

**The Helen Kanzira  
Memorial Lectures**

31st March, 2016  
At the Faculty of Law,  
University of Ghana, Legon

**Protecting Women's  
Reproductive Rights in Africa:  
A Moral or Legal Obligation**

**Delivered by Ms. Bernice Sam**  
Lawyer and Gender Advocate

Hosted by: University of Pretoria & University of Ghana

## **Abstract**

Protecting women's reproductive rights has engaged the international policy arena for many years. A number of international and regional legal frameworks and agreements require States to put in place all measures to make pregnancy and childbirth safe for women. The paper discusses these normative frameworks within the African socio-cultural setting which, despite the many customs around adulthood and procreation, apparently accepts death from preventable pregnancy-related complications and child birth without challenging the status quo. It discusses the causes of maternal death drawing from the grim global statistics particularly in Sub-Saharan Africa which is aptly described as '*the riskiest region to become pregnant*'. While progress was made towards achieving the MDG 5 target of reducing maternal mortality by three-quarters, 830 women die every day from complications in pregnancy and child birth. To change this, it is time for a paradigm shift in the provision of health services, and a shift in the way of thinking and behaviour of society. The paper concludes that women's reproductive health is as much a moral obligation for the pregnant woman, partner, family and society as it is a legal obligation of the State.

**The Vice Chancellor of the University of Ghana, Professor Ernest Aryeetey**

**The Provost, School of Humanities, Professor Agyei**

**The Dean of the School of Law, Professor Kofi Quashigah**

**Members of the School of Law**

**The Director, Centre for Human Rights, University of Pretoria, Professor Frans Viljoen**

**Members of the donor and NGO communities**

**Alumnae, Students**

**Ladies and Gentlemen**

I am humbled by the invitation to give this year's public lecture in honour of an illustrious woman and advocate Helen Kanzira. I learned a lot in researching for this paper, and I have no doubt that you will also have some useful take-aways. Reproductive health and rights is a broad topic; for the sake of this presentation, my focus will be on pregnancy and childbirth.

**A. Our stories**

1. A Kenyan proverb says *“Every woman who gives birth has one foot in her grave”*. Sadly this statement, which should have reflected history, is rather manifesting in present day lives. In Africa, death arising from pregnancy-related complications is not a respecter of status. A doctor in Accra went through a difficult pregnancy and birth. She lost her life following delivery. Naana, a 14-year old from Central Region, died giving birth to her first child. So did Helen Kanzira. These women and teenager with different socio-demographic characteristics have one thing in common – they wanted to give life but lost their lives!
2. I am lucky to be alive. I have three children. Researching for this lecture brought back memories from the past, some of which I have deliberately forgotten. Two litanies won't leave my mind. With my first pregnancy, I retained the placenta (afterbirth) which the doctor could not remove manually eventually landing me in the operating theatre. I lost a lot of blood before and after the surgery. A week after delivery, I was back in the theatre from complications arising from the surgery. I kept asking myself “Am I going to die, will I die?”
3. “Please God help my baby” “Please God help my baby” These were my words when I delivered my second child. My family was asked to donate some blood, just in case I needed it. I attended antenatal clinic for six months yet the medical personnel did not identify, from the several ultra-scan examinations, that I was carrying a breech foetus. My family had to comb half of the city of Accra to find a particular medicine to induce labour. By the time they arrived with the medicine, the foetus and I were distressed. I

vividly recollect when the midwife said “*Bernice push*”; I could not push. I lost consciousness, then regained consciousness and gave that push my all. I gave life, but my son struggled to remain alive.

4. I have no litany for my third delivery. I was highly inquisitive, eager to experience birth in a developed country; and I was not disappointed. I looked forward to the choices I had in determining my birthing method and indeed the race of the doctor to deliver my child. I could lie in a Jacuzzi during contractions, had a coach to rub my lower back when I had contractions, and yes there were equipment and tools in the delivery room for a normal birth or an emergency. Doctors, nurses and anesthesiologists were on hand; they literally doted on me. I was not afraid of dying.
5. Where I delivered my children matters because the first and second were public and private hospitals in Ghana, and the third a public institution in the United State of America. I lay emphasis on these institutions because they make a difference in the care that women receive.

#### B. Culture /Religion and women’s reproductive rights

6. Cultural and religious attitudes value women according to their ability to have children. Irrespective of how enlightened society has become, African societies do not tolerate childlessness.
7. Rites of passage for both males and females in African societies include among other things teaching the pubescent about marriage, sex and procreation. Among the Twa of the Great Lakes region of Central Africa, menstruating girls participate in the ‘*Elima*’ rites in which the girl is isolated to receive instructions about marriage and motherhood. The Anlo-Ewe of Ghana has the *Nugbeto* rites which also teach girls about womanhood. The Krobos also of Ghana have the ‘*dipo*’ rites to outdoor girls at puberty who are also taught about pregnancy and motherhood. The Maasai of Kenya have the ‘*Eunoto*’ ceremony which marks the end of a carefree life to one of responsibility.<sup>1</sup> And lastly, the Hamar people of South Western Ethiopia take their boys through the “*Jumping of the Bull*” ceremony to be ushered into manhood. All of these rites de passage emphasise marriage and children presuming that every married couple must produce children to continue the family name of the man. This kind of socialization fuels intolerance by the husband, the in-laws and communities of childless women.
8. Women who cannot have children are given labels. Some call them barren, the Fantis of Ghana call them ‘*saadwe*’ as if to say that aside motherhood a woman is not of much value. On February 1<sup>st</sup>, 2016, Peacefmonline.com reported that Ghana’s female comedian, Afia Schwarzenegger, called Delay Frimpong Manso a barren woman. In fact, the report says she posted the following on a blog “...*Before you discuss me and my brothers please try and be **useful** by attempting pregnancy!!!! Barrens don’t talk against*

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<sup>1</sup> [www.maasai-association.org/ceremonies.thml](http://www.maasai-association.org/ceremonies.thml)

*fruitful women and their children...that is termed jealousy...”<sup>2</sup> Another writer puts it thus, “a barren woman is no woman, she is no human. She is but an object that must be replaced for the family name to survive”.<sup>3</sup>*

9. It does not matter a woman’s intellectual abilities, or her status in society, her inability to have a child extends to the presumption that she cannot take a leadership position. It is not uncommon during political seasons for voters to assess whether a female candidate is married, and has children.
10. To avoid stigmatisation, women’s health is often endangered through sometimes desperate measures to have children. Women congregate at prayer camps and shrines seeking spiritual support to become pregnant. For those who can afford it, fertility clinics become their abode spending huge amounts of money undergoing procedures such as hormone injections, laparoscopic surgery, and removal of fibroids among others all in a bid to have children. Not surprisingly, there is proliferation of prayer camps and fertility clinics in Ghana, and I am sure in other parts of Africa. I read about a church in Ghana which organised a three-day prayer session under the theme ‘1000 babies’.
11. In other instances, there are repeated and often inadequately spaced pregnancies premised on the need to have a male child or that the husband wants a certain number of children. I daresay that women play God by giving life to new generations, but don’t determine whether a foetus should be an Adam or Eve! For some women, not having children is double jeopardy because they are also cast out of their marriages.
12. Codes of chastity about women’s sexuality deny women a right to a satisfying sexual life. Not only that, their sexuality is subordinated to that of men through customary practices like female genital mutilation or acts of bravery that leads to maternal deaths. Due to the power relations between men and women, the latter is often unable to refuse or negotiate safe sex which puts them at risk of contracting sexually transmitted diseases and having unwanted pregnancies. In 2013, an award winning documentary by the TV 3 Journalist Afua Acquah-Harrison shows Tadaale who lives in a hut in a Konkomba community in Northern Ghana who almost died from having her ninth child. For many women in this part of the country, enduring excruciating pain to deliver at home is a mark of bravery, or proof to the in-laws that a wife has remained faithful in her marriage.
13. A scoping study by Ai, a UK- based group in five African countries found that despite high level of priority at international policy level, maternal and neonatal survival is not part of popular conversation but rather limited to the private space.<sup>4</sup> The report further found that maternal death was considered normal, an act of God. If this is the way some parts of society perceive death then this annual public lecture is apt in jogging our thoughts not to accept maternal deaths.

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<sup>2</sup> Showbiz.peacefmonline.com/pages/news/201602/268630.php?storyid=100&

<sup>3</sup> [www.nairaland.com/2576478/plight-barren-woman-africa](http://www.nairaland.com/2576478/plight-barren-woman-africa)

<sup>4</sup> <http://advocacyinternational.co.uk/advocacy/engaging-the-african-public-in-maternal-and-newborn-survival>

### C. Data on Maternal Deaths

14. An ancient African proverb says ***“Giving birth is like crossing a narrow bridge. You can walk to the bridge with someone. You can have someone meet you at the other side. But you have to cross the bridge alone”***. Thousands of women die crossing that bridge.
15. Statistics on maternal deaths are shocking. The World Health Organization (WHO) reports that despite a gradual decrease in maternal deaths globally from 532,000 in 1990 to 303,000 in 2015 (43%), every day 830 women die from complications of pregnancy and child birth. 99% of this number occurs in developing countries. Sub-Saharan Africa and South Asia account for 88% of maternal deaths worldwide. Sub-Saharan Africa accounts for two thirds (66 per cent) of all maternal deaths per year worldwide.<sup>5</sup>
16. In 2015, Ghana had 319 deaths per 100,000 live births. Sierra Leone had a MMR of 1,360 deaths per 100,000 live births. In Nigeria, MMR is 814, in Liberia it is 725. In the Democratic Republic of Congo it is 693, in Eriteria 501 and in Uganda it is 343. Still in Africa - Morocco MMR is 121, Algeria 140, Egypt 33, Libya 9 and Tunisia 62.<sup>6</sup> For every woman who dies, approximately 20 others suffer serious injuries, infections and disabilities.
17. ***“Sub-Saharan Africa is still the riskiest region in the world for dying of complications in pregnancy and childbirth”***.<sup>7</sup> The Special Rapporteur on Rights of Women in Africa, Ms. Soyata Maiga, confirmed this fact when she reported at the 52<sup>nd</sup> Session of the African Commission on Human Rights in 2012 that *‘the maternal death rate related to pregnancy and childbirth in Africa is still one of the highest in the world despite the adoption of legislation and corrective measures to protect the lives of women’*.<sup>8</sup>
18. Like the case of Tadaale, the Konkomba woman, maternal mortality is higher in women living in rural and among poorer communities. Like Naana, young adolescents face a high risk of complications and death from pregnancy than older women.

*“A 15 year-old girl living in Sub-Saharan Africa faces a one in 40 risk of dying during pregnancy and childbirth during her lifetime. A girl of the same age living in Europe has a lifetime risk of one in 3,300”*. Geeta Rao Gupta, Deputy Executive Director, UNICEF.

Specifically, in Sweden, the lifetime risk of dying from complications of pregnancy and childbirth is much lower at one in 17 400<sup>9</sup>

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<sup>5</sup> <http://data.unicef.org/maternal-health/maternal-mortality.html#stjasi/JDCq61xA.dpuf>

<sup>6</sup> [www.who.int/gho/maternal\\_health/countries/en/](http://www.who.int/gho/maternal_health/countries/en/)

<sup>7</sup> Ludovicia Iaccino <http://www.ibtimes.co.uk/top-five-countries-highest-rates-maternal-mortality-1447398>

<sup>8</sup> Para 55 of the Report of Ms. Soyata Maiga, Special Rapporteur for on the Rights of Women in Africa at the 52<sup>nd</sup> Ordinary Session of the African Commission on Human and Peoples Rights, Cote D’Ivoire, October 2012

<sup>9</sup> [http://www.who-int/maternal\\_child\\_adolescent/news\\_events/events/2008/mdg5/article/en](http://www.who-int/maternal_child_adolescent/news_events/events/2008/mdg5/article/en)

## D. Causes of maternal deaths

19. The causes of maternal deaths are well known.

- a. Haemorrhaging is still the leading cause of maternal death accounting for 27% of deaths. This means in addition to pregnant women eating iron rich foods and taking iron supplements during pregnancy, there should be blood available at blood banks across hospitals. Yet, year in year out, hospitals do not have enough blood. In Ghana churches, corporate and media houses organise blood donation campaigns to help stock blood banks.
- b. Hypertensive disorders in pregnancy (including eclampsia - a condition in which one or more convulsions occur in a pregnant woman suffering from high blood pressure, often followed by coma; sepsis- an infection that usually develops within six weeks of delivery. It is sometimes called blood poisoning which can lead to tissue damage, organ failure and death; and embolism which is rare but occurs when amniotic fluid – the fluid that surrounds a baby in the uterus during pregnancy – enters the mother’s blood stream). Let us note that these complications can occur without warning at any time during pregnancy and childbirth. On 6<sup>th</sup> March 2016, a doctor friend recounted how a healthy-looking woman in labour held on to a nurse shouting “*Nurse bi bi yE me*” (meaning something is happening to me) and within minutes she was dead leaving behind a distraught husband and son. Cause of death – embolism!
- c. Unsafe abortions account for thousands of deaths particularly among young women and adolescents. WHO reports that each year about 22 million unsafe abortions occur worldwide; almost all in developing countries. In 2008, there were 47,000 deaths due to unsafe abortions. In developing countries, 5 million women are admitted to hospitals as a result of unsafe abortions while 3 million women who have complications following unsafe abortions do not receive care.<sup>10</sup> Poor women are more likely to have an unsafe abortion than affluent women.
- d. Civil strife and war are in themselves difficult contexts due to disruption of basic social services. This is worse for pregnant women who are unable to access the required care, even if those were available. It is therefore not surprising that countries in conflict in Sub-Saharan Africa record the highest maternal deaths. In 2015, Chad had 856 deaths and Democratic Republic of Congo 693.
- e. HIV/AIDS contributes to high maternal deaths in Africa. In 2013, of the 7,500 AIDS- related maternal deaths, 6,800 (91%) were in Sub-Saharan Africa. WHO reports that 41.4% of HIV-related global deaths were in South Africa alone.

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<sup>10</sup> [www.who.int/mediacentre/factsheet/fs388/en/](http://www.who.int/mediacentre/factsheet/fs388/en/)

## E. The Normative Framework

20. Both binding and non-binding international frameworks place emphasis on protecting women's reproductive rights. Permit me to mention a few.
21. The UN Convention on the Elimination of all Forms of Discrimination against Women (CEDAW)<sup>11</sup> requires States to pursue a policy of eliminating discrimination in all its forms. CEDAW defines discrimination broadly as

*'any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women irrespective of their marital status, on a basis of equality of men and women of human rights and fundamental freedoms in the political, economic, social, cultural, civil and any other field'.*

Article 12 (1) places an obligation on State Parties *'to take all appropriate measures to eliminate discrimination against women in the field of healthcare in order to ensure on a basis of equality of men and women, access to healthcare services, including those related to family planning.'*

It further stipulates (2) that State Parties *'should ensure to women appropriate services in connection with pregnancy, confinements, the post-natal period, granting free services where necessary as well as adequate nutrition during pregnancy and lactation'*. (Emphasis mine)

What is interesting is that the CEDAW Committee has noted that discrimination under the Convention is not restricted to actions by or on behalf of the State. This means that States may be responsible for acts of discrimination perpetrated in the private sphere by non-governmental actors including health care providers.

22. The International Conference on Population and Development (ICPD, 1994) presented a comprehensive set of mortality-reduction goals, calling particular attention to the need to reduce infant, child and maternal mortality.
23. The Millennium Development Goal 5 required States to commit to improving maternal health by reducing maternal mortality by three-quarters (MDG5a) and achieving universal access to reproductive health by 2015 (MDG5b). During the 15-year time frame, several policy measures, programmes and resources were dedicated to this goal. Yet, despite these efforts, MDG 5a was missed. Presently, the Sustainable Development Goals set a target to reduce global maternal mortality ratio to less than 70 deaths per 100,000 live births between 2016 and 2030.

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<sup>11</sup> UN Convention on the Elimination of all Forms of Discrimination against Women, 1975

24. At the continental level, the Protocol to the African Charter on the Rights of Women (Maputo Protocol)<sup>12</sup> provides under Article 14 that

*(1) State Parties shall ensure that the right to health of women including sexual and reproductive health is respected and promoted. This includes: (a) the right to control fertility; (b) the right to decide whether to have children, the number of children and spacing of children; (c) the right to choose any method of contraception; (d) the right to self-protection and to be protected against sexually transmitted infections including HIV/AIDS; (e) the right to be informed of one's health status and on the health status of one's partner, particularly if infected with sexually transmitted infections, including HIV/AIDS in accordance with internationally recognised standards and best practices; (f) the right to family planning education.*

*(2) State Parties shall take all appropriate measures to (a) provide adequate, affordable and accessible health services, including information, education and communication programmes to women especially those in rural areas; (b) establish and strengthen existing prenatal, delivery and postnatal health and nutritional services for women during pregnancy and while they are breastfeeding; (c) protect the reproductive rights of women by authorizing medical abortion in cases of sexual assault, rape and incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus.*

25. To further demonstrate its commitments, the African Union (AU) had a Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA) in 2009 which aimed at achieving universal access to comprehensive Sexual and Reproductive Health Rights in Africa by 2015. Subsequently, the AU launched the Decade for Women (2011-2020) which emphasised women's health and maternal mortality to galvanise concerted efforts by Member States to improve their maternal mortality rates.

26. Furthermore, there are regional frameworks that support the campaign to reduce maternal deaths. One of the policy commitments in the South African Development Community (SADC) Gender Policy under Article 4.9 is that

*'SADC Member States shall promote equality of access to and control over health care services in order to accord women as well as men their rights to physical, social and mental health'. In this regard, States are to promote programmes aimed at **reducing infant and maternal mortality** including the establishment of gender responsive and easily accessible clinics'. (Emphasis mine)*

27. A 2013 draft proposal for an ECOWAS Protocol on Equality of Rights Between Women and Men for Sustainable Development<sup>13</sup> states under Article 12 that

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<sup>12</sup> Protocol to the African Charter on Human and Peoples Rights on the Rights of Women in Africa, 2004

<sup>13</sup> <http://campagneprotocole.files.wordpress.com/2013/02/draft-proposal-for-ecowas-protocol-on-ewm.pdf>

*‘State Partners shall ... in accordance with provisions contained in regional and international legal instruments regarding health, adopt and implement legislative frameworks, policies, programmes and services to provide appropriate and affordable gender-sensitive health services to (a) considerably reduce maternal mortality rates (b) develop and implement policies and programmes to address mental, reproductive and other health needs of women and men’.*

#### **F. National Policy Frameworks**

28. These international and regional frameworks are reflected in national laws, policies and programmes. In Ghana, the 1992 Constitution of Ghana provides that *‘special care shall be accorded to mothers during a reasonable period before and after child-birth; and during those periods, working mothers shall be accorded paid leave’* (Article 27 (1)).
29. The Health Sector Gender Policy (2009) acknowledges the fact that men and women are different in terms of their health care needs and their diseases and epidemiology. The Goal of the policy is to contribute to better health for both women and men, through health researches, policies and programmes which give due attention to gender considerations and promote equity and equality between men and women.
30. Still in Ghana, the National Health Insurance Law (NHIL) and National Health Insurance Scheme (NHIS) ensure pregnant women receive free maternal health care including safe delivery. Similarly, babies get free post-natal care up to three months. Many health facilities are being upgraded. Other policies are the National Reproductive Health Sector Policy and Standards (2003) to make among other things reproductive health services accessible and affordable. An Adolescent Reproductive Health Policy in 2000 requires health agencies to provide information on adolescent sexuality for adolescents, and promote policies that enhance the development and implementation of adolescent sexual and reproductive health programmes. It also calls on health agencies to provide quality sexual and reproductive health services for adolescents. Others are the Safe Motherhood Campaign, 2002 and Post Abortion Care programme and strategy in 2003.

#### **G. Case law**

31. Judicial bodies have forayed into pronouncing State complicity in maternal deaths occurring in a public or private health facility. Permit me to give the facts and decisions of two cases to illustrate this point.
32. In the 2011 Brazilian case of Alyne da Silva Pimental Teixeira, the CEDAW Committee found that Brazil had failed to ensure that Alyne received appropriate services in connection with her pregnancy, in violation of article 12(2) of CEDAW. Recalling its General Recommendation No 24, the Committee affirmed that *“it is the duty of States*

*parties to ensure women's right to safe motherhood and emergency obstetric services, and to allocate to these services the maximum extent of available resources".*

The CEDAW Committee expressly noted that State Parties to CEDAW are obligated to ensure women have access to timely, non-discriminatory, and appropriate maternal health services, **irrespective of whether services are provided by public institutions or are outsourced to private institutions**. The Committee explained that *"the State is directly responsible for the action of private institutions when it outsources its medical services, and that furthermore, the State always maintains a duty to regulate and monitor private health-care institutions"*.

**Alyne da Silva Pimentel Teixeira (deceased) v Brazil, CEDAW, UN Doc CEDAW/C/49/D/17/2008 (10 August 2011)**

**Failure to prevent avoidable maternal death violates rights to life, health and non-discrimination**

### **Summary**

The UN Committee on the Elimination of Discrimination against Women has found that Brazil's failure to prevent the avoidable maternal death of Alyne da Silva, a 28-year-old Brazilian woman of African descent, violated articles 2 and 12 of the *Convention on the Elimination of All Forms of Discrimination against Women* (CEDAW), in conjunction with article 1. The Committee's landmark decision is the first maternal mortality case decided by a UN treaty body.

### **Facts**

Alyne da Silva was six months pregnant with her second child when she died of complications after her local healthcare centre misdiagnosed her symptoms and delayed emergency obstetric care. The deceased's mother, Maria de Lourdes da Silva Pimentel, submitted a communication to the CEDAW Committee claiming that Brazil's failure to ensure appropriate medical treatment in connection with her daughter's pregnancy and subsequent failure to provide timely emergency obstetric care, constituted a violation of the rights to non-discrimination, life and health in articles 1, 2 and 12 of CEDAW.

### **Decision**

#### ***Access to adequate maternal healthcare***

After determining that the death of Alyne da Silva was 'maternal' (i.e., resulting from obstetric complications related to pregnancy), the CEDAW Committee found that Brazil had failed to ensure that she received appropriate services in connection with her pregnancy, in violation of article 12(2) of CEDAW. Recalling its General Recommendation No 24, the Committee affirmed that "it is the duty of States parties to ensure women's right to safe motherhood and emergency obstetric services, and to allocate to these services the maximum extent of available resources".

It further affirmed that “measures to eliminate discrimination against women are considered to be inappropriate in a health-care system which lacks services to prevent, detect and treat illnesses specific to women”.

#### ***State responsibility for healthcare services provided by private institutions***

The CEDAW Committee expressly noted in its views that States Parties to CEDAW are obligated to ensure women have access to timely, non-discriminatory, and appropriate maternal health services, irrespective of whether services are provided by public institutions or are outsourced to private institutions. The Committee explained that “the State is directly responsible for the action of private institutions when it outsources its medical services, and that furthermore, the State always maintains a duty to regulate and monitor private health-care institutions”. Applying the due diligence obligation in article 2(e) of CEDAW, the Committee noted that Brazil is obligated “to take measures to ensure that the activities of private actors in regard to health policies and practices are appropriate”. In the Committee’s expert view, Brazil’s failure to act accordingly had resulted in a violation of article 12(2) of CEDAW.

#### ***Access to effective judicial protection and remedies***

The Committee found that Brazil had failed to establish a judicial system capable of effectively protecting the rights of Alyne da Silva or ensuring her family access to adequate judicial remedies, in violation of articles 2(c) and 12 of CEDAW. In so finding, the Committee condemned Brazil’s failure to initiate proceedings to identify the person(s) responsible for providing medical care to Alyne da Silva. It also noted its concern that civil proceedings filed by the victim’s family had languished in domestic courts for more than eight years without resolution, and criticised the decision to deny the family access to mechanisms that could have prevented this unwarranted delay.

#### ***Recommendations***

The CEDAW Committee urged Brazil to provide reparation to the mother and daughter of Alyne da Silva. It also called on Brazil to adopt measures to address the systematic nature of the violations experienced by Alyne, including ensuring women’s right to safe motherhood and affordable access to adequate emergency obstetric care, sanctioning health professionals who violate women’s reproductive health rights, and reducing preventable maternal deaths through the implementation of its National Pact for the Reduction of Maternal Mortality.

33. In 2013, a South African court awarded Charlotte Mmowa 547,000 rand (\$50,000) compensation for a suit against the Limpopo Province health authorities, who the court decided had been negligent. Charlotte’s mother had retained placenta following childbirth bleeding profusely for many hours as doctors tried unsuccessfully to manually remove it. Health personnel ordered blood at 4 p.m. and by 9 p.m. when she died, the blood had not

arrived. The health personnel argued they had done their best to save the woman's life except they had to drive a long distance for the blood.

## **H. Progress on maternal health**

40. But the picture is not all gloomy! With various interventions, there has been a 44% drop in maternal mortality globally between 1990 and 2015. There has been progress in some African countries. In Ghana, in 1990 the MMR was 634 and in 2015 it was 319. In Uganda, in 1990 MMR was 687, it is 343 in 2015. In Sierra Leone, in 1990 MMR stood at 2,630, in 2015 it is 1,360. In South Sudan in 1990 it was 1,730 and now 789. South Africa, in 1990 had 108, now it is 138. It dropped to 62 in 1995 and picked up from 2005. In Morocco, it was 317, and now 121<sup>14</sup>.

## **I. Another paradigm shift required**

41. The normative frameworks and marginal progress notwithstanding, the fact remains that no pregnant woman deserves to die. We have another shot at further working under the Sustainable Development Goals to reduce global MMR to 70 deaths per 100,000 live births. Sub-Saharan African cannot miss the mark, or our governments would have failed women.
42. In order to achieve significant change with the current maternal mortality rates, it is necessary to have a combination of political will, inter-sectoral collaboration and community participation. Political will is needed to make the health and well-being of women a priority and to ensure that women, especially in rural areas, have access to skilled medical care during pregnancy and at delivery. This can be achieved when resources are committed to this cause. The Civil Society Budget Advocacy Group in Uganda is advocating the Government of Uganda commits 13.5 billion Shillings to recruit and retain 300 doctors and pharmacists the country needs.<sup>15</sup> This is only a paltry figure compared to the deficit of 3,542 health workers.
43. The Special Rapporteur on Rights of Women in Africa should use her mandate more effectively one of which is to undertake promotion and fact-finding missions to African countries which are Members of the African Union with a view to publicizing AU human rights instruments and investigating the situation of women's rights. In addition, the African Court on Human Rights must unambiguously pronounce State complicity in maternal deaths when it receives such communication.
44. Inter-sectoral collaboration among Non-Governmental Organisations, private businesses, Universities and research institutions, and state agencies is equally important. The Marie

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<sup>14</sup> [www.who.int/gho/maternal\\_health/countries/en/](http://www.who.int/gho/maternal_health/countries/en/)

<sup>15</sup> [www.mamaye.org/en/blog/government-uganda-fill-our-health-worker-gap](http://www.mamaye.org/en/blog/government-uganda-fill-our-health-worker-gap)

Stoppes Foundation, Evidence 4 Change in Sierra Leone, The Mama Ye Campaign that covered five African countries, the Maternal Health Channel on Ghana TV supported by UNFPA and the Human Rights Centres of the Universities are some examples.

45. Community participation is crucial in enabling women to get medical care in a timely fashion. Community members need to educate each other on the importance of antenatal care and the need to have a trained traditional birth attendant or a midwife present at all deliveries. Community leaders need to modify or change customs and attitudes that perpetuate gender inequalities. Preference for a male-child, home-delivery as a sign of bravery, inability of women to use contraceptives without consent of their male partners, women's inability to determine the number and spacing of children, child marriages and taboos about pregnancy and childbirth should be reviewed. African communities must change the perception that death from pregnancy is 'acceptable'. It is also about family members and in-laws desisting from putting undue pressure on a couple to have a child.
46. Partners of pregnant women should educate themselves on what has to be done, what could go wrong, what preparations must be taken to provide the needed support such as saving money, accompanying wives sometimes to ante-natal care, and being present at delivery. It is also the pregnant woman's moral obligation to herself to do the right thing by attending antenatal care during pregnancy. Post-partum care is equally important; women must practice good hygiene and any forms of infection should be detected early and treated.
47. To those of us gathered here, our singular responsibility is to ask – why are pregnant women dying from preventable causes? What can you do to change the horrifying statistics and fact that Sub-Saharan Africa is the riskiest place to have a child? Our collective effort is to work in tandem with States through advocacy, case law, research and public lectures like this to find answers to those questions.  
I agree with Professor George Lakoff of University of California that “*Frames are the mental structures that shape the way we view the world...they shape the goals we seek, the plans we make, the way we act and what counts as good or bad outcome of our actions....To change our frames is to change all of this. Reframing is social change*”.<sup>16</sup>
48. WHO sums the above by reporting that the traditional approach to antenatal care services generally focuses on clinical services which are the prevention of potential complications and assessment of the physical risk of the mother-to-be, but overlooks the psychosocial aspects of pregnancy. WHO studies show that women simply want a positive pregnancy experience. Women want to maintain physical and sociocultural normality, they want to maintain a healthy pregnancy which includes preventing and treating risk, illness and

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<sup>16</sup> George Lakoff, “Don’t Think of an Elephant”, 2004, Chelsea Green Publishing, White River Junction, Vermont, USA quoted in <http://advocacyinternational.co.uk/advocacy/engaging-the-african-public-in-maternal-and-newborn-survival>

death, effective transition to a positive labour and birth and achieving positive motherhood (including maternal self-esteem, competence and autonomy).<sup>17</sup>

The expectation is that ante-natal care services would be designed from a woman-centred approach to include tailored rather than routine clinical practice integrated with **local practice and knowledge where appropriate, relevant and timely information** (physiological, biomedical, behavioural and socio-cultural), support (social, cultural, emotional and psychological) and a change in the attitudes and behaviours of formal and informal care providers to pregnant women.<sup>18</sup>

## **J. Conclusion**

49. In conclusion, I emphasise that maternal health is as much a moral duty for women, partners, families and communities as it is a legal obligation on the State to provide the necessary resources for pregnancy care and child birth.

I could have died twice in Ghana, and stayed alive in the USA. I insist that where I gave birth is immaterial because no woman should have to cross that proverbial bridge alone!

**Thank you.**

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<sup>17</sup> [http://www.who.int/reproductivehealth/topics/maternal\\_perinatal/anc/en/](http://www.who.int/reproductivehealth/topics/maternal_perinatal/anc/en/)

<sup>18</sup> Ibid.