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Examining High Rates of Preventable Maternal Mortality in Kenya: Could Provisional Measures be an Effective Tool to Guarantee Safe Pregnancy?

Clara Burbano-Herrera*
Human Rights Centre, Ghent University
Clara.BurbanoHerrera@UGent.be

Abstract

This article analyses the barriers that expectant mothers face in accessing appropriate, quality medical services in Kenya, and investigates the potential for the regional African human rights adjudicator to use provisional measures (PMs) to protect expectant mothers. The article aims to explore whether PMs adopted by the African Commission on Human and Peoples' Rights could be an appropriate legal tool to secure protection for expectant mothers who are dealing with obstacles in obtaining the medical services that they need. In that regard, this contribution suggests that the situation of certain expectant mothers in Kenya meets the two necessary conditions to grant PMs under the African Human Rights system: that the situation is urgent and the measures are necessary to prevent irreparable damage. It suggests that, following the tendency of other international human rights bodies, the Commission has the potential to play a relevant role in the context of maternal mortality.

Keywords

Maternal mortality, provisional measures, African Commission on Human and Peoples' Rights, sexual and reproductive health rights, women's rights

INTRODUCTION

> "I went to Mama X's bed and found that she had taken off all her clothes and was sweating profusely. I enquired of her why she was completely undressed and she said that she felt like her body was on fire. She then pulled me closer to her and said 'nisaidie' [help]. I did not know what to do, so I went to Dr P and told her what the patient had said. The doctor then told me, 'I am coming. Let me finish my round. You know, the patients here are very dramatic. She

* Postdoctoral research fellow, Faculty of Law, Human Rights Centre, Ghent University, Belgium and affiliated postdoctoral research fellow, Centre on Law and Social Transformation, University of Bergen, Norway. The author would like to thank Prof Alicia Yamin of Harvard University for her valuable comments on this article. The author wrote this contribution as a research fellow at Harvard University, with the financial support of a Fulbright grant.

should wait!' Taking her word for gospel truth, I went back to the patient and told her, 'vumilfa tu mummy, daktari anakuja' [take heart, the doctor is on the way]. I then went on checking on the other patients."

A few minutes later, she called me again and this time, in between gasps of air, she told me 'miguu zinaganda' [legs are freezing]. She was losing sensation in her legs. I went to the doctor again and told her that the patient was losing feeling in her legs. More irritated than before, she waved me off and said in a stern voice, 'I will come once I'm done with the round'. So I went back to the patient and said, 'tafadhali vumilfa tu mum, daktari anakuja' [please take heart, the doctor is on the way].

The same lady called one of my colleagues and asked her to help. My colleague went to the doctor and was told the same thing. Since this patient had asked for help so many times we decided to tell one of the nurses and see whether they could help. Nurse A immediately came to where the patient was when we told her what was happening and decided that we needed to draw blood for grouping and cross matching before she was taken to theatre. As soon as she fixed a cannula into the patients arm and started drawing blood, the patient collapsed. Nurse A began to shout and call for help. Everyone ran to where we were. The other nurses started trying to fix another cannula but the patient's veins had already collapsed. She was in hypovolemic shock! Nurse D then shouted, 'Call the doctor!' I rushed through the ward but could not find Dr P anywhere. I then rushed out of the ward and to the theatre and started shouting for help from any doctor. The staff there all just looked at me in shock, none responding in a matter suggesting that there was an emergency. Eventually Dr P appeared and I told her that the patient was dying. She then responded, 'Bring the patient to theatre'. I asked, 'Shouldn't we try to resuscitate her first as we bring her?' The doctor responded, shouting 'I've said bring the patient here! We'll resuscitate here!'

So I ran back to the ward and told them that the doctor said we wheel the patient to theatre. Everyone started trying to transfer the patient onto the stretcher to take her to theatre. As we lifted her off the bed, the only IV line that had been gotten came off. We then wheeled her to theatre, as one of the students ran to the lab to get blood for transfusion. By the time the blood was gotten, the patient, mama X, had already passed on …

We all went back to the ward, emotions running high. We, the students, were in total shock. The nurses sat at the nurses' desk and began discussing the matter. We overheard them say that it was our fault because we removed the only line that had been put in when transferring the patient onto the stretcher. We ignored this and decided to continue helping the ladies who were still trying to deliver …

After this last ordeal, it was now time for us to leave. We were all distraught and depressed by what we saw that day. No human being should go through what those ladies delivering their children go through in that institution."[1]

1 Transcript of an interview with a medical student at Pumwani Maternity Hospital, Nairobi (25 May 2015) (on file with the author).

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Despite legal advances in recognizing women's rights and the implementation of public policies to improve maternal health, it is still common to find news articles, human rights organizations, scholars and Kenyan citizens expressing concern over the terrible conditions in which mainly poor women continue to be attended at the country's medical facilities. Mama X's case is far from isolated. Indeed, Kenya is rated among the ten most dangerous countries worldwide for pregnant women and has registered only a very minor decrease, of 12 per cent, in its maternal mortality rate (MMR)[2] over the last 25 years.[3]

In Kenya, the proportion of expectant mothers who are able to seek medical care in health care facilities is low. Overall, only 44 per cent of births are delivered under the supervision of a skilled birth attendant; traditional birth attendants continue to assist with 28 per cent of births; relatives and friends with 21 per cent; and in 7 per cent of births mothers receive no assistance at all.[4] This means that fewer than half of births take place at health facilities under the supervision of a skilled birth attendant; some expectant mothers are dying or becoming seriously ill in medical facilities as a result of inadequate health

2 Maternal mortality is commonly understood as "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy and its mode of termination, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes": World Health Organization (WHO) "International Classification of diseases" (10th rev, 2004), available at: <http://www.who.int/classifications/icd/en/> (last accessed 8 May 2017).

3 In 1990, Kenya had an MMR of 687 deaths per 100,000 live births and this declined to 510 in 2015. Globally, MMR fell by 43.9% during the same period: from 385 deaths per 100,000 live births in 1990 to 216 in 2015. There were 303,000 maternal deaths worldwide in 2015. See WHO et al "Trends in maternal mortality: 1990 to 2015: Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division" (2015), available at: <http://www.who.int/reproductivehealth/publications/monitoring/maternal-mortality-2015/en/> (last accessed 8 May 2017) and L Alkema et al "Global, regional, and national levels and trends in maternal mortality between 1990 and 2015, with scenario-based projections to 2030: A systematic analysis by the UN Maternal Mortality Estimation Inter-Agency Group" (2015), available at: <http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(15)00838-7/abstract> (last accessed 8 May 2017).

4 See World Bank Report (2015), available at: <http://databank.worldbank.org/data/Views/Reports/ReportWidgetCustom.aspx?Report_Name=HNP-MDG-5-Birth-attended-by-skilled-health-staff&Id=c2358f5f48&inf=n&zm=n> (last accessed 28 May 2017) and <http://databank.worldbank.org/data/Views/Reports/ReportWidgetCustom.aspx?Report_Name=HNP-MDG-5-Birth-attended-by-skilled-health-staff&Id=c2358f5f48&inf=n&zm=n> (last accessed 8 May 2017). See also Kenyan Ministry of Health "Policy proposal on the presidents' [sic] initiative on free maternal health services in Kenya", available at: <http://www.healthpolicyproject.com/ns/docs/kenyanewsfreematernalhealthattachment.pdf> (last accessed 8 May 2017) and N Bourbonnais "Implementing free maternal health care in Kenya: Challenges, strategies, and recommendations" (2013, Kenya National Commission on Human Rights) at 3, available at: <http://www.knchr.org/Portals/0/EcosocReports/Implementing%20Free%20Maternal%20Health%20Care%20in%20Kenya.pdf> (last accessed 28 May 2017).

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services, poorly trained and / or negligent personnel and inadequate infrastructure.

The World Health Organization (WHO) reports that 8,000 expectant mothers died from pregnancy related complications in Kenya in 2015 alone. This means that in Kenya that year, 22 women died each day from causes related to pregnancy and childbirth.[5] In 99 per cent of cases maternal mortality impacts low income women from the global south;[6] as most of these deaths are preventable, maternal death in Kenya is clearly a problem linked to discrimination and inequality.[7] Furthermore, the fact that rates of preventable maternal mortality have remained high over a long period reflects a systemic failure on the part of states either to protect women's rights or to address the structural disparities and problems underlying unsafe pregnancy.

Although several (direct and indirect) structural factors, including cultural, legal, economic and social issues such as women's low social status, malnutrition, lack of education and information, early marriage and unsafe abortion, could explain these deaths, this article focuses on maternal deaths related to inadequate healthcare services and deficient infrastructure. It analyses the obstacles that expectant mothers face in accessing appropriate, quality medical services in Kenya, and investigates the potential for Africa's regional human rights system "provisional measures"[8] mechanism (PMs, also called interim or precautionary measures)[9] to protect expectant mothers.

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5 See WHO et al (2015) "Maternal mortality in 1990–2015: Kenya", available at: <http://www.who.int/gho/maternal_health/countries/ken.pdf> (last accessed 8 May 2017).

6 See WHO Media Centre "Maternal mortality" (fact sheet, November 2016), available at: <http://www.who.int/mediacentre/factsheets/fs348/en/> (last accessed 29 May 2017).

7 See ibid. A major challenge in addressing maternal deaths is the lack of accurate data. Although information on the numbers of women dying and the reasons for their deaths is improving, much remains unrecorded and unreported. Indeed, in many low-income countries, maternal deaths often go uncounted as the cause of death is unknown or incorrectly recorded, particularly when women die at home. See WHO et al "Trends in maternal mortality: 1990 to 2013: Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division" (2014) at 1, available at: <http://apps.who.int/iris/bitstream/10665/112682/2/9789241507226_eng.pdf> (last accessed 8 May 2017); L Say, D Chou, A Gemmill et al "Global causes of maternal death: A WHO systematic analysis" (2014) 2/6 *The Lancet Global Health*, available at: <http://www.thelancet.com/journals/langlo/article/PIIS2214-109X(14)70227-X/fulltext> (last accessed 8 May 2017); and WHO Media Centre "Maternal mortality", above at note 6

8 The measures adopted by the African Commission and African Court on Human and Peoples' Rights (Court) are called "provisional measures". See art 27(2) of the Court Protocol, rule 51 of the Rules of Court and rule 98 of the 2010 Commission Rules of Procedure.

9 The measures adopted by the European Court of Human Rights are called "interim measures" in English, or *mesures provisoires* [provisional measures] in French; see rule 39 of the Rules of Court. The measures adopted by the Inter-American Commission on Human Rights are called "precautionary measures" and the measures adopted by the Inter-American Court of Human Rights (IACtHR) are called "provisional measures"; see American Convention on Human Rights, art 63(2) and Rules of Procedure of the

This article aims to explore whether PMs adopted by the African Commission on Human and Peoples' Rights (Commission) could be an appropriate legal tool to secure protection for expectant mothers who face obstacles in obtaining the medical services that they need. It suggests that the situation of certain expectant mothers in Kenya meets the two necessary conditions to grant PMs under the African human rights system: that their situation is urgent and that the measures are necessary to prevent irreparable damage.[10]

The focus here is on PMs, rather than on findings on the merits, for three main reasons. First, the immediacy of the measures makes them particularly relevant to expectant mothers. An ex post facto determination that a woman's rights have been violated may be important when seeking to determine the state's legal responsibility, but may easily render the affected woman's rights illusory. Secondly, PMs are of primary importance in time-sensitive situations where an urgent response is required. Thirdly, as evident from the discussion below, PMs in Africa have almost never been invoked in the context of women's rights, even though the normative framework does not preclude the application of PMs to protect women, their reproductive rights or right to health. While the Commission granted 32 PMs between 1994 and 2015, women were only the beneficiaries of such protection on one occasion, making them the group with the lowest number of PMs.

In order to achieve its aim, the article is divided into seven parts. The first details the normative basis under which the Commission has competence to request PMs. It outlines how, as is the case with other human rights mechanisms, the African system does not restrict the possibility of gaining protection under PMs to a particular group of people or to a particular category of rights. The primary requirements for requesting PMs are that there is a situation of danger and an objective fear that irreparable damage may occur if PMs are not imminently adopted. The article also shows how PMs have mainly been applied to protect individuals, although they have also been employed to protect groups. The next part considers the frequency of the use of PMs in the African human rights system and notes that the Commission has only adopted PMs in 32 cases. The number of PMs adopted could be low because the Commission can only adopt PMs when a "communication", or formal request, has been submitted. However, it could also be the case that PMs have been adopted on other occasions, but that the public does not have access to this information given the Commission's lack of record keeping for such measures. Equally, the Commission may have opted not to publish details of other PMs, in accordance with the principle of

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IACtHR, art 25. For simplicity, this article refers to these various tools collectively as "provisional measures" or PMs.

10 Commission Rules of Procedure, rule 98. See also below at note 14.

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confidentiality outlined in article 59 of the African Charter on Human and Peoples' Rights (African Charter).[11]

Given that the Commission has not granted PMs to protect expectant mothers, nor has it decided communications related to maternal mortality, the article then analyses, from a comparative perspective, other international cases where states have been declared responsible for preventable maternal mortality, and cases in which PMs have been applied to protect expectant mothers in danger. The next part focuses on the Kenyan legal framework and shows that Kenya has formally committed to respect and protect women's rights, in that it has a modern constitution that incorporates sexual and reproductive health rights and has also ratified international human rights treaties. The article illustrates the contrast between these formal commitments and the reality for expectant mothers, such as Mama X, who seek medical care. It outlines the critical condition of Kenya's healthcare facilities and the consequences for expectant mothers' basic rights. It suggests that the Commission, following the work of other international human rights bodies, has the potential to play an important role in the context of maternal mortality. Accordingly, it argues that the Commission should order PMs that instruct Kenya to improve the medical services offered to expectant mothers. The conclusion emphasizes some aspects of maternal mortality and makes some recommendations.

LEGAL FRAMEWORK

The fundamental purpose of PMs in the international system for human rights protection is to prevent irreparable damage to the rights of persons.[12] Once irreparable damage has occurred, it is impossible to restore the victim's rights and granting PMs would no longer make sense. In these circumstances, it would be necessary to await reparations from the state after it is declared liable under international law. For this reason, the requirement that a situation be urgent also implies that it would be impossible to wait for a judgment on the merits in order to adopt protective measures, given the risk that the threatened damage may occur in the interim.

PMs therefore have: a "preventive function", in that they are issued to avoid violations of human rights; a "protective function", as they maintain a legal

11 The African Charter was adopted in Nairobi (Kenya) on 27 June 1981 and entered into force on 21 October 1986.

12 For more information on PMs, see C Burbano-Herrera and F Viljoen "Provisional measures issued by the African Commission and African Court on Human and Peoples' Rights" in Y Haeck and C Burbano-Herrera (eds) *Interim Measures in International Human Rights Law* (forthcoming, 2017, Oxford University Press); F Viljoen *International Human Rights Law in Africa* (2012, Oxford University Press) at 306; E Rieter *Preventing Irreparable Harm: Provisional Measures in International Human Rights Adjudication* (2010, Intersentia); and GJ Naldi "Interim measures of protection in the African system for the protection of human and peoples' rights" (2002) 2 *African Human Rights Law Journal* 1.

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situation while safeguarding human rights; and a "precautionary purpose", as they allow states to act expeditiously to correct situations that may prima facie cause irreparable damage. In this sense, the PMs that states do comply with also afford them the opportunity to avoid legal liability at the international level, because they are able to correct, in a timely manner, situations in which violations of human rights could have occurred. Compliance with PMs therefore shows respect for the human rights bodies that issue them, as well as for human rights themselves.

Consequently, the objective of applying PMs in cases related to maternal health is not to find states legally liable for the violations of the rights of women who have already died, but rather to protect expectant mothers who are currently at risk.

The Commission is empowered to adopt PMs related to Kenya and the other African Union (AU) member states, which have (with the exception of newcomer South Sudan) all ratified the African Charter.[13] The legal basis for the Commission's competence to issue PMs can be found in rule 98(1) of the Commission's 2010 Rules of Procedure (Rules),[14] which states: "[a]t any time after the receipt of a Communication and before a determination on the merits, the Commission may, on its initiative or at the request of a party to the Communication, request that the State concerned adopt Provisional Measures to prevent irreparable harm to the victim or victims of the alleged violation as urgently as the situation demands."

According to rule 98, three conditions must be met in order to seek the adoption of PMs: PMs should be necessary to prevent irreparable harm; the situation should be urgent; and the request for PMs should be submitted within the context of a communication.

As is the case with other human rights mechanisms, the African system does not restrict the possibility of gaining protection via PMs to a particular group of people or to a particular category of rights. The primary requirements for requesting PMs are that there is a situation of danger and an objective fear that irreparable damage may occur if PMs are not imminently adopted. Furthermore, under its Rules, the Commission need only have sufficient apprehension (rather than proof "on a balance of probabilities" or "beyond reasonable doubt") that a situation is urgent, mainly because the ordering

13 The Institute for Human Rights and Development in Africa, a Banjul-based NGO, publishes the Commission's and Court's decisions regarding PMs at: <http://caselaw.ihrda.org> (last accessed 8 May 2017). The Centre for Human Rights of the University of Pretoria also publishes decisions on PMs on its website: <http://www.chr.up.ac.za/index.php/browse-by-subject/538-interimprovisional-measures.html> (last accessed 8 May 2017).

14 The Commission included powers to adopt PMs in 1988 in its first set of Rules of Procedure (rule 109). When these were amended in 1995, the Commission outlined its competence to adopt PMs in rule 111. Since 2010, information on these powers has been restated in rule 98. See Burbano-Herrera and Viljoen "Provisional measures", above at note 12.

of PMs is without prejudice to the merits of the communication. However, that is not to suggest that the Commission will adopt PMs for every situation with the potential to cause harm, as not all potential violations of rights would result in "irreparable damage" to the person concerned. It should indeed be borne in mind that PMs are principally of an exceptional nature and that the main aim pursued by human rights supervisory organs is to avoid irreparable harm.

As the Rules do not provide detailed definitions of the concepts "irreparable harm" and "urgent", and because the Commission does not adopt reasoned decisions on PMs, it is difficult to conduct a rigorous analysis of the circumstances that give rise to PMs. Nonetheless, from the rare cases in which the African system has adopted PMs, it is clear that the Commission considers as especially grave any instances of potential damage to individuals over whom the state serves as guarantor, such as those under state custody. For example, detainees have been protected in a number of instances, including individuals alleging unlawful arrest,[15] or who have been sentenced to death[16] or kept in appalling conditions.[17]

Given the special situations of danger in Africa, the Commission has adopted PMs in order to protect both individuals and groups. However, in most cases, the beneficiaries are individuals. The Commission has only adopted PMs of a collective character on two occasions. In one case, PMs were granted to protect a group of victims of the armed conflict in Djibouti and, in the other, they were awarded to approximately 15,000 members of the indigenous Ogiek community of the Mau Forest, who had been subjected to harassment and forced eviction by the Kenyan state over a number of years.[18]

Although the African Charter makes some social and economic rights, in particular the rights to education[19] and health,[20] unequivocally justiciable,[21] the case law on PMs seems biased in that PMs are, with very few exceptions, adopted to protect traditional civil and political rights. To date, there has only been a single instance of the Commission adopting PMs to protect the

15 Comms 140/94, 141/94 and 145/95 *Constitutional Rights Project, Civil Liberties Organisation and Media Rights Agenda v Nigeria*, paras 2 and 49; and appln 2/2013 *African Commission (in respect of Saif Al-Islam Gaddafi) v Libya* (*Gaddafi's Son Provisional Measures*).

16 Comm 334/06 *Egyptian Initiative for Personal Rights and Interights v Arab Republic of Egypt*.

17 Comms 137/94, 139/94, 154/96 and 161/97 *International Pen, Constitutional Rights Project, Interights (in respect of Ken Saro-Wiwa Jr and Civil Liberties Organisation) v Nigeria*; *Constitutional Rights Project v Nigeria*, above at note 15; and *Gaddafi's Son Provisional Measures*, above at note 15, para 15.

18 Comm 133/94 *Association pour la Défense des Droits de l'Homme et des Libertés v Djibouti* (2000) AHRLR 80 (ACHPR 2000); and appln 6/2012 *African Commission (in respect of the Ogiek Community of the Mau Forest) v Kenya*.

19 African Charter, art 17.

20 Id, art 16.

21 Id, art 22.

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right to health.[22] It is therefore ironic that the Commission has made more sparing use of its seemingly more generous legal standards. It remains to be seen if, in future, the Commission will adopt PMs in relation to serious violations of socio-economic rights, such as those resulting from failures to provide medication or adequate medical treatment to those who are seriously ill, but lack financial resources, or who are at risk due to manifestly inadequate housing or a lack of basic education.

Another factor to take into consideration is that the request for PMs should be made in the context of a communication.[23] In this regard, it is essential to submit both a communication regarding Kenya's international responsibility for preventable maternal deaths in health facilities, and a request for PMs to protect current expectant mothers who are in a situation of danger.[24]

AFRICAN COMMISSION ON HUMAN AND PEOPLES' RIGHTS CASE LAW

Although PMs are intended to prevent irreparable harm to those in a situation of serious risk, such measures have been adopted only very rarely in Africa. Indeed, while the Commission has been empowered to adopt PMs for over 27 years, between 1988 and 2015[25] they were only granted on 32 occasions.[26]

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22 In comms 140/94, 141/94 and 145/95, above at note 15, the Commission ordered the state to ensure the victims' health was not endangered.

23 The Rules, rule 98(1). The Commission will consider a communication where it meets the conditions outlined in art 56 of the African Charter, that it: "(1) Indicates its author(s) even if the latter request(s) anonymity; (2) Is compatible with the Charter of the Organisation of African Unity or with the present Charter; (3) Is not written in disparaging or insulting language directed against the State concerned and its institutions or to the Organisation of African Unity; (4) Is not based exclusively on news disseminated through the mass media; (5) After exhausting local remedies, if any, unless it is obvious that this procedure is unduly prolonged; (6) Is submitted within a reasonable period from the time local remedies are exhausted or from the date the Commission is seized with the matter; and (7) Does not deal with cases which have been settled by those States involved in accordance with the principles of the Charter of the United Nations, or the Charter of the Organisation of African Unity or the provisions of the present Charter".

24 This point is addressed in more detail in the section below on "Applying theory to practice".

25 The Commission has had powers to adopt PMs since 1988, but did not exercise them until 1993. According to available data, 22 out of 28 PM requests were granted between 1 January 1993 and mid-2014.

26 See comm 83/92 *Jean Yakovi Degli v Togo*; two decisions in *Saro-Wiwa*, above at note 17; *Constitutional Rights Project v Nigeria*, above at note 15; comm 212/98 *Amnesty International v Zambia* (2000) AHRLR 325 (ACHPR 1999); *la Défense des Droits de l'Homme v Djibouti*, above at note 18; comm 290/2004 *Open Society Justice Initiative (in respect of Njawe Noumeni) v Cameroon* (2006) AHRLR 75 (ACHPR 2006); comm 284/03 *Zimbabwe Lawyers for Human Rights and Associated Newspapers of Zimbabwe v Republic of Zimbabwe*; *Egyptian Initiative for Personal Rights*, above at note 16; comm 402/11 *Kordofan Provisional Measures v Sudan*; comm 413/12 *Centre for Human Rights, University of Pretoria (in respect of David Mendes) v Angola*; comm 430/2012 *Gabriel Shumba and Others (Represented by Zimbabwe Lawyers for Human Rights) v Zimbabwe*; *Gaddafi's Son Provisional*

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Furthermore, PMs have mostly protected detainees[27] and have on only one occasion been granted to protect an individual woman.[28]

Given the number and severity of the human rights violations committed across Africa during this period, it must be asked why the Commission has issued so few PMs and almost none to protect women. This is particularly curious given that, with the exception of newcomer South Sudan, all AU member states have ratified the African Charter.[29] Most did so in the 1990s, meaning that they have long fallen under the supervision of the Commission.[30]

The number of requests for PMs could be apparently so low because their adoption requires a communication to be pending before the Commission and because information about some PMs is not publicly accessible as the Commission does not keep a record of all requests. This lack of information about previous PMs is reflected in the Commission's words in its final decision in *Saro-Wiwa*. After the state had deliberately failed to comply with the Commission's request to suspend death penalty orders, the Commission stated that "executions had been stayed in Nigeria in the past on the invocation by the Commission of its rules on provisional measures and the Commission had hoped that a similar situation will obtain in the case of Ken Saro-Wiwa and others. It is a matter of deep regret that this did not happen."[31] However, before this finding, there is no official record or registration whatsoever of any PMs related to Nigeria.

Furthermore, it remains unclear how many PMs the Commission has been prevented from publishing as a result of the application of article 59(1) of the African Charter. This article states that all measures taken within the provisions of chapter III (procedure of the Commission) of the African Charter

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Measures, above at note 15; *Ogiek of Mau Forest*, above at note 18; comm 239/2001 *Interights (in respect of Sikunda) v Namibia* (2002) AHRLR 21 (ACHPR 2002); comm 256/2002 *Woods and Another v Liberia* (2003) AHRLR 125 (ACHPR 2003); comm 250/2002 *Zegveld and Another v Eritrea* (2003) AHRLR 84 (ACHPR 2003); comm 258/2002 *Miss A v Cameroon* (2004) AHRLR 39 (ACHPR 2004); comm 269/03 *Interights (in respect of Safia Yakubu Husaini et al) v Nigeria*; comm 231/99 *Avocats Sans Frontières (in respect of Bwampamye) v Burundi* (2000) AHRLR 48 (ACHPR 2000); comm 260/02 *Bakweri Land Claims Committee v Cameroon* (2004) AHRLR 43 (ACHPR 2004); and comm 276/03 *Centre for Minority Rights Development (Kenya) and Minority Rights Group (in respect of Endorois Welfare Council) v Kenya*. The last 11 PMs were adopted between May 2014 and April 2015.

27 C Burbano Herrera and F Viljoen "Danger and fear in prison: Protecting the most vulnerable persons in Africa and the Americas by regional human rights bodies through interim measures" (2015) *Netherlands Quarterly of Human Rights* 163 at 163.

28 The beneficiary was a nursing mother from Nigeria who was sentenced to death by stoning by a Sharia court for the alleged crime of adultery. See *Safia Yakubu Husaini*, above at note 26.

29 The AU is an international organization that, after South Sudan's accession in 2011, consists of 54 African states. The only African country that is not an AU member is Morocco, which withdrew in 1984 after the AU recognized Western Sahara as a sovereign state.

30 By 1999, the African Charter had been ratified by all states that were then AU members.

31 *Saro-Wiwa*, above at note 17, para 103.

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"shall remain confidential until such a time as the Assembly of Heads of State and Government shall otherwise decide".

PREVENTABLE MATERNAL MORTALITY IN AN INTERNATIONAL HUMAN RIGHTS FRAMEWORK

Given that the Commission has never granted PMs to protect expectant mothers or decided communications related to maternal mortality, this section examines whether any other international human rights bodies have done so and whether they have found states internationally responsible for preventable maternal death. A comparative analysis of human rights mechanisms outside Africa shows that both international and national organs have applied human rights law to hold governments legally accountable for preventable maternal deaths. The analysis outlined below also shows that, in the Americas, PMs have been requested with the aim of protecting expectant mothers. Overall, these decisions highlight the shortcomings in the healthcare system from the perspective of pregnant women, establish that governments are legally accountable for rectifying these shortcomings and emphasize the link between maternal mortality, poverty, discrimination and inequality.

International responsibility for preventable maternal mortality

UN treaty bodies that supervise states' commitments under the core UN human rights treaties have declared that the prevention of maternal mortality and the right to safe pregnancy and childbirth are part of the right to life, the right to health, the principle(s) of equality and non-discrimination, and freedom from cruel, inhuman and degrading treatment.[32] They have indicated that elevated rates of maternal mortality are related, among other things,[33]

32 See, for example, Committee Against Torture (CAT Committee) "Concluding observations: Peru", UN doc CAT/C/PER/CO/5–6 (2013), para 15; CAT Committee "Concluding observations: Paraguay", UN doc CAT/C/PRY/CO/4-6 (2011), para 22; CEDAW Committee, comm 17/2008 *Alyne da Silva Pimentel Teixeira v Brazil*, UN doc CEDAW/C/49/D/17/2008 (2011), paras 7.5–7.6, available at: <http://www.ohchr.org/Documents/HRBodies/CEDAW/Jurisprudence/CEDAW-C-49-D-17-2008_en.pdf> (last accessed 8 May 2017); CAT Committee "Concluding observations: Brazil", UN doc E/C.12/BRA/CO/2 (2009), paras 28–29; Human Rights Committee "Concluding observations: Mali", UN doc CCPR/CO/77/MLI (2003), para 14; Human Rights Committee "Concluding observations: Mongolia", UN doc CCPR/C/79/Add.120 (2000), para 8(b); Human Rights Committee "Concluding observations: Peru", UN doc CCPR/CO/70/PER (2000), para 20; Human Rights Committee "Concluding observations: Trinidad and Tobago", UN doc CCPR/CO/70/TTO (2000), para 18; CEDAW Committee "Concluding comments: Belize", UN doc A/54/38/Rev1 (1999), para 56.

33 The treaty bodies have also indicated that elevated rates of maternal mortality are related to abortion laws and unsafe or illegal abortion. See Human Rights Committee "Concluding observations: Chile", UN doc CCPR/C/CHL/CO/6 (2014), para 15; Human Rights Committee "Concluding observations: Panama", UN doc CCPR/C/PAN/CO/3 (2008), para 9; CEDAW Committee "Concluding observations: Paraguay", UN doc CCPR/C/PRY/CO/3 (2013), para 13; CEDAW Committee "Concluding observations:

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to the lack of comprehensive reproductive health services.[34] They have also stated that states should take targeted measures to address maternal mortality in marginalized groups that have disproportionately elevated rates of maternal death, including young women,[35] low-income women[36] and women from rural areas.[37]

The Human Rights Committee (HR Committee) was the first treaty body to indicate clearly, in 1982, that states must adopt proactive measures to protect the right to life.[38] This committee has indicated that states have a fundamental duty to protect individuals from arbitrary and preventable loss of life,[39] including maternal death.[40] Similarly, the Committee on the Elimination of Discrimination against Women (CEDAW Committee)[41] and the Committee on the Rights of the Child (CRC Committee)[42] have explicitly interpreted the right to life as including obligations on the state to prevent and address maternal mortality.[43] These treaty bodies have expressed concern over Kenya's high

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Eritrea", UN doc CEDAW/C/ERI/CO/3 (2006), para 22; CEDAW Committee "Concluding observations: Guatemala", UN doc CCPR/C/GTM/CO/3 (2012), para 20.

34 CEDAW Committee "Concluding observations: Mexico", UN doc CEDAW/C/MEX/CO/7-8 (2012), paras 30–31.

35 CRC Committee "Concluding observations: Nicaragua", UN doc CRC/C/NIC/CO/4 (2010), paras 64–65.

36 HR Committee "Concluding observations: Argentina", UN doc CCPR/CO/70/ARG (2000), para 14.

37 ESCR Committee "Concluding observations: Brazil", UN doc E/C.12/BRA/CO/2 (2009), para 28.

38 The HR Committee monitors state compliance with the International Covenant on Civil and Political Rights.

39 HR Committee "General comment no 6, art 6 (right to life)" (16th session, 1982) in "Compilation of general comments and general recommendations adopted by human rights treaty bodies", UN doc HRI/GEN/1/Rev1 at 6 (1994), para 5, available at: <http://www1.umn.edu/humanrts/gencomm/hrcom6.htm> (last accessed 8 May 2017).

40 HR Committee "General comment no 28: Equality of rights between men and women" (68th session, 2000) in "Compilation of general comments and general recommendations adopted by human rights treaty bodies", UN doc HRI/GEN/1Rev9 (vol 1) (2008) at 229, para 10, available at: <http://www1.umn.edu/humanrts/gencomm/hrcom28.htm> (last accessed 8 May 2017).

41 The CEDAW Committee monitors state compliance with the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). See CEDAW Committee "General comment no 24: Art 12 of the Convention (women and health)" (20th session, 1999) in "Compilation of general comments", id (vol 11) at 365, para 31(c).

42 The CRC Committee monitors state compliance with the Convention on the Rights of the Child.

43 See CEDAW Committee "Concluding comments: Belize", UN doc A/54/38/Rev1 (1999), para 56: "the Committee notes that the level of maternal mortality due to clandestine abortions may indicate that the Government does not fully implement its obligations to respect the right to life of its women citizens." HR Committee "Concluding observations: Mali", UN doc CCPR/CO/77/MLI (2003), para 14: "So as to guarantee the right to life, the State should strengthen its efforts in ensuring the accessibility of health services,

incidence of maternal deaths, lack of quality healthcare and basic infrastructure, and abusive behaviour by medical staff towards patients.[44]

In the first ever legal case regarding maternal death (*Alyne da Silva Pimentel v Brazil*) the CEDAW Committee ruled in 2011 that preventable maternal mortality constitutes an international violation of state obligations.[45] The CEDAW Committee found that Alyne, a 28 year old Brazilian woman, died because she was not provided with appropriate healthcare to treat obstetric complications related to her pregnancy. As a result, it found that Brazil had breached its obligations under the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) by failing to prevent a maternal death. This decision established the principle under international law that governments have an obligation to guarantee all women in their countries, regardless of their income level or racial background, access to timely, non-discriminatory and appropriate maternal health services in public and private health facilities.[46] This was the first decision in which the committee specifically required a state to provide adequate and quality maternal healthcare services as part of its non-discrimination obligations.[47]

At the regional level, the Inter-American Court of Human Rights (IACtHR) found Paraguay had violated Remigia Ruiz's right to life[48] and right to exercise that right without discrimination.[49] She was an expectant mother and indigenous woman who died aged 38.[50] The IACtHR held Paraguay responsible for Remigia's death and described her death as having occurred during a labour in which she lacked adequate medical care, of being linked to the victim's situation of extreme poverty and lack of access to adequate health services, and of not being accompanied by documentation on the cause of death.[51]

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including emergency obstetric care." CRC Committee "Concluding observations: Democratic Republic of Congo", UN doc CRC/C/COD/CO/2 (2009), paras 33–34.

44 See text below at notes 99 and 101 to 109.

45 The CEDAW Committee requires that states ensure that women have access to appropriate services in connection with pregnancy, childbirth and the postnatal period, including family planning and emergency obstetric care. See *Alyne da Silva*, above at note 32, paras 7.6 and 7.7.

46 Id, para 7.6. Even when governments outsource health services to private institutions, the committee ruled that states remain responsible for the actions of these contractors and have a duty to regulate and monitor private health centres.

47 CEDAW, art 12(2). See also RJ Cook "Human rights and maternal health: Exploring the effectiveness of the *Alyne* decision" (2013) 41 *Global Health and the Law* 103 at 103.

48 American Convention on Human Rights, art 4(1).

49 Id, art 1(1).

50 *Xakmok Kasek Indigenous Community v Paraguay* IACtHR (24 August 2010), merits, reparations and costs judgment, paras 2, 214, 217, 232, 234, 275, 301, 303 and 306.

51 The decision regarding Remigia's death was part of a petition on indigenous land. The court ruled that the government's failure to guarantee the property rights of the Xakmok Kasek indigenous people over their ancestral territory served to keep this

Domestic courts in other regions have reached similar verdicts. In 2010, the High Court of Delhi, India found the government had violated Shanti Devi's constitutional right to life and health[52] for her preventable death in childbirth.[53] Having been denied her legal entitlement to hospital care for those living below the poverty line, Shanti had to give birth at home, without the assistance of a medical professional. She died immediately thereafter, leaving a husband and three living children. The direct cause of her death was postpartum haemorrhage due to a retained placenta. Contributing factors included her socioeconomic status, which resulted in her being denied the resources and services she needed, and her poor health condition resulting from anaemia, tuberculosis and repeated unsafe pregnancies.

More recently, in 2015, the High Court of Uganda found the local government liable for the death of Nanteza Irene, an expectant mother who did not receive the timely, immediate and emergency obstetric care she required to deal with the complications of her obstructed labour.[54] The direct cause of death was a ruptured uterus secondary to anaemia. Nanteza was in hospital for eight hours, but the duty doctor arrived only a few minutes before she died. The court held the local government responsible for the violation of the deceased's right to access appropriate medical and health services, for depriving her children of their right to be cared for by their mother, and for the resultant suffering and mental anguish of her husband and son. This decision demonstrates that preventable maternal mortality violates several rights and affects multiple people. It constitutes a violation not only of the rights of the women who do not obtain adequate medical care when they experience complications during pregnancy or delivering, but also of the rights of their relatives who suffer as a result of their loss.[55]

Four points should be noted with regard to these decisions. First, national and international human rights organs are increasingly clear that maternal mortality is a human rights issue and that states may be declared (inter)nationally responsible for such deaths. Secondly, preventable maternal mortality is the result of the systemic failure of states to put in place adequate policies to guarantee women a safe pregnancy. These deaths are not inevitable and are overwhelmingly concentrated among women from the global south. Thirdly, maternal mortality mainly affects women from disadvantaged groups

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community in a vulnerable state regarding its health and welfare. See id, paras 214, 232, and 273.

52 Indian Constitution, art 21.

53 *Laxmi Mandal v Deen Dayal Harinagar Hospital & Others* WP (C) Nos 8853/2008 High Court of Delhi (4 June 2010), paras 40, 42, 51 and 53.

54 High Court of Uganda, civil suit no 111 of 2012 (30 April 2015) at 12.

55 Alicia Yamin has carried out extended research on this issue. See, for example, the panel discussion "Women's lives matter: The impact of maternal death on families & communities" (7 October 2014), available at: <http://fxb.harvard.edu/womens-lives-matter/> (last accessed 12 May 2017).

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in society, including those from low income groups, those who form part of a minority group, such as indigenous or black women, and / or those who live in rural areas. Finally, maternal mortality does not affect just the women who die, but also the families they leave behind.

Provisional measures to protect expectant mothers at risk

Expectant mothers in situations of extreme danger have been protected by PMs under the Inter-American human rights system.[56] The PMs that have been granted have sought to enable expectant mothers to obtain the medical treatment they need to protect their rights. In these cases, the failure to provide the necessary treatment predominantly led to the loss of the foetus. As is demonstrated below, requests for PMs have served to highlight the legal and social obstacles that pregnant women have to overcome in obtaining the medical treatment they need.

In these cases, both the Inter-American Commission on Human Rights (IACHR) and the IACtHR have requested that the state concerned provide the medical treatment recommended by the doctors. For example, the IACHR called on Nicaragua to protect Amelia, a 27 year old woman with cancer who was also the mother of a ten year old girl. She was denied the necessary medical attention to treat her cancer because of her pregnancy. The doctors had recommended that Amelia urgently begin a course of chemotherapy or radiotherapy treatment, but this was refused by the hospital due to the high risk that the treatment could provoke an abortion.

Since 2006, abortion has been banned in Nicaragua under all circumstances, even where the pregnancy is the result of rape or incest or where it puts the mother's life and health at risk.[57] Currently, Nicaraguan doctors are forbidden from treating pregnant women with cancer, HIV/AIDS, malaria and cardiac diseases, and face the threat of custodial sentences if they provide health services or information related to abortion. In this individual case, Nicaragua informed the IACHR, within the mandated deadline, that it had initiated the requested treatment.[58]

In another instance, the IACtHR granted PMs to protect a pregnant woman known as "B". She suffered from lupus and her foetus was determined to have anencephaly, a condition in which a major part of the brain is missing.[59] The absolute ban on abortion in El Salvador prevented the doctors from terminating the pregnancy in order to protect B's rights.[60] In the PM resolution the

56 In the Inter-American system, authorization to request the adoption of PMs is governed by the American Convention and the Rules of Procedure of the Inter-American Court and Commission. The specific provisions are outlined in art 63(2) of the convention, art 26(1)(2)(3) of the rules of the court and art 74(1) of the rules of the commission.

57 Nicaraguan Penal Code, art 16.

58 IACHR, MC 43-10, *Amelia v Nicaragua*, 26 February 2010.

59 IACtHR, PM, *B v El Salvador*, 19 August 2013.

60 Salvadorian Penal Code, arts 133–37.

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IACtHR ordered El Salvador to adopt the necessary measures so that B's doctors could perform whatever procedures they considered relevant in order to avoid irreparable harm to B's rights to life, personal integrity and health. The court, citing medical opinions, concluded that B's situation was indeed urgent and, in terms of irreparability, the court indicated that if B's pregnancy continued she could suffer from severe medical complications or death, as well as harm to her mental health. The measures were lifted five days after they were granted as, in the intervening period, B had gone into labour and the doctors had performed a caesarean section.

These cases lead us to conclude that, in the Americas, PMs have been an important tool to protect expectant mothers in situations of danger. They also show that, if international human rights bodies take their function of protecting expectant mothers seriously, at least from the perspective of women who have been the beneficiaries of PMs, they can have an enormous impact in terms of guaranteeing women's rights in practice.

APPLYING PROVISIONAL MEASURES WITHIN THE AFRICAN HUMAN RIGHTS FRAMEWORK

Kenyan legal framework: The obligation to respect, protect and fulfil women's rights

Kenya provides strong legal protection for women's rights at both the national and international level. Within the framework of the AU, Kenya has ratified the African Charter.[61] Although silent on women's rights in general and reproductive rights in particular, the charter provides for a general set of human rights, including the right to life and integrity of the person, the right to health and freedom from discrimination.[62] Additionally, Kenya has ratified the Protocol to the African Charter on the Rights of Women in Africa (Maputo Protocol), which provides for women's health and sexual and reproductive health rights.[63] This is the main legal instrument for the

61 The Commission has adopted various instruments of relevance to this topic, including the Guidelines on Economic, Social and Cultural Rights in the African Charter (2005), the Resolution on Maternal Mortality (2008), the Resolution on the Health and Reproductive Rights of Women (2007), the Resolution on the Status of Women in Africa (2005) and the Resolution on the Situation of Women and Children in Africa (2004).

62 The African Charter, arts 4, 16 and 2 respectively. F Viljoen "An introduction to the Protocol to the African Charter on Human Rights and Peoples' Rights on the Rights of Women in Africa" (2009) 16 *Washington and Lee Journal of Civil Rights and Social Justice* 11 at 19.

63 Maputo Protocol, art 14. The scope of the charter has been extended by the adoption of the Maputo Protocol, over which the Commission and Court also have jurisdiction, including powers to issue PMs. It was ratified by Kenya on 8 October 2010. Kenya entered a reservation on art 14(2)(c) disallowing legal abortion in cases of rape and defilement and where the life and health of the mother and foetus are in danger. This is inconsistent with art 26(4) of the 2010 Kenyan Constitution.

protection of women's rights in Africa and commits states to establish and strengthen existing prenatal, delivery and postnatal health and nutritional services for women.[64] Kenya has also ratified the African Charter on the Rights and Welfare of the Child,[65] which indicates that every child shall have the right to enjoy the highest attainable state of physical, mental and spiritual health.[66] This charter also indicates that states should ensure appropriate healthcare for expectant and nursing mothers.[67]

At the UN treaty level, Kenya has ratified seven of the nine core human rights treaties[68] and they provide an important human rights framework for the protection of women's rights.[69] These instruments comprise: the International Convention on the Elimination of All Forms of Racial Discrimination,[70] Covenant on Civil and Political Rights,[71] the Covenant on Economic, Social and Cultural Rights,[72] CEDAW,[73] the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or

64 The African Commission published "General comment no 2 on art 14.1(a)(b)(c) and (f) and art 14.2(a) and (c) of the Maputo Protocol", available at: <http://www.achpr.org/instruments/general-comment-two-rights-women/> (last accessed 8 May 2017).

65 The African Charter on the Rights and Welfare of the Child was adopted in Addis Ababa, Ethiopia on 11 July 1990 and entered into force on 29 November 1999. The African Children's Committee is its supervisory body. By ratifying this charter, states automatically accept the jurisdiction of the African Children's Committee to "receive" individual and inter-state communications. See Organisation of African Unity doc CAB/LEG/24.9/49 (1990), arts 32, 43 and 44. However, this body has not explicitly been granted competence to adopt PMs. Kenya ratified the charter on 25 July 2000 and it is available at: <http://www1.umn.edu/humanrts/africa/afchild.htm> (last accessed 8 May 2017).

66 African Charter on the Rights and Welfare of the Child, article 14(1).

67 Id, art 14(2)(e).

68 Kenya has not ratified the International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families, which was adopted on 18 December 1990, or the International Convention for the Protection of all Persons from Enforced Disappearance, which was adopted on 20 December 2006.

69 State reporting is a mandatory requirement for the nine core UN human rights treaties. Each of these requires states to submit initial reports to be followed by periodic updates indicating what measures they have taken to implement the rights enshrined in the treaties. See also UN "Manual on human rights reporting" (1997).

70 Adopted on 21 December 1965, entered into force on 4 January 1969, ratified by Kenya on 13 September 2001.

71 Adopted on 16 December 1966, entered into force on 23 March 1976, ratified by Kenya on 1 May 1972.

72 Adopted on 16 December 1966, entered into force on 3 January 1976, ratified by Kenya on 1 May 1972.

73 Adopted on 18 December 1979, entered into force on 3 December 1981, ratified by Kenya on 8 April 1984.

Punishment,[74] the Convention on the Rights of the Child[75] and the Convention on the Rights of Persons with Disabilities.[76]

Domestically, Kenya also has a modern constitution (the Constitution), which entered into force in 2010 and includes broad and far reaching formal recognition of women's rights. Furthermore, according to the Constitution, human rights treaties ratified by Kenya are an integral part of national law.[77] Under article 43(1)(a), the Constitution guarantees every person the right to the highest attainable standard of health, including the right to healthcare services and reproductive healthcare. Therefore, reproductive health is explicitly recognized in this document and includes family planning, antenatal, delivery and postnatal health services. Alongside this, article 26(4) states that abortion is permitted if, in the opinion of a trained health professional, the life or health of the mother is at risk.[78] The Constitution provides special protection for poor women and women who are in a particular position of vulnerability. It declares that no-one shall be denied emergency medical care[79] and that the state shall provide appropriate social security to persons who are unable to support themselves and their dependants.[80] It also states that children, minorities and marginalized groups have the right to access health services.[81] More broadly, the Constitution recognizes the right to inherent dignity and the right to have that dignity respected and protected.[82] In addition, the Constitution creates two oversight bodies with responsibility for ensuring that the rights and freedoms recognized in the Constitution are effectively enjoyed by women: the Kenya National Commission on Human Rights (KNCHR)[83] and the National Gender Equality Commission (NGEC).[84] The KNCHR Act 2011 awards the Commission powers

74 Adopted on 10 December 1984, entered into force on 26 June 1987, ratified by Kenya on 21 February 1997.

75 Adopted on 20 November 1989, entered into force on 2 September 1990, ratified by Kenya on 26 June 1990.

76 Adopted on 13 December 2006, entered into force on 3 May 2008, ratified by Kenya on 19 May 2008.

77 Constitution, art 2(6).

78 The Constitution relaxed the stringency of Kenya's abortion laws. Previously, the penal code criminalized any attempt to procure an abortion from a third party (art 158), any attempt by a pregnant woman to perform an abortion on herself (art 159) and the supply of drugs for the purposes of an abortion (art 160). These offences carried heavy penalties of 14, seven and three years in prison, respectively.

79 Id, art 43(2).

80 Id, art 43(3).

81 Id, arts 53 and 56.

82 Id, art 28.

83 KNCHR was first established as a statutory body in 2003 pursuant to the KNCHR Act (No 9) of 2002. In August 2011, KNCHR was reconstituted as a constitutional commission by art 59(4) of the Constitution. The act outlines the Commission's mandate, including its powers to conduct investigations into any complaints of human rights violations in the country.

84 NGEC was established by an act of Parliament in August 2011, as a successor to the Kenya

to investigate any violation of human rights, either on its own initiative or following a complaint made by any individual or group. In recent years, the Commission has led public inquiries covering violations of reproductive health rights.[85] Further, and as shown in the following section, KNCHR examined the conditions of hospitals, including maternity hospitals, and published a report in 2012[86] criticizing the deplorable services that expectant mothers receive there.

The Kenyan authorities have also implemented several policies and drawn up strategies targeting sexual and reproductive rights, and launched campaigns against maternal death, such as the National Road Map for Accelerating the Attainment of the Millennium Development Goals Related to Maternal and New-born Health in Kenya,[87] the National Reproductive Health Strategy[88] and the Health Policy.[89] One of the campaigns specifically aimed at tackling maternal mortality was Campaign Beyond Zero,[90] which led, in 2014, to the creation of the Beyond Zero Foundation, which works in cooperation with the government to reduce maternal mortality.

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National Human Rights and Equality Commission and pursuant to art 59 of the Constitution. NGEC's objectives are to promote gender equality and freedom from discrimination.

85 In September 2009, the Federation of Women Lawyers, Kenya (FIDA) and the Centre for Reproductive Rights, USA (CRR) submitted a complaint to KNCHR alleging violations of women's reproductive rights in Kenyan health facilities, specifically the Pumwani Maternity Hospital. The complaint was based on the findings of a joint study conducted between November 2006 and May 2007 that included findings from a sample of women, healthcare providers, hospital administrators, leaders of medical associations, and licensing and regulatory officials. The report "Failure to deliver" found that the Kenyan state was responsible for numerous, severe violations of reproductive rights: FIDA and CRR "Failure to deliver" (2009), available at: <http://reproductiverights.org/sites/default/files/documents/pub_bo_failuretodeliver.pdf> (last accessed 8 May 2017).

86 KNCHR "Realizing sexual and reproductive health rights in Kenya: A myth or reality?" (2012), available at: <http://www.knchr.org/portals/0/reports/reproductive_health_report.pdf> (last accessed 8 May 2017).

87 Republic of Kenya "National road map for accelerating the attainment of MDGs related to maternal and newborn health in Kenya" (August 2010), available at: <https://www.k4health.org/sites/default/files/Roadmap%20to%20Maternal%20and%20Newborn%20Health%20Booklet.pdf> (last accessed 8 May 2017).

88 Republic of Kenya Ministry of Public Health and Sanitation, Ministry of Medical Services "National reproductive health strategy: 2009–2015", available at: <https://www.k4health.org/sites/default/files/National%20RH%20Strategy_0.pdf> (last accessed 8 May 2017).

89 Republic of Kenya "Health Policy (2012–30)", available at: <http://hennet.or.ke/wp-content/uploads/2015/02/KENYA_HEALTH_POLICY_29-01-2014.pdf> (last accessed 28 May 2017).

90 Further information on the campaign can be found at: <http://www.beyondzero.or.ke/> (last accessed 8 May 2017).

CONTEXT OF KENYAN HEALTH FACILITIES

The lack of resources, infrastructure, equipment, staff and quality services within Kenya's health system has been well documented. These issues explain why expectant mothers, such as Mama X, have died either in health facilities or shortly after having attended such a centre. In its 2013 report, the World Bank found that only 44.6 per cent of public health providers could properly manage maternal / neonatal complications.[91] Moreover, only 36 per cent of public health facilities offering delivery services possess the basic delivery room infrastructure and equipment needed.[92] Furthermore, Kenya's public health system has long been plagued by reports of abuse, mistreatment and neglect of patients by staff.[93]

Over the years, national human rights institutions,[94] international human rights bodies,[95] international UN-related non-human rights institutions,[96] (inter)national non-governmental organizations[97] and the media have extensively and publicly denounced the appalling manner in which expectant mothers are treated in Kenya's public hospitals. They have repeatedly requested that Kenya improve its sexual and reproductive health services. Consequently, state authorities have been well-informed of the problems surrounding medical services for expectant mothers.

In 2012, the KNCHR reached the same conclusions as those presented by the CEDAW Committee in 2007.[98] The latter had deemed Kenya's maternal mortality rate to be consistently high, stating that "the Committee is deeply concerned about women's lack of access to quality sexual and reproductive health services … It is also concerned that negative attitudes of health workers may be an impediment to women's access to health-care services".[99] The

91 H Martin and O Imphidzai *Education and Health Services in Kenya: Data for Results and Accountability, Service Delivery Indicators: Education / Health* (2013, International Bank for Reconstruction and Development / The World Bank) at 2–4; see also Bourbonnais "Implementing free maternal health care", above at note 4 at 8.

92 KNCHR "Realizing sexual and reproductive health rights", above at note 86 at 48 and 49.

93 Bourbonnais "Implementing free maternal health care", above at note 4 at 6 and 7; M Wasamu "We need accountability, not money, to fix the health sector" (31 July 2013) *The Star*, available at: <http://www.the-star.co.ke/news/2013/07/31/we-need-accountability-not-money-to-fix-the-health-sector_c809515> (last accessed 8 May 2017); and A Jamah "Free maternity services in Kenya could endanger mothers' lives, experts warn" (18 July 2013) *Standard*, available at: <https://www.standardmedia.co.ke/health/article/2000088679/why-free-maternity-services-could-endanger-mothers-lives> (last accessed 8 May 2017).

94 KNCHR "Realizing sexual and reproductive health rights", above at note 86; See also Kenyan Ministry of Health "Policy proposal", above at note 4.

95 The CEDAW Committee and the ESCR Committee. See also below at notes 99, 101 and 106.

96 World Bank Report (2015), above at note 4.

97 See above at note 85.

98 See KNCHR "Realizing sexual and reproductive health rights", above at note 86.

99 CEDAW Committee "Concluding comments: Kenya" (39th session, 23 July–10 August

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committee recommended that Kenya increase its efforts to reduce the incidence of maternal mortality and called for measures to ensure that health workers adopted a client-friendly attitude that would improve access to quality healthcare.[100] In 2011, the CEDAW Committee repeated its remarks about Kenya, saying it was "particularly concerned that maternal mortality rates have increased" and noting "women's limited access to quality reproductive and sexual health services".[101] Importantly, in a Brazilian case in 2011, the CEDAW Committee conceptualized preventable maternal death and the associated accountability mechanisms in justiciable terms.[102]

For its part, the Committee on Economic, Social and Cultural Rights (ESCR Committee)[103] has declared that states' obligations to guarantee maternal health care, including prenatal and postnatal care, are comparable to a core obligation[104] under the right to health.[105] In 2008, the ESCR Committee highlighted the problem of the high rate of maternal deaths in Kenya. This committee, much like the CEDAW Committee, referred to "the lack of adequately equipped maternal health care facilities and skilled birth attendance … and de facto discrimination against poor women, older women and women with HIV/AIDS in access to maternal health care".[106] The ESCR Committee recommended that Kenya take immediate measures "to ensure that all expectant mothers … have affordable access to skilled care free from abuse during pregnancy, delivery, postpartum, postnatal periods, and to

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2007), para 37, CEDAW/C/KEN/CO/6, available at: <http://www.refworld.org/docid/46d280ff6.html> (last accessed 8 May 2017).

100 Id, para 38.

101 CEDAW Committee "Concluding observations: Kenya" (48th session, 17 January – 4 February 2011), paras 37–38, CEDAW/C/KEN/CO/7, available at: <http://www2.ohchr.org/english/bodies/cedaw/docs/co/CEDAW-C-KEN-CO-7.pdf> (last accessed 8 May 2017).

102 See text above at notes 44 and 46.

103 The ESCR Committee monitors state compliance with the International Covenant on Economic, Social and Cultural Rights (ICESCR). An important landmark in defining the right to health was its adoption of general comment no 14, outlining the framework of the "highest attainable standard of health" in art 12 of the ICESCR. This instrument holds that the right to health requires sufficient health facilities and trained health professionals to be made available. See Bourbonnais "Implementing free maternal health care", above at note 4 at 4.

104 Core obligations are the minimum essential level of each right that states must meet immediately.

105 ESCR Committee "General comment no 14: The right to the highest attainable standard of health (art 12)" (22nd session, 2000), in "Compilation of general comments and general recommendations adopted by human rights treaty bodies", UN doc HRI/GEN/1/Rev9 (vol 1) (2008) at 80, para 12, 81, para 14 and 83, para 21.

106 CESCR Committee "Consideration of reports submitted by states parties under arts 16 and 17 of the covenant: Concluding observations: Kenya" (41st session, 3–21 November 2008), E/C.12/KEN/CO/1, available at: <http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=4slQ6QSmlBEDzFEovLCuW2MbmIr6bjcj69OB9bDJS0h6wnzTN86b8rPdVp2riZPw4cBjzaTfLoZp3OAnmL1knuEha0fsDxAF2IbbocyN%2f6SjUE%2bEHqLvoKUmHEW2xPDU> (last accessed 8 May 2017).

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care of the new-born, including in remote rural areas".[107] While the Committee against Torture (CAT Committee)[108] has not made individual reference to Kenya, it has expressed concern about high maternal mortality rates around the world, indicating that preventable maternal deaths may constitute violations of the right to freedom from cruel, inhuman and degrading treatment.[109]

Although state authorities have put in place a range of actions to address the issue, these are yet to produce the desired results. This is most probably due to the lack of a detailed and integral understanding of the problem. For example, on 1 June 2013, Kenya introduced a policy of free maternity services in all public facilities with the aim of improving access to medical services.[110] Health facilities soon began to feel the effect of this policy. Hospitals were ill-prepared and lacked the capacity to respond adequately to the increased numbers of expectant mothers arriving at their facilities. Overcrowding of maternity wards became more widespread, with some mothers forced to leave hospital early in order to make room for others, or even to deliver on the hospital floor due to a shortage of beds.[111] Nurses also reported being overburdened as a result of the policy, with as few as three nurses aiding 20 mothers at a time and nearly all having to work overtime.[112] On the day of the policy announcement, the Pumwani Maternity Hospital (Pumwani Hospital), the largest in the country, delivered an unprecedented 100 babies and was uncertain how to reconcile its obligations to comply with the new policy with the need to cover costs.[113] For example, one matron noted that, while the hospital used to charge KES 5,000 (47 euros) for a normal delivery and KES 10,000 (95 euros) for a caesarean, the government would reimburse them at a flat rate of KES 5,000 per delivery, leaving a substantial budgetary shortfall.[114]

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107 Ibid.

108 The CAT Committee oversees state compliance with the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

109 CAT Committee "Concluding observations: Paraguay", UN doc CAT/C/PRY/CO/4–6 (2011), para 22; CAT Committee "Concluding observations: Peru", UN doc CAT/C/PER/CO/5–6 (2013), para 15.

110 "Speech by HE Hon Uhuru Kenyatta, CGH, president and commander-in-chief of the defence forces of the Republic of Kenya during the Madaraka Day celebrations" (Nyayo National Stadium, 1 June 2013), available at: <https://www.scribd.com/document/145055942/President-Uhuru-Kenyatta-s-Madaraka-Day-Speech> (last accessed 8 May 2017).

111 Bourbonnais "Implementing free maternal health care", above at note 4 at 6–7.

112 Id at 6, referring to Jamah "Free maternity services", above at note 93.

113 M Waimiru "Despite newly free deliveries in Kenya, some mothers opt for traditional birth attendants" (23 July 2013) *Global Press Journal*, available at: <https://globalpressjournal.com/africa/kenya/despite-newly-free-deliveries-in-kenya-some-mothers- opt-for-traditional-birth-attendants/> (last accessed 28 May 2017). See also Bourbonnais, id at 3.

114 Bourbonnais, id at 6.

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The critical situation of expectant mothers in health facilities has also been affected by other factors. For example, four months after free maternal healthcare was introduced (in September 2013) the Pumwani Hospital was closed for several days as a result of strike action by Nairobi county government workers.[115] In May 2015, it was reported that 2,000 doctors had quit public service during the previous year because of their alleged poor treatment by county governments.[116]

An additional issue is that Kenya allocated only 4.5 per cent of its total budget to health in 2014–15, down from the 5.9 per cent, 6.1 per cent and 7.2 per cent spent in 2012, 2011 and 2010, respectively.[117] As a result, the country's medical expenditure falls well short of Kenya's commitment to the 2001 AU Abuja Declaration, which required states to allocate at least 15 per cent of their national budget to public health by 2015.[118]

APPLYING THEORY TO PRACTICE: ADOPTING PROVISIONAL MEASURES TO PROTECT EXPECTANT MOTHERS AT PUMWANI HOSPITAL

Although medical centres in Kenya are in a critical condition as a whole, for methodological reasons the Pumwani Hospital was selected as a case study to illustrate how a PM should be granted to protect pregnant women at risk. The author visited the hospital and interviewed its staff in April 2015.[119]

Pumwani Hospital is located in Nairobi and is the busiest maternity hospital in East and Central Africa, with an average of 80–100 deliveries per day.[120] This

115 More than 2,000 nurses at the Kenyatta National Hospital went on strike to demand that the authorities introduce a promised 46% increment in their basic pay that had been awarded by the High Court in September 2012. See id at 8.

116 Under the new Constitution, responsibility for primary healthcare, including the financing and management of health facilities, falls on county governments; see Constitution, art 186. See also "2,000 doctors have quit public service" (15 March 2015) *Daily Nation*, available at: <http://www.nation.co.ke/news/2000-doctors-have-quit-public-service/-/1056/2654670/-/gnbwgj/-/index.html> (last accessed 8 May 2017).

117 See UNAIDS "Abuja +12: Shaping the future of health in Africa" (2013), available at: <http://www.unaids.org/sites/default/files/media_asset/JC2524_Abuja_report_en_0.pdf> (last accessed 8 May 2017).

118 Institute of Economic Affairs "Kenya budget 2014/2015: Balancing financing concerns while responding to spending inefficiencies" (2014) at 13.

119 While in Nairobi, the author also conducted interviews with staff of the Kenyan Legal and Ethical Issues Network on HIV and AIDS, KNCHR, NGEC and FIDA.

120 W Kigan "Socio-cultural factors influencing nutritional status among women attending Pumwani Maternity Hospital" (2010), available at: <http://erepository.uonbi.ac.ke/handle/11295/4078> (last accessed 8 May 2017). See also M Kimani "Investing in the health of Africa's mothers" (January 2008) *African Renewal*, available at: <http://www.un.org/africarenewal/magazine/january-2008/investing-health-africa%E2%80%99s-mothers> (last accessed 8 May 2017); Center for Strategic and International Studies "Studying Kenya's largest maternity hospital" (10 August 2009), available at: <http://www.smartglobalhealth.org/blog/entry/studying-kenyas-largest-maternity-hospital/> (last

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means that it handles between 29,000 and 36,000 births each year, the highest number in the country.[121] In 2005, 80 per cent of all hospital births in the country took place there.[122] Most expectant mothers who seek medical services there are young and poor. As such, any PMs granted in relation to this hospital could have a substantial impact in terms of the number of women protected and, in turn, on efforts to tackle social injustice in Kenya.

The article now explains how the three conditions for requesting PMs are met in the case of expectant mothers at Pumwani Hospital. It then describes the main provisions of potential PMs that the Commission could request to address the issue.

Condition 1: Situation of danger

Numerous academic contributions and reports prepared by national institutions and NGOs have repeatedly arrived at the same conclusion regarding Pumwani Hospital: that it suffers several structural problems related to infrastructure, staff shortages, lack of supplies and equipment, deplorable staff behaviour, lack of appropriate staff skills and weak external supervision systems.[123] Together, these problems represent a danger to the expectant mothers who seek medical attention at this facility. The Federation of Women Lawyers, Kenya, together with the Centre for Reproductive Rights, USA, and KNCHR published reports on this problem in 2007, 2009 and 2012.[124] The reports indicate that women suffer from unsafe delivery conditions, a lack of sensitivity to patients' cultural norms and beliefs, as well as abusive behaviour from staff. The author witnessed some of these problems first-hand during her visit to the hospital and they were also confirmed by the interviewees. Such structural problems put the rights of expectant mothers who seek medical services at Pumwani Hospital at risk. These factors have contributed to high rates of maternal and infant mortality, lasting psychological and physical repercussions and a loss of public confidence in this particular hospital, as well as the healthcare system more generally. Furthermore, state authorities and society at large are well aware of the critical situation at the hospital because of the continuous media coverage of the

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accessed 8 May 2017); and Bourbonnais "Implementing free maternal health care", above at note 4 at 168.

121 See interview with Pumwani Hospital's chief executive officer, Fridah Govedi, in 2011 in "Nurses' go-slow highlights ills at maternity hospital" (18 March 2011) *IRIN*, available at: <http://www.irinnews.org/report/92229/kenya-nurses-go-slow-highlights-ills-at-maternity-hospital> (last accessed 8 May 2017). In 2014, the online newspaper *All Africa* mentioned that the hospital was delivering 80 babies per day: J Mwambai "Kenya: First lady donates eight incubators to Pumwani Maternity Hospital" (2 September 2014) *All Africa*, available at: <http://allafrica.com/stories/201409030225.html> (last accessed 8 May 2017).

122 KNCHR "Realizing sexual and reproductive health rights", above at note 86 at 168.

123 Bourbonnais "Implementing free maternal health care", above at note 4.

124 See above at notes 85 and 86.

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violations that occur there.[125] Reflecting the scale of the problem, it is notable that all those interviewed as part of this study responded that they would never bring their wife, daughter, mother or female friend to Pumwani Hospital because of fears that they may die as a result of the poor medical attention provided there.

The measures adopted by the state over the years, such as the ratification of international human rights treaties, the constitutional recognition of the right to life, the right to health, sexual and reproductive health rights, as well as the campaigns launched against maternal mortality and the policy of free maternal services in all public facilities, are important signs that authorities are concerned about this issue. However, these measures have clearly been insufficient to tackle the problem.[126]

Condition 2: Irreparable damage

Expectant mothers currently at Pumwani Hospital remain at risk of suffering violations of their rights. Their rights could be irreparably harmed because these patients are in the very same precarious conditions as the expectant mothers who have already died as a consequence of the inadequate medical services. They are all in need of protection. Given this context, PMs must be requested to protect all those who can be identified by the two objective criteria of being pregnant and being at Pumwani Hospital. Although such a PM would not include the exact number of beneficiaries, an approximate number could be estimated using the register of expectant mothers that each maternity hospital is legally obliged to keep.[127]

Intervention by the Commission in the form of PMs would seek to prevent irreparable violations to the rights to life, health, freedom from discrimination, equality[128] and reproductive rights.[129] PMs would be framed as an order for Kenya to implement a series of specific measures to ensure that expectant mothers obtain the medical care they need. More broadly, PMs would also enable pregnant women to enjoy fully the rights set out in the various international human rights treaties ratified by Kenya.

125 Several news articles on this topic are available online, for example E Opondo "Address maternal health violations" (26 January 2017) *Standard Digital*, available at: <https://www.standardmedia.co.ke/article/2000231237/address-maternal-health-violations> (last accessed 28 May 2017).

126 See above under "Context of Kenyan health facilities".

127 The Commission can request protection for unidentified individuals. In these cases, the beneficiaries are not named and the Commission does not normally know exactly who or even how many there are. Instead, the Commission identifies them by objective elements and can work out where they are broadly located in order to offer the required protection. See text above at note 18.

128 African Charter, arts 4, 16, 2 and 3 respectively.

129 Maputo Protocol, art 14.

Condition 3: Communication

As mentioned above, in order to request PMs it is necessary for a communication to be submitted to the Commission, seeking to establish Kenya's international responsibility for preventable maternal deaths.[130] A further pre-requisite is that domestic remedies must have already been exhausted before the submission of the communication.[131] This second requirement is founded on the principle of subsidiarity that establishes that a national government must be made aware of, and given the opportunity to remedy, human rights violations before a claim is submitted to an international body.[132] Although this is a key principle in international human rights law, it also has an important exception, which could be applied in cases related to preventable maternal deaths in Kenya. This exception is detailed in article 56(5) of the African Charter, which states that communications may be submitted to the Commission "after exhausting local remedies, if any, unless it is obvious that this procedure is unduly prolonged".[133]

The latter part of this article means, in effect, that domestic remedies need not be exhausted if it can be proven that they would not be effective anyway.[134] Since the number of preventable maternal deaths remains disproportionate and the state of medical services at health facilities continues to be deplorable, despite the repeated criticisms of various national and international actors, it can reasonably be argued that domestic remedies need not be exhausted in this case. This is both because it is impractical to do so and because the violations are so pervasive and ubiquitous that it may safely be concluded that the state has long had the knowledge and opportunity to rectify the violations in question.[135] On this point, the Commission has observed, in relation to a case of detention without trial in Sudan, "[e]ven where no domestic legal action has been brought by the alleged victims, the government has been sufficiently aware to the extent that it can be presumed

130 Commission Rules of Procedure, rule 98(1).

131 See note 23 above.

132 Comms 25/89, 47/90, 56/91, 100/93 *World Organization against Torture and Others v Zaire* (*Zaire Mass Violations*) (9th annual activity report), para 36; comm 71/92 *Rencontre Africaine pour la Défense des Droits de l'Homme v Zambia* (*Zambia Expulsion*) (10th annual activity report), para 11.

133 The rule and the exception are also included in the Commission's Rules of Procedure, rule 93(2)(i).

134 For more on the exhaustion of domestic remedies in the context of the Commission, see H Onoria "The African Commission on Human and Peoples' Rights and the exhaustion of local remedies under the African Charter" (2003) 3/1 *African Human Rights Law Journal* 1 at 1 and Viljoen *International Human Rights Law*, above at note 12 at 316–19.

135 See Viljoen, id at 317. See comms 25/89, 47/90, 56/91, 100/93 (joined) *Free Legal Assistance Group and Another v Zaire* (2000) AHRLR 74 (ACHPR 1995) (9th annual activity report), para 37; and comm 155/96 *Social and Economic Rights Action Centre (SERAC) and Another v Nigeria* (2001) AHRLR 60 (ACHPR 2001) (15th annual activity report), paras 38–40.

to know the situation prevailing within its own territory as well as the content of its international obligations".[136]

Additionally, the Commission observed that, in such situations, it would be highly impractical for each individual victim of the violations to present a claim before domestic courts.[137] This exception to the requirement to exhaust domestic remedies must therefore be applied in the case of Kenya to allow a communication and a request for PMs to be submitted to the Commission.

The content of the requested provisional measures

The current state of Kenya's medical facilities illustrates the clear failings of the state to meet its legal obligations. Kenya has failed to adopt effective measures to ensure respect for and full enjoyment of women's rights.[138] A request for PMs would see the Commission order Kenya, on the basis of rule 98 of the Rules and article 1 of the African Charter,[139] to adopt a series of measures to protect expectant mothers currently being attended at the Pumwani Hospital. The Commission should request that Kenya take specific measures to address maternal mortality in order to protect women's basic rights. More concretely, the Commission should call on Kenya to do four things.

First, Kenya should adopt forthwith any measures deemed necessary to prevent the deaths of all expectant mothers being attended at Pumwani Hospital. Secondly, it should immediately introduce the following reforms: recruit an adequate number of health professionals with the necessary skills to provide medical attention to the required standard; ensure that the Pumwani Hospital has the necessary medical equipment and well-equipped rooms to offer expectant women the medical services they need; ensure that the Pumwani Hospital has the basic essential obstetric care services as indicated by WHO, including parenteral antibiotics, parenteral oxytocic drugs, parenteral sedatives for eclampsia, manual placenta removal and manual removal of retained products. Comprehensive essential obstetric care services should also: include surgery, anaesthesia and blood transfusions; provide special training to health professionals so that they can offer the healthcare that expectant mothers need and ensure that health professionals treat expectant mothers with respect and sensitivity to their cultural norms and beliefs; provide expectant mothers with all the medical care they may need, both in terms of quantity

136 Comms 48/90, 50/91, 52/91, and 89/93 *Amnesty International and Others v Sudan (Sudan Detention Without Trial)* (13th annual activity Report), para 33. See also *Zaire Mass Violations*, above at note 132, para 15.

137 Onoria "The African Commission", above at note 134.

138 Maputo Protocol, art 14(2)(b). During pregnancy, women's sexual and reproductive health should be respected and state authorities have a special duty to protect them.

139 African Charter, art 1: "The Member States of the Organisation of African Unity, parties to the present Charter shall recognise the rights, duties and freedoms enshrined in the Charter and shall undertake to adopt legislative or other measures to give effect to them."

and quality; and ensure the participation of women and the complainants when taking these measures.

Thirdly, it should investigate the circumstances that gave rise to the adoption of the PMs and, if so required, identify those responsible for violations and issue the corresponding punishments, including administrative and disciplinary sanctions. Fourthly, it should inform the Commission, within 15 days of being served notice of the PM, regarding any measures taken in compliance with the order.[140]

The Commission should also request that the complainants present their observations on the report presented by the state within 15 days of its submission, and hold a private meeting during its next period of sessions with the beneficiaries' representatives, the beneficiaries of the PMs and agents of the state.

CONCLUSIONS

Preventable maternal mortality violates several rights and affects multiple people. It constitutes a violation of the rights to life, health, equality and non-discrimination of all women who do not obtain adequate medical care during their pregnancy or delivery, while also violating the rights of their relatives and communities who suffer from their death. Preventable maternal mortality also constitutes a violation of the obligations assumed by states, at both international and national levels.

Unfortunately, preventable maternal mortality has been a serious problem in Kenya, with high death rates consistently recorded over a prolonged period. Indeed, the decrease in maternal mortality rates has been very small: only 12 per cent over the past 25 years. Although several (direct and indirect) structural factors, including women's low social status, malnutrition, lack of education and information, early marriage and unsafe abortions, could explain these deaths, this article has focused on factors related to the country's inadequate healthcare system. It has shown that expectant mothers are dying or become seriously ill in health facilities, largely as a result of the substandard medical care, poorly trained health personnel, professional negligence and inadequate infrastructure. In other words, this article has described how some maternal deaths in Kenya are connected to the deplorable conditions in which pregnant women in Kenyan hospitals often find themselves. Furthermore, the critical situation of health centres in Kenya and the negative impact on expectant mothers has been continually reported by state organs, national and international NGOs, as well as by international human rights bodies.

In this context, this article has suggested that the Commission should use its powers to request PMs in order to protect expectant mothers in Kenya. PMs are

140 Under rule 98(4) of the Rules, a state must respond to a "request" for PMs within 15 days, indicating how it has implemented it.

a legal tool that would attract the attention of international human rights bodies because their objective is not merely rhetorical, but rather to guarantee the practical effectiveness of rights. This is particularly important in a context in which international human rights bodies and national tribunals are becoming increasingly explicit in identifying maternal mortality as a human rights issue. In this sense, PMs could play an important role in guaranteeing the basic rights of expectant mothers when they find themselves at imminent risk. Ultimately, the most important outcome would be not only that these rights are recognized at the international level, and that states can accordingly be found liable in the event of their violation, but also that all individuals, including women, can truly trust that their rights will be guaranteed in practice.[141] PMs are a legal tool that, while not having the power to combat all the structural factors related to maternal mortality, has the potential to make safe maternity a reality in certain circumstances. That said, this article recognizes the barriers that PMs have in terms of compliance among states party to the African Charter. For example, PMs can only have a positive impact if there is political will on the part of the authorities to comply with them. Despite such obstacles, this article has highlighted concrete examples from other regions in which states have effectively complied with PMs, indicating the potential for such experiences to be replicated within the African human rights system.

Finally, it must be stressed that adopting a human rights approach to the problem of maternal death in Kenya also implies ensuring government accountability for policies and practices that lead to sexual and reproductive health rights violations. Similarly, it implies the need to empower citizens in general, and women in particular, to advocate for their rights, and to offer civil society a way to engage constructively in dialogue with national authorities about their responsibility to protect maternal health. 8,000 maternal deaths occurred in Kenya in 2015; these deaths should not be thought of merely as an unfortunate tragedy, but rather as a scandalous social injustice. It is now time to think much more seriously about this pressing societal issue.

141 C Burbano Herrera *Provisional Measures in the Case Law of the Inter-American Court of Human Rights* (2010, Intersentia) at 1.

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