A RIGHTS-BASED APPROACH TO PREVENTABLE MATERNAL MORTALITY AND MORBIDITY WITH SPECIFIC REFERENCE TO ETHIOPIA AND KENYA

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Contents

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Executive Summary

The thesis shows that maternal mortality and morbidity is the outcome of several factors where the condition of human rights of women is found at the center of the problem. It shows that the application of a rights-based approach overcomes the challenges in the field of maternal health. It evaluates the sexual ad reproductive health programs of two neighboring countries namely Ethiopia and Kenya in light of a rights-based approach.

The research is basically undertaken via desktop research. It has adopted literature review, the usage of human rights instruments both at the international and regional level, analysis of Constitutions, as well as sexual and reproductive health strategies and studies conducted by various researchers.

In line with the above mentioned statement of research the thesis shows gaps in existing sexual and reproductive health strategies of Ethiopia and Kenya. It also signals opportunities for improvement which in the writer's opinion will contribute in curbing the high maternal mortality and morbidity.

Introduction

Background to the study

> *"Kadja is a 14 years of old teenager who leads a married life at her husband's family. When she got pregnant her husband undertook her task of collecting firewood. While gathering wood, he was bitten by snake and died and his family blamed Kadja. When her water broke she did not realize this meant that she would soon be in labour and she delayed telling anyone until few days later when she was in pain. The family chose not to take her to the hospital due to distance and cost. She at the age of 19 and her baby died unattended."*[1]

Even though pregnancy is considered to be one of the most blissful moments in woman's life,[2] for the past twenty years it has become major cause for loss of women's lives especially in developing countries.[3] The above picture gives us glimpse of the situation. This huge risk is known as maternal mortality and morbidity.[4] World Health Organization defines maternal mortality as "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or

[1] Mindy, Jane Roseman, *Bearing Human Rights: Maternal Health and the Promise of ICPD*, in Laura Reichenbach and Mindy Jane Roseman, Philadelphia (eds), *Reproductive health and Human Rights; the Way Forward 91, 99* (University of Philadelphia, 2009)

[2] Jose L. Alvarez, et al, *Factors associated with Maternal Mortality in Sub-Saharan Africa: an Ecological Study*, BMC Public Health, 2009)online at http://www.biomedcentral.com/1471-2458/9/462 (visited January 12, 2011)

[3] Sofia Gruskin, et al, 86 *Using Human Rights to Improve Maternal and neonatal Health: History, Connections and a proposed Practical approach*, in *Bulletin of the World Health Organization*, at 589,(World Health Organization, August 2008),*see also* Ebenezer Durojaye, *The Human Rights Council's Resolution on Maternal Mortality: Better late than never* in 10AHRLJ.293,293. (2010)

[4] Centre for Reproductive Rights, *Broken promises: Human rights Accountability and Maternal Death in Nigeria*, at 5(Centre for Reproductive Rights, 2008)

aggravated by the pregnancy or its management, but from accidental or incidental causes".[5] The main causes of maternal mortality are "severe bleeding (25 %), infections (15 %), eclampsia (12 %), obstructed labour (8 %) and unsafe abortion (13 %)" at the global level.[6] In addition, women also suffer due to causes that are not related with normal pregnancy, labour as well as child birth but which convoluted during pregnancy, labour or birth such as infection, disease or injury which is defined as maternal morbidity.[7]

According to a recent data, every hour 60 up to 65 women die as a result of pregnancy related causes.[8] Besides that, mothers that survive death in most cases face decades of plights as a result of health complications that nearly took their lives.[9] 9.5 million and 1.4 million women are estimated to suffer pregnancy –related illness and near miss events respectively annually.[10] Damage to the pelvis is one example of the near miss events where Gambia a country with high number of such events can be cited as a good example.[11] Moreover, financial complications resulting from unexpected costs for health care together with psychological problems it creates and societal related issues that arise following it makes those who face such ordeals more vulnerable.[12] This situation makes surviving mothers less lucky in most cases.

[5] Durojaye, 10AHRLJ at.293 (cited in note 3)
[6] Rebecca Amollo, *To let a Woman Die is to Fail: Placing Maternal Health on the Agenda,at 5 (*Unpublished Phd Dissertation, University of the Western Cape, Faculty of Law2009)
[7] Durojaye, 10AHRLJ. at 293 (cited in note 3) see also Pascale Baraté and Marleen Temmerman, *Why Do Mothers Die? The Silent Tragedy of Maternal Mortality,* 5 Current Women's Health Reviews 230,231(2009)
[8] Durojaye,10AHRLJ. at 294 (cited in note 3)
[9] Veronique Filippi et al, *Maternal health in Poor Countries: the Broader Context and a Call for Action*, 368 the Lancet Series, online at www.thelancet.com doi;10.1016/S0140-6736(06)69384-7(visited January 14,2011)
[10] Id
[11] Id
[12] Id

The issue of maternal mortality and morbidity has been recognised as global challenge in both developed and developing countries before the 19th century.[13] But developed countries have been able to do away with the challenges of pregnancy.[14] Conflicts, changes in economic situations, social upheavals that took place at the time contributed a lot in dealing with the challenges of maternal health.[15] From the dawn of the 19th century, the rate of maternal death decreased greatly in developed countries but remains to be a burning issue for developing countries.[16] "Among sixteen women in Sub Saharan Africa one woman die where as the risk is 1: 2800 in the industrialized countries".[17] In addition, 99 percent of the tragedy takes place in Sub Saharan regions seconded by South and Central Asia.[18] These statistics account for more than half of the maternal deaths that occur around the globe. [19]

Statement of the Research Problem

This thesis will show that the root of maternal mortality and morbidity is the situation of women in the society and by applying a rights-based approach these challenges will be addressed. It will be shown that countries should follow a rights-based approach to maternal mortality and morbidity in order to attain better results in the maternal mortality and

[13]S.A.Orshan, *Maternity, Newborn and Women's health Nursing; Comprehensive Care across the Life Span*, at 15(Lippincott Williams and Wilkins,2008) *see also* Gruksin et al, *Using Human Rights to Prevent Maternal and Neonatal Death*, at 590(cited in note 3)
[14] Id
[15] Gruskin et al, *Using Human Rights to Prevent Maternal and Neonatal Death*, at 590(cited in note 3)
[16] Orshan, *Maternity, Newborn and Women's health Nursing*, at 15(cited in note 12) *see also* Gruksin et al, *Using Human Rights to Prevent Maternal and Neonatal Death*, at 590(cited in note 3)*see also* Ebenezer, 10AHRLJ, at 293 (cited in note 4) see also Filippi et al, *Maternal Health in poor Countries* (cited in note 8)

[17] Id see also Paul Hunt and Judith Bueno de Mesquita, *Reducing Maternal Mortality; The Contribution of the Right to the Highest Attainable Standard of Health* at 4(University of Essex) online at www2.essex.ac.uk/human_rights_centre/ visited on February 15,2011)
[18] Durojaye, 10AHRLJ, at 293-4 (cited in note 4) *see also* Gruskin et al, *Using Human Rights to Prevent Maternal and Neonatal Death*, at 589(cited in note 3)
[19]Victoria Okwor Uchechukwu, *Where are the mothers? Interrogating maternal mortality as a violation of the rights to life and health: a Nigerian and Ethiopian perspective Faculty of Law* 13(Unpublished Masters Dissertation,2009) see also Gruskin et al, *Using Human Rights to Prevent Maternal and Neonatal Death* (cited in note 3)

morbidity rate. This thesis will evaluate the effectiveness of the sexual and reproductive health strategies followed by Ethiopia and Kenya by focusing on how it will help achieve maternal health.

Hypothesis and Research Questions

As mentioned above the thesis asserts that maternal mortality and morbidity will be reduced effectively via the application of a rights-based approach as purported by ICPD's Programme of Action. This requires examining some of the developments in maternal health and literature review so as to enlighten the reader on how the writer has come to this assertion and what the writer aspires to prove. Besides that, thorough understanding of a rights-based approach is imperative. Accordingly, the thesis will address major concepts, frameworks and other related matters of a rights-based approach. In addition, it has been mentioned that the thesis will evaluate the effectiveness of sexual and reproductive health strategies applied by Ethiopia and Kenya. This calls for analysis of the sexual and reproductive health strategy adopted in each country.

Limitations of the study

Due to time and resource constraints the research has limited itself to analysis of Constitutions and Sexual and reproductive health strategies of Ethiopia and Kenya. In addition, the analysis of the strategies does not include their implementation. Besides that, the research relies on data from other studies.

Thesis structure

The thesis is divided in three chapters. The first chapter starts by discussion on the trends of maternal health. This will be followed by a literature review addressing different justifications given for high maternal mortality and delays in meeting the set objectives and how a rights-based approach will overcome these challenges.

The second chapter is devoted to a rights-based approach. It discusses its definition, concepts; framework and other elements. It describes the framework including major international and regional human rights instruments that recognise sexual and reproductive rights. The discussion will also continue in the forth chapter where it will address the maternal health related human rights monitoring and evaluation mechanisms both at the regional and international level.

The third chapter focuses on analysing the Constitutional Protection of sexual and reproductive rights and monitoring and evaluation mechanisms availed by the Constitutions of Kenya and Ethiopia. These are neighbouring countries that are found at similar economic situation and geographic location. Subsequently, it moves on to showing how a rights-based approach can be applied in programmes to be more specific in sexual and reproductive health strategies to reduce maternal mortality and morbidity. Based on this information, it analyzes what Kenya and Ethiopia are doing to reduce maternal mortality and morbidity via their sexual and reproductive health strategies. Finally, there is a section for conclusion.

Chapter One: Maternal Mortality and Morbidity from Curse to Human Rights Violation

Introduction

Currently, maternal mortality and morbidity are recognised as a human rights violation.[20] But, the recognition of maternal morbidity and mortality as a human rights concern and the application of human rights in achieving the well being of mothers had a gradual growth and not an easy one.[21] Starting from being considered as something beyond the human capacity and as a tragedy every expecting mother should fear to go through[22] there have been different developments in maternal health. This chapter will discuss these developments, the level of changes recorded as well as justifications for delays.

Section One: Developments in Maternal Health

Different initiatives have been engaged to curb this challenge starting from as early as the 19th century.[23] At the early stages of its development, there was maternal and child health program.[24] Subsequently, there was the safe motherhood program which was the outcome of the International Conference on Safe Motherhood followed by the International Conference on Population and Development Conference and its plan of action, the Millennium Declaration and its development goals and recently the Human Rights Council's resolution recognising the fact as a human rights violation came.[25]

[20] Durojaye, 10AHRLJ at 298 (cited in note 4)
[21] Gruskin et al, *Using Human Rights to Prevent Maternal and Neonatal Death*, at 589-593 (cited in note 3) see also Luisa Cabal, Morgan Stoffregen, *Calling a Spade a Spade: Maternal Mortality as a Human Rights Violation*, 16 No.2 Hum. Rts. Brief 2,4(2009)
[22] Roseman, *Bearing Human Rights at 93* (cited in note 1)
[23] Id see also Amollo, *To let a Woman Die is to Fail* at 12(cited in note 6)
[24] Id
[25] Roseman, *Bearing Human Rights at 93* (cited in note 1) see also Amollo, *To let a Woman Die is to Fail* at 12-14 (cited in note 6)

This chapter is devoted to discussing these trends in maternal health at the global level and changes recorded. Following, this discussion there will be a literature review on justifications for high maternal mortality and morbidity rate.

1.1 Maternal and Child Health Program at the Global Level During the 19th century

Maternal and child health program treated maternal mortality and morbidity as a public health issue.[26] The program adopted multiple interventions such as global vaccination programmes, dietary measures, protection from and cures against diarrhoea including child development supervision mechanisms.[27] Though this program was successful in saving the lives of many new born babies, it could not relieve mothers from the plight they were experiencing as a result of labour and pregnancy complications.[28] This is due to the fact that the approach endorsed by this program took rather indirect route targeting the health and survival of new born child rather than the mother.[29]

As studies carried out around this time showed, causes of maternal mortality were not related with the causes that result in the birth of still child and health of new born babies.[30] It was after the publication of a very renowned article written under the title "where is the mother in maternal and Child Health program?" written in 1985 that maternal and child health program suffers from absence of concerns to the need of the mother was recognised at the global

[26] Id
[26] Id
[27] Gruskin et al, *Using Human Rights to Prevent Maternal and Neonatal Death*, at 590(cited in note 3) *see also* Roseman, *Bearing Human Rights at 94* (cited in note 1)
[28] Gruskin et al, *Using Human Rights to Prevent Maternal and Neonatal Death*, at 590(cited in note 3)
[29] Id at 590-591
[30] Roseman, *Bearing Human Rights at 93-4* (cited in note 1)

level.[31] This showed that it was high time measures employed under this program are replaced by the ones that can enhance the health of mothers.[32]

In addition, the then flourishing movements such as feminism strongly advocated that women should be treated as human beings and that family planning should be done on voluntary basis among other issues.[33] These movements also contributed to the growth of attention to the issue of maternal health around the globe.[34] They played a great role in setting the human rights basis for the upcoming development in matters of maternal health.[35]

One of the achievements of the feminists' movements besides raising the attention was the launching of the "International Day of Action for Women's health" which was held in the 1987.[36] The main theme of this day was "Preventing Maternal Mortality" which emphasized that women's lack of power to be in charge of their own lives is found at the heart of the cause of maternal mortality and morbidity.[37] Subsequently, associations especially those engaged in human rights, recognized the paramount importance of application of human rights in what was termed as sexual, reproductive and related matters.[38]

1.2 The Safe Motherhood Program

Though there were initiatives to curb the high number of women who die while giving birth or prior to delivery, the issue of maternal mortality got worldwide concern as a human rights

[31] Gruskin et al, *Using Human Rights to Prevent Maternal and Neonatal Death*, at 590-591(cited in note 3)
[32] Roseman, *Bearing Human Rights at 93-94* (cited in note 1)
[33] Id
[34] Id
[35] Gruskin et al, *Using Human Rights to Prevent Maternal and Neonatal Death*, at 590 (cited in note 3)
[36] Id
[37] Id
[38] Id at 591-592

issue for the first time in the late 20th century.[39] One of these initiatives that led to such recognition was the International Conference on Safe motherhood held at Nairobi, Kenya. [40] At this conference, prejudice towards women was boldly mentioned as the cause of maternal mortality. [41] The Safe Motherhood Initiative was developed in order to overcome this challenge.[42]

Though the impact of discrimination in maternal health was recognized, the measures taken such as "risk screening during care or training traditional birth attendants" did not bring change in the lives of women as anticipated.[43] In other words, these measures could not overcome the discrimination women face in the society they live in.[44] Human rights were applied to identify causes of maternal mortality and morbidity but the approaches were not successful in addressing women's issues that found on the ground such as their inability to make decisions on their lives.[45]

The 1997 Safe Motherhood initiative review confirmed that there was no change in the situation; mothers in developing countries were still losing their lives due to causes that could have been prevented prior to their occurrence.[46] This initiative has brought invisible change in addressing the problem and the number of deaths sustained.[47] But even if the measures taken failed to tackle the cause, its recognition of women's status as a cause for maternal

[39] Gruskin et al, *Using Human Rights to Prevent Maternal and Neonatal Death*, at 590 (cited in note 3)
[40] Id
[41] Id *see also* Roseman, *Bearing Human Rights at 94* (cited in note 1)
[42] Id *see also* Durojaye, 10AHRLJ. at 293-294 (cited in note 3)
[43] Roseman, *Bearing Human Rights at 94* (cited in note 1)
[44] Id
[45] Id
[46] Roseman Jane Mindy, Jd,PhD and Reichenach Laura,ScD,MPA, *International Conference on Population and Development at 15 Years: Achieving Sexual and Reproductive Health and Rights for All?* 100 American Journal of Public Health 591,591(2010) *see also* Gruskin et al *Using Human Rights to Prevent Maternal and neonatal Death*, at 591(cited in note 3)
[47] Durojaye, 10AHRLJ, at 294 (cited in note 3)

morbidity has laid down the ground work for future application of human rights in the field of maternal health.[48]

1.3 The International Conference on Population and Development (ICPD) and its Plan of Action

Apart from accelerating the consideration of human rights in maternal health programs, the then existing movements especially feminism paved the way for the 1994 International Conference on Population and Development(ICPD).[49] The main agenda of the conference was ensuring reproductive health of individuals via primary health care system till the year 2015 in all countries.[50] This conference was centered on the thesis that deep rooted inequity and prejudice towards women was the cause of maternal mortality and morbidity and that securing human rights is a suitable measure to address the challenge.[51]

As a result of the conference, the definition of sexual and reproductive health was expanded to accommodate reproductive rights.[52] This was a ground breaking achievement in women's rights and sexual and reproductive health.[53] Prior to this conference, the concept of reproductive health and reproductive health programs concentrated on "family planning, fertility control" as well as "safe motherhood" from the perspective of population control.[54] The definition adopted at the conference introduced the concept of human rights and right to health in the realm of sexual and reproductive health.[55]

[48] Roseman, *Bearing Human Rights at 94-5* (cited in note 1)
[49] Gruskin et al, *Using Human Rights to Prevent Maternal and Neonatal Death,* at 591 (cited in note 3) see also Roseman, *Bearing Human Rights at 91* (cited in note 1)
[50] Roseman, *Bearing Human Rights at 94* (cited in note 1)
[51] Id
[52] Id
[53] Sally Griffin, *Literature review on Sexual and Reproductive Health Rights: Universal Access to Services, focussing on East and Southern Africa and South Asia* at 1 (relay and realizing rights,2007)
[54] Id
[55] Id

In addition, the program of action identified obstacles global health faces nowadays.[56] These obstacles are an overlooked health system, growth of poverty and discrimination, continuous gender disparity, and stagnated health indicators across the territory.[57] The conference was adjourned with a plan of action which was adopted by 179 countries.[58] Major objectives of the plan of Action were enhancing the primary health care and the family plan services, increasing the number of births attended by professionals and the number of skilled attendants and the ratio of those who use contraceptive to those who make decisions in the family planning.[59] The Plan of Action has identified a number of sexual and reproductive health programs in line with the above mentioned objective and also an approach that would bring effective and efficient results i.e., a rights-based approach.[60]

Subsequent to the ICPD's meeting, an announcement was made by major international organizations.[61] The announcement underscored that governments' obligations towards the right to life among other things includes promotion of favourable environment vital for individual's life and survival.[62] The announcement also recognized that governments' have the obligation to avail maternal health services and ensure safe motherhood and delivery.[63] This announcement confirmed the alliance with the outcome of the ICPD conference.[64] In addition, the outcome of the meeting held in 1995 on women in Beijing also contributed a

[56] Id
[57] Id
[58] Farina G Abrejo1, Babar T Shaikh and Sarah Saleem, *ICPD to MDGs: Missing links and common grounds*,(Reproductive Health Review,2008) online at http//:www.reproductive-health-journal.com/content/5/1/4 visited February 12,2011 see also Griffin at 1 (cited in note 53)
[59] Id
[60] Id
[61] Gruskin et al, *Using Human Rights to Prevent Maternal and Neonatal Death*, at 589 (cited in note 3)
[62] Id
[63] Id
[64] Id

great deal in advocating women's rights especially women's sexual and reproductive rights as well as reaffirm the commitment made at the ICPD in Cairo.[65]

1.4 The Millennium Development Goals

In the year 2000, leaders of the world assembled in New York at United Nations' office to reaffirm their vow to give more attention to development problems they are facing. [66] At the end of the meeting, states passed eight resolutions known as the Millennium Development Goals or MDGs in the Millennium Declaration to overcome existing challenges such as poverty, discrimination etc.[67]

Reduction of maternal morbidity is one of the Millennium Development Goals.[68] This goal has two sub sets i.e, "reduction of maternal mortality ratio by three quarters, between 1990 and 2015" [69] and "achievement of universal access to reproductive health."[70] This document was adopted by 189 countries.[71] Accordingly, countries attained the obligation to reduce the ratio of maternal mortality till 2015.[72] Under section five of the Millennium Declaration which deals with "human rights, democracy and good governance" governments have a

[65] Gruskin et al, *Using Human Rights to Prevent Maternal and Neonatal Death,* at 591 (cited in note 3) see also Griffin (cited in note 51)
[66] United Nations General Assembly, United Nation's Millennium Declaration , (A/55/L.2/ 55/2 date of release available at http://www.un.org/millennium/
[67] Id see also Souad Abdennebi-Abderrahim, *Millennium Development Goals and the Protocol on the Rights of Women in Africa* , in Patrick Burnett Shereen Karmali and Firoze Manji, ed *Grace Tenacity and Eloquence, the Struggle for Women's Rights in Africa* 22, 25 (Fahamu,2007)
[68] Amollo, *To let a Woman Die is to Fail* at 13 (cited in note 6)
[69] Id see also M. Langford, *Claiming the Millennium Development Goals; A Human Rights Approach* at 29,(United Nations, 2008)
[70] Langford, *Claiming the Millennium Development Goals at* 31 *and see also* UN, Fact Sheet, United Nations summit 202-22 September New York , High level plenary meeting of the General Assembly, Issued by the UN Department of Public Information – DPI/2650 E/Rev.1 - September 2010 online at http://www.un.org/millenniumgoals/pdf/MDG_FS_5_EN_new.pdf (visited November 15,2010) see also Durojaye, 10AHRLJ, at 296 (cited in note 3)
[71] WHO, "Millennium Development Goal" Fact Sheet WHO/MPS/08.15 online at http://www.who.int/making_pregnancy_safer/events/2008/mdg5/mdg5_vs3.pdf (visited November 12,2010)
[72] Id

commitment to work towards democracy, strengthen the rule of law and ensure human rights recognized in the various international instruments. [73]

In the subsequent years, some development has been witnessed in achieving Millennium Development Goals.[74] In the case of maternal health, antenatal care service is one of the areas where progress has been recorded at the global level.[75] The number of women seeking antenatal care has shown tremendous change especially in the Northern parts of Africa, Southern and Western Asia.[76] In addition, though the rate is slower than the previous years the use of contraceptives has also increased.[77] Based on the report issued by "World Health Organization (WHO), the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA) and the World Bank, countries have been able to decrease the number of women dying as a result of complications during pregnancy and childbirth has lowered by 34% from an estimated 546, 000 in 1990 to 358, 000 in 2008 at the global level".[78]

Though this statistics shows a decrease in the rate, it is still lagging behind what has been planned to be achieved in the Millennium Development Goals to be more specific reduction of maternal death by 75% until the year 2015.[79] In order to reach this target 5.5% of reduction of maternal death per year is required.[80] When calculated in percentage, the decline exhibited since 1990 amounts to an average annual decline which is 2.2% lower than

[73] Id at 5
[74] United Nations, *Factsheet* at 1 (cited in note 70)
[75] Id
[76] Id
[77] Id
[78] WHO, *News Release 2010* online at http://www.who.int/mediacentre/news/releases/2010/maternal_mortality_20100915/en/index.html (visited November 12, 2010)
[79] Id
[80] Id

the required.[81] According to several reports, countries will not be able to achieve this goal by that time.[82] For instance in the case of Ethiopia, the 2010 special issue of the Ethiopian Journal of Health Development reports that evaluation of the Health sector development program has witnessed constraints in the achievement of the goals.[83] The Journal also adds that it is unlikely to achieve the goals set by MDGs if the existing obstacles are not removed.[84]

1.5 The Human Rights Council's Resolution on Preventable Maternal Mortality and Morbidity

Taking the number of maternal mortality and morbidity that is increasing at alarming rate, the Human Rights Council issued a resolution on Preventable maternal mortality and morbidity and human rights on the 11th of June 2009.[85] In this resolution, the Council recognized maternal morbidity and mortality as a human rights violation and expressed its deep concern towards the fear of not being able to meet the MDGs by the scheduled time frame.[86] The resolution also urges countries and other stake holders to give more attention in terms of dedication, determination, collaboration and support towards maternal health issues.[87] Similarly, the Women's Protocol, section of the African Commission on human and People's Rights Charter that deals with human rights of women recognizes this issue at the regional level.[88]

[81] Id
[82] Durojaye, 10AHRLJ at 295 (cited in note 3)
[83] Solomon Tesfaye, *A National Scoping Exercise and Strategic Recommendations for Working with Individuals, Families and Communities to improve Maternal and Neonatal Health in Ethiopia,* 24*Ethiop. J. Health Dev* 89,89 (Addis Ababa University,2010)
[84] Id
[85] Durojaye, 10AHRLJ at 298 (cited in note 3)
[86] Id
[87] Id
[88] Id at 299

Section 2 Justifications for High Rate of Maternal Mortality and Morbidity

In the previous section, it has been shown that the issue of sexual and reproductive rights got more emphasis in the various meetings, programs that followed the ICPD.[89] But, the world has not scored visible change in the years following the ICPD.[90] This situation has been recognised as a development breakdown as an indication of the difference between the developed and developing countries, the rich and the poor, and men and women.[91] Several authors have presented various causes for the absence of rapid change in the rate of maternal mortality and in the inability to meet the ICPD or the Millennium development goals which will be addressed in this section.

Some set lack of sufficient funds and absence of attitudinal change as a cause for failure to meet the ICPD goals.[92] HIV/AIDS pandemic that took over the world and attention contributed a lot in the absence of sufficient fund.[93] As a result donors and other financial institutions were not interested in spending money on maternal health care and services such as family planning, sexually transmitted diseases etc.[94] The wrong perception that the crisis related to population was over also exacerbated the lack of financial support.[95] The weakening of the financially strong governments i.e. United States also dwindled the

[89] Id
[90] Durojaye, 10AHRLJ at 295 (cited in note 4) see also Guido Schmidt-Traub, *The Millennium Development Goals and human rights-based approaches: moving towards a shared approach*, 13The International Journal of Human Rights 72,74(February 2009) see also Griffin at 1 (cited in note 51)
[91] Cabal & Stoffregen, 16 No. 2 Hum. Rts. Brief F at 2 (cited in note 20)
[92] Ana Langer,Cairo after 12 years: successes, setbacks, and challenges, published online DOI:10.1016/S0140-6736(06)69486-5(November 1, 2006)
[93] Roseman and Reichenach, 100 American Journal of Public Health at 404 (cited in note 45) see also Langer (cited in note 92)
[94] Langer (cited in note 92)
[95] Id

availability of funds.[96] Absence of political will resulted from the negative attitude towards the use of contraceptives etc. [97] In most cases it was considered as promoting promiscuity in the society.[98]

Other researchers have stated that the high rate of maternal mortality and morbidity is not due to lack of resources but lack of political will due to the sensitivity of the issues.[99] Sally Griffin in her review suggests the contrary. She stated that the delays in achieving the set goals are attributed to a combination of two factors i.e., socio cultural and political.[100] Unlike what has been stated above she argued that lack of political will is the outcome of socio cultural factors exhibited across the different cultures.[101] These socio cultural factors that perceive men as powerful and adventures and women as submissive as well as the traditional practices such as seeking traditional practitioners instead of public health services exacerbated the situation.[102] These situations have resulted in absence of supportive legal framework and accountability ensuring mechanisms.[103] Taking both arguments the writer believes that factors mentioned above financial, socio-cultural and political reinforce one another. Even though sexual and reproductive health has been recognised as human right and vests states with obligations to be met it has not been put in practice and various states the high rate of maternal death failed to get the necessary attention it required in order to divert attention towards this matter.

[96] Id
[97] Id
[98] Id
[99] Id
[100] Griffin at 2 (cited in note 53)
[101] Id at 3
[102] Id
[103] Id

Abrejo and his/her colleagues justify the situation by analyzing the health care system. The writers stated that maternal mortality results from series of uncoordinated initiatives and lack of collaboration among different organs, narrow approaches that failed to accommodate the various ICPD's agendas.[104] These problems were reflected in the insufficient health care systems, transformation of health sector with blurred objectives, absence of mechanisms for reporting and accountability at the domestic level for government activities, ineffective outcome of institutions engaged in development issues and policies of funding organizations and insufficient NGOs' policy advocacy capacity.[105]

Cabal and Stoffregen's explanation on the complexity of maternal mortality and morbidity issue can be an explanation to what has been mentioned as absence of reporting and accountability at the domestic level for government activities. The writers state that the fact that maternal mortality and morbidity involves several factors such as education, nutrition etc makes it hard to pinpoint the perpetrator.[106] IN another research, the creation of constructive accountability mechanism via a rights-based approach has been suggested as a solution.[107] This solution has also been supported by other writers such as Alica El Yamin.[108] Similarly, in another study it has been pointed out that countries' failure to meet MDG is attributed to the absence of a rights-based approach in their initiatives towards meeting the goals.[109]

[104] Farina G. Abrejo, Babar T Shaikh and Sarah Saleem,, *ICPD to MDGs: Missing Links and Common Grounds*, *Reproductive Health Journal*,(September 2008online at http://www.reprodctive-health-journal.com.content/5/1/4 (visited March 15,2011)
[105] Id at 3
[106] Cabal & Stoffregen, 16 No. 2 Hum. Rts. Brief F at 4 (cited in note 20)
[107] Kirstan Hawkins et al, *Developing a Human Rights-Based Approach to Addressing Maternal Mortality*, at 6(DFID Health Resource Centre,2005)
[108] Alicia Ely Yamin, *Toward Transforming Accountability: Applying a rights-Based Approach to fulfil maternal health obligations*, 7Sur J 94,96(June 2010)
[109] Abdennebi-Abderrahim, *Millennium Development Goals and the Protocol on the Rights of Women in Africa at* 22 (cited in note 67)

The study conducted by Abrejo, provides list of recommendations which indicate similar solution. Accordingly, countries need to reinforce their level of resource allocation, enhancing primary health care services and emergency obstetric care as well as the application of good governance to increase the interest of the human resource.[110] Such initiatives should be based on national policies formulated based on evidence," reproductive health services which are affordable, accessible and culturally acceptable and responsive to societal health needs."[111]

In another research, it was emphasized that impediments in accessing information and reaching available, qualified health services in/on time is also one of the causes that result in maternal mortality and morbidity.[112] For instance in the case of Ethiopia very weak financial condition stand as one of the constraints in getting proper health care.[113] Besides that, lack of sufficient number of health centres, providers and hospitals in the nearby is also another challenge.[114] This idea gives an insight as to insufficient health care system discussed by Abrejo.

Traub provides human rights perspective to the justifications. This writer identified absence of good governance, or unfulfilled obligations towards the realizations of human rights especially civil and political rights or external factors, uneven progress and absence of due attention or combination of the above mentioned situations have been identified as

[110] Abrejo, Shaikh and Saleem, *ICPD to MDGS* (cited in note 58)
[111] Id
[112] Abdella Ahmed, *Maternal Mortality Trend in Ethiopia*, 24Ethiopian J. of Health Dev. 115, 115 (2010) *see also* Durojaye, 10AHRLJ at 293 (cited in note 3) *and see also* Filippi et al at P. 1535(cited in note 9)
[113] Melaku Yilma, Mulugeta Betre and Solomon Tesfaye, *Utilization of Post-Abortion Care Services in Three Regional States of Ethiopia*, 24Ethiop. J. Health Dev. 123,123 (2010)
[114] Id

challenges in achieving the ICPD's expected goals. [115] Especially in the case of maternal health, lack of due attention resulting from either lack of awareness on how to deal with the issue or prioritization has stood as an obstacle.[116] The study puts the causes in terms of human rights and duties of governments. Though the language is different this justification concurs with Abrejo's justification. Thus, the lack of awareness mentioned in the above discussion suggests absence of a rights-based approach.

Other studies in the field of maternal health state that causes of maternal death go beyond the provision of quality healthcare services and are mainly due to women's low status.[117] This situation among other things is reflected in discrimination women face, life of destitution they lead and absence of women's decision-making powers. [118] This brings back the absence of attitudinal change as an underlying cause. In the study, it was asserted that maternal mortality is high because its the issue of women who apparently hold low position among societies, who are vulnerable groups of the society.[119] A very renowned Doctor known as Dr Halfdan's Mahler stated that;

> *"Maternal mortality is a neglected tragedy and it has been neglected because those who suffer it are neglected people with the least power and influence over how national resources shall be spent; they are the poor, the rural peasants and above all, women"*[120]

[115] Id *see also* Traub, *The Millennium Development Goals and human rights-based approaches* at 74-76(cited in note 86)
[116] Roseman and Reichenach, 100 American Journal of Public Health at 403 (cited in note 45)
[117] Mindy, Jane Roseman, *Bearing Human Rights* at 94(cited in note 1)see also Gruskin et al, *Using Human Rights to Prevent Maternal and Neonatal Death,* at 591 (cited in note 3) and also Ebenezer, 10AHRLJ at 298 (cited in note 3) and also Filippi et al, *Maternal health in Poor Countries* (cited in note 9)and also Alvarez, et al, *Factors associated with Maternal Mortality in Sub-Saharan Africa* at 5 (cited in note 2)
[118] Id
[119] Id
[120] Roseman, *Bearing Human Rights* at 94(cited in note 1)

Looking at the status of women in developing countries where the rate of maternal mortality and morbidity is high, women have been considered lower than men for long. [121] Consequently, they have been neglected the right to education, work, participation, equality and been subjected to discrimination in different aspects of their lives and disempowerment.[122] Ever since they were born, their lives were filled with inability to make one's own choices and decisions regarding ones education, relationships, sexual and reproductive rights.[123]

In addition to the above mentioned causes, harmful traditional practices such as early marriages, marriage by kidnap also play a great role in increasing the number of the death tolls via unplanned pregnancies and risk of abortions hazardous to one's health. [124] Female genital mutilation one of the harmful traditional practices is still practiced in many parts of developing countries.[125] Starting from "Sunna mutilation, excision and infibulations" several forms of it have been practiced in Africa, the middle and far eastern countries.[126] Besides depriving women of their reproductive organs, it subjects them to infections and complicated delivery.[127]

All the studies address causes that are intertwined and part of the bigger picture. But, the research conducted by Rebecca Amollo gives a comprehensive analysis and provide a bigger picture that reflected underlying causes maternal mortality and morbidity. As the study

[121] Abrejo1, Shaikh and Saleem, *ICPD to MDGs* (cited in note 58)
[122] Yamin, 7Sur J at 95(cited in note 100)
[123] Id see also Cabal & Stoffregen, 16 No. 2 Hum. Rts. Brief F at 2 (cited in note 20)
[124] Melaku Yilma (cited in note 104)

[125] Bruce A Robinson, *Female Genital Mutilation (FGM) in Africa, the Middle East & Far East,* online at http://www.religioustolerance.org/fem_cirm1.htm (visited March 15, 2010)
[126] Id
[127] Id

conducted by Rebecca Amollo points out several factors contribute to the failure to meet these goals where most of them can be written as violation of women's human rights.[128]

The first point summarizes what has been said about the low status of women. It states that the situation of women among the society contribute to the current situation.[129] Women are denied education, forced to get married and give birth at early stages of their lives.[130] They have no power to make decisions particularly decision related with their reproductive life as well as poor nutrition.[131]

Secondly, there are traditional beliefs entrenched in the society that shutter awareness regarding symptoms of problems during pregnancy and needs.[132] Thirdly, inaccessible, economically unaffordable and poor quality health care services with insufficient number of qualify stuff, supplies, utensils and inadequate referral systems exacerbate the situation.[133] At last but not least, there is a legal and policy framework that does not provide the necessary support or where there is lack of effective implementation of laws.[134] These factors are most of the time reciprocally reinforcing, has straight relationship with poverty.[135] When redefined in terms of human rights, the above mentioned factors directly point at violation of women's

[128] Kirstan Hawkins et al, *Developing a Human Rights-Based Approach to Addressing Maternal Mortality*, at 6(cited in note 99)
[129] Id
[130] Id
[131] Id
[132] Kirstan Hawkins et al, *Developing a Human Rights-Based Approach to Addressing Maternal Mortality*, at 6(cited in note 99)
[133] Id
[134] Id
[135] Id

human rights.[136] These challenges can be addressed via the application of a rights-based approach.[137]

Conclusion

Maternal Mortality and Morbidity is one of the major causes of death at the global level. Though it has been recognised as a curse each and every expecting mother should fear to go through via gradual development the world today recognizes it as a human rights violation. The conference held in Cairo on Population and Development issues in 1994 played a pivotal role in introducing human rights in the realm of sexual and reproductive health. The plan of action which is the product of the conference incorporates list of activities to ensure sexual and reproductive health as well as approach to follow. Accordingly, it introduced a rights-based approach. The various reproductive health programs developed in the plan of action have been adopted by 179 countries and reaffirmed in the upcoming conferences such as the Beijing platform of Action.

Though all these promises have been made, the world has recorded insignificant changes in ensuring sexual and reproductive health rights as well as reduces the number of maternal mortality and morbidity. Various justifications have been provided by different researchers which have been entertained in this chapter. Lack of financial resource, political wills, socio cultural factors, unfulfilled obligations, dysfunctional health system, situation of women in the society have been raised as a justifications. It has been concluded that the high rate of

[136] Kirstan Hawkins et al, *Developing a Human Rights-Based Approach to Addressing Maternal Mortality*, at 7(cited in note 99) see also International Intitiave on Maternal Mortality and Human Rights, *Human Rights based Approaches to maternal Mortality Reduction Efforts* at 6(International Intitiave on Maternal Mortality and Human Rights, 2010)
[137] Id

maternal mortality and morbidity is due to combination of these several factors which are intertwined. All these factors can be redefined in human rights terms and that via the application of a rights-based approach as purported by the ICPD and affirmed by Beijing plat form for action etc these challenges can be overcome. The second chapter is devoted to discussing what this approach is, its components and other related issues.

Chapter Two: International, Regional and Domestic Human Rights Standards and Monitoring and Evaluation Mechanisms

Introduction

Various international NGOs have adopted human rights as a means to "constructively engage" with governments so that they would be able to realize their human rights obligations.[138] In the United Nations for instance, it was the former secretary general's remark in the year 1997 that opened the way for the application of a rights-based approach in the works of the United Nations.[139] This chapter will discuss the definition, concepts, and frameworks of a rights-based approach.

Section One: A Rights-Based Approach: Definition and Basic Concepts

2.1 Definition of a Rights-based Approach

Though it has been put to practice, a rights-based approach has never got its own definition.[140] Organizations have been giving it interpretations in line with their own objectives, visions and missions keeping the human rights principles, norms etc.[141]

2.2 Basic Concepts of a rights-based approach

Though a rights-based approach does not have its own specific definition, building up from their experience the UN agencies issued a document known as "statement of common

[138] Roseman *Bearing Human Rights* at 101 (cited in note 1)
[139] UNFPA, *A Human Rights–Based Approach to Programming: Practical Implementation Manual and Training Materials* at 39 (UNFPA, Harvard School of Public health , 2010)
[140] Roseman, *Bearing Human Rights* at 101 (cited in note 1)
[141] Id

understanding" of a rights-based approach.[142] According to this statement, a rights-based approach means that all "development" plans, projects, etc should be geared towards making human rights a reality.[143] These programmes should be developed and channelled through international human rights instruments.[144] "Development" plans, projects, should be designed, developed, implemented, monitored and evaluated in light of human rights principles, norms, standards.[145] These norms, standards etc are to be applied in each step starting from the beginning i.e., the selection of interventions, identification and selection of targets, enumerating resources and communications followed by effective and efficient implementation etc.[146] All these features give a rights-based approach a unique nature.[147]

As mentioned above, a rights-based approach functions with a human rights standards, principles, goals. The various human rights instruments both at the international and regional level provide the goals, norms and standards within which a rights-based approach functions.[148] Monitoring and evaluation mechanisms found at the international and regional level also form part of a rights-based approach framework.[149] While the monitoring and evaluation mechanisms will be addressed in the third chapter in the present chapter, the human rights principles and standards that form the framework for a rights-based approach will be discussed below.

[142] United Nations ,*State of the World's children* (United Nations 2004)at 91 online at http://www.unicef.org/sowc04/files/annexB.pdf (visited November 17,2010)
[143] *Id.*
[144] Langford, *Claiming the Millennium Development Goals* at7(cited in note 70)
[145] UNFPA, *A Human Rights–Based Approach to Programming* at 154(cited in note 139)
[146] Traub, *The Millennium Development Goals and human rights-based approaches* at78-83(cited in note 90)
[147] Hawkins et al, *Developing a Human Rights-Based Approach to Addressing Maternal Mortality* at 49(cited in note 107)
[148] Id.
[149] UNFPA, *A Human Rights–Based Approach to Programming* at 180*(cited in note 139)*

2.3 The Human Rights Principles and standards that establish the framework for application of a rights-based approach

It is well known that by virtue of their nature individuals have human rights.[150] These human rights are "'universal, inalienable, indivisible, interdependent and interrelated".[151] The universal nature of human rights indicates that each individual is vested with human rights at all times.[152] These rights are inalienable in that it is impossible to throw them away whether willingly or unwillingly as well as take ownership of other individuals' human rights.[153] Article 55-56 of United Nations Charter and Universal Declaration of Human Rights in its articles 1 and 2 including the Vienna Declaration in its article 1 imply these principles.[154]

Interrelatedness of human rights refers to the intricate connection the various human rights have with one another.[155] Interdependent nature of human rights can be interpreted in two ways.[156] It refers to the relationship between the rights themselves and between those who own them i.e., individuals.[157] In order to realize right to life individual's right to food must be realized. In addition, absence of realization of right to education affects a person's ability to realize his/her right to work. These two examples illustrate what has been mentioned regarding interdependence of human rights.

[150] Gillian Macnaughton and Diane F. Frey, *Decent Work for All: A HolisticHuman Rights Approach, 26 Am.U.Int'l L'Rev 441,455(2011)*
[151] Id
[152] Id
[153] Id
[154] Id at 456
[155] Id at 456
[156] Id at 457
[157] Id at 457

The definition of indivisibility of human rights is a bit obscure when compared with the other characteristics.[158] Some define it in terms of the value human rights have to one another where the value of one rights is amplified by the presence of the other.[159] Others define it in terms of obligations they vest government with i.e. the measure of the obligations to defend support and fulfil.[160]

All human rights are also inherent to individuals.[161] Due to this fact, there is no hierarchy or order among the various human rights. [162] The preamble of Universal Declaration of Human Rights as well as International Covenant on socio economic rights and the Vienna Declaration affirm this.[163] All these characteristics or principles of human rights form part of the human rights framework.

Section two: Human Rights Standards Constituting a Framework of a Rights-Based Approach

As it has been mentioned previously, a rights-based approach functions within a framework composed of human rights standards, principles, goals and norms. This framework is made up of "soft" and "hard" human rights laws' standards found at the international or regional level and also at the domestic level.[164]

[158]Id at 460
[159] Id
[160] Id
[161] Id
[162] Id
[163] Id
[164] Yamin, 7Sur J 94 at 97 (cited in note 108)
[164] Id *see also* Cabal & Stoffregen, 16 No. 2 Hum. Rts. Brief F at 2 (cited in note 21)

Maternal health is a major component of right to highest attainable standard of health [165]. UDHR in Article 25 recognizes that individuals are entitled to a living standard sufficient for their health as well as the well-being of their family. The same article also gives due recognition to motherhood and the special assistance it requires.

Article 10(2) of ICESCR states that mothers should be provided with special care before and after they give birth for a reasonable period of time. Article 12 sub article 1 of the same document acknowledges the right to health though it does not mention maternal health. Among other things this right obliges states to ensure reasonably priced, suitable, high quality and all-inclusive reproductive health services and also fair distribution of existing resources.[166]

In General comment Number 14, the ICESCR committee elaborates on article 12 of the socio economic rights convention. [167] In paragraph 8 of this commentary, the committee emphasised that the right to health is not an entitlement to be healthy but it does incorporate two notions.[168] The first one is the authority to have a say on one's health and body which also includes sexual and reproductive autonomy as well as liberty from interference such as torture, medical treatment without consent etc.[169] Accordingly as stated in the commentary, individuals are entitled to a scheme that works based on equity so that they will be able to

[165] Hunt and Bueno de Mesquita, *Reducing Maternal Mortality; The Contribution of the Right to the Highest Attainable Standard of Health at 5* (cited in note 17)
[166] UNFPA, *A Human Rights–Based Approach to Programming* at 180(cited in note 139)
[167] General Comment No. 14, ESCR Committee 22nd session(2000) in United Nations, *compilation of general comments and general recommendations adopted by human rights treaty bodies* , HRI/GEN/1/Rev.7 at 86 (12 May 2004)
[168] Id at 88
[169] Id

reach the highest standard of health.[170] The General Comment further states that equity enables individuals to get services from range of facilities, supplies, and circumstances necessary for the realization of the right.[171] As stated in the commentary, among other things the right includes four major elements i.,e "*availability accessible, acceptability and quality".*[172]

In relation with article 12 (2) (a) though the article does not specifically address maternal health, it can be understood from paragraph 14 of the General Comment that it does give recognition to maternal and reproductive health rights as well as child health.[173] The Committee in this commentary stated that ensuring maternal and child health incorporates putting in place measures including family planning services, care during and after child birth, obstetric services in time of emergency, and availability of information and resource to exercise on that information.[174] In terms of maternal health, this entitles women to services during pregnancy and after delivery as well as to range of services on sexual and reproductive health as well as provision of information.[175] These services include access to skilled attendance during delivery, emergency obstetric services, sexual and reproductive health education and information and in cases where it is not contrary to the law access to service of safe abortion and other relevant sexual and reproductive health services.[176]

[170] Id.
[171] General Comment No 14 cited in note 167
[172] See General Comment para 12 at 88-89 (cited in note 167)
[173] General Comment No 14 at 90 (cited in note 167)
[174] Id.
[175] Amollo, *To let a Woman Die is to Fail* at 18(cited in note 6)
[176] Id

Article 5 of CERD on the other hand obliges states to ensure the "right to public health, medical care, social security and services without discrimination". CEDAW obliges states to guarantee equitable access to services of health care as well as family planning in article 12(1). In addition, sub article 2 talks about services appropriate to pregnancy, during pregnancy, confinement, after birth period including nutrition. In its Article 14(2) this document gives special attention to women living in rural areas. It obliges states to take the necessary measures to eradicate discrimination and ensure they participate in and enjoy the benefits of development in rural areas especially access to sufficient health care services as well as counselling and family planning. Article 24(1) and 2 of CRC also recognises Children's Right to health. CRPD in its Article 25 acknowledges this right in respect of people living with disability without discrimination.

At the regional level, the African charter in its article 16 recognizes the right to health and States' obligation in its sub article 2. The Women's Protocol in its article 14(1) obliges states to guarantee health and sexual and reproductive entitlements. This article also adds that the right to reproductive rights includes women's right to control how many children to have children, when to have them and contraception means. This article also embraces self protection and protection against sexually transmitted infections, information on health status of oneself and partners in line with internationally recognised rules and excellent practices.

As per article 14(2) states have the obligation to put in place the required measures to ensure sufficient health services which are reasonably priced and accessible by the society which also provide data and facts, education, and communication giving emphasis to women living in rural areas. This article also adds that states also have the duty to build up and enhance the

capacity of existing health services before, after and during delivery. The article, also added that states have the obligation to set up and build the capacity of existing health and nutritional services before, during and after birth including breast feeding period. Moreover, the article addresses the right to legalized termination of pregnancy via medical means in cases of women who are victims of sexual assault, rape, when incest is committed and where sustaining pregnancy imperils status of the mother or her life or that of the foetus mentally and physically. Article 14 of the Charter on the Rights and Welfare of the Child and the Abudja Declaration on HIV/AIDS address the same issue.

Among the soft human rights laws found at the international level[177], Programme of Action of the ICPD in its, Principles 8 and paragraph 41 of the Vienna Program of Action acknowledge the right to health. Paragraph 7.2 of the ICPD program action defines the term reproductive right. Paragraph 89, 92 and 94 including 106(c, e and i) of the Beijing Platform of Action also talk about the same right. Though they are not binding on states, these documents hold guiding principles that give details on provisions addressing vulnerable groups, and craft a link between health and human rights.[178]

Besides the right to highest standard of health, sexual and reproductive health entails a range of other rights besides the right to highest standard of healthi.e., "right to life[179], liberty and security of person[180], right to decide the number and spacing of children[181], right to found a

[177] UNFPA, *A Human Rights–Based Approach to Programming* at 46 (cited in note 139)
[178] Id
[179] UDHR Art 3, ICCPR Art 6(1), CRC Art 6, and CRPD Art 10. the African Charter Art 4 and the protocol to the African Charter on the Rights of Women Article 4(1) see also ICPD's Program of Action: The first principle
[180] UDHR Art 3, ICCPR Art 9(1), CRPD Art 14 the African Charter Article 6**,** see also ICPD's Program of Action**,** principle 1, para 7.3 , Beijing Platform of Action Para. 7.17, and 96

family and marriage,[182] right to privacy,[183] right to equality and non-discrimination,[184] freedom of women and girls from harmful practices,[185] right not to be subjected to torture or other cruel, inhuman, or degrading treatment or punishment,[186] freedom from sexual and gender-based violence,[187] right to receive information,[188] right to enjoy the benefits of scientific progress[189]„.[190]

As it can be noted from the foot notes components of this right have been recognized in international human rights instruments such as Universal Declaration of Human Rights(UDHR), International Convention on Civil and Political Rights (ICCPR), International Convention on Economic Social and Cultural Rights (ICESCR), Convention on

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[181] CEDAW Art 16(1) e, CRPD Art 23(1), the protocol to the African Charter on Women's Rigths Art 14 , ICPD Programme of Action, principle 8,. para 7.3, and 7.12 , the Beijing Platform of Action Para 223

[182] UDHR Art 16(1), ICCPR Art 23(2) and, (3) and (4) , ICESCR Art 10(1) of the, CEDAW Art 16(2), CRPD Art 23, the Protocol to the African Charter on rights on women Article 6, ICPD's Program of Action Principle 9,The Beijing Platform for Action Para 274(e)

[183] ICCPR Art 17(1), CRC Art 16 and CRPD Art 22(1), ICPD's Program of Action Para 7.45, The Beijing plat form of actions Para 107(e)

[184] ICCPR and ICESCR Art 2(1), CEDAW preamble, Art 1, Art 3, CRC Art 2, Article 5, CRPD Art 6(1), the African Charter Art 18(3), Article 28, of the Protocol to the African Charter on the right of women Art 2(1), Vienna Declaration Para 18, ICPD Programme of Action principle 1. Paragraph 4.4, Beijing Platform for Action PAra 32 and Paragraph 232(a)

[185] CEDAW Art 2(f), CRC Art 5(a), The Protocol to the African Charter on Women's Rights Art 2(1), Article 2(2), Article 5, The Vienna Declaration Para 38 and paragraph 49, the ICPD Program of Action Para 5.5 and 224

[186] UDHR Art 5, CRC Art 37 (a), CRPD Art 15(1), ICCPR Art, CAT Art 1,,Article 15(2), The African Charter Art 5,The Vienna program of action Para 56, The ICPD Programme of Action Para 4.10

[187] CEDAW Art 5(a) and Art6, CRC Art 19(1) and Art 34, CRPD Art 16(1),The Protocol to the African Charter on the Rights of Women, Article 3(4) Art 4(2),The Vienna Declaration Para 18, ICPD's Programme of Action Para38, Principles 4

[188] CEDAW Art 10, CRPD Art 23, the African Charter Article 9(1), TheProtocl to the African Charter o the Rights of women Art 14(1)e, ICPD's programme of Action Para 7, paragraph 7.46, Beijing's Platform of Action Para74

[189] UDHR Article 27(1), ICCPR Art 7, ICESCR Art 15(1) and Vienna Declaration Para 11

[190] Centre for reproductive Rights, *Reproductive Rights are Human Rights* , at 7 (United states,2009,) *see also* Amollo, *To let a Woman Die is to Fail at* 15(cited in note 6)

the Elimination of Discrimination against Women (CEDAW), Convention against Torture (CAT), Convention on the Rights of the Child (CRC), etc.[191] The recently adopted Convention on the Rights of Persons with Disabilities(CRPD) recognized the rights to sexual and reproductive health expressly as a right for the first time.[192] At the regional level there are human rights documents i.,e the Charter on Human and Peoples' Rights (the African Charter) and the Charter on the Rights and Welfare of the Child including the Charter on the Rights of Women in Africa (Protocol on the Rights of Women in Africa) specifically addresses this issue.[193] These documents constitute the hard laws that make up the framework of a rights-based approach to sexual and reproductive right.

Ratification of these instruments confers an obligation to respect, protect and fulfil.[194] The obligation to respect obliges states to refrain themselves from violating or interfering with the rights in any way. [195]The obligation to protect obliges states to take measures to protect individual from third party interference.[196] The obligation to fulfil obliges states to take measures positive and effective so as to ensure realization of these rights.[197] In the case of socio economic rights the states attain the duty to make the various rights available, accessible, affordable and acceptable.[198] Moreover their obligation is divided into immediate

[191] Id at 7
[192] Id at 5-6
[193] Id *see also* Amollo, *To let a Woman Die is to Fail at* 16(cited in note 6)
[194] Tenywa Aloysius Malagala, *Is there a need for a human rights based Approach to health in Uganda?* 35Commonwealth Law Bulletin 463,475(September 2009) see also Hunt and and Bueno de Mesquita ,*the Rights to Sexual and Reproductive Health*, at 10 (cited in note 17)
[195] Malagala, *Is there a need for a human rights based Approach to health in Uganda?* at 476 (cited in note 186) see also Hunt and Bueno de Mesquita at 10 (cited in note 17)
[196] Id at 475 and at 10 respectively
[197] Id at 476 and at 10 respectively
[198] Id

measures and measures they have to put in place progressively unlike civil and political rights where states are obliged to take steps immediately.[199]

Section three: Added values of application of a rights-based approach

While utilizing a rights-based approach to programs on maternal health etc, accountability, non-discrimination, participation, empowerment and evidence based prioritization will be ensured.[200]

3.1 Ensuring Accountability of duty bearers

Accountability of organs vested with responsibilities is not only a key element but the main centre of a rights-based approach.[201] As the former special rapportteur of the right to health at the United Nations, Paul hunt has mentioned in his speech, human rights demand accountability and without accountability there is no guarantee that obligations, pledges, promises and good intentions will be ensured.[202] Hence, it is imperative that all programs should have accountability creating mechanisms so as to ensure duty bearers undertake their responsibilities effectively and efficiently.

[199] Id
[200] Hawkins et al, *Developing a Human Rights-Based Approach to Addressing Maternal Mortality* at 11(cited in note 107)
[201] Id *see also* Yamin, 7Sur J 94 at 96 (cited in note 108)
[202] Paul Hunt, UN Human rights Council panel on Maternal Mortality and the Human Rights of Women 5 June 2008, online at http://www2.essex.ac.uk/human_rights_centre/rth/pressreleases.shtm (visited July 20,2011)

Accountability can be ensured in two ways.[203] The first method is by focusing on the human rights treaties and conventions and applying them as formal laws.[204] This rights-based approach uses the human rights standards recognized in the human right treaties and conventions in an explicit manner to design the parameters for programs.[205]

The second way of ensuring accountability is by creating positive accountability so as to create a system beneficial to the society.[206] It emphasizes building a positive accountability so as to create a health system responsive to people's needs.[207] This positive accountability resorts to alternative means such as rights focused monitoring and follow up, public discussion and bigger number of public participation in matters that affect the public's life to ensure accountability.[208] But, it does not mean that legal recourse is out of the purview of a rights-based approach.[209] It adds a different perspective in the analysis of situations and does not abandon the contribution of expertise from a different field and design of an effective program.

This approach will bring better result in the case maternal mortality.[210] It recognizes that maternal mortality is a combination of different factors which are political, societal, and fiscal and developmental.[211] In this method, human rights are applied to intensify the analysis

[203] Hawkins et al, *Developing a Human Rights-Based Approach to Addressing Maternal Mortality* at 9(cited in note 99)
[204] Id
[205] Id
[206] Id
[207] Hawkins et al, *Developing a Human Rights-Based Approach to Addressing Maternal Mortality* at 9(cited in note 107)
[208] Id
[209] Id at 11-12
[210] Id.
[211] Hawkins et al, *Developing a Human Rights-Based Approach to Addressing Maternal Mortality* at 9(cited in note 107)

and understanding of the causes of maternal mortality and strengthen measures that would be taken to avert the situation.[212] This approach does not only focus on human rights but also opens avenue for other means applied by health and policy analysts.[213]

3.2 Ensuring Participation

Ensuring participation of right holders/community in the design, implementation and monitoring and evaluation is the other key aspect of a rights-based approach.[214] Besides being key element, participation is one of the fundamental human rights recognized in various instruments.[215] Accordingly, maternal health initiatives should ensure the inclusion and representation and opportunity to speak out for women and the impoverished ones.[216] A meaningful participation undertakes identification of various stakeholders, development of selection criteria, ensuring inclusion of representatives from local or national government.[217] It also requires preparation of a list of issues to be addressed and to what extent they should address these issues, the identification of the relationship between the group and the political structure and authority dynamics in the society.[218] Thus, it's one form of empowerment and aids individuals to take part in the design and plan of sexual and reproductive health programs they will benefit from.

[212] Id
[213] Id
[214] Id
[215] Hawkins et al, *Developing a Human Rights-Based Approach to Addressing Maternal Mortality* at 9(cited in note 107)
[216] Id at 12
[217] Id
[218] Id.

3.3 Empowering right holders

Empowerment of right holders also has a paramount importance in a rights-based approach and in the creation of a system that is beneficial to society.[219] It plays a key role in the realization of social and political change by enabling both individual and groups that advocate individual's right to demand and directly claim rights.[220] Empowerment works by enhancing the relationship between individuals and government by identifying their respective entitlements and duties.[221] One way of empowerment is human rights focused education.[222] This enables individuals to become assertive of their rights by enhancing their consciousness of their entitlements and the gaps between their entitlements.[223] They will also be aware of their government's effort to realize these rights and also helping them seek ways to close the gaps i.e., coming up with recommendations on how to best make maternal health services available to those who need it.[224] Thus, empowerment helps individual live a life they deserve by strengthening the accountability systems.

3.4 Inclusion and non-discrimination

A rights-based approach focuses also on inclusion and non discrimination.[225] The principle of inclusion incorporates non discrimination within itself which requires addressing all sections of the society or the challenges hindering access to such services.[226] In the present case, it emphasizes on the achievement of health, the capacity to achieve good health besides the

[219] Hawkins et al, *Developing a Human Rights-Based Approach to Addressing Maternal Mortality* at 12(cited in note 107)
[220] Id
[221] Id at 10

[222] Id
[223]Hawkins et al, *Developing a Human Rights-Based Approach to Addressing Maternal Mortality* at 12(cited in note 99)
[224] Id
[225] Id
[226] Id

distribution of health care, non-discrimination in the health system, issues of social justice and equity in its overall sense.[227] Through this approach individuals who are disadvantaged, vulnerable or marginalized will be reached.

As it has been mentioned above a rights-based approach works on participation, empowerment and non-discrimination of especially vulnerable groups of the society, it makes it sensitive to culture and gender issues.[228] Culture refers to beliefs, attitude, values, behaviours and tradition upheld as a result of affiliation and socialization to certain groups that differ from place to place resulting in varying cultures.[229] This entails the importance of ensuring the participation of religious leaders, faith based organizations and the community at large.[230] Gender sensitivity entails that programs starting from designing should address concerns of both men and women so as to ensure equal opportunity to benefit from programs.[231] Both attitudes contribute in the creation of suitable and effective programs.

3.5 Evidence Based Prioritization

Additional point worth mentioning in relation with a rights-based approach is the fact that it gives due attention to resources.[232] Since sexual and reproductive health is major component of the right to health and at the same time raises other socio economic rights such approach also calls for the recognition of the fact that these rights will be realized progressively.[233] It is

[227] Hawkins et al, *Developing a Human Rights-Based Approach to Addressing Maternal Mortality* at 12(cited in note 99)
[228] Id at 24
[229] Id *at* 27
[230] UNFPA, *A Human Rights–Based Approach to Programming* at 179(cited in note 139)
[231] Hawkins et al, *Developing a Human Rights-Based Approach to Addressing Maternal Mortality* at 30(cited in note 99)
[232] Id
[233] Id at 12-13

imperative to take into consideration resource limitations. [234] Hence, in order to make a rights-based approach to maternal mortality effective, evidence based prioritization of activities is important in collaboration with beneficiaries, activists and governments.[235] The application of a rights-based approach ensures this issue is duly considered while developing national programs.[236] This will ensure the creation of a political will and an effective program towards maternal health.

Section Four: Monitoring and Evaluation Mechanisms at the International and Regional Level

There are mechanisms both at the international and regional level established to ensure states keep their share of responsibility, promote the realization of human rights etc.[237] These mechanisms are also important in a rights-based approach.[238] At the international level, there are the Human Rights Council, Charter Based monitoring and evaluation mechanisms as well as treaty based mechanisms including the different branch organizations of United Nations such as UNICEF, UNFPA, UNDP etc and other international organization such as WHO.[239] As these organizations are vast this chapter will discuss only the works of Human Rights, council, charter and treaty based mechanisms, and the African Human Rights commission at the regional level.

[234] Id
[235] Hawkins et al, *Developing a Human Rights-Based Approach to Addressing Maternal Mortality* at 12-13(cited in note 99)
[236] Id
[237] Callmard Egnes, 77 *Accountability, Transparency and freedom of Expression n Africa* at 1213 (Winter 2010)

[238] UNFPA, *A Human Rights–Based Approach to Programming at* 180(cited in note 139)
[239]Id at 57

4.1 Monitoring and Evaluation Mechanisms at the International Level

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4.1 .1 Human Rights Council

Human Rights Council is a subsidiary organ of the United Nations created by the United Nations in 2005.[240] This is the organ that replaced the United Nations General Assembly.[241] Human Rights Council is established to strengthen the realization of human rights around the world.[242] This organ deals with human rights violations, encourages assistance towards human rights and education, assists international human rights law development, reassesses the human rights records of states that are member to United Nations, undertakes human rights abuse prevention tasks, takes action in cases of urgent situations and works as a worldwide platform for conversation on issues related with human rights.[243] The first members which are 47 were elected on May 9, 2006.[244]

The resolution it issued in 2009 which explicitly acknowledged that preventable maternal mortality as a human rights violation is a very good example.[245] Though this document has been discussed lightly in the first charter its advantageous to reiterate it and add more information. The Human Rights Council in this resolution on preventable maternal mortality and morbidity and human rights recognizes that most causes of maternal morbidity and mortality are preventable.[246] These causes are outcomes of health, development and human

[240] Id at 54
[241] Id
[242] UNFPA, *A Human Rights–Based Approach to Programming at* 54(cited in note 139)
[243] Id
[244] Id
[245] Yamin, 7Sur J 94 at 97(cited in note 107)
[246] Resolution on preventable and morbidity and human rights, Human Rights Council, 11th session, (16 June 2009)a/hrc/11/l.16/rev.1

rights obstacles.[247] Thus, this requires effective realization of human rights of women and girls and specifically the right to life, right to equality and dignity, right to education, freedom to seek and receive information, right to benefit from scientific progress, freedom from prejudice, the right to exercise the highest attainable standard of health both at the physical and mental level as well as sexual and reproductive health.[248]

In addition, the resolution pledges all governments to revise their political commitment, provide deeper attention and allocate resources towards reducing the number of maternal deaths at all levels.[249] Moreover, it calls on states to introduce human rights in their initiatives as well as reinforcing their endeavours, exchange good practices to guarantee the realization of human rights as well as commitment they made during the international conference, program of actions etc.[250]

4.1.2 Charter Based Mechanisms

Resolutions of the United Nations Organs for instance those of the Human Rights Council's are sources of these mechanisms.[251] Special procedures are part of the charter based accountability ensuring mechanisms.[252] The special procedure, which is a general name given to Human Rights Council's mechanism refer to individuals or working groups usually consisting of five members.[253] These individuals are usually known as Special Rapporteur',

[247] Id
[248] Id
[249] Id
[250] Resolution on preventable and morbidity and human rights, Human Rights Council (cited in note 246)
[251] UNFPA, *A Human Rights–Based Approach to Programming at* 55(cited in note 139)
[252] Id
[253] Id

'Special Representative of the Secretary-General', 'and Representative of the Secretary-General 'or 'Independent Expert'.[254]

These mechanisms conduct study, observe, recommend and report openly on human rights situations specific to a country or on thematic issues around the different parts of the world.[255] At the country level, they have a call on the mandate holders in specific country.[256] This task is undertaken with the Office of the High Commissioners staff, logistical and study aids so as to assist them in fulfilling their duties.[257]

The special procedures incorporate various types of activities such as dealing with individual complaints, carrying out studies, providing technological assistance at the national level, and participate in supportive activities.[258] They carry out country visit or operation to reveal facts to study the human rights situations in a certain country including specific organizational, authorized, judicial, managerial and de facto circumstances found within the limits of their power. [259] They also convene with government officials, affiliates of human rights organizations at the national level, CSOs, survivors of human rights violations etc.[260] Based on their finding they prepare concluding remarks and pass recommendations via the official reports submitted to the Human Rights Council and to the General Assembly.[261] Articulation

[254] Id
[255] UNFPA, *A Human Rights–Based Approach to Programming at* 55(cited in note 139)
[256] Id
[257] Id
[258]Id
[259] UNFPA, *A Human Rights–Based Approach to Programming at* 55(cited in note 139)
[260] Id
[261] Id

of international human rights obligation to assist government in carrying out their obligations also falls under their mandate.[262]

4.1.3 Treaty Based Mechanisms

When countries ratify international human rights instruments, they will be vested with the obligation to report occasionally to the respective treaty body on steps they have put in place to realize the rights recognized.[263] Treaty bodies are teams composed of autonomous professionals' recommended and chosen by States parties to the particular treaties, these bodies observe the execution of main international human rights treaties which are eight in number.[264]

These treaty bodies exist for the "Convention on Economic, Social and Cultural rights, the International Convention on Civil and Political Rights, the Convention on the Elimination of Racial discrimination, the Convention on the elimination of discrimination against women, the Convention against torture, Convention on the rights of the child, Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, Convention on the Rights of Persons with Disabilities (CRPD)".[265]

Theses bodies assess reports submitted to them every five years approximately together with additional information gathered from other various sources as well as UN agencies, civil

[262] Id
[263] UNFPA, *A Human Rights–Based Approach to Programming at* 56(cited in note 139)
[264] Id
[265] Id

society where the representative of the reporting country is present.[266] States have the duty to report to these organs every five years approximately.[267] Consideration of the reports is wind up by endorsing concluding observations/comments which compliments positive steps and points out concerns and specific recommendations.[268] These treaty bodies also prepare documents called general comments where they interpret respective treaties so as to elucidate the scope and definition of the standard incorporated in the articles.[269]

4.2 Monitoring and Evaluation Mechanisms at the regional level: The African Human Rights Commission

At the regional level there is the African Human Rights Commission. Since 1987 this organ has attained the responsibility to several tasks; it assesses reports submitted by governments describing the human rights situations in their countries, studies complaints related with human rights submitted by individuals and non-governmental organizations known as "communications", pass "resolutions" via its regular meetings, assist countries in improving the human rights situation by passing recommendations, assign special reporters to look into specific human rights concerns and endorse action; and assemble seminars and conferences.[270]

The African Commission functions with eleven members that are serving in their personal capacity. [271] These members are designated by Assembly of the Union of Africa or in short

[266] Id at 57
[267] UNFPA, *A Human Rights–Based Approach to Programming at* 57(cited in note 139)
[268] Id
[269] Id
[270] IPas, Africa Alliance for Women's Reproductive Health and Rights, *A Handbook for Advocacy in the Human Rights System* at60(cited in note 199)
[271] Id *at 61*

AU. [272]As per article 33 and 34 of the Charter not more than one person is designated from a single state.[273] Part of the designations is representation from all parts of the continent.[274] Chairman and vice chairman are selected among the commissioners.[275] In Banjul, Gambia there is a secretary for the commission that works full time.[276]

Conclusion

Applying a rights-based approach to maternal health programs means that maternal health programs should be geared towards making women's right to health and other related rights a reality. These programs should be developed and channeled through international human rights instruments that recognize these rights. These programs should be designed, developed, implemented, monitored and evaluated in light of human rights principles norms, standards. These norms, standards, principles etc are to be applied in each step starting from the beginning i.e., the selection of interventions, identification and selection of targets, enumerating resources and communications followed by effective and efficient implementation etc. The basic principles of human rights form part of a rights-based approach. Besides that, the various international human rights instruments that recognise the rights to highest standard of health and related rights as well as the non binding instruments such as the International Conference on Population and Development's, Beijing platform for action etc constitute a rights-based approach to maternal health programs. By functioning within this framework a rights based approach ensures accountability, non discrimination and inclusion, participation, empowerment and evidence based prioritization of activities. Besides

[272] Id
[273] Id
[274] IPas, Africa Alliance for Women's Reproductive Health and Rights, *A Handbook for Advocacy in the Human Rights System* at60(cited in note 199)
[275] Id
[276] Id

what has been discussed in this chapter monitoring and evaluation mechanisms found at the international and regional level constitute a rights-based approach which have been discussed in a selective manner. These monitoring and evaluation mechanism undertake different tasks depending on their mandates such as assist the promotion and protection of human rights, receive complaints, undertake studies, issue resolutions, recommendations etc. This takes us to the next chapter that deals with application of a rights-based approach.

Chapter Three: A Rights-Based Approach to Preventable Maternal Mortality and Morbidity

Introduction

One of the causes for high rate of maternal mortality and morbidity as mentioned in the previous chapters is absence of supportive domestic legal framework. Thus prior to the discussion on the application of a rights-based approach in sexual and reproductive health programs this chapter will undertake comparative analysis of Constitutional protection of sexual and reproductive rights and monitoring and evaluation mechanisms availed by the Constitution of Ethiopia and Kenya. As mentioned in the introductory part due to time and resource limitation this chapter is limited only at the Constitutional level which in both cases is the supreme law of the land and that any law in contradiction will not be effective. [277] .

Subsequently, there will be discussion on the application of a rights-based approach. Following this, there will be analysis of sexual and reproductive health program of Ethiopia and Kenya in light of this discussion. Kenya designed a health strategy for the years 1997-2010 which was revised in 2009 in reaction to the International Conference on Population and Development,[278] Ethiopia has also developed a sexual and reproductive health strategy in 2006 that would be operational for the years 2006-2015.[279]

[277] Kenya Const Art 2(4) *see also* FDRE Const Art 9(1)
[278] Ministry of Public Health and Sanitation and Ministry of Medical services(hereafter words referred to as MPHS and MMS), *National Reproductive Health Strategy,2009-2015* at IV(MPHS and MMS, August 2009)
[279] Federal Democratic Republic of Ethiopia, Ministry of Health, *National Reproductive Health Strategy 2006-2015* at VI(Ministry of health, March 2006)

Section One: Constitutional Protection of Sexual and Reproductive Rights in Ethiopia and Kenya

Following the downfall of the Derg Regime Ethiopia became a federal state and designed a new Constitution in the year 1994.[280] Kenya also revised its constitution in the year 2010.[281] Both countries are part of international human rights instruments.[282] Ethiopia has a good history when it comes to ratifying international human rights instruments.[283] The country is party to six of the seven core United Nations human rights treaties.[284] These international human rights that have been ratified by Ethiopia become essential element of the law of the territory.[285] Similarly, by virtue of Article 19, the Bill of Rights chapter of the Constitution of Kenya becomes essential element of the law of the land.[286] Both Constitutions address human rights in a separate chapter.[287] Moreover, both constitutions assert that interpretation of the rights shall be in line with internationals set norms and principles.[288]

[280] Constitution of Ethiopia 1994
[281] Constitution of Kenya 2010
[282] Federal Democratic Republic of Ethiopia, *Combined Report (initial and four periodic reports) to the African Commission on Human and peoples' Rights on Implementation of the African charter on Human and Peoples' Rights* at 65 available at http://www.achpr.org/english/state_reports/Ethiopia/Initial%20Report%20_Ethiopia.pdf (visited on May 12,2011) see also Muthee Thuku, *The Kenyan Bill of Rights (2010): Consolidating the Gains and Analyzing the Domestication of International Human Rights Instruments* at 4-5 **(**April 2011) available at http://www.amanikenya.com/wp-content/uploads/2011/04/The-Kenya-Bill-of-Rights-_2010_.pdf (visited August 27,2010)

[283] Eva Brems, *Ethiopia Before the United Nations Treaty Monitoring Bodies*, 20Afrika Focus, 49, 52 (2007)
[284] Id
[285] FDRE Const, Art 9(4)
[286] Thuku, *The Kenyan Bill of Rights (2010)* at 30 (cited in note 282)
[287] FDRE, Const Chapter III see also Kenya Const Chapter IV,
[288] FDRE Const Art 13(2) see also Kenya Const Art 259 (1) (b) see also Thuku, *The Kenyan Bill of Rights (2010)* at 31 (cited in note 282)

Article 36 of the F.D.R.E. Constitution deals in detail with issues of women's rights where one of them is protection against harmful traditional practices.[289] In the case of Kenya, the Constitution talks about social justice in its preamble and Article 10. It also recognizes the right in the various articles and considered to be a great step forward in the protection of human rights of women. [290] Non discrimination, dignity, equality, protection against harmful traditional law are some of the rights explicitly recognized under the Constitution of Kenya.[291]

Both Constitutions expressly prohibit laws that keep down or have unfavourable effect on women.[292] Similarly, one can find dignity, right to life, liberty, and prohibition from inhuman treatment, equality explicitly mentioned under the Ethiopian Constitution.[293] Moreover, the Constitution of Kenya forbids both direct and indirect discrimination based on sex, marital condition and the status of being pregnant.[294]

In addition, the Constitution of Kenya gives due attention to the situation of women and recognizes their vulnerability and vests the organs with the obligation to pay due attention while rendering their responsibilities. [295] The Constitutional requirement of not giving more

[289] FDRE Const, Article 36 see also http://lib.ohchr.org/HRBodies/UPR/Documents/Session6/ET/SRI_ETH_UPR_S06_2009.pdf see also Thuku, *The Kenyan Bill of Rights (2010)* at 26 (cited in note 250)
[290] Thuku, *The Kenyan Bill of Rights (2010)* at 26 (cited in note 282) see also Nduku Kilonzo, *Health NGOs Network, Kenya*, (27 August 2010) online at http://www.rhmjournal.org.uk/news.php?newsID=665 (visitedMay,23 2011)
[291] Thuku, *The Kenyan Bill of Rights (2010)* at 26-27 (cited in note 282) see also Kenya Const Article 27, 28, 53, 55
[292] FDRE Const Art 35(4) see also Thuku, *The Kenyan Bill of Rights (2010)* at 31 (cited in note 282)
[293] FDRE Const Arts 14,1 5, 17, 18,24 25
[294] Concluding observations of the Committee on the Elimination of Discrimination against Women(Kenya), Committee on the Elimination of All Forms of Discrimination against Women, 48th session (February 2nd 2011) CEDAW/C/KEN/CO/7 .2.(concluding observations on Kenya's seventh periodic report to the Committee)
[295] Thuku, *The Kenyan Bill of Rights (2010)* at 27 (cited in note 282)

than two third of the parliament seat to be occupied by members of the same sex also ensures participation of women in matters that affect their lives.[296] In addition, while the Ethiopian Constitution under 41(3) recognized equal opportunity to public service while the Kenyan Constitution in Article 232 ensures the provision of equal opportunities to both men and women in the public service as fundamental principle of the Constitution.[297]

In the case of Kenya, abortion has been addressed as an act that should be done only in limited circumstances under Article 26 sub article 4 of the Constitution. According to this article, abortion can be done only if qualified health professional's opinion suggests it or if the mother is in need of an urgent medical attendance or if the pregnancy proves to be lethal to the health of the mother or if it is allowed by another written law of the country.

In the case of Ethiopia, abortion has been addressed in a very strict manner than Kenya. To start with the Constitution is silent about it and it has been treated as an offence against life unborn in the Article 528 of the Criminal Code. Abortion is not punishable only if it is conducted on medical grounds as stated in article 534. In a country where larger section of the society is illiterate[298] such measure by itself could be one cause for increased maternal mortality and morbidity.[299] This has been one of the main agenda of the General Assembly's

[296] Id See also Kenya Const Art 27(8)
[297] Thuku, *The Kenyan Bill of Rights (2010)* at 28 (cited in note 250)
see also Kenya Const Art 232
[298] Federal Democratic Republic of Ethiopia, Ministry of Health, *National Reproductive Health Strategy* At 3(cited in note 279)

[299] General Assembly, 29th & 30th meetings (October 24,20110) ga/shc/4018(providing information, using contraception, abortion — should be 'decriminalized)

meeting held recently. One of the issues mentioned at this meeting was tha the criminal law is used to monitor the manner and decision making processes of those governed by it.[300] By making abortion a crime the states is stepping in the domain of the individual and making a decision on behalf of the individual and that individual has no choice but to accept.[301] Such measure further violates the right to health of individuals and reflects unequal treatment of women in their decision making power and role in their family and society they live in.[302]

Study conducted in Kenya in 2010 shows that every year more that 2500 women lose their lives due to unsafe abortions.[303] Additional, 21000 women require medical attention annually as a result of unfinished and unsafe abortions.[304] These numbers do not include the amount of women who lose their lives as a result of unsafe abortion or remain disabled and never visit health centers or their cause of death remains unrecorded.[305] Similarly, unsafe abortion results in high maternal mortality in Ethiopia too.[306]

Above that, the Constitution recognizes civil, political and social economic and cultural rights which are not the case in the Constitution of F.D.R.E. [307] Apart from recognizing the socio economic rights Article 43 of the Kenyan Constitution specifically states reproductive right.[308] While exercising article 43 if the states faces shortage of resources, it has to shows

[300] Id
[301] Id
[302] Id
[303] Center for Reproductive Rights, *In Harms way': the Impact of Kneya's Restrictive Abortion Law*, at 8 (centre for Reprodutive Rights, 2010)
[304] Id
[305] Id
[306] Id
[307] Thuku, *The Kenyan Bill of Rights (2010)* at 29 (cited in note 282) *see also* Action Professionals' Association for the People, Ethiopian Human Rights Council et al, *Joint UPR Submission by CSO Coalition* at 7 (2009)
[308] Kenya Const Art 43(1) (a)

there is such a case.[309] The state has the obligation to prioritize ensuring the right or the exercise of freedom while allocating resources.[310] But so as to avoid difference in opinion, the court, tribunal or any other authorized organ is barred from interfering in the decision of the government regarding allocation of resources.[311] The issue of public health services has been further addressed by the national health policy.[312]

Section Two: Monitoring and Evaluation Mechanisms availed by the Constitution of Kenya and Ethiopia

Both Constitutions of Ethiopia and Kenya guarantee the establishment of human rights institutions.[313] In the case of Ethiopia, the Constitution addresses the establishment of Ombudsperson.[314] Unlike the Constitution of Ethiopia that leaves the authority to decide duties and function of these organs to another organ the Constitution of Kenya goes one step further.[315] As stipulated in Article 59 of the new constitution the commission has clearly set duties to promote, monitor and protect human rights.[316]

One unique feature of the new constitution of Kenya is the fact that it not only ensures rights of citizens but also sets up avenue for protection of these rights.[317] Accordingly Under the Kenyan Constitution Court actions can be initiated by "*a person acting on behalf of another person who cannot act in their own name or a person acting as a member of, or in the*

[309] Kenya Const Art 20(5) (a)
[310] Kenya Const Art 20(5) (b)
[311] Kenya Const Art 20(5) (c)
[312] F.D.R.E, National Health Policy(1993)
[313] FDRE Const Art 55(14) & (15) se also Kenya Const Art 59
[314] Id
[315] Kenya Const Art 59
[316] Id
[317] Thuku, *The Kenyan Bill of Rights (2010)* at 29 (cited in note 282)

interest of, a group or class of persons or a person acting in the public interest; or an association acting in the interest of one or more of its members".[318] In addition, Article 22(1) recognizes individuals' right to take their case to court in case of denial, violation or infringement of their human rights.

In the case of Ethiopia, the access to justice is recognized but the case of Public interest litigation which has a paramount importance in the protection and promotion of human rights is unclear.[319] The Constitution under Article 37 states that "everyone has the right to bring justiciable matter but the word "everyone" can be interpreted to mean either individuals initiating their own case or others' case which makes it open to controversies.[320]

Both Constitutions are driven by the principles set in the Universal Declaration of Human Rights.[321] All government and state organs should abide by the laws enshrined in the constitutions.[322] But in the case of Kenya the new Constitution is considered to be a huge step in the protection of reproductive rights of women Constitution protection.[323] Article 19 provides strong protection to individual human rights.[324]

[318] Kenya Const Art 22 *see also* Thuku, *The Kenyan Bill of Rights (2010)* at 31 (cited in note 282)
[319] Yoseph Mulugeta Badwaza, *Public Interest litigation as practiced by South African Human rights NGOS: Any Lessons for Ethiopia*?(Unpublished LLM Dissertation, University of Pretoria, 31 October 2005) online at http://etd.uwc.ac.za/usrfiles/modules/etd/docs/etd_gen8srv25nme4_1448_1181888276.pdf at 40(visited June 24,2011)
[320] Id
[321] Federal Democratic Republic of Ethiopia, *Combined Report (initial and four periodic reports) to the African Commission on Human and peoples' Rights at* 13 (cited in note 250)

[322] FDRE Const Art 13 see also Kenya Const Art 20
[323] Thuku, *The Kenyan Bill of Rights (2010)* at 26 (cited in note 282)
[324] Id at 30

In the case of Ethiopia and Kenya, both countries are part of major international human rights instruments and enshrine the principles of human rights but the Constitution of Kenya addresses each and every issues in detailed manner where as the constitution of Ethiopia has left certain important matters open which does have adverse effect on the promotion and protection of human rights.[325] For instance, in the case of socio economic rights, absence of recognition in the Constitution has crippled their implementation in the judiciary.[326] Whereas the Kenya constitution is considered to be a huge step in the realization of human rights and also human rights of women and the Ethiopia Constitution requires a lot improvement."[327]

Section Three: Sexual and Reproductive Health Strategies and a rights-based approach

In every program planning there are three steps; the initial stage, the actual designing stage and the implementation.[328] The initial stage is where assessment and situation analysis is conducted.[329] Then based on the outcomes of the assessment and situation analysis activities will be set.[330] This is done in the second stage of the programming.[331] The final stage is the implementation of the activities designed in the second stage.[332] Rights based approach is applied in all these stages.[333] As it has been discussed previously, all these processes and their outcomes should be geared towards realization of human rights, should be channelled through human right instruments and reflect the above mentioned operational principles.

[325] Action Professionals' Association for the People, Ethiopian Human Rights Council et al, *Joint UPR Submission by CSO Coalition* at 7 (cited in note 269)
[326] Id
[327] Badwaza, *Public Interest litigation as practiced by South African Human rights NGOS* at 45-50 (cited in note 319)
[328] UNFPA, *A Human Rights–Based Approach to Programming at 178-193*(cited in note 139)
[329] Id at 178
[330] Id at 188-192
[331] Id at 192
[332] UNFPA, *A Human Rights–Based Approach to Programming at 192*(cited in note 139
[333] Id at 178-193

Thus, this section will address how a rights-based approach is applied in the initial and designing stage of programming without dealing with the implementation of the strategies.

3.1 Applying Human Rights Canons at the Initial Stage

A rights-based approach commences at the initial process of designing sexual and reproductive health programmes i.e., in the assessment and situation analysis.[334] The main objective of carrying out this situation analysis and assessment is to identify challenges and their root causes.[335] In a rights-based approach, the initial stage of programme designing consists of several activities; situation analysis which includes data gathering, legal and policy environment revision, causality analysis, determination of right holders and duty bearers and capacity gap analysis and finally setting priority issues.[336]

As it is a rights-based structure, putting human rights canons i.,e "universality, and inalienability, indivisibility, interdependence and interrelatedness, equality and discrimination, participation and inclusion, accountability and rule of law" in all these stages is a vital step.[337] Carrying out the above mentioned steps in the assessment and situation analysis in a participatory manner where right holders and duty bearers take part guarantees the application of most of the above mentioned principles.[338]

In the case of Kenya, revision of the Sexual and reproductive Health Strategy was undertaken by the participation of various stakeholders including reproductive health coordinators both at the provincial and district level including development partners, experts,

[334] Id at 178)
[335] Id
[336] UNFPA, *A Human Rights–Based Approach to Programming at* 179-182 (cited in note 139)
[337] Id at 176
[338] Id at 179

individuals, institutions, civil society and religious organizations, and the private health sector via inclusive and consultative process.[339] A series of workshops were held to obtain information on what the revised strategy should address and to collect feedback on the draft strategy in addition to dissemination of the first draft to all participants ensuring accountability.[340]

In the case of Ethiopia, the Sexual and health Strategy is designed via the continuous participation of relevant governmental organs both at the regional and federal level, experts at the domestic level, civil society organizations, and stakeholders at global local, federal and regional level, including community members from all parts of the country.[341] In both cases, there has been an attempt made to include both right holders and duty bearers. But, it has not been expressly addressed who these organs are and their level of participation. The main objective of a rights- based approach is ensuring accountability. Hence, it would have also created a strong accountability mechanism if the health strategy including those who took part in the revision of the strategy were advertised to the public and there was a public discussion to ensure greater participation of the right holders and securing the human rights canons.[342]

3.2 Data Gathering Process

During data gathering, the inclusion of information on the needs of the marginalized sections of the society including those facing the most risk contributes to ensuring equality and non

[339] MPHS and MMS), *National Reproductive Health Strategy,2009-2015* at IV (cited in note 278)
[340] Id at 6-7
[341] Id
[342] UNFPA, *A Human Rights–Based Approach to Programming at* 179-182 (cited in note 139)

discrimination.[343] Marginalised or vulnerable groups include sections of the society with low access to related services and information due to several factors such as poverty, or hard-to-reach areas, or groups that may be unrecognized at the national level due to political or other motives such as sex workers, certain ethnic minority groups, migrant, or groups whose Sexual and Reproductive Health needs are unobserved i.e., immigrant/migrants, youth, female inmates etc..[344] Thus, the data should also incorporate maternal mortality ratios, data showing the need for family planning, contraception, skilled labour etc and how much of this has been met, data showing the level of emergency obstetric care available, service provided and level of distribution.[345] The more the partners that take part in the data gathering the more it enables to clear up disparities.[346] The task force or committee developing such programs shall ensure that each ministry and other relevant government organs including nongovernmental organizations participate in the provision of data.[347]

The revision of the Kenyan, Sexual and Reproductive Health Strategy relied on Demographic Health Survey conducted in 2003 and 2008.[348] The data provides statistics based on fertility, history of the country's mortality rates, life expectancy, proportion of women taking number of antenatal health care services, skilled care, contraceptive prevalence, family planning needs, level of economic growth etc.[349] Data from the Kenya Aids Indicator Survey of 2007 also provided statistics on HIV prevalence.[350] Besides the above mentioned data sources the various stakeholders did not take part in the data gathering. This will limit the level of

[343] Id
[344] Id at 178
[345] Yamin 7Sur J 94,96 at 103-104 (cited in note 108)
[346] UNFPA, *A Human Rights–Based Approach to Programming, at 179* (cited in note 139)
[347] Id
[348] Id at P.2-3
[349] Id
[350] UNFPA, *A Human Rights–Based Approach to Programming, at 2-3* (cited in note 139)

participation of the various stakeholders. It would have also helped to get disaggregated data, reveal disparities and who is at most risk.

Similarly, Ethiopia's Sexual and Reproductive health strategy relies on few sources of data. The census report conducted in 1994 and the demographic health survey reports conducted in the years 2001 and 2005 provided the statistics.[351] The participation of other relevant organs such as Civil Societies has been limited in this aspect. As mentioned previously the gathering data from all stakeholders ensures participation and help avoid disparities.

3.3 Performance Assessment in a Participatory Manner

Performance assessment that is conducted in a participatory manner results in the identification of rights that are violated or are endangered or not realised. [352] Kenya's Sexual and Reproductive Health Strategy has conducted assessment of achievements and challenges of the previous health strategy.[353] One of these documents is the previous health strategy which is built upon ICPD and its outcomes. [354] The assessment of the previous strategy and programs has identified the causes of high maternal morbidity etc..[355] Accordingly, social and cultural attitude and traditions, women's disempowerment and men's participation in decisions contribute to the high number of maternal morbidity.[356] As it has been mentioned above, developing a cultural sensitive programme is a vital step in designing an effective programme.[357] In line with this, it would have helped to deeply understand these contexts

[351] Federal Democratic Republic of Ethiopia, Ministry of Health, *National Reproductive Health Strategy 2006-2015* at 36(cited in note 279)
[352] Okumba, *Notes on A Method for Human Rights Based Approach to Programming*, at 1 (Africa Youth Trust, November and December 2009)
[353] Id at .3-5
[354] Id
[355] MPHS and MMS), *National Reproductive Health Strategy,2009-2015* at 3-4 (cited in note 278)
[356] Id
[357] Id

including the overall religious and cultural aspects of the country if a research was conducted on this issue and incorporated in the revision programme.

One of the justifications for the revision of the Sexual and Reproductive Health Strategy of Kenya as described in the strategy is the need to have a clear guidance for the sexual and reproductive health policy issued in 2007.[358] Besides that change in government's approach, the need to engage strategic planning across all sectors and ministries and the need for evidence based management and enhanced citizens' participation called for revision of the strategy.[359] The need for a strategic planning transverse among the various sectors and ministries was additional cause for the revision of the health strategy.[360] This indicates the recognition of the importance of a rights-based approach. It also contributes to ensuring the realization of one of the main principles of rights based approach i.e., participation but will also contribute in ensuring the realization of the various human rights related with reproductive health. This is a lesson Ethiopia can share also.

3.4 Revision of Legal and Human Rights Environment

The objective of revision of legal and human rights environment is to put the programs in line with the domestic law and international and regional human rights treaties the country is party to.[361] Such revision process also aims at identifying laws that could impede the success of the programme.[362] Accordingly human rights treaties ratified reports of various organizations like Human Rights Commission, Ombudsperson, NGOs, poverty assessments

[358] Id at 5
[359] MPHS and MMS), *National Reproductive Health Strategy,2009-2015* at 5 (cited in note 278)
[360] Id
[361] UNFPA, *A Human Rights–Based Approach to Programming*, at 184 (cited in note 139)
[362] Id

and information from the community including reports of special rapporteurs and comments of treaty bodies including the Constitution and other domestic laws should be revised.[363]

The Sexual and Reproductive Health Strategy of Kenya reviewed various documents such as national policies, strategies, and implementation plans.[364] But it did not assess the legal and human rights environment though it has been stated that it is guided by respect for human rights.

One good aspect of the Ethiopian Sexual and Reproductive Health Strategy is that it undertook legal environment assessment, poverty and socio economic situation analysis enriched with statistics. In the revision it has been identified that the F.D.R.E. Constitution recognises the right to public health services, also discussed the national health policy, substantive laws of the country including obstacles standing in their effective implementation.[365] It has recognized absence of effective implementation as one challenge.[366] But besides this, the assessment of the legal environment did not cover existing gaps such as absence of recognition of socio economic rights in the Constitution, absence of recognition of reproductive rights, the situation of public interest litigation etc.

In addition, Ethiopia's Sexual and Reproductive Health Strategy has not mentioned anything about international human rights or duties and responsibilities the government is vested with as a result of ratification. Hence, it can be concluded that, did not consult international human rights instruments Ethiopia is part of, concluding observations of treaty bodies etc. In addition, In its assessment individual's rights to public health service is the only mentioned

[363] Id. at 184
[364] *Id.*
[365] Federal Democratic Republic of Ethiopia, Ministry of Health, *National Reproductive Health Strategy 2006-2015* at 4(cited in note 279)
[366] Id at 4

right. It does not reflect the interrelatedness and interdependency of human rights. Its assessment is restricted to the certain aspects where as the situation of maternal health as it's globally recognized engages several rights. Without appreciating these facts it will not be able to come up with sustainable and effective plan. Though it acknowledges the recognition of the right, the respective duty it vests the government with has not been mentioned.

3.5 Causality Analysis

Subsequent to revision of legal and policy environment there comes causality analysis.[367] This focuses on analysis on challenges in terms of human rights and their causes in light of priorities set at the national level and human rights obligations.[368]

One of the reasons why Kenya's Strategy has been revised is the need to have a strategy in line with the new Sexual and Reproductive Health Policy issued in 2007.[369] It is for the first time that the country issued such a policy.[370] It provides structure for a successful sexual and reproductive health service provision that is of high quality in an equitable manner.[371] It also pays due attention to the section of the society that are in great need of such service as well as vulnerable ones.[372] Besides the need to have a strategy in line with the new policy, the importance of adopting a multisectoral approach, evidence-based administration of programs, including the need to enhance population participation in the design and implementation of programs are additional causes for the revision of the programs.[373]

[367] UNFPA, *A Human Rights–Based Approach to Programming,* at 182-3 (cited in note 139)
[368] Id
[369] MPHS and MMS, *National Reproductive Health Strategy,2009-2015* at 5 (cited in note 278)
[370] USAID Health Initiative, *Kenya Adopts First National Reproductive Health Policy*, (October 2007) online at www.healthpolicyinitiative.com (visited on August 25,2011)
[371] Id
[372] Id
[373] MPHS and MMS, *National Reproductive Health Strategy,2009-2015* at 6 (cited in note 278)

Though it does not specifically state what kind of education, Ethiopia's Health Strategy recognized the importance of primary and secondary education.[374] As education is a human rights such recognition plays a vital role. Though the role of sexual and reproductive education has not been given due attention in the strategy as it has been spelt out as one of the causes of high maternal mortality and morbidity the fact that it is recognised should be appreciated. But as mentioned above other human rights and their situation in light of maternal health should be duly recognised.

The Sexual and Reproductive Health Strategy of Ethiopia, has also assessed poverty, the situation of women and the health care system and including the social and institutional bound of women in the country. [375] Poverty, one of the identified cause is an outcome and at the same time cause of violation of human rights.[376] But, it does not show the impact of poverty has resulted in such situation and the section of the society affected by this situation. As mentioned previously, violation of human rights result from absence of implementation of responsibilities vested on the government via the human rights instruments the country is part of Ethiopia is part of several international and regional human rights instruments as mentioned previously. The Strategy lacks this perspective and this would have helped shape most of the strategies to be more effective.

Women's low status and its outcome, which is inability to decide on their reproductive rights, have been mentioned in the Sexual and Reproductive Health Strategy of Ethiopia.[377] Though, low status of women has been recognised but it does not analyze how women are affected by

[374] Federal Democratic Republic of Ethiopia, Ministry of Health, *National Reproductive Health Strategy 2006-2015* at 3(cited in note 279)
[375])Id
[376] Hunt and Bueno de Mesquita, *Reducing Maternal Mortality;* at 10(cited in note 17)
[377] Federal Democratic Republic of Ethiopia, Ministry of Health, *National Reproductive Health Strategy 2006-2015* at 4(cited in note 279

this. It does not address the underlying causes of these problems and the impacts they have on the reproductive health status of women. The absence of this connection results from absence of application of human rights and affects the effectiveness of the strategy.

The Ethiopian Sexual and Reproductive Health Strategy has addressed absence of effective implementation of human rights treaties the country is part of.[378] In its assessment of the legal environment, it does not address challenges that stand in the effective implementation of laws. The strategy does not incorporate analysis of how this situation has created problem in terms of responsibility, authority and resources.[379] It does not put these challenges in terms of rights violated and duties not fulfilled. But putting these problems in such a manner will get to the core problem, see the challenges in a clearer manner and design effective strategy.

4.3.5 Determination of the right holders and duty bearers

Determination of the right and duty bearers and their respective entitlements and obligations which aims at identifying target groups should also be carried out.[380] It is imperative to ensure that the list especially the right holders' one addresses those that are most vulnerable.[381] Special attention should also be paid to groups that might counter manifold inequalities such as women with disabilities living outside of cities.[382] Explicit identification of duty bearers has not taken place at the initial stage in sexual and reproductive health strategies of both countries. In the case of Sexual and Reproductive Health Strategy of Kenya, one can find list of duty bearers in the implementation section where both government and non government organizations (civil society organizations, religious

[378] Id at 4
[379] Okumba, *Notes on A Method for Human Rights Based Approach to Programming* at 1(cited in note 352)
[380] UNFPA, *A Human Rights–Based Approach to Programming,* at 186-7(cited in note 139)
[381] Okumba, *Notes on A Method for Human Rights Based Approach to Programming* at 1(cited in note 3352)
[382] *Id.*

organizations) have been addressed.[383] The section of the sexual and reproductive health strategy addressing strategies, outputs and tasks though not tailored in this manner do address the entitlements of the right holders. In the case of Ethiopia, the recently enacted law on civil society organizations gravely limits their capacity to take part in human rights related activities.[384]

4.3.6 Capacity gap analysis

This identification of right holders and duty bearers also facilitates the capacity gap analysis.[385] Capacity gap analysis focuses on identifying challenges and serves as the basis for the interventions that will be endorsed in the programmes and priorities that will be set.[386] It focuses on assessing the ability of right holders to claim their rights and duty bearers to undertake their responsibilities.[387] This process involves the assessment of acceptance and environment internalization of duties, authority, and availability of the means which can be summarised as human, economic resources and organizational.[388] The human resources include skills, knowledge, time, whereas economic resource refers to land, technology.[389] Organizational resources deal with structures, systems and rules. [390]

The Ethiopian Sexual and Reproductive Health strategy does address gaps[391] but the analysis lacks human rights perspectives. Absence of such perspective shutters the opportunity to

[383] MPHS and MMS), *National Reproductive Health Strategy 2009-2015 at* 53-57(cited in note 278)

[384] CHANGE, Center for Health and Gender Equity, *Women's Sexual and Reproductive Health and Rights in Ethiopia: The Role of the National Government and U.S. Foreign Assistance* at 4(CHANGE, 2010)
[385] UNFPA, *A Human Rights–Based Approach to Programming,* at 187(cited in note 132)
[386] Okumba, *Notes on A Method for Human Rights Based Approach to Programming* at 1(cited in note 310)
[387] UNFPA, *A Human Rights–Based Approach to Programming,* at 183(cited in note 132)
[388] Id
[389] Id
[390] Id
[391] Federal Democratic Republic of Ethiopia, Ministry of Health, *National Reproductive Health Strategy 2006-2015* at 3-5(cited in note 279)

clearly address the core problems. Even though the strategy has conducted assessment of the legal environment lacks analysis of implementation of human rights obligation and responsibilities at every stage. The analysis is limited to the legal frameworks only. The importance of fulfilling human rights have not been given due attention.

Kenya's Strategy has addressed the need to revise the previous strategy and one of the justifications was the need for a strategy that is in line with Kenya's first Sexual and Reproductive Health policy issued in 2007.[392] This document is said to be in line with ICPD and has brought a paradigm shift in Kenya's approach towards maternal health.[393] The decreasing economical situation of the country, insufficient allocation of budget towards the health sector, and in equality in resource allocation in the health sector and lack of efficient referral systems accessible to impoverished section of the society as well as regions hard to reach.[394] The challenges raised indicate key elements in ensuring sexual and reproductive health and more specifically maternal health.

4.3.7 Setting Priorities

Subsequent to the above mentioned steps, priorities will be set.[395] Such priorities that will be set should foster human rights, address sexual and reproductive health disparities, reach the most marginalised groups of the society, and address the gaps identified while conducting situation analysis.[396] These priorities should be geared towards enabling right holders to claim their entitlements and duty bearers to undertake their obligations.[397] Usually, it focuses on duty, power, capital, communication ability and decision making process of both the

[392] MPHS and MMS), *National Reproductive Health Strategy,2009-2015* at 5 (cited in note 278)
[393] Id
[394] Id
[395] UNFPA, *A Human Rights–Based Approach to Programming,* at 183(cited in note 139)
[396] Id
[397] Okumba, *Notes on A Method for Human Rights Based Approach to Programming* at 2 (cited in note 310)

entitled ones and the responsible ones.[398] Depending on the priority and urgency and other justifications the priority areas focus on Advocacy and Social transformation, data and facts, Training, teaching and Service provision.[399]

With Ministry of Health as the leader and in partnership with other stakeholders together with the coordinating committee, three overriding priorities have been set out in Ethiopia's Sexual and Reproductive Health Strategy.[400] The first one focuses on fulfilling the Millennium Development Goals. Among the eight goals, this strategy focuses on maternal health, gender equality and HIV/AIDS.[401] The need to ensure the above three mentioned goals have been emphasized during the strategy formulation process.[402] Though the word rights have been mentioned here and there, the concept of sexual and reproductive health has not been recognised as a human right or it has not been internalized. Hence, with maternal health recognised as human rights violation and the importance of human rights to the achievement of Millennium Goals and the relevance of constructive accountability via a rights-based approach it is not clear how the strategy aspires to meet the obligation is has attained via the various human rights instruments it is part of.

The Second priority of the strategy focuses on reflecting the political, cultural and socio demographic path the country is following.[403] As it has been recognized in the strategy though inclusion is the main feature of the reproductive health concept, nearly 80 percent of the total population is situated in the rural areas, sixty percent of the population is below the age of 20 and almost all are married at the age of 18 and not many of them will reach their

[398] Id
[399] Id
[400] Federal Democratic Republic of Ethiopia, Ministry of Health, *National Reproductive Health Strategy 2006-2015* at vii-viii (cited in note 279)
[401] Id
[402] Id
[403] Id at 2

55th birthday.[404] From the reading of the strategy, it can be assessed that inclusion is not main priority of the strategy. With more than half of the population being located in rural areas and other data mentioned above, it is not clear how the strategy aspires to meet the Millennium Development Goals.

Moreover, the strategy states that it does not incorporate the full range of activities assumed under the reproductive and sexual health but aspires to reflect the socio-economic, political and demographic factors that define Ethiopia.[405] But as it mentioned in the previous chapters, the full ranges of activities are vital to the realization of individuals' sexual and reproductive health. In addition, the strategy has identified harmful traditional practices as one challenge. Thus, putting political, socio demographic aspects of the country above the range of sexual and reproductive health activities which are also rights affects the effectiveness and efficiency of the program.[406]

The third strategy focuses on building upon previous experiences.[407] According to this strategy there has been significant improvement in the field of maternal health.[408] The strategy stated that outcome of previous assessment revealed unmet health needs, gap in the health care service, and possible solution to curb these challenges. "If a system lets a woman die then the system has crashed".[409] Though the strategy acknowledges such fact reading from other sources mentioned in the first chapter, state that Ethiopia will not be able to meet

[404] Federal Democratic Republic of Ethiopia, Ministry of Health, *National Reproductive Health Strategy 2006-2015* at vii-viii (cited in note 279)
[405] Id
[406] Id
[407] Id
[408] Federal Democratic Republic of Ethiopia, Ministry of Health, *National Reproductive Health Strategy 2006-2015* at vii-viii (cited in note 279)
[409] Id

the Millennium Development Goals. So what possible positive outcomes are there for the country to build upon?

Though Kenya's the strategy does not have a section addressing priorities from the justifications given for revising the previous strategy it can be concluded that the need to have a strategy in line with the sexual and reproductive health policy as well as the other justification mentioned thereof and which has also been discussed previously reflect issues that have been given priority.

Section 2 A rights-based approach in planning and designing stage of Sexual and Reproductive Health Program

The second stage of every programming is designing[410]. This is a stage where interventions will be developed based on the data and evidence gathered at the initial stage.[411] In a rights-based approach, the application of human rights canons such as participation, equality, non discrimination, universality etc., also continues in the planning and designing stage.[412] The outcome of the planning and designing process should contribute to enabling duty bearers to undertake their obligation and right holders to assert their entitlements.[413] It should reach the marginalised sections of the society.[414] As it has been mentioned above, the main target of a rights-based approach is creating strong constructive accountability system. Accordingly, the plans should have alternative accountability creating mechanisms besides judicial remedies

[410] UNFPA, *A Human Rights–Based Approach to Programming,* at 190-191 (cited in note 132)
[411] Id
[412] Id
[413] Id
[414] UNFPA, *A Human Rights–Based Approach to Programming,* at 190-191 (cited in note 132)

such as monitoring and evaluation mechanisms based on previous discussions. In order to create a health system beneficial to all the plans and designs should be based on evidence.[415]

Looking at the objectives of the two strategies, Kenya's Sexual and Reproductive Health Strategy aspires

> *"to reduce rates of maternal, prenatal and neonatal morbidity and mortality in Kenya. This will be achieved by "increasing equitable access to maternal and newborn services; improving quality, efficiency and effectiveness of service delivery at all levels; and improving responsiveness to the client needs" and it also has an output set as "Increased availability, accessibility, acceptability, and utilisation of skilled attendance during pregnancy, childbirth and the post partum period at all levels of the health care delivery system"* [416]

Whereas, Ethiopia's Sexual and Reproductive Health Strategy's goal aspires "To reduce maternal and neonatal mortality in Ethiopia" [417] The strategy does not have set output. Kenya's Sexual and Reproductive Health Strategy is detailed and reflect components of maternal health where as the Ethiopia's is obscure meaning it does not show any relation with human rights standards. Absence of human rights analysis resulted in crafting a well tailored objective and clear direction towards the reduction of maternal mortality and morbidity.

Both strategies have adopted certain strategies to meet the set goals. In the case of Kenya, the Sexual and Reproductive Health Strategy has adopted six core activities to achieve the set goals.[418] The first one focuses on strengthening and building capacities of health systems to make delivery effective and efficient.[419] The detailed activities under this strategy focus on

[415] Yamin 7Sur J at 99 (cited in note 108)
[416] MPHS and MMS), *National Reproductive Health Strategy 2009-2015 at 26(cited in note 278)*

[417] Federal Democratic Republic of Ethiopia, Ministry of Health, *National Reproductive Health Strategy2006-2015* at 17(cited in note 279)

[418] MPHS and MMS), *National Reproductive Health Strategy 2009-2015 at 26-29(cited in note 278)*
[419] Id at 26

increasing the budget allocation enhance supervision mechanisms; enhance communication and referral systems, as well as information system and networking. [420]

The second strategy focuses on ensuring equitable access to maternal health services.[421] The detailed activities focus on undertaking needs assessment on reproductive health and service provision, enhancing the system to make it capable to respond to women's needs especially those with special needs and preparation of tools to assess client's satisfaction.[422] The third strategy focuses on increased availability of maternal health services.[423] Detailed activities focus on integrating maternal health services in very stage; enhance capacity of post abortion care as part of reproductive health services, provision of the necessary equipments and supplies as well as frequent revision and updating service delivery guidelines, manuals etc.[424]

The last strategy focuses on increasing community engagement, ensuring access to professional attendance during pregnancy, delivery and after delivery, improving the quality of health services. [425] The detailed activities focus on identifying needs, enhancing supervision mechanisms and developing guidelines. [426] The strategy has also adopted maternal morbidity review.[427] The detailed activities focus on legal notification of causes of death, implementation of mechanism at all levels; distributions of outcomes of maternal death reviews and implement recommendation of the reports.[428] Such approach creates positive accountability system.

[420] Id
[421] Id at 27
[422] MPHS and MMS), *National Reproductive Health Strategy 2009-2015 at 27(cited in note 278)*
[423] Id
[424] Id
[425] Id at 28
[426] MPHS and MMS), *National Reproductive Health Strategy 2009-2015 at 28(cited in note 278)*
[427] Id at 29
[428] Id

The tasks adopted address skilled labor attendance, emergency obstetric care, referral systems as well as family planning in the same strategy.[429]. These four elements are known to be basic services in maternal health. [430] One of the strategies focuses on monitoring and evaluation i.e., maternal death review.[431] Monitoring and evaluation mechanism is also the other cross cutting issue addressed by the strategy.[432] Enhancing the basic infrastructure, management and logistics of the health systems has also been duly addressed in this strategy.[433] This contributes in ensuring the existence of functional health system. One of the reasons why a rights-based approach is a good means to reduce maternal mortality and morbidity is the fact that it introduces good development practices such as maternal death review.[434] "Maternal death audits" and "reviews" are means of investigating cause of deaths of women at the individual level.[435] But, such methods are used only if they are strictly confidential; provide due process; and the scope of the investigation extends beyond the facility. [436] Besides the maternal death review the strategy has incorporated its own monitoring and evaluation schemes such as supervision, tools to assess client satisfaction.[437] As mentioned in this strategy such monitoring and evaluation mechanisms help identify the gaps and creates strong constructive accountability mechanism and creates awareness on the expected responsibilities. Ethiopia's Sexual and Reproductive Health Strategy doe not incorporate this.

[429] Id.
[430] Yamin 7Sur J at 99 (cited in note 108)
[431] MPHS and MMS), *National Reproductive Health Strategy 2009-2015 at 29(cited in note 278)*

[432] Id at 12
[433] Id
[434] Id
[435] Yamin 7Sur J at 98(cited in note 108)
[436] Id
[437] MPHS and MMS), *National Reproductive Health Strategy 2009-2015 at 26-29(cited in note 278)*

The other important aspect of the strategy is it has identified the need to increase budget.[438] In fact budget is one of the cross cutting issues discussed in detail at the beginning of the strategy. Budget is one indicator of Government's level of prioritization.[439] The strategies adopted will contribute in increasing and creating sustainable financial resources and also shows the government's political will towards the issue of sexual and reproductive health of its people and more specifically maternal mortality and morbidity. Moreover the strategy has incorporated the need to conduct researches and the creation of data to the betterment of evidence based decision making process. [440] Besides that the Kenyan Sexual and Reproductive Health strategy is guided by the respect for human rights, gender equality, taking on evidence-based practices, quality advancement, setting benchmark and audit, and application of suitable and cost-effective technologies.[441] Ethiopia's Sexual and Reproductive Health Strategy lacks the above mentioned aspects.

Ethiopia's Sexual and Reproductive Health Strategy has adopted two strategies to reduce maternal mortality.[442] The first strategy designed empowerment as one strategy.[443] But this strategy focuses on informing the community so as to reduce delays in seeking help and delays. The document recognizes that one cause of maternal mortality is the society's attitude towards maternal morbidity and mortality. Taking from this without changing the society's attitudes provision of information on how to avoid delays will achieve any results. Intensive Human rights education both in formal and non formal education is necessary. The second

[438] Id at 9
[439] Yamin 7Sur J at 100(cited in note 108)
[440] MPHS and MMS), *National Reproductive Health Strategy 2009-2015 at 13(cited in note 278)*
[441] Id at 8
[442] Federal Democratic Republic of Ethiopia, Ministry of Health, *National Reproductive Health Strategy 2006-2015 at 17-18(cited in note27)*

[443]Id at 17

strategy adopted is ensuring core package of maternal and neonatal services.[444] At the beginning it has been stated the strategy does not address the full range of sexual and reproductive health strategies.

Especially when reading it in line with the strategies goals previously mentioned i.e. not addressing all ranges of reproductive health activities it makes it difficult to tell the activities it has given incorporated. This strategy has incorporated list of issues that should be given due attention.

One of the issues is the fact the community still perceives maternal morbidity as natural.[445] At the beginning the strategy lack of education has been mentioned as one of the challenges. Besides that looking from the identified strategy there is absence of comprehension of one's identity, human rights among the society. In this kind of situation it is difficult to imagine that the community will thoroughly comprehend the underlying causes of maternal mortality and design solutions via provision of information on the importance of seeking delivery service etc but this approach is not going to change the deep entrenched wrong perception about maternal mortality.

The strategy focuses on increasing the number of human resource[446] But it is silent about the supply of equipments etc and also the economic and physical accessibility of maternal health services. These are some of the reasons why expecting mothers keep losing their lives which has been mentioned in the previous chapters. These issues have been mentioned as challenges in the section addressing maternal and neonatal health. The strategy has also designed the

[444] Id at 18
[445] Id at 16
[446] Id at 19

development of another national strategy addressing maternal and neonatal health[447] which has not been developed till now.

Both strategies address gender related issues[448] but Ethiopia's strategy misses gender equity and equality and emphasizes on harmful traditional practices. In the case of Kenya, the strategy also incorporates increasing men's participation in reproductive health programmes and empowers women to take part in reproductive health decision making. It has paid special attention to educating health care providers on the need to be conscious of reproductive right while they render their service[449], whereas Ethiopia's strategy focuses on only increasing awareness[450]. It did incorporate strengthening the legal framework but it lacks human rights education in its aspect. It does talk about increasing awareness on laws such as family code etc but the role of international instruments; has not been addressed.

In both cases, the strategies focus on the health system. As it has been mentioned previously sexual and reproductive health raises other rights Ethiopia's strategy has raised the importance of increasing the literacy rate.[451] Kenya's strategy has not shown analysis in this aspect. But it has also incorporated human rights education.[452]

[447] Id at 20

[448] Federal Democratic Republic of Ethiopia, Ministry of Health, *National Reproductive Health Strategy 2006-2015 at 8-11(cited in note279) and* MPHS and MMS), *National Reproductive Health Strategy 2009-2015 at 37-40(cited in note 278)*

[449] MPHS and MMS), *National Reproductive Health Strategy 2009-2015 at 37-40(cited in note 278)*

[450] Federal Democratic Republic of Ethiopia, Ministry of Health, *National Reproductive Health Strategy 2006-2015 at 8(cited in note279*

[451] Federal Democratic Republic of Ethiopia, Ministry of Health, *National Reproductive Health Strategy 2006-2015 at 8-11(cited in note279)*

[452] MPHS and MMS), *National Reproductive Health Strategy 2009-2015 at 37-40(cited in note 278)*

Kenya's Sexual and Reproductive Health Strategy has taken a step in this aspect. It has identified list of organizations both governmental and on governmental and listed their responsibilities which is absent in the case of The Sexual and Reproductive Health Strategy of Ethiopia.

Conclusion

Ethiopia is party to several international and regional human rights instruments. As a result the country has obligations that need to be carried out. Nevertheless, the Constitution does not recognise socio economic rights. Though, the sexual and reproductive health strategy has identified the need to focus on implementation of laws its focus is only on the legal frameworks. The strategy lacks a human rights analysis and a framework. This has resulted in gaps such as failure to address vital elements of maternal health issues such as economic and physical factors, absence of accountability creating mechanisms, attention to budgetary implications, recognition of duty bearers and their duties and effective empowerment mechanisms and other details discussed. It has failed to give due attention on how to create equitable health care systems, promote gender equality and application of standards by health care providers. The strategy does follow community based approaches. Though this increases the level of participation there is a risk of transferring governments' responsibility to the community. In order to ensure the provision of health care the strategy has adopted community based strategy that focus on increasing the number of health care workers. On the other hand Kenya has developed an exemplary constitution and its sexual and reproductive health strategy has taken a great step towards the application of a rights-based approach. The strategy is built upon the sexual and reproductive health policy of Kenya which is gain built upon ICPD's goals. The strategy is also driven by the respect for human rights and specifically respect for sexual and reproductive health rights. The basic objective of the

strategy addresses key points of sexual and reproductive health lights components. It has incorporated maternal death audits as a monitoring and evaluation mechanisms. It has paid due attention to financial aspects. It outlines duties and responsibilities of various stakeholders where civil society and religious among others organizations have their own vested duties and responsibilities. In the writers opinion this developed is worthy of recognition and could be set as an example for the various African nations.

Conclusion

It is a tragedy that women risk the loss of life while giving birth to another life. The fact that the causes of death could be prevented makes the situation even worse. As it has been discussed in the first chapter several factors that reinforce one another are found at the bottom of this problem. But on top of these factors the situation of women in the society plays a pivotal role. These challenges can be overcome via the application of a rights based approach.

By a rights-based approach, it is meant that maternal health programs should be geared towards making women's right to health and other related rights a reality. These programmes should be developed and channelled through international human rights instruments that recognize these rights. These programs should be designed, developed, implemented, monitored and evaluated in light of human rights principles norms, standards. These norms, standards etc are to be applied in each step starting from the beginning i.e., the selection of interventions, identification and selection of targets, enumerating resources and communications followed by effective and efficient implementation etc. This also takes into consideration the various international and regional monitoring and evaluation mechanism.

The domestic legal framework plays a vital role in the effective application of a rights-based approach. Accordingly analysis of Constitutional protection of sexual and reproductive rights has been undertaken by taking Ethiopia and Kenya. The analysis points out positive as well as challenging aspects of both constitutions. But all in all, Kenya's new Constitution has taken as step towards the realization of women's human rights whereas the Constitution of Ethiopia still needs improvement.

Going to more specific topics it has been shown how a rights-based approach can be applied in Sexual and Reproductive Strategies. It has been discussed that every program designing has three stages i.e., the initial process, the actual program developing process and the implementation process. It has also been discussed how the initial and actual program designing process can be undertaken in light of a rights-based approach. Following that it has undertaken if the sexual and reproductive health strategies of Ethiopia and Kenya have considered factors and steps mentioned in the discussion. The outcome of the comparative analysis has shown positive aspects as well as weaknesses and opportunities for improvements. Again looking at the overall analysis the Sexual and Reproductive Health Strategy of Kenya has incorporated several steps that will contribute to the realization of sexual and reproductive rights of all Kenyans where as Ethiopia's sexual and Reproductive Health Strategy needs to be improved.

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