TO LET A WOMAN DIE IS TO FAIL: PLACING MATERNAL HEALTH ON THE AGENDA*

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> The human rights community must be urged to remonstrate and demonstrate about maternal mortality just as loudly as it complains about extrajudicial executions, arbitrary detention, unfair trials and prisoners of conscience.
>
> Paul Hunt, Former UN Special Rapporteur.

> Maternal mortality is a neglected issue because those who suffer it are neglected people, with the least power and influence over how national resources shall be spent; they are the poor, the rural peasants, and above all, women.
>
> Ann Starrs, Co-Founder Family Care International, 1987

> Countries must recognise that they are violating their own values by allowing unsafe motherhood
>
> Rebecca Cook, University of Toronto Faculty of Law

1. INTRODUCTION

Pregnancy and childbearing have generously contributed to death and disability among women though out the narration of humanity. Moreover pregnancy and child bearing are not diseases. Maternal mortality is a key indicator of women's health and status, and shows most touchingly the difference between rich and poor, both between countries and within them. Over half a million women die each year due to complications during pregnancy and birth. [2] In 2000, the estimated number of maternal deaths worldwide was 529,000.95 per cent of these deaths occurred in

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* Research Paper 2009.

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[2] P Hunt & J Bueno De Mesquita 'Reducing Maternal Mortality: The contribution of the right to the highest attainable standard of health' United Nations Family Planning Association, 2007.

Africa and Asia.[3] While women in developed countries have only a 1-in-2,8000 chance of dying in childbirth – and a 1 – in – 8,700 chance in some countries – women in Africa have a 1 – in – 20 chance. The Leading country is Niger where the risk of dying due to pregnancy-related causes is one in seven. In 1999, WHO estimated that over 2 million women living in developing countries remain untreated for obstetric fistula, a devastating injury of childbirth. [4]

Women living in poverty and in rural areas, and women belonging to ethnic monitories or indigenous populations, are among those particularly at risk.[5] This is compounded by gender and other inequalities, a lack of information, weak health systems, a lack of political commitment, and cultural barriers are other barriers that need to be overcome if women are to access technical services and information that can often prevent maternal mortality and morbidity. In the last 20 years, a series of international commitments and initiatives has pledged to reduce maternal mortality. While many countries have made progress in reducing maternal mortality, progress has stagnated or been reversed in many of the countries with the highest burden of maternal mortality.[6] Most parts of the world are lagging to meet the MDG target of reducing maternal mortality.[7] This includes South Africa.[8]

The deaths of these women are directly related to lack of available and accessible reproductive and maternal healthcare. According to the WHO, in order to reduce the number of maternal deaths, women should have access to, among other things, family planning services, antenatal care, high-quality and delivery care, emergency

[3] UNFPA website. Available at www.unfpa.org/mothers/statistics.htm. Accessed11 November 2009.

[4] World Health Report 2005: *Making Every Mother and Child Count*, WHO, 2005

[5] M Wirth et al 'Setting the Stage for Equity-sensitive Monitoring of the Maternal and Child Health MDGs' (2006) 84 *WHO Bulletin*.

[6] World Health Report 2005: *Making Every Mother and Child Count*, WHO, 2005

[7] A Starrs 'Safe Motherhood Initiative: 20 Years and Counting' The Lancet, Maternal Survival Series, September 2006; UN Millennium Project, *Investing in Development: A Practical Plan to Achieve the Millennium Development Goals*, UNDP, 2005.

[8] See M Chopra et al 'Saving the lives of South Africa's mothers, babies, and children: can the health system deliver? (2009) 374 *The Lancet* 835; UNGASS Progress Report for South Africa, 2007. *Available at* data.unaids.org/.../Report/2008/south_africa_2008_country_progress_report_en.pdf -. Accessed 13 November 2009.

obstetric care, and post-natal care.[9] The reason why these services are often not available is not just found in lack of money, but rather it is, on many occasions, due to a discriminatory allocation of funds whereby maternal healthcare, as a service especially required by women, is subordinate to more *gender-neutral* or andocentric facilities. According to Shaw, 'women are not dying because of diseases we cannot treat. They are dying because societies have yet to make the decision that their lives are worth saving.'[10] Maternal health continues to run on the peripheries of the global health agenda as compared to other critical health issues like HIV and AIDS.[11] Some concerns relate to the fact that it is methodologically difficult to measure maternal mortality as compared to other health outcomes like infant mortality.[12] There have also been issues around the conflation of women with children they bear.[13] Furthermore, there has been resistance from a section of feminists to the usage of terms like 'safe motherhood' as placing women within the reproductive arena and thus perpetuating their child bearing roles.[14] The cause has also been described as lacking a UN agency ownership.[15]

Above all the ironies, almost all cases of maternal mortality are preventable. An estimated 74 per cent of maternal deaths could be averted if all women had access to the interventions for preventing or treating pregnancy and birth complications, in particular emergency obstetric care.[16] Preventable maternal mortality occurs where

[9] World Health Report 2005: *Making Every Mother and Child Count*, WHO, 2005

[10] D Shaw, 'Sexual and reproductive rights in action – obligations and opportunities' (2004) 84 *International Journal of Gynecology & Obstetrics*: XXX.

[11] J Shiffman & S Smith, 'Generation of political priority for global health initiatives: A framework and case study of maternal mortality' (2007) 370 *The Lancet* 1.

[12] C Standon, et al. 1997 'DHS maternal mortality indicators: an assessment of data quality and implications for data use. Calverton: Macro International.

[13] MJ Roseman 'Bearing Human Rights: Maternal Health and the Promises of ICPD' in L Reichenbach and MJ Roseman (eds) *Reproductive health and human rights: the way forward* Havard University Press 2009 93.

[14] J Shiffman & S Smith, 'Generation of political priority for global health initiatives: A framework and case study of maternal mortality' (2007) 370 *The Lancet* 1370-1379

[15] J Shiffman & S Smith, 'Generation of political priority for global health initiatives: A framework and case study of maternal mortality' (2007) 370 *The Lancet* 1370-1379.

[16] A Wagstaff & M Claeson, *The Millennium Development Goals for Health: Rising to the Challenges* World Bank, 2004.

there is a failure to give effect to the rights of women to health, equality and non-discrimination. This goes to show that maternal death is a matter of social justice as it thrives amidst inequity. Inequity has been defined as an injustice that is unnecessary, unfair and avoidable.[17]

Against this backdrop, this paper argues that maternal health chiefly corresponds with the obligation on the state to fulfill its obligation on the right to the highest attainable standard of health as encapsulated in the International Covenant on Economic, Social and Cultural Rights (ICESCR).[18] The paper argues that approaches must endeavour to provide goods and services relating to sexual and reproductive health. This includes rights and entitlements on health care services and information. The paper argues for a human rights approach to programming and interventions. Further, the paper argues that it requires participation by stakeholders in policy formulation and highlights the place of accountability for maternal health. The author relies on the capabilities approach to argue that actions have to be taken to break down political, economic, social and cultural barriers that women face in accessing the interventions that can prevent maternal mortality. The paper concludes that if maternal health should be counted and accounted for.

2. WHAT IS MATERNAL MORTALITY AND WHAT CAUSES IT?

Mortality 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. Maternal Mortality Ratio (MMR) is the number of maternal deaths in a population divided by the number of live births and Maternal Mortality Rate is the number of maternal deaths in a population divided by the number of women of reproductive age.

[17] J Wilson 'Health Inequities' in A Dawson (ed) *Public Health Ethics: Key Concepts and Issues in Policy and Practice*. 2009 Cambridge: Cambridge University Press; A Green 2007 *An Introduction to Health Planning for Developing Health Systems* Oxford: Oxford University Press.

[18] Article 12 thereof. The ICESCR was adopted in 1966.

The key causes of maternal mortality are; severe bleeding(25 %),infections (15 %), eclampsia (12 %), obstructed labour (8 %) and unsafe abortion (13 %).Other direct causes (largely complications during interventions (for example ectopic pregnancy, embolism, anaesthesia-related causes accounting for 8 % and indirect causes (diseases that are not complications of pregnancy but complicate pregnancy or are aggravated by it (for example, malaria, anaemia HIV/AIDS and cardiovascular disease accounting for 20 %.[19]

2.1 OBSTETRIC FISTULA – AN EXAMPLE

As a way of demonstrating what maternal health means to a woman, I use the example of obstetric fistula. Fistula used to be present in the U.S. and Europe, but was largely eliminated in the latter part of the 19th century and early 20th century with improved obstetric care in general and the use of caesarean-sections in particular to relieve obstructed labour.[20] The United Nations Family Planning Association (UNFPA) has described obstetric fistula as 'the most devastating of all pregnancy-related disabilities'.[21] Currently, the World Health Organization estimates that approximately 2 million women have untreated fistula and that approximately 100,000 women develop fistula each year. Fistula is most prevalent in sub-Saharan Africa and Asia.[22] There are an estimated 100,000 women suffering with untreated fistula, and another 9,000 women who develop fistula each year. Less than 6 in 10 women in developing countries give birth with any trained professional, such as a midwife or a doctor. When complications arise, as they do in approximately 15% of all births, there is no one available to treat the woman, leading to disabling injuries like fistula, and even death.

[19] WHO Report 2005. Make Every Mother and Child Count. Geneva, WHO, 2005.

[20] Facts from the Fistula Foundation website. Available at http://www.fistulafoundation.org/aboutfistula/faqs.html. Accessed 13 November 2009.

[21] Facts from the Fistula Foundation website. Available at http://www.fistulafoundation.org/aboutfistula/faqs.html. Accessed 13 November 2009.

[22] Facts from the Fistula Foundation website. Available at http://www.fistulafoundation.org/aboutfistula/faqs.html. Accessed 13 November 2009.

The root causes of fistula are poverty and the low status of women and girls. In developing countries, the poverty and malnutrition in children contributes to the condition of stunting, where the girls' skeleton and pelvis a, do not fully mature.[23] This stunted condition can contribute to obstructed labour, and therefore fistula. Fistula is both preventable and treatable. For instance, the Addis Ababa Fistula Hospital has treated over 30,000 women over 33 years.[24] Their cure rate is over 90%. Fistula can be prevented if labouring women are provided with adequate emergency obstetric care when complications arise.[25]

Fistula also poses social problems, stigma and marital challenges to women. For example, a recent study conducted in Malawi found that many women in the country were unaware that the condition is treatable and preventable which in turn affected their ability to seek health care.[26] A woman in Malawi had this to say:[27]

> My mother-in-law says she wants grandchildren. It pains me because it was her who took me to the Azamba instead of the hospital. If I had gone to the hospital earlier, doctors could have assisted me…today, she wants my husband to marry another woman, as if I deliberately planned to find myself in this condition. She is not being fair. I walk with difficulty and I need special care…most people do not come near me because of the bad smell I produce. Sometimes you think that dying would save you a lot of trauma.

The report also highlighted challenges of transport and access to health care facilities. The interviewee above had this to say:[28]

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[23] Facts from the Fistula Foundation website. Available at http://www.fistulafoundation.org/aboutfistula/faqs.html. Accessed 13 November 2009.

[24] Facts from the Fistula Foundation website. Available at http://www.fistulafoundation.org/aboutfistula/faqs.html. Accessed 13 November 2009.

[25] Facts from the Fistula Foundation website. Available at http://www.fistulafoundation.org/aboutfistula/faqs.html. Accessed 13 November 2009.

[26] MALAWI: Lucy Chikoti, "My husband wants to marry another woman because I have obstetric fistula". IRIN News. Available at http://www.irinnews.org/report.aspx?ReportID=86990. Accessed 13 November 2009.

[27] MALAWI: Lucy Chikoti, "My husband wants to marry another woman because I have obstetric fistula". IRIN News. Available at http://www.irinnews.org/report.aspx?ReportID=86990. Accessed 13 November 2009.

[28] MALAWI: Lucy Chikoti, "My husband wants to marry another woman because I have obstetric fistula". IRIN News. Available at http://www.irinnews.org/report.aspx?ReportID=86990. Accessed 13 November 2009.

> My village is about 20 kilometres from the main town of Balaka, where the main district hospital is. Most expectant mothers do not go for antenatal check-ups because of the distance… sometimes women deliver on the way to the hospital. Vehicles pass through our village once in a while. The bicycle taxis that we use here are not as reliable as vehicles. In my case I delivered at the hospital, but I arrived there late…my mother-in-law took me to an Azamba [traditional birth attendant] to assist me, but it was a big mistake. I spent a night there but nothing happened. It was after my situation had worsened that they decided to take me to the hospital.

The state of maternal health in sub Saharan Africa is therefore deplorable. It is little wonder that the Fourth Ordinary Session of the African Union Ministers of Health Conference, described it as an 'an embarrassment'. [29]

3. THE SOUTH AFRICA CASE

South Africa is one of the countries that has not registered success in bringing down maternal deaths. This has been exacerbated with the HIV and AIDS epidemic now described as hyper endemic in the country.[30] Moreover women still bear the yoke of the epidemic. HIV prevalence remains disproportionately high for females overall in comparison to males peaking in the 25-29 age group, where in one in three (32.7%) were found to be HIV positive in 2008. [31] Data shows that the maternal mortality ratio was more than six times higher in HIV-positive women (776 deaths per 100,000 births) than in HIV-negative women (124 per 100,000).[32] Nearly half of the 108 women who passed away between 2003 and 2007 died from HIV-related causes, most commonly tuberculosis and pneumonia.[33] The double burden of HIV and AIDS

[29] This was during the roundtable debate on the theme 'Universal access to essential health services: To improve maternal, neonatal and child health.' Report of the ministers' meeting, Fourth Ordinary Session of the African Union Conference of Ministers of Health, 4-8 May 2009, Addis Ababa, Ethiopia 6.

[30] UNAIDS, 2008 *Report on global AIDS epidemic*. Geneva:UNAIDS.

[31] See South African National HIV Prevalence, Incidence, Behaviour and Communication Survey, HSRC, 2008. Xvi.

[32] Black et al 'Effect of Human Immunodeficiency Virus Treatment on Maternal Mortality at a Tertiary Center in South Africa: A 5-Year Audit' (2009) 114 *Obstetrics & Gynecology* 292-299.

[33] Black et al 'Effect of Human Immunodeficiency Virus Treatment on Maternal Mortality at a Tertiary Center in South Africa: A 5-Year Audit' (2009) 114 *Obstetrics & Gynecology* 292-299.

and maternal mortality has therefore placed upon the health system a heavy burden. This scenario also means that South Africa has to put an extra effort to meet its obligation to fulfil women's right to the highest attainable standard of health.

Discussion of maternal health in South should be located within the prevailing health system. The Country's apartheid history left a legacy of ill health and poor health system the brunt of which women continue to bear. Racial and gender discrimination, the colonial subjugation, apartheid dispossession and the ensuing inequality inevitably affected the health system.[34] In 1990, it was reported that there was still discrimination in the provision of funds for health services. [35] It was also reported that 'black hospitals are overcrowded and ill equipped whereas white hospitals are underutilised', and that 'there is inadequate or insufficient health care in the "homelands" and rural areas'. [36] Because of this, the black population does not have access to health care services equal to whites, which is argued to constitute a violation of the obligation to respect equal access to health care services. [37]

Currently, the country's health system consists of a large public sector and a smaller but fast-growing private sector. [38] The state contributes about 40% of all expenditure on health. The public health sector is under pressure to deliver services to about 80% of the populations. Despite this, most resources are concentrated in the private health sector, which sees to the health needs of the remaining 20% of the population. The public sector is largely under-resourced and over-used, while the mushrooming private sector, run largely on commercial lines, caters to middle- and

[34] C Hoosen et al 'The health and health system of South Africa: historical roots of current public health challenges' (2009) 374 *The Lancet* 817.

[35] Nightingale et al ' Apartheid Medicine, Health and Human Rights in South Africa' (1990) 264 *Journal of the American Medical Association* 2102 quoted in CA Toebes (1999) The right to health as a human right in international law Intersentia: Hart 320.

[36] Nightingale et al ' Apartheid Medicine, Health and Human Rights in South Africa' (1990) 264 *Journal of the American Medical Association* 2102 quoted in CA Toebes (1999) The right to health as a human right in international law Intersentia: Hart 320.

[37] Nightingale et al ' Apartheid Medicine, Health and Human Rights in South Africa' (1990) 264 *Journal of the American Medical Association* 2102 quoted in CA Toebes (1999) The right to health as a human right in international law Intersentia: Hart 320.

[38] Department of Health, 2008. Available at www.doh.gov.za.

high-income earners who tend to be members of medical schemes.[39] The private sector also attracts most of the country's health professionals.[40] Most women attend the public health sector.

On maternal health, the country has run a Confidential Enquiries system into maternal deaths since 0ctober 1997. Confidential enquiries into maternal deaths (CEMD) can be defined as:[41]

> A systematic multidisciplinary anonymous investigation of all or a representative sample of maternal deaths occurring in an area, region (state) or national level which identifies the numbers, causes and avoidable or remedial factors associated with them. Through the lessons learnt from each woman's death, and through aggregating the data, confidential enquiries provide evidence of where the main problems in overcoming maternal mortality lie and an analysis of what can be done in practical terms, and highlight the key areas requiring recommendations for health sector and community action as well as guidelines for improving clinical outcomes

The country has conducted four Confidential Enquiries. The first was report was published in 1999 and dealt with maternal deaths occurring in 1998.[42] The second report covered the triennium 1999-2001.[43] The third covered 2002-2004.[44] The fourth

[39] Department of Health, 2008. Available at www.doh.gov.za.

[40] As above.

[41] G Lewis 'Confidential enquiries into maternal deaths. In: Beyond the numbers: Reviewing maternal deaths and complications to make pregnancy safer'. World Health Organisation, Geneva 2004, 77-102 as quoted in NCCEMD 'Saving Mothers 2005-2007: Fourth Report on Confidential Enquiries into Maternal Deaths in South Africa'.Available at http://www.doh.gov.za/docs/savingmothers-f.html. Accessed 13 November 2009. P. 4.

[42] NCCEMD 'Saving Mothers 2005-2007: Fourth Report on Confidential Enquiries into Maternal Deaths in South Africa'. Available at http://www.doh.gov.za/docs/savingmothers-f.html. Accessed 13 November 2009. P 4.

[43] NCCEMD 'Saving Mothers 2005-2007: Fourth Report on Confidential Enquiries into Maternal Deaths in South Africa'. Available at http://www.doh.gov.za/docs/savingmothers-f.html. Accessed 13 November 2009. P 4.

[44] NCCEMD 'Saving Mothers 2005-2007: Fourth Report on Confidential Enquiries into Maternal Deaths in South Africa'. Available at http://www.doh.gov.za/docs/savingmothers-f.html. Accessed 13 November 2009. P 4.

deals with the period 2005-2007.[45] The earlier three reports described the magnitude of the problem of maternal deaths, the avoidable factors, missed opportunities and substandard care related to these deaths and made recommendations concerning ways of decreasing the number of maternal deaths.[46]

Findings in the latest report for 2005-2007 (the report) reveal that a total of 4077 maternal deaths were reported (including coincidental deaths), up from 3406 reported in the 2002-2004 triennium. Thus Kwazulu Natal had the highest number of maternal deaths as also the most populous.[47] The report revealed that most maternal deaths occurring outside of health institutions are not reported to the National Committee on Confidential Enquiries into Maternal Deaths (NCCEMD).[48] It is estimated that only between 20% and 60% of maternal deaths occur in health institutions.[49] This therefore affects the statistics presented in the reports.

The report reveals that there is an excess of maternal deaths due to complications of hypertension occurring in women less than 20 years when compared with the general population. [50] Also, the percentage of maternal deaths due to antepartum, haemorrhage, postpartum haemorrhage, ectopic pregnancies, embolism, acute collapse and preexisting medical conditions are higher in the general pregnant

[45] NCCEMD 'Saving Mothers 2005-2007: Fourth Report on Confidential Enquiries into Maternal Deaths in South Africa'. Available at http://www.doh.gov.za/docs/savingmothers-f.html. Accessed 13 November 2009. P 4.

[46] NCCEMD 'Saving Mothers 2005-2007: Fourth Report on Confidential Enquiries into Maternal Deaths in South Africa'. Available at http://www.doh.gov.za/docs/savingmothers-f.html. Accessed 13 November 2009. P 4.

[47] NCCEMD 'Saving Mothers 2005-2007: Fourth Report on Confidential Enquiries into Maternal Deaths in South Africa'. Available at http://www.doh.gov.za/docs/savingmothers-f.html. Accessed 13 November 2009. P.5.

[48] NCCEMD 'Saving Mothers 2005-2007: Fourth Report on Confidential Enquiries into Maternal Deaths in South Africa'. Available at http://www.doh.gov.za/docs/savingmothers-f.html. Accessed 13 November 2009. P. 4.

[49] NCCEMD 'Saving Mothers 2005-2007: Fourth Report on Confidential Enquiries into Maternal Deaths in South Africa'. Available at http://www.doh.gov.za/docs/savingmothers-f.html. Accessed 13 November 2009. P 5.

[50] NCCEMD 'Saving Mothers 2005-2007: Fourth Report on Confidential Enquiries into Maternal Deaths in South Africa'. Available at http://www.doh.gov.za/docs/savingmothers-f.html. Accessed 13 November 2009. P 6.

population in women older than 34 years.[51] The report shows that deaths due to non-pregnancy related infections peak at 25-29 years and this peak is mirrored in deaths due to complications of abortion and pregnancy and related sepsis following a viable pregnancy. [52]

The report cited non attendance and delayed attendance at the health institutions as the most common patient oriented problems. [53] Poor transport facilities, lack of health care facilities and lack of appropriately trained staff were the major administrative problems.[54] The report shows that the most frequent health care provider avoidable factors were failure to follow standard protocols and poor problem recognition and initial assessment. [55] Assessors therefore thought 38.4% of the deaths were clearly avoidable within the health care system. The South African scenario displays a high mortality rate in a system where women are enmeshed in health inequalities and inequities that can be remedied through a human rights approach to maternal health. This is not only in light of its international treaty obligations but also in terms of its constitutional imperative which expressly includes the right to access to health as including reproductive rights.[56] It is also important to note that issues pertaining to maternal health are inextricably bound with the rights to equality and dignity which occupy unique places within the country's constitutional scheme.

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[51] NCCEMD 'Saving Mothers 2005-2007: Fourth Report on Confidential Enquiries into Maternal Deaths in South Africa'. Available at http://www.doh.gov.za/docs/savingmothers-f.html. Accessed 13 November 2009. P. 6.

[52] NCCEMD 'Saving Mothers 2005-2007: Fourth Report on Confidential Enquiries into Maternal Deaths in South Africa'. Available at http://www.doh.gov.za/docs/savingmothers-f.html. Accessed 13 November 2009. P 6.

[53] NCCEMD 'Saving Mothers 2005-2007: Fourth Report on Confidential Enquiries into Maternal Deaths in South Africa'.Available at http://www.doh.gov.za/docs/savingmothers-f.html. Accessed 13 November 2009. P 3.

[54] NCCEMD 'Saving Mothers 2005-2007: Fourth Report on Confidential Enquiries into Maternal Deaths in South Africa'.Available at http://www.doh.gov.za/docs/savingmothers-f.html. Accessed 13 November 2009. P 3.

[55] NCCEMD 'Saving Mothers 2005-2007: Fourth Report on Confidential Enquiries into Maternal Deaths in South Africa'.Available at http://www.doh.gov.za/docs/savingmothers-f.html. Accessed 13 November 2009. P 3.

[56] NCCEMD 'Saving Mothers 2005-2007: Fourth Report on Confidential Enquiries into Maternal Deaths in South Africa'.Available at http://www.doh.gov.za/docs/savingmothers-f.html. Accessed 13 November 2009. P 3.

4. KEY TRENDS AND DEVELPOMENTS ON MATERNAL HEALTH

There have been a string of developments on maternal health. These include; the International Conference on Safe Motherhood which launched the Safe Motherhood Initiative, [57] the International Conference on Population and Development (ICPD), [58] the Fourth World Conference on Women (FWCW), [59] the 10 Year Safe Motherhood Initiative Evaluation, [60] the Making Pregnancy Safer Initiative,[61] the United Nations Millennium Declaration which adopted the Millennium Development Goals (MDGs),[62] UN Millennium Development Task Force on Child and Women's Health,[63] the Partnership for Maternal, Newborn and Child Health,[64] Women Deliver Initiative which yielded the International initiative on maternal mortality and human rights (IIMMHR) [65] the World Summit on Children,[66] and the World Conference on Human Rights (Vienna Conference). [67] Most of these had follow up sessions.[68] Recently, the United Nations Human Rights Council adopted a resolution recognising maternal

[57] The Conference was held in Nairobi, Kenya in 1987.

[58] The Conference was held in Cairo, Egypt in 1994.

[59] The Conference was held in Beijing, China in 1995.

[60] The Conference was held in Sri Lanka in 1997.

[61] Of 1999.

[62] Adopted on 8 September 2000 following a three day Millennium Summit. For more on the MDGs, go to http://www.oecd.org/about/0,2337,en_2649_34585_1_1_1_1_1,00.html. Accessed 11 November 2009.

[63] Of 2005.

[64] Of 2005.

[65] Of 2007.

[66] Of 1990.

[67] World Conference on Human Rights was held by the United Nations in Vienna, Austria during 14 to 25 June 1993.

[68] For example the Vienna Conference, the International Conference on Population and Development, the Fourth World Conference on Women and the World Summit for Social Development had 5 year reviews. See also, the 2000 United Nations Millennium Declaration Resolution (the MDGs), the 2001 United Nations General Assembly Special Session on HIV/AIDS and the 2002 United Nations General Assembly Special Session on Children.

death and illness as pressing human rights concerns.[69] This paper discusses the Millennium Development Goals arising from the United Nations General Assembly Special Session on HIV/AIDS and the Women Deliver Initiative - IIMMHR.

4.1 The Millennium Development Goal 5

The Millennium Development Goal 5 seeks to improve maternal health. In order to realise this goal, two targets have to be met; the global maternal mortality ratio, that is the number of maternal deaths during a given time period per 100 000 live births during the same time-period, must be reduced by three quarters and universal access to reproductive health must be attained.[70] To reach the first target by 2015 it is required that the maternal mortality ratio shows an annual decline of at least 5.5%. This target is by far not met, for at present, the annual decline is only less than 1%.[71] As regards the second target, the World Health Organization (WHO) reports that although the use of contraception has improved impressively during the past two decades in many regions, the need for family planning that has not yet been met is still unacceptably high in low- and middle-income countries. For example, in sub-Saharan Africa, 24% of women who want to delay or stop childbearing have no access to family planning.[72] This figure varies between 10–15% in the other world regions and further varies across population groups.[73] MDG 5 is *the* Goal where the *least* progress has been made. It is argued that the MDGs have now attained the status of customary international law.[74] Several reports propose human rights based

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[69] Adopted on 17 June 2009. The document is available at http://www.mfat.govt.nz/downloads/humanrights/HRC-Res-Maternal-Mortality.pdf. Accessed 13 November 2009.

[70] See MDG 5 and targets.

[71] WHO, 2008. Fact sheet: Millenium Development Goal 5. Available at http://www.who.int/making_pregnancy_safer/events/2008/mdg5/mdg5_lr.pdf (accessed: 13 October 2009).

[72] WHO, 2008. Fact sheet: Millennium Development Goal 5. Available at http://www.who.int/making_pregnancy_safer/events/2008/mdg5/mdg5_lr.pdf (accessed: 13 October 2009).

[73] WHO, 2008. Fact sheet: Millennium Development Goal 5. Available at http://www.who.int/making_pregnancy_safer/events/2008/mdg5/mdg5_lr.pdf (accessed: 13 October 2009).

[74] P Alston, 2005. Ships Passing in the Night: The Current State of the Human Rights and Development Debate Though the Lens of the Millennium Goals 6 *Human Rights Quarterly* 755.

approach to achieve the MDGs in 2015.[75] This approach is said to have several advantages: it builds upon already existing legal obligations for states; it incorporates the norms of non-discrimination and equality; and there are accountability mechanisms already in place. The MDG-based plan can also be a good instrument to engage donors in discussions to scale up resources towards MDG achievement in developing countries.[76] The MDG agenda is therefore viewed as one that opened windows to changes in policy and could be utilised to put maternal health on the agenda.

4.2 Women Deliver Initiative - IIMMHR

This Initiative was launched at the Women Deliver Conference in 2007. It represents the first civil society human rights effort which is targeted at reducing maternal mortality.[77] It is a human rights approach which includes a call for greater political will on behalf of governments and donors to take the necessary steps to reduce maternal mortality, and in turn, more effective accountability mechanisms to ensure that women's right to maternal health becomes a reality. It aims to do this by; holding governments accountable for implementing effective and equitable policies and programs, securing increased resources at the global and national levels and promoting understanding among, and providing expertise to, key stakeholders on addressing maternal mortality as human rights cause. The former UN Special

[75] P Alston, 2005; Ships Passing in the Night: The Current State of the Human Rights and Development Debate Though the Lens of the Millennium Goals 6 *Human Rights Quarterly* 755; S Dairiam, 2005. The Relevance of the Links Between Human Rights, The Beijing Platform for Action and The Millennium Development Goals, paper prepared for the Expert Group Meeting on the achievements, gaps and challenges in linking the implementation of the Beijing Platform for Action and the Millennium Declaration and Millennium Development Goals, Baku, Azerbaijan; Alston, P 2004. A Human Rights Perspective on the Millennium Development Goals, Paper prepared as a contribution to the work of the Millennium Project Task Force on Poverty and Economic Development.

[76] See C Flore-Smereczniak during a Sub-Regional Workshop on MDG-based Planning, Costing and Budgeting for the Ploynesian Countries, Cook Islands 26-29 May 2008. See also, Borghi, Ensor, Somanthian et al 2006; Ronsman and Graham, 2006 as cited in L Reichenbach and MJ Roseman (eds) *Reproductive health and human rights: the way forward* Havard University Press 2009 91.

[77] The Initiative was founded by the AMDD program at Columbia University, USA, CARE, the Centre for Reproductive Rights, Family Care International, Physicians for Human Rights and the former UN Special Rapporteur on the right to the highest attainable standard of health, Paul Hunt.

Rapporteur on the right to the highest attainable standard of health, Paul Hunt had this to say about the IIMMHR:[78]

> This Initiative is unique…never before have such diverse organisations with different perspectives joined together to use human rights in the struggle against maternal mortality. The Initiative reflects the growing maturity of the health and human rights movement. It is an initiative of the twenty first century.

It is therefore clear that several efforts and synergies exist around issues relating to maternal health. A combination of the political and legal mechanisms auger well for a cause such as this. A discussion of the legal developments and obligations follows.

5. INTERNATIONAL LEGAL OBLIGATIONS AND STANDARDS

The World Conference on Human Rights set the pace for *women inclusive* approaches to human rights. The Conference emphasised the position that human rights monitoring bodies should include the status and human rights of women in their deliberations and findings.[79] The Vienna Declaration and Programme of Action, the outcome document of the Conference, the representatives of 171 states publicly recognised that the *mainstream* UN human rights system ignored human rights of women.

The body of rights implicated in the bid to realised women's health in this context are vast. These include; the right to life, the right to the highest attainable standard of health, right to equality, right to freedom from discrimination, right to decide the number and spacing of children, right to be free from cruel, inhuman or degrading treatment, right to privacy, right to education, right to information and the right to enjoy the benefits of scientific progress. These rights are contained in the Universal Declaration of Human Rights (UDHR),[80] and core treaties: the International

[78]Centre for Reproductive Rights website. Available at http://reproductiverights.org/en/initiatives/maternal-mortality. Accessed 13 November 2009.

[79] Vienna Declaration and Programme of Action, UN doc. A/CONF.157/23; See also, FC Leeuwen, 'A Woman's Right to Decide? The United Nations Human Rights Committee, Human Rights of Women, and Matters of Human Reproduction' (2007) 25 *Netherlands Quarterly of Human Rights* 101.

[80] Adopted 1948.

Convention on the Elimination of All Forms of Racial Discrimination (CERD),[81] the International Covenant on Economic, Social, and Cultural Rights (CESCR),[82] the International Covenant on Civil and Political Rights,[83] the International Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW),[84] Convention against Torture and Other Cruel, Inhuman or Degrading Treatment (CAT),[85] the Convention on the Rights of the Child (CRC), [86] the Convention on the Protection of Migrant Workers and their Families (CMW) [87] and Convention on the Rights of Persons with Disabilities (CRPD). [88]

Some of the above treaties have bodies which are charged with the responsibility of monitoring their implementation and to examine state reports in public sessions. These include, *inter alia*, the Committee on Economic, Social and Cultural Rights (CESCR Committee), the Committee on the Elimination of discrimination against Women (CEDAW Committee), the Committee on the Rights of the Child (CRC Committee) and the Human Rights Committee. After a consideration of country reports or issues, the different treaty bodies issue General Comments, General Recommendations and Concluding Observations.

The CESCR and CEDAW Committees have respectively have dealt with maternal health.[89] The CESCR provides for the right to the highest attainable standard of health but does not explicitly mention maternal health. Rather, infant mortality is

[81] Adopted 1965.

[82] Adopted 1966.

[83] Adopted 1966.

[84] Adopted 1979.

[85] Adopted 1984.

[86] Adopted 1989.

[87] Adopted 1990.

[88] Adopted 2006.

[89] See the CESCR General Comment 14, para 14 and the CEDAW General Recommendation 24, para…

referred to.[90] The CESCR has however clarified that this treaty obligation must be "understood as requiring measures to improve child and maternal health, sexual and reproductive services, including access to family planning, pre- and post natal care, emergency obstetric services and access to information, as well as to resources necessary to act on that information".[91] The Comment explains that compliance with the right to health requires that "functioning…health care facilities, goods and services" be sufficiently available, accessible, and acceptable.[92]

The CESCR Committee has said:[93]

> The provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child' (Article 12.2 (a)) may be understood as requiring measures to improve child and maternal health, sexual and reproductive health services, including access to family planning, pre- and post-natal care, emergency obstetric services and access to information, as well as to resources necessary to act on that information.

The CEDAW Committee has issued a General Recommendation on women and health which explains that neglect of health care that only women need, such as maternity care, constitutes sex discrimination.[94] The CEDAW Committee has stated:[95]

> States parties should include in their reports how they supply free services where necessary to ensure safe pregnancies, childbirth and post-partum periods for women. Many women are at risk of death or disability from pregnancy-related causes because they lack the funds to obtain or access the necessary services, which include ante-natal, maternity and post-natal services. The Committee notes that it is the duty of States parties to ensure women's right to safe motherhood and emergency obstetric services and they should allocate to these services the maximum extent of available resources

[90] Article 12 (2).

[91] General Comment 14, para 14; See also the CESCR Concluding Observations on Mali and Nigeria.

[92] General Comment 14, para 12.

[93] CESCR General Comment 14, Para 14.

[94] CEDAW General Recommendation 24.

[95] General Recommendation 24, para…

Committee on the Rights of the Child has stated:[96]

> Adolescent girls should have access to information on the harm that early marriages and early pregnancy can cause, and those who become pregnant should have access to health services that are sensitive to their rights and particular needs.

6. WHAT KIND OF SERVICES AND ACTIONS ARE REQUIRED

The right to the highest attainable standard of health entitles women to services in connection with pregnancy and the post-natal period, and to other services and information on sexual and reproductive health. These entitlements encompass the key technical interventions for the prevention of maternal mortality, including access to a skilled birth attendant, emergency obstetric care, education and information on sexual and reproductive health, safe abortion services where not against the law, and other sexual and reproductive health-care services.[97] In many countries, health systems are chronically under-funded and in a state of collapse. Increased expenditure and policies which strengthen health systems and give priority to maternal health are essential for reducing maternal mortality.[98] In order to address some of these injustices, states must focus on improving the following services within their health systems. In this regard, Amnesty International has noted that:[99]

> States' obligations include ensuring reproductive, maternal (prenatal and postnatal) and child health care, guarantee the equitable distribution of health facilities, goods and services; protect the right of access without discrimination; provide appropriate training for health care personnel in relation to these duties and responsibilities; and guarantee the population access to information on major health problems, including the means of preventing and controlling them

[96] CRC General Comment 4, para…

[97] Paul Hunt, 2006 Report to the UN General Assembly.

[98] Paul Hunt, 2006 Report to the UN General Assembly.

[99] S Gruskin 'Maternal Mortality : A Public Health and Human Rights Imperative' Program on International Health and Human Rights Department of Global Health and Population Harvard School of Public Health. Available at www.ccr.org.br/uploads/noticias/Sofia%20Gruskin.ppt. Accessed 12 November 2009.

6.1 Ante – natal care

Skilled care at childbirth is but one element of the continuum of care that is required throughout and following pregnancy.[100] Antenatal care provides opportunities for regular check-ups to assess risks, as well as to screen for and treat conditions that could affect both the woman and her baby.[101] Delivery care ensures that obstetric emergencies are effectively managed. Postpartum care is important for detecting and treating infection and other conditions, including postpartum depression, and for providing advice on family planning. Unfortunately, at present few women receive such continuing care throughout pregnancy, childbirth and the postpartum period.[102] Evidence from several African countries shows a dramatic drop in the coverage of care during the antenatal, delivery and postpartum periods.[103]

According to the WHO, Antenatal care is particularly important because many women have nutritional deficiencies when they begin their pregnancy.[104] Iron deficiency anaemia and deficiencies of vitamin A and iodine are common. It is estimated that almost half of all pregnant women and one third of non-pregnant women worldwide have anaemia, a deficiency that significantly increases the risks to health for both mothers and infants. Maternal deficiencies in micronutrients may also affect the infant's birth weight and chance of survival, and poor vitamin A intake increases the mother's risk of night blindness.[105]

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[100] World Health Organisation, 2009 'Women and Health: today's evidence tomorrow's agenda' WHO, 2009. P 42.

[101] World Health Organisation, 2009 'Women and Health: today's evidence tomorrow's agenda' WHO, 2009. P 42.

[102] World Health Organisation, 2009 'Women and Health: today's evidence tomorrow's agenda' WHO, 2009. P 42.

[103] World Health Organisation, 2009 'Women and Health: today's evidence tomorrow's agenda' WHO, 2009. P 42.

[104] World Health Organisation, 2009 'Women and Health: today's evidence tomorrow's agenda' WHO, 2009. P 42.

[105] World Health Organisation, 2009 'Women and Health: today's evidence tomorrow's agenda' WHO, 2009. P 42.

6.2 Gender-based Violence

Many women report being physically abused during pregnancy.[106] Violence during pregnancy is associated with an increased risk of miscarriage, stillbirth, abortion and low birth weight. Unsafe abortion causes a significant proportion of maternal deaths. Nearly 70 000 women die each year due to the complications of unsafe abortion.[107] Poor women and those affected by crises and conflicts are particularly at risk. Where there are few restrictions on the availability of safe abortion, deaths and illness are dramatically reduced.[108]

6.3. Access to contraceptives

The use of modern contraception has reduced the need for induced abortion,[109] yet young women, especially when they are unmarried, often face difficulty in obtaining contraception and may resort to unsafe abortion. Globally, women of all ages seek abortions but in sub-Saharan Africa, which has the highest burden of ill-health and death from unsafe abortion, one in four unsafe abortions is among adolescents aged 15–19 years.[110] Women's ability to plan the number and timing of the children they bear has greatly reduced the health risks associated with pregnancy and is an important success story. The use of contraception in developing countries rose from 8% in the 1960s to 62% in 2007.[111] Even so, research shows that, for example, in sub-Saharan Africa, one in four women who wish to delay or stop childbearing does

[106] World Health Organisation, 2009 'Women and Health: today's evidence tomorrow's agenda' WHO, 2009. P 42.

[107] World Health Organisation, 2009 'Women and Health: today's evidence tomorrow's agenda' WHO, 2009. P 42.

[108] World Health Organisation, 2009 'Women and Health: today's evidence tomorrow's agenda' WHO, 2009. P 42.

[109] World Health Organisation, 2009 'Women and Health: today's evidence tomorrow's agenda' WHO, 2009. P 43.

[110] World Health Organisation, 2009 'Women and Health: today's evidence tomorrow's agenda' WHO, 2009. P 43.

[111] World Health Organisation, 2009 'Women and Health: today's evidence tomorrow's agenda' WHO, 2009. P 43.

not use any family planning method. Reasons for non-use include poor quality of available services, limited choice of methods, fear or experience of side-effects, and cultural or religious opposition.[112] All these barriers bear traces of gender inequities and inequalities which call for a human rights approach to maternal health. A discussion on the human rights approach follows.

7. THE UTILITY OF A HUMAN RIGHTS APPROACH TO MATERNAL HEALTH: PROGRAMMING AND INTERVENTIONS

The human rights framework imposes on governments the obligation to respect, protect and fulfil human rights, including health. Furthermore, international human rights law allows for a system of formal accountability, advocacy and programming.[113] A human rights approach also relates to designing, implementing, monitoring and evaluating policies and programmes.[114] This feeds into women's right to participate, right to non-discrimination, the right to health in respect of the principles of availability, accessibility, acceptability and quality. It also relates to the ethos of transparency and accountability. These can then be applied to deal the notorious three delays; delay the decision to seek care, delay arrival at a health facility and delay the provision of adequate care.[115]

A human rights approach to reducing maternal mortality has several benefits; it empowers people to advocate for rights related to maternal health, offers civil society a means by which to engage in a constructive dialogue with governments around their responsibility to ensure safe pregnancy and childbirth, places women's equality

[112] World Health Organisation, 2009 'Women and Health: today's evidence tomorrow's agenda' WHO, 2009. P 43.

[113] MJ Roseman 'Bearing Human Rights: Maternal Health and the Promises of ICPD' in L Reichenbach and MJ Roseman (eds) *Reproductive health and human rights: the way forward* Havard University Press 2009 91; Cook 1999, Cook 1998; D Maine and AE Yamin (1999); L Freedman 2002, L Freedman 2001.

[114] RJ Cook and B Dickens *Advancing safe motherhood through human rights.* Geneva: World Health Organization, 2001.

[115] Dealing with the three Delays Model - Thaddeus S, Maine D. Too far to walk: maternal mortality in context. Soc Sci Med 1994;38:1091-1110; Physicians for Human Rights. Deadly Delays: maternal mortality in Peru-A rights-based approach to safe motherhood. Cambridge: PHR, 2007.

and well-being at the center of governmental responses to reproductive rights and health issues, plays a critical role in legitimizing, promoting and enforcing norms, policies and programs that seek to reduce maternal mortality.[116] As noted by WHO:[117]

> The right to life is a fundamental human rights, implying not only the right to protection against arbitrary execution by the state but also the obligations of governments to foster the conditions essential for life and survival. Human rights are universal and must be applied without discrimination on any grounds whatsoever, including sex. For women, human rights include access to services that will ensure safe pregnancy and childbirth.

UNICEF has also noted:[118]

> A human rights-based approach to improving maternal and neonatal health focuses on enhancing health-care provision, addressing gender discrimination and inequities in society through cultural, social and behavioural changes, among other means, and targeting those countries and communities at risk.

7.1 The AMDD example

An illustrious example of a human rights approach is the Averting Maternal Death and Disability Program (AMDD) of Columbia University, USA built on the previous work of Columbia's Prevention of Maternal Mortality Program (1987-1997). It used a rights-based approach without necessarily concerning itself with the formal human rights system. It was inspired by the analysis that most of the obstetric complications that lead to maternal death can neither be predicted not prevented, but that the vast majority of women can be saved through prompt treatment. The AMDD's primary

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[116] IIMMHR. About maternal mortality. yhttp://righttomaternalhealth.org/about-maternal-mortality. Accessed 10 November 2009 quoted in S Gruskin, Program on International Health and Human Rights Department of Global Health and Population Harvard School of Public Health - http://www.hsph.harvard.edu/pihhr/.

[117] WHO/UNFPA/UNICEF/World Bank Joint Statement ,1999.

[118] State of the World's Children 2009. UNICEF. State of the World's Children 2009. http://www.unicef.org/sowc09/. Accessed 10 November 2009; See also, UNFPA 'Putting rights into practice: making motherhood safer. http://www.unfpa.org/rights/motherhood.htm. Accessed10 November 2009.

objective was to upgrade health facilities to address the causes of maternal death and disability, including missing or poor equipment, lack of emergency drugs, insufficient blood supplies, inadequate or inexistent life-saving and other skills, and poor provider attitudes. Its analysis was inspired by rights claims – providing adequate facilities for emergency obstetrical care as a fundamental obligation of governments. The AMDD established refurbished, trained, staffed and provisioned emergency obstetric facilities.[119] As a means of connecting its work to the formal human rights accountability, the health professions were to "use UN process indicators" so that in the end government would "report on progress in implementing international conventions," and the treaty bodies would be equipped to evaluate progress made in understandable and acceptable terms.[120]

7.2 WHO – Harvard Project example

Another example of the human rights example originated with WHO in conjunction with the Program on International Health and Human Rights at the Harvard School of Public Health entitled "Using Human Rights for Maternal and Neonatal Health: A Tool for Strengthening Law, Policies and Standards of Care".[121] Its objective is to assists governments in meeting their human rights obligations related to maternal health. Governments are the principal recipients of the policy although civil society and other stakeholders participate in the assessment process. [122] The tool is divided into two parts: a data collection instrument and a process that incorporates human rights principles and analysis. The data collection component uses human rights and internationally agreed upon conference targets as laid out by the ICPD, to frame the collection of information. The tool was pilot tested in Mozambique, Brazil and Indonesia between 2003 and 2006. In Indonesia, researchers found that

[119] MJ Roseman 'Bearing Human Rights: Maternal Health and the Promises of ICPD' in L Reichenbach and MJ Roseman (eds) *Reproductive health and human rights: the way forward* Havard University Press 2009 102.

[120] MJ Roseman 'Bearing Human Rights: Maternal Health and the Promises of ICPD' in L Reichenbach and MJ Roseman (eds) *Reproductive health and human rights: the way forward* Havard University Press 2009 102.

[121] WHO Program on International Health and Human Rights, 2001 – see Roseman, p 102.

[122] Roseman, 103.

discrimination on the basis of marital status kept adolescents and single women away from information and care. The tool then mapped poor reproductive health indicators in those populations to this discriminatory regulation. This was then used to propose legal and policy reform to remove married status as a condition for reproductive health services.[123]

The above two examples provide insight into what South Africa and other African countries can consider in order to entrench maternal health as a human rights issue requiring measures that utilise rights as tool of action. Within the African continent, the above two models may face the challenges of funding and professionals to carry out the research described above and to engage with governments in the manner described above. Nevertheless, the fact that the WHO-Harvard model is currently being piloted in Mozambique, a sub Saharan country, presents an opportunity to see how it will work within our context. The Mozambique pilot program is currently under analysis.[124]

7.3 Accountability

A key component of the human rights approach is how it addresses accountability. A recent United Nations' publication makes the point that 'the *raison d'etre* of the rights-based approach is accountability. [125] Further, the recently formed International Initiative on Maternal Mortality and Human Rights (IIMMHR) argues for a rights-based approach to safe motherhood on the basis that it "ensures that we can hold governments and others to account for their policies, programs, projects and pledges to reduce maternal mortality." [126] In this regard, Potts categorises accountability in the several forms of administrative accountability, professional accountability, financial accountability, social accountability, political accountability and legal

[123] Gruskin et al, 2006 as cited in Roseman, 103.

[124] Roseman 103.

[125] M Langford, *Claiming the Millennium Development Goals: A Human Rights Approach* (New York: United Nations, 2008), p15.

[126] See "Mission Statement," International Initiative on Maternal Mortality and Human Rights. Available at ….Accessed 11 November 2009; See also, AE Yamin 'Beyond compassion: The central role of accountability in applying a human rights framework to health' *Health and Human Rights* p

accountability. [127] Thus, Yamin argues that impunity is a greater problem in the area of Economic, Social and Cultural rights in that most errors in the health system are rooted in institutional and systemic defects. [128] She argues that a human rights perspective should not focus on, for example, a medical malpractice *per se*[129] , but on the system that condones wanton disregard for patients' well being. Within the South African context, for example, there have been anecdotal reports of women abandoning mothers seeking antenatal and obstetric care. Yamin argues that if such a health professional is summarily dismissed or reassigned, without any procedure to discern whether they were, in fact, responsible for death, such unwritten policies create perverse incentives for health professionals to avoid dealing with obstetric emergencies , both as individuals and institutions.[130] Here, the author makes the point that such action diverts attention from the systemic institutional problems that led to the woman's death. For example, that the health facility may lack the necessary medicines and supplies. This is supported by London's assertion that:[131]

> Frontline health workers are frequently unable to provide adequate access to care because of systemic factors outside their control and because of management systems that disempower them from acting independently and effectively.

This argument is relevant in South Africa and most of Africa's health systems where nurses, midwives and other health care providers are under resourced, under paid, unmotivated and excluded from decision making procedures. In such a scenario, simply laying the blame at the foot of a professional does not deal with the underlying issues of lack training and poor budget allocation for example. It also ignores the fact that women are at the frontlines of health care provision and yet are rarely represented in executive or management -level positions, tending to be

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[127] H Potts *Accountability and the Highest Attainable Standard of Health* (Colchester, UK: University of Essex/Open Institute, 2008), p5 as quoted in AE Yamin 'Beyond compassion: The central role of accountability in applying a human rights framework to health' *Health and Human Rights* p

[128] Yamin, above.

[129] Yamin, above.

[130] Yamin.

[131] L London 'What is a Human-Rights Based Approach to Health and Does it Matter?' as quoted in Yamin above.

concentrated in lower-paid jobs. As health care providers therefore, Margaret Chan stated that 'women are often unsupported, unrecognized and unremunerated'.[132] There is therefore a need to pay attention to the health care providers if a human rights approach through accountability is to work in improving maternal health care.

Furthermore, accountability in the context of maternal health care extends to the provision of *appropriate* services. In this regard, the CEDAW Committee has called upon states to report on the measures they have adopted "to ensure that women *appropriate* services in connection with pregnancy, confinement and post- natal period". [133] The CESRC Committee has made the same call.[134] Thus, to be appropriate, services to address maternal mortality should emerge from best evidence in clinical medicine and public health.[135] For instance, changing understandings of the epidemiology or pathology of a particular condition.[136] In South Africa and most of sub Saharan Africa, for example, in light of the escalation of HIV and AIDS related maternal deaths, the provision of Anti-retroviral drugs (ARVs) requires a treatment that addressees both the HIV and AIDS and the condition of pregnancy. This is because merely providing ARVs without taking into account this new development, renders the service inappropriate.

8. THE CAPABILITIES APPROACH: THE WAY FORWARD

It is clear from the preceding discussion that dealing with the issue of maternal deaths entails the removal of political, economic, social and cultural barriers standing in the way of maternal health (and women's health generally). Inevitably, the capabilities approach will have to be employed. The capabilities approach as propounded by Amartya Sen has evolved as the leading alternative to standard economic frameworks for thinking about poverty, inequality and human

[132] Margaret Chan, Director General, World Health Organisation in Forward to 'Women and Health: today's evidence tomorrow's agenda' WHO, 2009.

[133] General Recommendation 24, para 26.

[134] General Comment 14, para …

[135] Yamin, as above.

[136] Yamin, as above.

development.[137] The capabilities approach was also later developed in relation to women's development and philosophy by Martha Nussbaum. [138]

Within the context of improving women's access to maternal health care, the capabilities framework provides an important analytical approach for addressing gender inequality. The approach allows the analysis of 'what is a woman able to do and to be' on multiple levels. It has already been shown that a poor woman's health and well-being depends not only on their economic income and access to medical services but on many other elements as shown above. Hence, the approach is viewed in light of substantive equality thereby going beyond the traditional legal framework of formal equality that merely seeks to treat likes alike. Substantive equality therefore goes to the root of the matter, seeking to eliminate deep-seated barriers as orchestrated and sustained by historical, cultural and socio-economic factors. Hence, the centrality of the capabilities approach is that it looks at what is needed to enable poor women to function fully within society and family. The approach provides a benchmark to reflect upon the complex links among different areas in a women's life that can secure health and well being for women in the context of poor maternal health care. The approach advocates for changing women's

[137] A Sen (1980) 'Equality of What' in Sterling M McMurrin (ed), *The Tanner Lectures on Human Value*, Salt Lake City: University of Utah Press, pp 195-220; A Sen (1984) *Resources, Values and Development*, Oxford: Basil Blackwell; A Sen (1985) *Commodities and Capabilities*, Oxford: Elsevier Science Publishers ; A Sen (1987) *The Standard of Living : The Tanner Lectures*, Cambridge: Cambridge University Press; A Sen (1992) *Inequality Re-examined*, Oxford: Clarendon Press and A Sen (1999) *Development as Freedom*, Oxford: Oxford University Press.

[138] MC Nussbaum, (1988) Nature, Function and Capability: Aristotle on Political Distribution., *Oxford Studies in Ancient Philosophy*, Supl. Vol., 145.84; MC Nussbaum (1990) Aristotelian Social Democracy in B Douglas, G Mara & H Richardson (eds), *Liberalism and the Good*, New York: Routledge, pp. 203.52.; MC Nussbaum (1995)Human Capabilities, Female Human Beings in MC Nussbaum & J Glover (eds), *Women, Culture and Development*, Oxford: Clarendon Press, pp. 61.104; MC Nussbaum (2000), *Women and Human Development: the Capabilities Approach*, Cambridge: Cambridge University Press; MC Nussbaum (2003) Capabilities as Fundamental Entitlement: Sen and Social Justice., *Feminist Economics*, 9(2-3), 33-59; MC Nussbaum (2005a) Well-Being, Contracts and Capabilities in L Manderson (ed) *Rethinking Well-Being*, Perth: API Network, pp.27-44; MC Nussbaum (2005b) Women.s Bodies: Violence, Security, Capabilities., *Journal of Human Development*, 6(2), 167-83; MC Nussbaum & G Jonathan (eds) (1995), *Women, Culture and Development*, Oxford: Clarendon Press; MC Nussbaum & A Sen (1989) Internal Criticism and Indian Rationalist Traditions in M Krausz (ed) *Relativism, Interpretation and Confrontation*, South Bend: University of Notre Dame Press, pp. 299.325; MC Nussbaum & A Sen(eds) (1993), *The Quality of Life*, Oxford:Clarendon Press.

conditions of vulnerability and creating an enabling environment as succinctly out by Nussbaum:[139]

> people committed to the capabilities approach need to be 'working in the right place and looking at the right thing…we need to rely on the ingenuity of those who suffer from deprivation to help us find ways to describe their predicament

Within the above context, Nussbaum lists elements of what she calls combined capabilities for poor women as: Life; Bodily Health; Bodily Integrity; senses, Imagination and Thought; Emotions; Practical Reason; Affiliation; Other Species; Play and Political and Material Control over one's Environment. It is then argued that women's well-being is only possible if all conditions of combined capabilities are met, within themselves, the family, the community and the larger environment.[140] I argue that within the context of poor maternal health care, the state should undertake to create enabling environments for women to see the combination of these capabilities. This includes dealing with access to health care services and other ills like gender-based violence.

On the above basis, the state should employ its resources to enable women, *inter alia*; access to information, access to family planning, access to pre- and post-natal care , measures to help women prevent unwanted pregnancies, access to emergency obstetric services when needed, adolescents who become pregnant should have access to health services that are sensitive to their rights and particular needs, resources necessary to access necessary services should be made available to the maximum extent of available resources, disaggregated data on pregnancy- and childbirth-related deaths of women should be made available. Furthermore, gender-disaggregated data should be provided on infant mortality rates. In essence,

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[139] MC Nussbaum 2001:28 (M Nussbaum (2000) 'Women's Capabilities and Social Justice', *Working Paper for Beijing +5 Review*, Geneva: United National Research Institute for Social Development as quoted in W Harcourt (2001) The capabilities approach for poor women: empowering strategies towards gender equality, health and well-being 'The Capabilities Approach for Poor Women: empowerment strategies towards gender equality, health and well-being'. Available at http://www.hdca.org. Accessed 11 November 2009.

[140] W Harcourt (2001) The capabilities approach for poor women: empowering strategies towards gender equality, health and well-being 'The Capabilities Approach for Poor Women: empowerment strategies towards gender equality, health and well-being' in Justice and Poverty: Examining Sen's Capability Approach available at http://www.hdca.org.

the state should pay attention to the four core elements of health as enunciated by the CESR Committee: availability, accessibility, acceptance and quality.[141]

9. CONCLUSION

Beneath the death of women due to pregnancy and child birth, lies the 'epidemic of inequity and inequality in health'. Thus, the right to health should be the crux of the human rights response to maternal mortality. Governments should not treat human rights and accountability as mere moral calls but as legal imperatives. The human rights approach offers a common language that many understand and can relate to in achieving equality and dignity for women. There is no short cut to this. The human rights imperative should be augmented by the capabilities approach as a tool of political significance which seeks to turn around approaches to women's well being and health as a major step to achieving gender equality and social justice in dealing with maternal mortality and women's health generally.

This paper has highlighted the severity of maternal mortality globally and in South Africa. The paper has emphasized that to improve maternal health, states, especially sub Saharan and Asian, must fulfil their treaty obligations on the right to the highest attainable standard of health as encapsulated in the instruments and consensus documents discussed. The paper argued for a human rights approach to maternal health especially in the provision of goods and services relating to sexual and reproductive health. The paper suggested reliance on the capabilities approach to argue that actions have to be taken to deal with political, economic, social and cultural barriers that women face in accessing the interventions that can prevent maternal mortality. Further, the paper argues that accountability is key to the human rights approach and that it should it requires participation by health professionals in order to deal with structural and systemic barriers in health systems. The paper has recommended the areas of concern in which women's capabilities should be harnessed. Women count, should be counted and maternal health should be accounted for. To let a woman die is to fail.

[141] See General Comment 14, para 12.