

Maternal mortality in Ethiopia: can a rights-based approach cure?

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Preventable maternal death as a human rights concern is gaining greater momentum. This article examines the normative framework applying to maternal mortality, and highlights the important link that exists between women's right to health and several other rights. It then discusses the differing, yet complementary, aspects of the nature of women's right to health as a right relevant to shaping a human rights approach to maternal mortality, namely: achieving health-care services that are available, accessible, acceptable, and of high quality; engagement of civil society organisations in the promotion and protection of women's health rights; and ensuring functioning accountability mechanisms. Even though the country recognises the right to health and other complementary rights in its current constitution, and also subscribes to numerous human rights instruments that incorporate the right to health, which equally apply to women, the article finds that there is a selective approach to women's access to health goods and services; the room for mobilising civil society is restrictive; and an inefficient accountability system exists. Relying on the requirements of human rights norms and standards, the article argues for the potential role of operationalisation of the rights-based model to further reducing or eliminating maternal mortality in the Sustainable Development Goals period.

Key words: human rights, maternal health, maternal mortality, rights-based approach to health

Introduction

The World Health Organisation (WHO) estimates that around three hundred thousand women worldwide lose their lives in the process of giving birth every year (Ighobor, 2014). Of these deaths, about 99% are from developing countries. With about 470 mothers dying in every 100,000 live births (LB) Ethiopia is one of the six countries¹ that contribute to about 50% of maternal deaths worldwide (WHO, 2014: 32, 38).² Although

1 The remaining five countries are India, Nigeria, Pakistan, Afghanistan, and the Democratic Republic of Congo. Ethiopia is the fourth country in the world in terms of the highest concentration of maternal death.

2 It should, however, be noted that data over the actual rate of mortality varies from one source to another. Concerning this see Berhan & Berhan (2014a: 3, 12) who note 'the Institute for Health Metrics and Evaluation, WHO and other UN agencies showed inconsistent results'. The variation is mainly due to absence of 'vital events' reporting in many countries including Ethiopia. According to UNICEF less than 40% of the countries have a complete civil registration system with good attribution of cause of death, which is necessary for the accurate measurement of maternal mortality. For the details on these, see WHO (2014: 1).

the country is considered to have made progress over the past two decades in terms of improving public health service delivery, the maternal mortality rate (MMR)³ remains among the highest in the world. The leading causes of maternal death in Ethiopia are postpartum haemorrhage (PPH), unsafe abortion, infection, pregnancy related hypertension, and obstructed labour (Raifman *et al.*, 2013: 15).

To the dismay of the human rights community, most of these deaths, as in the rest of the world, are from preventable causes, which could be averted if women had access to the interventions for preventing or treating pregnancy and birth complications, in particular emergency obstetric care. Many of the women subjected to such premature death worldwide have lived lives marked by deprivation, poverty and discrimination (Yamin, 2010: 95-12).

The considerable number of maternal deaths from preventable causes presents a growing concern that maternal mortality is a violation of human rights, which governments are obliged to prevent (UNICEF, 2003: 3). The international system has started to deliver specific decisions enjoining States to guarantee that all women, irrespective of their income or racial background, have access to timely, non-discriminatory, and appropriate maternal health services (*Alynedá Silva Pimentel v Brazil*, 2011). It has also become increasingly clear that meaningful and equitable progress on maternal health both in the pre- and Sustainable Development Goals (post-2015) era requires a focus on rights-based approaches to maternal mortality.⁴

It is crucial to consider human rights, the principles underlying them, and the values they embody in order to understand how a human rights-based approach can further efforts to reduce or eliminate maternal mortality, and to ensure the right to life and dignity of Ethiopian women.

This article, after setting out the global and regional law context, turns to the lived reality of women in Ethiopia through an examination of their rights to health-care services. It then highlights the factors affecting access to maternal health care in Ethiopia. While the Ethiopian government has repeatedly identified maternal mortality and morbidity as a pressing problem and developed laws and policies in response, these actions have not been translated into equitable improvements in maternal health throughout the country. The article shows that access to maternal health-care is a fundamental right

3 Maternal mortality refers to the death of a woman while pregnant or within 42 days (just over 1.5 months) of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related or aggravated by the pregnancy or its management. On the other hand, MMR is the number of maternal deaths during a given time period per 100,000 live births during the same time-period (see WHO *et al.*, 2007).

4 See Resolution 11/8 Preventable maternal mortality and morbidity and human rights. In: United Nations Human Rights Council, 11th session, New York (17 June 2009), available at: http://ap.ohchr.org/documents/E/HRC/resolutions/A_HRC_RES_11_8.pdf (accessed 15 February 2015); Resolution 15/17 Preventable maternal mortality and morbidity and human rights: Follow-up to Council Resolution 11/8 In: United Nations Human Rights Council, 15th session, New York (7 October 2010), available at: <http://daccess-ddsny.un.org/doc/UNDOC/GEN/G10/167/35/PDF/G1016735.pdf?OpenElement> (accessed 15 January 2015); Resolution 18/2 Preventable maternal mortality and morbidity and human rights, 18th session of the Human Rights Council – resolutions, decisions and President’s statements (2011) (A/HRC/RES/18/L.8), available at: <http://daccess-ddsny.un.org/doc/RESOLUTION/LTD/G11/162/25/PDF/G1116225.pdf?OpenElement> (accessed 11 February 2015).

and investigates the factors that militate against access to this right in Ethiopia, such as culture, poor facilities in the health-care sector, lack of an enabling environment in which civil society can be engaged to mobilise maternal health-care claims, and, weak accountability mechanisms for the enforcement of this right. To mitigate these pitfalls, the Kenyan and Indian experiences are assessed to extrapolate the rich experience of these comparable jurisdictions with a focus on the role of accountability for maternal health.

To do this research, the writer reviewed the scholarly literature, court cases, human rights laws, and relevant organizational statements. While the paper relies heavily on elaborations given by relevant United Nations (UN) treaty bodies to identify elements of rights based approaches, an interview with former Minister of Women's Affairs of the Federal Democratic Republic of Ethiopia was also conducted to gather feedback. The sources for institutional statements are primary websites of UN agencies and treaty bodies, major government bilateral organizations, and international Non-Governmental Organisations working actively in health.

A rights-based approach (RBA) to promote maternal health

Human rights relevant to maternal mortality

Human rights are necessary for the enjoyment and safeguarding of human life. Human rights preserve maternal survival as necessary for women to enjoy health freedom, to live humanly and in dignity. A clear understanding of human rights applying to maternal mortality helps to enhance women's capacity to claim their rights from actors responsible to fulfil their obligations towards women.

Numerous human rights guarantees, such as the rights to life (ICCPR, 1976: art 6; African Charter, 1981: art 4; African Women's Protocol, 2005: art 4(1)), health (ICESCR, 1976: art 12; CEDAW, 1981: art 12; African Charter, 1981: art 16; African Women's Protocol, 2005: art 14(2)(a-c)), equality, non-discrimination (ICCPR, 1976: art 2(1) & 26; CEDAW, 1981: art 12(1); African Charter, 1981: art 18(3); African Women's Protocol, 2005: art 2), and information (ICCPR, 1976: art 19(2); CEDAW, 1981: art 10(h), 14(2)(b) & 16(1)(e); African Charter, 1981: art 9(1); African Women's Protocol, 2005: art 14) are relevant to a safe motherhood. All these rights are interrelated for their implementation, justiciable at national and international levels, and compel governments to uphold them. Today, every country in the world has ratified treaties that guarantee women's right to life or health. In addition to treaty commitments all governments have entered into a global social contract to reduce the global maternal mortality ratio to less than 70 per 100,000 live births by 2030 (USAID, 2014: 10). Recognition of these rights entails that reducing or eliminating preventable maternal mortality becomes not merely a policy choice for the state, but a legally-binding responsibility. By ratifying the relevant treaties stated above, governments commit themselves to the progressive realisation of these rights. Among other things, the state must take steps that are 'deliberate, concrete and targeted toward realisation of the right'. This wide range of rights related to safe motherhood reinforces the importance of human rights realisation for maternal mortality reduction. In addition, ratification requires states to align their domestic laws with treaty provisions and to ensure that structures in society, at national and sub-national level, respond in a way consistent with the letter and intent of the law.

Mainstreaming human rights in the national legal and policy framework engenders ‘a historical shift from state and subject relationships based on clientelism and patronage, to state and citizen relationships based on political, civil, economic, social and cultural rights with associated sets of rules governing mutual obligations’ (UNICEF, 2003: 4). These mutual obligations are observed in claim-holder and duty-bearer relationships. Claims gather legitimacy through the growing recognition that they are not claims to privilege but rather a matter of right; that is, society recognises their denial as an injustice. In this light, judicial and quasi-judicial mechanisms, among others, must recognise that avoidable maternal mortality is a denial of human dignity which constitutes an injustice, and that they are obliged to prevent such maternal deaths. These bodies alone, however, are not able to carry out their mandate to advance safe motherhood, without the contribution of other actors. Crucially, civil society should promote and protect vulnerable women’s interests knowing that maternal mortality is unjust by each country’s own standards of fairness, in response to which their governments have subscribed to international standards by their free consent, in the exercise of their sovereignty (UNICEF, 2003: 4). The faith placed on the civil society emanates from the fact that civil society organisations (CSOs) play a significant contribution in the promotion and protection of health rights through public interest litigation or advocacy as discussed in the subsequent section of this paper.

A human rights-based approach (HRBA) to maternal health

In order to address growing health inequalities, a HRBA to health has the potential to play a significant part. This article focuses on three complementary aspects of a HRBA relevant to maternal maternity, namely, (a) achieving available, accessible, acceptable and high quality for all (AAAQ) health-care services; (b) engagement of civil society organisations in the promotion and protection of women’s health and their other complimentary rights; and (c) the existence of functioning accountability mechanisms.

Mere recognition of standards and norms in the domestic system is not sufficient in itself to address women’s health. Essentially, states are enjoined to ensure that health-care goods, services, and facilities in relation to preventing maternal mortality must be AAAQ (General Comment 14, 2000: para 12). Availability means an adequate number of goods, services and facilities necessary for maternal health, as well as sufficient numbers of qualified personnel to staff the services (Hunt & De Mesquita, 2003: 6). Accessibility relates to maternal health and sexual and reproductive health services which are both physically and financially accessible (Hunt & De Mesquita, 2003: 6). Accessibility means health services must be accessible on the basis of non-discrimination—addressing discriminatory laws, policies, practices and gender inequalities in health care and in society that prevent women and adolescents from accessing good quality services (Hunt & De Mesquita, 2003: 6). Equally, access implies the right to seek, receive and impart information and ideas concerning health issues, including information that can help prevent maternal mortality. Acceptability means health-care services are sensitive to maternal and other sexual and reproductive rights and respect the cultures and needs of pregnant

women, including those from indigenous and other minority groups. The fourth element, quality, denotes medically appropriate and good quality maternal health-care services. Where the quality and appropriateness of the services are compromised, women's decisions to seek care are negatively affected.

Although the foregoing clearly indicates that States, by agreeing to human rights treaties affecting maternal health, assume the obligation to ensure that health services and goods are AAAQ, it is not a guarantee that they will comply with their duties. Partly for this reason human rights laws underscore the role of different actors, one taken for the purpose of this discussion is CSOs, to promote and protect state and non-state actors' compliance to prevent maternal mortality. London (2008: 65-80) notes 'a human rights approach that lacks such social mobilization is one that loses its transformative potential'. Not allowing enough space for the operation of the human rights society is thus sabotage against the realisation of women's right to health. In this light, in order to heighten efforts to prevent avoidable maternal mortality, civil society, such as human rights non-governmental organisations (NGOs), has a vital role to play. For instance, the Treatment Action Campaign (TAC) case demonstrates that human rights NGOs have the potential to deliver meaningful agency to protect and promote vulnerable groups such as women and children through judicialisation of constitutionalised health rights (*Minister of Health and Others v Treatment Action Campaign (TAC) and Others*, 2002). However, human rights NGOs operate in an environment or space that enables them to discharge their mandate, which ultimately leads to ascertaining accountability of those who wield power to prevent maternal mortality.

Accountability is another, and central, element in a HRBA to maternal health. A HRBA to accountability is a vital mechanism to improve women's wellbeing, and has the potential for solidifying health systems and changing the rights discourse into practical health policy and programming tools and into adequate budgeting for meaningful implementation of policies and programmes (WHO, 2012). Potts (2008: 17) lists five broad categories of accountability mechanisms: (a) judicial, for example judicial review of executive acts and omissions; (b) quasi-judicial, for example national human rights institutions (NHRIs) and international human rights treaty-bodies; (c) administrative, for example the preparation, publication and scrutiny of human rights impact assessments; (d) political, for example parliamentary processes; and (e) social, for example independent involvement or in cooperation with government of the civil society in budget monitoring, health centre monitoring, public hearings, and social audits. This article focuses on the significance of judicial and quasi-judicial accountability.

The foregoing describes the law and mechanisms aimed at addressing maternal mortality. But, what do the Ethiopian legal, policy, and institutional frameworks look like in the context of the country's obligation to prevent maternal mortality?

The situation in Ethiopia

Background

Despite over two decades of discourse on sexual and reproductive health in Ethiopia, progress has been unsatisfactory in terms of reducing women's health inequalities, and poor health outcomes continue to exist. Ethiopia, along with Nigeria and the Democratic Republic of Congo, is one of the three countries in Africa that constitute the highest maternal mortality rates in the world. Ethiopia's estimated maternal mortality was 676 deaths per 100,000 LB according to the Ethiopian Demographic and Health Survey (EDHS) 2011, and 673 per 100,000 LB according to the EHDS 2005 (CSA & ICF, 2012: 271). The mortality ratio was almost the same over the period between 2000 and 2011. Although the WHO report in 2014 shows that the ratio has dropped to 470 (WHO, 2014), the rate of mortality is still among the highest. Still women, particularly in vulnerable communities, are dying. With this recent report Ethiopia is the fourth country in the world with the highest concentration of maternal deaths, contributing to 4% of maternal deaths in the world.

In addition to the barriers discussed earlier, unsafe abortion, lack of access to voluntary family planning services, gender inequality, and harmful traditional practices contribute to the high rates of maternal morbidity and mortality in the country (CHANGE, 2010: 17).

National legal and policy response

The Ethiopian legal system recognises women's right to health and their other complimentary rights, and if implemented properly, could make a significant contribution to further reduce preventable maternal mortality. To begin with the highest law of the land, the Federal Democratic Republic of Ethiopia (FDRE) Constitution, dedicates a specific provision to the rights of women due to their vulnerability. In article 39(9), the Constitution stipulates that women have the right to prevent harm arising from pregnancy and childbirth and in order to safeguard their health, women have the right of access to family planning education, information and capacity. It also states, in article 41(4), that the state shall allocate progressively increasing funds for the purposes of promoting people's access to health, education and other social services. Similarly, article 39(4) provides for the right to equality of women and men, and further provides for the obligations of the state to eliminate the influences of harmful customs, laws and practices that oppress or cause bodily or mental harm to women. Moreover, women have the same rights that all other persons are entitled to under the Constitution. These include women's right to life, information, equality and non-discrimination, access to public health and education, clean water, housing, food, and social security to the extent the country's resources permit.

The Criminal Code of the FDRE (2004) is another piece of legislation that has the potential to combat maternal mortality. As noted above unsafe abortion is one of the causes of maternal mortality. In view of this and other considerations, articles 545, 546, 547 and 548 of the Criminal Code prohibit the intentional abortion or termination of pregnancy (by the pregnant woman or by another person), which is punishable with imprisonment. Notwithstanding this, in terms of article 551, within a period permitted by

the medical profession, abortion is permitted if the pregnancy is the result of rape or incest; if the continuance of the pregnancy endangers the life of the mother or the child; if the child has an incurable and serious deformity; or if the pregnant woman is physically as well as mentally unfit to bring up the child.

Ethiopia has ratified the following global and regional human rights law commitments that are relevant to maternal survival: the International Covenant on Civil and Political Rights (ICCPR, in 1993); the International Covenant on Economic, Social and Cultural Rights (ICESCR, in 1993); the Convention on Elimination of Discrimination Against Women (CEDAW, in 1993); and the African Charter (in 1998). Article 9(4) of the Constitution states that, upon ratification these treaties become an integral part of the law of the land. Accordingly, in terms of article 13(1), the judiciary, national human rights institutions, and all other organs of the state, at all levels, have a duty to respect and enforce the fundamental rights and freedoms. In a similar vein, the country assumes the obligation to undertake legislative, administrative and other measures to realise all women's survival rights.

The global and regional human rights instruments described above convey the standard of action that the participating States have committed to undertake in order to protect the human rights of each individual. At the national level, Ethiopia has developed various policies and strategies to guide its standard of health-care provision for all segments of the population, including those specifically geared towards the provision of child health care. While these policies are not legally enforceable, they serve as guidelines for conscientious governments, and as concrete measuring tools for holding inefficient governments accountable. The National Health Policy, which was adopted in 1993 and is currently under revision,⁵ has been the umbrella for the development of the National Health Policy on Women and other health-related policies and strategies.

In order to translate the National Health Policy statement into action, the Ethiopian Health Sector Development Programme (HSDP) was launched in 1997/98, and is rolling out over five-year intervals. At the time of conducting research for this article Ethiopia was in the third programme: HSDPIV 2010/11-2014/15 of the Federal Ministry of Health (FMoH). This rolling programme is partly intended to reduce the rate of maternal mortality throughout the country as one of its foremost objectives (Ethiopian MoH, 2012: v). The Health Extension Programme, which serves to complement the HSDP, is another driving force. Using this programme, the country is able to significantly improve women's and girls' access to health services through training health extension workers (HEWs) on maternal health and emergency obstetric care and by expanding the number of primary health-care units, health centres and hospitals. There are also several other programmes, policies, strategies, and plans of action aimed at

5 Currently, Ethiopia is working to update the existing health policy. The revision is motivated by the need to address new circumstances arising globally and locally and ensure the health sector is guided by the country's aspiration of achieving the health outcomes of a lower-middle-income country by 2025 and a middle-income country by 2035.

protecting women's health, which include the Ethiopian National Reproductive Health Strategy (2014-2018) and the Health Sector Transformation Plan (2015/1-2019/2010).

More importantly, maternal mortality is high on the political agenda of the Ethiopian government. This has been expressed in the introductory notes of the numerous women-related policies, plans, strategies, reports and other documents issued by the FMOH. Again, the country's representatives similarly reaffirm maternal mortality as a priority agenda in those conferences, meetings and symposiums in which the delegates participate.⁶ This is an indication of a certain level of political determination by the government to reduce child and maternal mortality.

The foregoing highlights the legislative and policy measures the Ethiopian government has taken, measures designed to reduce the high ratio of preventable maternal mortality. However, despite these efforts, the Ethiopian government faces numerous challenges in the implementation of women's right to health. The article now turns to the discussion of the factors that affect women's right to health.

Barriers for access to maternal care in Ethiopia

Despite the improvement made in terms of reducing MMR, serious challenges remain. As this section reveals, there are substantial backlogs in the infrastructure; an ever-increasing demand for more health goods and services, including those of socially and geographically mobile communities; and acute concerns about quality, which in turn are the by-product of the inadequacy or lack of implementation of laws and policies.

Availability

As was highlighted above, the right to health or a rights-based approach to women's health incorporates the element of availability of a working public health system and health-care facilities, goods and services, such as safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical staff and essential drugs (General Comment 14, 2000: para 12(a)). However, Ethiopia is lacking in the provision of most of these elements.

The WHO identifies Ethiopia as among the 57 countries in the world facing a critical shortage in its health workforce. It indicates that per 10,000 people, there are <0.5 physicians, 2 nursing and midwifery workers, <0.5 dentistry workers, <0.5 pharmaceutical personnel, <0.5 environmental and public health workers, 3 community health workers, and 2 hospital beds (WHO, 2012). In addition, there is low availability of medicines due to the fact that the medicine supply system is unreliable and has long procurement procedures. Essential medicines are only available to 52% of the hospitals in the public sector and 88% in the private sector (WHO, 2012).

6 For instance, Dr. KA Birhane, FDRE Minister of Health, in his speech at the Two Years Anniversary of: A Promised Renewed: Celebrating Progress and Mapping the Road Ahead, in Washington, DC (25 June 2014) outlined his government's political commitment in implementing MDG V (on reducing maternal mortality), available at: http://www.moh.gov.et/home/-/asset_publisher/R8nRKVXvQAuo/content/h-e-dr-keseteberhan-admasu-speech-in-the-two-years-anniversary-of-a-promised-renewed-celebrating-progress-and-mapping-the-road-ahead-washington-d-c- (accessed 20 July 2015).

Despite substantial improvements in recent years, access to and utilisation of primary health services remain limited in the country. According to the 2011 welfare monitoring survey (CSA & ICF, 2012), 64.7% of households are within less than five kilometres of the nearest health post, 40.1% are within five kilometres of a health centre, and 14.2 % are within five kilometres of a hospital (Workie & Ramana, 2013: 8). There is also a significant urban-rural disparity in the distribution of health facilities. For instance, in urban areas, health service providers, that is health posts, health centres, and hospitals, are available within less than five kilometres for about 88.2%, 87.7%, and 49.4% of the households, respectively (Workie & Ramana, 2013: 8).

In addition, there is limited access to well-equipped health facilities and obstetric care in Ethiopia (IMC, 2012). Especially in the rural areas, the problem is stark as much research conducted in these areas has revealed. In these areas, there are not enough ambulances. As the freelance journalist, blogger, and social good advocate Nicole notes, 'wooden stretchers are ambulances'. Also, examination rooms are barren, faced with a dearth of necessary medical equipment (THIRDEYEMOM, 2014). An assessment of the quality of health care in the Jimma Zone, South West Ethiopia, shows that the human aspect of care is 'poor', and that the health institutions are facing shortages of human and material resources (Beyene et al., 2011: 49-58). Moreover, in connection with assessing the implementation of the obligation of the country concerning the right to health care as a social right, the UN Committee on Economic, Social and Cultural Rights (CESCR) reaffirmed the challenges indicated above (CESCR Concluding Observation on Ethiopia, 2012: para 25):

The Committee is concerned that there is no universal health-care coverage. It is also concerned about the low number of qualified health-care professionals per capita in certain regions and critical shortages at health centres, both in medical equipment and staff. The Committee also notes with concern the high rate of maternal and infant mortality, and the low number of births that are assisted by a skilled attendant, especially in rural areas. It is further concerned that access to maternal and infant health care remains poor, in particular in the Somali National Regional State of Ethiopia.

The United Nations Population Fund (UNFP) equally observes (IRIN, 2014):

Most of the health facilities which are far from Addis Ababa are either not fully staffed with skilled service providers or fully equipped with the necessary supplies and equipment that can provide quality services related to complications during pregnancy and childbirth. Limited human resources, especially midwives, hamper efforts to provide adequate services, especially in rural areas. Gaps in training and remuneration have led to attrition and turnover among public sector healthcare professionals. Public facilities routinely suffer stockouts and obstetric care equipment shortages due to budget deficits and poor management.

The range of limitations above in terms of availability of health-care facilities, goods and services restricts the full realisation of women's right to health care and the underlying determinants of health care. Non-fulfilment of the right to health is the major cause of maternal mortality, and the unavailability of the health-care facilities, goods and services would significantly affect efforts to further reduce the rate of maternal mortality. Among other things, Ethiopia needs to intensify its efforts to improve the availability of health goods and services, including increased allocation of resources and measures to address significant rural and urban disparities in health-care provision.

Accessibility

Human rights norms require that health facilities, goods and services must be within safe physical reach for all sections of the population, economically affordable for all, accessible without discrimination and especially to the most vulnerable or marginalised sections of the population (General Comment 14, 2000: para 12(b)). Despite this necessity, the country has a long way to go to comply fully with this obligation. As discussed below, studies reveal that coverage of basic health services and infrastructure in Ethiopia has been low and unevenly distributed (see, for instance, Berhan & Berhan, 2014b: 142).

The Ethiopian state is composed of different climatic and geographical settings, where exchange of goods and services and the maintenance of social networks are inherently fragile because of long distances, economies of scale and harsh environments. That this poses serious challenges to the delivery of health services is a well-documented mark of inequity in the country (Byrne *et al.*, 2014: 3). Women in the nomadic communities of the Afar regional state in Ethiopia face their own particular challenges. These communities move regularly with their livestock in search of water, pasture and other resources, and often in remote areas at great distances from essential services such as health care. Access to the underlying determinants of a healthy lifestyle, such as safe and potable water, adequate sanitation facilities, and health-care services are not within safe physical reach for most of the vulnerable communities in this region (Anglican Overseas Aid, 2014).

In addition, although the Ethiopian government provides public health services to the uninsured through the different public health institutions, many poor Ethiopians turn to private health services (Nair *et al.*, 2010: 60). As the cost of private health care is high, this impedes poor families' ability to pay for other necessary health goods or it means families are forced to go without health care altogether. Consequently, women are at greatest risk in the hours during and following childbirth. Limitations on access to maternal and child health care contribute to high maternal and infant death rates (Nair *et al.*, 2010: 60).

Furthermore, despite the improvements made in expanding access to health services, the disease burden is still high and the service utilisation rate remains low in the country, partly due to the burden of high out-of-pocket spending that restricts an already poor society from health-care utilisation (WHO, 2012). A recent survey indicates that inaccessibility of transport, long distances from functioning health-care facilities, and the lack of

confidence in the services provided are some of the barriers impeding access to maternal health care (Berhan & Berhan, 2014b). Similarly, the 2011 EDHS study shows that the major barriers for pregnant women to access health-care services are lack of transport to a facility (71%), lack of money (68%), and distance to a health-care facility (66%) (CSA & ICF, 2012: 132). Among the various reasons, the most important ones were the limited number of health facilities and medical personnel in the rural areas; and the fact that the few government and private hospitals available were constructed around the big towns while more than 85% of the population live in the rural areas. The problem is worse in the rural parts and there is regional variation in terms of women's access to health care.

Acceptability

An important dimension of access to health care is its acceptability in society. More specifically, acceptance of antenatal care (ANC) and postnatal care (PNC) services significantly affects trends of mortality in a given population (Regassa, 2011: 390-397). For this reason, an important component of efforts to reduce health risks of mothers is increasing the proportion of babies that are delivered in health facilities. Nevertheless, under-utilisation of modern health-care services for various reasons is one of the major challenges for poor health in developing countries. A recent study indicates that in Ethiopia close to 90% of birth deliveries occur outside of a health service facility: 45% because mothers did not think it was necessary, and 33% because mothers stated that it was not customary (CSA, 2014: 50).

The acceptance of the delivery of health services has a correlation with the socio-cultural situation of a country. Since Ethiopia is a populous nation constituting several ethnic groups, giving attention to the many cultural preferences of its people is a key to delivering the highest quality of care (The Borgen Project, 2014). It has been observed that the birthing position used at the health centres (which made the women feel uneasy) was one of the reasons for Ethiopian women choosing to deliver at home rather than at a local health centre (The Borgen Project, 2014). It was later noted that more women felt comfortable coming to the health-care centre for pre- and postnatal care after efforts were made to rectify their birth positioning. The incidence is indicative of the fact that, when government attempts to expand the health facilities, it will be equally crucial to train health-care workers to understand and respect the culture of the local community to avoid maternal and child mortality as a result of birth complications.

Quality

The final element of the right to health care that is interrelated with the three above is quality. The requirement of quality includes that 'health facilities, goods and services must also be scientifically and medically appropriate and of good quality' (General Comment 14, 2000: para 12(d)). Despite this, the country's quality of health goods and services, for instance related to obstetric and new-born care services is low. Various factors contribute to the low quality of services, especially to the lower segment of the population in the country. Delay in providing treatment is usually the major reason for the poor quality of

service (Berhan & Berhan, 2014b). In any country, a health service is conducted by a team involving staff with different backgrounds, such as administrative and support, clinical, laboratory, imaging and pharmacy. The reasons for the delay in giving treatment as early as possible may therefore be multi-factorial. In the context of Ethiopia the following are identified as the main causes for delay in treatment.

First, the number of well-trained health professionals is insufficient and this accounts for the biggest delay in providing medical care for those who have access to a health facility (Berhan & Berhan, 2014b). It is common to see only one or two midwives, one to three general practitioners, and rarely one gynaecologist in hospitals in big towns (outside of Addis Ababa). Understaffing in these hospitals often leaves health professionals under work pressure which is likely to result in burnout.

Second, the few available health professionals often exhibit poor knowledge and skill. This is associated with poor evaluation and a lack of diagnostic skill or a lack of qualified health professionals in the rural areas and in some instances in big towns, which results in incorrect diagnosis, leading to delays in getting timely treatment (General Comment 14, 2000: para 12(d)). In some instances it can lead to the death of mothers. In connection with the skill of health professionals, an assessment made of 19 hospitals in Ethiopia reveals that only about 40% of the health service providers knew how to prevent, identify, and manage common maternal and perinatal complications like obstructed labour, preeclampsia/eclampsia, postpartum haemorrhage, maternal sepsis, neonatal sepsis, and new-born resuscitation (Berhan & Berhan, 2014b).

Third, non-functioning health facilities due to a lack of medical equipment, drugs, supplies, reagents, a blood bank, oxygen, magnesium sulphate, and a broad spectrum of intravenous antibiotics that are essential to manage obstetric problems. The lack of these essential medical goods in laboratories, imaging facilities, delivery suites, and operating theatres further lowers the quality of treatment.

Fourth, poor leadership in hospital settings, uncooperative behaviour of patients or relatives who refuse medication, procedures, blood donation or blood transfusion, and the inability of patients or relatives to afford health service costs are further factors that lead to delays in the timely provision of treatment for pregnant women (Berhan & Berhan, 2014b).

Finally, although the health infrastructure has been rapidly expanding in the past decade, the expansion in infrastructure networks has not matched the necessary quality requirements. The government celebrates progress on the reduction of maternal and child mortality rates mainly because of its political commitment to train and deploy the HEWs. In fact, these community health workers have widely been engaged to provide care for a broad range of maternal and child health issues. Nevertheless, the HEWs have not received sufficient practical training and lack skills in assisted delivery. HEWs are found to be weak in health facility deliveries, skilled birth attendance, and on-time referral through early identification of danger signs. In a recent study, more than half (54%) of HEWs had poor knowledge about the contents of prenatal care counselling, and the majority (88%) had poor knowledge about danger symptoms, danger signs, and complications in pregnancy (Medhanyie *et al.*, 2012: 1-9).

Accountability mechanisms for maternal health

Civil Society Organizations

As was highlighted earlier, a human rights approach that lacks such social mobilisation is one that loses its transformative potential to curb the odds in access to health amenities. More broadly, CSOs play a significant contribution in the promotion and protection of human rights through public interest litigation or advocacy. Equally, the role of human rights advocates for the realisation of vulnerable women's health and their other human rights cannot be taken lightly. Numerous global and regional documents reaffirm this role. To focus on the African human rights system, the African Commission on Human and Peoples' Rights underscores the 'crucial work of human rights defenders in promoting human rights, democracy and the rule of the law'.⁷ Also, the African Charter on Democracy, Election and Governance obliges states to create 'conducive conditions for civil society to exist and operate within the law' and to work in partnership with and foster the participation of CSOs in the areas of social, political and economic governance (African Charter on Democracy, 2012: arts 12(3), 27(2) & 28). Ethiopia ratified this Charter in May 2008.

In the area of public interest litigation, CSOs' contribution in litigating constitutional matters is of paramount importance. For instance, in post-apartheid South Africa, CSOs have litigated most, if not all, major constitutional human rights cases representing groups that have similar interests (TAC case). In this section, I focus on the potential role of CSOs in Ethiopia in this regard and the challenges that affect their effectiveness.

Ethiopian law governing CSOs dates back to the 1960s. The 1960 Ethiopian Civil Code provides for the legal framework governing associations and others working on a non-profit basis. However, this law was not comprehensive enough to address the peculiar features of charitable organisations and there was a huge demand to come up with a more detailed law. Subsequently, in 2009 Ethiopia adopted legislation to regulate the activities of CSOs (Proclamation 621/2009).

Three types of CSOs are classified under this new legislation, namely, Ethiopian Charities or Societies; Ethiopian Residents Charities or Societies; and Foreign Charities Proclamation 621/2009, art 2(2-4 & 15). The Proclamation defines 'Charitable Purpose' – a defining feature of CSOs recognised in terms of the law – to include 'the advancement of human rights' (Proclamation 621/2009, art 14(2)(j)). It indicates that CSOs are also mandated to promote maternal survival or health rights in Ethiopia, such as through litigation, advocacy or education. Nevertheless, the CSO law makes further classification of CSOs based mainly on nationality and source of funding and the areas of their operation. Only Ethiopian Charities or Societies can engage in activities related to human and democratic rights, gender equality, rights of children and disabled persons, conflict resolution, and support to the judiciary (arts 2 and 14 of the CSO law). Women's right to health and their other rights fall under the broader category of human and democratic rights. However, the requirement of limiting Ethiopian CSOs to cover 90% of their funding source domestically

7 African Commission on Human and Peoples' Rights, Res. (XXXV) 04: Resolution on the Protection of Human Rights Defenders in Africa (2004).

cripples the human rights work of these CSOs for it is practically impossible for them to fund this percentage locally in a country where the government itself derives about a quarter to one-third of its budget from foreign aid. In this light, the CSO law restricts the promotion of human rights and continues to impede progress towards increased access to comprehensive health care that efficiently and effectively results in positive women's health outcomes.

Following the adoption of the restrictive law, the functioning of women's human rights defender CSOs has been significantly debilitated. The law has had a dramatic impact on human rights organisations. For instance, the Ethiopian Women Lawyers Association (EWLA), which has represented women resisting abduction, female genital mutilation, and other harmful traditional practices that are a violation of human rights and critically affect the health and lives of women, has had to cut services and activities following this law (CHANGE, 2010: 13). In connection with the limitation that the new CSO law brings about regarding the work of human rights organisations, the Committee on ESCR underscores (CESCR, 2012: para 7):

The Committee notes with concern that certain provisions of the Charities and Societies Proclamation (No. 621/2009) have had a profound obstructive effect on the operation of human rights organizations. It is also concerned that the Charities and Societies Agency has frozen assets of some of those organizations, including the Ethiopian Women Lawyers Association, forcing them to downsize, close regional offices and suspend some of their services.

Overall, although there are no public interest-centred CSOs in Ethiopia, the Proclamation makes the emergence of human rights litigating CSOs more difficult. In this light, the contribution that the civil society could make to ensure accountability for women's right to health and its complimentary rights is deemed slimmer.

Working in parallel with CSOs, NHRIs such as national human rights commissions have an important bearing on the realisation of maternal health rights. This is particularly so in view of an important role they play in ensuring government accountability for maternal health (Center for Reproductive Rights, 2011: 3).

National Human Rights Institutions

The Ethiopian legal system also recognises NHRIs as one avenue designed for the implementation and enforcement of constitutionally or legislative protected human rights. Article 55(14) of the FDRE Constitution requires the House of People's Representatives (legislative body) to establish a national human rights commission. As a result, the Ethiopian Human Rights Commission (EHRC) was established in 2000 through Proclamation 210/2000. This Proclamation provides, through article 6(4), for the powers and duties of the EHRC which include undertaking investigation, upon complaint or its own initiation, in respect of human rights violations. In terms of article 26, it is also tasked with the power and duty to issue appropriate remedies, including ordering the discontinuation of the act that caused the grievance and remedying the injustice suffered.

To address the specific needs of women and children, the EHRC has a Commissioner heading Children and Women Affairs specifically responsible for protecting and promoting children's and women's rights. This quasi-judicial mandate, if exercised properly, helps to ensure accountability for maternal mortality, which can lead to the constant improvement of existing programmes and policies, and to redress and propose reparations when pregnancy-related violations occur. Despite its mandate, the EHRC has not investigated or delivered reports to parliament and the public at large on occurrences of violation of maternal mortality, unlike its counterparts in other countries such as in Kenya or India – countries that also have high mortality rates. In an interview conducted with the Commissioner heading Children and Women Affairs, at the EHRC's office, Ms Ubah Ahmed (former Minister of Women's Affairs of the FDRE), explained that the role of the Commissioner's office in the area of maternal rights to health or reduction of maternal or child mortality is yet to be ascertained.⁸ Despite its potential for the realisation of maternal survival or their other human rights, several factors militate against the EHRC's effectiveness, including but not limited to, lack of independence, inaccessibility, and operational inefficiency (see, for instance, Marin 2011: 1, 3, 6, 24, 27 & 31). The identification of these gaps in the Ethiopian system leads us to look at other similarly situated systems to draw inspiration on best practices.

Strengthening accountability: the experience of India and Kenya

As highlighted previously, governments are obliged to respect, protect, and fulfil women's health rights and are mainly accountable to ensure maternal health-care is accessible equitably and universally. Without accountability, women's health rights can become no more than window dressing (P Hunt, Foreword to Potts, 2008: 2). The high rate of MMRs out of preventable causes compels a state to account for the violation of women's right to health, reproductive health, non-discrimination and others. Typologies of accountability strategies exist for the violation of the right to health, in general, and specifically for preventable maternal deaths (Afulukwe-Eruchalu, 2014: 129). Countries and institutions have begun to apply elements of HRBA accountability to women's health to ensure women have a chance of surviving during pregnancy and after delivery. This presents an opportunity to learn from their rich and diverse experiences of better performing comparative jurisdictions (Bustreo *et al.*, 2013: 13). Due to space constraints, this is not the place to discuss all types and levels of accountability. Rather, this article focuses on the role of judicial and non-judicial bodies by taking examples from India and Kenya. These countries have been chosen because of their similarity to Ethiopia in terms of level of maternal mortality deaths and economic and social development.

India has the highest number of maternal deaths on earth. The leading causes of maternal mortality are similar to the causes identified in the sub-Saharan region (CRR, 2008: 13-21). In response to this, a growing number of court decisions in India moniker the transformative role of courts in compelling actors to reduce preventable maternal

8 Interview with Ms. Ubah Ahmed, former state Minister of Women's Affairs of the FDRE (13 January, 2015) Addis Ababa, Ethiopia.

deaths and injuries, including by issuing declarations and interim orders to address urgent maternal health needs (Afulukwe-Eruchalu, 2014: 139). In the public interest lawsuit, *Sandesh Bansal v Union of India and Others*, the petitioner argued that the state of Madhya Pradesh had failed to implement the state's (Madhya Pradesh) policies in relation to maternal health (*Sandesh Bansal v Union of India and Others*, 2008: para 5.13). Mention was made in the petition of the poor conditions of primary health-care centres in the state that frequently lack electricity, water and basic sanitation. The petition further mentioned the failure of the state's relevant body (Rogi Kalyan Samiti) to discharge its responsibility to ensure that funds are properly expended for services needed by pregnant women (*Sandesh Bansal v Union of India and Others*, 2008: para 34.6).

In its final decision in 2012, the Court pronounced that the state of Madhya Pradesh had violated women's right to life by failing to provide proper prenatal care and maternal health-care services in a timely and appropriate condition. Accordingly, it ordered, among other things, the state to apply the national policies that are designed to protect maternal health. The state was further ordered to ameliorate the conditions in health facility centres by ensuring 24-hour delivery, making basic infrastructure improvements, ensuring 24-hour availability of emergency vehicles for all health centres, and providing vaccination of pregnant women and their new-borns (Ibanez, 2013: 61).

The decision of the Indian Court in the above matter demonstrates the importance of judicial accountability mechanisms to bring a potential remedy when the executive organ fails to discharge its role to reduce maternal mortality. It further reaffirmed the close relationship between the fundamental right to health of women and the right to life. Also, it exemplifies the appropriateness of public interest litigation strategy in times where there exists a widespread failure of a health system in a certain state.

NHRI compensation is the second accountability mechanism to ensure women receive the appropriate health care during and after delivery. By way of example, the article considers the experience of the Kenyan National Commission on Human Rights (KNCHR), one of the well-functioning NHRIs in the sub-Saharan region which has conducted public inquiries into rights violations in general and into the right to health in particular. Recently, the KNCHR piloted a public inquiry involving women's reproductive health in the Pwamani maternity hospital in Kenya (Afulukwe-Eruchalu, 2014: 142-143). The findings of the report noted the Kenyan government's responsibility for severe violations of reproductive rights on the following grounds: (a) there was a delay in access to medical services due to different reasons, such as a lack of qualified health professionals; (b) the health facilities were underfunded and there were shortages of the relevant equipment and supplies; (c) the mechanisms of accountability for violations in access to health-care facilities were lacking and victims of violations were not provided with redress or remedy by the government; (d) women failed to get medical assistance during birth – nurses used abusive words and in some instances were physically abusive; (e) and the fee charged for access to health services was a limitation to the poor which resulted in serious delays and denials of care which, in some cases, caused the death of women.

Using the foregoing findings, the KNCHR used the inquiry as a mechanism to hold the Kenyan government to the commitments it made in international, global and national human rights law. Responding to the findings of the KNCHR will provide the Kenyan government an opportunity to reduce preventable maternal mortality and morbidity.

Conclusion

There have been various approaches to cutting the number of maternal deaths in Ethiopia over the years. This article outlines the potential of a HRBA as a complementary approach to the existing initiatives aimed at curbing the challenge of preventable maternal death. After agreeing to be bound by the right to health, and other health-related rights of women, the Ethiopian government is obliged to take adequate measures to implement them. Reducing maternal mortality remains at the centre of the Ethiopian health development agenda. This is a commendable starting point on which the country can build to further stimulate the existing initiatives of addressing mortality problems in the Sustainable Development Goals period.

There are, however, numerous limitations. They include a selective approach to women's access to the underlining determinants of their right to health. To mitigate human loss in the country, this article argues that the government should sustain a firm commitment to women's human rights – a complementary approach to the country's health development efforts. In this light, the government should heighten efforts to end a selective approach to maternal health care by ensuring the availability of key maternal health medicines, supplies, and equipment; enhancing awareness and knowledge of service provision guidelines for maternal health; expanding existing training programmes for HEWs and health-care providers; and increasing data collection and evaluation of service provision at the lowest health-care level. To reinforce this, there should be space for advocacy, litigation, mobilisation and allocation of adequate and sustainable resources for the implementation of maternal health-care interventions. Overhauling the CSO law to enable CSOs to engage in women's right advocacy or litigation would foster these goals and strengthen accountability. Equally, the capacity of the country's national human rights office should be enhanced, and its independence guaranteed. The failure to put these measures in place is a failure to meet the necessary obligations to save women's lives, protect their rights to health, equality and human dignity as stated in national, regional and global laws to which Ethiopia is a signatory.

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