

**EXPLORING THE IMPLICATIONS OF THE INTERNATIONAL
COVENANT OF ECONOMIC, SOCIAL AND CULTURAL RIGHTS FOR
SOUTH AFRICA WITH a FOCUS ON MATERNAL MORTALITY**

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Acknowledgement

This dissertation is dedicated to my parents Falesi and Feston Zambezi who have supported me and made many sacrifices to ensure my education throughout my life. Thank you for your patience, love and continuous encouragement.

Declaration

I, **Denise Zambezi** declare that the work presented in this dissertation is original. It has never been presented to any other university or institution. Where other works have been used, references have been provided. It is in this regard that I declare this work as originally mine. It is hereby presented in partial fulfilment of the requirements for the award of the LLM degree in Multidisciplinary Human Rights.

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List of abbreviations

- AIDS** Acquired Immune Deficiency Syndrome
- CEDAW** Convention on the Elimination of All Forms of Discrimination against Women
- CERD** Convention on the Elimination of All Forms of Racial Discrimination
- CESR** UN Committee on Economic, Social and Cultural
- CRC** Convention on the Rights of the Child
- GDP** Gross Domestic Product
- HIV** Human Immunodeficiency Virus
- ICCPR** International Covenant on Civil and Political Rights
- ICESCR** International Covenant on Economic, Social and Cultural Rights
- MDG** Millennium Development Goals
- MMR** Maternal Mortality Ratio
- MTCT** Mother to Child Transmission
- NGO** Non Governmental Organisation
- NHA** National Health Act
- OP-ICESCR** The Optional Protocol to the International Covenant to Economic, Social and Cultural Rights
- TB** Tuberculosis
- UDHR** Universal Declaration of Human Rights
- UN** United Nations
- WHO** World Health Organisation

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Introduction

Chapter 1

1.1. Introduction to study

Maternal mortality has been defined by the World Health Organisation¹ (WHO) as ‘the death of a woman while pregnant or within 42 days of termination of pregnancy or from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.’ It has been reported by WHO that over 500 000 women die every year as a result of maternal mortality. Approximately 99% of these deaths happen in developing countries. These deaths can be prevented.² Preventable maternal mortality is a public health problem that should not be happening in today’s society. It is therefore important to explore ways in which maternal mortality can be reduced. A woman’s reproductive health has wide consequences as it is connected to fertility patterns in society, health, mortality and the well-being of their families.³

Victims of maternal mortality are deprived of their right to access and enjoy the highest conceivable standard of physical health *inter alia*.⁴ Health is a fundamental socio-economic right to which every human being is entitled.⁵ WHO’s Constitution describes health as a ‘state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity.’⁶ Maternal health is therefore a human right. Human rights are universal, indivisible, interdependent and interrelated. Human rights do not discriminate. They are there to improve the social situation of

¹ The World Health Organization is an agency established by the United Nations that specializes in ensuring the highest level of health for every person. Its mandate also includes providing assistance to states in health matters, proposing conventions, agreements and recommendations. The organisation also promotes maternal mortality and welfare. <https://www.WHO.int> (accessed 20 November 2015)

² HD Pihno ‘Prioritizing women’s health: On the “Rights” Track: The importance of a Rights-Based Approach to Reducing Maternal Deaths’ in A Clapham & M Robinbson, et al, (eds) *Realizing the right to health right to health* (2009) 111.

³ N Redelinghuys ‘Health and the Health status of the South African Population’ in HCJ van Rensburg (ed) *Health and Healthcare in South Africa: second edition* (2012) 285.

⁴ Article 12, The International Covenant of Economic, Social and Cultural rights.

⁵ S Gruskin & D Tarantola ‘Health and Human Rights’ in S Gruskin, & D Tarantola (eds) *Perspectives on Health and Human Rights* (2005) 14.

⁶ Constitution of The World Health Organisation 1948. www.who.int/about/definition/en/print.html (accessed 20 November 2015)

every single individual. The international community must treat all human rights with equality and fairness, and the state has the obligation to ensure that human rights are realised.

1.2. Background

South Africa has the largest and fastest growing economy in Africa.⁷ A democratic government was conceived in 1994 and there has since been steady economic growth.⁸ After 1994, the democratic government had the duty to transform a fragmented health system inherited from apartheid into a single national health system founded on the values of equality, dignity and accessibility to all.⁹

Regardless of the transition from an apartheid state to a democratic state, many of the institutional and structural features which formed the apartheid state were inherited. These perpetuate discrimination and poverty. According to the World Bank, despite being identified as an upper middle income country, South Africa has the highest level of inequality in the world. The poorest fifth of the population accounts for 2% of the country's income and consumption, while the richest fifth accounts for 72%.¹⁰ Multiple studies have found that maternal mortality among poor women is four times greater than among wealthier groups.¹¹ Poverty places a greater number of women at risk of complications during pregnancy and childbirth. HIV/AIDS and poverty-related diseases such as tuberculosis and cholera also aggravate maternal health. Mothers, babies and children from poor families are confronted with more difficulties in accessing high-quality care on time.

The delivery of healthcare is generally a major challenge for South Africa. There is insufficient accountability, monitoring and evaluation, and health personnel frequently

⁷ <http://www.Gautengonline.gov.za> (accessed 26 May 2015).

⁸ N Nattrass 'Democracy works: Post-Apartheid and Growth' (2014).

<http://www.cde.org.za/wp-content/uploads/2014/04/democracy-works---south-africa-conference-paper---post-apartheid-democracy-and-growth---by-nicoli-nattrass-pdf-.pdf> (accessed 27 October 2015).

⁹ N Nattrass & J Seekings 'The economy and poverty in the twentieth century in South Africa' (2010) <https://nicspaull.files.wordpress.com/2011/04/the-economy-and-poverty-in-the-20th-century-in-sa.pdf> (accessed 27 October 2015).

¹⁰ M Keymanthri & K Rowe 'Patients as consumers of health care in South Africa: The ethical and legal implications' (2003) 14.1 *BMC Medical Ethics* 15.

¹¹ The World Bank is an important source of financial and technical guidance to developing countries around the globe. Its objective is to reduce poverty and support development <http://www.worldbank.org/> (accessed 1 June 2015).

abuse the system. Economic, political, institutional, cultural¹² and geographic detriments all contribute to maternal mortality.

The level of maternal healthcare is poor in South Africa, especially considering economic variables and legislative documentation. One of the conventional measures used to determine the extent of maternal mortality is the maternal mortality ratio (MMR), defined as the number of maternal deaths per 100 000 live births. The United Nations (UN) estimates 147 MMR per 100 000 live births, with 1 600 being the annual number of maternal deaths in South Africa.¹³ The maternal mortality ratio illustrates the number of women dying from complications during pregnancy and/or childbirth. It includes deaths resulting from unplanned or induced abortion.¹⁴

In 2000, South Africa signed the United Nations Millennium Development Goals¹⁵ (MDGs). The development targets include *inter alia*, reducing maternal deaths by three-quarters by the year 2015 as compared to the figures of 1990¹⁶, promote gender equality and empower women,¹⁷ and to stop and begin to reverse the spread of HIV/AIDS between 1990 and 2015.¹⁸ The goal to reduce maternal deaths by three-quarters has not been met.

HIV/AIDS remains one of the leading indirect causes of maternal mortality. The prevalence of HIV/AIDS among pregnant women remains extremely high despite the progress which has already been made to improve testing, prevent mother-to-child transmission, and in the provision of anti-retroviral treatment.¹⁹

In 2013, the maternal mortality rate was 140 per 100 000 lives. South Africa's maternal mortality rate is higher than several African countries including Egypt (45 per 100 000) and Namibia (130 per 100 000), but a good deal lower than Malawi (510 per

¹²N Redelinghuys & HCJ van Rensburg 'Health, morbidity and mortality: The health status of the South African population' in HCJ van Rensburg (ed) *Health and Health Care in South Africa* (2004) 266-267.

¹³ South Africa Department of Health's Demographic & Health Survey 2002 *Will South Africa Meet the Goals? Every Death Counts: Saving the lives of mothers, babies and children in South Africa*.

¹⁴ N Redelinghuys 'Health and the Health status of the South African Population' in van Rensburg (ed) *Health and Healthcare in South Africa: second edition* (2012) (n 3 above) 240.

¹⁵ United Nations Millennium Declaration: resolution adopted by the General Assembly 18 September 2000, 55/2.

¹⁶ MDG 4.

¹⁷ MDG 3.

¹⁸ South Africa's National Department of Health's 'Saving Mothers 2008-2010 Fifth Report on Confidential Enquiries into Maternal Deaths in South Africa.'

¹⁹ n 13 above.

100 000) and Zimbabwe (470 per 100 000). During the time period during which this data was recorded, South Africa had a higher gross domestic product (GDP)²⁰ than any of above-mentioned countries.

1.3 Legal policy

There are various human rights inscribed in the 1996 Constitution of the Republic of South Africa (hereafter referred to as the Constitution) which protect maternal health rights directly or indirectly. In section 27(a) it is inscribed that all persons are entitled to healthcare services. Further, it is stipulated that all persons are entitled to reproductive healthcare services. The right does not, however, mean that all medical treatment will be given free of charge.²¹ This is clear from section 27(1) (b) which requires the state to act reasonably when implementing legislative measures. The state should take cognisance of the availability of natural resources in order to progressively realise this right.

Every individual is entitled to bodily and psychological integrity. This includes the right to make informed decisions regarding reproduction, security and control of one's own body.²² No one can be denied emergency medical treatment.²³ Everyone has equal rights and equal protection before the law²⁴. Therefore, pregnant women must not be discriminated against under any circumstances. In addition, everyone has the right to dignity,²⁵ life,²⁶ education and an environment that does not threaten their health and well-being.²⁷ Further health provisions include section 28(1)(c), which makes provision for accessibility to healthcare services for children, while section 35(2)(e) provides for adequate medical treatment for people detained and in prison at the expense of the state. Since 1996, these rights have in subsequent policy and legislation been further articulated and endorsed, and given more substance.

²⁰ 'GDP is the value of final goods and services that were produced a state over a certain period of time.' <http://econweb.tamu.edu/jinkooklee/econ203/Chapter8.pdf> (accessed 5 November 2015).

²¹ N Redelinghuys 'Health and the Health status of the South African Population' in van Rensburg (ed) *Health and Healthcare in South Africa: second edition* (2012) (n 3 above).

²² Constitution section 12(2).

²³ Constitution section 27(3).

²⁴ Constitution section 9.

²⁵ Constitution section 10.

²⁶ Constitution section 11.

²⁷ Constitution section 24.

The 1948 Universal Declaration of Human Rights (UDHR)²⁸ is globally condoned as the primary guide to the scope of human rights commitments. UDHR affirmatively states that each person is entitled to a standard of living that is sufficient for a healthy lifestyle and adequate well-being for the individual and their family.²⁹

There are various international treaties that must be referred to in order to justify maternal health as a human right. While all the human rights treaties protect and promote the rights of all peoples, the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)³⁰ specifically addresses the rights of women and girls. It includes provisions regarding the health rights of pregnant women.³¹

The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa is an important development in the safeguarding and promoting of women's rights in Africa.³² Article 14 covers sexual and reproductive health.

The most important international document regarding healthcare is the International Covenant on Economic, Social and Cultural right (ICESCR).³³ In January 2015, the South African government ratified ICESCR – more than 20 years after signing it. ICESCR establishes an international framework for the protection and realisation – by state parties – of the right to healthcare.

1.4. Rationale of study

State parties which have ratified ICESCR are responsible for ensuring the realisation of the socio-economic rights set out in ICESCR. It is inscribed in Article 12(1) that state parties to ICESCR accept that everyone has the right to the highest attainable

²⁸ The Universal Declaration of Human Rights, adopted 10 December 1948 by the General Assembly Resolution 217 A(III).

²⁹ UDHR Article 25.

³⁰ The Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) is an international treaty adopted in 1979 by the United Nations General Assembly.

³¹ CEDAW Article 12.

³² Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, adopted 11 July 2003, (entered into force 25 November 2005), 2nd Ordinary Session of the Assembly of the African Union, AHG/Res. 240 (XXXI).

³³ The International Covenant on Economic, Social and Cultural Rights and the International Covenant on Civil and Political Rights were adopted by the General Assembly by its resolution 2200 A (XXI) of 16 December 1966.

standard of health, both mentally and physically.³⁴ State parties to ICESCR must take steps towards achieving the implementation of the rights prescribed. This includes steps necessary to reduce the still-birth rate and infant mortality, and towards the healthy development of the child.³⁵

1.5. Research problem statement and research objectives

1.5.1. Statement of problem

Between 1990 and 2010, South Africa made significant progress towards improving maternal health.³⁶ If one considers the status of the economy and legal policy, the maternal mortality rate in South Africa is higher than it should be.

ICESCR has the potential to influence the state of maternal mortality. The Constitution prescribes that courts and other legal bodies must give regard to international law when interpreting the Bill of Rights.³⁷ South Africa is bound by an international treaty after the National Assembly and the National Council of Provinces has approved of it. This applies unless the international treaty it is self-executing or of a technical, administrative or executive nature.³⁸ When interpreting legislation, courts must give preference to a reasonable interpretation consistent with international law, as opposed to other alternative interpretations that are inconsistent with international law.³⁹

Ratification of ICESCR can, however, be insignificant in the reduction of maternal mortality.⁴⁰ When a treaty is not accepted as national law, the state is not bound. Nonetheless, it is still binding under customary law.⁴¹

1.5.2. Research questions

- To what extent can the ratification of ICESCR impact the reduction of maternal

³⁴ ICESCR Article 12(1).

³⁵ ICESCR Article 12(2)(a).

³⁶ World Health Organization's Health Report *Health Systems Financing: The Path to Universal Coverage* 2010.

³⁷ Constitution section 39.

³⁸ Constitution section 231(2).

³⁹ Constitution section 233.

⁴⁰ EU member states http://europatientrights.eu/countries/signing_and_ratifying_a_treaty.html (Accessed 1 October 2015).

⁴¹ n 40 above.

mortality in South Africa?

- What are the key reasons why maternal mortality has been high in South Africa, despite the fact that health has been recognised as a socio-economic right under the South Africa Constitution?
- What are the challenges faced by international law in the fight against maternal mortality?
- What benchmark does ICESCR provide in determining a state's obligations to prevent maternal mortality?

1.6. Literature review

Various scholars have discussed the implication of ICESCR on socio-economic rights in South Africa, and indeed there are many scholarly articles and books discussing health as a human right. However, there has not yet been a focused study on what ICESCR means in the battle against maternal mortality in South Africa.

*Health and Health Care in South Africa 2nd edition edited by HCJ van Rensburg*⁴² is a useful account of health in South Africa in general.⁴³ The book provides the historical background of health in the country and also looks at the current status thereof. The progression South Africa has made in terms of human resources, the public health system and disparities between the poor and the rich are vital themes in the book. There is an important section in Chapter 5, which looks at the health status of women in South Africa.⁴⁴ It provides a background study that stands as a guide to understanding the factors which impact women's reproductive health. The chapter concludes that women suffer more than men from the socio-economic legacy of apartheid. HIV is also looked at in the book, which states that the decreased immunity status of HIV-infected mothers makes them more prone to other infectious diseases. HIV infection may put the mother and her unborn child at higher risk during pregnancy and labour. While the book deals with key factors regarding health, and factors that link directly and indirectly to maternal mortality, it fails to explore international conventions with regard to maternal health. The observations made with regard to legal provisions are primarily based on national law.

⁴² JE Ataguba et al 'Health and Health care in South Africa' in van Rensburg (ed) *Health and Healthcare in South Africa: second edition* (2012).

⁴³ Redelinghuys (n 3 above) 285. 215.

⁴⁴ Redelinghuys (n 3 above) 285.

In *'Realizing the Right to Health'*⁴⁵ it is acknowledged that implementing the right to health requires serious attention on strengthening healthcare services and transforming health systems so that they cater to the needs of women. A human rights approach means understanding the social detriments that hinder realisation of the right to health. The author addresses maternal mortality in a chapter entitled *'On the "Rights" Track: The importance of a Right Based Approach to Reducing Maternal Deaths'*. De Pinho addresses, among other things, how a rights-based approach would reduce maternal mortality. While the rights in the treaty do not mean that services will automatically be available, a rights-based approach does determine how states respond to the problem of maternal mortality.

In *'Strengthening protection of sexual and reproductive health and rights in the African region through human rights'*⁴⁶, Afulukwe-Erachalu addresses the discourse of maternal mortality in Sub-Saharan Africa in a chapter entitled *'Accountability for non-fulfilment of human rights obligations: A key strategy for reducing maternal mortality in sub-Saharan Africa'*. Sub-Saharan Africa has, and continues to have, one of highest maternal mortality ratios internationally. The author prescribes the advancement of accountability in instances where African countries fail to implement and adhere to human rights that promote safe motherhood. The author explores how the application of human rights law can advance accountability and the obligation of national human rights institutions. It was concluded that lack of accountability is a major impediment in the fight against the reduction of maternal mortality as opposed to legal provisions themselves.

In *'Maternal Mortality as a Human Rights Issue: Measuring Compliance with International Treaty Obligations'*⁴⁷ Yamin and Maine approached the subject of maternal mortality by claiming that human rights are valuable in the sense that they bring the subject of maternal mortality into the public sphere, despite the fact that these rights are insufficient in radically reducing maternal mortality. The article

⁴⁵ A Clapham et al *Realizing the Right to Health* (2009).

⁴⁶ O Afulukwe-Erachalu 'Accountability for non-fulfilment of human rights obligations: A key strategy for reducing maternal mortality in sub-Saharan Africa' in C Ngwena & E Durojaye (eds) *Strengthening protection of sexual and reproductive health and rights in the African region through human rights* (2014) 119.

⁴⁷ AE Yamin & DP Maine 'Maternal Mortality as a Human Rights Issue: Measuring Compliance with International Treaty Obligations' (1999) 21 *Human Rights Quarterly* 563.

provides a detailed scope of maternal mortality and the state of the various public health approaches to addressing the matter, before exploring the reasoning behind, and implications of, using the UN guidelines in assessing maternal mortality. Another important theme is the legal context for establishing the state's obligation to reduce maternal mortality as part of the right to health, which in turn forms part of its economic and social rights obligation under specific international treaties. The article proposes three ways to use the UN Guidelines to set standards that are enforceable with respect to the state's obligations to take steps to reduce maternal mortality on a non-discriminatory basis. The first of these is to adopt objectively measurable and verifiable indicators to judge whether states are taking steps; the second is to determine whether states are taking the effective steps; and the third is to determine whether such steps are being taken on a non-discriminatory basis.

1.7 Methodology

The methodology chosen stems from deductive analysis and is primarily based on desktop and library-based research. Research will be conducted with reference to books and journal articles, in addition to an overview of seminar discussion reports, international treaties, news reports, policy documents and web sources.

1.8 Overview of chapters

Chapter 1 (outlined above) is an introduction to the study. Chapter 2 encompasses the history of South Africa in relation to socio-economic rights and the right to health. Chapter 3 looks at the current status, scope and challenges of maternal mortality. Chapter 4 explores the national and international instruments that make provision for maternal mortality. In Chapter 5, a holistic approach is given to provisions in ICESCR. Chapter 6 formulates the main conclusion and recommendations.

A historical background of maternal healthcare South Africa

Chapter 2

2.1 Introduction

In every society, fertility and the dynamics of maternal mortality are linked to the broader issues of socio-economic development, social attitudes, access to healthcare and general standards of living – particularly where these affect women’s health and social well-being.⁴⁸ To understand the factors impacting women’s reproductive health, one needs to look at the controversial history of healthcare and maternal mortality in South Africa.

History explains the reason for the current status of women in South Africa, the health system and the reasons why maternal mortality is at the level it is currently. The laws and policies of the apartheid dispensation negatively affected the health of millions of women in South Africa, particularly black women. Safe motherhood and safe abortion are a necessary part of post-apartheid transformation.

The Constitution makes provision for the right to healthcare, equality and dignity *inter alia*. These rights did not apply to the entire population during apartheid. Despite legal recognition there remains a wide gap between the values inscribed in the Constitution and reality. The government has the challenge of tackling entrenched patterns derived from the colonial and apartheid era and which continue to affect society. As a result of apartheid policies, even those policies and laws developed since the advent of democracy are struggling to overcome these deep-rooted problems.⁴⁹

Healthcare in South Africa has significantly improved over the past decade as a result of fundamental investments made by both the government and development partners. The health sector is one of the best resourced sectors in South Africa. The government allocates most of the state's funds to the health budget. The estimated budget for health according to the National Treasury’s estimates of National Expenditure 2015 is R36 468 million between 2015 and 2016.

⁴⁸ Redelinghuys (n 3 above).

⁴⁹ S Khoza (ed) *Socio-Economic Rights in South Africa: A resource book* (2007) 21 -22.

Hospitals, tertiary health services and human resources development are the most-funded programmes, with budgets amounting to approximately R19 000 million. This is followed by expenditure on HIV/AIDS, tuberculosis, and maternal and child healthcare. The expenditure on maternal and child health care is approximately R14 000.⁵⁰ One of the objectives of the maternal and child healthcare programme is to reduce the MMR to be below 100 per 100 000 live births by the year 2019.⁵¹ This is to be done through a review process for maternal mortality and by ensuring that suitable initiatives are implemented. Another objective of the programme is to improve access to health services, including reproductive and sexual health. More than 5 000 healthcare workers are to be trained on family planning.⁵²

Despite increases in the health budget year after year, recent health sector studies⁵³ show that government health sector allocations are not adequate to fund current health sector costs. This puts pressure on the need to reduce HIV/AIDS and tuberculosis, but is most important to this discourse – maternal mortality.⁵⁴

South Africa's history has played a significant role on the current status of the health of the country's people, and the structure of its health policies and services. Historical factors have shaped the current status of healthcare in South Africa and ultimately impacted the state of maternal mortality. The chapter is divided into three sections: the first is a discussion of the state of health in South Africa during apartheid; the second looks at the status of healthcare immediately following the formation of the new democratic government; and the third looks at the current status of healthcare services. This historical context will include the body of social, political and legislative determinants on the healthcare system, the unique concurrence of events in the country's history and the course of development.

2.2 Historical background of health

⁵⁰The National Treasury's estimates of National Expenditure (2015)
<http://www.treasury.gov.za/documents/national%20budget/2015/ene/FullENE.pdf> (accessed 28 October 2015).

⁵¹ n 50 above, 324.

⁵² n 51 above.

⁵³ D Harrison 'An overview of Health and Health care in South Africa 1994-2010: Priorities, Progress and Prospects for new Gains' (2009).

⁵⁴ 'Will South Africa meet the goals? Every Death Counts: Saving the lives of mothers, babies and children in South Africa'. <http://www.healthynewbornnetwork.org/resource/every-death-counts-supplement-will-south-afri-ca-meet-goals> (accessed 30 October 2015).

South Africa's history saw a division between the indigenous people of the country and those of European descent. There was no health services system in the early years, stretching back to 1652, at the Cape of Good Hope, when a European settlement was first established by the Dutch East India Company for the provisioning of its ships in the East. The indigenous people had their own traditional, tribal healthcare system relied upon to ensure the maternal health of pregnant women. In the centuries that followed, indigenous people were excluded from representative government and many rights and privileges.⁵⁵ This included the right to health. Two developments in particular affected healthcare services and systems: racial and gender fragmentation of health services and the deregulation of the health sector.

2.2.1 Racial and gender fragmentation

The apartheid government passed special laws and policies to enforce racial inequality in access to healthcare services. Furthermore, health facilities were racially segregated, and the country's health departments were divided into 'white', 'coloured', 'Indian' and 'black'.⁵⁶ These laws had a negative impact on the health of millions of black people, who did not have adequate access to schools, housing, water, sanitation, hospitals or medical care. Improvised living conditions lead to a poor state of health. Black women in particular did not have access to maternal healthcare facilities of adequate standard. The average European settler enjoyed high standards of health and received four times more per-capita income than the average black person.⁵⁷ The coloured and Indian population received somewhat intermediate shares.

The Pass laws that were implemented meant that black people were legally forbidden from living in 'white' urban residential areas in the absence of permission from a relevant authority. As a result, millions of black people lived in townships where the standard of living had adverse effects on their health. The migrant labour system caused the relocation of millions of men from their homes to single-sex hostels in

⁵⁵ Juta's Statutes (eds) *The Constitution of the Republic of South Africa: 14th Edition* (2015) xiii.

⁵⁶ Colour qualifications such as "white", "coloured", "Indian" and "black" are constantly referred to in this chapter. The use of this racial terminology is based on the realities from South Africa's past where there were various inequality and inequity structures and also discrimination in the health care. Such usage is part of apartheid history and therefore unavoidable. Redelinghuys (n 3 above) 70.

⁵⁷ HCJ van Rensburg 'A history of health and health care in South Africa: 1952-1994' in HCJ van Rensburg (ed) *Health and Health care in South Africa* (2012) 66.

urban areas where poverty ensued. Diseases such as cholera and tuberculosis spread quickly due to overcrowding. These living conditions made men and women reliant on sex work, which led to the rapid spread of sexually transmitted infections (STIs) and later, HIV/AIDS.⁵⁸ The apartheid regime made black people vulnerable to illnesses.⁵⁹

Gender oppression was particularly rife during apartheid, where women were oppressed on the basis of their race and class, in addition to their skin colour. Black women were regarded as inferior to men.⁶⁰ It was unusual for women to be involved in politics and in instances where women were involved, this was not on an equal basis. As a result of the absence of women in the public domain, issues of specific relevance to women, such as childcare, sexual violence, maternal care and reproductive rights, were not broad political concerns. While women from many other nations were benefitting from those international instruments which had come into force from the early twentieth century, such as the UDHR and CEDAW, which prohibited any type of discrimination, South African women continued to endure the indignity of gender discrimination across all spheres of national life.

When the ANC came to power in 1994, its goal was to implement those principles enshrined in the Freedom Charter, which was adopted in 1995. The document set out to create free medical services and hospitalisation for every individual, with special care to mothers and young children. Public healthcare was the core of the ANC's approach to health.⁶¹

2.2.2 Deregulation of the health sector

In addition to racial division, health services in South Africa were divided according to geographic location and whether they were public or private services. The country was divided into numerous small geographical parts or regions. Each of these had a different approach to health provision and there was insufficient coordination between

⁵⁸ <http://www.section27.org.za/wp-content/uploads/2010/04/Chapter1.pdf> (accessed 13 June 2015) 2-29.

⁵⁹ <http://www.theway.org.uk/Back/s093Sideris.pdf> (accessed 16 June 2015).

⁶⁰ H Coovadia et al 'The health and health system of South Africa: historical roots of current public health challenges.' (2009) 374.9692 *The Lancet* 817.

⁶¹ K Kautzky & SM Tollman 'A perspective on Primary Health Care in South Africa: Primary Health Care: in context' (2008) *South African health review* 23.

regions and central level.⁶² Functions and services, for example curative and preventative healthcare, were run in an uncoordinated manner by different agencies. The Public Health Amendment Act 23 of 1897, for instance, separated curative and preventive services. The best services were provided in big cities to white people who could afford medical aid and who could go to private doctors and hospitals. Structural trends during the founding period shaped South African healthcare.⁶³ Maternal health should be comprehensive and include promotive, preventative, curative and rehabilitative care. However, due to deregulation, women were denied these features.⁶⁴

The process of urbanisation, which was introduced in the later part of the nineteenth century by the discovery of diamonds and gold, flourished in the twentieth century as a result of extensive mining industrialisation. South Africa gradually changed from a rural to an urban society, though not uniformly for different population groups.

The apartheid system further entrenched fragmentation of healthcare when separate departments of health for each of the ten Bantustans (and their government departments) were created. Bantustans served the African population under the Homelands Policy of 1950,⁶⁵ and consisted of separate departments for the coloured, Indian and white racial profiles. This was stipulated in the 1983 Constitution.⁶⁶ The Bantustans acted independently of each other. Towards the end of the apartheid era, there were 14 separate health departments and health services were focused on the hospital sector. Primary level services were underdeveloped.

2.2.3 Healthcare immediately post-apartheid

In 1990 the numerous laws entrenched during apartheid were overthrown. Negotiations regarding a new constitution for the country were initiated. The National Policy for Health Act of 1990,⁶⁷ which makes provision for the alteration of government

⁶² Redelinghuys (n 3 above) 88.

⁶³ n 62 above.

⁶⁴ World Health Organization. 'The World Health Report 2008: Primary health care (now more than ever).' (2014).

⁶⁵ South Africa's History <http://www.sahistory.org.za/special-features/homelands> (accessed 12 June 2015).

⁶⁶ Constitution of the Republic of South Africa Act 110 of 1983.

⁶⁷ National Policy for Health Act 116 of 1990.

was promulgated by the new democratic government.⁶⁸

In 1994, after a long struggle for equal rights, the Interim Constitution was drafted. It was based on the rejection of unrestrained power from the apartheid government and a need to formulate a government system in which power was directed and constrained by law.⁶⁹ The inclusion of socio-economic rights in the Bill of Rights and subsequent legislation illustrates South Africa's strong commitment to reconstruction, development and social justice for every individual. Socio-economic rights, which are especially important for vulnerable and disadvantaged groups in society, comprise the right to adequate food, shelter, education, housing, social security and healthcare, as well as reproduction.

After the Government of National Unity in 1994, a variety of anti-discrimination laws and programmes were initiated in the public sector. Many of these were inspired by provisions in the Reconstruction and Development Programme (RDP).⁷⁰ The new National Health Plan (NHP) envisioned the fundamental rearrangement of the national health system. The core goal of the NHP was to develop a more equitable national healthcare system.⁷¹

In 1994, the use of maternal health services increased and maternal and child healthcare services in public hospitals and health centres were freely provided.⁷² Antenatal attendance improved in 8 out of 13 areas where research was conducted by an average of 14.9%. Child deliveries increased in 11 of 12 areas by 4.6%.⁷³ The amalgamation of what were previously independent health departments into one unified system was achieved. However despite a more unified health system, ongoing challenges remained.⁷⁴

⁶⁸ Act 116 of 1990.

⁶⁹ S Hutson *Gender Oppression and Discrimination in South Africa* (2007) 85.

⁷⁰ The Reconstruction and Development Programme 1994 (RDP) is a socio-economic policy framework aims to put together all people and resources in order to abolish the apartheid structure. It introduced the concept of maternal and child health care. This encompasses of transport cost and training of midwives. One of the targets was to ensure that 90 percent of pregnant women have accessibility to antenatal care and 75 percent of child deliveries are supervised.

⁷¹ The Reconstruction and Development Programme 1994.

⁷² South African Government <http://www.gov.za/about-SA/health> (accessed 21 October 2016).

⁷³ J Borghi 'What is the Cost of Maternal Health Care and how can it be financed?' published thesis, MSC in Health Economics. Privada San Miguel Coyoacan, 17.

⁷⁴ D McCoy & B Engelbrecht 'Establishing the district health system' *South African Health Review*(1999) 133 www.healthlink.org.za/uploads/files/chapter11_99.pdf (accessed 28 October 2015).

2.3 Modern status of maternal healthcare services

It is now over 20 years after a democratic government was elected in 1994. South Africa is still transitioning and recovering human rights violations that happened systematically under apartheid laws and policies. In a review of the performance of health systems, WHO ranked South Africa at number 175 out of 191 member countries. Although South Africa ranked 57th in terms of monetary expenditure on health, it was 182nd with regard to effectiveness of its spending. Furthermore, it ranked 142nd when it came to fairness in the distribution of health resources. The eight measures used by WHO included fairness of contribution, responsiveness and health level achieved, and how the overall measures relate to health system expenditure, among other measures.⁷⁵

In most cases the current private health sector is exclusive, providing high quality healthcare at a premium cost financed through medical aid schemes and cash payments. Highly specialised care is limited to those who can afford private care, which is a minority of the population. The public healthcare system, conversely, is plagued with problems of maladministration, human resource constraints and struggles with shortages of medical equipment, facilities and medication. This sector is responsible for the healthcare needs of 80% of the country's population.⁷⁶

The new government has improved health among the nation's approximately 52 million people via improvements in various areas, such as stabilisation of the economy, substantial economic growth, and the reversal of discriminatory legislation. Basic primary healthcare is available freely to all residents regardless of race or gender. Many new laws, initiatives and programmes were entrenched to improve healthcare. These included the National Ministerial Committee on Confidential Enquiries into Maternal Deaths in 1997 to study and provide recommendations on maternal mortality. The other two Ministerial Committees dealt with recommendations on perinatal and under-five morbidity and mortality.⁷⁷

⁷⁵ JA Lauer & DB Evans (eds) *Measuring overall health system performance for 191 countries* (2001).

⁷⁶ K Lomahoza 'Monitoring the Right to health care in South Africa: An analysis of the policy gaps, resource allocation and health outcomes' (2013) 4 *Studies in Poverty and Inequality Institute*.

⁷⁷ n 15 above.

The White Paper on the Transformation of the Health System in South Africa 1997 focused on the equity, acceptability, accessibility, affordability and availability of health services. The National Health Act of 2003 (the National Health Act) ⁷⁸ aims to *inter alia* ensure equal access to health services. It incorporates the rights of pregnant women and children to free access to care in the public sector if they are not on medical aid. The White Paper and National Health Act will be discussed in greater detail in Chapter 3. The Hospital Rehabilitation and Reconstruction Programme initiated in 1998 aims to construct new clinics and revive hospitals, as well as to improve the education of health workers.

A range of social determinants of ill-health, such as poverty and insufficient quality education ⁷⁹ are beyond the capabilities of the health sector. There has been an overall decrease in life expectancy as a result of HIV/AIDS. In 1990, HIV prevalence among pregnant women was estimated to be 0.7%. By 2005, it had risen to 30.2%. It was furthermore estimated that 5.6 million people were HIV positive. Women who do not have access to information are poor and do not have absolute control over their bodies. They are thus more prone to HIV infection.

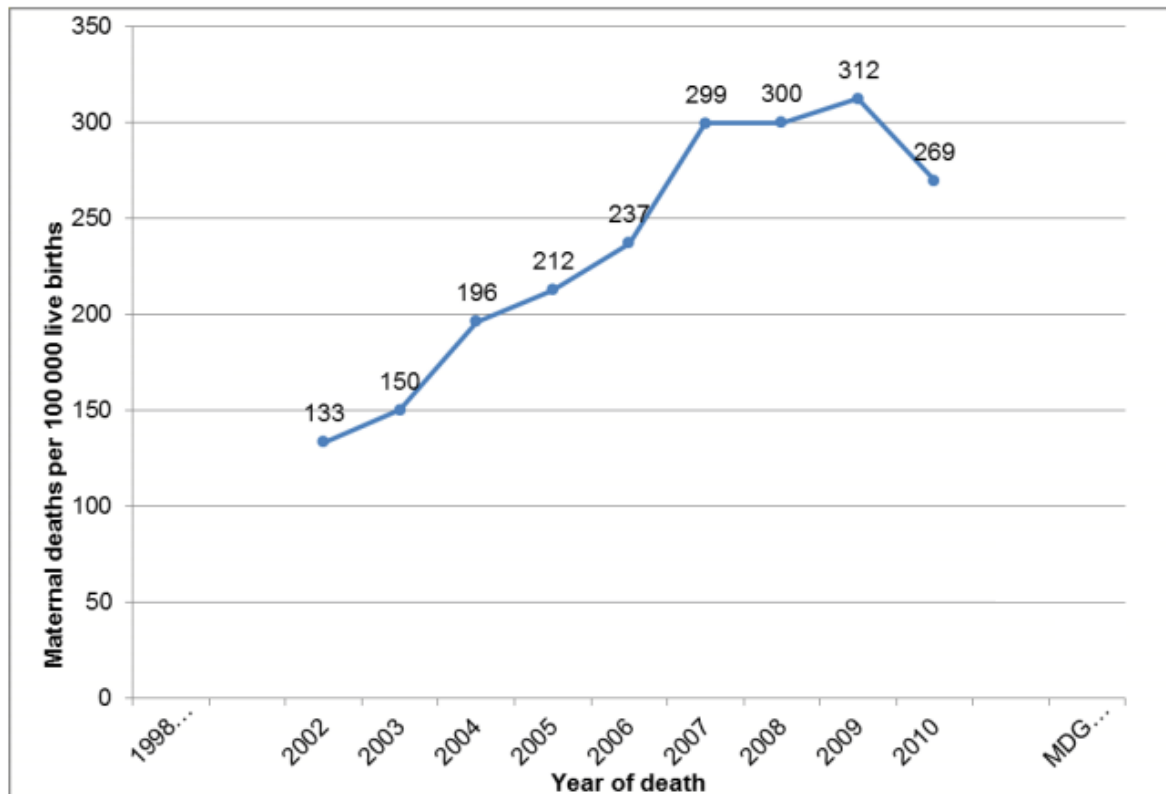
Disparities still exist between municipalities due to the distribution of government funds. Rural areas are poorly funded compared to urban areas, and healthcare services are sometimes inaccessible due to geographical location. Impoverished women – particularly those living in rural areas – are attended to by nurses or midwives for prenatal care and child delivery, whereas in most cases women living in urban areas receive prenatal care and delivery from a physician. Racial, socio-economic and rural-urban inequities in healthcare outcomes and between the public and private health sectors therefore largely remain a challenge. Figure 1 (below) illustrates the progression towards the reduction of maternal mortality from 1998 to 2010.⁸⁰

Figure 1: maternal mortality rates between 1998 and 2010

⁷⁸National Health Act 61 of 2003.

⁷⁹M Bongan et al 'The burden of non-communicable diseases in South Africa.' (2009) 374.9693 *The Lancet* 934-947.

⁸⁰Millennium Development Goals Report 2013.



Source: Millennium Development Goals Report 2013.

From the above it is clear that there is a huge disparity between the levels of maternal mortality from 1998 - 2010. The maternal mortality rate increased from 2002 to 2008, reaching its peak in 2009 before significantly declining in 2010. The Saving Mothers 2008-2010: Fifth report on the Confidential Enquiries into Maternal Deaths in South Africa found that there were 4 867 maternal deaths entered on the database for 2008 - 2010 by 15 April 2011.⁸¹

2.4 Conclusion

The privilege to live in a progressive society that actively promotes and practises gender equality and allows women to be socially and economically empowered does not necessarily mean that all women in these societies are truly on equal standing with men. From the above assessment of South African history it is clear that gender and racial disparities still exist in the country, having historically played a significant role in the position of women in the country.

⁸¹ The Saving Mothers Report 2008-2010 (n 18above) XI.

An analysis of factors leading to high levels of maternal mortality

Chapter 3

3.1 Introduction

Maternal mortality is a social injustice which places a financial, social and psychological burden on a victim's family. For every woman who dies from a pregnancy-related cause, another 30 suffer injury, infection or disability. Maternal mortality is the leading cause of death among women of reproductive age and although substantial reductions have been registered in many countries including South Africa, women around the world continue to die during childbirth in numbers as large as 20 years ago. Women living in rural communities in particular are oftentimes subjected to patriarchal social cultures and stigmas that negate their ability to exercise control over their health and well-being, or to control the health and well-being of their children.⁸²

The three fundamental causes of maternal mortality in South Africa include the following:

- Medical causes consisting of pre-existing or co-existing medical problems which happen as a result of pregnancy;⁸³
- Underlying social and economic conditions;
- The structure of health system laws and policies which determine accessibility, acceptability and quality of reproductive health services.⁸⁴

Adherence to the right to health should be assessed with regard to the availability, accessibility, acceptability and quality of healthcare facilities, goods and services.⁸⁵

The availability particularly requires that a standard of treatment options, personnel, facilities and medicines must be made available – in adequate quantities – in the health sector concerned. Accessibility means that health services are affordable and

⁸² FF Songane 'Maternal Mortality: An overview' in P Hunt & TJ Gray (eds) *Maternal Mortality, Human Rights and Accountability* (2013) 3.

⁸³ n 3 above, 287.

⁸⁴ Global Health Watch 'Maternal Mortality: Need for a broad framework of intervention' <http://www.ghwatch.org/sites/www.ghwatch.org/files/B6.pdf> (accessed 1 July 2015).

⁸⁵ CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Article 12).

geographically accessible to every person. Acceptability means healthcare facilities are culturally suitable and adhere to medical ethics and values. Quality healthcare implies that every citizen has access to medical practitioners, scientifically approved and safe medical equipment and adequate sanitation and healthcare facilities.⁸⁶

This chapter primarily explored the medical, social and economic factors that lead to both direct and indirect maternal deaths with the backdrop of accessibility, acceptability and quality healthcare requirements. Maternal death reveals a variety of disparities and inequities. As an indicator of health, the MMR reveal that there is a wide gap between developed and developing countries, as well as a gap between rich and poor. Furthermore, there is gender disparity – women still face discrimination and inequality. All of these factors, among others, will be discussed further in this paper. It is important to explore these factors because, in order for a suitable solution to be found, the full scope of the problem needs to be understood, and areas of weakness requiring reformation found.

3.2 Medical causes of Maternal Mortality

Maternal health may be defined as the state of a mother before, during and after pregnancy. Direct maternal death refers to maternal deaths caused by obstetric complications while in the pregnant state (pregnancy, delivery, postpartum), interventions, omissions, wrong treatments, or from a series of events that result in any of the above. Indirect maternal death is the result of previously existing diseases or diseases that developed during pregnancy, and which are not the result of direct obstetric events but which are aggravated by the physiological effects of pregnancy.⁸⁷

Globally, as much as 80% of maternal deaths are directly caused by complications during pregnancy and delivery. These are largely preventable.⁸⁸ A 2008 report from The National Committee on Confidential Enquiries into Maternal Deaths (NCCEMD) found that the five most significant causes of maternal death in South Africa from 2005 - 2008 were non-pregnancy-related infections primarily the result AIDS,

⁸⁶ General Comment No 14 (n 85 above).

⁸⁷ 'Family Planning and Reproductive Health indicators Data base: Maternal Mortality Ratio' http://www.cpc.unc.edu/measure/prh/rh_indicators/specific/sm/maternal-mortality-ratio-mm. (accessed 10 August 2015).

⁸⁸ n 3 above, 4.

complications from hypertension, obstetric haemorrhage, pregnancy-related sepsis, and pre-existing maternal diseases.⁸⁹ These account for nearly 70% of all maternal deaths. All of them can be avoided.

In the article 'Saving Mothers: Report on Confidential Enquiry into Maternal Deaths in South Africa 2005-2007'⁹⁰ poor initial assessment of the patient was found to be one of the primary medical causes for maternal death. It was established that 30% of patients who died as a result of maternal mortality were superficially assessed and not monitored thereafter. Maternal deaths as a result of obstetric haemorrhage and hypertension were found to be possibly and probably avoidable in 81% and 61% of cases respectively. It should be noted that it can be difficult to assimilate numerous abnormalities found and to formulate a solution for every patient even where prior assessment was done. Nonetheless, careful inspection and initial emergency management can lead to a reduction in maternal deaths.⁹¹ The care given has to be appropriate and adequate and satisfy the essential health needs of pregnant women. Furthermore, it has to be provided by methods acceptable to the affected parties.⁹²

3.3 Social factors

In addition to medical causes there are various social factors that lead to maternal mortality. These include discrimination, which is most prevalent among patriarchal communities. Discrimination against pregnant women can be based on race, ethnicity, religion, caste or the absence of an education. Only a minority of the world's women – almost all in the developed world – are in a position to exercise control over their natural and social environment and thus wield the power over their health and well-being.⁹³

3.3.1 Rural and urban disparities

⁸⁹ n 87 above.

⁹⁰ NCCEMD Fourth report on confidential enquiry into maternal deaths. (n 17 above).

⁹¹ National Department of Health of South Africa 'Saving Mothers Policy and Management Guidelines for Common cause of maternal deaths' [Http://kznhealth.gov.za/savingmothers.pdf](http://kznhealth.gov.za/savingmothers.pdf) (accessed 27 June 2015).

⁹² United Nations Population information network Guidelines on Reproductive Health <http://www.un.org/popin/unfpa/taskforce/guide/iatfrephe.gdl.html> (accessed 10 October 2015).

⁹³ L Cabal & M Stoffregen 'Calling a spade a spade: Maternal mortality as a human rights violation' (2009) 15 *Human Rights Brief* 2-6.

The status of health in South Africa is poor in both rural and urban areas. In the Tenth Interim Report of Maternal Deaths 2011 and 2012, Northern Cape and the Western Cape showed to have health outcomes than KwaZulu-Natal and Gauteng for example. In towns and cities, maternal delivery takes place in hospitals and homes under the supervision of a midwife and is directed by medical practitioners and/or registered midwives. Conversely, in rural areas, pregnant women are encouraged to visit prenatal clinics and to arrange for delivery to take place at the rural clinic where a midwife is readily available. However, there remain plenty women in these areas who deliver by themselves at home or who are helped by friends and relatives.⁹⁴

One of the major problems for women living in rural areas is geographic accessibility. This means the distance, travel time and means of transportation to relevant health services.

For many women in the South Africa, the high cost of treatment and the distance required to travel to healthcare services mean that effective and comprehensive maternal care is out of reach.⁹⁵ Mothers prefer cheaper means of delivery or treatment, which also increases the risks of infections and complications. Greater access barriers are experienced by rural compared to urban communities. Rural populations are especially disadvantaged in terms of emergency transport to access healthcare services. A recent maternal death enquiry from South Africa found that 18% of avoidable deaths are caused by transportation problems, while 57% of deaths were the result of problems in service management during emergencies.⁹⁶

3.3.2 Poverty and Maternal Mortality

The inability to sustain a state of health is often linked to poverty.⁹⁷ Health improves with higher income due to better health resources, but it may also be the case that good health increases income due to higher productivity. While poverty is not confined to one specific population group, it is concentrated among black people in

⁹⁴ G Bernhard & M Versteeg. 'The state of the right to health in rural South Africa' (2011) *South African Health Review* 101-103.

⁹⁵ n 3 above, 18.

⁹⁶ n 17 above.

⁹⁷ R Dodd & L Munck *Dying for Change: Poor People's Experience of Health and Ill-health* World Health Organization (2001).

particular.⁹⁸ The availability and utilisation of health services and education for women are efficacious in bringing about changes in a nation's fertility trends and population dynamics.

High maternal mortality is a manifestation of gross underdevelopment. Hence its permanent reduction requires societal transformation. The situation for the majority of women in the developing world is not comparable to that of women in developed nations, where pregnancy and childbirth result in complications in only a small percentage of women. Among poor people, professional delivery care is below 30% in numerous countries.⁹⁹ Poverty and unhealthy living conditions therefore place a large sector of women in the developing world at risk of complications during pregnancy and childbirth.¹⁰⁰

Despite the fact that maternal mortality is not as common in developed countries, inequities in the risk of maternal death exist everywhere. For example, in the United States of America (USA), a first-world country, women of colour, low-income, indigenous women, immigrant women and women with limited English face additional risks to maternal health.¹⁰¹ African American women are three to four times more likely to die than Caucasian women during pregnancy – a disparity that has remained unchanged for six decades.¹⁰² Women from lower socio-economic backgrounds are more likely to be exposed to risks during pregnancy, with women living in the lowest-income areas twice as likely to suffer maternal death compared to women in the highest-income areas. Higher poverty rates increase the risk of maternal mortality for all women.¹⁰³

Not only is poverty distributed unevenly among South Africa's nine provinces and population groups, but it also differs sharply among male and female-headed households. Food security and dietary quality remain a challenge for many South Africans and have a profound impact on pregnant women. Women living in poverty

⁹⁸ J Paulick & S Vollmer 'Maternal and Child Health in Sub-Saharan Africa' in U GroB & K Wydra (eds) *Maternal-Child Health: Interdisciplinary Aspects within the perspective of Global Health* (2013) 146.

⁹⁹ TAJ Houweling et al 'WHO's 'Huge poor—rich inequalities in maternity care: and international comparative study of maternity and child care in developing countries.' <http://www.who.inr/bulletin/volumes/85/10/06-038588/2n/> (accessed 23 October 2015).

¹⁰⁰ n 98 above.

¹⁰¹ n 98 above.

¹⁰² n 98 above.

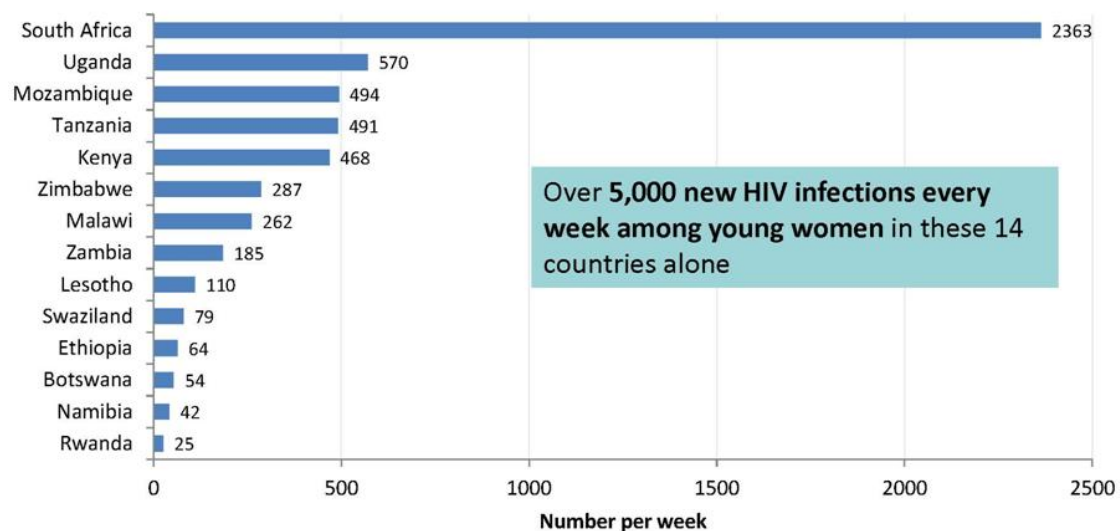
¹⁰³ Songane (n 82 above) 4.

generally tend to have limited power over their reproductive health, either as a result of low education, economic factors or socio-cultural influences. This prevents them from making informed decisions about having children, the spacing of their children, and the care of their children once born.¹⁰⁴ Late decision making compromises the management of reproductive-related illnesses and infections and easily leads to maternal death, or at least long admission days at health centres.¹⁰⁵

3.4.3 Maternal Mortality and HIV/AIDS

The number of people living with HIV in South Africa has decreased. In fact, South Africa recorded the highest decline in the number of new infections in the world. There were 98 000 less infections in 2013 compared to 2010.¹⁰⁶ A pregnant mother who is infected with HIV/AIDS can pass the virus on to her infant during pregnancy or childbirth. Approximately 40% of all deaths in the 15 - 49 age group in South Africa are HIV/AIDS related.¹⁰⁷ According to UN AIDS 2013 data, South Africa has the highest HIV incidence among young women in women East and Southern Africa.

Figure 3: New HIV infections in East and Southern Africa per week among young women aged 15-24 years, 2012



¹⁰⁴ n 3 above, 267.

¹⁰⁵ A Olajide & A Temitayo 'Household Food Insecurity and Hunger: Implications for Maternal and Child Health in Nigeria' in U GroB & K Wydra (eds) *Maternal-Child Health: Interdisciplinary Aspects within the perspective of global health* (2013) 63.

¹⁰⁶ Millennium Development goal report 2015.

¹⁰⁷ 'South Africa: AIDS Mortality Report' http://www.africa.upenn.edu/Urgent_Action/apic-101501.html (accessed 1 October 2015).

Source: Global Report 2013- UNAIDS

HIV/AIDS is associated (albeit indirectly) with more than one-third of all maternal and child deaths. Women are discriminated against when trying to access healthcare and support after they have become infected with HIV.¹⁰⁸ There are ongoing initiatives by the South African Aids Council (SANAC) to educate men and women about HIV/AIDS and safe sexual behaviour.¹⁰⁹ However, knowledge about HIV/AIDS does not necessarily result in safe sexual behaviour.

A person with HIV has a low immune system which makes them prone to other infectious diseases. Such infection may place a pregnant mother and her unborn child at higher risk during pregnancy and labour. Once it is found that a mother is HIV positive she has to start anti-retroviral therapy. Women infected with the virus must be given professional advice regarding the choices they have regarding their health and that of their unborn child.

While some infections can be diagnosed and treated, this is not always the case. Women are often unaware of the risk factor of having these infections or do not receive appropriate antenatal care. The effect of HIV on maternal mortality has increased over the years. At the end of the 1990s, about 28% of maternal deaths were the result of indirect causes. Within these deaths, a large number of women were found to be HIV positive. More current data shows that 43.7% of maternal deaths are the result of indirect causes, of which 22.4% resulted from HIV infections.¹¹⁰

In light of the above, it should be noted that there is disparity between people living with the virus in formal-informal and rural-urban areas. This disparity can be linked to the distribution of poverty and healthcare services, unemployment *inter alia*. There are increased instances of high-risk sexual behaviour in informal areas, and research has found that males living in informal areas tend to have multiple partners in

¹⁰⁸ n 3 above, 268.

¹⁰⁹ SANAC is a trust created by the Government in 2000 to enhance the fight against HIV, tuberculosis (TB) and sexually transmitted infections (STIs). <http://sanac.org.za/> (accessed 11 October 2015).

¹¹⁰ n 3 above, 288.

comparison to those living in formal areas.¹¹¹

3.4.4 Culture and tradition

Healthcare services must be culturally competent and gender sensitive. Discriminatory attitudes that prevent or discourage women from accessing the healthcare they need when they need it can have serious consequences on their chance of being healthy prior to as well as during pregnancy and childbirth. Discriminatory attitudes to women who do not speak the local language also exacerbate barriers. Gender inequality guarantees that women have no control over their health. In many poor societies, the decision to seek maternity care can only be made by men.

The situation regarding maternal mortality is much worse for the overall majority of women living in more traditional communities where they continuously have to battle social and economic constraints that impede their ability to control their natural environments and social lives. Women's powerlessness is illustrated in their failure to control decisions concerning fertility and contraception, and in the frequency with which women and girls are exposed to violence and sexual abuse from their male partners.¹¹²

The decision to visit a healthcare centre and even the utilisation of healthcare information are culturally constructed in certain communities. Women in rural areas are sometimes made to observe dietary regulations, practises and taboos during and after pregnancy in order to ensure safe delivery and good child health. Some of these cultural practices are beneficial, while others have negative effects on the health of the mother and child.¹¹³

Cultural practices, traditions, norms and beliefs may have an indirect effect on women's health. For example, they may actively restrict pregnant women from seeking antenatal care in modern health facilities. They delay access to health; exacerbate non-compliance of health information, guidelines and protocols; affect the utilisation, uptake and acceptance of health programmes and projects; and affect the

¹¹¹ n 3 above, 302.

¹¹² n 3 above 285.

¹¹³ <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4504131/> (accessed 2 June 2014).

nutritional status of women and children, resulting in malnutrition. With the exception of female genital mutilation and early child marriage – both of which affect health outcomes and have attracted international attention – other cultural practices, traditions, norms and beliefs which have an indirect effect on maternal health have received little international attention.¹¹⁴

3.3.5 Fertility rates

A woman's reproductive right includes fertility regulation. Fertility and the dynamics of population growth can be linked to socio-economic development, access to healthcare and standards of living.¹¹⁵ Higher fertility rates mean many women are pregnant and spend a large amount of their time either being pregnant or taking care of children. With many pregnancies, and the inability of health services to ensure the health of the mother and her children, women's risk of long-term health problems and even death is greater. When a woman does not have the power to control the number of children she wants to have, fertility rates are concurrently high.¹¹⁶

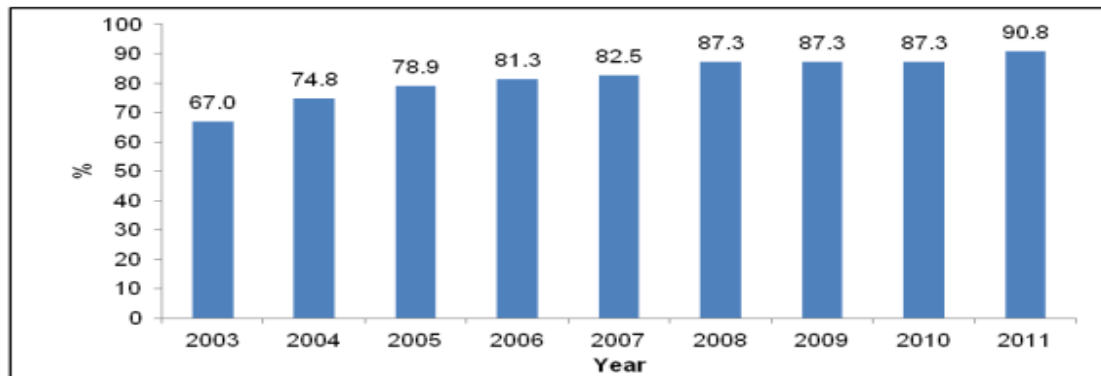
Access to healthcare services and education for women can change the fertility trends of a nation. Lower fertility rates are indicative of positive changes in society which enable women to exercise control over the number and spacing of their children. Women in South Africa have modern methods of family planning available to them and are generally knowledgeable on how to use these methods. This means they can prevent or delay pregnancy and can therefore exercise control, to some extent, over the number and spacing of their children. Figure 2 illustrates the percentage of deliveries that were estimated to take place in health facilities between 2003 and 2011.

Figure 2: Child deliveries estimated to take place in health facilities 2003-2011

¹¹⁴ BA Barnieh 'Cultural practices, beliefs, traditions and norms in Atwima Nwabiagya district: A blessing or a curse for Maternal Health' in U GroB & K Wydra (eds) *Maternal-Child Health: Interdisciplinary within the perspectives of Global health* (2013) 174.

¹¹⁵ n 3 above 286.

¹¹⁶ n 3 above 285- 289.



Source: Saving Mothers Report 2008-2010

A large percentage of women are accessing healthcare facilities for childbirth. The figures increased significantly between 2003 (67.0%) and 2011 (90.8%). This assumes that the high numbers of maternal mortality could be linked more to health facilities than to social structures. MMR in health institutions increased overall in 2011, compared to 2005 - 2007.¹¹⁷

The Choice Termination of Pregnancy Act¹¹⁸ permits nurses and midwives to be taught to conduct termination of pregnancy.¹¹⁹ Abortion is thus permitted under South African law provided that it is requested during the first 12 weeks of pregnancy under prescribed circumstances.¹²⁰ The Act clearly outlines that the purpose of the nurse is to notify patients of their rights.¹²¹

3.4.6. Resources

Human resources in the health sector are insufficient and there are disparities with regard to the distribution of medical personnel and services between the public and private sectors.¹²² The health infrastructure and services rendered should be equitably distributed so that the well-being of individuals is enhanced. If the best infrastructure does not exist in an environment where people have poor health and nutrition habits, those people's future is at risk. Although most mothers make at least one antenatal visit during their pregnancy, delivery assisted by skilled health

¹¹⁷ Saving Mothers Report 2008-2010 (n 86 above).

¹¹⁸ Act 92 of 1996.

¹¹⁹ Act 92 of 1996 section 2(1).

¹²⁰ Act 92 of 1996 section 2(1)(a).

¹²¹ Act 92 of 1996 section 6.

¹²² n 3 above, 409-410.

personnel remains low among communities with low resource settings and those with limited access to health services.¹²³

There is a shortage of health personnel in rural and urban areas. The vast inequality in staffing can be linked to historical reasons, especially if you consider deregulation of the health system during apartheid. The shortage of health personnel originates from several factors including misdistribution, population increase, mismanagement, restricted budgets, non-competitive earnings, poor working conditions and restrictive service conditions in the public sector.¹²⁴ There is a higher supply of health personnel in the private health sector than in the public sector. Furthermore, health personnel in the public sector are moving to the private sector. In 2010, almost 70% of medical practitioners worked in the private sector.¹²⁵ Shortages are particularly severe at facilities in deeply rural areas, for example, in small rural hospitals and clinics. Some facilities in these areas do not function and there is a shortage of staff.¹²⁶

Further exacerbating the problem is the fact that health professionals in South Africa are choosing to migrate overseas. This means the loss of professionals with the experience to ensure maternal health. This phenomenon takes place primarily from developing to developed countries, or lower-income countries to higher-income countries. The reasons for overseas migration include absence of management support, limited career and education opportunities, low pay, work overload anxiety, poor infrastructure, and lack of sufficient resources, among other factors.¹²⁷ South Africa is seriously affected by this. From 1998/9 - 2001/2, the number of South African nurses who were registered with the United Kingdom's (UK) Nursing and Midwifery Council increased from 599 to 2 114.¹²⁸

The quality of healthcare provided in South Africa is highly variable, with many women receiving substandard care – especially those in low-income areas where clinics and hospitals are more likely to be overcrowded and understaffed. The

¹²³ S Muthoka & E Kamuau-Mbulbia 'Nutrition, Sanitation and Reproductive Health in Maternal-Child Health: Challenges in low resource centers' in U GroB & K Wydra *Maternal-Child Health: Interdisciplinary Aspects within the Perspective of Global health* (2013) 2.

¹²⁴ n 97 above.

¹²⁵ n 3 above 415.

¹²⁶ n 3 above 414.

¹²⁷ n 3 above 418.

¹²⁸ n 3 above 417.

concept of quality of healthcare services is multidimensional, and does not apply to all circumstances uniformly. Quality maternal healthcare can be defined as meeting technical standards as well as the needs and expectations of its receivers.¹²⁹ In the public sector, there is often low worker morale, a lack of work ethic and failing productivity. The reasons for this vary, with adverse factors including corruption, theft, HIV/AIDS, and more.¹³⁰ Staff morale influences the manner in which health personnel interact with pregnant women and the quality of care these women receive. The perception of quality maternal care is influenced by the expectations of women before they receive the various healthcare services, and whether these expectations are met once said services have been received.¹³¹

3.5 Conclusion

Structural, behavioural and biomedical factors greatly influence the prospect of survival for pregnant women during and after pregnancy. These factors ultimately depend on intervention from the state and relevant stakeholders. Structural and biomedical factors can be addressed through the provision of funds and political will. Behavioural factors are somewhat more complicated. For example, the government can provide the necessary infrastructure for pregnant women but ultimately it is the choice of the woman whether to make use of these services or choose to rely on traditional methods.

¹²⁹ 'Ministry of Health Report of Tanzania' 2000.

¹³⁰ n 3 above 419-420.

¹³¹ A Makoi 'Maternal health care in rural areas of Tanzania: how do beneficiaries perceive the quality of services?' in U GroB & K Wydra (eds) *Maternal-Child Health: Interdisciplinary Aspects within the perspective of Global Health* (2013) 101.

The scope of National and International Legal Policies pertaining to Maternal Mortality

Chapter 4

4.1 Introduction

The right to access healthcare implies that all women have the right to safe pregnancy, delivery, postnatal outcome, and access to emergency obstetric care in the event that any complications develop.¹³² When one considers the discriminatory attitudes in many countries, it is little surprise that many women do not expect or seek protection from the law. The occurrence of maternal mortality is a serious violation of several human rights. The law in South Africa recognises human rights on a national and international scale. The law can be used as a tool of transformation. If maternal mortality is to be reduced, legal instruments are an important foundation that must be analysed.

In this chapter, focus is given to legal provisions pertaining to mortality, specifically, national and international laws to which South Africa is legally bound. This chapter looks at reproductive rights. Reproductive rights, for the purpose of this chapter, include the rights to family planning, to spacing of children between pregnancies, safe motherhood, safe abortion, and post-abortion care.¹³³

The chapter seeks to give an understanding of where South Africa stands on a legal platform with regard to issues of maternal health. This information is useful in order to particularly understand the scope of provisions set out in ICESCR, which is the legal instrument at the core of this study. The Chapter is divided into two sections: an analysis of national standards regarding reproductive rights and a discussion of the international standards.

4.2 National Law

4.2.1 Introduction

¹³² Pihno (n 2 above) 115.

¹³³ M Hauser 'Supporting Women Subjected to Sexualized Violence: Health and Human Rights Challenges and Approaches in War and Post War Areas' in A Clapham & M Robinson et al (eds) *Realizing the Right to Health* (2009)147.

It is the responsibility of the state to create policies and legislation on important health issues such as reducing the maternal mortality rate.¹³⁴ The state has shown commitment to the reduction of maternal mortality in South Africa and towards the overall improvement of the health system through national legal provisions.

4.2.2 The Constitution

The legislative framework for health within South Africa is governed by the Constitution, which provides for the right to access healthcare services. It expressly includes reproductive healthcare in section 27. The connection of the right to health to other socio-economic rights is clear from the inclusion of the right to sufficient food, water and social security within the same right. The state has the mandate to progressively bring about the realisation of the right to health, and no persons to be refused emergency medical treatment. The right to self-determination with regard to reproductive health is further protected through the right to freedom and security of person, as women are given the power to make decisions regarding reproduction. This right includes decisions on prenatal, delivery and postnatal care; family planning; prevention and treatment of reproductive tract and sexually transmitted infections; and abortions.¹³⁵ Section 9 of the Constitution protects women by giving them full enjoyment of all rights free from discrimination.

Socio-economic rights are regarded as justiciable rights under the Constitution. Therefore, reproductive health is a justiciable right. Justiciability means that the right can be invoked directly and indirectly by litigants. An example of the prominent role courts play in the implementation of reproductive rights can be found in the case of *Minister of Health v Treatment Action Campaign*¹³⁶. The Constitutional Court found that by limiting access to the Nevirapine drug to research and training sites, the state had violated its negative duty to desist from impairing the right to access health services. The Court in this case gave brief focus on women within the context of Prevention of Mother-to-Child Transmission (PMTCT). The Court also acknowledged the importance of having every pregnant woman counselled and tested for HIV and

¹³⁴ MT Laden *Law and Policy: on health, HIV-AIDS, Maternal Mortality and Reproductive rights in Nigeria* (2007) 111.

¹³⁵ B Goldblatt & K Mclean *Women's Social and Economic Rights: Development in South Africa* (2011) 190-191.

¹³⁶ *Minister of Health v Treatment Action Campaign 2001 (1) SA 46 (CC)*.

held that a woman aware of her HIV status has a greater capability to make informed choices regarding earlier access to care. Furthermore, women who are aware of their HIV status have sufficient time to terminate pregnancy if they so desire, and the ability to make learned decisions regarding sexual practices and future fertility. Most importantly, the Court sufficiently discussed women's reproductive needs. The court viewed women as individuals needing protection. Apart from the protection of the unborn child, the state also has an obligation to consider women's particular needs.¹³⁷

4.2.3 The White Paper of 1997

Prior to the Constitution, important reference to reproductive rights was made in the White Paper of 1997, which was primarily a recommendation in the development of a central health system. The White Paper was explicit on the subject of reproductive rights and proposed various implementation strategies designed to meet maternal needs. It recognised the dire need for the reduction of maternal mortality post-apartheid. The goals of the White Paper as inscribed in its preamble included, *inter alia* reduction of the maternal mortality rate by 50% by the year 2000. Chapter 8 of the White Paper looked at Maternal, Child and Women's health (MCWH). It further recognised the vital role that education plays in the reduction of maternal mortality by stipulating that 'individuals, households and communities should have adequate knowledge and skills to promote positive behavioural related to maternal, child and reproductive health'. The Department of Health has the mandate to improve the quality of health services provided and ensure general access to health services to mothers, children, adolescents and women of all ages while simultaneously improving the quality of services provided. The Department of Health, together with provincial health departments, must monitor the distribution of adequate resources in order to provide inclusive and integrated MCWH services.

4.2.4 The National Health Act

The National Health Act 61 of 2003 (NHA) provides a framework for the establishment of an organised and uniform health system. The state has the

¹³⁷ Goldblatt & Mclean (n 135 above) 195.

obligation to promote and improve the national health system within South Africa.¹³⁸ One of the goals of the NHA is to fulfil and protect the rights of vulnerable groups, such as women. There is an obligation placed on community healthcare centres funded by the state to provide pregnant and lactating women with free health services, as well as free termination of pregnancy services subject to the Choice on Termination of Pregnancy Act.¹³⁹ A woman who seeks to terminate a pregnancy shall be informed by the medical practitioner or registered midwife of her rights by the person concerned.¹⁴⁰

There must be disclosure in respect of the range of diagnostic procedures and treatment options available to patients, including the risks, costs, advantages and consequences commonly associated with each diagnostic procedure. It is also the patient's right to decline health services and to receive a full explanation about the implications, risks and obligations of their refusal.¹⁴¹

4.3 International instruments and declarations

4.3.1 Introduction

In 1979, the United Nations (UN) General Assembly adopted CEDAW.¹⁴² Under this Convention, the rights of women were recognised as international human rights. Prior to CEDAW, the human right to health was narrowly interpreted to disregard the needs and experiences of women. It did not address impediments women face when making decisions regarding their health and acquiring healthcare services. Furthermore, the notion of reproductive health as a human right did not exist. As a result, many women were left unexposed and disregarded. Since the 1993 World Conference on Human rights in Beijing¹⁴³ and the International Conference on Population and Development (ICPD) in Cairo¹⁴⁴ in 1994,¹⁴⁵ there has been a strong movement to give meaningful implement reproductive rights. In 1993 at the

¹³⁸ Goldblatt & Mclean (n 135 above) 191.

¹³⁹ Choice of Termination of Pregnancy Act 92 of 1996.

¹⁴⁰ Goldblatt & Mclean (n 138 above) para 4.

¹⁴¹ n 135above.

¹⁴² 'UN Women: United Nations Entity for Gender and the Empowerment of women' <http://www.un.org/womenwatch/daw/cedaw/cedaw.html>.

¹⁴³ United Nations Fourth World Conference on Women in Beijing, China (September 1995).

¹⁴⁴ International Conference on Population and Development in Cairo, Egypt (5–13 September 1994)

¹⁴⁵ Hauser (n 133 above) 148.

conference in Beijing it was affirmed in the Vienna Declaration and Programme¹⁴⁶ that women have the right to access and attain adequate healthcare, including a variety of family planning services. During the ICPD, a set of principles were adopted confirming the principle that women have the right to access reproductive health services, including sexual health and family planning.¹⁴⁷

These conferences eventually lead to an increasing body of customs and jurisprudence which have widened human rights interpretations and confirmed that reproductive decision making and access to reproductive healthcare services are protected as human rights.¹⁴⁸

The Universal Declaration of Human Rights (UDHR) is neither binding nor a treaty, however, it is the foundation of the UN's human rights programme and is considered to encompass essential obligations to which all states have to adhere and respect. The rights and freedoms set out in the UDHR are expressed more specifically in ICESCR, which is the core instrument that monitors socio-economic and cultural rights.¹⁴⁹ It is stated in the UDHR that every individual is entitled to a standard of living that is adequate for the health and well-being of his person and family. This includes clothing, shelter, food, social services and medical care.¹⁵⁰ This formulation of the right to health highlights how interconnected various rights are and how important all of these are in successfully achieving the right the health. Section 27 of the South African Constitution is quite similar to the aforementioned UDHR Article. In the Constitution, Article 25(2) broadly refers to reproductive right, stating that mothers and children have the right to special care and assistance.¹⁵¹

The Convention on the Rights of the Child plays a vital role in the discourse of maternal mortality for many women under the age of 18 dying of pregnancy-related complications, as they are classified as children under this Convention.¹⁵² Article

¹⁴⁶ Vienna Declaration and Programme of Action. Adopted by the World Conference on Human Rights in Vienna on 25 June 1993.

¹⁴⁷ n 133 above.

¹⁴⁸ L Cabal & J M. Todd 'Reframing the Right to Health: Legal Advocacy to Advance Women's reproductive rights'in A Clapham et al (eds) *Realizing the Right to Health* (2009) 120-121.

¹⁴⁹ K Arambulo *Strengthening the Supervision of the International Covenant on Economic, Social and Cultural Rights: Theoretical and Procedural Aspect* (1999) 185.

¹⁵⁰ Article 25.

¹⁵¹ Article 25 (2).

¹⁵² Yamin & Maine (n 47 above) 565.

24(2)(d) and (f) stipulates that state parties shall seek the full realisation of the right and thereof take suitable measures to ensure suitable prenatal and postnatal healthcare for the mother. States must also establish preventative healthcare, supervision for parents, and family planning education and services.

4.3.1 ICESCR

Article 12(1) of ICESCR prescribes that everyone has the right to the enjoyment of the highest attainable standard of physical and mental health.¹⁵³ The Committee for the Convention on the Elimination of Discrimination against Women issued a number of general recommendations on socio-economic rights which are intended to clarify the content and meaning of the provisions in ICESCR. The most important of these in the context of reproductive health is General Comment No.14. The scope of General Comment No.14 is further discussed in the following chapter, along with an in-depth look at all relevant provisions directly pertaining to maternal mortality in ICESCR. In addition to Article 12, ICESCR prescribes that everyone is entitled to the same rights without discrimination of any kind.¹⁵⁴ The state must ensure equality between men and women.¹⁵⁵

When it comes to socio-economic rights in international law, each state has the obligation to take the necessary steps with regard to available resources to progressively succeed in implementing the rights entrenched in the treaty.¹⁵⁶ This formulation is similar to that of national law where the state has the duty to ensure socio-economic rights are available. Spouses entering into a marriage are entitled to free consent. ICESCR is discussed in detail in the following chapter.

4.3.2 Convention on the Elimination of all forms of discrimination against Women

In CEDAW, women's survival rights are supported. Article 12 of CEDAW requires states to take all appropriate measures to eradicate discrimination against women in healthcare and ensure equal access to healthcare services. With specific reference to

¹⁵³ ICESCR Article 12.

¹⁵⁴ ICESCR Article 2.

¹⁵⁵ ICESCR Article 3.

¹⁵⁶ ICESCR Article 5.

reproductive health, Article 12 requires states to supply women with services that are suitable with respect to pregnancy, postnatal period, fee services and confinement. Where it is necessary, sufficient nutrition must be provided during pregnancy and lactation.¹⁵⁷

Other articles in CEDAW which complement Article 12 include Article 14, which states that rural women must have the right to adequate living conditions, participation in development planning and access to healthcare and education. Article 5 provides that states must eliminate cultural practices or traditions that are discriminatory. As discussed in the previous chapter, rural women are the most susceptible to maternal mortality in South Africa.

CEDAW includes a provision regarding family planning,¹⁵⁸ and women are guaranteed rights to freely decide on the number of children they would like to have and the spacing between them.¹⁵⁹ Article 16 has a significant clause on reproductive rights; the exercise of this right is connected with the survival of both women and children.¹⁶⁰

General Recommendation 24 elaborates on the provisions inscribed in Article 12 of CEDAW *inter alia*. It clarifies the mandate of the state with regard to health rights of women and proposes ways in which states can achieve provisions set out in Article 12. The state has to ensure that there is nothing hindering women's access to health services, information and education. This includes sexual and reproductive health. The state must give priority to ensuring that unwanted pregnancies within the family unit are prevented through family planning and sex education. The reduction of maternal mortality rates and safe motherhood services should also be a priority. Further, health services must complement women's human rights in that women must have the right to autonomy, confidentiality, privacy, informed consent and choice. Women must be informed by qualified personnel of their options regarding treatment, procedure, alternatives and effects of treatment.¹⁶¹ In their reports, states parties should stipulate the procedures that have been taken to ensure access and

¹⁵⁷ Laden (n 3 above) 110.

¹⁵⁸ CEDAW Article 16.

¹⁵⁹ Goldblatt & Mclean (n 135 above) 29.

¹⁶⁰ Laden (n3 above) 111.

¹⁶¹ Paragraphe 20 General Comment No 14 (n 85 above).

acceptability of reproductive rights.¹⁶² They must further provide information highlighting the degree to which these procedures have reduced maternal mortality and morbidity in their individual countries. Further, the state must make sure that funding towards health services is to the maximum extent of available resources.¹⁶³

The supervisory body to CEDAW is the CEDAW Committee. Individuals may bring petitions to the Committee against state parties which have ratified the Optional Protocol to CEDAW. In 2007, the Centre for Reproductive Rights and Citizen's advocacy for Human Rights (ADVOCACI) presented a petition to the CEDAW Committee on behalf of a pregnant Afro-Brazilian woman named Alyne da Silva Pimentel Teixeira Alyne who died during childbirth. Her death could have been prevented. The CEDAW committee was approached after the victim's family had failed to find recourse at a national level. It was alleged that the victim's rights to life and health had been violated. (These rights are stipulated in both CEDAW and the Constitution of the Federative Republic of Brazil 1988) In addition, the Brazilian courts did not offer compensation. Ultimately, the victim's family was compensated by the Brazilian government. The Alyne case is significant because it is the first case that can potentially elevate the CEDAW Committee's analysis and recommendations regarding preventable maternal mortality as a contravention of human rights, and in so doing, affirm that there is practicality behind treaty monitoring body interpretations and jurisprudence.¹⁶⁴

4.3.3 Regional instruments

Regional mechanisms for protecting human rights can be easier to access than international ones. This is because there is less distance and the cost requirements are less when monitoring or applying rights. The primary regional instrument relevant to reproductive rights is the African Charter on Human and Peoples' Rights (African Charter)¹⁶⁵, which South Africa became a party to in 1996. Article 16 of this Charter states that every person is entitled to the enjoyment of the best conceivable state of

¹⁶² Paragraphe 23 General Comment No 14 (n 85 above).

¹⁶³ Paragraphe 22 General Comment No 14 (n 85 above).

¹⁶⁴ Committee on the Elimination of Discrimination against Women's 49th Session, 11 to 29 July 2011.

¹⁶⁵ African Charter on Human and Peoples' Rights, adopted 27 June 1981, entered into force 21 October 1986, OAU Doc. CAB/LEG/67/3 Rev. 5, 1520 U.N.T.S. 217 (African Charter).

physical and mental health.¹⁶⁶ Article 16(2) further prescribes that states should take all required steps to protect the health of the citizens and ensure that medical assistance is accessible to them when they are sick. South Africa is a state party to the African Charter to the Rights and Welfare of the Child where it is obliged to ensure that there is appropriate healthcare for pregnant women and nursing mothers.¹⁶⁷

In 2003 a detailed list of sexual and reproductive health rights of women was added to the African Charter.¹⁶⁸ These are inscribed in the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Women's Protocol). The Women's Protocol protects a variety of women's rights, including reproductive rights.¹⁶⁹ Article 14(1) stipulates that state parties must see to it that the right to health of a woman, including the right to sexual and reproductive health, is promoted and respected. Two general comments that have been adopted by the African Commission clarify the content of Article 14 on women's reproductive rights. The general comments on Article 14(1)(d) and (e) were adopted by the African Commission in 2012. In 2014, General Comment No.2 on Article 14(1)(a), (b), (c) and (f) and Article 14(2)(a) and (c) was adopted.¹⁷⁰ In the following, the necessary provisions are discussed in view of what is stated in the General Comments.

In Article 14(1)(a), (b) and (c), women have the right to control their fertility, to decide whether to have children, the number of children and the spacing of children and the right to choose any method of contraception. These rights are connected and give women the opportunity to make informed personal decisions with regard to matters that affect their bodies. The state should refrain from interfering and must remove any impediments to the promotion of these rights, such as tradition or religious and cultural practices. Health workers may not discriminate or withhold available resources.

In section 14(d) it is stipulated that all women have the right to select which method of contraception to use and have the right to protect themselves against STIs, including

¹⁶⁶ African Charter Article 16.

¹⁶⁷ African Charter on the Rights and Welfare of the Child adopted July 1990, (entered into force 29 November 1990), Organisation of African Unity (OAU) Doc.CAB/LEG/24.9/49

¹⁶⁸ Goldblatt & Mclean (n 135 above) 189-190.

¹⁶⁹ Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, adopted 11 July 2003, (entered into force 25 November 2005), 2nd Ordinary Session of the Assembly of the African Union, AHG/Res. 240 (XXXI).

¹⁷⁰ General Comments on Article 14(1) (d) and of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa 2012.

HIV/AIDS. This right can be linked to a woman's right to make an informed decision regarding reproductive health. It is also stipulated that every woman be educated on family planning education.¹⁷¹

Under Article 14(2), state parties have to take all necessary measures to provide adequate, affordable and accessible health services. All women, especially those in rural areas, must have access to information, education and communication programmes. The existing prenatal, delivery and postnatal health and nutritional services for women during pregnancy and while they are breastfeeding must be strengthened and established. Women must be healthy before, during and after pregnancy, as well as while they are breastfeeding. The reproductive rights of women must be protected through the authorisation of medical abortion in cases where there has been sexual assault, rape or incest, or where the continued pregnancy puts the mental and physical health of the mother or the life of the foetus and mother at risk.¹⁷² This means women should not be prosecuted, punished or discriminated against for an abortion. In addition to reproductive and sexual rights, every woman has the right to other interconnected rights, such as the right to equality, peace, education, work, positive cultural context and food security.

4.3.4 The African Union

Through instruments, resolutions and initiatives, the African Union (AU) acknowledges the dire situation regarding maternal mortality in Africa and has taken steps to ensure that African states recognise this and commit to doing something about it. Various policies were put into place to realise the shortcomings and attempt to remedy them.

- **The Abuja Declaration on HIV/AIDS, Tuberculosis and Other Infectious Diseases**

The Abuja Declaration on HIV/AIDS, Tuberculosis and Other Infectious Diseases, created in 2001, calls for states to allocate 15% of their national budget to health. States must ensure that market based economic development strategies do not take

¹⁷¹ Women's Protocol Article 14(1)(e).

¹⁷² Women's Protocol Article 14(2).

away their obligation to ensure the right to health. Health policies, initiatives and reforms must adequately consider poor women and women from rural areas. Antenatal and obstetric services must be free, available, and accessible in a way that is practical. A human rights approach must be adopted with regard to maternal and reproductive health.

- **Declaration on Economic, Social and Cultural Rights**

It is enshrined in the Declaration on Economic, Social and Cultural Rights of 2004 that the absence of political will, privatisation and necessary services, failure to distribute adequate resources and 'brain drain', among other things, are at the core of the failure to realise economic, social and cultural rights in Africa.

- **Promotion of Sexual and Reproductive Health and Rights in Africa**

The Sexual and Reproductive Health and Rights Continental Policy Framework established in 2005 as a response to high maternal and infant mortality rates in Africa.¹⁷³ States acknowledge that sexual and reproductive health is important. Failure to realise sexual and reproductive health is a violation of the right to health and other human rights. Further, they acknowledge that there is a connection between gender inequality and women's health and failure to access healthcare services and acquire necessary knowledge regarding their sexual health. States must ensure equality and effective solutions to reduce preventable maternal mortality.¹⁷⁴ States commit to ensuring realisation of MDG 4 to reduce maternal mortality, and that the health of young girls, adolescents and women at a reproductive age is not ignored.¹⁷⁵ The policy also looks at the importance of prevention, coordination, mobilisation of resources, strengthening of health systems and the eradication of current gaps in reproductive health services.

- **The Maputo Plan of action**

¹⁷³ The African Union Commission's 'Sexual and Reproductive Health and Rights Continental Policy Framework' (2005) 5.

¹⁷⁴ Sexual and Reproductive Health and Rights Continental Policy Framework, The African Union Commission (2005) 23.

¹⁷⁵ n 72 above, 24.

The Maputo Plan of Action (MPoA) was created in 2006 with the goal of reducing MMR in Africa. The initiative features the guarantee of access to comprehensive sexual and reproductive health for all individuals and includes the adoption of HIV/AIDS services as reproductive and sexual rights. It promotes family planning and uses that platform to address unsafe abortions. It supports the needs of adolescents and young people in issues regarding sexual and reproductive health. It also supports the provision of affordable health services and promotes motherhood.¹⁷⁶

- **Resolution on Maternal Mortality in Africa**

The Resolution on Maternal Mortality in Africa of 2008, recognises the improvement of maternal and reproductive health as both regional and international obligations. One of the reasons for this resolution was the concern that many member states of the AU had not made progress in reducing maternal deaths in their respective states. The resolution includes recommendations regarding how maternal mortality with reference to the Abuja Declaration on HIV/AIDS, Tuberculosis and Other infectious Diseases of 2001. Further, the resolution recommends how strategies and programmes to reduce maternal mortality must operate. This includes participation of women, positive discrimination, education of women and girls, training of health workers and ensuring adequate staff in rural areas.

- **The Campaign for Accelerated Reduction of Maternal Mortality**

On 7 May 2009, the African Union launched the Campaign for Accelerated Reduction of Maternal Mortality (CARMMA) in order to address the issue of maternal mortality in African countries. CARMMA was not meant to be a new or innovative initiative. Rather, it was launched within the context of the AU policy framework for the promotion of Sexual and Reproductive Health and Rights in Africa (2005) and the MPoA. The goal was to ensure coordination and implementation of existing initiatives.¹⁷⁷

The criteria used for the selection of member states were based on the high incidence of maternal mortality and high commitment from political and international bodies. The initiative promotes the generation and provision on maternal and new born

¹⁷⁶ Maputo Plan of Action African Union <http://pages.au.int/pages/carmma/maputo> (accessed 24 October 2015).

¹⁷⁷ CARMMA <http://m.carmma.org> (accessed 24 October 24, 2015).

mortality rates. It encourages stake holders to show political will and use resources to ensure maternal and newborn health. It is to set into motion activities set to reduce maternal mortality.¹⁷⁸

4.4 Conclusion

The right to health is widely protected on a national, regional and international scale through legislation and policy. The various legislative documents discussed above accommodate the biological and physical needs of women. While some documents are more detailed with regard to the scope of maternal healthcare than others, it is clear that the realisation of the right to maternal healthcare depends on the socio-economic infrastructure and societal behaviour (this includes the behaviour of men, women and healthcare workers).

¹⁷⁸ n 174 above.

An outline of the scope of maternal mortality in ICESCR

Chapter 5

5.1. Introduction

ICESCR includes provisional norms addressing maternal mortality that need to be explored. Every woman's social, economic and cultural rights include the right to mental and physical health, reproductive rights, sexual freedom, social security and social protection.¹⁷⁹ Economic, social and cultural rights are particularly important to women's well-being because women are unfairly affected by social and cultural marginalisation.¹⁸⁰ Despite significant legal achievements towards women's equality, the MMR in South Africa remains unreasonably high. With this in mind, this study seeks to discover whether the addition of ICESCR as a binding international treaty has the potential to advance the reduction of maternal mortality and therefore promote reproductive rights. This chapter looks at provisions in ICESCR which directly address maternal mortality, the ways in which these provisions are to be implemented and the restrictions that may or may not affect the realisation of these provisions. ICESCR will now be briefly discussed as a customary law.

5.2 ICESCR as Customary law

Customary international law is an important source of international law. It draws its origin from customs exercised over an extended period of time by certain states. The customs are not formally written in legal instruments, however, they have been established as international norms to which states must adhere. States can be bound to a treaty regardless of the fact that they did not ratify it. The two main characteristics of customary law are that it is practiced by the state and *opinio juris*, which is the state's acknowledgement of their legal duty. Under the principle of customary international law, if a state has widely ratified UN and regional treaties, as well as other instruments recognising international law, it can be deduced that international customary law of human right also applies to that state. States which have not ratified the treaty or legal instrument still have an obligation even though there has not been

¹⁷⁹ M Senyonjo *Women's Economic, Social and Cultural Rights* (2000) 245 para 1.

¹⁸⁰ Senyonjo (n 176 above) para 2.

ratification.¹⁸¹ For example, ICESCR is arguably customary international law due to its universal acceptance. Therefore, it may have been binding to South Africa prior to ratification.¹⁸²

5.3 Legal provisions

5.3.1. Article 12

The right to the highest attainable standard of health is expressed in Article 12(a) of ICESCR. This normative provision is not very clear, however, when the reduction and prevention of maternal mortality in particular is considered.¹⁸³ The right can promote and legitimise policies and programmes that opt to prevent maternal mortality. Article 12(2)(a) places a duty on the state to ensure that the stillbirth rate and infant mortality are reduced. Article 12(2)(c) envisions an enabling environment where medical services and medical treatment are available.¹⁸⁴ Article 12 is further enhanced by Article 10(2), which stipulates that it is the duty of state parties to ensure protection to mothers within reasonable time prior to and after childbirth.¹⁸⁵

The right to health is based on the values of equality and freedom from all forms of discrimination. This feature is important to maternal mortality as it may reinforce programmes and policies that are associated with the equal distribution of healthcare services. This means that mothers living in poor or indigenous area will have healthcare services available to them. The right to the highest attainable standard of health can also reinforce the prioritisation of emergency obstetric care which can increase their safety during child birth. Finally, health as a principle that promotes equality and non-discrimination also promotes cultural sensitivity, privacy, dignity and confidentiality. This has the potential to improve the relationship between health personnel and expecting mothers. It can also encourage women to report to healthcare providers.¹⁸⁶

¹⁸¹ JL Goldsmith & EA Posner *The limits of international law* (2005) 199.

¹⁸² D Desierto *Public Policy in International Economic Law: The ICESCR in Trade, Finance and Investment* (2015) 205-206

¹⁸³ Yamin & Maine (n 47 above) 586.

¹⁸⁴ ICESCR Article 12 2(b).

¹⁸⁵ Yamin & Maine (n 47 above) 166.

¹⁸⁶ Yamin & Maine (n 47 above).

The right to the highest attainable standard also includes the right to partake in the development of policies on a local, national and international level. If relevant stakeholders, including women, have the opportunity to participate in the process, more effective and substantial programmes can be implemented, exclusion can be reduced and accountability can be increased.¹⁸⁷ Accountability and the monitoring of programmes is another important feature of the right to health. This can, in effect, also reduce maternal mortality. The right to health calls for accountability from healthcare providers, local health establishments, the state, international organisations and civil society. Within the framework of maternal mortality policies, these features assist in empowering women and ensuring that policies are likely to be sustainable and effective.¹⁸⁸

In General Comment No.14, the Committee explains that the right to health should be understood as including rights that are linked and mutually supporting, which function jointly in order for the highest standard of health to be achieved.¹⁸⁹

As a package, General Comment No.14 includes:

- a) The right to health and the freedom to make informed decision. This includes the right to have control over one's health and body;
- b) Control of personal autonomy when pursuing healthcare;
- c) Participation in decisions that are related to health;
- d) Reproductive freedom and freedom from torture.

5.3.2 General Comment No.14

The international community has, in the form of General Comment No.14, adopted guidelines to clarify the scope of Article 12. These guidelines accord to human rights principles and specify measurable steps that states bound by ICESCR should take.¹⁹⁰

¹⁸⁷ B Sauk et al *The international covenant on economic, social and cultural rights. Commentary, cases and materials* (2014) 1033.

¹⁸⁸ Sauk (n 187 above) 1034.

¹⁸⁹ General Comment No 14 (n 85 above).

¹⁹⁰ Yamin & Maine (n 47 above) 591.

General comment No.14 therefore enhances the discourse of maternal mortality within ICESCR.¹⁹¹

In Paragraph 33 of General Comment No.14 it is stated that the right to health, like all other human rights, places obligation on state parties to respect, protect and fulfil. The obligation to respect requires state parties to neither directly nor indirectly obscure the realisation of the right to health. The obligation to protect requires states to stop third parties from violating the rights inscribed in Article 12. The obligation to fulfil requires states to implement suitable legislative, judicial, financial, administrative, promotional and any supplementary measures that will, in effect, guarantee the right to health.¹⁹²

General Comment No.14 elaborates on the content of Article 12(2)(a), which prescribes a decrease in the stillbirth rate, infant mortality and promotes health development of the child. In General comment No.14 it is stated that scope of this provision should be accepted to include measures that improve the health of the child and the mother, and sexual and reproductive healthcare facilities which include access to family planning, emergency obstetric services, prenatal and postnatal care and access to information, including the provision of funds to take necessary steps on the basis of that information.

General Comment No.14 also gives meaning to Article 12(2)(d) regarding the right to health goods and services. In Article 12(2)(d) the state has the duty to create an environment which ensures medical service and medical attention in the case of sickness. This includes equal and appropriate access to fundamental preventative, rehabilitative health services and health education; systematic screening programmes; appropriate treatment of recurring illnesses, injuries, diseases such as HIV/AIDS, and disabilities, all preferably at community level.¹⁹³

With regard to women and the right to health, General Comment No.14 stipulates that in order to eradicate discriminatory attitudes towards women, a comprehensive national programme must be developed. This programme must promote women's health for their entire lifespan and must consist of interventions directed at the

¹⁹¹ Songane (n 82 above).

¹⁹² Bekker *Compilation of Essential documents on the right to health* (2000) 140.

¹⁹³ Bekker (n 192 above) 100.

treatment and prevention of diseases, particularly those which affect women. Furthermore, the programme should offer access to a quality healthcare, which is affordable – including sexual and reproductive facilities. The primary objective should be to reduce maternal mortality and health risks. It is vital that preventative, promotive and remedial steps are undertaken to protect women from the effects of degrading traditional cultural practices and norms that hamper the enjoyment of their reproductive rights.¹⁹⁴

5.4 Progressive realisation and available resources

In contrast to the right to education and children's rights, the right to healthcare is subject to internal limitation. One of the causes of maternal mortality is the absence of available resources. Article 2(1) of ICESCR determines the extent of state responsibility with regard to the right to health. State parties must take cautious steps, through all appropriate measures and to the availability of maximum resources, in order to achieve progressively the full enjoyment of socio-economic rights.¹⁹⁵ There is much debate about what the term 'progressive realisation' implies. The limitation clause does not specify precise time limits, the percentage or treatment coverage of people over time or how the state is to fund access to health in order to realise reproductive rights.

The following is a brief assessment on the scope of the phrase 'progressive realisation' and 'available resources' as submitted by relevant bodies.

The Committee to ICESCR made various comments with regard to the qualification 'available resources'. The intention of this qualification is to make the right to health practical. Where resources are unavailable, the state must be able to show that it has used all of the available resources, to the maximum extent, in order to realise the obligation. The provision also ensures that states are not called to deliver resources which are beyond their means. Therefore, the obligation is not absolute.

When providing minimum essential levels of emergency obstetric services the state must use maximum available resources for all healthcare services. The UN

¹⁹⁴ Bekker (n 192 above).

¹⁹⁵ ICESCR Article 2(1).

Guidelines include a primary standard for emergency obstetric care which can guide state parties on the manner in which they should allocate healthcare budgets and expenditure. Any significant deviation from the minimum levels stated in the UN Guidelines, any discrimination to a particular group of the population in terms of emergency obstetric coverage, or any backtracking or active deprivation with respect to the provision of such care is an immediate violation of this feature of the right to health. Moreover, a comparison can be made between information about the country's resources with the measured per capita GDP, to states that have similar resources.¹⁹⁶

In 1986 experts in international law gathered by the international commission of jurists came to discuss the obligation of State parties to the ICESCR. The result of the meeting was the Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights. The Maastricht Guidelines on Violations of Economic, Social and Cultural Rights followed 10 years later.¹⁹⁷

The Limburg Principles on the implementation of ICESCR explicitly stipulate the mandate to implement progressively the full realisation of inscribed rights. State parties must work as expeditiously as possible. In addition, General Comment No.14 states that the progressive realisation of the right to health over a period of time must not be construed as eliminating state parties' obligation. Instead, progressive realisation means that states parties have an explicit and ongoing obligation to move as expeditiously and effectively as possible in order to fully realise Article 12.¹⁹⁸

The Maastricht Guidelines, articulated in 1997, highlight the requirement of immediate steps. It is stated that the fact that the full realisation of majority of economic, social and cultural rights can only be achieved progressively does not change the nature of the legal mandate upon states, which requires particular steps to be followed instantaneously. With regard to health specifically, the Committee to ICESCR further expressed that there is a minimum core obligation not to deprive

¹⁹⁶ Yamin & Maine (n 47 above) 593.

¹⁹⁷ Office of the United Nations High Commissioner for Human Rights (OHCHR) *Economic, Social and Cultural Rights Handbook for National Human Rights Institutions:2005*

¹⁹⁸ n 85 above.

Domestic case law has explored the terminology ‘progressive realisation’ and ‘within available resources’. In the *Grootboom*¹⁹⁹ case, the claimant approached the court claiming the socio-economic right to housing. The Constitutional Court interpreted the articulation ‘progressive realisation’ inscribed in section 26(2) of the Constitution²⁰⁰ to impose a duty on the state to progressively enable access to housing by investigating legal, administrative, operational and financial impediments and, if it was possible, lowering these over time. The phrase ‘within available resources’ was interpreted to mean the speed at which the obligation is accomplished as well as the reasonableness of procedure taken to achieve the result should be based on the availability of resources. According to the court, section 26 of the Constitution does not require the state to do more than what they can within the available resources.

In the *Soobramoney*²⁰¹ case the term ‘available resources’ was referred to by the applicant, who claimed that certain provisions regarding kidney dialysis treatment from a provincial government hospital infringed on his right to emergency medical treatment²⁰² and right to life. The court dismissed the application founded on these two rights. The court discussed the potential success of the claim had it been brought on the grounds of section 27(1)(a) – right to access to healthcare services. The court further commented that section 27(1)(a) is complemented by section 27(2), which *inter alia* determines that the state only has the obligation to give effect to the section 27(1)(a) within its available resources.

5.5 Implications of ICESCR

The ratification of ICESCR implies several things for South Africa as a state party to the Covenant. South Africa can look to the international community for assistance in implementing reproductive rights and reducing maternal mortality. International law can help legitimise and strengthen reproductive rights or related rights as expressed in the Constitution. In the Constitution, the implementation of the right to health is

¹⁹⁹ *Government of the Republic of South Africa & Others v Grootboom & Others* 2000 11 BCLR 1169.

²⁰⁰ Section 27(6) of the Constitution ‘Everyone has the right to have access to adequate housing.’ 26(2) stipulates that the state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of this right.

²⁰¹ *Soobramoney v Minister of Health (KwaZulu-Natal)* 1998 (1) SA 765 (CC).

²⁰² Constitution Section 27(3).

restricted by a reasonable test.²⁰³ It can also be expected that courts will develop a reasonableness test and include a requirement that the government prioritises protection to the right to access to healthcare. Under ICESCR, state parties must provide data on the maternal mortality indicators as prescribed by WHO with respect to the number of women who have access to qualified health personnel during pregnancy, as well as the number of women who were attended to by such personnel during labour. This includes the MMR prior to and after childbirth.²⁰⁴

Furthermore, with ratification of ICESCR, South Africa is eligible to sign and ratify the Optional Protocol to the International Covenant on Economic, Social and Cultural Rights (OP-ICESCR).²⁰⁵ This instrument enables women whose reproductive rights have been violated to seek redress where domestic remedies are insufficient. Communications can be submitted on behalf of individuals or groups of individuals to the Committee, alleging that their state has violated the relevant rights contained in ICESCR, or has unreasonably delayed them. A state party has the capacity to address the non-fulfilment of the obligations stipulated in ICESCR by another state party. The OP-ICESCR requires state parties to distribute ICESCR, the OP-ICESCR and views and recommendations which the Committee has made. Widespread knowledge of the state's obligation to ensure the right to health can be a powerful tool in increasing civil society's awareness of the state of maternal mortality and encouraging their involvement in holding the state accountable for failing to adhere to their obligation. OP-ICESCR offers an inquiry procedure whereby the Committee may examine information and submit its observations, which will improve the state's devotion to reducing maternal mortality.²⁰⁶

In respect of the South African Constitution, it should be noted that rights related directly and indirectly to reproductive rights in ICESCR are also stipulated in the Constitution. In fact, several constitutional provisions and their constructions were inspired by, and indeed resemble, the provisions of ICESCR. The phrase 'subject to

²⁰³ Section 36 (1) *'The rights in the Bill of Rights may be limited only in terms of law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom'*.

²⁰⁴ Gruskin & Tarantola (n 5 above).

²⁰⁵ Adopted by the General Assembly on 10 December 2008 and was opened for signature on 24 September 2009.

²⁰⁶ F Viljoen & N Orango 'An argument for South Africa's Accession to Optional Protocol to the International Covenant on Economic, Social and Cultural rights in the light of its importance and implications'(2014) 17 *Potchefstroom Electronic Law Journal (PLJ)*2554.

available resources' in the Constitution is similar to the phrase 'to the maximum of its available resources' found in Article 2(1) of ICESCR. The description of the means through which the state is required to realise socio-economic rights in the Constitution is articulated as 'reasonable legislative and other measures'²⁰⁷ is similar to those mentioned in Article 2(1) of ICESCR, which reads 'all appropriate means, including particularly the adoption of legislative measures'.

As found in the case study above, the Constitution also makes provision that realisation of the right must be progressive and within available resources. ICESCR is more explicit, however, about the scope of reproductive rights and the obligation of the state through general comment No.14. In the Constitution, the right to healthcare is preceded by the term 'access to'. The formulation in the Constitution can be understood as meaning that an enabling environment²⁰⁸ where the right to health can fully be realised has to first be created. In ICESCR, the formulation is rather direct. The General Comments issued by the Committee can play an important role in assisting courts in sustaining uniformity between domestic laws and policies and South Africa's obligations under ICESCR.²⁰⁹

CEDAW is also clear on maternal health as a human right to which every woman is entitled. It furthermore looks at relevant social features that lead to maternal mortality such as family planning.²¹⁰ The phrase progressive realised in ICESCR is expressed differently in CEDAW. CEDAW phrased slightly differently. It is inscribed that the state must 'take all appropriate measures to eliminate discrimination in healthcare; this includes special measures for pregnant women.' This wording, however, does not mean that the state parties to CEDAW have the freedom to indefinitely avoid taking appropriate action with respect to such rights.

5.6 Conclusion

ICESCR encompasses detailed provisions regarding reproductive rights and maternal healthcare. The ratification of ICESCR is a significant step towards the reduction of preventable maternal mortality. It is explicit about the standard that must

²⁰⁷ Constitution section 27(2).

²⁰⁸ The Constitution Section 24(a).

²⁰⁹ Viljoen & Orango (n 206 above).

²¹⁰ CEDAW Article 10(h), Article 12 & Article 14(b).

be employed when dealing with issues of maternal health, and shows the important link between maternal mortality and the implementation of socio-economic rights. While ICESCR is somewhat limited, this does not erode the fact that it is a necessary addition in the enhancement of maternal healthcare.

Conclusion and Recommendations

Chapter 6

6.1. Introduction

It has by now been established that maternal mortality is a serious matter in South Africa, and that many of these deaths are preventable. The current maternal mortality rate in South Africa of 147 MMR per 100 000 live births is unacceptable, especially if you take into account that the country is economically well-developed and human rights are highly regarded. South African national law envisions a health system where every person has equal access to health services. International law is vital to the progress of human rights. The Constitution requires courts to view international law as a valid source of law. When South Africa ratified ICESCR, it inherited the benefits. The protection and implementation of socio-economic rights is strengthened because now the international community can, for instance, intervene in the discourse regarding maternal mortality on the grounds that South Africa has failed to meet its socio-economic duties. Accountability and transparency can strengthen the state's mandate to respect, promote and fulfil the right to maternal health. This thesis questions whether ratification of ICESCR can indeed lower the maternal mortality rate. ICESCR does, after all, comprise of a detailed scope regarding maternal mortality inscribed in General Comment No.14. The Constitution merely states that every person has the right to reproductive rights.

6.2 Maternal Health as a Socio-economic Right

Notwithstanding possible developments, ICESCR will play a minimal role if there is a lack of political will by relevant bodies. If the status of socio-economic rights in the international community is also considered, the commitment of states in ensuring their implementation is not as strong, especially compared to civil rights. Various states regard socio-economic rights as idealistic goals due to the fact that their implementation is primarily dependent on natural resources. An example of a state which has not ratified ICESCR is the United States of America (USA). This in itself speaks volumes about the status of socio-economic rights, considering the fact that the USA is one of the world's most influential developed nations. The USA has a lower

MMR than South Africa. In 2013 it was estimated that the North American maternal mortality rate was 28 per 100 000 live births while, in South Africa at that time it was 140. However, it should be noted that the MMR of the USA was found to be the highest among developing countries, with the United Kingdom at 8 per 100 000 MMR.²¹¹

Several developing nations that ratified ICESCR long before South Africa still have staggering MMRs, for example, Sierra Leone. It is estimated that Sierra Leone is the developing country with highest MMR at 1 100.²¹² Sierra Leone ratified ICESCR on 23 August 1996. That said, other developed states which ratified ICESCR have made significant developments, such as Rwanda. Rwanda's MMR has decreased at a fast rate – 50% between 2000 and 2010. According to the Atlas of African Health Statistics modelled data, the country has achieved an MMR of 340 per 100 000 live births. Rwanda ratified ICESCR in 1975.²¹³ The Rwanda Demographic Health Survey (RDHS) data illustrated an MMR of 476 per 100 000 in 2010.²¹⁴ Declines in maternal mortality were found to be linked to improvements in the contraceptive prevalence rate and trained birth attendance. Rwanda is on track to meet the MDGs to reduce maternal mortality. There has been a 76% reduction since the goals were inscribed in 2000.²¹⁵ Conversely, South Africa has failed to meet this goal.

6.3 Maternal Mortality as Customary Law

Maternal health was already customary law prior to South Africa's ratification. It was already recognised in domestic law and inscribed in other international and regional instruments such as CEDAW²¹⁶ and the Women's Protocol, which South Africa already ratified prior to its ratification of ICESCR.²¹⁷ Both of these documents include strong provisions regarding women's maternal health and reproductive rights. Domestic law provides for maternal mortality in the Constitution, and the White Paper can be used as an important guide in the reduction of maternal mortality.

²¹¹ WHO, UNICEF, UNFPA, THE World Bank and the United Nations 2014 Population decision *Trends in Maternal Mortality: 1990 to 2013*, 34-35.

²¹² WHO, UNICEF, UNFPA, The World Bank and the United Nations Population decision (n 194 above) 2.

²¹³ WHO's *The Atlas of African Health Statistics* (2012) 146.

²¹⁴ *The Rwanda Demographic Health Survey* (2010) 26.

²¹⁵ Ministry of Health, Rwanda *Success Factors for Women's and Children's Health for Women's and Children's Health: Rwanda* 2014.

²¹⁶ Ratified in 1995.

²¹⁷ Ratified in 2004.

6.4. Concluding Observations

The UN Committee's have made concluding observations regarding issues of maternal mortality. This section provides a brief discussion of concluding observations made by the UN Committee on Economic, Social and Cultural Rights (CESCR) and the UN Committee on the Elimination of Discrimination against Women. The discussion includes an assessment of concluding observations made on randomly selected African states.

The UN CEDAW Committee expressed concern regarding the availability of health facilities for women and the high levels of maternal mortality in Zambia.²¹⁸ The Committee commended the state for the adoption of the Mental Health Policy and the commencement of the Campaign for Accelerated Reduction of Maternal Mortality in Africa.²¹⁹ The Committee advised the state to take serious initiative to ensure that women's access to reproductive health facilities within the structure of general recommendation No.24 on article 12 of CEDAW.²²⁰

The UN CEDAW Committee commented on the high levels of maternal mortality in South Africa. The committee noted the fact that a great number of maternal deaths are caused by non-pregnancy associated diseases such as HIV.²²¹ The Committee recommended, amongst other things, that the state must ensure the implementation of the Maternal Child and Women's Health Strategy (2009-2014)²²² and continue to respond to the problem of HIV/AIDS among girls and women *inter alia*.²²³

Women and girls in Tanzania are disadvantaged by socio-economic inequalities that negatively affect their right to sexual and reproductive health information, goods and services. The CESCR recommended that steps must be taken to ensure that these

²¹⁸ Concluding Observations of the UN Committee on the Elimination of Discrimination against Women: Zambia, adopted 11-29 July 2011, Committee on the Elimination of Discrimination against Women, 49th session, page 33, CEDAW/C/ZMB/CO/4-6 (2011).

²¹⁹ n 218 above, para 5.

²²⁰ n 218 above, para 34 (a).

²²¹ Concluding Observations of the UN Committee on the Elimination of Discrimination against Women: South Africa, adopted 17 January—4 February 2011, Committee on the Elimination of Discrimination against Women, 48th session, para 35, CEDAW/C/ZAF/CO/4 (2011).

²²² n 221 above, para 36(a).

²²³ n 221 above, para 36(b).

women have improved access to health facilities.²²⁴ The state must strive towards universal healthcare coverage with utmost determination. This includes ensuring enhancement to women's access to obstetric and neonatal care, especially in rural areas.²²⁵

In the concluding observations that the CESCR made towards Kenya, the link between HIV/AIDS and maternal mortality is well established.²²⁶ Pregnant women living with HIV must be informed that they have free access to antiretroviral medication during pregnancy, labour and after birth. The Committee urged the state to ensure that no woman faces mistreatment or discrimination during pregnancy and delivery.²²⁷ Further, maternal fees in public hospitals must be reduced without this negatively impacting the quality services.²²⁸

The concluding observations made by UN Committees are important because they broadly clarify the overall status of maternal mortality. They are an opportunity for comparisons to be made between states; they offer guidelines and enhance the implementation of rights. From the above, it can be concluded that maternal mortality is a public health concern and reducing maternal mortality and morbidity is at the core of international and national commitments.

6.5 Concluding remarks

The use of the international or regional system to advance rights can be more complex and time consuming than national laws. One needs to have exhausted the local remedies to have the capacity to engage the international mechanisms. International and regional bodies play a greater role for those countries without strong and independent domestic institutions. There are various institutions within South Africa that support the reduction of maternal mortality, such as an independent judiciary, national human rights commissions and public protectors. As a result, the

²²⁴ Concluding Observations of the UN Committee on Economic, Social and Cultural Rights (CESCR): Tanzania, adopted 23-30 November 2012, Committee on Economic, Social and Cultural Rights, 49th session, para 8, E/C.12/TZA/CO/1-3 (2012).

²²⁵ n 224 above, para 24.

²²⁶ Concluding Observations of the UN Committee on Economic, Social and Cultural Rights (CESCR): Kenya, Committee on Economic, Social and Cultural Rights, para 39, E/C.12/KEN/CO/1 (2008).

²²⁷ n 226 above, para 32 (a).

²²⁸ n 226 above, para 32 (b).

need to use the international institutions to protect rights is weaker. There is a clear link between HIV/AIDS infections and maternal mortality.

Ultimately, it comes down to political will, which is absent both on a national and international level. In light of this it is difficult to see how ICESCR and its provisions specifically regarding maternal health can significantly reduce maternal mortality.

6.6 Recommendations

The issue of maternal mortality must be dealt with and regulated on a domestic level. Domestic law makes important provisions regarding reproductive rights and safe motherhood. The issue lies in practicality rather than policy.

The governance structure in the health system needs to be strengthened. The strengthening of accountability, monitoring and evaluation can ensure that relevant health personnel and health service providers take the necessary steps to ensure that mothers experience safe pregnancy, childbirth and motherhood. The behaviour of health personnel must be monitored to ensure that the human rights of pregnant women are being respected. Any contradictory behaviour should be reported and discouraged.

There needs to be better accountability and transparency with regard to government expenditure on health facilities. If the necessary funds are utilised appropriately, quality health facilities can be made available and accessible to pregnant women regardless of geographical location. Focus should be placed on improvised and isolated areas.

There is a need for a change in social attitudes towards pregnancy and childbirth. All women attending maternal healthcare facilities must be offered HIV/AIDS testing. Furthermore, they must be made aware of the risk factors of being pregnant while HIV positive. Local and international initiatives that aim to reduce HIV/AIDS infections must be strengthened. Initiatives towards educating both young men and women should be enforced with urgency and efficiency. High-risk groups in particular must be targeted. This includes females under the age of 18. The health risks during pregnancy, family planning and human rights must be included in study curriculums.

The treatment of pregnant women at health institutions by health personnel must be addressed by the state. In November 2015 the Gauteng Department of Health appointed industrial psychologist to assist and improve how nurses interact with patients. This was after the department received high number of complaints about the negative behaviour of nurses towards pregnant women. The program will be based at mother and child hospitals where nurses will be trained on how to interact with difficult patients, diversity, cultural and language differences.²²⁹ The program is yet to be implemented and its success or failure is yet to be documented. However, such initiative is important and should be expanded to rural areas.

Finally, a human rights-based approach must be implemented in the discourse of maternal mortality, as this can break down social barriers such as discrimination and traditional values preventing women from accessing healthcare facilities. A human rights approach will ensure that the state acts accordingly. It will also ensure the realisation of every individual's socio-economic rights.

Under human rights law, maternal mortality is a violation of a cluster of rights. If all relevant stakeholders make maternal mortality a primary matter of concern and ensure that provisions inscribed in all relevant legal documents are met, maternal mortality can be significantly reduced in South Africa, and initiatives towards reduction can successfully be accomplished.

²²⁹ 'South Africa: Gauteng Health appoints psychologist to assist nurses improve patient care' <http://www.allafrica.com/stories/2015111811431.html> (accessed 19 November 2015).

Bibliography

Books

Afulukwe-Erachalu, O 'Accountability for non-fulfilment of human rights obligations: A key strategy for reducing maternal mortality in sub-Saharan Africa.' In Ngwena, C & Durojaye, E (eds) (2014) *Strengthening protection of sexual and reproductive health and rights in the African region through human rights* Pretoria: PULP

Arambulo, K (1999) *Strengthening the Supervision of the International Covenant on Economic, Social and Cultural Rights: Theoretical and Procedural Aspects* Antwerpen: Intersentia

Ataguba, JE, Benatar, SR, et al (2012) *Health and Health Care in South Africa: Second Edition* The Free State: Van Schaik Publishers

Barnieh, BA 'Cultural practices, beliefs, traditions and norms in Atwima Nwabiagya District: A blessing or a curse for Maternal Health?' in U GroB & K Wydra (eds) (2013) *Maternal-Child Health: Interdisciplinary Aspects within the perspective of Global Health* Göttingen: Göttingen International Health Network

Bekker, G (2000) *Compilation of Essential documents on the right to health* Pretoria: PULP

Desierto, D (2015) *Public Policy in International Economic Law: The ICESCR in Trade, Finance and Investment*: Oxford University Press

Dodd R & Munck L (2001) *Dying for Change: Poor People's Experience of Health and Ill-health* Washington DC: World Health Organization

Gruskin, S & Micheal A. Gordin et al (2005) *Perspectives on Health and Human Rights* New York: Routledge, Taylor, and Francis group

Goldblatt, B & Mclean, K (2011) *Women's Social and Economic Rights: Development in South Africa* Cape Town: Juta

Hunt, P & Gray, T (2013) *Role of National and International Courts' book-maternal*

mortality, human rights and accountability Routledge, Taylor, and Francis group

Laden, MT (2007) *Law and Policy: on health, HIV-AIDS, Maternal Mortality and Reproductive rights in Nigeria* Abuja: Faith Printers and Publishers

Makoi, A 'Maternal health care in rural areas of Tanzania: how do beneficiaries perceive the quality of services?' in U GroB & K Wydra (eds) (2013) *Maternal-Child Health: Interdisciplinary Aspects within the perspective of Global Health* Göttingen Göttingen: International Health Network

Murphy, T (2013) *Health and Human Rights* Nottingham: Hart Publishing

Pieterse, M (2014) *Can Rights Cure? The impact of human rights litigation on South Africa's health system* Pretoria: PULP

Olajide, A & Temitayo, A 'Household Food Insecurity and Hunger: Implications for Maternal and Child Health in Nigeria' in U GroB & K Wydra (eds) (2013) *Maternal-Child Health: Interdisciplinary Aspects within the perspective of Global Health* Göttingen: Göttingen International Health Network

Paulick, J & Vollmer, S 'Maternal and Child Health in Sub-Saharan Africa' in U GroB & K Wydra (eds) (2013) *Maternal-Child Health: Interdisciplinary Aspects within the perspective of Global Health* Göttingen: Göttingen International Health Network

Pinho, DH 'Prioritizing women's health' in Clapham, A et al (eds) *Realizing the right to health right Swiss Human Rights Book (vol.3)* Berlin: Ruffer & Rub

Sauk, B, Kinley, D & Mowvra, J (2014) *The international covenant on economic, social and cultural rights: commentary, cases and materials* Oxford: Oxford University Press

Senyonjo, M (2000) *Women's Economic, Social and Cultural Rights* London: Hart Publishing

Songane, FF 'Maternal Mortality: An overview' in Hunt & Gray (eds) (2013) *Maternal Mortality, Human Rights and Accountability* Edinburgh: Routledge

Welsh, D (2009) 'The Rise and Fall of Apartheid' Johannesburg and Cape Town:
Jonathan Ball Publishers

Van Rensburg, HCJ, et al (1992) *Health Care in South Africa. Structure and
Dynamics* Free State: Van Schaik Publishers

Van Rensburg, HCJ, (ed) (2004) *Health and Health Care in South Africa* Free State:
Van Schaik Publishers

Journal Articles

Bernhard, G & Versteeg, M 'The state of the right to health in rural South Africa.' (2011)
South African Health Review 99-106

Cabal, L & Stoffregen, M 'Calling a Spade a Spade: Maternal Mortality as a Human
Rights Violation' (2009) *16 Human Rights Brief* 2-6

Coovadia, H 'The health and health system of South Africa: historical roots of current
public health challenges' (2009) 374.9692 *The Lancet* 817

Hutson, S 'Gender oppression and discrimination in South Africa' (2007) 5 *ESSAI* 26

Keegan, K & Tollman, M 'A perspective of primary health care in South Africa' (2008)
South African Health Review 17

Keymanthri, M & Rowe, K 'Patients as consumers of health care in South Africa: The
ethical and legal implications' (2003) 14.1 *BMC Medical Ethics* 15

Yamin, AE & Maine, DP 'Maternal mortality as a Human Rights Issue: Measuring
Compliance with international Treaty Obligations' (1999) 21 *Human rights quarterly*
563

Viljoen F & Orango N 'An argument for South Africa's Accession to Optional Protocol
to the International Covenant on Economic, Social and Cultural rights in the light of its
importance and implications'(2014) 17 *Potchefstroom Electronic Law Journal*
(PLJ)2554

International Instruments

African Charter on Human and Peoples' Rights, adopted 27 June 1981, entered into force 21 October 1986, OAU Doc. CAB/LEG/67/3 Rev. 5, 1520 U.N.T.S. 217 (African Charter).

African Charter on the Rights and Welfare of the Child adopted July 1990, (entered into force 29 November 1990), Organisation of African Unity (OAU) Doc.CAB/LEG/24.9/49

Convention on the Elimination of All forms of Discrimination against Women, adopted and opened for signature, ratification and accession by General Assembly resolution 34/180 of 18 December 1979. Entry into force 3 September 1981, in accordance with article 27(1)

The International Covenant on Economic, Social and Cultural Rights and the International Covenant on Civil and Political Rights were adopted by the General Assembly by its resolution 2200 A (XXI) of 16 December 1966

Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, adopted 11 July 2003, (entered into force 25 November 2005), 2nd Ordinary Session of the Assembly of the African Union, AHG/Res. 240 (XXXI).

The Universal Declaration of Human Rights, adopted 10 December 1948 by the General Assembly Resolution 217 A(III).

National Legal Instruments

Choice of Termination of Pregnancy Act 92 of 1996

Constitution of the Republic of South Africa 1996

National Health Act 61 of 2003

White Paper for the Transformation of the Health system in South Africa (Notice No. 667 of 1997).

Case Law

Government of the Republic of South Africa & Others v Grootboom & others 2001 (1) SA 46 (CC)

Minister of Health & Others v Treatment Action Campaign & Others 2002 (5) SA 721 (CC)

Soobramoney v Minister of Health, KwaZulu-Natal 1998 (1) SA 430 (D)

Websites

‘Democracy works: Post-Apartheid and Growth’ (2014)

<http://www.cde.org.za/wp-content/uploads/2014/04/democracy-works---south-africa-conference-paper---post-apartheid-democracy-and-growth---by-nicoli-nattrass-pdf-.pdf> (accessed 27 October 2015)

‘The economy and poverty in the twentieth century in South Africa’

<https://nicspauill.files.wordpress.com/2011/04/the-economy-and-poverty-in-the-20th-century-in-sa.pdf> (accessed 27 October 2015)

Global Health Watch ‘Maternal Mortality: Need for a broad framework of intervention’

<http://www.ghwatch.org/sites/www.ghwatch.org/files/B6.pdf> (accessed 1 July 2015)

‘Maternal mortality: Need for a framework of intervention’

<http://www.ghwatch.org/node/547> (accessed 1 June 2015)

National Department of Health of South Africa ‘Saving Mothers Policy and Management Guidelines for Common causes of maternal deaths’

<http://www.kznhealth.gov.za/savingmothers.pdf> (accessed 27 June 2015)

Phatlane, SN ‘Poverty, health and disease in the era of high apartheid: South Africa’

(2006) <http://www.theway.org.uk/Back/s093Sideris.pdf> (accessed 16 June 2015)

‘Saving Mothers 2008 – 2010: Fifth Report on Confidential Enquiries into Maternal Deaths in South Africa’

<http://www.doh.gov.za/docs/reports/2012/savingmothersshort.pdf> (accessed 9 April 2015)

'The South African Economy and its engine room Gauteng' <http://www.Gautengonline.gov.za> (Accessed 26 May 2015)

Scholarly Articles

Lomahoza, K 'Monitoring the Right to health care in South Africa: An analysis of the policy gaps, resource allocation and health outcomes' published thesis Studies in Poverty and Inequality 2013 4

Sibaya, W & Muller, M 'Transformation management of primary health care services in two selected local authorities in Gauteng' published PhD Thesis University of South Africa, 2000

Conference Papers and Reports

Report of the Committee on the Elimination of Discrimination against Women's 49th,, 11 to 29 July 2011. New York; CEDAW

Borghi J 'What is the Cost of Maternal Health Care and How can it be financed?' published thesis, MSc in Health Economics. Privada San Miguel Coyoacan, Mexico, 17

Concluding Observations of the UN Committee on Economic, Social and Cultural Rights (CESCR): Kenya, Committee on Economic, Social and Cultural Rights, E/C.12/KEN/CO/1 (2008).

Concluding Observations of the UN Committee on Economic, Social and Cultural Rights (CESCR): Tanzania, adopted 23-30 November 2012, Committee on Economic, Social and Cultural Rights, 49th session, E/C.12/TZA/CO/1-3 (2012)

Concluding Observations of the UN Committee on the Elimination of Discrimination against Women: Zambia, adopted 11-29 July 2011, Committee on the Elimination of Discrimination against Women, 49th session, CEDAW/C/ZMB/CO/4-6 (2011)

Concluding Observations of the UN Committee on the Elimination of Discrimination against Women: South Africa, adopted 17 January—4 February 2011, Committee on the Elimination of Discrimination against Women, 48th session, CEDAW/C/ZAF/CO/4

(2011)

United Nations Millennium Declaration: resolution adopted by the General Assembly
18 September 2000, 55/2

Ministry of Health Rwanda, PMNCH, WHO, World Bank, AHPSR and participants in
the Rwanda multi-stakeholder policy review (2014) 'Success Factors for Women's
and Children's Health: Rwanda'

Nattrass, N 'South Africa: Post-Apartheid and Growth' *Legatum Institute* 2014

WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division
(2014) 'Trends in Maternal Mortality: 1990-2013'