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RELEVANCE AND CHALLENGES OF THE HUMAN RIGHTS BASED APPROACH TO MATERNAL HEALTH IN ETHIOPIA.

BY

DUNIA MEKONNEN TEGEGN

FEBRUARY, 2011

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A THESIS SUBMITTED TO THE INSTITUTE OF HUMAN RIGHTS AT ADDIS ABABA UNIVERSITY IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF THE DEGREE OF MA IN HUMAN RIGHTS

ADVISOR

Emezat Mengesha (LL.B, LL.M, PhD)

FEBRUARY 2011

DECLARATION

I, Dunia Mekonne Tegegn**,** hereby declare that this dissertation is my own original work and has never been presented in any other institution. I also declare that where sources are used, they are duly acknowledged.

With Regards!

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RELEVANCE AND CHALLENGES OF THE HUMAN RIGHTS BASED APPROACH TO MATERNAL HEALTH IN ETHIOPIA.

BY

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ACRONYMES

ACHPR	African Charter on Human and Peoples' Rights
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CRC	Convention on the Rights of Child
CESCR	Committee on Economic, Social and Cultural Rights
CRC	Convention on the Rights of Child
ESCRs	Economic, social and Cultural Rights
DHS	Demographic Health Survey
FGD	Focused Group Discussion
FDRE	Constitution of the Federal Democratic Republic of Ethiopia
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic and Social Rights
ICPD	International Conference on population and Development
UDHR	Universal Declaration of Human Rights
UN	United Nations
UNHCHR	United Nations High Commissioner for Human Rights
MCH	Mother and Child Health

CHAPTER ONE

1.1Background of the study

In the International Statistical Classification of Diseases and Related Health Problems WHO describes Maternal Mortality as:

> *"The death of a woman while pregnant or within the 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes".*[1]

At a global level, Maternal Mortality was not known as a public health issue until the end of the 20th century. By early 1980's, the health concerns of the international women's movement started to flourish. Many women from all over the world gathered together through the international women and health meetings .This enabled the participants raise and discuss on the fundamental concerns which are common to most of them. Among such basic concerns the need for safe and affordable contraceptives was the primary one.[2]

These meetings with various Non -Governmental Organizations had contributed to what we call the United Nations decade for women which refers to the period between 1976-1985.This in turn has contributed to attract not only governments attention but also that of the international community to the health of women most importantly to women living in developing countries. [3]

In 1985, an article by the title "where is the M in MCH**"** was published which was found to be provocative to women who were already engaged in advocacy for women's health rights. The article presented the inherent neglect of women in maternal and child health programs. Afterwards, international attention started to focus on the health of pregnant women.[4]

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[1]World Health Organization , International Statistical Classification of Diseases and Related Health Problems (1992)

[2] C. Garcia and A. Claro, "Challenges from the women's Health movement: Women's rights versus Population control," *in* G, Sen., A .Germain and LC Chen, population polices reconsidered health, empowerment and rights *(1*994), p 47

[3] M Berner and RTK Sundari, Preventing Maternal Mortality: Evidence, Resources, Leadership, and Action, Reproductive Health Matters (1993), p 3

[4]A Rosen field and D Maine, Maternal mortality: a neglected tragedy. Where is the "M" in MCH?(1985) Available at_ http: // www.the lancet.com accessed on 20 April 2010

Even then, those programs that focused on maternal health were mostly motivated by concerns about infant and child health, which considered the health of mothers as basic only because they give birth to children.

Interventions essential for pregnant women were insignificant to women suffering injury or dying from child birth and pregnancy related causes.

This being so, the international conference on safe motherhood held in Nairobi, Kenya, in February 1987, urged for member states of the United Nations to improve health conditions and prioritize the health needs of women in general and to reduce maternal mortality in particular. That same year, international agencies, governments, and a few international non-governmental organizations began the safe motherhood initiative. The aims of this endeavor were highlighting the persistence of maternal ill health and develop effective remedies for maternal mortality and morbidity.[5]

Hand in hand with these efforts to address maternal mortality within the public health community, international feminist movements, especially, women's activism around health and rights, both within countries and globally were also growing. In addition, human rights organizations started to demonstrate how human rights could work for women in the so called private sphere, which also includes sexuality and reproduction. This was strengthened through researches on the area, which together with advocacy, contributed to awareness raising on women's right to health as part and parcel of Economic, Social and Cultural rights throughout the 1990's.[6]

The women's health and human rights movement has contributed a lot to the development of the 1994 International Conference on Population and Development (ICPD) in Cairo, and the 1995 fourth world conference on women in Beijing. The Cairo and Beijing outcome documents recognized the need to promote and protect women's rights, particularly in matters relating to reproductive health and sexuality to advance women's health. Both documents also focused on the need for women to have access to information and services to go through pregnancy safely.[7]

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[5] RHO Archives, Safe Motherhood links(2005) available at http://www.rho.org/html/sm_links.htm#SMinititative accessed on 22 Sep, 2010

[6] D. Sullivan, "The public/private distinction in international human rights law", in J Peters and A Wolper (eds), Women rights –human rights : international feminist perspectives(1995), pp 126-134.

[7] United Nations, Program of Action of the International Conference on Population and Development (1994), para7.2.

To this end the program of action for the ICPD defined Reproductive Health as:

> *"The right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant*".[8]

Despite the recognition achieved by the Safe Motherhood Initiative along the decade, that is starting from the year 1987 onwards, the goal of the initiative, which is reducing maternal mortality by 50% by the year 2000 has challenged both public health specialists and women's health right advocates.

By the year 2000 the goal was far from being realized, hence, the global community reaffirmed its commitments and the UN issued the eight Millennium Development Goals out of which the fifth goal indicated a reduction of maternal mortality rate by 75% by the year 2015.

1.2 Objective of the study

1.2.1 General objective:

The overall objective of this research paper is to elucidate the relevance and the challenges of the human rights based approach to maternal health in Ethiopia.

By a rights-based approach to maternal health, we are referring to transforming existing policies and programs so that women's rights and wellbeing are placed at the center and that government policy conform to the principles of meaningful participation, empowerment, non-discrimination, monitoring, and accountability.[9] In relation with maternal health, human rights based approach is not only about an increase in number of deliveries in hospitals, but also the way women are treated by those working at hospitals during childbirth.[10] Also, it focuses on developing the capacities of both duty-bearers and right-holders in order to bridge the communication gap between them and create an open dialogue.[11]

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[8]United Nations ,Program of action of the International Conference on Population and Development (1994), para7.3

[9] International Initiative to Maternal Mortality and Human rights, Human rights based approach to maternal mortality reduction efforts(2010) available at http://www.right to maternal health.org /resource /mm_hr accessed on 20 April 2010

[10] Ibid

[11] Ibid

1.2.2. Specific objectives:

- To assess the existing policies and programs that are related to maternal health in the country and see those against the principles of the human rights based approach to maternal health.
- To explore the accessibility, affordability and quality of the existing maternal health care services in the country.
- To identify the major causes of maternal mortality in the country.
- To point out the existing interventions undertaken by stake holders to avert the problem of maternal mortality in the country.
- To signify the added value of the human rights based approach to maternal health and the existing interventions to reduce maternal mortality in Ethiopia.
- To show areas not effectively addressed by stake holders and recommend on what need to be done in such areas in the future.

1.2.3 Statement of the research problem

Maternal Mortality is one of the shocking failures of development and a dreadful social injustice. According to the most recent UN official figures, **536,000** women die every year during pregnancy and birth. This is one death every minute. Out of the **536,000** maternal deaths, 99% are experienced by women in developing countries. For every maternal death, an estimated 20 to 30 women suffer pregnancy-related injuries and disabilities. Additionally, inaccessible health services, inadequacy and absence of information and education on sexuality, and discrimination of gender, class and race, leave literally hundreds of millions of women unable to exercise control over their reproductive and sexual lives.[12]

The highest maternal mortality rates are in Africa; with a lifetime risk of 1 in 16.The extent of the problem is worse in countries found in Sub-Saharan Africa including Ethiopia. It accounts for 53 % of all maternal deaths in the world.[13]Being found in

[12]World Health Organization, United Nations Children Fund ,United Nations Population Fund and the World Bank, Maternal mortality in 2005 (2007) available at http://www.who.int/reprdructive health/publications/maternal _mortality_ 2005 /index/html accessed on 15 August 2010

[13]World Health Organization , United Nations Children's fund , United Nations Population fund and the World Bank ,Maternal mortality in 2005 (2007) available at http : // www.who.int/reprdructive health/publications/maternal _mortality_ 2005 /index/html accessed on 15 August 2010

Sub-Saharan Africa, the rate of maternal mortality remains at high level in Ethiopia. According to Demographic Health Survey (DHS) 2005, it is attributable to the death of 673, per 100,000 live births.[14] This number is higher than the number of deaths in adjacent countries and is indicative of the additional risk women living in Ethiopia face.[15]

Over 25,000 Ethiopian women and girls die each year due to pregnancy-related complications. Additionally, more than 500,000 women and girls will suffer from disabilities caused by complications during pregnancy and childbirth.[16]

Skilled care basically depends upon women's health status in the country. Women at the poorest situation have approximately 4 times less access to skilled care compared to those who are not poor. Delivery through emergency obstetric care during child birth is very low. It accounts for only 1% of the births delivered. Only 27.6% of mothers who had had a live birth in the five years before the 2005 survey had received any antenatal care from a health professional and only 5.7% were attended by a health professional during delivery. Regional differences in the source of maternal health care are also quite noteworthy. Nine in ten mothers in Addis Ababa receive antenatal care from a health professional, compared with less than one in ten mothers in the Somali Region.[17] Moreover, most of the health facilities are found in town and many women are not able to pay for transportation. These problems, together with the tradition of home delivery, contribute to birth without assistance, especially, in rural areas. This in turn causes maternal death. [18]

The majority of maternal deaths and related disabilities are preventable. In addition to the public health concerns that contribute to maternal death, maternal death is often the result of policy decisions that directly or indirectly discriminate against women. It also relates to lack of women's full enjoyment of all their human rights.

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[14] Central Statistical Agency (Ethiopia) and ORC macro, Ethiopia Demographic and health survey 2005 (2006)

[15] Ethiopia federal Ministry of women Affairs , United Nations Development fund for Women and Population council, To be counted is to be included: Women and men of Ethiopia in national statistics (2010), p 39

[16] US AID, Maternal health in Ethiopia available at http:// www.usaid gov/our work/global health/mch/mh/countries/Ethiopia/ accessed on 23 August,2010

[17] Central Statistical Agency (Ethiopia) and ORC macro, Ethiopia Demographic and health survey 2005 (2006), pp 112-113

[18] Ethiopia federal Ministry of women Affairs , United Nations Development fund for Women and Population council, cited at note 15 above,p5

Maternal death is also often an indicative of inequalities between men and women in their enjoyment of the right to the highest attainable standard of health. Women have a right to access a wide range of sexual and reproductive health services as part of preventing maternal mortality and morbidity. However, the right to maternal health has not always been linked to the human rights entitlements of those affected and the accountability of those responsible for change.

1.3. Research Question

This paper primarily sees the importance of a human rights approach or perspective to maternal health and it is searching to answer the following questions.

- What would be the practical implication of the human right based approach to maternal health in Ethiopia?
- What are the challenges of the human rights based approach to maternal health in Ethiopia?
- What is the added value of the human rights based approach to maternal health in Ethiopia?
- To what extent is the health sector, available, accessible (including non-discrimination, physical accessibility, economic accessibility or affordability, and information accessibility) and acceptable?

1.4 Methodology of the study

1.4.1 Research Approach:

The researcher used a qualitative approach in order to get the relevant information to the study.

1.4.2 Data collection tools:

Critical analysis of policy and program documents related to maternal health is the major research method employed in conducting this research. Also, to complement the information gained through critical analysis of relevant documents, primary methods were also employed to gather additional information on the area. Key informant interviewees are selected based on purposive sampling method from the Federal Ministry of Health, Federal Ministry of Women, and Youth and Children affairs, Federal Ministry of Finance and Economic Development and Central Statics

Agency. Accordingly, the researcher has made intensive and in-depth interview with 6 key informants. 2 interviewees from the federal Ministry of health ,2 interviewees from the Ministry of Finance and Economic Development, 1 interviewee from Ministry of Women, Youth and Children affairs and 1interviwee from Central Statics Agency. In addition to the key informant interview, the researcher employed a focused group discussion among women, in order to get in-depth information on the perception and ideas of the participants about the issue at hand. Through the FGD, participants can discuss on the issues among themselves and rich information can be gained with in short period of time and at relatively low cost. The researcher also used this method because focused group discussions are effective when combined with other methods such as key informant interviewees.[19]

The Focused group discussions (FGD) were undertaken with randomly selected women with in the reproductive age group who at least had one child before the conduct of this study. Two FGD's with 6 women in one FGD was undertaken in order to make the FGD's successful.

1.4.3 Scope of the study

The research focuses on the development polices of Ethiopia which have relevance to maternal health. These include, the Growth and Transformation Plan (GTP) (2010-2015), the Ethiopian Health Policy, Health Sector Development Programs (HSDP's), Ethiopia National Women's Policy, National Reproductive Health Strategy and National Women's Development Package**.**

The researcher elaborates and analyzes these policies and programs, and other relevant documents taking into account the principles of the human rights approach to maternal health.

On top of this, the researcher has considered the practical implications of the human rights based approach to maternal health through a focused group discussion with women residing at East Shewa Zone, Dembi Woreda**.** This selection is primed solely, by the number of high mortalities in this particular area, aggravated by various factors.

[19] Ranjit Kumad , Research methodology: A step by step guide for beginners(1996) pp 108 – 126

1.5 Significance of the study

The researcher believes that this study will contribute as source of data to policy designers, programmers and other interested parties who want to acquire information about the human right based approach to maternal health, its relevance and challenges. likewise, since maternal health is set as one of the primary areas for the intervention of the current Growth and Transformation Plan, the research findings could add up to those efforts that have already been started by the government. Besides, the research findings can also serve as bedrock for other researchers who want to work on this area.

1.6 Limitation of the study

Given the fact that not many literatures are available in Ethiopia which talk about the principles of the human rights based approach, the research may lack sources that could be relevant to examine the concept at national level. On top of this, the nonexistence of a national health account which is prepared every year has limited the researcher's discussion on certain important parts of the paper. Likewise, most of the materials that are relevant to the area of the research are only found on the web, and, as a result, the research may suffer from lack of citation of books relevant on the area.

1.7 Organization of the Thesis

This dissertation is organized into five chapters.

1. **Preliminary part-** This part of the paper includes the cover page, preface, acknowledgement and acronyms.

2. **Chapter one:** This part of the paper includes background of the problem, objective of the research, statement of the problem, research questions, methodology and scope, significance and limitation of the research.
3. **Chapter two:** deals with the relationship between health and human rights, indicators of the right to health and obligations of states towards the right to health.
4. **Chapter three** This chapter discusses the concept of the human right based approach to health and its relevance to maternal health.

5. **Chapter four**: this chapter presents the human rights based approach to maternal health in Ethiopia. It will look at the different policies, programs and the practice based on the principles of the human rights based approach to maternal health.
6. **Chapter five** is the final part of the paper where the conclusion and recommendations of the research are found.

CHAPTER TWO

2. Meaning, Scope and content of the right to health

2.1 The Meaning of the right to health

The term right to health best relates to what is enshrined under international human rights provisions that formulate health as a human right. One of the major human rights instruments that provide a definition of the right to health is the International Covenant on Economic Social and Cultural Rights. Article 12 of the covenant defines the right to health as '*the highest attainable standard of both mental and physical health*', which actually is not limited to health care services but also encompasses other social and economic factors that are essential to leading a healthy life.[1] Besides, the Preamble of WHO formulates the highest attainable standard of health as a fundamental right of every one. Furthermore, it describes health as a state of complete physical, mental and social well being: and not merely as the absence of disease or infirmity.[2]

The declaration of Almata also understands health rights as a means to a better life rather than simply an end in and of itself.[3] Moreover the former special rapporter on the right to health, Paul Hunt, also defined the right to health as a right to an effective and integrated health system, encompassing health care and the underlying determinants of health, which are open to national and local priorities.[4]

The documents produced during several UN world conferences, including the Vienna declaration, the Program of Action of the Cairo Conference and the Beijing Declaration and Program of Action have also discussed the meaning and scope of the right to health. Especially, as it relates to women's right to health the outcome of these two major conferences has paramount importance.[5]

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[1] International Covenant On Economic Social and Cultural Rights(Here in after ICESCR) art 12 GA Res 2200 (XXI) of 16 December 1966,entered into force 3 January 1976, UNTS NO14531
[2] World Health Organization ,W.H.O Constitution ,in basic document of the World Health Organization (45th ed,2006)
[3] World Health Organization, Declaration of Almata, (1978), Para I3.
[4] Paul Hunt , United Nations special Rapporter on the Rights of every one to the enjoyment of the highest attainable standard of physical and mental health, (2005) available at http://www.essex .ac.uk/human_rights _centres/research/..../presentations aspx accessed on 25 may 2010
[5] Brigit Toebes, "Towards an improved understanding of the international human right to health" Human Rights quarterly, Vol. 21 (1999), p 664.

2.2 The Scope of the right to health

The right to health has economic, social and cultural aspects. It has an economic and social dimension to the extent that it seeks to protect individuals from suffering social and economic injustices with respect to their health.[6] Moreover, the right to health may have a cultural context because it seeks to safeguard that the available health services are sufficiently adapted to ones cultural back ground.[7]

2.3 The contents of the right to health

The elements that make up the right to health are divided into two categories. One of such dimensions is related to health care, while the others fall under what are considered as underlying conditions for health.[8] Medical care in the event of sickness, is the central feature or the main component of the right to the highest attainable standard of health.[9] It has to do with the provision of services relevant to the realization of one's right to health.[10] Whereas underlying conditions to health include, safe drinking water, adequate sanitation, adequate nutrition, health related information, environmental health and occupational health.[11]

The right to health overlaps with many other rights considered as underlying determinants of health. Such rights relate both directly and indirectly to health. These include the right to food, housing and clothing.[12]

On top of what is mentioned above, the right to health also contains freedoms and entitlements. The Freedoms include the right to be free from torture, and other cruel inhuman and degrading treatments and the right to be free from discrimination.[13]

There are also entitlements to the right to health which are composed of the right to primary health care, provision of health related information and education; the right to prevention,

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[6] Brigit Toebes, "The right to health as human Right in International Law", in Asbjorn Eide, Catarina Krause and Allan Rosas (eds), Economic, Social and Cultural rights (2nd ed, 2001), p 170.
[7] Ibid
[8] id., p. 174.
[9] ICESCR as cited in Paul Hunt and Rajat Khosla, "The human right to medicine'' International Journal of human rights, Vol. 8 (2008), p 100.
[10] Paul Hunt and Rajat Khosla "The human right to medicine," International Journal of human rights, Vol. 8(2008), p 100.
[11] Judith Asher, The right to health: a resource manual for NGOs (2004), p 18
[12] ICESCR, art 11
[13] Asher, cited at note 11 above, p 18

treatment and control of disease and access to medicines; the right to participation of the population in health related decision making at the national and community level; and provision of equal opportunity for everyone to enjoy the highest attainable standard of health.[14]

This being so, however, the right to health should not be seen as the right to be healthy and free from any type of disease. States cannot be held responsible for all types of health calamites that an individual faces in his life. It is impossible to expect states to guarantee people protection from being caught by all types of diseases, considering being healthy is also associated to biological and socio economic factors.[15]

A state cannot guarantee or provide health directly. Instead, the right to health should be understood as a right to the enjoyment of a variety of facilities and conditions which the state is responsible for providing as being necessary for the attainment and maintenance of good health.[16]

2.4 Sources of human rights to health

2.4.1 The universal Declaration of Human Rights (UDHR)

The right to health is recognized under article 25 of the Universal Declaration of Human Rights.[17] It proclaims that:

"*Everyone has the right to a standard of living adequate for the health and wellbeing of himself and of his family including food ,clothing ,housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness ,disability, widowhood ,old age or other lack of livelihood in circumstances beyond his control.*"

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[14] Gunilla Back man *eta*l, Health systems and the right to health assessment of 194 countries, (2008) available at http: // www.the lancet.com accessed on 20 April 2010.
[15] Asher, cited at note 11 above, p 17.
[16] D. Jamar Steven "The International Human right to health '' Southern University Law Review, Vol. 22 (1995) p 27.
[17] The Universal Declaration of Human Rights ,(Here in after UDHR) art 25,UN GA Res.217(III),10 December 1948,UN Doc.N810 (1948),

2.4.2 The International Covenant on Economic, Social and Cultural Rights (ICESCR)

The most authoritative statement of the right to health is found in article 12(1) of the Covenant on Economic, Social and Cultural rights which sates:

> *"State parties to the present covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."*[18]

The wordings of this covenant indicates that the right to health encompasses not merely a right to some base, minimal, which in turn encompasses a number of physical conditions conducive to health, but a right to a higher standard which expects greater commitment.[19]

2.4.3 The International Covenant on Civil and political rights (ICCPR)

Though the right to health is not discussed in detail under the International Covenant on Civil and Political Rights (ICCPR) as portrayed under the ICESCR or the UDHR, the convention discusses various rights that have a closer relation to health. These rights include the rights to life, privacy, liberty and security. These rights help everyone attain health or enjoy the right to health.[20]

2.4.4 Other Conventions

In addition to what we call the prominent International Bill of Human rights, there are other human rights instruments which recognize the right to health.

- The Convention on the Elimination of All forms of Racial Discrimination **(CERD)**, under article 5 (e) (IV), discusses rights on which discrimination cannot be allowed.
- The Convention on the Elimination of All forms of Discrimination against Women **(CEDAW)** recognizes the right to protection of health and safety in working conditions, including the safeguarding of the function of reproduction. The same convention recognizes the right to health of women under article 12.[21] It explicitly refers to maternal and reproductive health rights as constitutive of the right to health.

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[18] International Covenant On Economic Social and Cultural Rights(Here in after ICESCR) art 12 GA Res 2200 (XXI) of 16 December 1966,entered into force 3 January 1976, UNTS NO14531

[19] Steven cited at note 16 above, p 24

[20]C .Kuszlek Patricia ''Global health and the human right imperative'' Asian Journal of the world Trade Organization and International Health law and policy, Vol. 2,(2008) p108

[21] Convention on the Elimination of All forms of Discrimination Against Women (Here in after CEDAW) art 12,adopted 18 December 1979, entered into force 3 September 1981 ,GA Res .34 /180 ,UN DOC .A/34/46(1979)

It also embraces family planning health care services as part of the broad understanding of what we call health care services.

- The Convention on the Rights of the Child (**CRC**) under articles 24 and 27 recognizes the right of the child to health. It states that children shall enjoy a standard of living adequate for their physical, mental, spiritual, moral and social development.

In addition to International human rights instrument, Regional human rights documents also have accorded recognition to the right to health.

- The African Charter on Human and People's Rights (**the Banjul Charter**) recognizes the right to health under article 16.

It provides

> "*Every individual shall have the right to enjoy the best attainable state of physical and mental health*"

It further puts general obligation on state parties to take the necessary measures to protect the health of their people and establishes a duty on states to ensure that people receive medical attention when they are sick.[22]

- This same right is recognized under article 11 of the European Social Charter which states:

> "*High contracting parties undertake to take appropriate measures designed to promote health through education and advice, to encourage individual responsibility in matters of health, to prevent as far as possible the cause of ill health.*"

- The Protocol of the American Convention on Human Rights in the area of Economic, Social and Cultural rights (protocol Salvador) specifically recognizes the right to health under article 10.

2.5 <u>Guiding principles to the right to health</u>

The evaluation of any health care system from the right to health perspective should include criteria which are commonly called standards or key principles. Such standards include availability, accessibility, acceptability and quality of health services.[23]

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[22] Steven, cited at note 16 above, p 32

2.5.1 Availability

This relates to the number and distribution of health services available for the population as a whole.[24] The full realization of the right to health requires that efficient health systems are in place.[25] However, the actual nature of the facilities, goods and services will vary depending on the State's economic level.[26]

Not only health care centres but also drugs, health care professionals and equipments relevant in the provision of medical services should be made available and those which are available should be distributed effectively taking into account those areas which are in need.[27] By the same token the standard of availability of health services should take in to account the number of health care professionals in the country and ways need to be designed to encourage health personnel to stay and practice in the country.[28]

Availability also means the availability of health sector programs which are believed to contribute to the realization of the right. Furthermore, availability encompasses obtaining what we mentioned above as fundamental conditions to health such as safe drinking water, sanitation facilities and others.[29]

2.5.2 Accessibility

A health system must be accessible to all and by all we are referring to all sections of the society, not just the wealthy, but also those living in poverty, not just the majority ethnic groups, but minorities and indigenous peoples' as well. Not just those living in the urban areas, but also the remote villagers. The health system has to be accessible to all disadvantaged individuals and communities including women, children, the disabled and all the rest belonging to such groups.[30]

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[23] Asher, cited at note 11above, p 17.
[24] Toebes, cited at note 5above, p 177..
[25] Marry Robinson, ''Women's right to health: A conversation'' Emory International law review, Vol. 2, (2008), p 31.
[26] Sisay Alemahu, Justiciability of the right to housing and the right to health in Ethiopia: the Legal and policy framework, (Unpublished, Action Professionals Association for the People, April 2006) p 15.
[27] Ibid.
[28] Toebes, cited at note 5above p 667.
[29] Sisay Alemahu cited at note 26 above, p 15.
[30] Paul Hunt , cited at note 14 above

It needs to be emphasized here that by accessibility of health services we are not only referring to that of the physical (geographical) accessibility of health services**.** Accessibility also relates to the accessibility of information, the financial accessibility of health services and non discrimination in the access to health care.[31]

2.5.2.1 Non-discrimination:

Non discrimination is an important obligation if the state is to make health accessible to all. The state should give due attention to those groups of the society who are marginalized, and laws to such effect should exist and should be enforced to the benefit of those groups of the society.[32]

2.5.2.2 Financial Accessibility (Affordability)

Heath disparities occur when limited health resources are typically spent in urban areas by providing health centres to serve the relatively privileged and more voiced part of the population, while the rural poor and slum dweller is more likely to seek health care from expensive private providers.[33]

This standard requires that there be an arrangement or payment of health services for those who are economically under privileged and cannot afford the required care. This aspect of accessibility of health services should be seen as a means to bring about equity in health care.[34]The state's obligation in relation to making health care affordable also extends to monitoring the acts of the private sector so that privatization would not make health care services unaffordable. Basically, this could be seen when the private sector impose a higher user fee which would be unfair to the poor.[35]

2.5.2.3 Information accessibility

This has to do with the accessibility of what we call health information. It includes both getting information and disseminating it. States should design a strategy to reach individuals with such information. This would contribute a lot in raising the awareness and

[31]UN Committee on Economic Social and Cultural rights (CESCR), General Comment 14,The right to the highest attainable standard of health E/C 12/2000/4 Para 12.
[32]id., Para 18.
[33] World Health Organization, Health and the millennium development goals (2005), p 38.
[34] Toebes cited at note 6 above, p 178.
[35] Toebes cited at note 5 above, p 667.

empowerment of individuals to make a well informed decision in relation to basic health issues, such as reproductive health.[36]

2.5.2.4 Geographical accessibility

This standard sets the requirement that health services be within the reach of everyone. Basically there should not be an imbalance between individuals living in rural and urban areas in their right to access health care services. Priority should be set for people residing in rural areas to access health services without facing challenges in relation to infrastructure such as transportation system.[37]

Not only medical care, but also those fundamental determinants of health such as potable water, sanitation facilities and others should be physically accessible. Moreover, accessibility should also take into account the special needs of certain sections of the society, including the elderly and the disabled.[38]

2.5.3 Acceptability

Acceptability of health services relates to the adherence of all health facilities, goods and services, to medical ethics, culture and gender. In other words, they should be medically as well as culturally acceptable.[39]This obligation extends to the obligation to respect the cultural identity of various indigenous groups including but not limited to their use of traditional medicines which actually do not harm individual's health.[40]

2.5.4 Good quality

All services, goods and facilities must scientifically and medically be appropriate and of good quality. The quality of health services is essential as it monitors how effective the treatment of individuals at a health facility is. It evaluates whether there were skilled health professionals or not at a health facility, whether or not there were scientifically approved and unexpired drugs, hospital equipments, adequate sanitation and safe drinking water.[41]

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[36] CESCR, cited at note 31 above, Para 12/b.
[37] Toebes, cited at note 5 above, p 178.
[38] Toebes, cited at note 5 above, p 677
[39] Asher, cited at note 11above, p 39.
[40] CESCR, cited at note 31 above, Para 34.
[41] Sisay Alemahu, cited at note 11above, p 16.

2.6 The Tripartite Typology of states obligations towards the right to health

All human rights imply three different types of states' obligation which are referred to as the tripartite typology of states' obligations. These are the obligation to respect, the obligation to protect and the obligation to fulfil human rights.

2.6.1 The obligation to respect the right to health

The obligation to respect is an immediate obligation by nature. It requires States and all their organs and agents to refrain from carrying out, sponsoring or tolerating any practice, policy or legal measure violating the right of individuals or intruding on their freedom to access resources to satisfy their needs.[42]

The obligation to respect is also considered as a negative obligation since it imposes a duty on states to refrain from doing negative acts.[43] It includes the obligation to respect equal access for all to the existing available health services and not to impede individuals or groups from their access to the available services. Every member of the society should be able to access health services.[44]

This obligation also extends to the duty to abstain from implementing health policies which are somehow discriminatory and intentionally concealing health information relevant for one's health.[45]

2.6.2 The obligation to protect the right to health

Protecting the right to health applies mainly to obligations of governments to make efforts to minimize risks to health and to take all necessary measures to safeguard the population from infringements of the right by third parties.[46] These third parties include private industry, pharmaceutical companies, researchers and health care providers.[47]

This obligation further imposes on States a duty to guarantee access to legal remedies where the right to health is isolated. This obligation widens states' obligation from what was already understood as the usual duty of states not to interfere in the exercise of the right to health, to a

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[42] Toad Land man , Indicators for a Human rights based Approach to Health ,(2007) available at http://www.undp.org/oslocentre/docus06/HRBA%20**indicators**%20guide.pdf –*accessed on 12 march ,2010*
[43] Toebes, cited at note 5above, p 677.
[44] Toebes, cited at note 6above, p 180
[45] CESCR, cited at note 31 above Para 50.
[46] Asher, cited at note 11above, p 35.
[47] Patricia, cited at note 20above, p, 111.

more affirmative approach of protecting individual's right to health from third party intervention.[48]Such measures include the duty to pass and enforce laws forbidding companies from sending out health impairing pollution.[49] Here, it should be stressed that the duty of the state is more or less to make sure that the right to health is enjoyed without any infringement by third parties. Most importantly when the health sector is privatized or where health care is provided by third parties. Third parties should make health services including the underlying determinants of health, accessible, available, and acceptable and of good quality. The state should make sure that such standards have not been violated by the third parties.[50]

Moreover, the state should also make sure that health care professionals do not infringe the right to health and that they are undertaking their duty in due diligence. Besides, the fulfilment of this obligation requires that measures be taken to eradicate cultural practices which violate the right to health of individuals.[51]

2.6.3 The obligation to fulfil the right to health

This obligation applies to positive measures that governments are required to take. Such measures should enable the enjoyment of the right to health by all individuals. The obligation to fulfil include; the adoption of a national health policy; the devotion of a sufficient percentage of the available budget to health; the obligation to spread information on health, the obligation to provide the necessary health services or create conditions under which individuals have adequate and sufficient access to health services, including in particular, health care services as well as clean drinking water and adequate sanitation. All such measures by the state should result in positive outcome to the overall health status of individuals. Such positive measures also include steps taken by the state to make health care culturally appropriate. It involves issues of advocacy, public expenditure, and governmental regulation of the economy, the provision of basic services and related infrastructure, and redistributive measures which are necessary for the full enjoyment of the right to health .This obligation is considered to be the most onerous obligation of the three obligations under the ICESCR.[52]

[48] Land man, cited at note 42above.
[49] Maria Green,''What We Talked about When we talk About Indicators: Current Approaches to Human rights Measurement'' Human rights Quarterly, Vol. 23 (2001), p 1071.
[50]CESCR, cited at note 31above Para 35.
[51]Ibid.
[52] Land man, cited at note 42 above.

Under this obligation, States should try to remedy existing health disparity. In doing so, the state should give priority to some regions which need an immediate intervention on the area. Additionally, such priority should also consider those groups of the society who would be affected because of the existence of health inequalities. These groups include women, children and the poor. Women are more vulnerable due to the fact that there are a number of physical and cultural barriers to women's health care. In addition to the gender related stereotypes, due to their child bearing roles, they are subjected to sexual and reproductive health disadvantages, including but not limited to, mortality and morbidity.[53] The obligation to fulfil further requires states to acknowledge the right to health in the national, political and legal system, and further establishes mechanisms for its implementation.[54]

This obligation can be further divided into three categories: the obligation to facilitate, provide, and promote.

2.6.3.1 The obligation to facilitate

States are expected to take encouraging measures that enable and assist individuals and communities to enjoy the right to health. These measures in effect empower individuals to claim their right to health at national and local level.[55] An example of this type of obligation includes adopting national health policies and programs.[56]

2.6.3.2 The obligation to provide

In circumstances where individuals can not satisfy their right to health by any means it would be the obligation of the state to provide such needs to these individuals under the obligation to provide.[57]

2.6.3.3 The obligation to promote

This obligation of the state basically relates to information availability which has relevance to the fulfilment of the right to health. This is essential for individuals to make informed decision. Besides, it is a good asset if individuals are to lead a healthy life style.[58]

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[53] Asher, cited at note 11above, p 36.
[54] Sisay Alemahu, cited at note 26 above p 17.
[55] Alessandra Lundstom Sarelin, "Human rights Based Approaches to Development Cooperation, HIV AIDS and Food Security", Human Rights Quarterly Vol. 29 (2007) p 470.
[56] J. Michel David and P. David Stewart, "Justiciability of Economic Social and Cultural Rights" American Journal of International law. Vol. 98 (2004), p 479.
[57] Sarelin, cited at note 55 above, p 470.

In addition to the aforementioned obligations under the ICESCR, the Maastricht guideline on the implementation of Economic Social and Cultural Rights further discusses two types obligations to the rights provided under the Convention on Economic Social and Cultural rights. These are, obligation of conduct, and obligation of result.[59] Such obligations are considered concurrently with the obligations to respect, protect and fulfil which are discussed above.[60]

By Obligations of conduct we are referring to activities reasonably intended to realize the enjoyment of a particular right. In relation with the right to health, one good instance could be the adoption and implementation of strategies to reduce maternal mortality.

The Obligation of result requires states to achieve definite goals to satisfy a detailed substantive benchmark. In light of the right to health, it means the reduction of maternal mortality to a level agreed in the different UN conferences and also at the millennium summit in 2000.

2.7.Types of government obligation towards the right to health

2.7.1 Universal immediate obligations

Universal immediate obligations are those obligations which states must meet immediately without any consideration of time requirement. Furthermore, such obligations should be fulfilled with no due regard to the availability of resources or the fact that such resources are limited in the country concerned.[61]

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[58]Ibid

[59] Dankwa *etal* " Commentary to the Maastricht Guide line on Violations of Economic Social and Cultural Rights " Human Rights Quarterly , Vol. 20,(1998)Para 7 (On the 10th anniversary of the Limburg principles on the implementation of the International covenant on Economic Social and Cultural Rights, a group of more than thirty experts met in Maastricht from 22- 26 Jan 1997 at the invitation of the international commission of jurists, the urban Morgan institute for human rights and the centre for human rights of the faculty of law of Maastricht university. The objective of this meeting was to elaborate on Limburg principles as regards the nature and scope of violations of Economic, Social and Cultural rights and appropriate responses and remedies. The participants agreed on these guidelines which they regarded as the guidelines to reflect on the nature of international law starting from 1986.These guidelines are to be used by all who are concerned with the nature and understanding of violations of Economic, Social and Cultural rights and in providing remedy there to

[60] Scott Leckie, ''Another Step towards Indivisibility: Identifying the key features of Violations of Economic Social and Cultural rights'', Human Rights Quarterly Vol. 20 (1998), p 92.

[61] Asher, cited at note 11above, p 34.

In discussing universal immediate obligations, Mathew Craven in his article "the International Covenant on Economic, Social and Cultural Rights" states that each of the rights recognized under the ICESCR has a feature which does not require the existence of resources and which impose a duty to implement immediately on states.[62] For instance, the obligation of states to eliminate discrimination enshrined under article 2/2 of ICESCR is a universal immediate obligation, as it relates to all of the rights contained under the convention including the right to health.[63] Additionally, this obligation extends to taking steps which are deliberate, concrete and targeted towards the realization of the right to health.[64]

2.7.2 Progressive obligations

These obligations which are recognized under article 2 of the ICESCR are obligations that can only be achieved using resources as well as longer period of time. This means the satisfaction of progressive obligations can be affected by existing resources and time constraints.[65]

Patricia, discussing on this type of obligation in her article On "Global Health and the Human right imperative" stated that the inclusion of progressive obligations under General Comment 14 of the Committee on Economic, Social and Cultural Rights is to guide states as they make the legislative, policy and administrative changes necessary to realize the right to health.[66] However, not all types of states' obligations can be considered as progressive. For instance, the obligation to respect the right to health requires the state to only refrain from interfering in the right of individuals to enjoy the right. It only relates to negative obligations which are not as such resource dependent. On the other hand, obligations such as, to protect and fulfil the right to health, require positive measures by states which in effect need the allocation of resources and also the availability of longer time for the realization of such obligations.[67]

To further elaborate this point, we can take a look at the Limburg principles on the implementation of the ICESCR which clearly state that the obligation to achieve

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[62]Mathew Craven, The Covenant on Economic Social and Cultural Rights, (Unpublsihed, Abu Academy University, Turku, Finland, 2002) p 108.
[63]Ibid.
[64] Sarelin, cited at note 55 above 469
[65] CESCR, cited at note 31above, Para 9.
[66] Patricia cited at note 20 above, p 112
[67] Asher, cited at note 11 above 34

progressively the full realization of the rights under ICESCR require state parties to move as expeditiously as possible towards the realization of the rights. It affirms that all state parties have the obligation to begin immediately to take steps to fulfil their obligations under the covenant. Accordingly, the recognition of progressive realization does not give states any chance to put back their obligation to realize the right to health fully.[68]

Similarly, the Maastricht guideline further establishes that the burden of proof lies with each state party to the ICESCR to demonstrate that it is making measurable progress towards the full realization of the rights in question.[69] Progressive realization indicates the states continuing obligation to complete realization of the right to health.[70] This obligation further prohibits what is called retrogression. This occurs when States revert from taking steps towards realization of the right.[71]Retrogressive measures are irreconcilable with obligations set towards the realization of the right to health under the ICESCR, and if they are introduced, it should be after seeking for other alternatives. They can only be justified in consideration of the whole rights under the covenant and upon state's utilization of the maximum existing resources.[72]

2.7.3 Core minimum obligation

General comment number 3 of the Committee on ICESCR discusses the obligation of states to satisfy a core minimum level of each right. Here, it should be stressed that these obligations need to be given priority in every effort of states to realize the rights contained under the Convention on Economic, Social and Cultural Rights, including the right to health.[73]

In discussing the minimum core obligations, Young in his article "the minimum core of ESCR" stated that this obligation is about establishing certain core content for the

[68] _ "Limburg principles on the implementation of Economic Social and Cultural Rights "., **Human rights Quarterly** Vol. 9 (1987), (A group of 29 experts in international law convened by the international commission of jurists ,the faculty of law of the university of Limburg (Maastricht, the Netherlands) and the urban Morgan institute for human rights ,University of Cincinnati(Ohio, United states of America) met in Maastricht on 2-6 June 1986 to consider the nature and scope of the obligations of states parties to the international covenant on Economic Social and Cultural rights .The participants agreed unanimously on the Limburg principles which they believe reflect the present state of international law .

[69] Dankwa *etal* ,Super note 59 Para 8

[70] CESCR cited at note 31above,Para 31

[71] id. ,Para 32

[72] Jeff King, An activist manual on the Covenant on Economic Social and Cultural right (2003), p 97

[73] CESCR cited at note 31 above, Para 10.

implementation of Economic, Social and Cultural rights. It tries to recognize the minimum levels essential to the rights contained under the ICESCR, including the right to health. According to him, the minimum core is a minimalist strategy to the satisfaction of the maximum content of the rights contained under the ICESCR, including the right to health.[74] The basic characteristics of core minimum obligations are that they are non- derogable. They are supposed to be satisfied by states even in the existence of emergency situations.[75]

The minimum core obligation include, an obligation to satisfy a minimum threshold of each of the rights under the ICESCR, without whose absence it is hard to think of the existence of the rights as such. These minimum cores are what basically make up the rights under the covenant. Hence, it is an obligation to the satisfaction of those basics that encompass the essence of the right.[76]

The obligation towards the realization of core minimum levels of rights is all about which obligations should come first and which should follow. It does not, however, imply that the satisfaction of such core obligations suffices. States up on the fulfilment of their core minimum obligations should continue with the other elements of the right in question, including the right to health.[77]

With respect to the right to health, the ICESCR Committee has underlined the following core minimum obligations:

- The right of access to health services on non discriminatory basis, especially to vulnerable or marginalized groups.
- Access to nutritionally adequate minimum essential food.
- Access to shelter, housing and sanitation, and an adequate supply of safe drinking water.
- The provision of essential drugs.
- Equitable distribution of all health facilities, goods and services.[78]

[74] Katharine Young, "The minimum core of Economic and Social rights: a concept in search of content". , The Yale Journal of International Law Vol. 33(2008) p 113.
[75] King, cited at note 72 above, p 99.
[76] Katharine Young "The minimum core of Economic and Social rights: a concept in search of content", The Yale Journal of International Law Vol. 33, (2008), p 113.
[77] Toebes, cited at note 6 above, p 176.
[78] CESCR, cited at note 31above Para 43.

CHAPTER THREE

3. The human rights based approach to health

The human rights based approach to health is about realizing the right to health by explicitly recognizing the highest attainable standard of health as a human right.[1]Accordingly, becoming healthy and remaining so is regarded not merely as a medical, technical or economic problem, but as a question of social justice and of concrete government obligations where governments and other duty bearers will be held liable in the violation of this right.[2]

This approach requires attention both to outcome and process.[3] Both human right standards and principles are used to enhance the capacity of duty bearers to meet their responsibility and empower rights holders to effectively claim their health right.[4] Under the HRBA human rights standards are used to define bench marks for desirable outcomes while that of human rights principles represent conditions for the process and specify the criteria for an acceptable process to achieve an outcome.[5]Additionally, the human rights based approach to health is not merely about chasing and penalizing human rights violators. Rather, it is about taking human rights as a conceptual framework to evaluate what is done in health sectors and how that is done and design the same in a way that characterize such conceptual framework.[6]

Generally speaking the Human rights based approach has the following added value to maternal health.

- The human rights based approach is grounded on human rights including women rights which are enshrined in internationally accepted legal documents that have acquired global legitimacy. [7]

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[1] World Health Organization &the United Nations Office of the High Commissioner for Human rights,(Here in after WHO & UNHCHR) a human rights based approach to health available at http://www.who.int/hhr/news/hrba to health accessed on sep 22,2010

[2] Judith Asher, The right to health: a resource manual for NGOs (2004), p 21.

[3] Kirstan Hawkins *etal*, Developing a Human Rights-Based Approach to Addressing Maternal Mortality (2005) available at http:// www dfid.gov.uk/pubs/maternal –desk pdf accessed on 16 April 2010.

[4] WHO & UNHCHR, cited at note 1 above p 1

[5] Paul Greedy & Jonathan Ensor, Reinventing development translating rights based approach from theory to practice, (2005) p 49.

[6] Lynn freed man, "using human rights in maternal mortality programs from analysis to strategy, " International Journal of Genecology and Obstetrics ,Vol.75 (2001) p 53.

[7] Lynn Freed man , "Averting maternal death and disability , Human rights , Constructive accountability and Maternal mortality in the Dominican republic,'' International Journal of Genecology and obstetrics , Vol. 82 (2003) p .111

- The human rights based approach considers maternal mortality as a denial of women's human right and also as an issue of injustice by identifying maternal death as a systematic discrimination against women .[8]
- The human rights based approach prioritizes women's health by breaking the existing statuesque which only powerful people ,rich people and men have kept for longer time.[9]
- The human rights approach recognizes that women have human rights in and of themselves and do not accept that women have rights because of their socially determined roles.[10]
- The human rights approach not only denounces the injustice of maternal mortality, but can also be used as a cross reference to the design and implementation of programs to reduce maternal mortality.[11]

The human rights approach however is not a *one size fits all approach* .This is due to the fact that human rights issues in one setting may or may not be a priority concern in other places or settings. Similarly, while certain health programs and policies may fit in one place they may or may not fit in another place. However, central to the human rights based approach is the application of the principles of the human rights based approach including non discrimination and equality, participation, accountability and empowerment in all settings and in all programs and policies that relate to health.[12]

3.1 Key principles of the human rights based approach to health.

3.1.1. Equality and Non discrimination

Of all the human rights the violations, of the right to health clearly portrays the existing disparities among various races, gender, economic and social status .

[8] United Nations, Report of the Special Rapporter on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health(here in after UN report) U.N. General Assembly, 61st Sess., 14, U.N. Doc A/61/338 (2006).
[9]Lynn Freed man etal ,Back ground paper of the task force on child health and maternal health (2003) accessed from :http // www.Unmillennium project .org/documents /tf04pdf accessed on 20 April 2010
[10] P. Deborah and Yamin Alicia , " Maternal mortality as a human rights issue: Measuring compliance with International Treaty Obligations "Human rights quarterly Vol. 21 (1999), p 564
[11] Freed man, cited at note 6 above p. 52
[12]Asher, cited at note 2above p 21.

This is because the non fulfilment of health rights can be easily seen on the body and this greatly aggravates the gender, class and status differences that already characterize it.[13]

Article 2.2 and article 3 of the Covenant on Economic Social and Cultural rights list illustrative grounds of discrimination such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation civil, political, social or other status.[14] Moreover general Comment 14 of CESCR underlines that there is no permissible explanation for not protecting vulnerable members of society including women from health-related discrimination. The committee states that both clear and implied forms of discriminations are prohibited under the convention. As part of their minimum core obligation under the right to health states are obliged to ensure non discrimination even in the existence of resource constraints. The same comment further caution that the inappropriate allocation of health resources can result in discrimination.[15]

Consequently, states are required to address discrimination in laws, policies and practices such as in the distribution and provision of resources and health services. States can do so through legislations that uphold non discrimination and through a functioning national health information system with an available disaggregated data. These measures are important for the purpose of identifying whether exclusion and discrimination based on the above mentioned grounds exist or not.[16]

3.1.2 Participation

Since at least the Alma Ata Declaration on Primary Health Care in 1978, it has been a well recognized principle that '*the people have the right and duty to participate individually and together with others in the planning and implementation of their health care*'.[17]

The right to participation is recognized under various human right instruments .One among those human rights instruments, the International Covenant on Civil and Political rights article 25 / states:

[13] Rosa Petches &Pollack Lind, Global prescription : Gendering health and human rights, p.116

[14] UN Committee on Economic Social and Cultural rights (here in after CESCR) General comment 14 , the right to the highest attainable standard of health ,E/C 12/2000/4 Para 18.

[15] id., Para 19.

[16] WHO & UNHCHR, cited at note 1 above p 1

[17] World Health Organization, Declaration of Almata, (1978) Para 4

> Every citizen shall have the right and the opportunity, without … discrimination and without unreasonable restriction to take part in the conduct of public affairs, directly or through freely chosen representatives.[18]

Under the human rights based approach to health the principle of participation is applied in the various processes that are essential to the development of an effective health sector programs. This includes in setting priorities, in designing health related programs and policies, in implementing such programs and policies, in evaluating health programs and policies and in the allocation of budget essential to the health sector .[19]

Participation also relates to the empowerment of people enabling them to be part of the decision making processes to claim and realize their rights. It also means the right to access information relevant in a decision making process that directly affects their lives including, that which relates to their health.[20]Such information needs to be available on time to the people. It should also be in an accessible language so that it can easily be understood by the people and in an accessible format to the poor and to those who are residing in the rural areas.

The principle of participation also seeks the exercise of other rights such as freedom of association, freedom to speak without intimidation (freedom of expression) and freedom of assembly. These rights can facilitate an individual's participation by creating an enabling environment for the same.[21]

3.1.3 Empowerment

Empowering individuals is essential for it will help them to be able to claim their rights and hold their respective governments accountable.[22]Empowered individuals are more likely to be able to demand and bring about social, political and economic changes .As to issues relating to health, empowered individuals will be able to claim their health rights through an open dialogue with their government. One among various ways of empowering individuals is through education. Education helps individuals realize their right and the duties of others. It

[18] International Covenant on Civil and Political Rights ,GA Res.2200A(XXI),art 25,adopted 16 December 1966,entered in to force 23 march 1976 ,United Nations Treaty Series (UNTS)NO .14668,
[19] Asher, cited at note 2 above, p 20
[20] United Nations Children's Fund(Here in after UNICEF), A Human rights based approach to programming for maternal mortality reduction in a south Asian context,(2003) available at http://www.Unicef.org/rosa/Human Rights.PDF accessed on 20 April 2010
[21] Gunilla Back man *eta*l, Health systems and the right to health assessment of 194 countries, (2008) available at http: // www.the lancet.com accessed on 20 April 2010.
[22] UNICEF, cited at note 20 above

also helps to identify existing gaps in information and find ways on how this gap can be filled.[23]

Educated and empowered individuals can have the capacity to make their voice heard and have a stronger role in how health services are delivered. Because of empowerment individuals can further be able to interact with duty bearers on an equal footing.[24]

Individuals who are able to participate and access information will be empowered, as participation has an essential instrumental value for empowerment through using local knowledge, exposing local choices and maximizing ownership and sustainability.[25]

3.1.4 Accountability

Accountability is considered to be the main justification for the human rights based approach.[26] The international human rights system requires the principle of accountability for without accountability obligations, promises, pledges and other commitments cannot be enforced and would become mere statements with no legal force.[27]Accountability arises as soon as states willingly ratify human rights instruments. Such ratification implies that states have given their consent to implement human rights instruments and to be held accountable when they fail to do so.[28]

This being so, however, accountability should not always be related to blaming and shaming. It should be considered as a process where in, successful endeavours are kept and those which are not successful are avoided for the better realization of human rights including health rights. For this to be true all health systems need an independent accountability mechanism.[29]This independent accountability mechanism in turn requires monitoring and evaluation both by government and by those affected. Over and above, this accountability also presupposes the existence of programs which enable individuals hold duty bearers accountable. It further requires active participation in designing, implementing and evaluating

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[23] Hawkins *etal* ,cited at note 3 above

[24]UNICEF, cited at note 20 above

[25] United Nations High Commissioner for Human rights(here in after UNHCHR), Claiming the Millennium Development Goals: a human rights based approach (2008) available at http:// www.ohchr .org /documents /publications /claiming _mdgs_en.pdf accessed on august 22 2010

[26] Ibid

[27] UN report, cited at note 8 above

[28] Tobin John, '' Beyond the supermarket shelf: Using a rights based approach to address children's health needs'', International Journal of children's rights, Vol. 14 (2006), p 283.

[29] Freed man, cited at note 7 above P 111.

health sector programs and policies. This would definitely entail an obligation on the part of the government to allocate a certain amount of budget to these types of programs.[30]

3.2 Human rights relevant for ensuring maternal health

3.2.1 The right to life

In the words of Rebecca j. Cook *'a women's right to life is the most obvious right violated by avoidable death in pregnancy or birth.* [31]

The right to life is recognized under various international human rights instruments and various international consensus documents. This recognition is essential to hold governments accountable for the number of women's lives lost while giving birth.[32] Usually the right to life is used to refer only to 'the right to due process of law before someone is subjected to capital punishment'. This understanding of the right only promotes the interest of men as execution is a pressing issue for men than death from pregnancy.[33] Death from pregnancy however, is a pressing issue for women.[34]

Hence, the right to life should be understood broadly as it constitutes protection from arbitrary and preventable loss of life. This kind of interpretation was used by the human right council which has the mandate to interpret the ICCPR. Accordingly, the application of the right to life should not only be limited to criminal proceedings as explained above, but the protection should be extended to the protection of the right in the context of health care services.[35] In this regard, article 6 of the ICCPR elaborates obligations towards the right to life to comprise the adoption of positive measures to insure the right, including taking relevant steps to prevent unnecessary maternal death.[36]

The HRC in discussing what positive measures should be undertaken states that:

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[30]Back man etal , cited a at note 21 above

[31] Rebecca J Cook, ''International protection of women's reproductive rights'', New York University Journal of International law and politics ,Vol .24 (1992) p 18

[32] Rebecca J Cook , '' Reproductive health law where next , after Cairo and Beijing '' Medicine and law ,Vol. 16 (1997) p 2

[33] Cook, cited at note 31 *above* p 18

[34] Dina Bogecho, '' putting it to good use :the International Covenant on Civil and Political Rights and women's right to reproductive health, '' Southern California review of law and women's studies ,Vol.13 (2003-2004) p 244.

[35] Ibid

[36] Luisa Cabal and Morgan Stoffregen, '' Calling a spade a spade: maternal mortality as a human rights Violation '' Human rights brief, Vol .16 (2009), p 2.

"So as to guarantee the right to life, the state party should strengthen its efforts in that regard in particular in insuring the accessibility of health services including emergency obstetric care. The state party should insure that health workers receive adequate training. It should help women avoid unwanted pregnancies including by strengthen its family planning and sex education programmes and ensure that they are not forced to undergo clandestine abortions which endanger their lives" .[37]

In addition to what is mentioned above by the human right council, positive measures include progressive steps taken to ensure that an increasing rate of births are assisted by skilled attendants.[38]

3.2.2 The right to liberty and security of the person

The right to liberty and security of the person are essential guarantees to an individual's integrity and also to the right of maternity. In its historical context, this right is related to the prevention of arbitrary arrest or detention. However, currently it also covers the duty of governments to insure health services whenever the existing health care services are against the liberty and health security of women.[39]

The right to liberty and security are discussed under article 9 and article-7of the ICCPR. Additionally, these rights are also recognized under international consensus documents .The Beijing platform of action recognizes women's right to liberty by agreeing to consider reviewing of laws containing punitive measures against women who have undergone illegal abortions as these types of laws violate the right to liberty of women. In addition to this criminalization of contraception, voluntary sterilization and abortion also constitute a violation of these rights.[40]

The right to security is mainly about the right to safety. Security and safety are relevant components of women's health .Insecurity in the context of women's health can occur when

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[37] Concluding observation of the human rights committee : Mali 77th sess p 14 UN D.O.C ICCPR /CO/ 77/MLI(2003) as cited at Luisa Cabal and Morgan Stoffregen, '' Calling a spade a spade : maternal mortality as a human rights violation,'' Human rights brief, Vol .16 (2009), p 2.

[38] Cook etal., Advancing safe motherhood through human rights(2001) available at http//www.who.int/reproductive health /publications /maternal prenatal health /RHR 01 5/en/index .html accessed on 16 Oct , 2010

[39] id., p 38

[40] United Nations, Report of the fourth world conference on women(1995)UN Doc .A/conf 177/20 (here in after Beijing plat form) Para 106 k

women are treated as lesser beings and when the realization of their right to health and wellbeing is not given a high priority.[41] The right to liberty on the other hand has a strong linkage with the right to information, freedom of association and thought.[42] These rights are however, violated when a state denies women access to means of fertility control, the absence of which consequently results in untended pregnancies, which in turn has an adverse effect in increasing maternal mortality.[43]

3.2.3 The right to marry and found a family

The right to family is not a limited right which only applies to women during pregnancy and child birth .This right should also extend to the right of women to enjoy the highest standard of health throughout their life span.[44]

In this regard, article 16 /1/e of the women convention (CEDAW) requires states to ensure that women enjoy rights to decide freely and responsibly on the number and spacing of their children and to have access to the information; education and means to enable them to exercise these rights. [45]

The right to family also includes the right of children to survive birth and this presupposes the survival of mothers which is significantly based upon the type and quality of maternal health care a woman is provided with .The non fulfilment of such right, hence, means the violation of the right to family.[46]

It should be stressed here, that maternal death is not only a problem to women but also to their children as it has an adverse impact on children left behind who need their mothers, especially during their early age.[47]

Additionally, the right to found a family must include obligations of states to ensure that girls are matured enough for marriage and childbearing by prohibiting what we call early marriage through laws and by taking relevant measures when these laws are violated. After marriage, states have an obligation to ensure that women are provided with the relevant health care to

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[41] Rebecca J Cook ,Women's health and human rights (1994) p 29
[42] Ibid
[43] Cook, cited at note 31 above p 20
[44] id., p. 22.
[45] Convention on the Elimination of all forms of Discrimination Against Women(Here in after CEDAW) art 16/1/e, Dec 18 1979 ,1249 U.N.T.S.13
[46] Cook, cited at note 31 above p 53
[47] Anna Horsbrugh Porter ,Created equal: voices on women's right (2009) p 93

survive pregnancy and delivery. In the event of complications and durining child birth, states have a duty to make certain that women are able to get the proper treatment so that they can enjoy their right to family life.[48]

3.2 4. The right to the highest attainable standard of health

Generally speaking, effective and equitable health systems are essential requirements for the achievement of the millennium development goals including, that which relates to maternal mortality[49]

The right to health has a lot to offer to efforts towards reducing maternal mortality .This understanding has been discussed by many authorities including the committee on Economic Social and Cultural rights, the previous special rapporter on the right to health and also by the UN Human Rights commission.

In the words of Paul Hunt, the highest attainable standard of health entitles women to services in connection with pregnancy and the post natal period and to other services and information on sexual and reproductive health. Furthermore, it entitles them to an effective and integrated health system which is essential to measures taken in averting maternal death. For him, polices that are informed by the right to health are likely to be more equitable, sustainable and effective.[50] By the same token in 2004, the UN Human Rights Commission stated that sexual and reproductive health are integral elements of the right of every one to the enjoyment of the highest attainable standard of physical and mental health.[51] The ICESCR committee has also positioned preventable maternal death as a violation of the right to health which extends to the availability, affordability, accessibility and good quality of reproductive health care services. It further states, that governments have an obligation to prioritize measures promoting maternal health, among others when allocating limited resources.[52]The right to health is violated when governments fail to provide the essential health care services to women, including to those women who cannot get such services by themselves either due to their poverty or due to lack of knowledge or because they live very far from places where health care services are found. Such barriers to health care services essential to women are a violation of women's human right to health enshrined under different international human

[48]Cook etal., cited at note 38 above
[49] World Health Organization, Health and the millennium development goals, (2005) p 33 .
[50]UNReport, cited at note 8 above
[51] Cabal and Stoffregen, cited at note 36 above P 2.
[52] Ibid

rights treaties.[53] In this regard, CEDAW explicitly recognizes the right to health and to essential health services for pregnant women. It also indicates that these services shall be free where necessary.[54]

Similarly, the CEDAW committee on its general recommendation 24 indicates that states have the duty to insure women's right to safe mother hood by providing Emergency Obstetric Care services and that they need to allocate these services to the maximum extent of available resources.[55]

3.2.5 The right to equality and non discrimination

> "*Unlike men women not only have to fear human rights violations because they are human beings but also because of their gender.*" [56]

International human rights law confer women with equal rights independent of motherhood[57]. Besides, article 1of CEDAW entitles women protection against discrimination in both the public and private domains.[58]The right to equality requires that we treat the same interests with no discrimination but it also implies that we treat different interests in ways that adequately respect those differences. It should be emphasized here that the greatest threat to women's reproductive health is their inability to exercise this right.[59]Equality rights are violated when they fail to address the fundamental biological differences between men and women which account for year after year, the loss of lives for hundreds of women.[60]

Maternal mortality does not only reflect the violation of women's right to health but, it also indicates the systematic in equality and discrimination women face daily durining their entire

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[53] Cook, cited at note 38 above
[54] CEDAW, cited at note 45 above
[55] UN Committee on the Elimination of Discrimination Against Women, "General Recommendation No. 24 "as cited in Margaux J. Hall *etal*, " Answering the millennium call for the right to maternal health: the need to eliminate user fees "Yale human rights and development law Journal ,Vol. 12(2009) at 17

[56] AART Hendricks, "the right to health, promotion and protection of women's right to sexual and reproductive health under international law: the Economic Covenant and the Women's convention " American University law review Vol. 44 (1994-1995), p 1125.
[57] Hendricks, cited at note 56 above, p 1129
[58] CEDAW, cited at note 45 above as cited under Aart Hendricks, "The right to health ,promotion and protection of women's right to sexual and reproductive health under international law : the Economic Covenant and the Women's convention " American University law review ,Vol .44 (1994-1995), p 1123
[59] Cook etal., cited at note 38 above
[60] Chloe E .Bird and Patricia p. rieker ,Gender and health the effects of constrained choices and social polices (2008), p 56

life span.[61] All pregnancy related disadvantages are considered to be discriminatory because only women will suffer those disadvantages.[62]Moreover, the denial of health care interventions that are essential to women only such as the provision of Emergency Obstetric Care is a form of discrimination against women.[63]

In relation with this, WHO stated that:

"*Maternal mortality is an indication of disparity and inequality between men and women and the extent of the problem is a sign of women's place in a society and their access to social health and nutritious services and to Economic opportunities*".[64]

In addition to this, UN treaty bodies have established a women's inability to access reproductive health services including emergency obstetric services as a violation of women's right to equality.[65] To the same effect the committee on ESCR explained that women's lack of access to reproductive health services is discriminatory because it prevents them from fully enjoying their Economic Social and Cultural rights equally with man.[66]Additionally the CEDAW committee general recommendation 24 urges states to ensure their rights to health care system address the health rights of women from the perspective of women's needs and interests.[67]

Discrimination based on sex is also clearly prohibited under article 3 of the ICESCR. In this regard, states have obligations including the obligation to adopt legislation; to prohibit any kind of gender based discrimination, to repeal any kind of legislation with provision with discriminatory effect on equal right of women and men and the eradication of any type of custom or tradition that in effect constitutes discrimination against women.[68]

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[61]Cabal and Stoffregen, cited at note 36 p 3
[62] Cook, cited at note 31 above p 16
[63] Margaux J Hall etal, cited at note 55 above p 20
[64] World Health Organization etal, ''Reduction of maternal mortality'' as cited in Cabal Luisa and Stoffregen Morgan, " Calling a spade a spade : maternal mortality as a human rights violation ," Human rights brief, Vol. 16 (2009), p 3
[65] Cabal and Stoffregen, cited at note 36 above p 3
[66] Ibid
[67] UN Committee on the Elimination of Discrimination Against Women, ''General Recommendation No. 24 ''as cited under Rebecca J Cook etal., Advancing safe motherhood through human rights (2001) available at http//www.who.int/reproductive health /publications /maternal prenatal health /RHR 01 5/en/index .html accessed on 16 April 2010
[68] Magdalena Sepulveda, The nature of states obligation under the International Covenant on Economic Social and Cultural rights (2003) Vol .18 , p 407-409.

Similarly article 3 of CEDAW also prohibits practices that are detrimental to women as such including for instance non provision of emergency obstetric services.[69]

In addition to what is mentioned above as discrimination based on sex, maternal deaths indicate the violation of women's right to non discrimination as it relates to membership to groups that are considered to be disadvantageous such as women residing in rural areas with no access to health care centres, women with low income or for that matter women belonging to indigenous society implying discrimination.[70]

All violations of women's rights including that which relates to maternal health care are due to deep rooted patterns of gender discrimination and because of the existing stereotype towards women's role in child bearing. Such stereotypes are also reflected durining resource allocation for matters that are important to women's health including to maternal health care.[71] This in effect affects the capacity of women to properly function, as the fulfilment of health rights is instrumental to most of the rights that women are entitled to.[72] Though human rights by themselves cannot remedy avoidable death, it is possible to reduce the contribution of discrimination against women on grounds of their sex to high rates of maternal mortality. One way of doing this is repealing laws which go against the human right to non discrimination.[73]

3.2.6 Rights relating to benefits of scientific progress including to health information and education

The right to seek, receive and impart information are fundamental to the realization of reproductive health.[74] There is also a direct relationship between girls' access to education, information and the reduction of maternal mortality.[75] CEDAW is explicit in its various recommendations and provisions that women have the right to information and counselling on health and family planning.[76]

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[69] CEDAW, cited at note 45 (*art* 3) as cited under Rebecca J, Cook. '' International protection of women's reproductive rights', New York University Journal of international law and politics, Vol. 24 (1992) p 15.
[70] Cabal and Stoffregen, cited at note 35 above p 3.
[71] Kick Busch Hona *eta*l (eds) ,Globalization ,women and health in the 21st century(2005) p 17
[72] Sen. Amartya etal (eds) Public health ,ethics and equity (2006) at 18
[73] Cook , cited at note 38 above p 366
[74] Cook , Cited at note 31 above p 25
[75] Cook etal., cited at note 38 above
[76] Cook, cited at note 31 above p 25

In the traditional context, this right has been understood as a right which imposes a negative obligation to governments by prohibiting interference in its exercise**.** However, in the current understanding the right extends to taking what we call positive measures. In relation with reproductive health governments have an obligation to provide essential information relevant to the reproductive cycle**.**[77]

The right to receive information has a paramount significance to maternal health. Many women lose their life during child birth because they have no information on what an obstetric complication is or because they have no information of the means to prevent such complication or where to require health care service for complications. In addition to the right to information the right to education has an important role in promoting women's right to maternal health. This right is relevant to achieve the goal of both individual and reproductive health.[78]

It should be emphasized here that educated women are able to make their voice heard in connection with their reproductive lives compared to women with no education.[79] Lack of accurate sex education can be mentioned as one factor which aggravates the problem of maternal mortality.[80] Hence, reaching women with this type of information can protect women from hazards of pregnancy or child birth. In addition to this type of information education is important for women to differentiate customary practices that are detrimental to their pregnancy or child birth.[81] In relation to this, general recommendation 24 of the CEDAW committee states the need for the health education of adolescents including but not limited to information and counselling on all methods of family planning.[82]

[77] Cook etal., cited at note 38 above
[78] Cook, cited at note 31 above p 28.
[79] Centre for reproductive law and policy, Reproductive rights moving forward (2000) p 60.
[80] Porter cited at note 47 above p 96.
[81] Cook etal., cited at note 38 above
[82] UN Committee on the Elimination of Discrimination against Women [CEDAW], General Recommendation No 24 U.N. Doc A/54/38 (1999) Para 22.

CONCLUSION AND RECOMMENDATIONS

The human rights based approach to health is about the realization of the right to health by explicitly recognizing the right to health. The right to health is enshrined under various international and regional human rights instruments including the UDHR, ICESCR CRC, CEDAW, and ACHPR.

The human rights based approach to health is not only about outcomes but process. The approach does not only denounce the injustice of maternal mortality but can also be used as a cross reference to the design and implementation of programs .In this regard, principles of the human rights based approach to health including participation, empowerment, equality , non discrimination and accountability are relevant.

The principle of participation requires that individuals are made part of health related programs and polices including in setting priorities, in designing, in implementing in evaluating health sector programs and policies; and in the allocation of budget .Whereas, the principle of empowerment stress on the importance of health related information including information relevant to maternal health in the realization of the right to health.

The principle of non discrimination and equality prohibit exclusion in all health related programs based on the five grounds of discrimination. Furthermore, it requires national health registration systems and disaggregated data's that are also essential in order to identify which groups of the society including women are more vulnerable. Under this principle, inappropriate allocation of health resources is also considered as implicit discrimination. Another important principle of the human rights based approach is the principle of accountability. Accountability should not be seen only about blaming and shaming but it is also about identifying existing gaps in the capacity of both duty bearers and right holders in order to strengthen their capability for the better realization of the right to health. Effective accountability further requires monitoring and evaluation both by government and those affected.

The human rights based approach to health is relevant to maternal mortality as it is grounded on human rights including women rights enshrined in internationally accepted legal documents .These rights include the right to life, the right liberty and security, the right to marry and found a family, the right to the highest attainable standard of health, the right to

equality and non discrimination and rights relating to benefits of scientific progress including health related information and education.

Coming back to our country, the Ethiopian Government has been undertaking different efforts towards reducing maternal mortality .The country has ratified the ICESCR which is the most authoritative document as it relates to the right to health. Ethiopia is also one of the countries which have acceded to other international and regional documents that recognize the right to health including CEDAW, CRC, and ACHPR. The Constitution of Ethiopia, the supreme law of the land also recognizes the right to health (both under article 41 and article90).The country has also adopted a 20 years health sector development program which actually placed maternal health as one of the priority area for intervention. The government has also been increasing professional human resources on maternal health programs, accelerating the construction and expansion of health facilities and providing health facilities with proper drugs and equipments. In addition to this, the various development documents of the government which are very essential to the health of women including the women policy (1993), the Women Development package, (2005), the National Reproductive health strategy (2006_2015), and the recently designed Growth and Transformation plan included doctrines of the human rights based approach to health (participation, empowerment, accountability, non discrimination and equality) at least in principle.

However, when we take a look at the principles of the human rights based approach as enjoyed by individuals, the existing health system fails most of them.

There are no empowerment mechanisms that enhance women's awareness on information relevant to maternal health including but not limited to information on birth preparedness, on the danger signs of pregnancy, on cultural practices that are detrimental to women's health. This violates the right of women to benefits of scientific progress including health related information and education. Furthermore, the existing health system discriminates women on the ground of Economic status. Women who are better off are treated well and are able to get the proper treatment at health facilities. Whereas, those who cannot drive their own income or have low income are not able to get proper health care services due to unaffordable user fees and transportation costs. Health systems are also physically inaccessible to those who are living very far from urban areas. Rural women are discriminated from using health care services important to them including Emergency Obstetric care services (EMOC).At house hold level, women still have low decision making power as it relates to their reproductive

health. This violates the right of women to marry and found a family**.** Moreover, the resources allocated to maternal health programs are still insignificant compared to the magnitude of the problem. The absence of national civil registration system which could give adequate information on maternal deaths disaggregated based on the five grounds of discrimination has also its own negative impact in the designing of proper interventions by the government as these are imperative for monitoring failures and achievements of the system .This in turn elucidates the lack of principle of non discrimination and equality and violate women's right to equality and non discrimination which is relevant to maternal health**.** The development documents of the government are also not open for CSO participation as watch dogs of the system to track on governments activities on maternal health despite of the contribution this would have on the accountability of the government to maternal health programs .In practice, the participation of women at local level in designing maternal health programs and monitoring them is low. There are no channels to this effect .At facility level, the health system lacks monitoring and evaluation by beneficiaries including women. In practice, the principle of participation is absent in the interventions implemented to reduce maternal mortality.

The Ethiopian Government, like many of the countries who have agreed at the millennium summit to achieve the Millennium Development Goals is expected to achieve MDG 5 in the year 2015. But, given the aforementioned problems, it is very difficult for our country to achieve this goal if it continues with the same pace it came through .The researcher however, believes that the human rights based approach can have a greater role towards the achievement of MDG 5 and recommends the following:

- The government needs to strengthen its efforts in winding up its efforts towards designing a national registration system. Reducing maternal mortality is an obligation of result and the need for information officially collected and disaggregated is imperative.
- The researcher acknowledges the progress in the allocation of resources to maternal health programs. However, due to the magnitude of the problem the government still needs to prioritize budget allocations to maternal health programs without compromising other programs. This could be based on the principles of the HRBA
- The government also needs to properly track the implementation of the free primary health care policy to maternal health services in all regions and to all women.

- The government needs a proper information distribution mechanism to reach all women including those who are living in rural areas on health information and also on harmful traditional practices.
- The government needs to devise appropriate forums to participate women at local level in designing and monitoring maternal health programs. This also has empowering out come to those women participating in such forums.
- The system needs to be open to CSO participation especially as it relates to monitoring the human rights obligations towards maternal health .The newly designed GTP and HSDP IV should integrate CSOs working on sexual and reproductive health in monitoring and revision of these policy documents for the better realization of maternal health.[1]

[1] In addition to what is mentioned above, the practical challenges of the new CSO legislation needs to be acknowledged