential health facilities, goods and services in other countries, wherever possible, and provide the necessary aid when required.

Therefore it is clear that, unless poor countries receive help from rich countries, it may remain difficult, if not impossible, for them to effectively reduce maternal deaths.

Also, it is important to note that beyond the challenge of a lack of resources, there are also problems of corruption and the mismanagement of resources. For instance, a country like Nigeria, which has one of the highest maternal mortality ratios (1 100 deaths per 100 000 live births), cannot be said to lack the resources to prevent women from dying during pregnancy. Rather, what has been the problem in that country is endemic corruption and a gross abuse of state resources by its leaders.[58] It is estimated that Nigeria has lost about US $380 billion

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55 See Center for Reproductive Rights *Failure to deliver* (n 9 above) 87.

56 They include Angola, Benin, Burkina Faso, Burundi, Cape Verde, Central African Republic, Chad, Comoros, Democratic Republic of Congo, Djibouti, Equatorial Guinea, Eritrea, Ethiopia, The Gambia, Guinea, Lesotho, Liberia, Malawi, Mauritania, Mozambique, Niger, Rwanda, Sierra Leone, Togo, Uganda, Tanzania and Zambia.

57 General Comment 14 (n 23 above) para 39.

58 O Nnamuchi 'Kleptocracy and its many faces: The challenges of justicability of the right to Health care in Nigeria' (2008) 52 *Journal of African Law* 1-42.

to corruption and embezzlement since independence in 1960.[59] Such a huge sum of money can be utilised more judiciously in a country where one in 18 women is likely to die during childbirth. The World Bank has estimated that approximately US $2 spent on a woman per year can ensure basic maternal health services and prevent maternal deaths.[60] It would therefore have been necessary that the Human Rights Council emphasised the need for prudence and accountability in the use of available resources to address maternal deaths. Such a call would no doubt have assured rich countries and donor agencies of probity and judicious use of donations made to countries with high maternal mortality ratios.

Moreover, given the challenges poor regions continue to face in addressing maternal mortality, due largely to poor funding of the health care system, one would have expected the Human Rights Council to advocate a global fund on maternal mortality. While it is agreed that such a fund may not necessarily address the root causes of maternal deaths in poorer regions, it should contribute greatly to addressing some of the health-related problems that often result in maternal deaths. It would be recalled that in 2001, due to high mortality related to HIV/AIDS, tuberculosis and malaria and a lack of access to care and treatment, the international community established the Global Fund on HIV/AIDS, Tuberculosis and Malaria.[61] The impact of this Fund has been positive and funds disbursed to poor nations affected by these diseases have helped in providing access to care and treatment for those in need, thereby reducing mortality associated with these diseases. For example, in only six years the number of people receiving HIV treatment in low and middle-income countries has increased ten-fold, reaching almost 3 million people by the end of 2007.[62] This in turn has led to a reduction in the number of AIDS-related deaths across the globe.

4.3 Role of non-governmental organisations and other national institutions in reducing maternal deaths

The Human Rights Council also makes an important call to non-governmental organisations (NGOs) and human rights institutions to be more involved in monitoring governments' performance with regard to maternal mortuary. It is a matter of fact that NGOs play a key role in complementing governments' efforts with regard to health-related

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59 See conversation with Nuhu Ribadu, anti-corruption crusader, *The Sun* 24 May 2009.

60 Based on a presentation by A Tinker 'Safe motherhood as an economic and social investment', Safe Motherhood Technical Consultation in Colombo, Sri Lanka, 18-23 October 1997.

61 The decision to create the Global Fund was taken by heads of state at the 2001 G8 Summit in Genoa, Italy, at the urging of UN Secretary-General Kofi Annan.

62 UNAIDS *AIDS Epidemic Report* (2008) 17.

issues in many poor countries. Indeed, NGOs have been very dynamic and have been a great resource to many governments in the fight against HIV/AIDS in Africa. Nevertheless, apart from complementing governments' activities, NGOs and human rights institutions can play an important role in ensuring that governments are meeting their obligations under international human rights law with regard to addressing maternal mortality. The monitoring of governments' activities with regard to maternal mortality can help to bring the attention of governments to neglected issues that contribute to maternal deaths within a community or a country. Moreover, it can reveal disparities with regard to the nature and scope of maternal deaths among different communities within a country and pinpoint shortcomings in governments' policies and plans towards addressing maternal mortality.[63]

NGOs and human rights institutions may work together with governments to come up with realistic human rights indicators, in addition to existing health indicators, that will assist governments in meeting their obligations with regard to preventing maternal deaths. Human rights indicators, in the context of preventing maternal deaths, are important in the sense that they reveal the steps a government has taken to address maternal mortality and whether such steps are consistent with the government's obligations under international human rights law.[64] In this regard, the South African Human Rights Commission (SAHRC), mandated under section 184(3) of the Constitution, has been playing an important role in monitoring government's activities with regard to realising the rights to health, as guaranteed under section 27 of the South African Constitution of 1996. In addition to providing advocacy and training programmes on the right to health generally, the SAHRC has documented the rising infant and maternal mortality in the country, attributing this to the high incidence of HIV/AIDS and the dearth of health care providers in the country.[65] The SAHRC has therefore called on the South African government to take adequate steps and measures with a view to addressing these challenges.[66] Other human rights institutions in the region can learn a lot from the experience of the SAHRC.

Also, a good example of the role of NGOs in addressing maternal mortality is that of a community-based organisation-led initiative in India. It was stated earlier that India has one of the largest numbers of maternal deaths in the world. The National Rural Health Mission (NRHM) is conducting community-based monitoring of health services in order

63 See E Durojaye 'Monitoring the right to health and sexual and reproductive health: Some considerations for African governments' (2009) 42 *Comparative and International Law Journal of Southern Africa* 227-263.

64 Durojaye (n 63 above) 245.

65 South African Human Rights Commission *Fifth Economic and Social Rights Report* (2004).

66 As above.

to ensure that health care services, including maternal health services, reach those for whom they are meant, especially those residing in rural areas, the poor, women and children.1 This approach places people at the centre of the process of regularly assessing whether the health needs and rights of the community are being fulfilled. Through its activities, the organisation has identified key issues which were never contemplated by governments as major barriers to reducing maternal deaths in rural areas. Similarly, in Nigeria several NGOs are playing important roles in ensuring that childbirth is safe in that country. For instance, the Society of Gynaecology and Obstetrics of Nigeria (SOGON) has been involved in training and advocacy programmes across the country to address the problem of maternal mortality. More importantly, SOGON has continued to research and document the maternal mortality situation in Nigeria. The outcome of such research has been used as an advocacy tool to call government's attention to how maternal mortality may become a serious threat to women's health and lives.[67]

While it is true that NGOs and human rights institutions can play an important role in monitoring governments' obligations with regard to preventing maternal deaths, courts are also important institutions which can hold governments accountable for failing to meet their obligations under international law. Moreover, courts can set standards which will guide governments in realising their obligations to fulfil women's right to health, including maternal health. Already in some jurisdictions courts are beginning to question governments' unwillingness or reluctance to provide health care services needed by women.[68] Also, courts are beginning to affirm the sexual and reproductive autonomy of women to make decisions concerning their bodies. For instance, the South African Constitutional Court has affirmed the right of a girl below 18 to consent to medical abortion since this will fulfil her right to reproductive self-determination.[69] This decision is very crucial in the context of maternal mortality, given the fact most women in Africa do not have a say with regard to the number and spacing of their children and bearing in mind that unsafe abortion remains a major cause of maternal death in the region.[70] Therefore, the Human Rights Council perhaps could have pinpointed the importance of courts and other institutions in addressing the challenge posed by maternal mortality in poor regions.

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67 See A Bankole *et al Barriers to safe motherhood in Nigeria* (2009) 17.

68 See the case of *Minister of Health v Treatment Action Campaign & Others* 2002 10 BCLR 1033 (CC), where the South African government was held to be in breach of its obligation to fulfil the right to health of its citizens by failing to provide medicines to prevent mother-to-child transmission of HIV in accordance with constitutional provisions.

69 *Christian Lawyers Association v National Ministers of Health & Others* 2004 10 BCLR 1086.

70 See Glasier *et al* (n 4 above).

4.4 Role of the UN and its agencies

In paragraph 6 of the Resolution, the Human Rights Council calls on the Office of the UN High Commissioner for Human Rights, in conjunction with states and UN agencies such as the WHO, UNFPA and UNICEF, to prepare a thematic study on preventing maternal mortality in the world This study is undertaken to identify the human rights dimension of maternal mortality, to give an overview of initiatives and activities within the UN to address maternal mortality, and to show how the Council can add value to addressing human rights implications of maternal deaths. It is hoped that such a study will be found very useful by states with high maternal mortality ratios. These agencies have been at the forefront of advocating an international response to maternal mortality in poorer regions. They have, through their numerous activities, drawn the attention of the world to the appalling statistics with regard to maternal deaths in developing countries.

One important point which the Human Rights Council fails to emphasise is the fact that these agencies need to promote a more co-ordinated and integrated approach in working with community-based organisations in order to address the issue of maternal mortality in local communities.[71] In those regions where maternal deaths are high, many of the women who lose their lives during pregnancy are women in rural areas where access to basic amenities such as water, food and medical care, is acutely lacking. Studies have shown that most of the deaths resulting from maternal mortality could have been avoided had there been access to basic infrastructure in the health care setting.[72] This emphasises the need for a more collaborative and integrated approach between UN agencies and community-based organisations to address the root causes of maternal deaths.

The study proposed in paragraph 6 is expected to be submitted at the 14th session of the Human Rights Council, in June 2010, and further activities on the nexus between maternal mortality and human rights are expected to follow. The Council also invited the Office of the Commissioner for Human Rights, the WHO, UNFPA and the Special Rapporteur on the Right to Health to contribute to a discussion on this study.

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71 See Report of the Secretary-General on 'Co-ordinated and integrated United Nations system approach to promote rural development in developing countries, with due consideration to least developed countries, for poverty eradication and sustainable development' made at the substantive session of the Economic and Social Council, New York, 28 June to 23 July 2004, where it is stated that, although UN agencies have continued to play important roles in rural areas across the world, better results can be obtained if the activities of these agencies are well co-ordinated and integrated.

72 Center for Reproductive Rights *Broken promises: Human rights, accountability and maternal death in Nigeria* (2008); Amnesty International *Out of reach: The cost of maternal health in Sierra Leone* (2009).

5 Conclusion

One may argue that the Resolution emerging from the UN's highest human rights body should have come earlier, considering the fact that maternal mortality has been a major health challenge in the world for several years. On the other hand, however, one may say that it is better late than never. Unlike other health challenges, such as HIV/AIDS, tuberculosis and malaria, maternal mortality has not received sufficient attention from the UN and the international community as a whole.[73] It is in light of this that one must commend the Human Rights Council for finding the courage to agree to this very important Resolution. The fact that the Resolution frames maternal deaths as a human rights issue and calls on the international community to renew their political commitment to addressing maternal deaths has further brought to the fore the need for countries of the world to join hands in reducing deaths associated with pregnancy.

More importantly, the Resolution is a wake-up call to all nations, particularly those in developing regions such as Africa, to improve on the funding of the health care sector in general, and sexual and reproductive health care in particular. This is particularly true if the ambitious goals of the MDGs, especially goal 5 on reducing maternal mortality by 75 per cent, are to be realised. Although, as stated earlier, the Resolution is by no means binding, it remains an important reference point for member states of the UN on steps that should be taken in order to address maternal deaths. Indeed, this resolution represents a strong message by a UN organ to the international community on the need to pay greater attention to maternal mortality.

[73] Eg, in 2001 the UN General Assembly held a Special Session on HIV/AIDS known as the Declaration of Commitment.