Annals of Health Law

Volume 25
Issue 1 *Winter 2016*

Article 5

2016

Obstetric Fistula - a Menace to Maternal Health: Does Fidelity to Country Obligations under the Millennium Development Goals and Human Rights Regimes Provide an Antidote?

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Obstetric Fistula – a Menace to Maternal Health: Does Fidelity to Country Obligations under the Millennium Development Goals and Human Rights Regimes Provide an Antidote?

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"At first I didn't see myself as a human being since people didn't want to be around me. Now, I see healing and it's like life has returned again." Aminata, Sierra Leone.

"Like maternal mortality, fistula is almost entirely preventable. Yet at least 2 million women in sub-Saharan Africa, South Asia and the Arab region are living with fistula, and some 50,000 to 100,000 new cases develop each year. The persistence of fistula is a signal that health systems are failing to meet the needs of women." The United Nations Population Fund.

"Think for a moment of poverty as a disease, thwarting growth and development, robbing children of the healthy, happy futures they might otherwise expect. In the exam room, we try to mitigate the pain and suffering that are its pernicious symptoms. But our patients' well-being depends on more, on public health measures and prevention that lift the darkness so all children can grow toward the light." Perri Klass, M.D.

I. INTRODUCTION

Even if a work of fiction, the vignette recited below would still have been disturbingly horrific. But this story, as raw and chilling and profoundly compelling as the misery it narrates, is indeed true. The people are real – as are the suffering, shame, pain and hopelessness that, in most cases, must accompany them throughout their lives and unremittingly constrain their agency and pursuit of individual goods. It is an account of human frailty and vulnerability of the worst kind. For the girl whose tragic story is told, it began in March 2004:[1]

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* LL.B. (Awka), LL.M. (Notre Dame), LL.M. (Toronto), LL.M. (Lund), M.A. (Louisville), S.J.D. (Loyola, Chicago), Assistant Professor of Law, University of Nigeria; President & Chief Consultant, Centre for Health, Bioethics and Human Rights (CHBHR) Enugu, Nigeria. To those brave hearts (Western physicians) that were willing to sacrifice the comfort and leisure of their home countries to labor under the most excruciatingly suffocating conditions,

> Wobete Falaga, who is from a village in the northern Gojam province in Ethiopia's Amhara region, was only 13 when she became pregnant. Married at 11, just before her first menstrual period, her small underdeveloped body was not ready for the stress of childbirth. After five days of grueling labor at home, her child was finally born, but it was dead. As a result of the long, strenuous labor, Wobete suffered crippling injuries. There was a hole, or fistula, between her bladder and vagina and another between her vagina and rectum. The damage left her body unable to control its normal excretory functions, and urine and feces were constantly dripping down her legs. Her husband quickly rejected her, sending her home to her family. Wobete's mother took her to the government health clinic in the province's main town, Bahir Dar, but the nurses there said they were unable to treat the girl. They advised Wobete's mother to take the girl to the capital Addis Ababa as soon as possible and said if her condition remained untreated, she would face death from infection and kidney failure. The family sold a cow to pay for the three-day bus journey and arrived penniless at the gates of the Addis Ababa Fistula Hospital with Wobete.[2]

As incredibly touching as this story might sound, Wobete's experience is not at all atypical.[3] In fact, her ordeal is replicated in the lives of millions of women in regions of the world where stifling poverty makes early marriage appealing and restricts access to obstetric care.[4] Whilst fistula has been "unknown in the West for nearly a century," the condition remains pervasive in several other countries, mostly in resource-scarce settings.[5] The World Health Organization (WHO) reports that the poorest regions of the world, namely, sub-Saharan Africa and Southeast Asia, are sheltering the largest

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just to infuse a fresh lease of life to impoverished women in distant parts of the globe, and to Ada Obi Nnamuchi, my able assistant, I remain eternally grateful. The usual caveats apply.

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1. Sonny Inbaraj, *Married as Children, Women with Obstetric Fistulas Have No Future,* POPULATION REFERENCE BUREAU (Mar. 2004), http://www.prb.org/Publications/Articles/2004/MarriedasChildrenWomenWithObstetricFistulasHaveNoFuture.aspx.

2. *Id.*

3. Consider, for instance, this description of a patient by Dutch fistula surgeon Dr. Kees Waaldijk in 2005: "She managed to push out only her baby's head before collapsing from exhaustion in her hut, he said. Her brother carried her, balanced on a donkey, to a road, where a bus driver demanded 10 times the usual fare to take her to a hospital. She half-stood, half-sat for the trip, her dead baby's head between her legs, her urethra ripped open." *See* Sharon LaFraniere, *Nightmare for African Women: Birthing Injury and Little Help*, N.Y. Times, (Sept 28, 2005), http://www.nytimes.com/2005/09/28/world/africa/nightmare-for-african-women-birthing-injury-and-little-help.html.

4. *See When Childbirth Harms: Obstetric Fistula*, UNITED NATIONS POPULATION FUND 3, *available at* http://www.unfpa.org/sites/default/files/resource-pdf/EN-SRH%20fact%20sheet-Fistula.pdf (last updated Dec. 2012).

5. LaFraniere, *supra* note 3.

concentration of women afflicted with this horrendous condition – 2 million women living with untreated fistula.[6] Annually, about 50,000 to 100,000 women globally succumb to fistula,[7] and this has grave implications for global efforts at promoting maternal health. Identified as one of the five major causes of maternal morbidity and mortality[8], obstructed labor, which is directly linked to the development of fistula, is responsible for up to 6 percent of maternal deaths worldwide.[9]

This is how the United Nations Population Fund (UNFPA) sums up the circumstances that result in fistula:

> Obstetric fistula is a childbirth injury that . . . is usually caused by prolonged, obstructed labour, without timely medical intervention—typically an emergency Caesarean section. During unassisted, prolonged, obstructed labour, the sustained pressure of the baby's head on the mother's pelvic bone damages soft tissues, creating a hole—or fistula—between the vagina and the bladder and/or rectum. The pressure deprives blood flow to the tissue, leading to necrosis. Eventually, the dead tissue comes away, leaving a fistula, which causes a constant leaking of urine and/or feces through the vagina.[10]

In consequence of urinary incontinence, women, like Wobete, who experience fistula, often suffer social isolation, skin infection, kidney disorder and, if left untreated, death.[11] But the real tragedy lies not in physiological pathology; it reaches much deeper. As Catherine Hamlin, Australian gynecologist and founder of the Addis Ababa Fistula Hospital, explains:

> All the women who reach the gates of the hospital feel that their lives have been ruined . . . They have no self-worth and have become social outcasts from their community at a very young age through no fault of their own. They've suffered all this injury unnecessarily because they haven't got enough obstetric care in the provinces.[12]

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6. *10 Facts on Obstetric Fistula*, WORLD HEALTH ORG., http://www.who.int/features/factfiles/obstetric_fistula/en/ (last updated May 2014) [hereinafter WORLD HEALTH ORG., *10 Facts*]; *Maternal Health,* WORLD HEALTH ORG., (October 12, 2015, 10:15 AM) http://www.who.int/topics/maternal_health/en/ [hereinafter WORLD HEALTH ORG., *Maternal Health*].

7. *E.g., Obstetric Fistula: A Tragic Failure to Deliver Maternal Care,* UNITED NATIONS POPULATION FUND, http://www.unfpa.org/public/home/mothers/pid/4386 (last updated June 29, 2015).

8. WORLD HEALTH ORG., *Maternal Health*, *supra* note 6.

9. WORLD HEALTH ORG., *10 Facts*, *supra* note 6.

10. *When Childbirth Harms: Obstetric Fistula*, UNITED NATIONS POPULATION FUND, *supra* note 4, at 2.

11. WORLD HEALTH ORG., *10 Facts, supra* note 6.

12. Inbaraj, *supra* note 1.

Remarkably, fistula is not a recent medical phenomenon. As in 2050 B.C., when the first case of the condition was diagnosed,[13] the devastation suffered by its victims remains grave. The agony visited upon women with fistula is captured in this statement by 19-year old Zainabu Ado, who had leaked urine and feces for a year before coming to a fistula center in Nigeria, "[p]eople ran [away] from me, even members of my own family . . . My husband abandoned me. Nobody talked to me. Nobody visited me. For that whole year I stayed indoors."[14]

While this paper is centrally focused on fistula challenges in the most impoverished regions of the world, its overriding concern is much more cosmopolitan, and this is of great significance to health sector development in affected regions. The people whose life stories and experiences are animated in this discourse are those whose lives were predictably infested with deprivations in terms of access to health care. They have also been exposed to negative underlying or social determinants of health and other social dimensions of wellbeing. For these reasons, therefore, the issues of this essay are best seen as microcosmic of broader health system deficiencies, the failure of national health systems, particularly in sub-Saharan Africa and Southeast Asia, to respond swiftly and efficiently to the needs of the most vulnerable,[15] namely, female adolescents and women. A central task is to conceptualize fistula as imbedded in broader health sector and other developmental challenges, a product of adverse sociopolitical forces that render marginalized and vulnerable populations – but not others – inescapably susceptible to the condition.

This paper consists of four sections. Following this introduction, Part II discusses the major factors perpetuating fistula, namely, illiteracy, disempowerment, poor maternal health and poverty. Strikingly, rather than deconstruct these challenges in isolation, the section links them to the project of the Millennium Declaration, showing how implementing the MDGs could have an antidotal impact. In Part III, the paper casts fistula as a human rights challenge. Relying on the disclosure by WHO – that since 2003, just 12,000 women in more than 45 countries have received treatment in Africa, Asia, and the Middle East, even though uncomplicated fistula is treatable with a simple surgery[16] – the section projects the persistence of the injury as

13. Kate Grant, *Obstetric Fistula: No Longer A Neglected Tragedy,* HUFFINGTON POST (May 23, 2013, 10:16 AM), http://www.huffingtonpost.com/kate-grant/obstetric-fistula-no-long_b_3322474.html.

14. LaFraniere, *supra* note 3.

15. *See* UNITED NATIONS DEV. PROGRAMME, HUMAN DEVELOPMENT REPORT 2014: SUSTAINING HUMAN PROGRESS: REDUCING VULNERABILITIES AND BUILDING RESILIENCE 3 (2014) (defining the "most vulnerable" as inclusive of "[t]hose living in extreme poverty and deprivation").

16. *What Every Woman Should Know,* GUYANA CHRON. ONLINE (November 16, 2013),

reflective of void of political leadership, a violation of human rights. The conclusion – Part IV – is a clarion call for action, for the international community to recalibrate its strategies, this time –more purposefully, in the direction of erasing the scourge that perennially presents as fistula in the lives of long-suffering girls and women in resource-deficit settings. It is hoped that the analysis and conclusion of this paper will contribute to the on-going negotiations of UN Member States on the post-2015 development agenda and be reflected in the (yet to be unveiled) sustainable development goals (SDGs).

II. RESCUE ON THE HORIZON? EXAMINING FISTULA CHALLENGES IN LIGHT OF THE OPPORTUNITIES PROVIDED BY THE MDGS

This summation by a New York Times reporter is quite telling: "[f]ew doubt that the problem is most concentrated in sub-Saharan Africa, where poverty and rudimentary health care combine with traditions of home birth and early pregnancy to make women especially vulnerable."[17] The reporter was of the opinion that "fistulas point to the broader plight of millions of African women: poverty; early marriage; maternal deaths; a lack of rights, independence and education; a generally low standing."[18] Are there any relationships between these factors (giving rise to fistulas) and the targets and objectives of the MDGs? Would fidelity to the demands of the MDGs crystallize to eliminating these factors (and, ultimately, fistula) as major obstetric challenges in developing countries? Although these questions seem different, they are, in reality, two sides of the same coin – and this will become quite obvious as we explore the issues. The UNFPA offers this insight:

> Prevention is the key to ending fistula. Making family planning available to all who want to use it would reduce maternal disability and death by at least 20 per cent. Complementing that with skilled attendance at all births and emergency obstetric care for all women who develop complications during delivery would make fistula as rare in resource-poor countries as it is in the industrialized world today . . . Addressing social issues that contribute to the problem - such as early pregnancy, girls' education, poverty and women's empowerment - are important areas of intervention as well.[19]

Evident from this postulation are a number of useful measures, namely,

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http://guyanachronicle.com/what-every-woman-should-know/.

17. LaFraniere, *supra* note 3.

18. *Id.*

19. *Obstetric Fistula: A Tragic Failure to Deliver Maternal Care*, UNITED NATIONS POPULATION FUND, *supra* note 7.

(a) prevention (of the conditions or circumstances that contribute to fistula); (b) improving access to maternal health, including obstetric care and availability of skilled health personnel (SHP) to handle deliveries; (c) addressing early pregnancy/marriage; (d) improving access to education for girls; (e) promoting women empowerment; and, (f) eliminating poverty.[20] These, apparently, are crucial interventions and strategies with positively transformative impact in countries with significant fistula populations, assuming responsible authorities in those countries take them seriously. Strikingly, each of these measures is integrated into one or more of the MDGs.[21] It is this integration that lends credence to extant belief that the world is close, perhaps more than ever before, to consigning fistula to oblivion.

The MDGs consist of eight time-bound and quantifiable targets aimed at improving human wellbeing, with 2015 as the deadline for achieving most of them.[22] The benchmarks of the vast majority of the MDGs are closely related, as previously mentioned, to the measures identified by UNFPA as crucial to arresting fistula. But whether this hope will morph into reality depends on whether the obligations associated with each of the MDGs are taken seriously by political leadership in affected countries. The rest of this section considers these MDGs and their bearing on fistula.

A. Education

Multiple reasons underscore the importance of the maxim "prevention is better than cure" in the realm of public health.[23] Aside from cost saving, taking action that shields oneself from diseases and illnesses protects the individual from the pain, suffering and, possibly, death that could have been the end result of inaction.[24] Nevertheless, reaping the benefit of preemptive action is primarily dependent on the level of knowledge or awareness of the individual of necessary preventive measures – in other words, success is relative to the individual's academic attainment.[25] To illustrate how this relates to fistula, we travel all the way to Niger, a country ranked dead last in the latest human development index.[26] This is a real life event, as reported in

20. *Id.*

21. *MDGS: What They Are*, UNITED NATIONS MILLENNIUM PROJECT, http://www.unmillenniumproject.org/goals/index.htm (last visited Oct. 10, 2015).

22. *Id.*

23. *E.g.,* Stephen J. Genuis, *An Ounce of Prevention: A Pound of Cure for an Ailing Health System*, 53 CAN. FAM. PHYSICIAN 597 (2007).

24. *See generally* Rama K. Jayanti & Alvin C. Burns, *The Antecedents of Preventative Health Care Behavior: An Empirical Study*, 26 J. OF THE ACAD. OF MKTG. SCI. 6 (1998).

25. *See id.* at 9.

26. UNITED NATIONS DEVELOPMENT PROGRAMME, *supra* note 15, at 160–63.

a New York Times Op-Ed:[27]

> The first patient we met is Hadiza Soulaye; with an impish smile, she still seems a child . . . [S]he said that her family married her off at about 11 or 12. She knows that it was before she began to menstruate. She was not consulted but became the second wife of her own uncle.
>
> A year later, she was pregnant. Hadiza had no prenatal care, and a traditional birth attendant couldn't help when she suffered three days of obstructed labor. By the time Hadiza was taken to a hospital for a Caesarean delivery, the baby was dead and she had suffered internal injuries including a hole, or fistula, between her bladder and vagina.[28]

When interviewed, Hadiza admitted, "'I didn't know what had happened . . . I just knew that I couldn't control my pee, and I started crying.'"[29] As New York Times columnist Nicholas Kristof, whose efforts were instrumental in raising the funds (more than $500,000) used to build the Danja Fistula Center in that country, recounts, "Hadiza said she never went to school and doesn't [even] know her birth date."[30]

Is it possible that had Hadiza been educated, she could have been in a better position to lessen her exposure to the risk of fistula? The response is quite obvious, at least for two reasons. First, the number of years it takes to acquire education ensures that marriage is delayed till sufficient maturity for child bearing is attained.[31] Hadiza was married at a very young age (11 or 12),[32] at a time she should have been in school. Second, education equips one with the knowledge to prevent the occurrence of fistula.[33] It takes some level of knowledge and awareness to sufficiently appreciate the dangers of early marriage/pregnancy, which include the importance of family planning, timely access to high quality prenatal care and for births to be attended by qualified health professional – all of which are essential to fistula prevention.[34] It is this context that makes MDG 2 profoundly important in

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27. Nicholas Kristof, *Where Young Women Find Healing and Hope*, N.Y. TIMES (July 13, 2013), http://www.nytimes.com/2013/07/14/opinion/sunday/kristof-where-young-women-find-healing-and-hope.html?_r=0.

28. *Id.*

29. *Id.*

30. *Id.*

31. *See Child Marriage*, COUNCIL ON FOREIGN RELATIONS, http://www.cfr.org/peace-conflict-and-human-rights/child-marriage/p32096#!/?cid=otr_marketing_use-child_marriage_Infoguide#!%2F (last visited Oct. 18, 2015).

32. Kristof, *supra* note 27.

33. *See* Aduragbemi O. Banke-Thomas et al., *Current Evidence Supporting Obstetric Fistula Prevention Strategies in Sub Saharan Africa*, 18 AFR. J. OF REPROD. HEALTH 118, 122 (2014).

34. *See The Campaign to End Fistula: 10 Years On*, UNITED NATIONS POPULATIONS FUND 3, http://www.endfistula.org/sites/endfistula.org/files/pub-pdf/UNFPA_Fistula_10th_Anniv_

countries, like Niger, where fistula is a major problem.[35] By imposing an obligation on countries to provide a full course of primary schooling,[36] the MDG institutionalizes an environment enabling people like Hadiza to escape fistula.

A recent report by the UN projects education as not only crucial for the wellbeing of women but also "fundamental for preventing obstetric fistula and improving maternal health."[37] Educated women and girls, according to the report, are better placed than illiterates to make the right reproductive health choices, understand the benefits of seeking prenatal and postnatal care and appreciate the necessity of delaying marriage until adulthood.[38] Nonetheless, primary school level education (the stated objective of MDG 2) is hardly adequate to provide women and girls with the kind of knowledge that is essential to navigating the hazardous terrains of maternal health.[39] More is needed –a reason the UN Commission on the Status of Women recently reiterated its concern about "lack of progress in closing gender gaps in access to, retention in and completion of secondary education. . ."[40] As to why countries should move beyond primary level education, the Commission was unequivocal: "[Secondary level education] has been shown to contribute more strongly than primary school attendance to the achievement of gender equality, the empowerment of women, and the human rights of women and girls and several positive social and economic outcomes."[41]

Therefore, the best way to conceptualize the obligation imposed by MDG 2 is to see it as laying the foundation of a process, to use primary school education as a catalyst that spurs the pursuit of secondary and, possibly,

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Report_FINAL.pdf (last visited Oct. 18, 2015).

35. *See generally* OBSTETRIC FISTULA NEEDS ASSESSMENT REPORT: FINDINGS FROM NINE AFRICAN COUNTRIES 49 (Charlotte Bacon, ed., 2002), *available at* http://www.unfpa.org/sites/default/files/pub-pdf/fistula-needs-assessment.pdf; *see also New Danja Fistula Center Opens*, SIM (June 29, 2012), *available at* http://www.sim.org/index.php/content/danja-fistula-center-opens (noting that about 100,000 women and girls suffer from obstetric fistulas in Niger, with about 8,000 new cases added each year).

36. *Official List of MDG Indicators*, UNITED NATIONS STATISTICS DIVISION 1 (Jan. 15, 2008), http://mdgs.un.org/unsd/mdg/Resources/Attach/Indicators/OfficialList2008.pdf.

37. U.N. Secretary-General, *Supporting Efforts to End Obstetric Fistula: Report of the Secretary-General*, ¶ 2, U.N. Doc. A/67/258 (Aug. 6, 2012).

38. *Id.*

39. Ann M. Veneman, *Education Is Key to Reducing Child Mortality: The Link Between Maternal Health and Education*, 44 UN CHRONICLE 58, 59 (2007), *available at* http://unchronicle.un.org/article/education-key-reducing-child-mortality-link-between-maternal-health-and-education/.

40. *Challenges and Achievements in the Implementation of the Millennium Development Goals for Women and Girls,* U.N. COMM'N ON THE STATUS OF WOMEN 5 (Mar. 2014), http://www.unwomen.org/~/media/headquarters/attachments/sections/csw/58/csw58_agreed_conclusions.pdf.

41. *Id.*

tertiary education for girls and women –meaning that for some people, subsidy would be provided whilst others receive free tuition. This approach is not only consistent with the thrust of MDG 2, but also advances the objective of a key target of MDG 3, namely, to eliminate gender disparity in primary and secondary education.

B. The Empowerment of Women

The link between fistula prevention and the empowerment of women, the latter being the objective of MDG 3, is undeniable. The idea behind MDG 3 is two-fold, namely, to (a) achieve gender equality and (b) empower women.[42] These dual objectives are inextricably linked (the attainment of one directly leads to the actualization of the other and vice versa). They are seen as essential to improving the development and wellbeing of women – in other words, empowering. This is an important public health tool. The "kernel of individual empowerment," as elucidated in a recent work, is unmistakable: "it reduces exposure to [health] problems, saving the individual from the pain, suffering and expenses to which [she] could have otherwise been exposed."[43] Any concern as to whether this is the sort of empowerment envisaged by the MDG is quickly dispelled by a close scrutiny of the indicators specified for measuring compliance with this objective, namely: (1) ratios of girls to boys in primary, secondary and tertiary education; (2) share of women in wage employment in the non-agricultural sector; and (3) the proportion of seats held by women in national parliament.[44]

The first and second indicators are geared toward a common goal, namely, equalizing gender opportunity in terms of education and employment.[45] Although the third indicator is similarly intentioned, its reach is broader. Increasing female representation in elected positions means giving women equal voice in political governance, enabling or empowering them to spearhead women-centered agendas which are necessary to address maternal health in all its ramifications.[46] The Jamaican Patois expression, "who feels it knows it," immortalized by Bob Marley in the song "Running Away," is

42. *Goal 3: Promote Gender Equality and Empower Women*, UNITED NATIONS, http://www.un.org/millenniumgoals/gender.shtml (last visited Oct. 18, 2015).

43. OBIAJULU NNAMUCHI, THE RIGHT TO HEALTH: A MULTI-COUNTRY STUDY OF LAW, POLICY AND PRACTICE 3, 31 (Brigit Toebes et al. eds., 2014); *see also* UNITED NATIONS COMM'N ON THE STATUS OF WOMEN, *supra* note 40, at 7 (suggesting that empowerment of women is necessary not only for purposes of maternal health but also is a crucial factor in attaining other MDGS, including poverty and hunger eradication).

44. U.N. STATISTICS DIV., *supra* note 36.

45. *Id.*

46. *See, e.g.*, Physicians for Human Rights, *Maternal Mortality in Hearat Province, Afghanistan*, *in* PERSPECTIVES ON HEALTH AND HUMAN RIGHTS 343 (Sofia Gruskin et. al eds., 2005).

quite apposite;[47] felt experience confers a superior position of understanding (of the nature of the problem and its cure). Therefore, since women are the ones on the receiving end of the disadvantages of gender inequality, including, disproportionate burden of illnesses and diseases, they are better positioned to evolve and implement effective ameliorative policies. Yet, as the UN Commission on the Status of Women points out, nearly 15 years after the adoption of the MDGs, not even one country has achieved gender equality.[48] One of the inevitable results of adverse sociopolitical climate under which these women must survive is the persistence of "significant levels of inequality between women and men."[49] This could be posited as a major constraint to taking advantage of the opportunities provided by MDG 3. This is evidenced by the fact that the regions with the most ineffective governments are also the ones with the greatest number of fistula population. Governance without women representation often means sidelining women issues.

Former World Bank economist Robert Calderisi was correct when he stated that the "simplest way to explain Africa's problems is that [Africa] has never known good government."[50] Bad, or insufficient government expenditures to advance gender equality are a key reason Africa and South Asia are faring particularly poorly regarding MDG 3 indicators.[51] For example, gender disparities still exist in secondary school enrolment in many countries within the two regions.[52] In fact, in contrast to the rest of the world, the two regions with the most significant incidence of fistula, sub-Saharan Africa and South Asia, have significantly lower enrollment of young women than young men in their tertiary institutions.[53] In terms of employment, these regions still perform poorly; only 20 and 33 percent of women in South Asia and sub-Saharan Africa had jobs in non-agriculture sectors as recently as 2012.[54] Possible avenues through which this problem might be tackled include adopting legal or policy frameworks that promote women's entrance into the labor market, for example, by ensuring flexible time, parental leave and other family-friendly measures such as provision of child and elder care services for those in need.[55]

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47. BOB MARLEY & THE WAILERS, RUNNING AWAY (Island Records 1978).

48. COMM'N ON THE STATUS OF WOMEN, *supra* note 43, *at* 4.

49. *Id.*

50. ROBERT CALDERISI, THE TROUBLE WITH AFRICA: WHY FOREIGN AID ISN'T WORKING 57 (Palgrave Macmillan 2007) (2006).

51. Gumisai Mutume, *African women battle for equality*, AFRICA RENEWAL (July 2005), http://www.un.org/africarenewal/magazine/july-2005/african-women-battle-equality.

52. U.N., THE MILLENNIUM DEVELOPMENT GOALS REPORT 2014 21 (2014).

53. *Id.*

54. *Id.*

55. *Id.* at 22.

Empowering women through reservations of elective positions is problematic. Although the proportion of seats held by women in national legislative houses have increased, they are still very low (16 percent in South Asia and 23 percent in sub-Saharan Africa).[56] One possible solution would be to implement political affirmative action in statutory or constitutional regimes. However, this strategy fails to account for other dynamics at play in many of the countries in the two regions. Despite talk of democracy in Africa, John Agyekum Kufuor, former president of Ghana and champion of democracy in the region, notes that in reality, "in most of these countries, people are not allowed freedom and opportunity to choose their own leaders through genuine elections."[57] Some would say that rigged elections are the norm, with the result that most of the people that emerge as "winners" are handpicked by the government in power.[58] The ultimate consequence of such chicanery is that even where a substantial number of women manage to get "elected," they are hardly the kind that would take fistula or any other aspects of maternal health seriously.[59] Reversing the status quo requires action on the part of the people, those laboring under the yoke of the treachery and tyranny represented by this sort of imposition.

C. Maternal Health

By describing fistula as a "severe maternal morbidity which can affect any woman or girl who suffers from prolonged or obstructed labor without timely

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56. *Id.*

57. William Yaw Owusu, *Bad Governance Is Africa's Enemy – Kufuor*, DAILY GUIDE (Dec. 12, 2013), http://www.ghanaweb.com/GhanaHomePage/NewsArchive/Bad-governance-is-Africa-s-enemy-Kufuor-294899.

58. *See* ROBERT A. DIBIE, NON-GOVERNMENTAL ORGANIZATIONS (NGOS) AND SUSTAINABLE DEVELOPMENT IN SUB-SAHARAN AFRICA 12 (2007). ("The lack of electoral legitimacy in several African countries constitutes one of the reasons why the political environment is not conducive for a dynamic economy. The history of many African nations also reveals that most of their political leaders do not like to relinquish their position or power to other person. If they do at all, it had to be a hand-picked successor. This practice has made most African leaders to leave office unceremoniously because they are either forced out or they are unable to rig elections. (citation omitted) Further, many African countries do not have periodic, open, competitive, free and fair elections. As a result, rigged elections do not provide political executive the mandate to govern, rather it encourage [*sic*] them to be less accountable and transparent to the citizens").

59. *See* Sibonokuhle Ndlovu & Sani Boniface Mutale, *Emerging Trends in Women's Participation in Politics in Africa*, 3 AM. INT'L J. CONTEMP. RES. 72, 76 (2013). ("The large numbers of women in elected offices have not fully transformed into considerable legislative and resource gains. In this regard, while quotas are important in addressing the exclusion of women from the public political sphere, women have not fully benefitted much from the system. In most African countries women in the reserved seats as result of the quota systems have been like chess pieces, as they have been moved by men. Thus there are several issues which need to be improved or changed for women to wholly benefit from the emerging trends in their political participation.")

access to an emergency Caesarean section," the UN Secretary-General aims to bring the issue within the purview of MDG 5.[60] Of the MDGs, MDG 5 is most directly related to fistula prevention and cure as it focuses on improving maternal health.[61] Specifically, countries are required to reduce the maternal mortality rate ("MMR") by 75 percent, between 1990 and 2015, and by 2015, achieve universal access to reproductive health.[62] Progress, or lack thereof, toward these goals is measured by determining, *inter alia,* the proportion of births attended SHP, antenatal care coverage, and availability of family planning services.[63] Although the tenor is different, each of these indicators speaks to one or more dimensions of fistula. Capacity deficiency in terms of access to antenatal care, family planning or obstetric care is a predictor of fistula catastrophe, and vice versa. The organization "One By One" explains: "Making family planning available to all who want to use it would reduce maternal disability and death by at least 20 percent. Complementing that with skilled attendance at all births and emergency obstetric care for those women who develop complications during delivery would make fistula less common."[64]

But how many women in countries where fistula is a major public health challenge are able to access these services? To answer the question, insight may be gleaned from health service coverage indicators (the extent to which people in need actually receive important health interventions) in these regions.[65] In Africa, for instance, the contraceptive prevalence rate between 2006 and 2012 (which represents the availability of family planning services) was 27 percent, in contrast with 74 percent in the Americas.[66] Similarly, data from the years 2006 to 2013 indicate that only 47 percent of women in Africa were able to obtain antenatal care coverage (at least 4 visits) whereas in the Americas, the rate was 86 percent.[67] The number of women whose births were attended by skilled heath personnel, from 2006-2013 with access to SHP in these countries is equally low – 48 percent in Africa, in contrast to 94 percent in the Americas, and 98 percent in Europe.[68]

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60. U.N. Secretary-General, *Supporting Efforts to End Obstetric Fistula: Report of the Secretary-General*, *supra* note 37, at ¶ 3.

61. U.N., Statistics Div., *supra* note 36.

62. *Id.*

63. *Id.*

64. *How Does Obstetric Fistula Happen?*, ONE BY ONE, https://www.fightfistula.org/how-does-obstetric-fistula-happen/ (last visited Nov. 3, 2015).

65. *World Health Statistics 2014*, WORLD HEALTH ORG. 104 (2014), http://apps.who.int/iris/bitstream/10665/112738/1/9789240692671_eng.pdf?ua=1. ("Health service coverage indicators reflect the extent to which people in need actually receive important health interventions.").

66. *Id.* at 114.

67. *Id.*

68. *Id.*

What these figures suggest is that roughly half of women in Africa who suffer obstructed labor are at the risk of fistula and will not be able to access sufficient medical care.[69] Still, as the UNFPA asserts, "[e]nding the needless pregnancy-related deaths and suffering of women and girls is critical to meeting the Millennium Development Goals . . . which . . . serve as a blueprint for reducing poverty and improving lives."[70] Therefore, increasing funding to improve access to maternal health care (particularly SHP[71] and medications) will be indispensable for countries which seek to meet MDG benchmarks. Kalilou Ouattara, fistula surgeon in Mali, was quite on point: "[t]he existence of fistula is the barometer of maternal health in the country. If year by year fistula decreases, we know that maternal health is improving."[72]

D. Global Partnership for Development

MDG 8 is highly significant to combat both fistula and preventable maternal deaths.[73] Likewise, the entire MDG project, not just MDG 8, may be conceptualized as a pact between affluent and poor nations "to create an environment . . . which is conducive to development and the elimination of poverty."[74] In so doing, the global community acknowledged the reality that most developing countries may require foreign aid to meet the needs of their citizens. For these countries, even if their political leaders do not squander national wealth, their capacity to meet the basic health needs of their population is necessarily constrained by unavailability of resources, due to their dependency on externally sourced aid.[75] It was against this background that MDG 8 was adopted.[76] As a *quid pro quo* for "commitment to good governance," industrialized countries agreed to support poor countries in

69. *See id.*

70. *Neglected No More: Fighting Fistula*, UNITED NATIONS POPULATION FUND 2 (May 2014), *available at* http://w.endfistula.org/webdav/site/global/shared/documents/Fistula/Fistula%20brochure-Sep13.pdf.

71. *See* Obiajulu Nnamuchi, *Millennium Development Goal 5, Human Rights, and Maternal Health in Africa: Possibilities, Constraints, and Future Prospects*, 23 ANNALS HEALTH L. 92, 106 (2014) ("Having competent and appropriately trained personnel to deliver essential services is as important, if not more so, than having the needed material resources for health.").

72. *A Labor of Loss: Obstetric Fistula*, INT'L WOMEN'S HEALTH PROGRAM, http://iwhp.sogc.org/index.php?page=obstetric-fistula (last visited Nov. 3, 2015).

73. *See* U.N., *supra* note 52, MDG 8.

74. *Id.*

75. *See generally* Real Aid: Ending Aid Dependency, ACT!ONAID USA (Sept. 2011), *available at* http://www.actionaidusa.org/sites/files/actionaid/real_aid_3.pdf; *see also* Danielle Resnick, *Foreign Aid and Democracy in Africa* (Nov. 3, 2011), UNITED NATIONS UNIV., http://unu.edu/publications/articles/foreign-aid-and-democracy-in-africa.html.

76. UN, *supra* note 52.

their efforts to economically develop and reduce poverty[77] through trade concessions, debt relief, increased official development assistance (ODA),[78] and increased access to pharmaceutical medications.[79]

Evidently, therefore, the success of this MDG, in terms of improving overall wellbeing in developing countries hinges on two critical factors, namely, serious commitment of governments in these nations to good governance and unflinching support of development initiatives by wealthy nations. Regarding governance, whilst there are bright spots in certain countries (Ghana and Botswana, for instance) the vast majority of third world leaders are more committed to their pockets; consequently, achieving this MDG's goals is contingent upon on two critical factors: (i) political leaders' commitment to good governance, and (ii) reliable support for development initiatives from donor states.[80] However, the former factor runs contrary to the vast majority of how most African political leaders govern:

> They see the state as a source of personal wealth accumulation. There is high premium on the control of the state, which is the biggest and most easily accessible source of wealth accumulation. The people in power and those who seek power use all means to attain their goal . . . Many of the apparently senseless civil conflicts in Africa . . . are due to the battle for the spoils of power.[81]

Africa's crisis of self-governance has gotten so bad that even well-intentioned Africans are explicitly advocating neocolonialism. In a 1996 New York Times interview, George Weah, popular Liberian footballer who contested in that country's presidential election in 2005, intones the view of many of his countrymen, the "United Nations should come in and take over Liberia, not temporarily, but for life."[82] In substantiation of this seemingly odd position, Weah explains, that is the only way "to make Liberians believe in democracy, to make us believe in human rights."[83] For better or worse, Weah's disillusion with the political class in Africa runs deep throughout the length and breadth of the region.[84] Many have given up hope for anything

77. UN, *supra* note 52, Target 8.A.

78. UN, *supra* note 52, Target 8.B, 8.D.

79. UN, *supra* note 52, Target 8.E.

80. *See Law Comes First*, THE ECONOMIST (June3, 2015), http://www.economist.com/news/middle-east-and-africa/21653584-botswana-comes-top-continent-governance-and-rule-law-again-law-first; *see generally* UN, *supra* note 52.

81. Tunde Obadina, *Africa's Crisis of Governance,* AFR. ECON. ANALYSIS, (2000), *available at* http://www.afbis.com/analysis/crisis.htm.

82. Howard W. French, *Soccer Hero Voices Liberia's Anguish,* N.Y. Times (May 20, 1996), http://www.nytimes.com/1996/05/20/world/soccer-hero-voices-liberia-s-anguish.html.

83. *Id.*

84. *Id.*

good to come out from that part of the world.[85] It is this lacunae that MDG 8 is positioned to fill, for Western countries whose ODA is needed to pull the region out of its socioeconomic doldrums to demand accountability.[86]

Certainly, wealthy countries whose assistance is desperately sought by third world nations have a say on who gets their tax dollars and how the money is spent. In 2008, Canada enacted a statute aptly titled "Official Development Assistance Accountability Act," the purpose of which is to ensure that provision of ODA is consistent with, *inter alia,* Canadian values, the Paris Declaration on Aid Effectiveness of March 2, 2005[87] and human rights.[88] Disbursement of ODA funds is subject to three conditions: that the funds contribute to poverty reduction; take into account the perspectives of the poor; and is consistent with international human rights standards.[89] The implication, therefore, is that inability to demonstrate compliance with these conditions disqualifies a country from receipt of Canadian aid. This is not insignificant. Having aid-seeking nations demonstrate compliance with the imperatives of the statute is vital to eliciting good governance from hitherto irresponsible governments in the third world.

But whether Canada will stringently enforce these requirements as a *sine qua non* for receipt of its ODA remains to be seen. Nonetheless, by incorporating these measures as part of its foreign policy, the country sends a strong signal to developing nations that the era of irresponsible, business-as-usual, governance is over.[90] The message is that no longer could the "big men" in these countries treat national resources as their private largesse and, at the same time, expect foreign support.[91] No doubt, this is a good

85. *Id.*

86. *Official List of MDG Indicators*, UNITED NATIONS STATISTICS DIVISION (Jan. 15, 2008), http://mdgs.un.org/unsd/mdg/host.aspx?Content=indicators/officiallist.

87. The Paris Declaration represents an agreement between developed and developing countries aimed at reforming the ways ODA is delivered and managed in several ways. First, it recognizes the need for more aid. Second, it emphasizes that aid effectiveness must also be improved by ensuring that disbursements will be used for legitimate purposes. Third, it requires reliable assessments of performance, transparency and accountability of country systems. *See* THE PARIS DECLARATION ON AID EFFECTIVENESS AND THE ACCRA AGENDA FOR ACTION 1, 3-4, 15 (2008), *available at* http://www.oecd.org/dac/effectiveness/34428351.pdf.

88. Official Development Assistance Accountability Act, S.C. 2008, c. 17 §2(1), *available at* http://laws-lois.justice.gc.ca/PDF/O-2.8.pdf.

89. *Id.* at §4(1).

90. *See We Need a Plan to Make Poverty History: Submission to the Standing Committee on Finance Pre-Budget Consultations*, MAKE POVERTY HISTORY, *available at* http://www.makepovertyhistory.ca/submission-to-the-standing-committee-on-finance-pre-budget-consultations-from-make-poverty-history (last visited Oct 12, 2015) (reiterating that the legislation holds great potential for improving the quality of Canadian aid by focusing on poverty reduction and requiring much better government accountability for aid spending).

91. *See* THE PARIS DECLARATION ON AID EFFECTIVENESS AND THE ACCRA AGENDA FOR ACTION, *supra* note 87, at 20.

beginning;[92] it is also one that other industrialized countries should emulate in their dealings with third world nations.[93]

E. Poverty

It is indeed true, "[m]aternal death and obstetric fistula—stark examples of poor access to health care services and persistent socio-economic inequality—are largely preventable."[94] Nonetheless, they continue to ravage the lives of women in most third world nations. Why? The reasons are legion but the most proximate cause is resource deficit, lack of access to what is needed to take proactive measures, even if one is appropriately informed. This is affirmed in the latest World Health Statistics.[95] Women in countries classified as belonging to "low income" group shoulder the highest rate of unmet need for family planning services, at 22 percent compared to 10 percent in high-income countries.[96] Only 46 percent of women in these countries have access to SHP in contrast to women in high-income countries where virtually everyone (99 percent) deliver in hospitals.[97]

Further evidence of poverty as explanatory of fistula is provided by the reality that the two regions with the worst incidence of fistula – sub-Saharan Africa and South Asia – are also home to the highest number of impoverished people, individuals surviving on less than $1.25/day.[98] In fact, all the underlying causes of fistula, including childbearing at too early an age, malnutrition, and lack of education,[99] are squarely rooted in poverty.[100]

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92. *See id* at 21. (remarking that whilst the ODA Act "will not transform Canadian aid policy overnight, it sets the legislative framework to help improve the quality of the aid we give").

93. For example, the United States has a similar framework. Its Millennium Challenge Corporation (MCC, which replaced the Millennium Challenge Account) provides ODA to countries that can demonstrate commitment to (i) good governance; (ii) sound economic policies that promote open markets and private enterprise; and, (iii) investment in its people, particularly in health and education — all measured by 17 different benchmarks.

93. *See* 22 U.S.C. § 7706(b) (2007); *see* MILLENNIUM CHALLENGE CORP., POLICY ON PREVENTING, DETECTING, AND REMEDIATING FRAUD AND CORRUPTION IN MCC OPERATIONS (Mar. 18, 2009), *available at* http://www.mcc.gov/documents/guidance/mcc-policy-fraudandcorruption.pdf; *see also* Obiajulu Nnamuchi, *The Human Right to Health in Africa and its Challenges: A Critical Analysis of Millennium Development Goal 8*, 12 AFR. HUM. RTS. L. J. 178, 195–96 (2012).

94. *Neglected No More – Ending Fistula*, UNITED NATIONS POPULATIONS FUND, (last visited October 13, 2015) http://www.endfistula.org/sites/endfistula.org/files/pub-pdf/Fistula%20brochure-May14.pdf.

95. *See* WORLD HEALTH ORG., *supra* note 63, at 104-05,114.

96. *Id.*

97. *Id.*

98. United Nations Dev. Programme, *supra* note 15, at 180-81.

99. Inbaraj, *supra* note 1.

100. *Fistula, A Neglected Disease Causing Misery Among Women*, THE ZIMBABWEAN (Oct. 30, 2010, 1:55 PM), http://www.thezimbabwean.co/2010/10/fistula-a-neglected-

As EngenderHealth, a non-profit organization based in the United States, explains, "[t]he journey toward obstetric fistula begins with poverty . . . Poverty robs people of choices. It contributes to fistula by closing off options at critical points in a woman's life."[101] Instances of these "closing off options" include forced marriage and denial of reproductive autonomy.[102] Disempowered, these girls must rely on their parents, fathers and mothers whose ideas about marriage and reproduction are often at variance with their interests.[103] UNICEF notes, "these parents encourage the marriage of their daughters while they are still children in hopes that the marriage will benefit them both financially and socially, while also relieving financial burdens on the family."[104] In these bizarre dynamics, early marriage (and with it, the risk of fistula) becomes a poverty alleviation measure, but – quite often – with devastating consequences.

Margaret Mungherera, in her inaugural address as the president-elect of the World Medical Association, was echoing the spirit of the Millennium Declaration by provocatively stating: "[i]f you miss the poor, you've missed the point."[105] The Millennium Declaration affirms an obligation incumbent upon the international community to "promote gender equality and the empowerment of women as effective ways to combat poverty, hunger and disease and to stimulate development that is truly sustainable."[106] Indeed, the point of the Declaration was poverty and its impact on human development, explaining why the very first of the MDGs was specifically targeted at poverty eradication.[107] This premier positioning is not happenstance. It recognizes that the rest of the MDGs are not attainable in absence of resources with which individuals are able to pursue their individual goals. Amongst its major objectives is ensuring that even those without resources – impoverished girls and women struggling against the pain, shame and misery of fistula – are not without hope.[108] This, as the next section demonstrates, is

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disease-causing-misery-among-women.

101. Emily Verellen, *A Walk to Beautiful: Take Action Guide,* EngenderHealth (2014), http://www.engenderhealth.org/files/external/a_walk_to_beautiful_take_action_guide_low_res.pdf.

102. *Id.*

103. *Id.*

104. *Early Marriage: A Harmful Traditional Practice*, UNICEF 1 (2005), http://www.unicef.org/publications/files/Early_Marriage_12.lo.pdf.

105. Jane Parry, *The Disease of Poverty is Doctor's Business Everywhere,* BMJ BLOGS (Oct. 24, 2013), http://blogs.bmj.com/bmj/2013/10/24/jane-parry-the-disease-of-poverty-is-a-doctors-business-everywhere/.

106. G.A. Res. 55/2, ¶20, United Nations Millennium Declaration, 5 (September 18, 2000) [hereinafter *Millennium Declaration*], http://www.un.org/ga/search/view_doc.asp?symbol=A/RES/55/2.

107. U.N., *supra* note 52, at 5.

108. *See generally Sustainable Development Goals*, UNITED NATIONS DEV. PROGRAMME, http://www.undp.org/content/undp/en/home/mdgoverview/post-2015-

an important catechism of human rights.

III. HUMAN RIGHTS ANALYSIS

This report by the UN Secretary General is an apt illustration of the human rights dimension of obstetric fistula:

> Obstetric fistula is a devastating childbirth injury that leaves women incontinent, often stigmatized, and isolated from their communities. It is a stark outcome of socioeconomic and gender inequalities, human rights denial and poor access to reproductive health services, including maternal and newborn care, and an indication of high levels of maternal death and disability.[109]

Starkly put, the report is a powerful indictment of global inaction regarding a condition that is easily preventable but persists as a formidable obstacle to the "freedom, well-being and dignity" of a vulnerable demographic.[110] Obstetric fistula is a human rights concern for a number of reasons: it "occurs disproportionately among impoverished girls and women, especially those living far from medical services;" affects the "most powerless members of society;" and "touches on . . . reproductive health and rights, gender equality, poverty, harmful traditional practices and adolescent reproductive health."[111] The UNFPA was quite unequivocal, "[t]aking action to end fistula is a fundamental human rights challenge of the 21st century and directly advances the MDGs—in particular, child and maternal health targets (Goals 4 and 5)—as it brings us one step closer to making safe childbirth a reality for all women."[112] In other words, pursuing initiatives that advance child and maternal health would ultimately result in significant curtailment, even if not eradication, of fistula.

To demonstrate the nexus between the MDGs and human rights, and how exploring this link could positively impact women at the risk of fistula, a number of preliminary points would have to be fleshed out. First, it must be noted that although the MDGs are projected as representing a "partnership" that is squarely aimed at "development and the elimination of poverty,"[113]

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development-agenda (last visited November 10, 2015).

109. U.N. Secretary-General, *supra* note 37, at 1.

110. PHILIP ALSTON ET AL., UNITED NATIONS DEV. PROGRAMME, HUMAN DEVELOPMENT REPORT 2000 1 (2000), http://hdr.undp.org/sites/default/files/reports/261/hdr_2000_en.pdf.

111. *The Quest to Prevent and End Obstetric Fistula Worldwide*, FRIENDS OF UNFPA, http://www.friendsofunfpa.org/netcommunity/page.aspx?pid=1259 (last visited Nov. 7, 2015); *see* Alston et al., *supra* note 110, at 2 (emphasizing that a human rights approach to development prioritizes the needs and interests of the "most deprived and excluded, especially to deprivations because of discrimination").

112. *Neglected No More, Fighting Fistula, supra* note 70.

113. UNITED NATIONS DEV. GRP., INDICATORS FOR MONITORING THE MILLENNIUM

the type of partnership that is envisaged is one that is centrally rooted in human rights. This rootedness is clearly evident in an admonition by the Millennium Development Project (a task force charged with research and providing necessary technical expertise for the implementation of the MDGs) to countries interested in meeting their MDGs obligations:[114] to make references to the human rights obligations they assumed under international treaties in their MDGs-based poverty reduction strategy, "[a]cknowledging that human rights (economic, social, and cultural rights) already encompass many of the Goals, such as those for poverty, hunger, education, health, and the environment."[115] The Task Force describes the MDGs as "basic human rights—the rights of each person on the planet to health, education, shelter, and security as pledged in the Universal Declaration of Human Rights and the UN Millennium Declaration."[116] This description is consistent with a pronouncement by the UNDP in 2000, that human development initiatives (such as the Millennium Declaration and the MDGs)[117] are essential for actualizing human rights, just as human rights are indispensable to human development.[118]

The second point worthy of note is readily discernible from a declaration by the Millennium Development Project. In enumerating areas of congruence between the MDGs and human rights (such as poverty, health, and so forth),[119] the Task Force highlights a key dimension of human rights—indivisibility, interdependence and interrelatedness of all human rights.[120] The message of this paradigm is that the attainment of one genre of human rights is dependent on the extent to which others have been or are being realized.[121] Conversely, the neglect of, or failure to address, one genre of

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DEVELOPMENT GOALS: DEFINITIONS, RATIONALE, CONCEPTS AND SOURCES 1, 4 (2003), *available at* http://mdgs.un.org/unsd/mdg/Resources/Attach/Indicators/HandbookEnglish.pdf

114. JEFFREY D. SACHS, U.N. MILLENNIUM PROJECT, INVESTING IN DEVELOPMENT: A PRACTICAL PLAN TO ACHIEVE THE MILLENNIUM DEVELOPMENT GOALS 118 (2005), *available at* http://www.unmillenniumproject.org/documents/MainReportComplete-lowres.pdf ("The UN Millennium Project is an independent advisory body commissioned by the UN Secretary-General to propose the best strategies for meeting the Millennium Development Goals (MDGs).").

115. *Id.* at 119.

116. *Id.* at 1.

117. *See* U.N., *supra* note 52.

118. SACHS, *supra* note 114, at 2.

119. *Id. at* 119.

120. World Conference on Human Rights, June 14-25, 1993, *Vienna Declaration and Programme of Action*, ¶ 5, U.N. Doc. A/CONF/157/23 (July 12, 1993) [hereinafter *Vienna Declaration*]; United Nations, Econ. & Soc. Council, Comm. On Human Rights, The Limburg Principles on the Implementation of the International Covenant on Economic Social and Cultural Rights, ¶ 3, U.N. Doc. E/CN.4/1987/17 (Jan. 8, 1987) [hereinafter Limburg Principles]; *The Maastricht Guidelines on Violations of Economic, Social and Cultural Rights*, 20 HUMAN RIGHTS QUARTERLY 691, 692 (1998) [hereinafter *Maastricht Guidelines*].

121. *See e.g.*, ALSTON, ET AL., *supra* note 110, at iii (explaining the relationship in terms

human rights detrimentally impacts another.[122] This principle equally applies to the MDGs. That is, the attainment of one MDG (for instance, poverty eradication) leads to the fulfillment of another (access to maternal or child health care, for example) and, conversely, failure to attain the former ensures non-fulfillment of the latter.[123] This seems to be the point the Commission on the Status of Women was making in claiming that absence of "progress on gender equality has hindered progress towards all of the [other MDGs];"[124] and in so doing, validates an earlier statement by the UN Development Group, that all the "goals and targets [of the MDGs] are interrelated" and, as such, deserving of no less than holistic intervention.[125] The point of these policy statements is quite simple: countries should pursue all the targets of the MDGs (realizing that they are also human rights) with the same vigor and commitment, not privileging one over another.[126]

Are country practices consistent with this prescription? Hardly, and this is the crux of the problem, and is *ergo* the reason this section aligns itself with the World Development Report 2000.[127] The Report is important for recognizing that "human rights principles of accountability and social justice" could be brought to bear upon the "process of human development," precisely the type represented in the MDGs.[128] Before, however, undertaking an expansive discussion of these human rights principles and their possible contribution to attaining the benchmarks of the MDGs or, more precisely, usefulness in addressing fistula, some clarifications are warranted. There are two distinct sets of human rights violations implicated by fistula. First, there are infringements and deprivations, the result of which is the fistula. These infringements create the circumstances or negative social forces that mark

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that "[a]ccess to basic education, health care, shelter and employment is as critical to human freedom as political and civil rights are.").

122. *E.g.*, Premature death of a mother (on account of poor access to maternal care, for instance) adversely impacts the entire family and community. Children lose vital care and nurturing and, as a result, may not survive childhood. And aside from being deprived of emotional/psychological support, the surviving spouse might have to give up employment in order to attend to domestic duties, thereby imperiling the family's finances. The community suffers deprivation of the labor and productivity of the deceased and her contribution to solidarity and cohesion.

123. INT'L FED'N OF RED CROSS AND RED CRESCENT SOC'YS, IN SUPPORT OF THE MILLENNIUM DEVELOPMENT GOALS 12 (2006), *available at* https://www.ifrc.org/Global/Publications/Health/health-mdgs-en.pdf.

124. *Challenges and Achievements in the Implementation of the Millennium Development Goals for Women and Girls, supra* note 40, at 5.

125. UNITED NATIONS DEV. GRP., *supra* note 113, at 4.

126. *See generally id.* ("The goals and targets are interrelated and should be seen as a whole. They represent a partnership between the developed countries and the developing countries 'to create an environment – at the national and global levels alike – which is conducive to development and the elimination of poverty'.").

127. *See* Alston et al., *supra* note 110.

128. *Id.*

the women as victims long before the onset of fistula. The second class of rights are those trampled upon as a consequence of fistula, occurring after the individual has fallen ill such as being shunned by the public. Whilst not denying the relevance of both genres of affront to human rights, the focus of this section is on the former, an examination of those adverse circumstances (human rights violations) which subject some but not others to subpar human existence – a life of shame, ridicule and misery.

There are, of course, a sizeable number of human rights frameworks that are relevant to the plight of fistula patients, but the most significant is the International Covenant on Economic, Social and Cultural Rights (ICESCR).[129] The ICESCR is the foremost human rights instrument on economic, social and cultural rights and amongst the most widely ratified – 162 countries as of September 2014.[130] Regardless, we begin our analysis with the Universal Declaration of Human Rights (UDHR),[131] for the simple reason that not only does the Declaration predate the ICESCR, it is also its foundation. Eleanor Roosevelt's speech on the Adoption of the Universal Declaration of Human Rights in 1948 was striking for quite an array of reasons, but by far the most important was that it stated the "basic character of the document" – not a "statement of law or of legal obligation" but a "Declaration of basic principles of human rights and freedoms . . . to serve as a common standard of achievement for all peoples of all nations."[132] Despite not being a "document stating obligations on [S]tates," some of the provisions of the UDHR have, over the years, acquired legally binding character.[133]

Striding from a reaffirmation of a core tenet of human rights, that Member States of the UN "have pledged themselves to achieve, in co-operation with the United Nations, the promotion of universal respect for and observance of human rights and fundamental freedoms" (a point to which we shall return shortly),[134] the UDHR proceeds to stipulate a number of far-reaching provisions which now comprise the citadel of global human rights protection. A key provision of the UDHR is the equal entitlement of everyone,

129. G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, U.N. Doc. A/6316 (Jan. 3, 1976) [hereinafter ICESCR].

130. *Chapter IV Human Rights: International Covenant on Economic, Social and Cultural Rights*, UNITED NATIONS TREATY COLLECTION, https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-3&chapter=4&lang=en (last visited Nov. 10, 2015).

131. *See* Universal Declaration of Human Rights, G.A. Res. 217 (III) A, U.N. Doc. A/RES/217(III) (Dec. 10, 1948) [hereinafter UDHR].

132. Eleanor Roosevelt, On the Adoption of the Universal Declaration of Human Rights (Dec. 9, 1948) (transcript available at AmericanRhetoric.com); *see also* UDHR, *supra* note 131.

133. Roosevelt, *supra* note 132.

134. UDHR, *supra* note 131, at pmbl.

irrespective of rank in society or any other unjustifiable distinction, to "all the rights and freedoms set forth in this Declaration."[135] The significance of this provision is underscored by its incorporation into virtually all subsequent human rights documents, even those adopted by regimes with questionable human rights records.[136] The implication, therefore, is that even if other provisions of the UDHR remain mired in controversy, its prohibition against non-discrimination should be considered to have assumed a certain level of universal acceptability and affirmation.[137] This is the prism from which to examine human rights infractions pertaining to fistula.

The UDHR sets the stage by recognizing the right of everyone to a "standard of living adequate for the health and well-being of himself and of his family, including [inter alia] medical care,"[138] and stipulating that "[m]otherhood and childhood are entitled to special care and assistance."[139] The significance of these provisions lies not only in laying the foundation for the right to health but in specifying the need for special attention to mothers and children. This specification is critical for three reasons. First, it draws attention to the vulnerability of these demographics. Aside from being poorer than the general population, pregnant women and young children (as a consequence of diminished and evolving immunity respectively) are more susceptible to a wide range of diseases and illnesses than the general population.[140] Second, coupling the human rights of mothers and children emphasizes the indivisibility paradigm of human rights discussed previously – that is, a recognition that the needs of mothers cannot be addressed in isolation of that of children and vice versa. The third importance of the specification is that it speaks directly to the subject of this paper – fistula population. Most of the victims are children – individuals who became mothers before their bodies were ripe for motherhood.[141] They are also poor, a reason the concluding portion of Art. 25(1) – entitling everyone to "necessary social services, and the right to security in the event of . . . sickness, disability . . . or other lack of livelihood in circumstances beyond

135. *Id.* at art. 2; *see also id.* at art. 1, 7.

136. *Compare Human Rights Abuses by Country*, THE GUARDIAN, http://www.theguardian.com/Tables/4_col_tables/0,,258329,00.html (last visited Nov. 6, 2015), *with Vote of the General Assembly to Adopt the Universal Declaration of Human Rights*, GRAND COUNCIL OF CREES, http://www.gcc.ca/pdf/INT000000019b.pdf (last visited Nov. 6, 2015).

137. *See* UDHR, *supra* note 131.

138. *Id.* at art. 25.

139. *Id.*

140. *See e.g., GFR Fact Sheet on Malaria*, GLOBAL RISK FORUM (2009), http://grforum.org/fileadmin/user_upload/grforum/documents/Malaria_Factsheet.pdf (malaria as an illustration).

141. Suellen Miller et al., *Obstetric Fistula: A Preventable Tragedy*, 50 J. OF MIDWIFERY & WOMEN'S HEALTH 286, 287-88 (2005).

his [or her] control"[142] – is equally apposite.

The ICESCR stamps these provisions with the imprimatur of international law (binding legal force) by enshrining, amongst its provisions, the right to "the enjoyment of the highest attainable standard of physical and mental health"[143] and also according special protection to mothers and children.[144] As to how the right to health would be realized, States Parties to the ICESCR are under obligation to take such steps as are necessary to ensure, *inter alia,* "the reduction of the stillbirth-rate and of infant mortality";[145] the prevention, treatment and control of diseases;[146] and "the creation of conditions which would assure to all medical service and medical attention in the event of sickness."[147] Taking measures to ensure the reduction of pregnancies that result in stillbirth is particularly crucial to the subject of this paper given that in most cases of pregnancies resulting in fistula, the child had been stillborn.[148]

Subsequent human rights instruments (those adopted after 1966) have, by and large, toed the path sculpted by the ICESCR. The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW),[149] for instance, not only singles out gender-based discrimination as responsible for infringement of the rights of women and mandates its eradication,[150] it also imposes an obligation on States Parties to "ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary."[151] When taken seriously, this obligation requires the provision of antenatal and obstetric care to all pregnant women, irrespective of age, income level, or any other distinguishing characteristics. Similar obligations are imposed by the Convention on the Rights of the Child (CRC),[152] the most widely ratified

142. UDHR, *supra* note 131, at art. 25.

143. ICESCR *supra* note 129, at art. 12; *see generally* United Nations Econ. & Soc. Council, Com. On Econ., Soc. and Cultural Rights, General Comment No. 14: The Right to the Highest Attainable Standard of Health, ¶ 12, U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000) [hereinafter General Comment No. 14] (the right to health includes the following interrelated elements, or components, namely availability and accessibility of as well as acceptability and quality of health facilities, goods and services, including underlying determinants of health).

144. ICESCR, *supra* note 129, at art. 10.

145. *Id.* at art. 12, ¶ 2.

146. *Id.*

147. *Id.*

148. *See* Engender Health, *Obstetric Fistula,* U.S. AGENCY FOR INT'L DEV., http://www.fistulacare.org/pages/what-is-fistula/ (last visited Nov. 6, 2015).

149. Convention on the Elimination of All Forms of Discrimination Against Women, opened for signature, Dec. 18, 1979, 1249 U.N.T.S. 13 (entered into force Sept. 3, 1981).

150. *See* G.A. Res. 34/180, U.N. Doc. A/RES/34/180 (Dec. 18, 1979).

151. *Id.* at art. 12, ¶ 2.

152. G.A. Res. 44/25, U.N. GAOR, 44th Sess., Supp. No. 49, U.N. Doc. A/44/49, art. 24, ¶ 2(d) (Nov. 20, 1989).

human rights treaty – a total of 196 countries as of September 2015.[153] Regional instruments such as the African Charter on Human and Peoples' Rights[154] and the African Charter on the Rights and Welfare of the Child[155] replicate these obligations and, for ratifying countries, impose legally binding obligations.

Having fleshed out the relevant treaty provisions, the question that remains is, what is the exact nature of associated obligations? In other words, what specific strategies or programs are required to be adopted and operationalized in order to be compliant with the terms of these provisions? The first attempt at answering this question was made by the UN Committee on Economic, Social and Cultural Rights (Committee on ESCR)—the Committee charged with implementing the provisions of the ICESCR[156]—in 1990.[157] General Comment No. 3 was remarkable for marking the first articulation of the nature of the obligations incumbent upon States Parties to the ICESCR.[158] For purposes of this essay, the most significant of the explanatory pronouncements are the ones relating to progressivity of implementing the obligations and the concept of minimum core obligations. The Committee on ESCR acknowledges that due to resource difficulties, certain provisions would not be actualized immediately[159] but recognizes that others could be

153. *Chapter IV Human Rights: Convention on the Rights of the Child*, UNITED NATIONS TREATY COLLECTION, http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-11&chapter=4&lang=en (last visited Nov. 6, 2015).

154. African (Banjul) Charter on Human and Peoples' Rights, art. 16, OAU Doc. CAB/LEG/67/3 (June 27, 1981).

155. African Charter on the Rights and Welfare of the Child, art. 14, OAU Doc. CAB/LEG/24.9/49 (July 11, 1990).

156. *Committee on Economic, Social and Cultural Rights: Monitoring the Economic, Social and Cultural Rights*, OHCHR, http://www.ohchr.org/EN/HRBodies/CESCR/Pages/CESCRIntro.aspx (last visited Nov. 6, 2015) (the Committee was established under ECOSOC Resolution 1985/17 of May 28, 1985 to carry out the monitoring functions assigned to the United Nations Economic and Social Council (ECOSOC) in Part IV of the International Covenant on Economic, Social and Cultural Rights (ICESR). to carry out the monitoring functions assigned to the United Nations Economic and Social Council (ECOSOC) in Part IV of the International Covenant on Economic, Social and Cultural Rights (ICESR)).

157. United Nations Econ. & Soc. Council, Comm. On Economic, Social and Cultural Rights, General Comment No. 3: The Nature of States Parties' Obligations, U.N. Doc. E/1991/23 (Dec. 14, 1990) [hereinafter General Comment No. 3]. A remarkable characteristic of the interpretive exercise of the Committee on ESCR is that the magisterial force of its pronouncements transcends the ICESCR to apply in other regimes. For instance, in the performance of its role of interpreting the provisions of African Charter on Human and Peoples' Rights, the African Commission on Human and Peoples' Rights "draw[s] inspiration from international law" on human rights, including "instruments adopted by the United Nations" or within any of its "Specialized Agencies." African (Banjul) Charter on Human and Peoples' Rights, *supra* note 154, at art. 60.

158. *See* General Comment No. 3 ¶ 1.

159. *See* General Comment No. 3, *supra* note 157, ¶ 1, 9; *see also* UDHR, *supra* note 131, at pmbl (note that the Committee's progressivity jurisprudence was inspired by the UDHR. The UDHR requires "that every individual and every organ of society, keeping this

implemented immediately (for instance, the prohibition against discrimination).[160] Regardless of scarce constraints, the Committee is of the view that an obligation "to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights is incumbent upon every State party"–a duty that has come to be known as a "minimum core obligation."[161]

A refinement and reformulation of these pronouncements—this time, focusing specifically on the right to health—occurred in 2000.[162] In General Comment No. 14, the Committee on ESCR affirms that, like other human rights provisions of the ICESCR, Art. 12 imposes upon States Parties an obligation to *respect, protect* and *fulfill* the right to health.[163] Thus, the ability of countries to rise to the imperatives of this interpretation provides a basis of assessment of its commitment to making the right to health a reality in the lives of people within their respective jurisdictions. In addition, the Committee specifies a distinct category of obligations—which it describes as ensuring "the satisfaction of, at the very least, minimum essential levels of each of the rights enunciated in the Covenant, including essential primary health care"—as minimum core obligations:

(a) To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups;

(b) To ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone;

(c) To ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water;

Declaration constantly in mind, shall strive by teaching and education to promote respect for these rights and freedoms and by *progressive measures,* national and international, to secure their universal and effective recognition and observance, both among the peoples of Member States themselves and among the peoples of territories under their jurisdiction." (emphasis added)).

160. General Comment No. 3, *supra* note 157, ¶ 1.

161. *Id.* ¶ 10.

162. *See generally* General Comment No. 14, *supra* note 143.

163. *Id.* ¶ 33.

> The right to health, like all human rights, imposes three types or levels of obligations on States parties: the obligations to *respect*, *protect* and *fulfil*. In turn, the obligation to fulfil contains obligations to facilitate, provide and promote (footnote omitted). The obligation to *respect* requires States to refrain from interfering directly or indirectly with the enjoyment of the right to health. The obligation to *protect* requires States to take measures that prevent third parties from interfering with article 12 guarantees. Finally, the obligation to *fulfil* requires States to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health.

(For a more detailed exposition of these terms, *see id.* ¶¶ 34-37.)

(d) To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs;
(e) To ensure equitable distribution of all health facilities, goods and services;
(f) To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population.[164]

Aside from these, the Committee stipulates a number of other obligations which it posits as "obligations of comparable priority" including—and this is very important to the discourse on fistula—an obligation to ensure reproductive, maternal (pre-natal as well as post-natal) and child health care.[165]

These specifications are the minimum or basic thresholds, which States Parties to the ICESCR are under obligation to meet regardless of prevailing economic circumstances in their respective jurisdictions.[166] This strict interpretation represents a striking departure from General Comment No. 3, which excuses non-compliance with core obligations on the basis of resource constraints.[167] This more recent interpretation was emphatic that core obligations are non-derogable regardless of the circumstances.[168] The Maastricht Guidelines holds these obligations applicable "irrespective of the availability of resources of the country concerned or any other factors and difficulties."[169] Non-derogability is premised on the understanding that "compliance with such obligations may be undertaken by most States with relative ease, and without significant resource implications."[170] The idea is that no country is so resource challenged as to be incapable of responding to basic health care needs of its people, particularly considering that "both the resources within a State and those available from the international community through international co-operation and assistance" are taken into consideration in calculating the quantum of resources available for health.[171]

Non-derogable character of core obligations has very significant synergistic relationship with the MDGs. In what seems like a preemption of the Millennium Declaration, the Committee on ESCR interprets Art. 2(1) of

164. *Id.* ¶ 43.
165. *Id.* ¶ 44.
166. *Id.* ¶ 43.
167. *See* General Comment No. 3, *supra* note 157, ¶ 10 (noting that "any assessment as to whether a State has discharged its minimum core obligation must also take account of resource constraints applying within the country concerned.").
168. General Comment No. 14, *supra* note 143, ¶ 47.
169. *Maastricht Guidelines*, *supra* note 120, ¶ 9.
170. *Id.* ¶ 10.
171. General Comment No. 3, *supra* note 157,, ¶ 13; *see also Limburg Principles*, *supra* note 120, ¶ 26.

the ICESCR as requiring affluent States Parties and other actors to provide "international assistance and cooperation, especially economic and technical" in order to enable poor countries to fulfill their core obligations.[172] The thrust of this provision is similar to the stipulation of MDG 8—to develop a global partnership for development, through, *inter alia,* increase in ODA—an issue discussed in Part II.[173] They bear no repeating, except to note that the response of the international community (governments and private institutions) to prevailing developmental challenges in the third world, particularly in the health sector, makes resource constraints a timid and lame excuse. In 2012, ODA stood at $125.6 billion.[174] Although this represents a decline from a peak of $128.7 billion in 2010,[175] one thing seems quite glaring: add individual receipts to internally generated resources, however austere, in each aid-receiving country and it becomes clear that failure to rise to development challenges in many of these countries is not a product of resource deficit. The UNFPA estimates that it would cost $300 to provide fistula treatment—including surgery, post-operative care and rehabilitation support,[176] meaning that resource deficit is not an excuse.

The emphasis of this section on core obligations is driven by two considerations. First, recalibrating national health systems in tandem with the demands of the obligation is a surefire way not only to reduce the incidence of fistula but also improve the entire health system. Second, and perhaps more important, recalibration is possible immediately. The point is that

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172. General Comment No. 14, *supra* note 143, ¶ 45; *see also* General Comment No. 3, *supra* note 157, ¶ 14.

173. This idea has an antecedent in the U.N. Charter. Amongst the factors that propelled the establishment of the U.N. was a need to "reaffirm faith in fundamental human rights, in the dignity and worth of the human person, in the equal rights of men and women." U.N. Charter pmbl. A key objective of the Organization is to "achieve international co-operation in solving international problems of an economic, social, cultural, or humanitarian character, and in promoting and encouraging respect for human rights and for fundamental freedoms for all without distinction as to race, sex, language, or religion." U.N. Charter art. 1, para. 3. This objective underscores the pledge by Member Nations pledge to "to take joint and separate action in co-operation with the [UN]" in order to:

(a) attain higher standards of living, full employment, and conditions of economic and social progress and development;
(b) develop and implement solutions to international economic, social, health, and related problems; and international cultural and educational cooperation; and
(c) ensure universal respect for, and observance of, human rights and fundamental freedoms for all without distinction as to race, sex, language, or religion.

See U.N. Charter art. 55, 56*; see also* ICESCR, *supra* note 129, at art. 11.

174. *Aid to Poor Countries Slips Further as Governments Tighten Budgets*, ORG. FOR ECON. CO-OPERATION AND DEV. (Mar. 4, 2013), http://www.oecd.org/newsroom/aidtopoorcountriesslipsfurtherasgovernmentstightenbudgets.htm.

175. *Development Aid Reaches an Historic High in 2010*, ORG. FOR ECON. CO-OPERATION AND DEV., http://www.oecd.org/dac/stats/developmentaidreachesanhistorichighin2010.htm (last visited Oct. 11, 2015).

176. *When Childbirth Harms: Obstetric Fistula, supra* note 4.

resources needed to ensure compliance with core obligations are available even in resource-limited settings; meaning—and this is very striking—that this is not one of those circumstances where defaulting countries could unabashedly hide under the veneer of poverty. In essence, therefore, the most appropriate way to explain the existence of large fistula cases in many third world countries is to cast it as reflective of pursuit of measures that are incompatible with core obligations, a violation of the right to health.[177]

This violation extends to underlying or social determinants of health—that is, "socio-economic factors that promote conditions in which people can lead a healthy life,"[178] such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health.[179] The list is not exhaustive, and includes "adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs, as defined by the WHO Action Programme on Essential Drugs."[180] It is noteworthy that the items recognized as social health determinants share striking similarity with those identified as core obligations or of comparable priority[181]—meaning that the preceding analysis regarding core obligations and their violation apply with equal force to social health determinants.[182] The key, therefore, is to think of the pathology presenting as fistula as symptomatic of deficit of serious commitment to human rights, persistent failure on the part of political leadership in those countries to deploy resources that could have reinvigorated and revamped ailing health systems.[183]

IV. CONCLUSION

> "To meet only one of these mothers is to be profoundly moved. Mourning the stillbirth of their only baby, incontinent of urine, ashamed of their

177. General Comment No. 14, *supra* note 143, ¶ 48.

178. *Id.* ¶ 4.

179. *Id.* ¶¶ 4, 11.

180. *Id.* ¶ 12.

181. *See id.* ¶ 43-44.

182. *See generally* COMM'N ON SOC. DETERMINANTS OF HEALTH, WORLD HEALTH ORG., CLOSING THE GAP IN A GENERATION: HEALTH EQUITY THROUGH ACTION ON THE SOCIAL DETERMINANTS OF HEALTH (2008), *available at* http://apps.who.int/iris/bitstream/10665/43943/1/9789241563703_eng.pdf (providing an in-depth discussion of the concept of underlying determinants of health).

183. *See* WORLD HEALTH ORG., THE WORLD HEALTH REPORT 2000: HEALTH SYSTEMS: IMPROVING PERFORMANCE 152-55 (2000), *available at* http://www.who.int/whr/2000/en/whr00_en.pdf (providing evidence in a finding which shows that in terms of health system attainment and performance, these very health systems rank in the bottom vis-à-vis others).

> offensiveness, often spurned by their husbands, homeless, unemployable except in the fields, they endure, they exist, without hope . . ."
> Dr. Katherine Hamlin, Second Fistulae Hospital, Addis Ababa, Ethiopia.

Is fistula a neglected disease? The theme of a conference held in Pakistan in 2011—"No more neglected. Dignity restored."[184]—as well as a number of declarations by reputable global institutions such as the UNFPA ("Neglected No More")[185] and the mass media ("No Longer a Neglected Tragedy")[186] suggest a negative response. Yet, whilst it is arguable that at no point in time had fistula garnered greater global attention than now, the level of attention remains grossly inadequate to deal with a menace that continues to wreak havoc in the lives of 50,000–100,000 women annually.[187] Andrew Browning should know. The Australian-born obstetrician and gynecologist has spent more than a decade of his professional life treating fistula patients in some of the most remote and impoverished settings in the world.[188] Perhaps out of frustration with the status quo, Browning writes: "At the world's current capacity for dealing with the problem, it would take up to 400 years to treat the backlog of patients. Clearly we need many more centres equipped to care for women with fistula."[189]

Translation: more is needed. As was made very clear in the abstract of this paper, not only are the causes of fistula not shrouded in mystery, the solutions are well known, a theme pursued in considerable detail in Part II. More recently, The Campaign to End Fistula, an innovation of the UNFPA, has advanced a 3-pronged strategy for dealing with the condition: (a) adopt preventive measures, (b) treat women and girls who are affected, and (c) support women and girls after surgery.[190] Of all these strategies, the UNFPA projects the "key to ending fistula," is having in place a strategy or structure that would "prevent it from happening in the first place."[191] As to what a preventive strategy entails in this context, the agency holds that it requires "tackling underlying social and economic inequities through initiatives aimed at educating and empowering women and girls, enhancing their life

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184. *Pakistan: March 2011, A Conference to Raise Awareness About Fistula*, WOMEN & HEALTH ALLIANCE INT'L (Mar. 8, 2011), http://www.waha-international.org/?what-we-do=1186&pakistan-march-2011-a-conference-to-raise-awareness-about-fistula.

185. *See Neglected No More: Fighting Fistula, supra* note 70.

186. *See generally* Grant, *supra* note 13.

187. *When Childbirth Harms: Obstetric Fistula*, *supra* note 4, at 3.

188. *See Dr. Andrew Browning*, BARBARA MAY FOUND., http://www.barbaramayfoundation.com/dr-andrew-browning (last visited Nov. 5, 2015).

189. Andrew Browning, *Obstetric Fistula in Ilorin, Nigeria*, 1 PLOS MED 22, 24 (2004), *available at* http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.0010002; *see also* M.A. Ijaiya & P.A. Aboyeji, *Obstetric Urogenital Fistula: The Ilorin Experience, Nigeria*, 23 W. AFR. J. MED. 7, 7 (2004).

190. *Neglected No More: Fighting Fistula, supra* note 70.

191. *When Childbirth Harms: Obstetric Fistula*, *supra* note 4, at 3.

opportunities and delaying marriage and childbirth."[192]

This paper has labored to show that the necessary elements of this strategy are incorporated within the MDGs framework as well as human treaties to which the vast majority of countries in fistula prone regions are States Parties. A major argument of the paper is that preventing the occurrence of fistula is a key human rights obligation—an obligation that involves educating and empowering women, freeing them from the suffocating clutches of poverty, shielding them from early marriage, and so forth—in addition to respecting, protecting, and fulfilling their right to health. Shaping the analysis was decidedly an eye toward the population most affected by fistula, those to whom "States" are charged with "hav[ing] a special obligation . . . especially with respect to the core obligations of the right to health."[193] As argued elsewhere, the "productivity of human rights is at its peak, much like liberation theology, when it is 'on the side of the poor' and 'struggles alongside them against the poverty that has been unjustly created and forced on them.' " [194]

The Biblical adjuration—"whatever you did for one of the least of these . . . sisters of mine, you did for me"[195]—is a statement of canonical significance that transcends Christian morality. It has also a powerful human rights resonance. By using the term "least of these . . . sisters," the Good Book commands special attention to the needs of the most vulnerable amongst us (in this case, poor girls and women), for a special ministry to be carved out for their upliftment and reintegration into society.[196] Evidence that this prioritization (of the needs of vulnerable populations) is also a key human rights edict is provided by the use of the term "vulnerable" at least eleven times in the most authoritative document on the meaning and nature of the right to health.[197] The pronouncement of an earlier document is even more compelling, "that even in times of severe resources constraints," regardless of the cause, "the vulnerable members of society can and indeed must be protected."[198] As to how vulnerable they really are, the UNFPA elucidates:

> The women and girls suffering from obstetric fistula are living proof of

192. *Id.*

193. *See* General Comment No. 14, *supra* note 143, ¶ 19.

194. Obiajulu Nnamuchi, *Millennium Development Goal 6 and the Trifecta of HIV/AIDS, Malaria and Tuberculosis in Africa: A Human Rights Analysis*, 42 Denv. J. Int'l L. & Pol'y 247, 281 (2014) (quoting LEONARDO BOFF & CLODOVIS BOFF, INTRODUCING LIBERATION THEOLOGY 4 (Paul Burns trans., 1987)).

195. *Matthew* 25:40 (New International Version).

196. HOPE FOR CHILDREN IN POVERTY: PROFILES AND POSSIBILITIES 19-20, 22, 24 (Ronald J. Sider & Heidi Rolland Unruh eds., 2007), *available at* http://www.baylor.edu/content/services/document.php/145503.pdf.

197. *See* General Comment No. 14, *supra* note 143, ¶¶ 12(b), 18, 35, 37, 40, 43(a), 43(f), 52, 62, 65.

198. General Comment No. 3, *supra* note 157, ¶ 12.

> high maternal mortality. They survived the physical and emotional trauma of obstructed labour to become living reminders of health systems' failure and a tragic sign of global social injustice and inequity. All too often, however, they are hidden away and forgotten.[199]

Fistula victims are "hidden away and forgotten" for two simple reasons, namely, concentration (almost exclusively) of the disease in the poorest regions of the world, and, even in those countries, it is disproportionately suffered by the poorest of the poor, "the least of these . . . sisters False."[200] With no voice, either locally or internationally, they languish in obscurity, forgotten by those in a position to render assistance, even the governments to which they continue to pledge allegiance. This, unquestionably, is an affront to human rights, a "neglected public health and human rights issue" that is rooted in governance deficit in many of the affected countries.[201] The Committee on ESCR was stating the obvious in its conclusion that "good governance is essential to the effective implementation of all human rights, including the realization of the right to health."[202] That poor countries, the same that harbor the greatest burden of fistula, are also those afflicted with poor governance and human rights record deserves no argument. A commonality amongst these countries is the brazenness with which funds, even those sourced from ODA, are hijacked by the ruling elite. One of the most visible, albeit unenviable, surprises of postcolonial politicking in the third world is the speed with which national economies are being carved into private fiefdoms, no eyebrows raised. Nigeria is a typical example:

> The World Bank recently released numbers indicating that about $400 billion has been pilfered from Nigeria's treasury since independence . . . This amount - $400 billion - is approximately the gross domestic products of Norway and Sweden. In other words, Nigeria's corrupt ruling class stole the equivalent of the entire economy of a European country in four decades![203]

Is this World Bank revelation of any significance to the discussion at hand? Certainly. Chinua Achebe, arguably the best known African scholar, explains, "[t]his theft of national funds is one of the factors essentially making it impossible for Nigeria to succeed."[204] An earlier work was even more emphatic, "it [large scale embezzlement] is the key to understanding

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199. *Neglected No More: Fighting Fistula, supra* note 70, at 2.
200. *See Matthew, supra* note 195.
201. *See id.*
202. General Comment No. 14, *supra* note 143, ¶ 55.
203. CHINUA ACHEBE, THERE WAS A COUNTRY: A PERSONAL HISTORY OF BIAFRA 249 (2012).
204. *Id.*

the genealogy and intractable nature of current challenges facing the country, particularly within the health sector."[205] This scenario is repeated, to a large extent, in the vast majority of other fistula countries. Seen this way, it becomes quite easy to understand why countries perpetually populating the bottom half of Transparency International's Corruption Perception Index (which measures the perceived levels of public sector corruption) are also those with substantial fistula population: Afghanistan, Bangladesh, Benin, Chad, Cambodia, Ethiopia, Niger, Nigeria, Pakistan, Uganda, Sudan, and Somalia.[206] Quite unsurprisingly, these same countries are also underperformers according to the World Bank's Worldwide Governance Indicators (WGI)[207] and other critical indicators of human development, including those measured by the UNDP.[208] As a group, countries in the regions of sub-Saharan Africa and South Asia (fistula nations) are ranked worst in the latest UNDP report.[209]

A recent paper, which analyzes factors it projects as "fundamentally responsible for the dismal state of health and well-being of Africans,"[210] has it right when it blames docility—acquiescence to bad governance by failing to use the democratic process to effect changes—as a major culprit.[211] The same is true in South Asia.[212] But even so, the ability of ordinary citizens to

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205. Obiajulu Nnamuchi, *Kleptocracy and Its Many Faces: The Challenges of Justiciability of the Right to Health Care in Nigeria,* 52 J. AFR. L. 1, 12 (2008).

206. *See Corruption Perceptions Index 2013*, TRANSPARENCY INT'L, http://www.transparency.org/cpi2013/results (last visited Nov. 9, 2015).

207. *See The Worldwide Governance Indicators: Interactive Data Access*, THE WORLD BANK GRP., http://info.worldbank.org/governance/wgi/index.aspx#reports (last visited Nov. 9, 2015) (reporting aggregate and individual governance indicators for 215 economies over the period of 1996-2014, for six dimensions of governance: Voice and Accountability, Political Stability and Absence of Violence, Government Effectiveness, Regulatory Quality, Rule of Law, and Control of Corruption); *see also The Worldwide Governance Indicators: Home*, THE WORLD BANK GRP., http://info.worldbank.org/governance/wgi/index.aspx#home (last visited Nov. 9, 2015).

208. *See* United Nations Dev. Programme, *supra* note 15, at 160-63 (indicating the relevant countries rated low on the Human Development Index).

209. *Id.* at 163. The system used by the UNDP is known as the "Human Development Index"— introduced in 1990, as an alternative to GDP, to measure of income, education and health. Inequality, gender and poverty were subsequently added. *Id.* at 27.

210. Obiajulu Nnamuchi & Simon Ortuanya, *The Human Right to Health in Africa and its Challenges: A Critical Analysis of Millennium Development Goal 8*, 12 Afr. Hum. Rts. L. J. 178, 178 (2012).

211. *Id.* at 190-91.

212. *See Governance & Public Sector Management in South Asia: Overview*, THE WORLD BANK, http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/SOUTHASIAEXT/EXTSAREGTOPPRISECDEV/0,,contentMDK:20933428~pagePK:34004173~piPK:34003707~theSitePK:496671,00.html (last visited Nov. 9, 2015). Regarding the state of governance in South Asia and its consequences, the World Bank recently concluded:

> The region's growth has been affected by weak governance. The rule of law (especially property rights enforcement, and law and order) and judicial systems

force major sociopolitical changes is quite limited, and for a very simple reason. Instead of "deliver[ing] a better life for the people,"[213] political leadership in many of these countries is increasingly resorting to "bribing, threatening, and, on occasions, murdering any opposition in the process."[214] Cowed and terrified, there is little citizens can do—that is, without external assistance, precisely the kind that is encapsulated within the meaning of MDG 8. The MDG, as previously explained, requires wealthy advanced countries to carry others along in their march toward realizing the objectives of the Millennium Declaration.[215] The leverage of Western nations, whose funds sustain most third world regimes, is not at all insignificant. As summed up elsewhere, the "desperate need for development cash" in these countries "may ultimately be the catalyst that forces its political leadership to adopt much-needed good governance and anti-corruption reforms."[216] This leverage was used with considerable degree of success, even if for self-serving purposes, in the cold war era. It should be deployed again – only this time, for a good cause.

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are weak, and some parts of public administration appear to be worsening due to politicization, distorted incentives and limited accountability. The costs of poor governance—whether unenforceable property rights and contracts, deteriorating law and order, or widespread teacher and doctor absenteeism—are largely borne by the poor.

213. Hannah Beech, *People's President: Joko Widodo's election in Indonesia marks how the world's third largest democracy is evolving*, TIME, Oct. 27, 2014, at 36 (quoting president-elect of Indonesia Joko Widodo).

214. ACHEBE, *supra* note 203, at 245.

215. *See Millennium Declaration*, *supra* note 106.

216. Nnamuchi & Ortuanya, *supra* note 210, at 197.