FEATURE

Enhancing Respectful Maternity Care and Eliminating Obstetric Violence: The African Union's Human Rights Framework

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Introduction

The discourse on the elimination of obstetric violence during facility-based childbirth and the realisation of respectful maternity care (RMC) is rapidly gaining momentum in Africa and globally. Individuals and organisations alike are increasingly raising awareness of obstetric violence as a form of structural and interpersonal violence. These discussions focus on establishing access to respectful maternity care as a human right that embodies various other rights provided for in national, regional, and international human rights instruments.

Unfortunately, however, there is still a dearth of jurisprudence on RMC and obstetric violence in Africa. Unlike the case with the inter-American and European systems, the African human rights system has been little explored as an avenue for redress. This article thus briefly examines the role of African human rights mechanisms in protecting the right of birthing persons to receive respectful maternity care which is free from violence.

The concept of respectful maternity care

The World Health Organization (WHO) defines quality health care as safe, effective, timely, efficient, equitable, people-centred services that deliver the health outcomes communities want. This is reflected in its conceptualisation of RMC, which it defines as care provided to birthing persons in a way that maintains the dignity, privacy, and confidentiality of pregnant and birthing women, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labour and birth.

This type of care centres on the rights of a birthing person during pregnancy, birth, and the postpartum period, and seeks to ensure that the person's autonomy is safeguarded by medical service providers and hospital staff at all times. RMC is a universal human right of every childbearing woman in every health system.

As a human rights-centred approach to pregnancy and birth, RMC anchors itself on, among others, the right to dignity, the right to equality and non-discrimination, and the right of every person to the highest attainable standards of physical and mental health. RMC as a crucial component of the right to health in particular guarantees all pregnant persons the right to receive reproductive health care services throughout the cycle of pregnancy, birth, and the postpartum period in a dignified manner free from all forms of violence.

Pregnancy, childbirth, and the postpartum period are some of the most important reproductive experiences of childbearing persons. Besides being experiences

that usher in new life, they represent points in one's reproductive experiences where multiple systems of power and oppression intersect due to the socio-political position occupied by the birthing phenomenon. This position occupied by pregnancy and childbirth is, in many societies, a subject of great social, economic and political interest, resulting in the policing of the birthing bodies.

In sub-Saharan Africa (SSA), the conversation around health care has focused on the reduction of maternal mortality and morbidity. In many states, maternal mortality and morbidity remain a major challenge, one which is attributable to, among other things, the poor quality of care that characterises many maternal health systems in the region.

Presently, unsafe care in general is considered to be one of the 10 leading causes of death and disability worldwide, with low- and middle-income countries accounting for approximately 5.7 to 8.4 million of these deaths annually. With regard to maternal health care, as of 2017, it was estimated that 94 per cent of the 295,000 global maternal deaths occurred in low-income countries, with two-thirds of these deaths occurring in SSA.

The concept of obstetric violence

The term 'obstetric violence', albeit controversial terminology, comprehensively captures the systematic violence perpetrated against women during and after facility-based childbirth. This term has been instrumental in highlighting issues around quality of care in obstetric care. It conveys the pervasive power imbalance between medical practitioners and women and how these factors, put together, are a manifestation of deep-rooted systemic and structural forms of violence against women (VAW).

This nomenclature embodies the essential features of acts that amount to VAW, which perpetuates structural gender inequality, systematically devalues the lives of women and girls, and consequently disempowers them.

The term 'obstetric violence' has its roots in Latin America, where it is formally recognised in Argentina, Venezuela, Uruguay, Panama and Mexico. It was coined to refer to the mistreatment of all persons capable of getting pregnant by medical service providers and hospital staff during facility-based childbirth. Venezuela was the first country to legally prohibit obstetric violence through its Organic Law on the Right of Women to a Life Free of Violence. Under this law, obstetric violence is legislated as one of 19 types of VAW that are punishable by law.

Whereas the conversation on obstetric violence in Africa is not as advanced as in Latin America, reports have documented different forms of abuse that pregnant persons are subjected to during facility-based care.

The term 'obstetric violence' has been instrumental in highlighting issues around the quality of care in obstetric care.

Some of these human rights violations include physical abuse; humiliation and verbal abuse; coercive or unconsented medical procedures (including sterilisation); lack of confidentiality; failure to get fully informed consent; refusal to give pain medication; gross violations of privacy; refusal of admission to health facilities; neglecting women during childbirth to suffer life-threatening, avoidable complications; and postpartum detention of pregnant persons and their newborns in facilities after childbirth due to an inability to pay. These violations are structural and interpersonal, with the state culpable for the former and medical service providers and hospital staff, for the latter.

Moreover, pregnant persons' experience of obstetric violence is not uniform. Different persons experience different forms of obstetric violence differently, and this depends on individual identity and social location – in other words, on factors such as class, gender, age, education, marital status, and disability. Quite often,

multiple systems of oppression work together to predispose certain groups of people to rights violations more than others. Evidence demonstrates that one's social location and how that location intersects with systems of power and oppression determines one's experience of obstetric violence.

Thus, the term 'obstetric violence' is essential in addressing the structural dimensions through which this type of violence, which has an explicit connection with gender-based violence and social inequalities, manifests itself.

Indeed, obstetric violence was conceptualised as a form of VAW in a recent decision of the Committee on Convention on the Elimination of All Forms of Discrimination against Women in 2022, in the case of N.A.E v Spain, which established it as a particular type of violence against women during facility-based childbirth which is widespread, systematic, and ingrained in health systems.

VAW, according to the CEDAW Committee, in its General Recommendation No. 19 on Violence against Women, includes gender-based violence, be it 'physical, mental or sexual harm or suffering, threats of such acts, coercion, and other deprivations of liberty'. The recommendation obligates states to ensure that third parties, through private actions, do not violate the rights of other citizens. If states cannot fulfil this obligation, they may be held responsible.

The human rights framework for RMC in Africa

Regional human rights systems monitor governments' compliance with human rights obligations. RMC and obstetric violence are human rights issues that intersect with several rights enshrined in treaties and expanded on in resolutions and general comments. In this section, we briefly discuss some avenues through which the African human rights framework could help advance the discourse on RMC and the elimination of obstetric violence.

Equality and non-discrimination

The right to equality and non-discrimination is enshrined in article 2 of the African Charter on Human and Peoples' Rights ('African Charter'). Additionally, article 3(1) and (2) underscore that every individual shall be equal before the law and entitled to equal protection of the law. The Charter, under article 18, mandates all states to eliminate all forms of discrimination against women and ensure the protection of the rights of the woman and the child as stipulated in international declarations and conventions.

The right to non-discrimination is also provided under article 2 of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa ('Maputo Protocol'). This article calls upon state parties to adopt measures that, among other things, prohibit or curb harmful practices that endanger the health and general well-being of women.

Furthermore, it obligates African governments to take corrective measures to address persistent discriminatory practices against women, including adopting legislation to eliminate discriminatory practices against women; undertaking measures to address the social and cultural patterns that perpetuate discrimination against women and girls; and embarking on education and awareness campaigns to change people's attitudes.

The right to health

Persons capable of getting pregnant have higher health-system utilisation needs than those who do not. Unfortunately, however, as evidenced by the high rates

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of maternal mortality and morbidity in sub-Saharan Africa, health-system inefficiencies disproportionately impact birthing persons. As postulated by the WHO, this disparity within the health system indicates the persistent inequity between genders. It paints a picture of the subservient position occupied by persons capable of getting pregnant in society, as multiple systems of oppression intersect to increase adverse reproductive health outcomes for this social group.

The right to health within the African Union human rights framework is enshrined in article 16 of the African Charter. This is the cornerstone of health as a human right on the continent. The Maputo Protocol, on the other hand, strengthens this right by explicitly addressing women's health, including sexual and reproductive health. State parties are called upon to respect and promote the rights in the Protocol, ensuring access to essential health-care services.

The Maputo Protocol emphasises the importance of adequate resources for realising sexual and reproductive rights. It mandates states to allocate sufficient funds for health care and implement initiatives to prevent and eradicate violence against women. The Protocol requires states to provide accessible and affordable health services for women, particularly those in rural areas, and to establish robust prenatal, delivery, and postnatal care systems.

To achieve this, appropriate policy reforms to address health financing concerns that affect the availability, accessibility, and quality of services people receive in maternal health services are necessary. These structural reforms to increase the allocation of human and capital resources must include curriculum reforms to change how medicine is practised. All of this, unfortunately, depends on political will because allocating resources for health is a political decision ultimately brought to life by policies developed and subsequently implemented to facilitate the distribution of money, power, and resources.

The African Commission on Human and Peoples' Rights (ACHPR) has established mechanisms and standards to promote women's rights. It has adopted two general comments on article 14 related to women's health. In General Comment No. 1 on article 14(1)(d) and (e) of the Protocol, paragraph 22, the Commission states that the obligation to protect in relation to article 14(1)(d) and (e) requires states to take measures that prevent third parties from interfering with the rights in the Protocol. The same general comment in paragraph 23 provides that the obligation to promote in relation to article 14(1)(d) and (e) requires states to create legal, social and economic conditions that enable women to exercise their rights in relation to sexual and reproductive health. This involves engaging in sensitisation activities, in community mobilisation, and in training health-care workers and religious, traditional and political leaders on the importance of the right to protection and of being informed about one's health status and that of one's partner.

In General Comment No. 2 on article 14(1)(a), (b), (c) and (f) and 14(2)(a) and (c), the Commission, in paragraph 43, underscores that states' obligation to protect requires state parties to take the necessary measures to prevent third parties from interfering with the enjoyment of women's sexual and reproductive rights. Particular attention must be given to prevention as regards the interference of third parties in the rights of vulnerable groups such as adolescent girls, women living with disabilities, women living with HIV, and women in situations of conflict. The obligation entails formulating standards and guidelines for access to sexual and reproductive services.

This is particularly relevant in light of reports from various countries on non-consented forms of care, including forced and/or coerced sterilisation, forced contraception, and other routine procedures. The African Commission, in Resolution 260 on involuntary sterilisation as a violation of human rights, condemns all forms of involuntary sterilisation targeted at vulnerable groups, such as women living with HIV, as a violation of the rights to dignity, health, non-discrimination and freedom from cruel, inhuman and degrading treatment.

Lastly, the African Youth Charter, a unique instrument addressing youth rights, includes significant health provisions. It recognises the challenges young people face and calls for youth-friendly healthcare services. Article 16 guarantees the right to health, encompassing access to health care, determinants of health, and addressing non-communicable diseases.

The right to dignity and freedom from torture, cruel, inhuman, and degrading treatment

Another important right and freedom relating to RMC and the elimination of obstetric violence is the right to dignity and the freedom from torture, cruel, inhuman and degrading treatment. Both the African Charter and Maputo Protocol explicitly recognise these rights and prohibit all forms of such treatment.

The right to dignity is provided in article 5 of the African Charter and is integral to human rights, including the right to autonomy and control over reproduction and sexuality. Article 3 of the Maputo Protocol guarantees women's rights to dignity. In terms of article 4 of the Protocol, every woman has the right to dignity inherent in a human being, a right to respect as a person and a right to the full development of her personality.

The right to dignity has been underscored in *Legal and Human Rights Centre and Centre for Reproductive Rights (on behalf of Tanzanian girls) v United Republic of Tanzania.* In this communication, the African Committee of Experts on the Rights and Welfare of the Child (ACERWC) found that forced or mandatory pregnancy testing to access education was a violation of children's right to dignity, privacy, and freedom from torture.

Article 5 of the Charter also acknowledges the interdependent relationship between the right to dignity and the absolute prohibition of torture and other forms of ill-treatment. Additionally, in *Purohit and Moore v The Gambia*, the Commission held that 'exposing victims to 'personal suffering and indignity' violates the right to human dignity.

Lastly, General Comment No. 4, which focuses on the right to redress for victims of torture and other ill-treatment, addresses sexual and gender-based violence, which amounts to a form of torture and other ill-treatment in view of its specific, traumatic and gendered impact on victims, including the individual, the family, and the collective.

Control of reproduction and sexuality is an essential element of human dignity, both as a precondition for women to exercise their other rights and fulfil basic needs and as an end in itself. The right to dignity also forms the basis for the right to autonomy in making decisions regarding one's health, especially sexual and reproductive health. Therefore, it is argued that the Protocol affirms women's autonomy as a human right.

Autonomy revolutionises the provision of reproductive health care services by shifting service provision from being physician-centred to being patient-centred.

Liberty and security of the person

In many parts of Africa, the unaffordability of health care remains a significant barrier to accessing health care services, including SRH services. Evidence has shown that the extent to which states and other stakeholders invest resources in healthcare services directly affects the availability and accessibility of these services and the quality of care people receive.

The financial accessibility of maternal health care services remains a huge barrier in the quest to realise RMC. In many parts of the continent, access depends on individual purchasing power, as out-of-pocket (OOP) expenditure on health is the main way one can access care. OOP in the context of maternal health care not only limits access, but also predisposes pregnant persons to other forms of violations, including postpartum detention.

Postpartum detention healthcare facilities involve the arbitrary deprivation of liberty for non-payment of user fees and is one of the many forms of obstetric violence documented in Kenya, Democratic Republic of Congo (DRC), Burundi, Nigeria and Tanzania, among others. Article 6 of the African Charter provides that 'every individual shall have the right to liberty and security of their person respected'. No one may be deprived of their freedom without cause, except as provided for by law. In particular, no one may be arbitrarily arrested or detained. Furthermore, the Maputo Protocol calls upon member states to take legislative and administrative measures to eliminate VAW in all its forms, both private and public.

Beyond including the prohibition of arbitrary deprivation of liberty, the right to freedom and security of the person has also been interpreted to include the right to informed consent and decision-making, or the right to make autonomous decisions, regarding one's health and related procedural interventions and treatment. This interpretation means that no person shall be subjected to any form of forcible treatment or intrusion upon their bodily integrity.
Together, the right to bodily integrity, the right to informed consent, and the right to self-determination ground the principle of bodily autonomy, which entails respecting the capacity of persons to think for themselves and make judgments about what they deem to be good for themselves. Autonomy revolutionises the provision of reproductive health care services by shifting service provision from being physician-centred to being patient-centred. Health-care providers are expected to obtain informed consent from their patients before performing any medical intervention.

The role of the African Court and Commission

Obstetric violence, as a rights-centred framing conceptualised to capture various forms of human rights violations that occur during pregnancy and facility-based childbirth, is progressively taking root across the globe. Increasingly, various human rights bodies have used this terminology to highlight the gendered nature of the human rights violations experienced by pregnant persons during facility-based childbirth.

Although obstetric violence is yet to be formally recognised within the African human rights framework, cases involving related human rights concerns have been adjudicated upon or reported on at the regional human rights mechanisms since as early as 2003. *In Purohit and Moore v The Gambia*, for example, the African Commission, apart from demonstrating the nexus between discrimination and health, underscored the need for states to provide quality health-care services and not just focus on physical access.

Lessons from regional human rights mechanisms

The Inter-American Commission of Human Rights (IACHR) was the first international human rights body to hear and rectify a case relating to obstetric violence: *María Mamérita Mestanza Chávez v Perú* in 2003. This case, in which an indigenous woman was coerced into a tubal ligation and died from the procedure, resulted in a 'friendly settlement' in which Peru recognised its failure to fulfil its responsibilities under the various treaties to which it is party.

The IACHR also published a human rights report condemning reports of forced sterilisation in Mexico. Similarly, in 2021, the Inter-American Court of Human Rights (IACtHR) ruled in *Manuela et al. v El Salvador* that the state was responsible for the detention, conviction, and death of a woman who suffered an obstetric emergency. The court deemed El Salvador responsible for the death of Manuela, who in 2008 was unjustly sentenced to 30 years in prison for aggravated homicide after suffering an obstetric emergency that resulted in her pregnancy loss. The state was found to have violated Manuela's rights, inter alia, to life, health, judicial protections and guarantees, and freedom from discrimination and gender violence.

In November 2022, the IACtHR declared Argentina responsible for violating the rights to life, integrity, and health in *Britez Arce et al. v Argentina*, which marks

the first time the court applied the concept of obstetric violence. In September 2023, in Rodríguez Pacheco v Venezuela, the IACtHR reiterated the definition of obstetric violence and emphasised that states must regulate and supervise all health care provided under their jurisdiction, in both public and private settings, to prevent acts of obstetric violence and violations of the right to health and personal integrity. They must also take measures to investigate, punish, and remedy such violations when they occur.

Within the European human rights framework, obstetric violence cases, particularly non-consented care, were adjudicated as early as 2011 in *VC v SLOVAKIA*, where the Roma applicant was coerced into a tubal ligation. The European Court of Human Rights ruled that forced sterilisation is a violation of the European Convention on Human Rights (specifically article 3, which prohibits torture or inhuman and degrading treatment, and article 8, which protects the right to private and family life). However, in its judgments, the ECtHR has failed to recognise coerced sterilisation and hospital treatment as discrimination.

Conclusion

The African Court and Commission hold significant potential to advance the cause of RMC and eliminate obstetric violence in Africa. Through their respective mandates, these institutions can develop binding jurisprudence and influential standards that promote women's rights and hold states accountable for their obligations in this regard.

While the Commission has yet to directly address cases of maternal mortality, its jurisprudence on related human rights issues, such as the right to health and the prohibition of torture, can provide invaluable guidance and precedents. The African Commission, with its focus on the promotion and protection of human rights, can play a crucial role in raising awareness, advocating for policy reforms, and fostering regional cooperation to address the challenges of RMC. It would be timely for the Commission to adopt a resolution to conduct a continent-wide study on RMC and subsequently draft and adopt a general comment on the subject that provides further guidance and promotes accountability. The African human rights system has a major role to play in contributing to a just and more equitable healthcare system that ensures the safety and dignity of pregnant persons and newborns across the continent.

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References

African Charter on Human and Peoples' Rights (Banjul Charter) 1981.

CEDAW General Recommendation 19: Violence against Women, UN Doc. A/47/38 (1992)

General Comment No. 2: Article 14 (1) (a), (b), (c) and (f) and Article 14 (2) (a) and (c) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (2014).

General Comment No.4 on the African Charter on Human and Peoples' Rights: The Right to Redress for Victims of Torture and Other Cruel, Inhuman or Degrading Punishment or Treatment (Article 5) (2017).

General Comments No.1 on Article 14 (1) (d) and (e) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (2012)

Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol) (2003).

Purohit v. Gambia, Comm. 241/2001, ACHPR (2002-2003)

Resolution on Involuntary Sterilisation and the Protection of Human Rights in Access to HIV Services - ACHPR/Res.260(LIV)2013

VC v. *Slovakia* Application No.18968/07 ECtHR (2011).