The first decision of the African Commission on maternal mortality: *Community Law Centre and Others v Nigeria*

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ABSTRACT: This contribution examines the first decision of the African Commission on Human and Peoples' Rights under the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (African Women's Protocol), specific to the issue of maternal mortality. The discussion examines the issues raised in this Communication, and the findings of the African Commission in relation to admissibility and merits. More importantly, it evaluates the reasoning of the African Commission in relation to the decision on the merits, especially the reasons for the Commission's finding that the actions and non-action of the Nigerian government did not constitute a violation of any of the rights under the African Charter and the African Women's Protocol. The authors contend that the Commission adopted a restrictive and retrogressive approach to the interpretation of the African Charter and the African Women's Protocol. Furthermore, the authors note that the Commission missed an opportunity to contribute to jurisprudence on sexual and reproductive health, including maternal health guaranteed in the African Women's Protocol. It concludes by reflecting on the implications of this decision for future litigation on sexual and reproductive health and rights on the continent, particularly for the work of civil society and other stakeholders advocating for sexual and reproductive health and rights and other rights under the African Women's Protocol.

TITRE ET RÉSUMÉ EN FRANÇAIS

La première décision de la Commission africaine relative à la mortalité maternelle: *Community Law Centre et autres c. Nigeria*

RÉSUMÉ: Ce commentaire examine la première décision rendue par la Commission africaine des droits de l'homme et des peuples en application du Protocole à la Charte africaine des droits de l'homme et des peuples relatif aux droits des femmes en Afrique (Protocole de Maputo), portant spécifiquement sur la question cruciale de la mortalité maternelle. L'analyse s'articule autour des enjeux soulevés par la communication, ainsi que des conclusions de la Commission concernant la recevabilité et le fond de l'affaire. L'examen approfondi met en lumière le raisonnement juridique adopté par la Commission pour statuer sur le fond, en particulier les motifs ayant conduit à sa conclusion selon laquelle les actions et inactions du gouvernement nigérian ne constituaient pas une violation des droits protégés par la Charte africaine et le Protocole de Maputo. Les auteurs soutiennent que la Commission a adopté une approche restrictive et conservatrice dans son interprétation des dispositions de la Charte et du Protocole, ce qui reflète un recul par rapport aux objectifs progressistes

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de ces instruments. En outre, les auteurs soulignent que cette décision représente une opportunité manquée d'enrichir la jurisprudence sur les droits à la santé sexuelle et reproductive, en particulier la santé maternelle, garantie par le Protocole de Maputo. Enfin, les auteurs explorent les implications de cette décision pour les affaires futures concernant les droits à la santé sexuelle et reproductive sur le continent. Ils examinent notamment son impact potentiel sur le travail des acteurs de la société civile et des parties prenantes œuvrant pour la mise en œuvre et la défense des droits inscrits dans le Protocole de Maputo.

KEY WORDS: case discussion; *Community Law Centre and others v Nigeria*; African Commission on Human Peoples' Rights; Nigeria; maternal mortality; sexual and reproductive health

CONTENT:

1 INTRODUCTION

In May 2023, the African Commission on Human and Peoples' Rights (African Commission) adopted it first decision on the subject of maternal mortality as guaranteed under the African Charter on Human and Peoples' Rights (the Charter), and the Protocol to the African Charter on the Rights of Women (African Women's Protocol).[1] The decision followed a Communication brought to the Commission by the Community Law Centre, University of the Western Cape, and three other organisations against Nigeria in 2014. The decision comes in the context of global recognition of a period of stagnation, and in some aspects regression, in gender equality, including in the area of sexual and reproductive rights. Maternal mortality in particular is one in which there has been progress in general, but in respect of which Africa still leads in large numbers of per capita maternal deaths. According to the World Health Organisation (WHO), many of the countries with high maternal mortality ratios are in Africa, and accounted for 70 per cent of all deaths in 2020.[2] The odds of a woman dying during

1 Communication 564/2015, *Community Law Centre and Others v Nigeria*. Although the decision was adopted in 2023, it was transmitted to the parties only in August 2024, and was, by November 2024, yet to be published by the Commission (on its website). The decision is available online at https://www.chr.up.ac.za/images/researchunits/wru/documents_/caselaw/African_DECISION_ON_MERITS_ON_COMMUNICATION_564_TO_PARTIES-2.pdf (accessed 1 December 2024) (*Nigerian Maternal Mortality*).

2 World Health Organization and others *Trends in maternal mortality 2000 to 2020* (2020). According to the WHO, maternal mortality refers to the death of a woman while pregnant or within 42 days of pregnancy.

childbirth and pregnancy in Africa is put at 1 in 40, which is one of the highest in the world.[3] This reality portends grave danger for the health and lives of women and girls in the region. Several factors account for maternal deaths and morbidities in Africa. These include lack of skilled healthcare providers, discriminatory practices that perpetuate gender inequality, poor allocation of resources to maternal healthcare, lack of necessary facilities in healthcare settings, negative attitudes of healthcare providers, and limited access to safe abortion.[4]

The Communication was filed in the latter days of the Millennium Development Goals (MDGs), and just before the adoption of the United Nations Sustainable Development Goals (SDGs) in 2015. The MDGs aimed to reduce the maternal mortality ratio by 75 per cent, and to achieve universal access to reproductive health by 2015. Goals 3 and 5 of the SDGs, which set out the standard in place at the time of the decision, commit states to reducing the global Maternal Mortality Rates (MMR) to less than 70 per 100 000 live births by 2030, and to achieve gender equality and empower all women and girls.[5] SDG 3 further creates a basis for international assistance and cooperation in ending maternal mortality.[6] The Communication was therefore aligned to the prevailing political and social context. Beyond the SDGs, African governments have made other commitments to end maternal mortality, including adopting the Campaign for the Accelerated Reduction of Maternal Mortality,[7] and the Abuja Declaration on HIV/AIDS, Tuberculosis and other Infectious Diseases (Abuja Declaration).[8] These notwithstanding, the rates of maternal mortality remain unacceptably high in the region. Nigeria in particular has one of highest maternal mortality numbers in the world. This decision is therefore highly significant to the cause of reducing maternal mortality.

2 BACKGROUND TO THE COMMUNICATION

The Dullah Omar Institute at the University of the Western Cape,[9] and Alliance Africa, a non-governmental organisation based in Lagos, Nigeria, were concerned about the unacceptably high rates of maternal mortality in Nigeria despite numerous commitments by the country at the regional and international levels to address the phenomenon. They therefore filed a Communication with the Commission, alleging a series

3 As above.

4 As above.

5 United Nations Sustainable Development Goals, available at http://www.un.org/nsustainabledevelopment/sustainable-development-goals (accessed 5 September 2024).

6 As above

7 The Campaign for the Accelerated Reduction of Maternal Mortality is a collaborative project with UNFPA to address the high maternal mortality in Africa.

8 OAU/SPS/ABUJA/3, adopted at the African Union Assembly of Heads of States meeting, Abuja, Nigeria, April 2001.

9 At the time of filing, the Dullah Omar Institute operated under the name of the Community Law Centre, at the University of the Western Cape.

of violations of the Charter and the African Women's Protocol due to preventable maternal deaths of about 40,000 every year. In 2015 two other organisations, the Centre for Reproductive Rights and the Women Advocacy and Documentation Research Centre (WARDC), applied to join and were admitted as complainants.

Although the African Women's Protocol had been in place for more than ten years at the time of filing the Communication, the Commission had by then not yet decided a matter alleging the violation of rights under the Protocol.[10] This was despite the ground-breaking and potent nature of its provisions which seek to promote the equal rights of women in the region. The complainants thus considered it an ideal opportunity to explore the protection mandate of the Commission through a communication, so as to enforce Nigeria's duties to reduce the incidence of maternal mortality. The complainants also considered it an ideal opportunity for the Commission to pronounce itself on the protection of sexual and reproductive rights (SRHR), given the limited provisions on the subject in the treaties of the African human rights system.

3 FACTS OF THE COMMUNICATION

The complainants alleged that thousands of women in Nigeria had lost their lives due to the failure of the state to address the causes of maternal deaths in the country.[11] They contended that these deaths were preventable since the causes were well known, and that the high rates of maternal mortality in Nigeria were a matter of social justice that should be addressed by the state. The complainants alleged that maternal deaths in the country were aggravated by gender inequality, the inferior status of women in the society, and the patriarchal traditions of the society. They noted that Nigeria was endowed with natural resources, specifically oil, and yet, the per capita expenditure on health of 136 USD was much less than that of less endowed countries. The complainants argued that a three-year review of the budgets in Nigeria at the time revealed that spending on military and defence far exceeded the health sector and fell short of the recommendations in the Abuja Declaration.

The complainants further argued that since maternal mortality only affects women, the failure of Nigeria to address preventable maternal deaths constituted an act of discrimination against women. The complainants contended that the situation constituted a massive violation of women's rights to dignity, life, health and non-discrimination. They relied on reports by UN agencies and national institutions to corroborate the high maternal deaths in the country, and to demonstrate that the government of Nigeria was well aware of the

10 F Viljoen & M Kamunyu 'Articles 27 and 32: the interpretative mandate under the African Women's Protocol' in A Rudman and others (eds) *The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa: a commentary* (2023) 547 at 565-566.

11 *Nigerian Maternal Mortality* (n 1).

high maternal deaths, but had done little or nothing to address or remedy the situation.

The prayers of the applicants were therefore for the Commission to find that Nigeria had violated articles 2, 3, 4, 5 and 16 of the African Charter, and articles 2, 4, 5, 10 and 14 of the African Women's Protocol; to order Nigeria to provide free prenatal and maternal healthcare services to all women, particularly those in the rural areas and to establish health centres throughout the country; request Nigeria to invest its resources for the improvements of the health sector; award a sum of 5 billion Naira in damages or compensation to women and their families who have suffered physical and psychological trauma including debilitating injuries due to pregnancy or childbirth related complications in the country; and to request Nigeria to devote more resources to the health sector in order to address the high maternal mortality in the country.

4 DECISION ON ADMISSIBILITY

The Commission reasoned that while the complainants focused on article 56(5) of the Charter for the basis of admissibility, the prerequisites for admissibility under the other provisions of article 56 had also been met. Relying on its previous decisions, the Commission adopted a progressive interpretation of the provision of the Charter regarding exhaustion of local remedies. The Commission noted that article 56(5) requires individuals to exhaust local remedies before approaching the Commission, unless local procedure is unduly prolonged. The idea behind this requirement is that the respondent state should first be made aware of the nature of the violations alleged and if possible be able to remedy the situation before asking the Commission to entertain any communication related to the alleged violation. In this regard, the Commission noted that the three crucial considerations for determining the exhaustion of local remedies are that the remedy must be available, effective and efficient.[12] Reiterating its position in earlier decisions, the Commission explained that a remedy is available if the complaint can pursue it without any impediments, it is deemed effective if there is any prospects of success, and it is sufficient if it is capable of remedy for the violation of rights experienced.[13] The absence of any of these criteria would mean that the requirement to exhaust local remedies have not been met.

Affirming the position of the complainants, the Commission reasoned that local remedies were not available, efficient and sufficient given the large number of victims, the serious and massive violations of rights involved and the fact that the victims were from disadvantaged

12 See *Jawara v The Gambia* (2000) AHRLR 107 (ACHPR 2000) para 31.

13 As above.

communities without access to legal aid. Citing its decision in *Open Society Foundation v Côte d'Ivoire,*[14] the Commission emphasised the futility of exhausting local remedies where there have been massive violations of rights.

In the Commission's view, the prospect of success is an essential consideration for the exhaustion of local remedies where disadvantaged individuals without legal aid are involved. Furthermore, the Commission noted that the nature of rights violated by the Respondent state – that is, the right to health – were not enforceable under Nigeria's law because they were classified as Directive Principles of the state, which were not justiciable. The Commission noted that while the intention of section 6(6)(c) of the Nigerian Constitution is to make it impossible to enforce socio-economic rights, there was jurisprudence from Nigerian courts and the other bodies to the effect that these rights can still be enforced in the country. Citing *SERAP v Nigeria* as an example,[15] the Commission noted that the sum total of cases on this issue indicate that socio-economic rights are capable of being litigated in Nigeria.[16] Nevertheless, the Commission was satisfied that in light of the legal environment, the prospect of success in domestic litigation was undercut. Notably, Nigeria did not make any submissions on the admissibility of the complaint.

In sum, the Commission observed that in the totality of the facts available to it, the complainants had met the requirement for the exhaustion of local remedies. This reasoning of the Commission is commendable. Consistent with its previous jurisprudence, the Commission affirmed that massive violations of human rights constituted an exception to the rule of exhaustion of local remedies. Furthermore, the Commission's sympathetic consideration of disadvantaged groups without access to legal aid services resonates with the spirit of the SDGs that no one should be left behind. Arguably, through this decision, the Commission took additional steps towards broadening the scope of exceptions to the rule on exhaustion of local remedies to include massive violation of rights. However, it is still debatable whether the Commission was affirming that it would be inclined to waive the need to exhaust local remedies where there is massive violation involving disadvantaged groups, or whether this was mere *obiter dictum*.[17] If in the affirmative, the Commission's flexibility to waive the need to exhaust local remedies in the current Communication would be consistent with its previous jurisprudence, and would be progressive and in tune with growing development at international law. This is particularly important since the provision on the need to exhaust local remedies is one of the thorniest and most

14 See *Nigerian Maternal Mortality*, para 49. In Communication 318/06 *Open Society Foundation v Côte d'Ivoire* (2016) ACHPR, paras 48-50, the Commission determined that massive violations were a basis for derogation from the requirements of the exhaustion of local remedies.

15 Communication 300/05 *Socio-Economic Rights and Accountability Project v Nigeria* (2008) ACHPR.

16 As above.

17 *Nigerian Maternal Mortality,* para 48.

litigated aspects of article 56,[18] and has generated rich jurisprudence by the Commission.[19]

5 DECISION ON MERITS

While the Commission's reasoning on admissibility is progressive, the decision on the merits departs fundamentally from the prior jurisprudence of the Commission and established standards on socio-economic rights, adopts a restrictive approach to interpretation, is rather pedantic on the arguments of the complainants, and seems to absolve the respondent of responsibility even in respect of obligations already established in the African Charter.[20] This is despite the fact that Nigeria did not participate to counter any of the arguments or evidence filed. [21] Indeed, the Commission went out of its way to absolve Nigeria of its duty to prevent maternal deaths. The general tone of the decision is adversarial, often seemingly reprimanding the applicants' case, and overplaying interpretative technicalities. The approach is out of character with the Commission's prior approach, and misses the chance to address issues that have resonance in a majority of states parties to the Charter, and to break new ground in jurisprudence. The upshot is that the Commission found that Nigeria did not violate any of the rights alleged by the complainants.

We limit our analysis to four areas out of the several canvassed in the Communication. The featured areas are the rights to health, non-discrimination, life, and to be free from torture, inhuman and degrading treatment.

5.1 The right to health

The World Health Organisation (WHO) has noted that the direct causes of maternal injury and death are excessive blood loss, infection, high blood pressure, unsafe abortion, and obstructed labour, while the

18 See GM Musila 'The right to an effective remedy under the African Charter on Human and Peoples' Rights (2008) 2 *African Human Rights Law Journal* 442, 445*;* see also International Justice Resource Centre *Exhaustion of domestic remedies under the African human rights system* (2017).

19 For a detailed discussion on this, see H Onoria 'The African Commission on Human and Peoples' Rights and the exhaustion of local remedies under the African Charter' (2003) 3 *African Human Rights Law Journal* 1; and L Chenwi 'Exhaustion of local remedies rule in the jurisprudence of the African Court on Human and Peoples' Rights' (2019) 41(2) *Human Rights Quarterly* 374-398.

20 See for instance para 104 where the Commission observes that evidence is not produced to show that Nigeria has sufficient resources to prevent maternal deaths in the country. See also para 109, where the Commission made the argument that the implementation of the right to health is a long-term process, and that poverty and lack of resources is the reason why the right to an adequate standard of health is not realised.

21 *Nigerian Maternal Mortality,* para 42.

indirect causes include anaemia, malaria, and heart disease.[22] It further notes that maternal mortality is preventable with timely management by a skilled health professional working in a supportive environment. According to WHO, states are to ensure that healthcare providers deliver maternal healthcare services in the most respectful manner to pregnant women.[23]

In the case at hand, the complainants argued that the failure by the government of Nigeria to address preventable maternal deaths and morbidities constituted a violation of the right of health. Furthermore, they argued that most Nigerians pay for healthcare services out-of-pocket thereby making it difficult for a large number of the population, particularly women in rural areas, to access health services in general and maternal healthcare services in particular. They relied on norms and standards on the right to health under international law, including General Comments 14 and 22 of the Committee on Economic Social and Cultural Rights (CESCR), General Comments 6 and 35 of the Human Rights Committee, General Recommendation 24 of the CEDAW Committee, and the Resolutions and General Comments of the African Commission. However, the Commission found that the complainants had not proven that Nigeria had adequate resources to realise the right to health.

The approach of the Commission to the right to health is retrogressive. According to the Commission, the realisation of the right to health like other socio-economic rights is 'problematic in Africa' due to economic challenges and high poverty levels, thereby making it difficult to provide infrastructure and facilities to realise it.[24] The Commission noted that a state is only required to take 'positive and selective steps' under article 16 of the Charter to realise the right to health. The Commission concluded that the 15 per cent allocation to the health sector agreed during the Abuja Declaration is not binding on states and therefore cannot be enforced. Furthermore, the Commission noted that there wasn't enough evidence to show that Nigeria was not meeting its obligations as envisaged under article 14(2)(a). This conclusion is confusing, given that in the admissibility consideration, the Commission acknowledged its own prior jurisprudence that preventable maternal mortality was a violation of the rights to life, health and dignity of women in Africa. The complainants' argument was simply that the cost of health services in Nigeria is prohibitive and not in tune with the economic realities in the country. The Commission was not convinced by this argument, and therefore found no violations of the right to health against Nigeria. This outcome is retrogressive because it lowers the threshold of state responsibilities from settled standards, including those in the jurisprudence of the Commission itself.

22 WHO *Maternal Health* available at https://www.who.int/health-topics/maternal-health#tab=tab_1 (accessed on 2 November 2024).

23 See WHO *Recommendations on maternal health* (2017) 8.

24 *Nigerian Maternal Mortality*, para 109.

For instance, while it is true that the implementation of socio-economic rights, including the right to health, requires adequate resources, states are required to take concrete, positive and progressive steps towards realising this right.[25] One of the steps or measures that the government of Nigeria would be expected to take in this regard is to invest in primary healthcare services to facilitate access to healthcare for those in rural or disadvantaged communities. Even in the most literal sense, the term progressive implies incremental and measurable, as guided by a well-articulated and accountable plan. It cannot be interpreted, as the Commission seems to suggest, to mean that the state has absolutely no responsibility simply because it does not have resources.[26]

Furthermore, while the right to health as part of socio-economic rights is to be realised progressively, the minimum core content of the right is not subject to progressive realisation, but must rather be realised immediately.[27] The CESCR in its explanation of the minimum core in relation to the right to health, has referred to the Programme of Action of the International Conference on Population and Development, and the Alma-Ata Declaration as instruments reflecting an international consensus on the core obligations arising under article 12.[28] Furthermore, the Committee has recognised as part of the minimum core, the obligation '[t]o ensure reproductive, maternal (prenatal as well as postnatal) and child health care'.[29] In 2016, the CESCR adopted General Comment 22 on the right to sexual and reproductive health[30] and acknowledged as guidance for the purposes of specifying the minimum core 'contemporary human rights instruments and jurisprudence, as well as the most current international guidelines and protocols established by United Nations agencies, in particular WHO and the United Nations Population Fund (UNFPA)'.[31] It therefore seems that the Commission backtracked on well-established and generally-accepted standards. Furthermore, the argument of the Commission in this regard shifts the burden of proof of resources to the complainants, and yet such duty is already established by treaty to rest upon the state. Indeed, the state is presumed to have resources, unless it can demonstrate the lack of resources and corresponding failure to obtain assistance to fulfil its obligations. In its

25 See and UN Committee on Economic, Social and Cultural Rights (ESCR Committee General comments 3 Nature of states obligations under the Covenant and UN Committee on Economic, Social and Cultural Rights (ESCR Committee) General Comment 14: The Right to the Highest Attainable Standard of Health (Art 12 of the Covenant) 11 August 2000, E/C12/2000/4 (General Comment 14).

26 See for instance para 109 of the decision.

27 General Comment 14 (n 25).

28 General Comment 14 (n 25) para 43.

29 General Comment 14 (n 25) para 44(a).

30 UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment 22 (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights), 2 May 2016, E/C.12/GC/22.

31 General Comment 22 (n 14) para 49.

current iteration, the Commission seems to absolve the respondent state of its duties.

Rather than consolidate its position on the basis of the jurisprudence of the CESCR with regard to the nature of the state's obligation to realise the right to health, the decision refers to the state's duty to take 'positive and selective steps'[32] to realise socio-economic rights. This is a departure from the language of the CESCR's 'concrete and targeted' measures,[33] which has also previously been co-opted by the Commission.[34] The choice of terminology can be interpreted as introducing new parameters of interpretation. But this would be tantamount to lowering the standard. It is more plausible to assume a poor choice of terminology as opposed to a purposive redirection. The latter conclusion dents the credibility of the Commission's reasoning in the current decision, but may serve to discredit the influence of this line of reasoning in subsequent jurisprudence.

It is a settled standard that states ought not to take retrogressive steps in the realisation of the right to health. It is also generally established that beyond the question of the volume of resources, it is also about how judicious the state is in utilising the resources it has. The complainants had argued both that Nigeria had the resources as a result of its oil wealth, and established that the Nigerian government had allocated more resources to military and defence at the expense of the health sector, as a testament to the lack of political will to address maternal mortality in the country. Indeed, Nigeria is one of Africa's largest economies.[35] In the circumstances, and without a rebuttal of these representations by the state, the Commission ought to have assumed sufficiency of resources.

The concept of progressive realisation, implies incremental allocation to the health sector with a view to realising the right to health.[36] It is endorsed by the African Commission's Guidelines and Principles for the Implementation of the Socio-economic Rights in the Charter.[37] Based on an analysis of Nigeria's budgets for three years, the complainants had illustrated that the allocation to the health sector hovered between 5 and 6 per cent, while allocation to military and defence exceeded 10 per cent. This information was however not factored in the decision, thereby missing an opportunity to expound on the responsibilities of state parties in respect of resourcing the

32 *Nigerian Maternal Mortality,* para 110.

33 See General Comment 3 of the CESCR.

34 See Guidelines and Principles for the implementation of economic, social and cultural rights in the African Charter '(2011) para 14.

35 The World Bank Group 'World Bank in Nigeria' available at https://www.worldbank.org/en/country/nigeria/overview (accessed 25 September 2024).

36 L Chenwi 'Unpacking "progressive realisation" its relation to resources, minimum core and reasonableness, and some methodological considerations for assessing compliance' (2013) *De Jure* 39.

37 Guidelines and Principles for the Implementation of Economic, Social and Cultural Rights in the African Charter (2011).

implementation of women's rights, as required under article 10(3) of the African Women's Protocol.[38]

In the *Treatment Action Campaign* case, the Constitutional Court of South Africa rejected a similar argument of a lack of resources by the South African government on the basis that it did not provide evidence to support a lack of resources to roll out programmes for the prevention of mother-to-child transmission of HIV in the country.[39] In the absence of any evidence to the contrary, the Commission could have found the Nigerian state to be in breach of its obligation to realise the right to health under the Charter and the African Women's Protocol. This is significant because article 14(2)(a) of the African Women's Protocol is a codification of the reasoning of the CESCR in its General Comment 14 where it is stated that states are obligated to ensure available, accessible, acceptable and quality healthcare services to all.[40] In a country where the majority of women, particularly those in rural areas do not have adequate access to maternal healthcare services, it cannot be said that the government is meeting its obligations under the African Charter and African Women's Protocol.

Furthermore, the Commission held that there was no connection between access to safe abortion (article 14(2)(c)), and maternal mortality,[41] or between lack of family planning education and maternal mortality.[42] It is a settled fact that deaths from unsafe abortion contribute to maternal mortality. For instance, it has been noted that 77 per cent of abortions in sub-Saharan Africa are unsafe and about 6.2 million incidences of abortion take place each year,[43] thereby affecting the health of women and girls and contributing significantly to the high rates of maternal mortality in the region.[44] It is reported that an estimated 1.2 to 2 million abortions occur in Nigeria every year.[45] Coupled with restrictive abortion laws, it is not surprising that unsafe abortion contributes to the high rates of maternal mortality in Nigeria. There is an apparent break in logic, since the decision both

38 See A Budoo-Scholtz 'The right to peace' in A Rudman and others (eds) *The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa: a commentary* (2023) 223.

39 *Minister of Health and Others v Treatment Action Campaign and Others* (No 2) (CCT8/02) [2002] ZACC 15.

40 See E Durojaye 'An analysis of the contribution of the African human rights system to understanding of the right to health' (2021) 21 *African Human Rights Law Journal* 751. See also E Durojaye 'Article 14' in A Rudman and others (eds) *The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa: a commentary* (2023) 308.

41 *Nigerian Maternal Mortality,* para 121.

42 *Nigerian Maternal Mortality,* para 149.

43 A Bankole and others *From unsafe to safe abortion in sub-Sahara Africa: slow but steady progress* (2020).

44 As above.

45 PMA 2020 Abortion Survey Results (2018) available at https://www.pmadata.org/sites/default/files/data_product_results/NG-AbortionModule-Brief-v2-2020-03-18.pdf (accessed 28 November 2024).

acknowledges in the admissibility consideration that there was 'a significant number of victims involved in the respondent state'[46] and relies on this to waive the requirement of exhaustion of local remedies, but finds this immaterial to the responsibility of the state.

In terms of article 60 of the African Charter, the Commission should have drawn inspiration from decisions of UN treaty bodies and national courts in the region to affirm the links between lack of access to safe abortion, increased maternal mortality and violation of the right to health. For instance, in *Alyne da Silva Pimental v Brazil,*[47] the CEDAW Committee found the Brazilian government in violation of its obligation to realise the right to health and maternal healthcare of a woman from a disadvantaged and Afro-Brazilian community as guaranteed in article 12 of the Convention. The Committee affirmed that denial of maternal healthcare services violated Alyne's right to healthcare services. The Committee found that the state did not comply with its obligation under article 12(2) of the Convention to 'ensure to women appropriate services in connection with pregnancy, confinement and the postnatal period' because of its failure to meet Alyne's 'specific, distinctive health needs and interests' during pregnancy.[48] Cook has argued that the decision in the *Alyne* case has aided our understanding of maternal mortality as a violation of women's human rights and the articulation of collective obligations to ensure women's equal rights in the field of healthcare.[49]

Also, the Ugandan Constitutional Court held that the Ugandan government was in violation of the right to health of two women for failing to provide quality maternal healthcare services.[50] The Court found that the right to healthcare, including maternal healthcare services, guaranteed under the Ugandan Constitution, constituted a minimum core obligation which the government had to implement immediately.[51] More importantly, the Court held that maximum available resources include internal and external resources the state could mobilise in order to ensure effective delivery of maternal healthcare services thereby avoiding preventable deaths.[52] The Court invoked the indivisibility and interrelated approach to find that failure of the Ugandan government to prevent maternal deaths constituted violations of the rights to life, dignity, and health.

The Commission's views on the weight of the Abuja Declarations on HIV/AIDS, Malaria, Tuberculosis and other infectious Diseases (Abuja Declaration) for state responsibilities also raises concern. It noted that

46 *Nigerian Maternal Mortality*, para 54.

47 *Alyne Da Silva Pimentel v Brazil*, CEDAW/C/49/D/17/2008, 10 August 2011, para 7.7.

48 As above.

49 See RJ Cook 'Human rights and maternal health: exploring the effectiveness of the *Alyne* decision' (2013) 41(1) *Journal of Law, Medicine & Ethics* 103-123.

50 *Centre for Health, Human Rights and Development (CEHURD) & 3 Others v Attorney General* (Constitutional Petition 16 of 2011) [2020] UGCC 12 (19 August 2020) (*CEHURD* case).

51 *CEHURD* case (n 50) p 52.

52 *CEHURD* case (n 50) p 49-53.

the Abuja Declaration is not a binding instrument and that, as such, the Nigerian government could not be held accountable for not meeting the commitments in the Declaration.[53] It is true that the Abuja Declaration is a soft law norm and therefore not binding on states. However, it remains an important normative standard to gauge governments' commitments to realise the right to health in the region. The fact that a state is not complying with the Declaration is an indication of lack of political will to ensure the enjoyment of the right to health. The Declaration was made by the Assembly of Heads of State of African governments, the highest decision making organ of the AU. Therefore, even if it does not have binding force, it remains an important document to assess progress made by states towards resourcing health.

Nolan argues that 'soft law can include 'mechanisms [that] provide guidelines and principles which, while not legally binding, have force by virtue of the consent that governments, companies, and other civil society actors accord them'.[54] The author further notes as follows:[55]

> Thus to argue that soft law is simply not-law is perhaps too simplistic. The evolution of soft law instruments in the business and human rights sector has created at minimum, standards of expected conduct that, while not setting out to be legally binding, may have normative value that is intended to prescribe expected standards of behaviour.

According to Shelton non-binding normative instruments may do one or more of the following:[56]

(1) codify pre-existing customary international law, helping to provide greater precision through the written text;
(2) crystallize a trend towards a particular norm, overriding the views of dissenters and persuading those who have little or no relevant state practice to acquiesce in the development of the norm;
(3) precede and help form new customary international law;
(4) consolidate political opinion around the need for action on a new problem, fostering consensus that may lead to treaty negotiations or further soft law;
(5) fill in gaps in existing treaties in force;
(6) form part of the subsequent state practice that can be utilized to interpret treaties;
(7) provide guidance or a model for domestic laws, without international obligation, and,
(8) substitute for legal obligation when on-going relations make formal treaties too costly and time-consuming or otherwise unnecessary or politically unacceptable.

53 *Nigerian Maternal Mortality*, para 111.
54 J Nolan 'The corporate responsibility to respect rights: soft law or not law?' in S Deva & D Bilchitz (eds) *Human rights obligations of business: beyond the corporate responsibility respect?* (2013) 8.
55 As above.
56 DL Shelton 'Soft law' in D Amstrong (ed) *Handbook of international law* (2008) 8.

From the above it is clear that while soft law is not necessarily binding on states, it is an important consideration in measuring a government's commitments to realizing human rights. In any case, the Abuja Declaration is not an isolated document, but rather part of a regular approach of the African Union to express shared policy commitments consistent with its agenda. In a cumulative sense, the soft law of the African Union has been a basis for momentous political and policy actions, as in the case of the African Union Agenda 2063. It is difficult to reconcile the weight of such instruments with the apparent position that such instruments have no bearing on the actions of AU member states.

In making its argument on the weight of declarations, the Commission stated that a declaration has '*symbolic scope* and is essentially the expression of the political will … a declaration has *only a recommendatory* value … cannot be used as a legal basis to argue that rights therein have been violated'.[57] The choice of words discounts the value of declarations altogether, not only in relation to their lack of binding force. This is at odds with the fact that binding force is not the only measure of value of an instrument.

In any case, the African Commission has cited soft law to buttress its points in numerous past decisions. For instance, in the *Egypt Initiative for Personal Rights and Interights v Egypt,*[58] the Commission relied on the Guidelines and Measures for the Prohibition of Torture, Inhuman and Degrading Treatment or Punishment in Africa and the 'Declaration on the Elimination of Violence against Women' in arriving at its decision. Relying on this 'soft law' as a tool for interpretative guidance, the Commission found that the Egyptian government was in violation of article 5 of the African Charter on the right to dignity. Also, in *Huri-Law v Nigeria,* the African Commission relied on the UN Body of Principles for the Protection of All Persons under any form of Detention or Imprisonment to hold that the Nigeria government had failed in its obligations under the Charter to treat prisoners with respect and dignity.[59] In a nutshell, the Commission's approach to the weight of soft law as irrelevant in holding states accountable in its decisions is contradictory in as far as it considers them weighty in some instances and of little weight in other cases.

5.2 The right to life

Maternal deaths underscore failure on the part of the state to prevent loss of life. The complainants argued that since the deaths were preventable, the respondent state had failed to take positive steps to prevent loss of life. They relied on global and regional norms, including the jurisprudence of the Commission to support the argument.

57 *Nigerian Maternal Mortality,* para 111 (emphasis added).
58 Communication 323/06 of 2011.
59 *Huri-Law v Nigeria* Communication 225/98 of 2000, para 41.

For instance, the complainants referred to General Comments 6[60] and 36[61] of the Human Rights Committee on the Right to life, General Comment 3[62] of the Commission, and case law of the Commission.[63] However, the Commission found that no evidence had been presented to the effect that maternal deaths in the country were the result of the failure on the part of the Nigerian state to prevent such deaths. In particular, that there was no evidence that the respondent state had sufficient resources to prevent maternal deaths.

This is a restrictive approach by the Commission, particularly in light of plenty of evidence and reports including those of WHO, UNFPA, and the respondent state itself, indicating the high rates of maternal mortality in the country. The Commission did not reference its own jurisprudence such as General Comment 3 on the right to life, where it explains that states have the positive obligation to prevent loss of life, including preventable maternal deaths.[64] Furthermore, in *International Pen and Others v Nigeria*, the Commission affirmed that a violation of the right to health of a prisoner will result in the violation of the right to life.[65] Moreover, in Resolution 135 on Maternal Mortality, the Commission had declared maternal deaths in Africa a state of emergency and called on African governments to take decisive measures to address this.[66] The Commission further noted that maternal death is a violation of several rights of women, including the rights to life, dignity, non-discrimination and health.[67]

The approach of the Commission shows material inconsistencies in the approach to the link between the right to health and life. Needless to say, other human rights bodies[68] and national courts[69] have

60 Human Rights Committee General Comment 6 on the right to life in art 6 of the ICCPR.

61 Human Rights Committee General Comment 36 on the right to life in art 6 of the ICCPR.

62 General Comment 3 (n 18).

63 See, for instance, *Free Legal Assistance Group & Others v Zaire* (2000) AHRLR 74 (ACHPR 1995, *Sudan Human Rights Organization & Another v Sudan* (2009) AHRLR 153 (ACHPR 2009) and *Social and Economic Rights Action Centre (SERAC) & Another v Nigeria* (2001) AHRLR 60 (ACHPR 2001).

64 See General Comment 3, para 3.

65 *International Pen & Others (on behalf of Saro-Wiwa) v Nigeria* (2000) AHRLR 212 (ACHPR 1998).

66 African Commission on Human and Peoples' Rights, Resolution 135 of 2008 available at http://www.achpr.org/sessions/44th/resolutions/135/ (accessed 5 September 2024).

67 For more on this, see, see E Durojaye 'The approaches of the African Commission to the right to health under the African Charter' (2013) 17 *Law Democracy and Development* 393.

68 See for instance, Human Rights Council *Preventable maternal mortality and morbidity and human rights* A/HRC/11/L.16/Rev 1, 16 June 2009., see also, Human Rights Council, *Practices in adopting a human rights-based approach to eliminate preventable maternal mortality and human rights* 18th Session A/HRC/18/ 27; 8 July 2011.

69 See for instance, the decision of the Indian High Court in *Laxmi Mandal v Deen Dayal Haringar Hospital*; and *Jaitun v Maternity Home, MCD*, MANU/DE/1268/2010, cases WP(C) 8853/2008 and 10700/2009 (High Court of Delhi) judgment on 4 June 2010.

affirmed that maternal death constitutes a violation of the right to life. For instance, in the *Alyne* case of Brazil, the central question was whether the failure by the Brazilian government to prevent death during childbirth constituted a violation of the right to life, and the CEDAW Committee agreed that it did. Scholars also support this view. For instance, Cook and others argue that when women die during pregnancy and childbirth, it is an indication of failure on the part of the state to guarantee the right to life.[70] They further argue that the effective protection of the right to life requires states to take measures that will ensure access to healthcare services for women and guarantee safe delivery.[71] Echoing Cook and others, Yamin has argued that states must be held accountable for the death of women during pregnancy and childbirth as these deaths constitute a violation of the right to life.[72]

5.3 The right to non-discrimination

The CEDAW Committee affirmed in its General Recommendation 24 that failure by the state to provide healthcare services specifically needed by women constitute an act of discrimination prohibited under the Convention.[73] Maternal healthcare services are peculiar to women's needs, and when a state fails to ensure access to these services, it violates the right to equality and non-discrimination. Similarly, the disparities in healthcare services between women based on geographic location, rurality or socioeconomic status constitute an act of discrimination. The reasoning of the Commission seems blind to the impact of such intersectionality on maternal health, and therefore fails to appreciate the discriminatory nuances in the maternal health outcomes. The glaring structural inequalities compounded by discrimination on the basis of sex, gender, age, disabilities and marital status could have informed the Commission's analysis of equality and non-discrimination in the current context.

A woman-centred approach or 'asking the woman question',[74] was imperative in the analysis since gender inequality and cultural practices aggravate maternal mortality. By asking the woman question the Commission could have analysed the laws, policies and practices that perpetuate the low status of women and prevent them from exercising their agency. In particular, the Commission ought to have considered the existing legal and social-cultural barriers that hinder access to maternal healthcare services for women in Nigeria. This would have

70 RJ Cook and others *Reproductive health and human rights integrating medicine, ethics and law* (2003) 159.

71 As above.

72 A Yamin 'From ideals to tolls: Applying human rights to maternal health (2013) 10(11) *Plos Medicine* e1001546, see also P Hunt & JB de Mesquita *Reducing maternal mortality: the contribution of the right to the highest attainable standard of health* (2010) 6.

73 CEDAW Committee General Recommendation 24 on women and health (1999).

74 E Durojaye & O Oluduro 'The African Commission on Human and Peoples' Rights and the woman question' (2016) 24 *Feminist Legal Studies* 315-336.

provided a more purposive interpretation of article 2 of the African Women's Protocol and yielded a substantive approach to equality.

The interpretation of the Commission that differential treatment in article 2 of the African Women's Protocol, must be 'based solely on the ground of sex', does not align with feminist scholars' reasoning. The African Women's Protocol itself already lists grounds of discrimination beyond sex, including grounds yielding intersectional vulnerabilities such as rurality and disability. It is inconceivable to interpret it to mean that the 'sole' purpose of the Protocol is to eliminate discrimination between men and women. Even if that were the case, the Protocol is more aligned with fostering gender equality more generally, which subsumes sex equality.[75] The treatment of women, particularly in the context of reproductive health, is largely influenced and driven by social gender norms.

The right to non-discrimination is an integral part of the principle of equality, and has been described as the right of everyone not to be denied their rights on the grounds of sex, race, religion, language, political affiliation or other status.[76] In *Purohit and Moore v The Gambia*, the Commission noted that articles 2 and 3 are some of the most important provisions of the Charter[77] and that the enjoyment of all other rights in the Charter depend on them. Against this background, the Commission's restrictive interpretation of the discrimination provision in the African Women's Protocol as 'solely based on sex' is absurd. Comparatively, the CEDAW Committee in the *Alyne case* noted that since maternal health is peculiar to women, the Brazilian government was violating the right to non-discrimination of women by failing to provide maternal healthcare services. The CEDAW Committee has also noted in General Recommendation 24 that failure by the state to ensure healthcare services peculiar to the needs of women will amount to discrimination under the CEDAW.[78]

A formal approach to equality ignores the existing differences and historical disadvantages which require the adoption of corrective measures to address.[79] The disparity necessitates a substantive equality approach to close the gap. There is no doubt that a response based on the narrow interpretation preferred by the Commission ignores the suffering of these women, and would result in injustice. With over 40,000 maternal deaths annually, the majority of which occur in disadvantaged communities, the need for urgent and corrective

75 See generally E Lubaale 'Elimination of discriminations against women' and M Kamunyu 'Definitions' in A Rudman and others (eds) *The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa: a commentary* (2023).

76 See CESCR General Comment 20 Non-discrimination in economic, social and cultural rights (art 2, para 2, of the International Covenant on Economic, Social and Cultural Rights) July 2009.

77 *Purohit & Another v The Gambia* (2003) AHRLR 96 (ACHPR 2003).

78 General Recommendation 24 of CEDAW Committee.

79 See M Kamunyu 'Definition' in A Rudman and others (eds) *The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa: a commentary* (2023) 42.

measures to address the situation based on a substantive equality approach cannot be overstated.

5.4 The right to dignity and to be free from torture, inhuman and degrading treatment

The complainants argued that mistreatment of women and the negative attitudes of healthcare providers towards maternity patients contribute to the high maternal deaths in Nigeria. They argued that the mistreatment of women during childbirth constitutes a violation of the right to dignity and amounts to torture, inhuman and degrading treatment in line with the reasoning of human rights bodies.[80] The complainants had relied on the jurisprudence of the Commission and other human rights bodies in this regard, as well as decisions of national courts.[81] In its decision, the Commission ignored its own General Comment No. 4, where it stated that acts such as involuntary sterilisation and other mistreatment of women in health facilities constitutes torture, cruel, inhuman and degrading treatment.[82]

Instead, the Commission relied on the jurisprudence of the Human Rights Committee to argue that the mistreatment of women during pregnancy and childbirth does not constitute cruel, inhuman and degrading treatment.[83] It is not clear why the Commission would cite a decision of the Human Rights Committee and depart from its own norms on the same issue. For instance, while explaining the meaning of the right to dignity in the *Purohit* case, the Commission stated that

> the term 'cruel, inhuman, or degrading punishment and treatment' is to be interpreted so as to extend to the widest possible protection against abuses, whether physical or mental and that 'exposing victims to *personal suffering and indignity* violates the right to human dignity. Personal suffering and indignity can take many forms and will depend on the particular circumstances of each communication brought before the African Commission'.[84]

Until the present decision, the Commission had consistently followed this reasoning. For instance, in *Doebbler v Sudan*, the Commission noted that 'the prohibition of torture, cruel, inhuman, or degrading treatment or punishment is to be interpreted as widely as possible to

80 *Nigerian Maternal Mortality,* paras 67-73.

81 For instance, General Comment 4 of the African Commission, Report of the UN Special Rapporteur on violence against women and decision of High Court of Kenya.

82 African Commission on Human and Peoples' Rights General Comment 4 on the right to redress for victims of Torture and other Cruel, inhuman or degrading punishment or treatment (art 5).

83 *Nigerian Maternal Mortality,* para 126.

84 *Purohit and Moore v The Gambia*, 29 May 2003, Communication 241/01 (emphasis in original).

encompass the widest possible array of physical and mental abuses'.[85] In the *Equality Now* case,[86] which related to child and forced marriages, the Commission adopted a similarly progressive and purposive interpretation of the right to dignity as follows:

> At the core of human dignity is the idea and recognition that a human being has unique worth, value and significance that is innate, and not acquired. It also entails that a human being is a moral agent possessed with the conscience and personal volition to decide what happens to his or her body. The right to respect of dignity is a guarantee that a human being should not be subjected to acts or omissions that degrade or humiliate him or her. The worth, value and significance of a human being may not and need not be conceptualised with scientific precision.

In Resolution 260, the Commission declares that all forms of involuntary sterilisation violate, in particular; the right to equality and non-discrimination, dignity, liberty and security of person, freedom from torture, cruel, inhuman and degrading treatment, and the right to the best attainable state of physical and mental health as enshrined in regional human rights instruments such as the African Charter and the African Women's protocol.[87] Some studies have shown that abuse and mistreatment of pregnant women in health facilities contribute to high maternal mortality.[88]

The foregoing jurisprudence is consistent with the trend of human rights bodies, special mechanisms and national courts to frame mistreatment, forced sterilisation and other coercive treatment as constituting torture, inhuman and degrading treatment. For instance, the Human Rights Committee has noted that forced sterilisation contravenes article 7 of the ICCPR which prohibits torture, cruel, inhuman or degrading treatment, and article 17 on right to privacy.[89] In *VC v Slovakia,* the European Court on Human Rights found that sterilisation was carried out with gross disregard to the right to autonomy and choice of the Applicant, and was therefore a violation of articles 3 on the prohibition of inhuman and degrading treatment, and 8 on the right to family life, of the European Convention.[90]

Also, the Special Rapporteur on the rights of persons with disabilities has condemned forced sterilisation of women with disabilities calling on states to guarantee healthcare services to persons

85 See *Curtis Francis Doebbler v Sudan,* 4 May 2003, Communication 236/00. For a detailed analysis of this case, see E Durojaye & O Oluduro 'The African Commission on Human and Peoples' Rights and the woman question' (2016) 24 *Feminist Legal Studies* 315.

86 *Equality Now and Ethiopian Women Lawyers Association v Federal Republic of Ethiopia*, Communication 341/2007, para 118.

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

88 For instance, see Human Rights Watch 'Stop Making Excuses" Accountability for Maternal Health Care in South Africa' (2011) 8., see also, Amnesty International 'South Africa: Struggle for maternal health: Barriers to antenatal care in South Africa' (2014) 9.

89 See General Comment 28: Equality of rights between men and women, paras 11 and 20.

90 V*C v Slovakia* (no 18968/07), para 119.

with disabilities that are grounded in human rights, including respect for their autonomy, privacy, dignity, and to be free from torture, cruel, inhuman and degrading treatment.[91] Other human rights bodies such as the CEDAW Committee and the Special Rapporteur on violence against women have sometimes referred to the mistreatment of pregnant women in health facilities as obstetric violence. For instance, in *NAE* v *Spain* the CEDAW Committee found that mistreatment of a pregnant woman during delivery such as induced labour and separation from the new baby constituted obstetric violence. Echoing General Recommendation 24 on women and health, the Committee notes that

> quality health-care services are those that are delivered in a way that ensures that a woman gives her fully informed consent, respects her dignity, guarantees her confidentiality and is sensitive to her needs and perspectives.[92]

The Committee cited the definition of the Special Rapporteur on violence against women and its consequences as:

> as the violence against women experienced during facility-based childbirth and affirms that this form of violence has been shown to be widespread and systematic in nature or engrained in the health system.[93]

At the national level, the High Court of Kenya in *Millicent Awuor Omuya alias Maimuna Awuor & Another v The Attorney General & 4 Others* found that the detention and mistreatment of the petitioners, including being made to sleep on the floors due to inability to pay medical fees after delivery, constituted ill-treatment and undermined the right to dignity and to be free from torture, inhuman and degrading treatment.[94]

These developments point to the fact that coercion, abuse and mistreatment of women seeking maternal health services in health facilities is a form of torture, cruel inhuman and degrading treatment under international law. The Commission's departure from its own rights affirming reasoning to a restrictive interpretation of the right to dignity is therefore retrogressive.

6 IMPLICATIONS OF THE DECISION FOR THE REALISATION OF SRHR IN AFRICA

The present decision is a clear departure from some of the earlier decisions of the Commission, such as the *SERAC, Free Legal Assistance Group v Zaire* and *Sudan* cases.[95] In these decisions, the Commission demonstrated willingness to advance socio-economic

91 See Report of the Special Rapporteur on the rights of persons with disabilities 2018.

92 CEDAW Committee General Recommendation 24 on women and health.

93 A/74/137, paras 4, 12 and 15.

94 *Millicent Awuor Omuya alias Maimuna Awuor & Another v The Attorney General & 4 Others* (2015), Petition No 562 of 2012.

95 See n 63.

rights, including the right to health, robustly engaged with the issues, clarified state obligations, and elaborated on the nature of the rights. These decisions provide guidance and direction for states regarding their obligations to implement socio-economic rights at the national level.

Another concern with the decision relates to the length of time it took for the Communication to be finalised, given the nature of the underlying violations. The Communication was filed in late 2014 and the decision on the merits was only adopted in 2023, a period of nearly a decade. This is a major concern for a regional human rights body whose jurisdiction is only triggered after the exhaustion of local remedies. Delay in finalizing communication by regional human rights bodies does not inspire trust and confidence in the system. It undermines the goal of redressing injustice speedily. In the long-run, such delays would discourage victims of human rights violations, especially sexual and reproductive rights, from seeking redress with regional human rights bodies.

This decision is a missed opportunity by the Commission to clarify the nature of states obligations regarding the SRHR provisions of the African Women's Protocol. As the first Communication on maternal health under the African Women's Protocol, the Commission had an ideal opportunity to articulate a purposive and substantive position on the scope and content of sexual and reproductive rights, including the prospect of expansion beyond the scope of health. Instead, the Commission adopted a rigid approach, relying on technicalities peripheral to the subject, and seemed to ignore the human impact of avoidable and preventable maternal deaths and morbidities in the region. The Commission missed the opportunity to exert pressure on African governments to take urgent and decisive measures to address the high maternal mortality in the region.

The decision sets the clock back on the gains already recorded in advancing SRHR in the region through the progressive provisions of the African Women's Protocol and years of sustained advocacy for norms and standards on SRHR.

7 CONCLUSION

As the first decision of the Commission on the protection of SRHR under the African Women's Protocol, the current decision is disappointing. The Commission did not find any violation of the African Charter and the African Women's Protocol arising from the complaints made, even where the allegations were not contested. Our discussion is not nearly exhaustive of the issues emanating from the decision. Issues such as the apparent gender blindness in the reasoning of the Commission; the failure to appreciate and respond to the scourge of obstetric violence; the stance of the Commission that it cannot, of its own motion, address issues not directly raised by the applicants; the argument that violations must be specifically pleaded on the basis of specific articles; the approach that abandons the tenets of judicial notice especially in respect of widespread violations; the clear

departure from settled jurisprudence; the approach to the interpretation of what 'benefiting from scientific advancement' would entail; the question of reparations for SRHR violations; or the attempt to move the goalposts on the burden of proof in cases alleging violation of rights. Furthermore, some of the more obscure and peculiar issues highlighted in the complaint such as the question of mandated blood donation as a precondition for maternity care were overshadowed by the generally restrictive interpretation of the extent of state obligations. This is despite the fact that such practices resonate in a majority of the state parties to the Charter and would have benefited from clear pronouncement on related duties.

From the foregoing, the decision seems to have undone years of progressive jurisprudence on socio-economic rights including the right to health, and halted the momentum gathered towards upholding the reproductive rights of women and girls in Africa on an equal basis with the rest of the world. For a region plagued with high maternal deaths and lack of political will on the part of the governments, the Commission's position is utterly unresponsive on the subject matter, and contradicts its promotional mandate and prior commitments. There is an urgent need for the Commission to redeem itself from the aftermath of this decision, and for stakeholders to strategise towards containing the fallout from the decision.