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# A Human Rights-Based Approach to Maternal and Child Health in Ethiopia: Does it Matter to Promote Health Equities?

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## Abstract

A rights-based approach to health helps to address health equity gaps. While several aspects of health as a human right exist, this chapter highlights particular indicators relevant to shaping a human rights approach to maternal and child health in Ethiopia. These indicators include recognition of the right to health; national health plan; accessible and acceptable health-care services; accountability; and a civil society that draws on the agency of vulnerable groups. Probing the extent to which the Ethiopian health system includes these features, this chapter identifies that the Federal Constitution does not adequately recognize maternal and child health as a human right. While identifying the positive developments of increased access to women's and children's health-care services in Ethiopia, the chapter also charts problems that limit further improvement, including health workers' inability from making the right health-care decisions; extreme gaps in ensuring accountability; and a restrictive law that restrains social mobilization for a proper health rights movement. The chapter concludes by providing recommendations to the government of Ethiopia that addressing these problems using a rights-based approach offers an alternative pathway for the progressive realization of the right to health of women and children, and it thereby improves health inequities in the country.

**Keywords:** a rights-based approach, health, maternal, child, Ethiopia

## 1. Introduction

It is at present 40 years since the Alma-Ata Declaration on primary health care [1]. Grounded in certain human-rights norms and public-health principles, the declaration urged governments and other actors to ensure the attainment of maternal and child health-care through primary health care by the year 2000. However, despite the significant reductions, women and children are still dying of inadequate health-care services, particularly in vulnerable communities. In our world, the majority of deaths occur in relation to maternal and under-five child mortality. Needless, the causes for most of the deaths are both treatable and preventable. It is likewise discovered that increases in maternal and child health are not shared equitably and that between and within countries, health inequities or gaps have widened [2].

In order for governments to scale up primary health care and thereby to narrow health inequities, among other things, the declaration indicates the importance of universal health coverage, national health plans, and a health workforce that includes community health workers [2].

Following Alma-Ata various attempts have been constructed to delineate some of the right-to-health features of health systems. Acutely aware of the centrality of a human rights-based approach (HRBA) to health to the creation of equitable health systems, Gunilla et al., for instance, have attempted to identify some of these to include legal recognition, standards, participation, comprehensive national planning, accountability, equity, equality and nondiscrimination, and respect for cultural difference and quality and proposed 72 indicators that reflect some of these features [3].

Maternal and child health is equally a central challenge of the Ethiopian health system, and health gain disparities concerning these categories of persons exist within the various parts of the country. This chapter examines the degree to which the Ethiopian health system (1) promotes awareness of the complementary relation between the Ethiopian health system and the right to maternal and child health; (2) selects a manageable set of indicators to assess the degree to which a health system includes some of the right-to-health features; (3) increases accountability in relation to the Ethiopian health system and the right to maternal and child health; and (4) deepens the understanding of the important role of indicators in relation to the progressive realization of the right to maternal and child health.

For the discussion on the human-rights features of maternal and child health and measuring Ethiopian compliance of its obligation to the right to health, this chapter relies mainly on current literature, General Comment 14, the Alma-Ata Declaration, and elements of the World Health Organization (WHO) building blocks of a good health system, the Convention of the Right of the Child, General Comments 3 and 4 of the Committee on the Rights of the Child, and the requirement that health facilities and services are available, accessible, and culturally appropriate—respectful of the culture of those concerned— and of good quality [4–11]. Further, it draws an examination of relevant Ethiopian laws, policies, plans and institutional mechanisms. Before discussing these features, the chapter attempts to highlight the conceptual framework of a HRBA.

## **2. Understanding a HRBA in the maternal and child health**

Although conceptually rigorous, much has been written on the relevance of a HRBA to development and in particular to women and children's health care. There is consensus that the international community has lately achieved a full understanding that maternal and under-five mortality is no longer simply an issue of public health but a human rights concern [12]. This concern over a rights framework to maternal and child health grows due to the fact that a significant portion of maternal and under-five mortality is from preventable causes—an indication that avoidable maternal and child fatalities are potential violations of human rights constituting social injustice [13]. Essentially, a HRBA to maternal and child health aims to realize the right to the highest attainable standard of health (or “right to health”) and other health-related complementary rights of vulnerable women and children.

Various features can be used as useful indicators to measure compliance of state obligations to the right of health care of their population: (1) legal recognition of the right to health; (2) availability, accessibility, acceptability, and quality of health-care facilities and services; (3) participation; (4) equality and nondiscrimination; (5) national health plans; (6) well-trained and motivated health workers; (7) and

monitoring and accountability. This chapter analyzes how the Ethiopian health system deals with some of these features, in the section 'Access to maternal and child health care in Ethiopia'.

## **2.1 Legal recognition of the right**

Similar to many other rights, recognition of the right to health takes different levels. In the main are the global and domestic dimensions, where the former is expressed through ratification of human rights treaties and the latter deals with the recognition of the right to health in the national constitution or other statutes. Legal recognition requires acknowledgment of the range of binding human rights obligations in the national legal and policy framework, and the jurisprudence and other pronouncements elaborating upon treaty provisions over the past decades [14]. This feature further requires avoiding euphemisms and rather urges to employ the language of human rights law in adoption of development laws and policies which laws and policies may include in the area of health-care [15]. This means, for example, that words such as "needs", "equity", "good governance" to identify things that are human rights or "citizens' rights" are employed in a manner that avoids reference to employ human rights standards and are reckoned to constitute euphemisms. The latter is distinguished as an "effort to depoliticize development discourse" whether they relate to issues of health care or education [14, 15]. But, why unambiguous recognition of rights is central?

Legal recognition is significant as it increases stakeholders' accountability and gives attention to ways of empowering marginalized children and women or their representatives to be aware of and claim their rights [16]. It can too cause the authorities accountable before courts, contributing to tangible improvements in maternal and child health care services. However, the realization of the right to maternal and child health can mean a commitment towards the recognition of the right, this does not necessarily warrant the actual operation or success of implementation [3]. China's law on Maternal and Infant Care, which specifically targets the health of mothers and young children, is a notable exception and is thought to possess a positive effect on child survival rates. Similarly, Vietnam's Child Protection, Care and Education law provides free health care for children under six. As well, in some jurisdictions, recognition has generated judicial decisions and non-judicial mechanisms of accountability that have improved the delivery of wellness-related services [17].

## **2.2 National health plans and health workers**

The realization of women and children's right to health may be pursued through numerous approaches of which the adoption of national health plans that embraces health workers is one. General Comment 14 requires States parties to the International Covenant on Economic, Social and Cultural Rights (ICESCR) to develop a comprehensive home health plan encompassing human resources with a sentiment to assist them to realize their obligation of access to quality of health care to their population [18]. Adoption of national public health plan is a core obligation. But, what must a comprehensive national health plan, which incorporates health workers, exhibit?

First, health workers in preventive, curative, and rehabilitative health, encompassing physical and mental health must be available. Second, health workers must have appropriate preparation. Third, incentives must be in place to encourage the appointment, and retention, of health workers in underserved areas to better access, especially of marginal communities and populations. Fourth, human rights, including respect for cultural diversity and treating patients with courtesy, should



be a compulsory part of the training for all health workers. Fifth, health workers must receive domestically competitive salaries and other reasonable terms and conditions of employment.

### **2.3 Availability, accessibility, acceptability, and quality (AAAQ) of health-care**

General Comment 14 provides an in-depth articulation of the four interrelated and essential AAAQ elements, which can equally be applied to women's or children's right to health. *Availability* implies that structures, goods and services necessary for women and children's health are made available for the whole of the population within a state (this includes hospitals, clinics and other health-related buildings, medical and professional personnel, drugs and other equipment). Nevertheless, the handiness of such commodities and services depends on the physical and financial accessibility to those women and kids in need of them. Structures, goods and services have to be accessible to all women and children without discrimination —addressing discriminatory laws, policies, practices and gender inequalities in health care and in society that prevent children from accessing good quality services [18]. Accessibility has four dimensions: nondiscrimination, physical, economic, and information accessibility. *Acceptability* implies that structures, goods, and services are to be respectful of medical ethics and culturally appropriate [18]. *Quality* signifies structures, goods, and services must be scientifically and medically appropriate and of good quality [18].

### **2.4 Accountability**

Accountability is fundamental to a HRBA. Paul Hunt notes “human rights can become no more than window-dressing without accountability” [19]. When accountability operates in a system, duty-bearers are answerable for their human actions or omissions in relation to their responsibilities. As a procedure, “accountability provides right-holders with an opportunity to understand how duty-bearers have discharged, or failed to discharge, their obligations, and it also provides duty-bearers with an opportunity to explain their conduct” [20]. Accountability does not necessarily imply punishment or blaming but constitutes elements of responsiveness, monitoring, independent review, answerability, and remedial action.

Different international and national accountability mechanisms can be envisaged within and outside the health systems that aim to hold all actors responsible, identify gaps and failures of institutions and programs, and provide remedy and redress for those (such as children) whose rights have been violated. According to the UN Office of High Commissioner for Human Rights (UNOHCHR), four broad categories of accountability mechanisms are identified: judicial, quasi-judicial, administrative, and political [21]. Helen Potts identifies a fifth case of accountability mechanism, social [19].

This chapter will only concentrate on the part of judicial accountability. This is mainly because litigation is increasingly used to seek accountability and redress for violation of constitutional and international human rights law dealing with the right to maternal and child health [22]. Yet, for litigation to be in force, certain conditions must exist.

First, there must be a direct entrenchment of the justiciable right to health in the national law/s of a given country that presents a specific right to health accountability mechanisms, which in turn can provide access to the courts to enable rights-holders to challenge government legislation and policy through litigation. Fitting in with Leslie London's view, constitutional recognition of “human rights standards can and do inform more powerful methods to establish accountability for realizing

basic human needs” [23]. Furthermore, the stipulation of the international human right to maternal and child health has significantly contributed as an interpretive role to establish state obligations to ensure access to health care towards their population. Today each country is a state party to at least one of the international human rights instruments incorporating the right to health care [24]. Clearly, subscribing to these instruments raises an obligation upon state parties to guarantee accessibility of a detailed implementation program and comply with the AAAQ.

Second, due to their incapacity and vulnerability caused by biases and inequalities, women and children need an efficient legal representation to seek remedy before judicial bodies for systemic violation of their right to health [25]. Civil society organizations (CSOs) or human rights non-governmental organizations (NGOs) play a substantial role in this regard as discussed in the subsection below.

Despite the recent evolutions in the judicialization of maternal and children’s rights which has increased access to health-care services in nations such as India, South Africa, and Columbia, accountability in many health systems remains extremely light. In some states, the same body provides and regulates health services, as well as having those responsible to account [3].

## **2.5 Social mobilization**

Civil society organizations’ contribution in litigating constitutional matters concerning health rights is of paramount importance. London underscores that active agency by those vulnerable to human rights violations is an aspect of health as a right relevant to shaping a HRBA to health [23]. Civil society action has an emancipatory or transformative potential to challenge state neglect or omission of health rights of children and women. A good example is post-apartheid South Africa, where CSOs have litigated most, if not all, major constitutional human rights cases, inclusive of the right to health care affecting women and children [25].

The extent of the actual significance of CSOs in women and children’s rights advocacy and representation depends on the sociopolitical and legal environment in which they function. In emerging democracies, such as South Africa and Brazil, CSOs tend to sustain a relatively relaxed operational environment, and there is room for a mushrooming of vibrant human rights NGOs, whereas in restrictive settings—as in many African countries where laws are promulgated that constrain the natural processes and operational space of CSOs—they are regarded as obstructive by their governments [26]. In the latter case, the restriction on CSOs is manifested, for instance, in the content and implementation of legal instruments that are meant to govern their formation and operation. The next section analyzes the challenges presented to civil society in engaging human rights advocacy concerning women’s and children’s health care rights in Ethiopia.

## **3. Access to maternal and child health care in Ethiopia**

### **3.1 The legal framework of maternal and child health in Ethiopia**

With a population of above 100 million people, Ethiopia is the second most inhabited country in Africa and is one of the few countries in the globe with a high population of maternal and child deaths [27, 28]. There are legal, policy, and institutional mechanisms that respond to this challenge. The Federal Democratic Republic of Ethiopia (FDRE) Constitution (1995) along with the nine regional states constitutions dedicate a specific provision entirely dealing with the rights of women due to their vulnerability [29]. It states that women have the right “to prevent harm arising

from pregnancy and childbirth and in order to safeguard their health, women have the right of access to family planning education, information and capacity” [29]. Similarly, the constitution guarantees the right to equality of women with men and further provides for the obligations of the state to eliminate the influences of harmful customs, laws, customs, and practices that oppress or cause bodily or mental harm to women [29]. However, none of these provisions adequately mention women’s right to access to health care and the underlining determinants of health other than the ones mentioned under Article 35(9) of the FDRE Constitution. This particular sub-article provides for women’s right of access to family planning, education, information, and capacity.

With respect to minors, the FDRE Constitution equally incorporates a specific article exclusively governing on children’s rights but does not, nevertheless, take an express provision of children’s right to health or the underlining determinants of health, such as admission to food, safe drinking water, sanitation, and living accommodations. Although Ethiopia has acceded to international instruments of children’s rights the Convention on the Rights of the Child (CRC) in 1991; the International Convention on Economic, Social, and Cultural Rights (ICESCR) in 1993; as well as regional instruments such as the African Charter on the Rights and Welfare of the Child (ACRWC) in 2002, the constitution (article 36) fails to entrench children’s right of access to health care and their other socioeconomic rights explicitly [29].

However, children’s right to life and the best interests of the child are recognized in the constitution. Besides, women and children have the same rights as all other persons under the constitution, such as the right to life, information, equality, and nondiscrimination. However again, none of these provisions adequately incorporate children’s right to access to health care and the underlining determinants of health. The Backman et al. study also indicates the right to health not to have been explicitly recognized in Ethiopia [3]. Overall, this manifests lack of compatibility between the domestic law with the relevant provisions of the ICESCR and ACRWC in the area of health care. As clearly highlighted in the decision of the African Commission in the case of *Purohit and Moore V Gambia* (2003), when a state’s legislation in the area of health care does not meet human rights treaties that such state has ratified or acceded, then the state is required to repeal its existing laws and replace it with a new legislative regime to ensure compatibility [30]. While the author maintains the importance of explicit legal recognition of the right to health and proposes amendment of Article 35 and 36 of the constitution, in the absence of explicit and women’s and children’s right to health care and their other socioeconomic rights, the provisions dealing with the right to life and others should be invoked to realize health rights of women and children by way of temporal solution.

### 3.2 Analyzing the Ethiopian health care plan and health workers

Ethiopia restructured its health system in 1993, in the same year the national health policy was issued. Under the umbrella of the health policy, the Ethiopian health sector adopts a seemingly innovative and rolling health program, namely, the Ethiopian Health Sector Development Program (HSDP) [31]. The HSDP has been introduced in recognition of the failure of essential health such as in terms of the challenges of reaching health care services and goods to the people at grassroots level, in particular to the underserved rural population. It was projected based on the concept and principles of comprehensive primary health care, which essentially includes maternal and child health [32]. Its target has been the expansion of essential health system inputs towards the achievement of the Millennium Development Goals (MDGs)—an indication that its focus has not complied with the human rights obligations to health [33].



After evaluation of the second HSDP in 2002/2003, it was revealed that constraints existed in terms of availability of trained, high-level professionals, and essential services to reach the people at the grassroots level. In response to this challenge, in 2003 the Ethiopian Federal Ministry of Health launched a new health-care plan, the “Accelerated Expansion of Primary Health Coverage,” through a comprehensive health extension program (HEP). The HEP is designed to shift health-care resources from predominantly urban to rural areas and rests on the rapid vocational training and deployment of health extension workers (HEWs) starting in 2003. Ethiopia is one country unable to provide a skilled health workforce to the majority of its population, and the question arises: Is there any evidence that the Ethiopian health plan, which incorporates HEWs, will improve women and children’s prospects of survival and their well-being?

Health extension workers are expected to perform a wide range of functions—from preventive and promotive engagements to case management. HEWs’ engagement in these functions has brought about marked achievements. It has improved access to maternal and child health services to the rural poor, and after the introduction of the HEW program, the proportion of households with access to improved sanitation reached 76% in the intervention villages from 39% at baseline [34]. Likewise, child vaccination/immunization results indicate substantial gains. By June 2010, 86% of children had received Penta 3/DPT 3 vaccine, 82% had received measles vaccine, and 62% had been fully immunized—an average annual increase in the number of fully immunized children of 15% since 2006 [34]. In addition, maternal health services coverage has shown progress: 85% of health posts could provide family planning services, 83% could provide antenatal care, 59% could perform clean deliveries, and 47% could provide postnatal care [35].

Awareness of HIV/AIDS has also improved, with the level of knowledge of condoms as a means of preventing HIV increasing by 78% in HEP villages and 46 in control villages. Again, seeking behavior for malaria treatment shows marked progress which results in in-patient malaria cases falling by 73% and deaths in children under five by 62% [36].

Overall, the HEWs program and the intervention in the foregoing show remarkable results. Its impact for reduction of maternal and child fatality rate has been substantial. In this connection the former Ethiopian Minister of Health, Kesetebirhan Admasu, underlines that “the HEWs have led the way to achieve major reductions in child and maternal mortality” [37]. In the same vein, regarding the contribution of HEWs with respect to the reduction of child mortality rates in the country, USAID Administrator Rajiv Shah notes:

*... Between 2006 and 2010, infant mortality decreased by 23 percent and under-5 mortality by 28 percent. These achievements are largely a result of Ethiopia’s investment in a community health system and a cadre of 35,000 health workers who provide front-line care [38].*

Global agencies, such as UNICEF, share the sentiment that the endeavor to deploy health workers to the most remote parts of the country has helped bring about a steep reduction in child mortality [37]. The WHO et al. report in 2014 establishes a significant increase of the maternal mortality rate from 740 in 2005 to 420 in 2013—showing progress towards improving maternal health [39]. Nevertheless, the implementation of the HEWs program has its own challenges.

### **3.3 The challenges of engaging HEWs**

The task shifting from skilled providers to lower-level HEWs has been a model of success in Ethiopia for an extensive range of maternal and child services.



Nevertheless, while the commitment to introducing coherent and effective HEWs programs throughout the country is laudable, there are major obstacles.

First, HEWs lack the necessary knowledge and skills, which restricts the delivery of quality maternal and child health services [40]. A study by A. Medhanyie et al. has found that more than half (54%) of HEWs have poor knowledge about the contents of prenatal care counseling, and the majority (88%) have poor knowledge about danger symptoms, danger signs, and complications in pregnancy [39]. These workers lack the requisite skills to perform clean and safe deliveries. Research shows their basic health knowledge is quite poor regarding the major communicable diseases [40]. In one case, the parents of a 2-year-old child who had developed tonsillitis were taken to the Semera Health Post in Afar [41]. The health worker in charge prescribed amoxicillin pills. However, the next day the child's entire body became swollen, and he had to be taken back to the health post. The health professional in charge on that particular day noticed the complication the child had developed and referred him to a hospital in Dupiti, but the child died by the time he reached the hospital. It was noted that the child would not have died had he been immediately referred to the hospital at early stage examination and that the inappropriate drug exacerbated his condition [41]. This clearly raises the need for a proper system to hold HEWs accountable to the community they serve.

Second, attrition and retention pose further challenges. In contexts where the health-care system is weak and characterized by a severe shortage of health-care workers, HEWs may be the rural community's only contact with the health-care system, placing a heavy burden on them, possibly resulting in them leaving their jobs. Often one of the HEWs is a member of the community (*Kebele*) and is required to serve in the political administrative cabinet, which adds to the burden [42]. As in some instance, HEWs reside at a distance from their work places; poor transportation and communication which results in job dissatisfaction remains as another challenge [43].

Third, the sustainability of community health projects depends on the availability of on-going funding, a diversity of funding sources and ability to mobilize volunteers or low-paid workers who in the face of their own poverty are willing to care for the needy in their communities. Nearly all the challenges that community health projects faced relate to inadequate and sporadic funding. Funding limitations further affect the availability of health goods and services such as supervisors, medical equipment, supplies of drugs for minimum curative services, furniture, and vehicles [44].

Fourth, administrative functions such as monitoring, supervision, coordination, and management are critical for successful community-based programs. Many HEWs perform their job alone or in small groups in distant sites, which results in a lack of meaningful supervision and reduces HEWs' ability to provide effective focused antenatal care [43].

Fifth, lack of commitment is yet another challenge. Although many HEWs work enthusiastically, there are a few who are not fully dedicated to their everyday activities [43]. This is mainly due to a failure to integrate HEWs as part of the state's responsibility for health-care delivery.

### 3.4 Implementation challenges in relation to goods and services

As previously noted, General Comment 14 clarifies the obligation of states to ensure maternal and child-friendly health services, goods, and facilities are available, accessible, acceptable, and of high quality. Although Ethiopia has improved health coverage through deploying HEP, health goods and services are threatened by myriad challenges.

With regard to availability, the Committee on Economic, Social and Cultural Rights (ESCR) notes:

*The Committee is concerned that there is no universal health-care coverage. It is also concerned about the low number of qualified health-care professionals per capita in certain regions and critical shortages at health centres, both in medical equipment and staff. The Committee also notes with concern the high rate of maternal and infant mortality, and the low number of births that are assisted by a skilled attendant, especially in rural areas. It is further concerned that access to maternal and infant health care remains poor, in particular in the Somali National Regional State of Ethiopia [45].*

The United Nations Population Fund (UNPFA) equally observes:

*Most of the health facilities which are far from Addis Ababa are either not fully staffed with skilled service providers or fully equipped with the necessary supplies and equipment that can provide quality services related to complications during pregnancy and childbirth. Limited human resources, especially midwives, hamper efforts to provide adequate services, especially in rural areas. Gaps in training and remuneration have led to attrition and turnover among public sector health care professionals. Public facilities routinely suffer stockouts and obstetric care equipment shortages due to budget deficits and poor management [46].*

The range of limitations in terms of availability of health-care facilities, goods, and services restricts the full realization of women's and children's right to health-care and the underlying determinants of health.

With regard to accessibility, a myriad of challenges exist in the country. In one case story in 1980, an Ethiopian woman from the Oromo ethnic group was arrested without a court order. She was pregnant during her arrest and delivered her baby in prison without the help of a doctor. The baby's health was permanently damaged by the lack of timely help in her prison cell. This represents a clear case of limited access to health-care service to women and newborn babies in difficult situations. If there was a regard for human rights laws, the pregnant woman and her newborn baby would have had a health worker or professional who could have helped during childbirth [47].

A further challenge on access is, despite the improvements made in expanding access to health services, the disease burden is still high, and the service utilization rate remains low in the country, partly due to the burden of high out-of-pocket spending that restricts an already poor society from health-care utilization [48]. A recent survey by Berhan and Berhan in 2014 conducted in Ethiopia indicates that inaccessibility of transport, long distances from functioning health-care facilities, and a lack of confidence in the services provided are some of the barriers that impede access to maternal health facilities [49]. Similarly, the 2011 Ethiopian Demographic and Health Survey (EDHS) study shows that the major barriers for pregnant women to access health services are lack of transport to a facility (71%), lack of money (68%), and distance to a health facility (66%) [50]. Moreover, although child malnutrition has declined, many Ethiopian children continue to go hungry. Safe food is considered one of the underlying determinants of the right to health, but the rate of Ethiopia's stunted children (caused by malnutrition) is above the average of other African countries, the average rate for African countries being 38% and that of Ethiopia's is 58% [51]. Besides, although there are marked improvements in the coverage of access to child vaccination, clean water, and improved sanitation, the progress remains slow. This is likely to have a negative impact on the reduction of under-five mortality rates [52].

Acceptability of health-care services is another challenge. For instance, the Ethiopian Central Statistical Agency's study conducted in Ethiopia in 2014 shows that close to 90% of births occurred outside a health service facility for different reasons: 45% did not take place in a health facility because the mothers did not think it was necessary, and for 33%, mothers stated it was not customary [53]. In addition, it has been observed that the birthing position used at the health centers made the women feel uneasy and was one of the reasons for Ethiopian women choosing to deliver at home rather [53].

Further, the delay in providing obstetric and newborn care services and treatment is usually the major reason for the poor quality of service [49]. The following are identified as the main causes for delays in treatment: (1) the number of health professionals is insufficient; (2) available health professionals often exhibit poor knowledge and skill; and (3) nonfunctioning health facilities due to a lack of medical equipment essential to manage obstetric problems, such as drugs, supplies, reagents, a blood bank, oxygen, magnesium sulfate, and a broad spectrum of intravenous antibiotics [49]. The lack of these essential medical goods in laboratories, imaging facilities, delivery suites, and operating theaters further lowers the quality of treatment.

### **3.5 Judicial accountability**

Judicial accountability mechanisms for women's and children's health provide avenues for remedies and redress for women, children, and their caregivers or representatives when their rights to health care are violated. In Ethiopia, the judiciary is vested with the power to consider women and children's rights matters, and the courts are guaranteed, under the FDRE Constitution, to do so free from interference or influence of any governmental body, government official, or any other source [29]. However, interpreting and applying the socioeconomic right to health of women and children in the constitution is arguably the most challenging task facing lawyers and courts in Ethiopia on various grounds.

First, there are problems with the law. The FDRE and the nine regional state constitutions each have a specific provision that deals with the rights of children. Nevertheless, women and children's right to survive, to health, to access to food and safe drinking water, to adequate standard of living, and to other rights relating to the underlining determinants of the right to health have not been explicitly recognized in these constitutions. The absence of explicit recognition might create ambivalence for the judges to enforce these rights when violated. Nor are there special laws that address these rights.

Second, awareness of children's rights is crucial for their overall implementation. However, knowledge about the rights of children has been considered the main challenge [54]. Parents' or guardians' limited knowledge of children's rights and violations of their rights present a challenge to developing proper judicial channels of accountability for children's rights to health or survival.

Third, vulnerable women and children are unlikely to be able to bring claims for violations of their rights on their own behalf. Human rights NGOs could play a major role in representing women and children's rights cases before courts, but the current Ethiopian CSO law limits the possibility of legal representation by civil society for violation of human rights by the state.

Fourth, although the debate over justiciability of socioeconomic rights seems to have been settled in many parts of the world, research shows this is not case within the Ethiopian judiciary and among Ethiopian practitioners [55].

Fifth, the requirement of vested interest or locus standi is a further challenge for judicialization of women and children's social right to health. For instance,



according to the procedural law of the country, civil claims may be joined as a single case where they relate to the same transaction or series of transactions, such as in a case where a decision is sought by any group or person who is a member of or represents a group with similar interest [29, 56].

The foregoing renders the health inequality gap deeper and difficult among Ethiopian women and children and society at large. This challenge of inequality is in contradiction to the preamble of the FDRE Constitution, which underlines the need for Ethiopians to live on the basis of equality and without discrimination [29].

### **3.6 Non-transformative civil society**

Ethiopia has adopted in 2009 the legislation to regulate the activities of CSOs [57] (at the time of writing this Chapter, a proposal was submitted to the Ethiopian parliament to amend this law). Three types of CSOs are classified under this new legislation, “Ethiopian Charities or Societies”; “Ethiopian Residents Charities or Societies”; and “Foreign Charities” [57]. The proclamation defines “Charitable Purpose” to include “the promotion of the rights of the disabled and children’s rights” [57]. It indicates that CSOs are also mandated to promote child survival or health rights in Ethiopia, such as through litigation or advocacy or education. Nevertheless, the proclamation prohibits Ethiopian Residents Charities or Societies and Foreign Charities from engaging in issues, including, but not limited to, the advancement of human and democratic rights and promotion of the rights of the disabled and children’s rights [57]. This is restrictive as these activities are left to Ethiopian charities or societies alone—which are also required not to generate more than 10% of their funding from foreign sources.

The majority of the Ethiopian population lives below the poverty line, and requiring nationals to raise 90% from domestic sources to form charities not only questions their formation but also their sustenance. The limitation on funding has therefore disabled the work of Ethiopian charities on human rights and democratization issues, which clearly affects advocacy on violations of the rights to health of women and children. Besides, the law has deeply affected the ability of international organizations to work in the field of human rights promotion and advocacy in the country.

## **4. Conclusion**

Based on the conviction that an equitable health system is a core social institution and its potential for the realization of women’s and children’s right to health, this chapter argues that the essential HRBA features for ensuring maternal and child health rights in the Ethiopian context include (1) the explicit recognition of the right to health; (2) a national health plan encompassing human resources; (3) achieving health-care services that are available, accessible, acceptable, and of high quality; (4) accountability; and (5) a civil society that draws on the agency of vulnerable groups. Crucially, it examines the manner in which the Ethiopian system reflects such features and identifies the lacunae that exist in the country, including inadequate legislative framework and accountability mechanisms. To address these maladies, this chapter recommends the following: Firstly, the right of access to maternal and child health goods and services and processes to tackle causes of maternal and child mortality be explicitly enshrined in the national legislation. Secondly, the flaws in training, task allocation and supervision of HEWs need to be addressed, and adequate working conditions designed to boost HEWs’ morale. Thirdly, programs and strategies must be implemented progressively to ensure that maternal and child



health is accessible, available, acceptable, and of quality. Fourthly, accountability must be strengthened to monitor the implementation of the rights and the effectiveness of national programs tackling the issue of maternal and child survival. To enhance accountability, the legislature should amend legal provisions to allow CSOs to engage in human rights advocacy and litigation and promulgate legislation that creates a supportive and enabling environment for public interest litigation.

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