LLM (HUMAN RIGHTS AMD DEMOCRATISATION IN AFRICA) 2009

Topic: Where are the mothers? Interrogating maternal mortality as a violation of the rights to life and health: A Nigerian and Ethiopian perspective

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DECLARATION

I, **Okwor Uchechukwu Victoria**, do hereby declare that this research is my original work and that to the best of my knowledge and belief, it has not been previously, in its entirety or in part, been submitted to any other university for a degree or diploma. Other works cited or referred to are accordingly acknowledged.

Signed: .....

Date: .....

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This dissertation has been submitted for examination with my approval as University Supervisor.

Signed.....

Dr. Salah Hammad

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DEDICATION

To my grandmother

Mrs Victoria Okwor

Whom I am named after but never met

Cut in her prime in the dusty plains of Agbani

Writhing in the travails of childbirth

Until your last anguished breath

To your preventable death I dedicate this research.

LIST OF ABBREVIATIONS

ACHPR	**African Charter on Human and Peoples' Rights'**
AUC	**African Union Commission**
AU	**African Union**
CAMH	**Conference of African Ministers of Health**
CESCR	**International Covenant on Economic and Socio-cultural Rights**
CPI	**Corruption Perception Index**
EmOC	**Emergency Obstetrics Care**
ETB	**Ethiopian Birr**
FIGO	**International Federation of Obstetrics and Gynaecology**
HDI	**Human Development Index**
HEW	**Health Extension Workers**
HRC	**Human Rights Committee**
HSDP	**Health Sector Development Plan**
IMNCH	**Integrated Maternal and Neonatal Child Health**
ICM	**International Conference of Midwives**
ICCPR	**International Covenant on Civil and Political Rights**
Maputo Protocol	**Protocol to the African Charter on the Rights of Women in Africa**
MDG	**Millennium Development Goal**

MMR	Maternal Mortality Ratio
MICS	Multiple Indicators Cluster Survey
TBA	Traditional Birth Attendant
NGN	Nigerian Naira
Universal Declaration	Universal Declaration of Human Rights
UN	United Nations
UNDP	United Nations Development Programme
UNICEF	United Nations Children Emergency Fund
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
USD	United States Dollars
WHO	World Health Organisation

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ABSTRACT

'Women are conceived in violence, unwanted in birth, discriminated against throughout life and must struggle for their very existence. They are stripped of their human rights and treated as property, mere chattels. They work, they serve, they please. Yet they are raped, they are abused, they are even burned. In some places they are also stoned. The challenge is to create a better future by applying human rights principles so that all women can live in dignity and health.'

R Cook et al *'Advancing safe motherhood through human rights'* (2001) in UNICEF, *'A human rights based approach to programming for maternal mortality reduction'*.(2003) 3

The above depict the plight of majority of sub Saharan African women. The peculiar physiological function they carry out to perpetuate the human race has become for them, a constant venture in which the loose their own lives.

The right to health has been classified as a second generation right, therefore of socio economic category in relation to a state's obligation. Sadly, socio economic right is jaundiced with the now ubiquitous phrase of 'progressive realisation'. There is however, the minimum core requirement which is the very basics of a state's duty to guarantee its realisation. That minimum for women Nigerian and Ethiopian women is to conceive by choice, bear to term in health and bring forth alive. Any standard less than this infracts on their rights to health and life.

The basis for this lies in the inherent value of every woman. The era of conspiracy and of cold silence is over. The time to act is now. If we fail them we fail their children, we fail their communities, and we fail the very idea of human progress.. It is time for humanity to celebrate life, for every woman to reach self actualization and enjoy good health. The women of the world are waiting..!

J, Phumaphi
Assistant Director General
Family and Community Health

World Health Organisation WHO *Making Pregnancy safer* 'Midwives: making a difference in maternal health' (2006)

CHAPTER ONE

1.1 Background

Whereas states in the African continent have realised the paradox of the increasing scourge of lost lives in the process of bringing forth another human being,[1] more women still lose their lives every minute, every hour, every day[2]. Efforts have been made both at international, regional, and national levels geared towards curbing the trend of pregnancy related maternal deaths; even as these efforts are commendable, a lot still needs to be done for in giving life, women, an overwhelming majority of them of sub-Saharan African extraction, die in the process.

Maternal mortality 'is defined as the death of a woman while pregnant or within 42 days of termination of pregnancy irrespective of the duration and site of pregnancy or its management but not for accidental or incidental causes.'[3] It is the death of a

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1 'Africa Cares: No woman should die while giving life. Lunch of the African Union Campaign on accelerated reduction of maternal mortality in Africa (CARMMA) 4th session of the Conference of African Union Ministers of Health (CAMH4) Addis Ababa 4-8 May 2009.

2 Preamble of the Addis Ababa Declaration on the 4th session of the Conference of African Union Ministers of Health (CAMH4) Addis Ababa 4-8 May 2009.

3 MT Ladan *Law and policy on health, HIV and AIDS, maternal mortality and reproductive rights in Nigeria* (2007) 79.

woman from easily preventable deaths.[4] The fact that these deaths can easily be avoided makes it as much a developmental issue as it is one of human rights.

In the United Nation Millennium Development Goal Report 2008, maternal mortality rate regrettably remains high in sub Saharan Africa and other developing countries. Sub Saharan Africa and Southern Asia account for nearly 86% of all women who die from pregnancy related complications or die six week after delivery.[5] According to USAID, each year over half a million women, 99 percent of them in developing countries die from pregnancy and childbirth-related complications, and an additional 15 to 20 million women suffer debilitating consequences of pregnancy.[6] For every maternal life lost as a result of obstetric complications, about 30 other women suffer disability and injuries.[7] Researches reveal that maternal mortality is not unconnected with economic empowerment because women living in rural and poor areas as well as indigenous communities are most vulnerable.[8] All across the continent the scourge rages on: from the beaches and tropical woodlands of Sierra Leone,[9] through Nigeria, sweeping across Kenya[10], to the highlands of Ethiopia to mention a few.

In recent past, there is a realisation that maternal health is as much a human rights issue as well as it is a developmental and cross sectoral challenge; that maternal

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4 LP Freedman 'Averting maternal death and disability using human rights in maternal mortality programs: from analysis to strategy (2001) 75 *International Journal of Gynaecology and Obstetrics* 2.

5 'The United Nation Millennium Development Report 2008.'

6 The USAID on Maternal and Child Health: http://www.usaid.gov ;
The white ribbon alliance for safe motherhood: Global maternal mortality factsheet **www.whiteribbonalliance.org/ (**accessed 3 October 2009).

7 P Hunt & J Bueno de Mesquita *Reducing maternal mortality: The contribution to the right to the attainment of the highest attainable standard of health* (2008) 4.

8 M Wirth et al 'Setting the stage for equity-sensitive monitoring of the maternal and child health MDGs WHO Bulletin (2006) 84 in Hunt & J Bueno de Mesquita (n 7 above) 4.

9 Amnesty International 'Out of reach: Cost of maternal health in Sierra Leone' (2009).

10 Less than 10% of medical facilities Kenya are able to offer basic emergency obstetric care, and less than 6% can provide comprehensive emergency obstetric treatment. MMR for Kenya is estimated at 414 to 590 per 100,000 live births. Kenyan women stand a 1-in 25 lifetime risk of dying from birth related causes. See Central Bureau of Statistics, 2003 'Kenya Demographic and Health Survey' (2004)148; National Coordinating Agency for Population and Development, Ministry of Health & Central Bureau of Statistics, 2004; 'Kenya Service Provision Assessment Survey' (2005)111 in Centre for Reproductive Rights *Failure to deliver:Violations of women's right in Kenyan health facilities* (2007) 15 31.

mortality occurs when women are not economically empowered, discriminated against, treated unequally and are without information on reproductive health and services.[11]

With a population of over 140 million, Nigeria is the most populous nation on the continent, the tenth in the world and has an alarming high incidence of maternal death: only second to India.[12] To bring it further home, Dr. Odujirin a reproductive health consultant to World Health Organisation (WHO) in raising alarm on the rising rate of maternal mortality disclosed that in Nigeria, more than four thousand women die *every month* from pregnancy related causes.[13] The country therefore accounts for about 59,000 maternal deaths yearly[14].

The principal and widely acclaimed indicator for maternal mortality is the Maternal Mortality Ratio (MMR.) Nigeria's MMR is very high: a prevalence of deaths roughly at 1,100 per 100,000 live births,[15]but this does not occur at this ratio all over the country. The northern region (for reasons not unrelated to illiteracy and poverty) has an even higher ratio, rising as high as 1,500 per 100, 000 live births while the southern part of the country increasingly witnesses a continuous reduction to rations as low as 200 and 300 per 100,000 births.[16]However, the 1999 Multiple Indicators Cluster Survey (MICS) conducted by the Federal Office for Statistics in collaboration with UNICEF puts the figure at 704 per 100,000.[17]

Despite being the largest exporter of oil in Africa and the revenue accruing it, Nigeria's rich oil revenue has not translated in better health service for her women. It is clear that resources alone do not translate to improved maternal health care: a combination of factors such as lack of infrastructure and trained personnel and health care service providers, systemic corruption, illiteracy and difficulty in accessing health services all contribute to needless maternal deaths and morbidity.

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11 Hunt & J Bueno de Mesquita (n 7 above) 3.

12 WHO 'Maternal Mortality in 2005: Estimates developed by the WHO, UNICEF, UNFPA and the World Bank (2007) 15. See also Centre for Reproductive Rights Broken promises:*Human rights, accountability and maternal death in Nigeria* (2008) 9

13 *The Punch Newspapers* 25 July 2008.

14 WHO (n 12 above) 25 in Centre for Reproductive Rights (n 7 above) 13.

15 WHO (n 12 above) 13.

16 '2006 Health review.' (2006) 105 in Centre for Reproductive Health (n 12 above) 13.

17 This figure is contested given the inconclusive data collection.

Nigeria has no legal framework providing for reproductive and sexual health. There was a botched attempt to pass a bill to that effect sometime in the recent past but it met an untimely death as anti abortionists and social commentators would hardly let it be heard on the floor of the upper house. A mixture of the socio cultural misgivings of what reproductive health entails and a rather bifurcated understanding of the purport of the proposed bill; it was a situation of throwing away the baby and the bath water.

Maternal mortality ratio is equally disturbing in Ethiopia, with a prevalence of death roughly at 25,000 each year[18]. Its rate of 850 maternal deaths per 100,000 live births is one of the highest in the world.[19] On 6 June 2008 at the opening ceremony of a workshop co hosted by the Ethiopian Ministry of Health, WHO, UNFPA, UNCEF, and USAID to mark safe motherhood day, the then Minister for health declared that infant and mortality death rates were decreasing as a result of joint intervention by both state and non state actors.[20] However, in support of his opinion, the honourable health minster relied on data gathered four years ago to the effect that the present ratio is 77/1,000 births.[21] The present minister however, has conceded that 'there is still a huge challenge ahead'[22] as maternal death is preventable.

One of the principal ways of preventing maternal mortality is adequate and affordable health care, before during and after pregnancy. In the Ethiopia, 94% of all births occur at home, without the services of a professional.[23] This is one of the reasons for its high rates.

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[18] UNFPA in T Tekle 'Ethiopia lunches health project to curb maternal mortality'*Sudan Tribune* available at <http://www.sudantribune.com>(accessed 14 August 2009).

[19] Federal Democratic Republic of Ethiopia Ministry of Health, Family Health Department 'Report on safe motherhood community based survey Ethiopia' (2006) 1. See also 'WHO: 'Mortality country fact sheet 2006'.

[20] Shiferaw Tekelemariam, honourable minister for health's opening speech on the theme 'Deliver the promise to make pregnancy and childbirth safe in Ethiopia' in Ethiopian News Agency available at <http://www.ena.gov.et/EnglishNews> (accessed 14 2009.)

[21] S Tekelemariam (n 18 above).

[22] T Tekle(n 18 above).

[23] UNICEF 'Ethiopia statistics chart' available at <http://www.unicef.org/mdg/maternal> (accessed 14 August 2009).

In the light of international legal frameworks in providing for women rights to life and health some of which are the International Covenant on Civil and Political Rights [24] (ICCPR) International Covenant on Economic and Socio Cultural Rights[25] (CESCR), Protocol to the African Charter Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol)[26] Convention on the Elimination of All Forms of Discrimination Against Women,[27] (CEDAW) Nigeria and Ethiopia have to show greater commitment in the struggle to protect their women's life and health.

1.2 Research question

This dissertation makes bold to cut through thickets of interlocking forces to ascertain factors behind increasing maternal deaths in the face of a woman's right to life and to enjoy the highest standard of health; to detangle the rather complex factors that underlie maternal deaths. It interrogates the paradox of dying to give life, the undercurrents for this anomaly and the relevant laws in Nigeria and Ethiopia protecting women's right to life and health. It searches the nexus between life and health and obligations of state parties. This research seeks to ascertain the extent to which a denial of right to health diminishes a woman's right to life. The need for this research is even more pertinent in the light provision of international and regional legal frameworks on women's life and health to which both countries are signatories.

1.3 Methodology of research

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24 Adopted by the UN General Assembly in resolution 2200 A(XXI) of 16 December 1966 at New York , opened for signature ratification and accession on 19 December 1966 , entered into force on 23 March 1976.

25 Adopted by the UN General Assembly in resolution 2200 A (XXI) of 16 December 1966 at New York; opened for signature, ratification and accession on 19 December 1966 and entered into force on 3 January 1976.

26 Adopted 27 June 1981 by the 18th Assembly of Heads of State of the Organization of African Unity at Nairobi; opened for signature, ratification and accession on 27 June 1981; entered into force on 21 October 1986.

27 Adopted by the UN General Assembly in resolution 34/180 of December 1979 at New York ; opened for signature, ratification and accession on 18 December 1979.

The work will be based on review of past academic and developmental researches on women's health and maternal mortality, health reports, statements and survey studies of international health bodies, as well as works on international, regional and national health frameworks guaranteeing right to life and health. It will seek answers to the research questions through empirical and non empirical means and a review of primary and secondary sources of information.

The research will not be holistic without taking into account efforts of the government to address this issue, policies and programs put in place to realise women's health rights as it relates to the thematic import of the research. Interviews (see annexures i-iii) will be conducted with relevant governmental ministries and agencies, medical practioners, nongovernmental organisations, and women themselves.

1.4 Presumption and limitation

This research is premised on certain assumptions[28]. The first is that women, members of the female sex, do get pregnant and bring forth children. An ancillary assumption is that women die from pregnancies. This work presumes that the realisation of entrenched rights made possible by better health and social services as well as an integrated, rights based and multi sectoral approach can prevent these deaths. Conclusively, research effort is limited by time and resource and to maternal mortality in selected African countries: Nigeria (Enugu and Lagos States) and Ethiopia (Addis Ababa and Oromia Regions.)

1.5 Literature review

A rich repository of writings on women health rights particularly that of maternal mortality exist: from works of international women and development organisations to non profit organisations as well as books from scholars. Rebecca J Cook [29] is renowned for reproductive health rights of women and adolescents. Her latest work on the subject is an impressively detailed expose on the subject and more importantly brings the much needed synergy between reproductive rights, human rights and ethics. Her work also made an effort at analysing selected frameworks on

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[28] Used with reservations. The realities of the theme of this work belie to a great extent, the use of the term.

[29] RJ Cook 'Reproductive health and human rights: integrating medicine, ethics and law' (2003).

the rights of women with a woman centred approach. It however is not detailed in this regard. M Ladan is also renowned in this field as far as Nigeria is concerned. He has to his credit, a concise yet well researched work on maternal mortality. He bases his work on international health regimes and statistics from international health agencies as well as the health policies of the country. The recent work from the Nigerian based Women's Advocates Research and Documentation Centre in collaboration with Centre for Reproductive Health in depth and astute work on the state of health care in general, maternal health in particular and makes the crucial linkage with failure of governmental health policies and ineptitude in governance. [30] It is however restricted to the Nigerian situation.

1.6 Overview of proposed chapters

Chapter **one** introduces the study.

Chapter **two** forges the nexus between the rights to life and health.

Chapter **three** from a developmental prism, it examines maternal mortality.

Chapter **four** is devoted to governmental efforts in Nigeria and Ethiopia to halt the trend of maternal deaths.

Chapter **five** concludes the study and proffers general and peculiar recommendations.

CHAPTER TWO

Maternal mortality and the twin rights

> The M which should have stood for maternal health instead often stands for maternal deaths, missed opportunities, muddled thinking, mistaken priorities and messy organisation of health services.[31]

2.1 Introduction

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[30] Broken promises (n 12 above).

[31] A Rosenfield & D Maine *Where is the M in MCH? Maternal mortality: a neglected tragedy* (1985) 83-85.

Pregnancy is a positive development and a state to be celebrated but when it ends in fatality, it leaves a sour after taste. Every maternal death is a tragedy and as a neglected development problem, it sadly takes lives in situations that often times are easily preventable. The legal import of maternal death is twofold: it affects the rights to health and life in an absolute sense with the irreparable loss of lives. This chapter examines this interconnectedness and causes of maternal deaths, as well as obligation of state parties.

2.2 Maternal mortality: Concept and definition

According to the World Health Organisation, maternal mortality is

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 aggravated by the pregnancy or its management but not from accidental or incidental causes.[32]

It is the death of a woman while still pregnant or 42 days after she ceases to be pregnant for the very reason of her pregnant state and inefficient handling of her condition. The above precludes maternal mortality as death resulting from accident or incidental causes in relation to pregnancy.

Since 'modern life sustaining procedures' are capable of prolonging life and delay adverse outcomes of pregnancy and death sometimes, later maternal death is a concept which is used to define situations where a mother dies more after 42 days or after six weeks post partum period but less than one year after delivery from direct or indirect obstetric causes; from complications of pregnancy or child birth process.[33]

Unlike natural disasters, maternal mortality receives little or no headlines.[34]It is a silent scourge ravaging lives of women of productive age when they are in their prime sweeping across continents especially Africa and Asia. In certain regions or communities for example Wolayta Province in Ethiopia[35] and Northeastern region

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32 WHO 'International classification of diseases and related health problems' (1992) 10. See also WHO (n 12 above) 11.

33 Centre for Reproductive Rights (n 12 above) 5. See also WHO (n 12 above) 4.

34 Oxfam *The cost of child birth: How women are paying the price for broken promises on aid* (2004) 6.

35 Oxfam (n34 above) 6.

of Nigeria[36], pregnancy and child birth are tantamount to death sentences. We see in maternal mortality the paradox of dying to give life, an engendered injustice reflected in the continued loss of lives in one of the most essentially distinguishing natural functions of a woman in juxtaposition to a man.

2. 3 Scale of the Crisis

The increasing risk of a woman dying from pregnancy or birth related causes remain unabated in sub Saharan Africa and Southern Asia[37]. Globally, yearly maternal death is estimated at 536,000. Of this statistic, developing regions of the world account for 533,000 deaths. Sub Saharan Africa and Southern Asia account for more than 90% of the global statistics, exactly 517,000 of these deaths; as opposed to 960 deaths in developed regions of the world. In fact, sub-Saharan Africa alone accounts for 270,000 of the total 533,000 deaths yearly.[38]

Brought further home, the implication of the above is that for every minute, there is a maternal death. In addition to this, a conservative statistics records that over 15 million women are affected by birth complication which often times lead to long term or permanent disability. An example is obstetric fistulae often associated with obstructed labour.[39]

The risk of eventual maternal death in the lifetime of a young female is highest in Africa. WHO estimates the probability that 1 in every 26 year old female will eventually die of maternal or pregnancy related causes as opposed to 1 in 7,300 of developed countries.[40] The worst affected country is Sierra Leone where '1 in 6 women will die from complications related to pregnancy and child birth'[41]

According to the 2009 Millennium Development Goal Report, (2009 MDG Report) maternal mortality ratio (to de defined in next subtopic) decreased in sub Saharan Africa from 920 maternal deaths per 100,000 live births in 1990 to 900 per 100,000 live births by the year 2005. Least developed countries of which African countries

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36 O Ladipo 'Maternal and neonatal mortality: A national emergency' (2006)18.

37 UN 'Millennium Development Goal Report' (2008) 25.

38 See generally WHO (n 12 above) 16.

39 WHO 'Obstetric Fistulae: A review of available information' in Cook et al (2003) 294.

40 WHO (n 12 above) 1.

41 K Hawkins et al *Developing a human rights-based approach to addressing maternal mortality-Desk Review* (2005) 6.

are a substantial constituent, saw a reduction from 900 to 870.[42] The above statistical reduction though commendable, pales in comparison to prevailing standards in developed countries. The same 2009 MDG Report places maternal mortality ratio at 9 per 100,000 births in developed countries. With the exception of Afghanistan, the countries with the highest maternal mortality ratios are all in sub-Saharan Africa.[43]

The standard which may not be infracted from remains that no woman should die giving birth. The reduction as observed in the MDG report is a welcomed development, but a less than one percent decrease in sub-Saharan Africa, a region with the highest maternal crisis,[44] is in reality is a dismal performance the price of which is the death of millions of women in their productive stage.

In its 2007 MDG update, the UN Department for Public Information described maternal mortality as a regional scandal.[45] Furthermore, During the Fourth Ordinary Session of the African Union Minsters of Health Conference, while underscoring the need to address the crisis in the context of the millennium development goals, the state of continental maternal health was described as 'an embarrassment'[46].

Although maternal mortality ravages African counties at alarming rate, behind every maternal death is an individual story, a personal loss. In addition to the sorrow and grief upon a death by immediate and extended families, 'maternal deaths diminish the life-chances of a million or more children each year.'[47]

2.3.1 Causes of maternal deaths

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42 UN 'Millennium Development Goal Report '(2009) 11.

43 WHO 'Maternal mortality in the year 2000' (2004) 1.

44 UN Millennium Development Goal Report 2008 (n 37 above) 26.

45 UN 'Africa and the Millennium Development Goals' (2007) 2.

46 The description was made during the roundtable debate on the theme 'Universal access to essential health services: To improve maternal, neonatal and child health.' Report of the ministers' meeting, Fourth Ordinary Session of the African Union Conference of Ministers of Health 4-8 May 2009 Addis Ababa, Ethiopia 6.

47 Oxfam (n 34 above) 6.

The causes of maternal deaths are intricate and interdependent. Though there are clear medical causes, a broader approach reveal other underlying socio economic factors that contribute to and ultimately lead to a maternal death. Therefore for a holistic understanding, causes are neither strictly medical but one factored upon socio cultural context, political and economic realities.

According to WHO, maternal mortality may result from direct or indirect causes. Indirect causes of maternal deaths are due to diseases existing prior to or concurrent with the duration of the pregnancy. These diseases in themselves are not complications arising because of pregnancy but are made worse because of pregnancy and they consequently in turn, complicate pregnancy. Depending on each country's epidemiological context and health care delivery response, examples of such diseases include malaria, anaemia and cardiovascular diseases.[48]

Direct causes are the greatest contributors to maternal mortality, accounting for about 80% of all deaths. This is a direct fall out or consequence of the quality of health care and treatment received during pregnancy and childbirth, their promptness and efficiency. Complications manifest in bleeding or haemorrhage, eclampsia, obstructed labour and infections are in fact responsible for the lion share of all maternal deaths.[49]

a) Postpartum haemorrhage

Maternal death from haemorrhage is the bleeding to death of a woman, shortly after childbirth.[50] It is a fast killer, taking the life of even a healthy mother within two hours if unattended to swiftly and efficiently.[51] Postpartum haemorrhage is a major cause of death in both developed and developing countries alike for the severe bleeding leads to anaemia and eventual death.[52]

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48 WHO 'Attending to 136 million births, every year' in WHO 'World Health Report 2005' (2005) 62-3. See also Reduction of maternal mortality: a joint WHO/UNFPA/UNICEF/World Bank Statement (1999).

49 (As above) 62-3; WHO 'Mother-Baby Package: Implementing safe motherhood in countries' (1994)2 WHO/FHE/MSM/94.11 in Cook et al (n 29 above) 394.

50 Amnesty International (n 9 above) 5. The story of Yerie Marah, a 22 year old lady who bled to death the day after giving birth. Her plight is one out of the many tragedies that befall women, children, family and society in general.

51 WHO 'World Health Report 2005' (2005).

52 WHO *Making pregnancy safer* 'Reducing the global burden: post partum haemorrhage' available at

Some 1.6 million women die from this cause every year.[53] Risk of death may be controlled by the injection of oxytocin or ergometrine[54] immediately after delivery. However, the use of misoprostol which is cheaper, easy to store but less effective, is an alternative in situations where there is no professional care during delivery. While not ignorant of its side effects of shivering high temperature, WHO recommends that in the absence of skilled care givers, 600 micrograms of misoprostol be orally administered immediately after delivery.[55]

b) Infection

Infections also called sepsis, is the second highest direct cause of maternal deaths, responsible for more than 15 % of all deaths. 1 in every 20 still women develop an infection.[56] Situations of acute sepsis occur when the woman is fatigued from the travails of childbirth; complicate her situation then finishes her off.[57] (25) However the introduction of aseptics has greatly reduced the number of deaths resulting from this.

c) Eclampsia

Pre- eclampsia and eclampsia is the hypertensive disorder of pregnancy leading to convulsion seizures and then death. It accounts for 12% of all maternal deaths.[58] According to Cook, seeing a woman in fits of eclampsia is a scene that cannot be forgotten.[59]

<http://www.who.int/making_pregnancy_safer/documents/newsletter/pdf> (accessed 21 September 2009).

53 WHO (n 51 above) 63.

54 These are the two most commonly administered uterotonic for the treatment of atonic post partum Haemorrhage.

55 WHO 'Statement regarding the use of misoprostol for postpartum haemorrhage prevention and Treatment' (2009).

56 WHO World Health Report in Cook et al (n 29 above) 63.

57 Cook et al (n 29 above)394.

58 & See generally C AbouZahr & R Guidotti 'Hypertensive disorders of pregnancy' in C Murray A Lopez (eds) 'Health dimensions of sex and reproduction: the global burden of sexually transmitted diseases, HIV, maternal conditions, perinatal disorders, and congenitalanomalies' (1998) *Global Burden of Disease and Injury Series*, No. III 219-241.

59 Cook et al (n 29 above) 394.

d) Obstructed labour

Obstructed labour accounts for about 8% of deaths and is often manifest in 'uncontrollable and involuntary uterine contractions until the uterus gives way and is ruptured.'[60] It is sometimes caused by disproportion in sizes of the head of the foetus and pelvis of the mother or foetal mal presentation. The consequence for the mother is usually obstetric fistulae. The child may be stillborn or die soon after birth; or if alive, may suffer asphyxiation and brain damages.[61] During antenatal session, it is not easy to predict or diagnose a potentially would-be complicated delivery. The solution lies in availability of emergency obstetric and skilled care during delivery.[62]

2.3.2 Measurement and indicators

Maternal mortality ratio (MMR) is the total number of maternal deaths per 100,000 live births.[63] whereas the maternal mortality rate is maternal deaths per 100,000 reproductive aged women. Since we have defined maternal mortality as inclusive of all deaths resulting from pregnancy and childbirth[64], MMR is the annual total number of women who die from pregnancy during term and the process of childbirth, or 42 days post delivery divided by 100,000 live births.[65] In simple terms, it is the depiction of risk of death against number of live births.[66]

The challenge in measurement of maternal mortality is the difficulty in collating and recording data, especially in the developing countries in sub Saharan Africa where MMR is highest. Precise registration of deaths and cause of death is inaccurately kept because they usually occur at home and out of 'view'.[67] For this

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60 WHO (n51 above) 64.

61 As above 64.

62 A Fraser 'Approaches to reducing maternal mortality: Oxfam and the MDGs' *Gender and Development* 13 (2005)1 3 Originally published in Oxfam *The Cost of Child birth : Oxfam and the MDGs* (2004).

63 Oxfam (n 34 above) 8.

64 WHO (n 32 above) 10.

65 C Shena & J Williamson 'Maternal mortality, women's status, and economic dependency in less developed countries: A cross-national analysis' *Social Science & Medicine Journal* 49 (1999) 202.

66 WHO (n 12 above) 11.

67 Y Berhane & A Yigzaw in Epidemiology and ecology of health and disease in Ethiopia Y Berhane

reason, it the preferred means to employ the use of practical process indicators for all components of felt needs that add to or prevent maternal deaths.[68] Indicators as number of women who have access to antenatal, post natal and EmOC, proximity and availability of, as well as geographic spread in a country and percentage of deliveries with professional care give a picture of the state of maternal health care in a given country.

2.4 Legal frame works

2.5 The right to life

i) International

The right to life is a basic, fundamental right. It is the threshold upon which the body of other rights is realised. Its importance cannot be over emphasised for simply put, there cannot be rights without life.

The right to life is the thrust of one of the earliest human rights instruments. With the dawn of the first universally accepted framework of rights, the Universal Declaration of 1948 by the UN General Assembly Resolution 217, this right was recognised and protected in Article 3. The said article provides for the right of everyone to life, liberty and security of person. In this regard, mere existence is not by itself sufficient within the provisions of this article. Such contextual facts as quality of life, safety and freedom of the peoples are all invaluable determinants of the right to life.

In Article 6 of the ICCPR, state parties have reaffirmed the sacrosanct nature of the right to life inherent in man which is to be protected by law. In it, every human being has the inherent right to life which right is protected by law and no one may be arbitrarily deprived of the right to life. In elaborating on the normative content of this right, the Human Rights Committee (HRC) stated the right should not be subject to restrictive interpretation.[69] Further to the above and to accentuate the importance of this right, there are different regional instruments all providing for the right to life of her peoples.[70] On the African continent, article 4 of the African

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et al (eds) (2005) 376.

68 UNFPA 'Maternal mortality update (2002): A focus on emergency obstetric care' (2003) 14.

69 Human Rights Committee, General Comment No 6, article 6, sixteenth session 1982 para 1.

70 Article (1) American Declaration on the Rights and Duties of Man; article (2) of the European Convention on the Protection of Human Rights and Fundamental Freedoms(European

Charter on Human and Peoples' Rights' (ACHPR) in providing for the right to life describes human beings as inviolable, that everyone is entitled to the respect for his life and integrity of his person. In the wording of this article, right to life of everyone, including women of reproductive age, is inextricably linked to the personal integrity of the human person. Thus in the ACHPR, this right can be said to have three elements: inviolability, respect for and integrity of life and protection from arbitrary deprivation of same.

Respect for the rights to life and integrity of the human person places an obligation on states to protect these genres of rights, and refrain[71] from acts that would infract upon it such as torture and ill treatment. In fact, torture and ill treatment have been argued to constitute a *jus cogens*, a peremptory norm from which derogation may not be permitted.[72] It is an absolute provision in the sense that unlike other rights where infringement upon is permitted in situations of public importance and national emergencies,[73] the rights to life and integrity may not be derogated from, no matter the circumstance.[74]

In countries where the death penalty has not been abolished and non signatories to the Second Optional Protocol to the ICCPR aiming at the Abolition of the Death Penalty[75], the right is qualified by clauses which permit states to derogate from the absolute nature of the right to life. For example, imposition of the death penalty entitles a state to take life, but the sentence may be imposed only upon the commission of the most serious of crimes, in accordance with the law in force at the time of the commission. Furthermore, it may only be executed pursuant to a judgement rendered by a competent court of law of a country.[76] The HRC was of

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Convention).

71 General Comment No 31 on The Nature of the General Legal Obligation Imposed on States Parties to the Covenant (2004) para 6.

72 J Dugard *International law: a South African perspective* (2005) 43

73 See Paragraph 1 of General Comment No 14 on article 6 where the HRC made reference to General Comment No 6, where it had enunciated the right to life as a supreme right from which no derogation is permitted. See also General Comment No 5 on article 4 of the Human Rights Committee on further elaboration on obligations of state in situations of emergency and where derogation from this right has taken place.

74 Article 4(2) ICCPR.

75 Adopted by the UN General Assembly in resolution 2200 A(XXI) of 16 December 1966 at New York , opened for signature ratification and accession on 19 December 1966 , entered into force on 23 March 1976.

76 Paragraph 7 of General Comment No 6 on article 6 (no 52 above).

the opinion that imposition of death penalty for 'the most serious crimes' be read restrictively and applied only as an exceptional measure.

ii) Nigeria

The right to life has been distilled into domestic laws of several countries on the continent. In the Nigerian constitution, the right is guaranteed in section 33(1), prohibiting the intentional deprivation of life. Only upon the execution of a sentenced passed by a competent court regarding a criminal offence may life be taken.[77] Other instances include defence of property and from violence, to effect arrest and prevent escape from detention, to suppress riot, insurrection or mutiny.

iii) Ethiopia

The Ethiopian constitution guarantees the right to life in section 14.[78] It provides that every person has the inviolable and inalienable right to life and the security of his person and liberty'. Section 15 further provides that no one may be deprived of his right to life 'except as a punishment for a serious criminal offence.

In conclusion on this theme of right to life and exceptions where it may be denied an individual, maternal death has absolutely no direct or co relational nexus to this treaty prescribed circumstances. This fact is also traceable as seen above, to similar provisions in national legislation on the right to life and circumstances where it may be derogated from. We shall subsequently explore this further, drawing a causal link with the rights and elements upon which its realisation is hinged on, obligations of states and the thematic discourse of this research which is maternal mortality.

2.6 The right to health

i) International

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[77] Section 33(1) and (2) of 1999 Constitution.

[78] Constitution of the Federal Democratic Republic of Ethiopia Proclamation No 1/1995.

With the birth of the Universal Declaration[79], a general international standard for human rights was instituted. Inclusive in the plethora of guaranteed rights is the right to health in that 'everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food...and medical care.[80] Article 25 (2) Universal declaration provides for the 'special care and assistance' of people within the bracket of motherhood and childhood. This is an acknowledgement of the delicate state and importance of adequate care for women and children who fall within this category.

Another important provision on health rights is found in article 12 of the CESCR [81] which states that state parties to the CESCR recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. In providing for steps states may take to realise this right, article 12(1) and (2) is silent on maternal health.

CEDAW[82] states specifically that 'states Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.'[83]

On the continental level, the ACHPR [84] provides generally for the right to health by stating that all individuals have the right to enjoy the best attainable state of physical and mental health. However, the groundbreaking Maputo Protocol[85] considered as one of the most progressive legal instruments providing for women's rights, enshrines the protection of women from violence. It equally contains a most comprehensive provision on women's reproductive and sexual health rights. Its article 14 obliges state parties to 'establish and strengthen existing pre-natal, delivery

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[79] Adopted and proclaimed by the UN General Assembly in resolution 217 A (III) of 10 December 1948 at Paris.

[80] Article 25 (1).

[81] CESCR (n 25 above).

[82] CEDAW (n 27) above. See also article 14(2) (b) on the provision of health care facilities as well as family planning services to rural women.

[84] Article 16 (1).

[85] (n 26 above).

and post-natal health and nutritional services for women during pregnancy and while they are breast-feeding.' This article has an overarching reach across the three critical stages of child bearing: prenatal, delivery and post natal, mandating state parties in the same breath to provide health services for women in these stages.

Of a striking note is the absence of a definition of the right to health in the above international and regional instruments. This perceived deficiency may be remedied by the continued repetition of the right to the enjoyment of the '*highest attainable standard of health.*' This phrase may be interpreted to mean the right to an integrated, functional and affordable system of health care provision and services which meet the health needs of the people.[86] It means a responsive, well funded and resourced health care delivery system, which meets the health needs of the people without boring a deep hole into already shallow pockets.[87] To further clarify the import of the right to health as protected by article 12 of CESCR, the UN Committee on Economic, and Social and Cultural Rights (Committee on ESCR) adopted General Comment No 14 where it espoused that the right to health is in fact pivotal to the enjoyment for other human rights such as rights to life, food and an adequate standard of living. It is not merely the right to be healthy, but also contains both freedoms and entitlements one of which is the entitlement to health facilities and services.[88]

Pushing the point further home to sit squarely on the thematic import of this research work, the right to the enjoyment of the highest attainable standard of living translate in the provision of and access to certain core life saving health services to pregnant women in their delicate state. Such interventions include: emergency obstetric care, (EmOC)[89] skilled birth attendant, primary health care services, education and information on sexual and reproductive health.

ii)Nigeria:

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86 P Hunt & Bueno de Mesquita(n 7 above) 6.

87 L Freedman 'Achieving the MDGs: Health systems as core social institutions' WHO World Health Report 2005 in P Hunt & J Bueno de Mesquita (n 7 above) 5.

88 See generally articles 1, 3, and 8 of General Comment No 14 of the Committee on Economic, Social and Cultural Rights on the right to the highest attainable standard of health, adopted in 2000 at the UN twenty-second session.

89 The ability to perform a more surgical and complex interventions to relieve obstructed labour, collect, screen, store and administer blood transfusions when necessary, to stop haemorrhage. See UNFPA (n 68 above) 14. See further Committee on CEDAW, General Recommendation 24, para 2 27.

The Nigerian constitution divides political governance in the country into three distinct tiers: the federal, state and local government.[90] The same constitution in parts I and II also ascribed functions, powers and responsibilities to each tier of government but unfortunately, is silent on health issues; that is which tier bears what responsibility. This silence may be traceable to the constitutional provision on the right to health.

Health is guaranteed Nigerian peoples in these words: 'the state shall direct its policies towards ensuring that there is adequate health and medical facilities for all persons.'[91] The challenge here is that health is provided for in chapter two, which falls under Fundamental Objectives and Directive Principles of State Policies, a non-justiciable part of the constitution. This chapter contains a set of desired aspirations, not a right conferring provision for which government may be held accountable. The non-justiciable nature of the right to health may be responsible for its constitutional omission as a responsibility to any of the tier of government.

However, the 1988 National Health Policy and Strategy to Achieve Health for All Nigerians (1988 National Health Policy) stepped in to fill the vacuum by allocating provision of primary health care services to the local government, secondary to state and tertiary to the federal governments respectively.[92] The challenge about this is that it is once again, a 'mere' policy, without a binding force in law to compel its observance or penalise non observance.

In conclusion on this point, the resultant effect is that provision of health care services are left at the discretion of the cadre of government. They are not under any compulsion to provide basic health services even to the most vulnerable of her peoples. Women bear the greatest brunt of this anomaly in the exercise of their reproductive functions for its costs irreplaceable lives. It then follows that since women die from pregnancy related causes, some which are as a result of inadequacy in life saving health service delivery, the realisation of this right remains farfetched the lives of the average Nigerian woman.

iii) Ethiopia

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90 Sections 2 and 3 1999 Constitution.

91 Section 17 (3) (d) 1999 Constitution.

92 Centre for Reproductive Rights (n12 above) 17.

Health is provided for in section 90 of the Ethiopian constitution. It says: 'to the extent the country's resources permit, policies shall aim to provide all Ethiopians access to public health.' The only reference to health right in the constitution is clothed with the now ubiquitous phrase of 'progressive realisation' akin to realisation of economic and socio cultural rights. In 1993, the country's current health policy was formulated. Similar to the preamble of WHO constitution, health is defined in the Ethiopian Health Policy as consisting of 'physical, mental and social well being' not the mere absence of disease and infirmities.[93] The health policy in its paragraph 24, has as its principal objective to give a comprehensive and integrated primary health care delivery in a decentralised and democratic system in the country.[94]

2.6.1 Of obligations and entitlement

As mentioned above,[95] states parties to the ICCPR have undertaken to protect covenant rights, paramount among which is the right to life. In it, states are mandated to protect the right to life of her peoples from her agents, private entities and other third parties. Espousing that the right to life is the most essential of rights, the HRC held that the sacrosanct nature of life and states obligations are applicable to all persons on the state's territory and subject to her jurisdiction. It further precludes states from exposing to foreseeable danger of loss of life by capital punishment of anyone, even where not a citizen in fulfilment to any other bilateral or multilateral treaty.[96]

States' obligations with respect to the right to health are found in article 12 of the CESCR. In this article, perhaps the most important international instrument on the right to health, both the right itself (12(1) and steps (12 (2) state parties are to take in realising this right are outlined. Our interest here is however, on the latter.

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93 The Centre for Reproductive Law and Policy *Women of the world: Laws and policies affecting their reproductive lives anglophone Africa* (1997) 17.

94 Centre for Reproductive Law and Policy (n 93 above) 17.

95 General Comment No 31 (n 71 above).

96 *Roger Judge V Canada* (2003) Communication no 829/1998, UN doc. CCPR/C/78/D/829/1998 where the HRC reviewed its earlier interpretation of the inherent right to in *Kindler v Canada* paragraph 10.4 and 10.5. See as well, the individual opinion of committee member Mr. Rajsoomer Lallah.

In article 2 (1) of the ESCR, state parties have undertaken to

take steps, individually and through international assistance and co- operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.

The Committee on ESCR is the monitoring body for the CESCR and has over the years, through its General Comments and Concluding Observations elucidated on the normative content of the right contained in article 12 and states' obligations in 2 (1), as well as developing guideline for determining violations of socio economic rights in national scheme of events.

In its General Comment No 3, the Committee on ESCR emphasised that article 2(1) is crucial in understanding the extent of the responsibility of a state party in respect of the different provisions of the Convention.[97] It imposes both obligations of conduct and result on state parties. Conduct in this regard must be calculated towards the production of results which ultimately is the realisation of the right in the lives of the citizenry.

According to the Maastricht Guidelines[98], states have a threefold obligation in respect of economic and socio cultural rights: to respect, protect and to fulfil. Regarding obligation to respect, states must refrain from interfering in the enjoyment of economic and socio cultural rights; they are also obliged to protect its peoples from the interference of third parties in the enjoyment of these rights. The requirement to fulfil mandates states to undertake measures be they fiscal, administrative, judicial or legislative to guarantee the realisation of the rights in question.[99] Further explaining, within the obligations to protect, fulfil and respect is also the obligation of conduct and of result.[100] That is to say, that states must

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97 Committee on Economic, Social and Cultural Rights, General Comment No 3 the nature of states parties obligations, fifth Session, paragraph 1.

98 The Maastricht Guidelines on Violations of Economic, Social and Cultural Rights Developed in 1997 by the International Commission of Jurists to elaborate further on the Limburg Principles on implementation of the CESCR.The Limburg Principles precede the Maastricht Guidelines.

99 As above para 6.

100 As above para 7.

undertake conducts or practical actions geared towards the realisation of a right-socio economic right which in the context of our discourse, is right to health.

In General Comment No.14 on the attainment of the highest standard of health, [101] the Committee on ESCR in elaborating on states parties obligation reaffirmed the trifocal obligation to respect, protect and to fulfil. States are under the obligation to respect the right to health by refraining from denying or limiting equal access for all persons to preventive, curative and palliative health services; and to abstain from enforcing discriminatory practices as a state policy; to abstain from imposing discriminatory practices relating to women's health status and needs.[102]

States obligation to protect mandates it to 'adopt legislation or to take other measures ensuring equal access to health care and health-related services'. States are further obliged to ensure that harmful social or traditional practices do not interfere with access to pre- and post-natal care and family-planning. The state is equally to ensure that the right to health of her citizenry is not violated by third parties such as private health sector operators which hinder the availability, accessibility and quality of health care.[103] By formulating a national health policy and a detailed plan of action, giving them sufficient recognition in its national political and legal systems, a state realises its obligation to fulfil.[104]

This requirement which traces its roots to article 2(1) of the CESCR, on the duty of states parties 'to take steps' is mandatory, from which there may be no derogation from or qualification of. Aware of the paucity of funds at the disposal of the states, there is provision for states to progressively realise of socio-economic rights. The Convention uses the phrase 'to the maximum of its available resources.[105] In keeping faith with the duty to take steps, what states have however is the margin of discretion to employ any means of their preference to implement their obligations

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101 General Comment No 14 (2000) para 33 the right to the highest attainable standard of health.

102 As above para 14 34.

103 As above para 14 35.

104 As above 36.

105 Article 2(1).

under the CESCR. States may not use the 'progressive realisation' of article 2 to shield away from taking steps to realise the rights.[106]

From the above, we can clearly see that unlike erroneously thought that economic and socio cultural rights are mere aspirations and non binding on state parties, state parties on the contrary, owe in obligation to the CESCR, and to her citizens, to continuously take steps improve the health conditions of her people. To progressively realise the right to the best attainable standard of health concedes that rights may not be easily achievable within a short span of time, but not one which may be deferred for eternity.[107]

Although states are to undertake all steps as well as employ all appropriate means including legislative measures, the Committee on CESCR has remarked that the phrase 'all appropriate means including particularly the adoption of legislative measures' is by no means exhaustive. Measures should not be limited to legislative only, but should be given its full and natural meaning. Parties are free to decide what is appropriate in their different peculiar circumstances, but should indicate in their report, what factors justify the steps taken as most appropriate under the circumstance.[108]

States have a responsibility to ensure that the four interrelated elements to the right to health are met. These are: availability, accessibility, acceptability and quality. Availability entails that public health care facilities are available in adequate quantity. Accessibility means it is non-discriminatory, physically, informatory and financially accessible. By acceptability, health care services are culturally acceptable to the population. Quality ensures it is not all about numbers-medical quality is of equal importance.[109]

Article 12 (2)(a) was interpreted by the Committee to require the putting in place of measures to improve child and maternal health, sexual and reproductive health services, including access to family planning, pre- and post-natal care, emergency

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106 Maastricht Guidelines (n 98 above) para 8.

107 Ladan (n 3 above) 7.

108 Committee on ESCR (n 97 above) para 2 3 4.

109 As above para 12. See also Ladan (n 7 above) 8-9.

obstetric services and access to information, as well as to resources necessary to act on that information.[110]

The Committee on CESCR lists out certain core obligations which must be met to ensure that a minimum essential level of health is attained. Essential food and basic primary health care services are some of them[111] Core obligations are regarded as strict of which non compliance is not permissible. This strict approach can be gleaned from both the General Comment and the Maastricht Guidelines.[112]

In conclusion, the Africa Health Strategy 2007-2015 states that 'governments have a responsibility for guaranteeing health care for all their citizens...'[113] Article 26 of the Vienna Convention on the Law of Treaties, States Parties are required to give effect to the obligations under the Covenant in good faith. In the light of the expressly enumerated obligations and interpretative guidelines of economic and socio cultural rights in general and the right to the highest attainable standard of health in particular, it is laid bare that Nigeria and Ethiopia as signatories to these international frameworks have binding obligations to her citizens. The nature and extent are as above, conferring the irrefutable positive right and entitlement on women of productive age a right to the enjoyment of a variety of conditions, facilities and services necessary for the realization of the right to life and health.

2.6.2 Forging a nexus: maternal mortality as a violation of the rights to life and health?

The contention here is that right to health as it plays out and affects women in at the peak of their lives and in the exercise of their reproductive function is as much a violation as the right to health as it is a violation of their right to life.

Drawing from the details of the right to the attainment of the highest standard of health as provided for in international and regional legal frameworks which

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110 As above para 14.

111 As above para 43.

112 Para 9 10.

113 Outcome of the Third Ordinary Session of the African Union Conference of Ministers of Health (CAMH3) 'Strengthening of the health Systems for Equity and Development in Africa' Johannesburg, South Africa 9-13 April 2007 17.

provides for the right of every individual to enjoy the best attainable state of physical and mental health, governments of both countries have a responsibility to protect their rights to life and health. Nigeria bears a greater burden of responsibility because not only is she a state party to the ACHPR, but has ratified it to become an integral part of her legal system.[114]

The right to life is sacrosanct and inviolable, save in the circumstance enlisted above, replicated in the constitutions of both Nigeria and Ethiopia. Maternal health is none of the permissible reasons for which the right may be derogated from. On the contrary, it is one reason why health and life of women should be protected.

The point is that if the right to life is not to be infringed upon, as enunciated above. We have equally seen as well, ,how seriously the obligations of state are in respect to right to health. Despite the foregoing, African women die in the process of giving life, firstly their right to the best attainable standard of health is compromised by a combination of factors which is within the purview of the state's responsibility to provide. Their inability to attain this best standard of physical health, and the resulting death from the unavailability of an established, strengthened and existing pre-natal, delivery and post-natal health and nutritional services is a violation of the twin rights to life of Nigerian and Ethiopian women.

Conclusively, it follows that if women die from pregnancy and child birth related causes, some which are as a result of inadequacies of life saving health service delivery both the realisation of the constitutionally guaranteed right to life and desired aspiration of right to health right remains farfetched the lives of the average Nigerian and Ethiopian women.

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[114] The African Charter of Human and People's Rights (Ratification and Enforcement) Act Cap 10 Laws of the Federation of Nigeria, 2004.

CHAPTER THREE

Maternal Mortality: Human rights and development perspectives

Poverty greatly amplifies every other risk factor for maternal mortality and morbidity from grotesque female oppression to maternal under nutrition and to inadequate medical and physical infrastructure. [115]

3.1 Introduction

An old English adage has it that health is wealth. Health is essential for human happiness and central to holistic development of the human person. A healthy nation is a wealthy nation for its peoples are strong and able to contribute to the overall economic, political and social development of the country. This chapter examines the development aspect of maternal mortality.

3.1.1 Maternal mortality: a human development angle

The context in which development is used here is the process by which an individual to a greater or lesser extent is enabled develop his/her optimum potentials.[116] It is the development of intelligence and skill needed to effectively

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115 B Lanre- Abass 'Poverty and maternal mortality in Nigeria :Towards a more viable ethics of modern medical practice' available at <http://www.ncbi.nlm.nih.gov/pmc/articles >(accessed 21 October 2009).

116 Ladan (n 3 above)113.

participate in a constructive his society.[117] According to Oxfam's 2004 briefing on maternal mortality, sub-Saharan women represent 14% of the world's women, yet the same region account for more than half all maternal deaths in the world.[118]

Maternal deaths deprive a country of the benefits of the proportion of their economic contribution to the development of the nation; which in turn makes the country twice a looser from an unhealthy population and from its would-have-been contribution. The closest proof high maternal deaths and of low income earners is the Human Development Index (HDI) of the United Nations Development Fund (UNDP). The indicators by which the human development of a country is measured are: longevity or life expectancy, access to information, education or literacy levels and the general standard of living.

Maternal mortality is a crucial indicator of the developmental progress of a country for it is more than a mere coincidence that rich and industrialised nations have the least occurrence of maternal deaths. A healthy population have a longer lifespan, save more and are generally more productive.[119]

i) Maternal Mortality in the Context of the MDG

Since the Nairobi Conference on Safe Motherhood of 1987, the global health and development community has not rested in its oars. Several other conferences have been organised in which better maternal and child health have been the thrust. One of such is the 2000 Millennium Summit which was the largest gathering of world leaders, heads of state and government set 8 top priority goals to be achieved by the year 2015.[120]

There is a mutual interconnectedness between the direct and indirect causes of maternal mortality are. A number of them being of socio-economic dimension, the realisation of one means the nearer to success of another. It is the contention here

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117 Ladan(n3 above) 113.

118 Oxfam (n 34 above) 1.

119 WHO 'Health and development' available at http://www.who.int/hdp/en/index.html. (accessed 13 August 2009.)

120 UN Millennium Declaration Resolution (2000.) Adapted by the General Assembly, 55th Session of the United Nations General Assembly, New York.

that the same may be applicable to the context of the MDG for some of the MDGs are linked to the realisation of other goals.

Goal 5 of MDG is a typically dedicated towards the tackling of mm. Its target is the reduction of m by a three-quarter between 1990 and 2015. They represent different global commitments under the UN to addressing mm. Other goals of the MDG are complimentary towards the reduction of maternal mortality.

The first MDG targets the reduction of poverty by half. The realisation of this objective is hinged upon the reduction by half of the number of people who suffer from hunger or live on less than half a dollar a day. Malnutrition is an excercebating factor of maternal mortality, especially in occasions of haemorrhage after delivery. It follows therefore that a well fed mother will better withstand the effect of lost blood in such instances and prolong her life until the situation is salvaged.

The second and third MDGs are hinged on education, gender equality and women empowerment. As seen above, the link between education and maternal death reduction is one of strong bond. It is hereby argued that an educated woman is more likely to escape early marriage at adolescence, make informed choices on access to and use of reproductive health services. The question of gender empowerment is certainly at the heart if the struggle to reduce maternal mortality. An empowered woman is a liberated and economically independent, able to make financial choices that are in her best interest. This will increase her chances of access to primary and antenatal healthcare service which would reduce her chances at dying from pregnancy and child birth related causes. Her ability to make a decision is not subject to her husband or other detrimental socio cultural practice. One way we see this playing out is where there is no authority which usually is a man, to take a decision on whether or not a woman writhing in the pains of complication and threatened life should be taken to a health facility.

Conclusively, we have seen infection as contributing more than 10 percent of all maternal deaths. This is intricately linked with the environment in which pregnant women live. The 7th MDG is on environmental sustainability, an indicator which is slum dwellers' access to portable water and basic sanitation. The last goal is on a global call for a partnership for development. Crucial to this is the promise from industrialised countries to double aid to Africa by 2010. Most African countries

lack adequate financial, technical and man power resources to handle the crisis on their hands strategic to halting the increasing trend of maternal deaths.

3.1.2. Socio-economic dimensions of maternal mortality

a) Poverty

Poverty is a major contributor to maternal death. It affects women in the sense that it robs them the economic capacity to make informed choices directly affecting their own health needs. An example is the introduction of user fees in government and public health institutions. This poses a formidable barrier to women's access to their services and plays out in two ways: firstly it discourages women who are unable to pay the accompanying fees to seek medical help. Secondly those who have been attended to but cannot pay the fees are detained until such time which their relatives gather the demanded sum. Other out of pocket demands like flasks, syringes, gauze, cotton wools etc eat further deeper into the already shallow pockets of women. Upon the introduction of user fees in Nigeria, 'maternal deaths increased by 56% and hospital deliveries fell by 46%.'[121]The situation in Ethiopia is best captured in these words in the Oxfam's briefing paper:

> In Bolo Sore, one of the poorest provinces in Ethiopia, there is just one midwife for a population equivalent to the city the size of Leicester (UK) Even if a midwife is available; the costs of consulting her are prohibitive. Families simply don't have the income to send their female relatives to hospital when they go into labour, which would cost 15 birr or one British pound. Instead, they hire a traditional birth attendant who rubs the woman's abdomen and helps her through the birth. They cost 2 birr-8 pence- but have no formal qualifications. Compared with this, the cost of private care is astronomical: 2 birr for a midwife at a private clinic but as much as 4,000 if a caesarean section operation is needed.[122]

b) Social inequalities

On a regional perspective, the African woman suffers a number of societal injustices which negatively impact on state of health and final death in pregnancy related causes or childbirth. From education and literacy, statistics show that the boy child is often the preferred choice to receive formal education than the girl child. In sub-Saharan Africa, the percentage for boy-girl enrolment in formal institutions of

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121 UNFPA & UNIFEM 'Gender Responsive Budgeting and Women's Reproductive Rights: A Resource Pack' (2006) 74 in Centre for Reproductive Rights (n 12 above) 39.

122 ` Oxfam (n 34 above)11.

learning is 77-69 %[123]. For example, in a country like Nigeria, 62% of the 8 million children of school age who are out of school are girls.[124] Proper formal education is essential to living in today's world-it offers a better platform to achieving a decent standard of living, empowers in taking existential and major life saving decisions.

The link between education, economic empowerment and political influence cannot be over emphasised. An educated woman is most likely to better informed and empowered to take decisions in her own best interest, decisions geared towards protecting and preserving her life such avoiding early marriage, having better spaced children and use of modern health services.

c) Skilled birth attendance

Access to emergency health care services is crucial to reduction in maternal death and saving the life of both mother and child. The need for skilled personnel is crucial because early detection and management of complications is important to save life.

However, there is dearth of health workers willing to work in rural areas. The percentage of births attended by skilled personnel has become a benchmark indicator for maternal and neonatal mortality and a measure of availability and proximity of health services to the people.[125]

The availability of professional medical personnel goes a long way in saving lives in the event of complications during labour, delivery and post delivery stages. Where a woman in labour is left in the care of a non professional, the effect most often times is devastating. The need for professional services during childbirth is further underscored by the fact that complication during delivery is not easily detected

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123 K Klemp 'The general situation of women in Africa' in R Musa (eds) *Breathing life into the African Union Protocol on Women's Rights in Africa* (2006) 6.

124 J Igbuzor 'Developing a national gender policy for Nigeria? These women have come again! (2003)3 available at <http://www.dawodu.com/oigbuzor3.htm> accessed 17 July 2009.

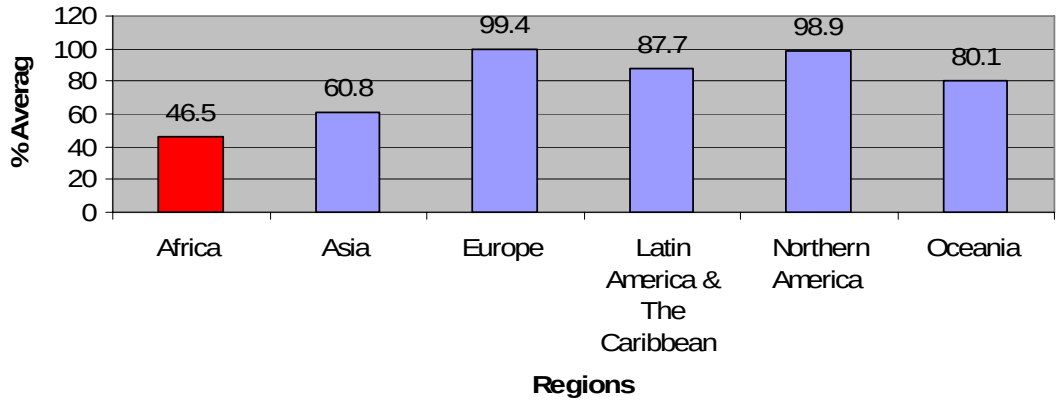
125 *Safe Motherhood Fact Sheet:* 'Skilled Care During Childbirth' (1998) Family Care International and Safe Motherhood Inter-Agency Group 40 in Unpublished: Z Chung 'Understanding maternal mortality and developing effective approaches' Unpublished thesis University of Connecticut (2003) 50.

during ante natal. It often times is sudden and escalate to life threatening stage is not skilfully handled.

In Africa, women in rural areas, encouraged by cultural and traditional values easily patronise Traditional Birth Attendants (TBA) who usually have no formal education on midwifery and still are unable to manage birth complications even after training.[126] They are however, relatively cheaper and are usually readily available than a formally trained professional. This development sometimes is welcomed, but the challenge is that upon the onset of complications, the TBA is often at loss on how to arrest the situation which often has drastic consequences.

According to the global graph below from the WHO, Africa with a 46% estimate has the least percentage of skilled birth attendance during and post childbirth. The implication of this is that 54% of all child births in Africa occur outside health care facilities or at home where the women are further rendered vulnerable either at the hands of the TBAs on their own. This is not encouraging when juxtaposed with Europe with a 99.4% as illustrated by the graph below.

Fig. 2. 2007 Average Regional Estimates of Proportion of births attended by skilled health personnel

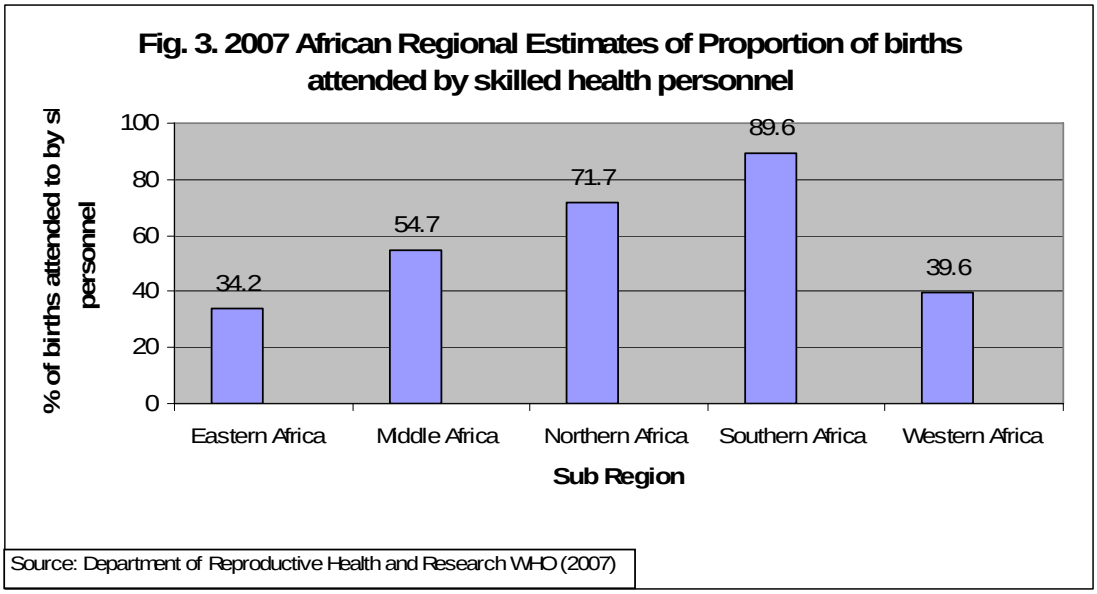


Source: Department of Reproductive Health and Research WHO (2007)

On yet a further breakdown of graphical regional statistics from the department of reproductive health, eastern Africa has the least skilled attendance at birth with

[126] H. Buttie¨ns et al 'Skilled attendance at childbirth: Let us go beyond the rhetorics' (2004) 9 *Tropical Medicine and International Health* 653–654 .

34.2%, followed by western Africa which has a 39.6%. Of note however, it the fact that southern Africa emerged as the sub region with the highest skilled attendance, beating northern Africa with a 17.9 margin.



Source: Department of Reproductive Health and Research WHO (2007)

Nigeria and Ethiopia belong to the two sub regions with the lowest skilled attendance. In Ethiopia, statistics reveal a huge gulf between the rich and poor in terms of economic disparities when measured by the ability to have a skilled birth in attendance during deliveries for 'the rich are 28 times more likely than the poor to have skilled attendant at delivery'.[127] Oxfam's briefing paper reveal that in the same country, only about 2% of all births are done by professionals. In Woreda the ratio is 41 professional health personnel to 288,000 residents. The general situation in the country is that more than 50% of all obstetricians practice in the capital Addis Ababa. All these have lead to an acute shortage of skilled health personnel in the rural areas.[128]

d) The three delays

In other to properly situate the underlying contextual socio-economic and cultural factors influencing maternal mortality, researchers have developed the simple three stages of delays culminating in the death a pregnant woman. The stages are depicted in the diagram below:

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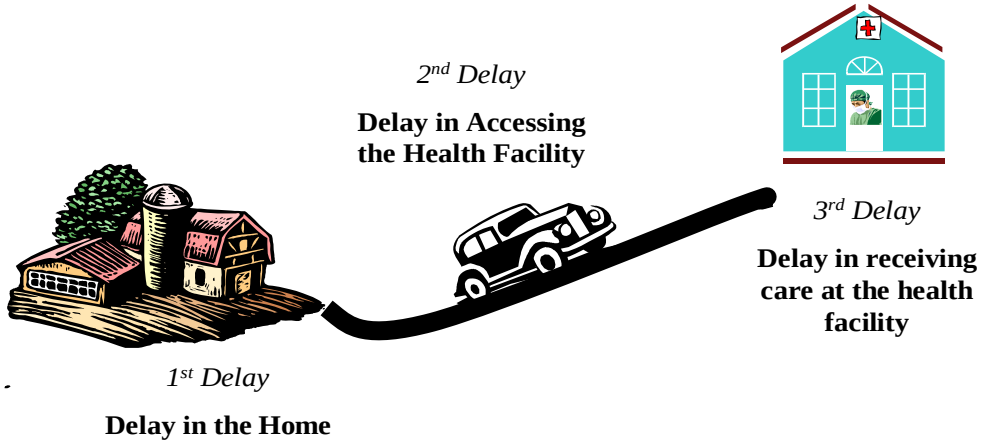
127 UN Statistics Division 'Progress towards the MDGs 1990-2005 Report on MDG 5 ' (2005) 3 in DFID 'Maternal health fact sheet' (2007) 2.

128 Oxfam (n 34 above) 11.

Box 3 THE THREE DELAYS



Culled from S Odujinrin *Making Pregnancy and Childbirth Safer: The W.H.O Initiative*

a) **First delay:** this first stage of delay is called recognition stage or delay at the home. It is as a result of a combination of factors which are both economical and cultural in undertone. There is a delay in firstly recognising that there is need for urgent EmOC intervention, then of the fear of the financial implications of seeking medical help in an institutional health service provider; and finally the absence of a decision maker.

b) Second delay: this stage is a delay caused by difficulties in accessing the health services, after the decision to seek medical attention is made and other challenges in stage one are overcome. Access to health service at this stage is fraught with difficulty in transportation. Finding a vehicle to convey the woman to the health facility through the deteriorated or sometimes impassable interconnecting link roads between rural and urban areas is the principal cause of delay at this stage. To get round the problem, communities sometimes develop a prepayment scheme and a communal fund for transportation as well as a strengthening the links between the community practitioners and formal health practitioners.[129]

[129] A focus on Obstetric care (n 68 above) 7.

c) Third delay: Upon making it past the first two hurdles to arrive at the health facility, it would have been envisaged that the woman receives immediate care as demanded by her state. We find out that this is not always the case as this stage represents delay in receiving health care. Factors such as unavailability of infrastructure such as beds, operating room, inadequate staffing; poor staffing amongst others militate against rendering prompt health services. Delay as is said, is dangerous. Here it means life or death for many a woman.[130]

e) The role of socio cultural practices and beliefs

A myriad of cultural and religious practices place the Nigerian and Ethiopian woman in an unfavourable situation in the societal scheme of things. Traditionally gender ascribed roles compel the woman to remain at home; attending to domestic chores often reduces her wage and income earning capacity thus disempowering her economically and socially. This whittles down her ability to help herself without the consent of the man, who is seen as the head of the household. Incidents such as early marriages, inheritance and property ownership encourage female dependence on men, limiting their access to social and health welfare schemes.

In the area of power relations, the woman is often unable to negotiate sex, when to and when not become pregnant. This is not unrelated with the cultural values that matters of sex and reproduction remain exclusively male domains. [131]

3.1.2 Conclusion

In this chapter, we have laid bare the intricacies of the right to health from a developmental perspective. This provides irrefutable proof of the unbroken chain of connectivity between the rights under discuss and economic productivity and general well being. It underscores that there are not only medically known causes of maternal deaths, but exposes the underlying socio economic dynamics which ultimately contribute to maternal mortality. In the next chapter, we shall explore governmental efforts to tackle the incidence.

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130 See also UNICEF 'A human rights-based approach to programming for maternal mortality in a south Asian context' (2003) 75.

131 S Arnfred 'African Sexuality/Sexuality in Africa' in *Rethinking sexualities in Africa* (2004) 59-76.

CHAPTER FOUR

National efforts at tackling maternal mortality

4.1 Nigeria

4.2 Introduction

In spite of the absence of a constitutional right to health in Nigeria, the government has not rested on its oars. Some of her efforts are examined below.

i) Policy

Realizing that the history of development efforts in the country has largely neglected gender perspectives, Nigeria adopted the 2006 National Gender Policy[132]

[132] Federal Republic of Nigeria, Federal Ministry of Women Affairs And Social Development National Gender Policy 2006.

which is structured in three parts. The Part I[133] give a contextual background to the general situation of women in Nigeria. Part II[134] contains the policy framework, principles, goals, objectives and priority target. Part III[135] deals on broad policy strategies, operational mechanisms, and institutional arrangements. Its objective amongst others are to establish the framework for gender responsiveness in all public and private spheres and adopt gender mainstreaming as a core value in social transformation efforts.

Nigeria's first health policy was the 1988 National Health Policy and Strategy to Achieve Health for all Nigerians (1988 Health Policy) In consonance with the Alma Ata Declaration of 1978[136], Nigeria's 1988 Health Policy recognised primary health care as an integral part of its policy, and stated that maternal and child health is one of the minimum services of primary health care services that must be made available.[137]

Acting further upon the then 1979 constitutional provision which listed health on the concurrent legislative list, assigned provision of primary health care to the local government, secondary health care to the state governments, and tertiary health care to federal government respectively in paragraph 5(5) (a-c).

The 2004 Revised National Health Policy[138] which replaced the 1988 Health Policy maintains the division of health care service provision and the shared responsibility of health service delivery by the three tiers of government.[139] Its overall policy objective is 'to strengthen the national health system such that it would be able to provide effective, efficient, quality, accessible and affordable health services.[140] The

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133 As above 1-14.

134 As above 16-19.

135 As above 23-34.

136 The Alma-Ata Declaration of 1978 emerged as a major milestone of the twentieth century in the field of public health from the International Conference on Primary Health Care of 1978. The Declaration identified primary health care (PHC) as the key to the attainment of the goal of Health for All. Primary health care is the availability of essential health services which are socially acceptable, scientifically proven and practical to a individuals, families and community and a cost they can bear. <http://www.enotes.com/public-health-encyclopedia/alma-ata-declaration> (accessed 19 October 2009.

137 1988 Health Policy, paragraphs 3.3; 4.3 in Centre for Reproductive Rights (n 12 above) 61.

138 Federal Ministry of Health (Nigeria) Revised National Health Policy 2004.

139 As above 4.

140 As above 3.

2004 policy gave an insight into the health situation in the country and stated that Nigeria's maternal mortality rate is one of the highest in the world, noting further the country's per capita expenditure on health was only USD 8 as opposed to the internationally recommended USD 34 per capita.[141]

The health target of the 2004 Revised National Health Policy is generally reflective of the MDGs. Its second target is to 'reduce by three-quarters, between 1990 and 2015, the maternal mortality rate'. It provides as well, national standards for reproductive health with the objective to reduce unwanted pregnancies by 50%, morbidity and mortality due to pregnancy and child birth. It goes further to list strategies for achieving these targets.[142]

The Health Sector Reform Programme: Strategic Thrusts with a Logical Framework and Plans of Action, 2004-2007 [143] is another governmental effort aimed at providing better health for Nigerians. It noted the country's deplorable health status, her high maternal death incidence in the sub-region.[144] Most importantly, it underscored that the absence of a constitutional mandate for health diminishes the obligations and responsibility of the tiers of government.[145]

However, this policy is most comprehensive, outlining the challenges of the health sector in all ramifications, resources, health financing and administration; and proffers solutions in each case. It is divided into three major parts: strategic thrusts, the logical framework and the plan of action, all converging to form a comprehensive national health policy for the country. The plan of action contains a clearly stated objective, activities, input and output, measurable indicators, time frame, names the key agency or ministry responsible and allocated funds or states source of funding for activities. It applies this plan in improving the stewardship

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141 As above 2.

142 As above 6.

143 Federal Republic of Nigeria, Federal Ministry of Health, Abuja Health Sector Reform Programme:
Strategic Thrusts with a Logical Framework and Plans of Action, 2004-2007 available at Health Reform Foundation of Nigeria <www.heron.org/rcentre.html >(accessed 19 October 2009).

144 As above 1.2.

145 As above 1.

role of government, strengthening the national health system and its management, improving availability of health resources and their management etc.[146]

Of mention as well is the 2007 Integrated Maternal, Newborn and Child Health Strategy[147] (2007 IMNCH Strategy.) The first advantage of this policy is that it holds, in a single document a holistic policy and intervention mechanisms addressing child, newborn and maternal health. It is in addition, a departure from previously fragmented approach to maternal and child health to one if integrated approach. The 2007 IMNCH Strategy is based upon the provision of primary health care and is phased in three stages: 2007-2009, 2010-2012, and 2013-2015. It further proceeds by setting out goals to achieve within specific time frames. For instance, to ensure that by 2015, 70% of all births will occur in health facilities, the provision of EmOc at primary health care clinics and general hospitals. [148] Acknowledging that poverty is a hindrance to reduction of maternal death, the strategy instituted a National Health Insurance Scheme to ensure free health services to expecting mothers, newborn and children under the age of 5.[149]

In the same vein, the mandatory National Youth Service Corps[150] whereby fresh university graduates are sent on a one year compulsory service to different parts of the country has been extended to include graduates of nursing and midwifery. They were hitherto excluded on the grounds that their training was not based on university curriculum. Now they are part of the scheme to avail their services to rural and hard-to-reach-areas.[151]

ii) Institutions

There are there are 26 accredited medical schools, 86 approved schools of nursing and 77 approved schools of midwifery. In addition to this, there are 12 medical

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146 As above 78-103.

147 Federal Republic of Nigeria Federal Ministry of Health 'Integrated Maternal, Newborn and Child Health Strategy' 2007.

148 As above 2.

149 As above 3. See also Centre for Reproductive Rights(n 12 above) 64.

150 Cap N84 Laws of the Federation, 2004.

151 A Labiran et al 'Health workforce for Nigeria' (2008) 9.

laboratory schools, 6 schools of physiotherapy, 5 schools of radiography, 9 schools of pharmacy, 19 schools of pharmacy technology, 40 schools of health records, 13 schools of community health officers and 43 schools of community health extension workers.[152] Approximately 53 % of Nigerians need not walk a distance of one kilometre to access healthcare facility.[153]

However, the geographical spread throughout the country is not exactly evenly distributed. While the south east and south-south regions of the country have 7 accredited medical schools, the north east and north west have 1 and 3 schools respectively. The same disparity if not of wider margin applies to schools of midwifery and nursing. While the south east zone has 17 schools of midwifery, north east has 7.[154]

iii) Health work force

Nigeria boasts of one of the largest pool of medical health workers in the Sub-region, comparable perhaps only to Egypt and South Africa. [155]In 2005, there are 39,210 doctors and 124,629 registered doctors and nurses respectively working in both private and public health sectors, amounting to 39 doctors and 124 nurses per 100,000 populations. According to the WHO, the average for the sun-region is 15 doctors and 72 nurses per 100,000 populations.[156] Again, the geographical spread is not even. There is a dearth of health workers in the northern part of the country, for reasons attributable to differential state policies in favour of indigenes.

iv) Challenges

In spite of the above, there are still some obstacles. Some of these are:

a) Uneven distribution of health workers

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152 As above 9.

153 Prof. Akin Osibogun The Chief Medical Director of Lagos University Teaching Hospital (LUTH),
Idi Araba in C Muanya 'A sick nation, weak health institutions' *Guardian Newspapers* 5 October 2009 available at <http://www.ngrguardiannews.com/focus_record/article01>(accessed 21 October 2009.)

154 Labiran (n 151 above) 28.

155 As above 23.

156 As above 22.

One challenge lies in the disproportionate distribution of health workers. Country wide, there is a general preference of the educated and elite to work in urban as against rural communities. Furthermore, there is considerable number of health workers in the southern part of the country, except states like Bayelsa in the Niger Delta[157] There is as well, an acute shortage in some northern regions. The Health Workforce Country Profile attributes this to difference to financial and social factors. As true as this may be, the volatile nature of some regions is also a factor. According to Dr Patrick Okoye[158] who served for one year in Maiduguri, capital of Borno State northwest zone, he returned back to the south east for fear of religious riots. He was the only resident doctor and since his departure, he is yet to be replaced.

b) Policy implementation

Policy implementation poses a formidable hiccup in the realisation of policies. No matter how brilliant a policy document is, it remains mere letters until put into action to touch the lives it seeks to better. For example, as discussed above, the National Health Insurance Scheme seeks provides for free health services to expecting mothers, newborns, children under the age of 5, but this is not implemented accordingly. According to Felicia Okafor[159] though the services are 'free' mothers are compelled to pay for registration cards which range from 300NGN to 500NGN, equivalent of $2 to $3 USD. In addition, expectant mothers are sometimes mandated to buy delivery items (such as flasks, blankets, razor blades, gauze, sanitary pads, cotton wool etc) from the nurses themselves, or a particularly recommended brand. According to her, she could buy the items at a more competitive price than the hospital price offered by the nurses. This experience was shared by Maria Nwodo.[160] Though these women live in different regions of the country, the practice appears to be widespread. She just bought it in other not to 'offend them'. In spite of the above, the Lagos and Borno state governments have introduced free emergency health care services to expectant women.[161] In an

[157] Labiran (n 151 above) 26.

[158] National Orthopaedic Hospital, Enugu.

[159] Primary school teacher and mother of four, lives in the Emene, South-east Enugu State.

[160] Mother of three and post graduate student at the French Village, Badagry, Lagos State.

[161] Centre for Development and Population Activities 'Safe motherhood project in Nigeria final

interview with Ms Celine Ugwu, Deputy Chairperson Enugu East Local Government Area, she confirmed the willingness of the local government authority to provide these services as outlined in the relevant policies, but shortage of funding militate against this. She cited as trite the slow passage of the 2009 budget. These events though it occurs at the topmost cadre of governance, eventually trickle down with momentous impact in the lives of communities at the grassroots level.

c) Corruption

Inevitably, we come to the scourge of corruption, a phenomenon which has become the bane of most African state, including Nigeria. Corruption has eaten deep into the very fabric of existence in Nigeria with devastating consequences for the health sector. In the words of the Chief Executive Officer of Medical Art Centre Maryland, Lagos Prof. Oladapo Ashiru 'widespread corruption has resulted in large-scale neglect, deterioration of the health sector and welfare of citizens..in primary health centres dilapidated and decorated with expired drugs...[162] incidents of corruption abound. For instance, Vamed Project[163] is a hospitals' equipment standardisation initiative of the federal government under the presidency of President Olusegun Obasanjo. The 17 billion naira project is believed to be a response to the poor state of infrastructure in 15 selected government hospitals. This multi billion naira project is now mired in controversy and allegations of fraud.[164] First there was an attempt to reduce the number of hospitals originally approved by the Federal Executive Council and of excessive quotation of prices so much so that a quoted price was enough to buy two different brands of the same equipment.[165] According to the Senior Special Assistant to the President on Due Process and Price Monitoring Dr Oby Ezekwesli, her 'office saved N672.4 million (4.1 million Euros)

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report' (2007) 3. See also S Isa 'CEDPA and safe motherhood in Nigeria' *Triumph Newspapers* 25 September 2009 available at <http://www.triumphnewspapers.com/cedpa2492009.html> (accessed 21 October 2009).

162 'Sick nation weak health institutions' *The Guardian Newspapers* 5 October 2009. <http://www.ngrguardiannews.com/focus_record/article01> (accessed 21 0ctober 2009).

163 Vamed Engineering Nigeria Limited is the local partners of Vamed Engineering Austria and winners of the contract.

164 G Haruna 'N17 Billion Hospital Project: Myth or Reality?' *Thisday Newspapers* <http://www.thisdayonline.com/archive> (accessed 21 October 2009.)

165 Emeritus Professor Oladapo Akinkugbe and chairman presidential committee on the vamed project. In Haruna, as above.

from a single project by the Ministry of Health meant to procure and supply equipment to tertiary health institutions.'[166] Uche Nnamani, Chairman Ujodo Development Council sums it: corruption is killing us.

d) Brain drain and migration

Brain drain is also a contributing factor. Qualified medical practitioners seek greener pastures in other continents, such Europe, United States of America. This is not unrelated with remuneration paid to medical practitioners, especially doctors who are incessantly embarking on industrial action. In 2007 3,567 doctors migrated out of the country while in 2008, the Nursing and Midwifery Council received a total of 3,194 requests from nurses and midwives seeking employment outside Nigeria.[167] Dr Nwajobi,[168] attributes this to poor and irregular remuneration benefits and working conditions.[169]

e) Work attitude

General work attitude of health workers leaves much to be desired. Different incidents scattered over time confirm appear to confirm this. When pregnant for her second son in 2006, Josephine Obunna housewife and mother of five recounted her ordeal at the Obodo Heath Centre Akpuoga-Nike as bitter. During contractions, the two nurses on duty openly sneered at her, telling her to better shut up her mouth and to 'remember when it was sweeting me.' This attitude makes government health institutions lose credibility in the eyes of the very members of the community it was created to serve. Geraldine Raymond-Okolo remarked that after her first delivery, she has vowed not to return to Obodo Health Centre. She had her four other children at the private establishment of a midwife. Antonia Okolo, who said she was with Josephine during her contractions and eventual delivery, did not bother to go to the Health Centre when she became pregnant in 2008. For Ment

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166 As above. See also B Ukwuoma & C Muanya 'Govt begins N1.3b upgrading programme for 15 hospitals' *The Guardian Newspapers* Available at http://www.ngrguardiannews.com/focus_record/article (accessed 21 0ctober 2009).

167 Labiran (n 151 above) 35.

168 President Emeritus National Association of Resident Doctors of Nigeria (NARD) Enugu State Chapter.

169 O Odunlami 'Report On collection Of Basic Obstetric Care/Emergency Care Process Indicators.'
in B Lanre-Abass 'Poverty and maternal mortality in Nigeria :Towards a more viable ethics of modern medical practice' available at http://www.ncbi.nlm.nih.gov/pmc/articles/ (accessed 21 October 2009).

Nnomeh, former Commissioner for Information and Special Adviser to the Enugu State Government, it is a cankerworm that pervades all sectors of the country.

v) Conclusion

From the foregoing, it is evident that the country has neither attained the state of nirvana nor Eldorado. We have seen policies, objectives, and plans of actions. We have also examined the challenges involved. The dual federal legislative houses have both passed the National Health Bill, currently awaiting presidential signature. Upon coming into force, the said Act will fill to a great extent, the present vacuum of authoritative legal document backed with the force of law.

4.3 Ethiopia

4.4 Introduction

In the face of high maternal deaths, the government of Ethiopia has not wrung its hands in despair. It has rather put in place, policies and phased projects to see a drastic reduction. Some of them are discussed below.

i) Policies

The Ethiopian constitution provides for certain collection of some rights, including equality rights in marriage[170] and affirmative measures.[171]. Depending on the nature of the work and the woman's health conditions, it further provides for the right of women to both prenatal and maternal leave[172]. Amongst others, section 35 (9) confers on women the right to access family planning education, information and capacity in other to prevent harm arising from pregnancy and childbirth. As part of efforts to effectively realise this, the National Adolescent and Youth Reproductive Health Strategy was adopted in 2006.[173]

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170 Section 35 (1).

171 Section 35 (3).

172 Section 35(5) (a) and (b).

173 Federal Democratic Republic of Ethiopia, Ministry of Health (2006) National Adolescent and Youth Reproductive Health Strategy (2006-2015.)

The National Reproductive Health Strategy[174] contains a broad based and detailed strategy for tackling the situation, setting targets at community, systems and policy levels.[175] It has one of its goals as the reduction of maternal and neonatal mortality in the country.[176] Its strategy for realising this is to 'empower women, men, families, and communities to recognize pregnancy-related risks. It further lists specific target to include increasing to 60% the proportion of birth attended by skilled health workers, equip one health facility per 5,000 populations to provide EmOC, and to reduce maternal mortality to 350 deaths per 100,000 live births by 2015.[177]

The National Policy on Ethiopian Women of 1993 has the objective to facilitate conditions conducive to speed up equality between men and women, to enable women participate in the political, social and economic life of their country and to seek 'ways and means of lightening their work load.'[178] The 2004 Criminal Code[179] contains sections expressly criminalising acts that endanger lives of women and children through traditional harmful practices such as soiling the umbilical cord of a newborn child with dung, shaking a woman in prolonged labour or through any other traditional practices known in the medical profession to be harmful to women and children.

To crown the above concerted effort, the government initiated an ambitious three phased Health Sector Development Programme.[180](HSDP) The HSDP is not a health development policy conceived in *vacuo*. It is fashioned in the model of such international health targets such as the MDGs and is at the third stage of implementation. While its overall vision is to see a healthy, productive and prosperous Ethiopia, its mission is to reduce morbidity, mortality and disability,

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174 Federal Democratic Republic of Ethiopia, Ministry of Health (2006) National Reproductive Health Strategy 2006-2015.

175 As above 16-18.

176 As above 17.

177 As above 18.

178 O Arowolo 'Population and gender issues in development planning in Ethiopia: Challenges and prospects' (2006)14.

179 The Criminal Code of the Federal Democratic Republic of Ethiopia 2004 Chapter III 'Participation in the commission of a crime.'

180 Federal Democratic Republic of Ethiopia, Ministry of Health Planning and Programming Department (2005)Health Sector Strategic Plan (HSDP III) 2005/6-2009/10.

and improve the health status of the Ethiopian people through providing a comprehensive health services.[181]

An appraisal of the success or otherwise of the first and second phases reveal a dramatic and consistent improvement in the health sector. In an interview with Dr Yared Bagnew[182] of Ipas a government partner, he remarked that if the pace of achievement of set objective is maintained, the world would be taken by surprise at the giant strides to revamp the entire Ethiopian health sector.[183]

ii) Institutions

According to the 2007/2008 Health and Health Related Indicator,[184] there are 149 hospitals, 732 health centres, 1, 517 health stations (inclusive of NHC first aid and primary health care givers.) in the country. Of the 732 health centres in the country, 548 provide integrated maternal, neo natal and child health care service. In addition to this, there are 1,788 profit oriented clinics and 271 non profit clinics. The most numerically strong health facility, covering a wider geographic spread is the health posts which are 11,446 in the country. Earlier in the month, the Afar Sate Health Bureau announced the proposed construction of 53 health centres at a cost of 97.4 million ETB this fiscal year.[185]

An examination of the 2008 distribution of health infrastructure chart, it is evident that some regions are not as endowed with infrastructures as others such as Harari with 4 hospitals, three health centres, and 23 health posts; Dire Dawa with 3 hospitals, 6 health centres and 39 health posts. This is in comparison with regions such as Amhara with 20 hospitals, 171 health centres, and 2,664 health posts.

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181 As above 47.

182 Obstetrician and Gynaecologist, Training and Service Delivery Improvement Officer, Ipas Ethiopia.

183 The WHO in her 2008 reported that Ethiopia is currently deployed 30 000 health extension workers to provide massive numbers of people with a limited package of priority preventive interventions'. See WHO The World Health Report 2008 ' Primary health care: Now more than ever (2008) 28.

184 Federal Democratic Republic of Ethiopia, Ministry of Health, Planning and Programming Department (2008) 3.

185 Aysaita 'Health Centres to be Constructed' The Ethiopian Herald 15 October 2009 2.

Oromia has as well, 31 hospitals, 242 and 3,758 health posts. Granted there is a wide margin of difference in size of population.[186]

iii) Health workforce

Ethiopia has one of the lowest doctors- population ratios in the world. Few qualified professional health workers are 'poached' by the private sector and international nongovernmental organisations.[187] The situation is further worsened by unattractive remuneration packages, even though in comparison to the national GDP, it appears attractive. Contract staff hired to help implement programmes are paid three times more than regular government employees.[188] As a result of poor working environment in the rural areas, health professional are generally reluctant to take appointment and reside in those areas which unfortunately, have greater need for their services.[189]

In spite of the above, government has embarked upon capacity development of her peoples to feed the health sector needs. For instance, in collaboration with the Carter Centre[190] the HSDP I and II has trained 7,500 Health Extension Workers (HEWs) each year from 2006-2009. Currently, about 24,571 HEWs are in training and would be ready for work by the end of the year.[191]

According to Meselech Assegi, Team Leader, Maternal and Child Health Department of the Ministry of Health, all HEWs at the community level are all female who have been nominated by their communities were enrolled for training. The target according to her is to have 2 HEWs per *kebele.*[192] They are basically

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186 Health and Health Related Indicator (n184 above) 18.

187 HSDP (n 180 above) 81.

188 K Stillman et al *System wide effects of the Global Fund interim findings from three country studies* (2005) in WHO (n 183 above) 13.

189 Dr Yirgu, Senior lecturer Department of Obstetrics and Gynaecology, College of Medicine Addis Ababa University.

190 The Carter Centre for Accelerated Health Officer Training Program. Available at http:www.pathfind.org/site/Programs_Ethiopia_Projects_CarterCentre (accessed 21 October 2009.)

191 (n 14 above) 1.

192 Closest unit of government to the people.

trained at any of the Vocational Training Centres for 1 year on four key thematic areas to wit: maternal and child health, hygiene and sanitation, communicable disease, and general health education. Family and child health package include training on family planning, maternal health, child health and immunization, adolescent reproductive health and nutrition.[193] The HEWs are supervised by health offices or nurses.

iv) Challenges

It is said success route is often strewn with thorns. Some of the challenges in Ethiopia include the following:

a) Inadequate infrastructure

As laudable government's initiative has been to improve health conditions in the country, the process is far from being without hiccups. According to Dr Fikru Abebe, Obstetric and Gynaecologist at the Adama Hospital in Oromia region of the country, his hospital is one of the busiest, performing about 15-20 normal deliveries, a minimum of 3 caesarean sections daily. There are inadequate operating rooms and as such, his department shares theatres with other departments. This, according to the respected gynaecologist, is unfortunate because being that the hospital is one with referral status with patients coming to it from all parts of the region, it is sad because a 30 minutes wait to have a free operating room may cost the life of a patient who has surmounted several challenges to get to the hospital.[194]

The health centre at Lideta has no ultra sound machine. 'In Jijiga Somalia, there is a high shortage of equipment even of materials as inexpensive as pairs of scissors...we are not talking about supplying ultra sound, just having a room for a woman to go and give birth in would be a start.'[195]

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193 HEWs benefit from a year of post-Grade 10 training (n 183 above) 28.

194 See chapter 3 above on the three delay model.

195 Oxfam (n 34 above) 14.

b) Poverty

Socio-economic factors are rife in the process of better health standards and curbing trends in maternal mortality. It diminishes women's chances of getting adequate treatment as rightly stated by Tefaye health officer at Lideta Medical Centre, there is a limit to drugs that are subsidised. In Adama Hospital, the issue of poverty as affecting nutrition is a concern. A health officer Ketema Dida Gobena remarked that 'during outreach and ante natal sessions, we tell them what to do, what they have to eat..but how to get these things? There is no money.'

According to Helen Ayalew, a senior midwife who has worked in the Lideta Medical Centre for 9 years, transportatiofn is a huge obstacle to attaining a reduced maternal death rate. She jokingly remarked that I am lucky to have been driven to the facility in a ministry of health truck, not all pregnant or sick mothers have that luxury. It costs about 1 ETB to get to the centre, but in reality, most families can't afford it. They often physically bear the women begin the arduous trek to the health centre.To help the situation, the government has recently cancelled the user registration fee of 1ETB for ante natal delivery and post natal service.

c) Skilled manpower

As stated above, there is paucity of medical doctors and physicians. Despite the efforts of government at training HEWs, health officers, midwives, etc there is still a dearth of skilled manpower. At the Adama Hospital, there are 3 gynaecologists to serve the entire hospital. The result is that doctors are on duty for 10 days in a stretch, morning and night before getting a break. Drawing from his experience at his previous place of work in Harari (one of Ethiopia's high lands and extremely cold regions) since his resignation on health grounds, he is yet to be replaced.

Taking me round the health infrastructure in Lideta, the post abortion room is locked up and not in use. This is as a result of lack of statutorily prescribed skilled health personnel to carry out safe abortion service.[196]

d) Socio-cultural norms

Meselech of the Ministry of Health remarked that despite government's efforts to provide health services, women still believe in going to relatives to deliver. This militates against the woman in no small measure because upon complications, it may be too late to first recognise that the situation is beyond them, organise for transport and then make the journey soon enough to save lives. Ketama Dida of Adama shares his experience from outreach programmes that women still harbour misgivings about contraception, especially as there is still a greater societal approval of more children.

v) Conclusion

The above analysis of the Ethiopian health situation cuts out a country filled with prospect for nationwide revolution in maternal deaths reduction. With governmental focus, as well as political commitment to tackle head on, alarming trends in maternal mortality are sure to decline. It is as well commendable, the bottom up approach adopted by training officers with different health skills and deploying same at grassroots level.

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[196] Federal Democratic Republic of Ethiopia, Ministry of Health Technical and Procedural Guidelines for Safe Abortion Services in Ethiopia (2006) 26-28.

CHAPTER FIVE

Reducing maternal mortality: Recipe for success

5.1 Introduction

Maternal mortality from preventable causes is a social injustice. It is the abrupt end of a woman's life in pools of blood, in the throes of convulsions or even in the agony of their bodies being torn apart. This dissertation makes a case for its drastic reduction. General summary drawn from the research and applicable to both countries are presented as well as context specific recommendations are preferred. The recommendations are listed not in order of priority but a realisation that the solution lies in forming a synergy of all recommendations to achieve a common set objective-reduction of maternal deaths in Nigeria and Ethiopia.

5.2 Summary of recommendation

a) Establishing a firm foundation for maternal care which is trifocal: skilled health personnel, facilities and essential medicine.

b) Availability of such care particularly in the rural areas.

c) Ensuring continuous usage and improvement of the quality of care.[197]

5.3 General Recommendation

a) Political commitment

[197] I Pathmanathan et al *Bank Investing in maternal health: Learning from Malaysia and Sri Lanka* (2003) 13.

Among all health workers interviewed in both Nigeria and Ethiopia for this research, a reoccurring feature is the conviction that with political commitment, maternal mortality will be reduced drastically. Both governments need a wakeup call to realise the tragedy behind the figures.[198]

b) Human resource and community intervention

At this stage of urgency facing both countries, investing in training health personnel which is central to the reduction of maternal death (footnote) is wisest venture for Ethiopia and Nigeria. Emphasis should be placed on (primary) and referral (secondary) skills, in particular on skilled attendants.[199] They should then be deployed en mass to rural parts of the countries. While Nigeria needs to borrow a leaf from Ethiopia's HSDP which has trained nearly 30,000 health officers, Ethiopia needs to expand its coverage to the rural parts of the country especially amongst its dessert and pastoral communities.

c) Infrastructure

Proximate health facilities are a pre-requisite to reduction of maternal deaths. This dissertation recommends constructing extensive health infrastructure of clinics and hospitals with focus on the rural areas. Granted, this is capital intensive, but the first stage of this concept is not of sophisticated, ultra modern hospitals, but a simple system of basic health structures and essential medicines. In the words of Dr Zufan Lakew,[200] what is required is simply a focused intervention requiring basic

198 DFID 'How to reduce maternal deaths: Rights and responsibilities' (2005) 2 3 5; J Shiffman et al 'The state of political priority for safe motherhood in Nigeria' BJOG (2007) 129. For a fresh perspective on role of professional bodies in garnering political support, see J Chamberlain et al 'Averting maternal death and disability : The role of professional associations in reducing maternal mortality worldwide' *International Journal of Gynaecology and Obstetrics* 83 (2003) 94–102.

199 WHO *Making pregnancy safer* 'Midwives making a difference in maternal health.' Excerpt from a presentation by Joy Phumaphi, Assistant Director General, Family and Community Health, to the 27th International Congress of Midwives Issue 2 April 2006 available at<http://www.who.int/making_pregnancy_safer/documents/newsletter/mps_newsletter> (accessed 21 September 2009); WHO *Making pregnancy safer:* 'The critical role of the skilled attendant: a joint statement by WHO, ICM and FIGO' (2004); see also Federal Republic of Nigeria Federal Ministry of Health 'Strategies for strengthening the secondary health care delivery service' (2005) 12-16.

200 Consultant Gynaecologist African Union Medical Centre, Former Dean Tikur Anbessa General

skills, site and essential drugs-at this stage of need. Gradually, the facilities will be upgraded to handle more complex cases. Recently in Nigeria, Niger state government took delivery of health equipments.[201] While this is commendable, it is recommended it is matched with capacity building as well.

d) Reproductive health services

At the heart of the call for a reduced maternal death rate is the need for increased information and access to reproductive health services. Effective family planning can reduce maternal deaths by 35%[202] in reducing maternal deaths evidence and action. Not only is law reform required, socio cultural beliefs against its use needs to be advocated against to achieve a change in mindset and create a gradual but certain paradigm shift.

e) Status of women

It is unanimously agreed in all interviews conducted and questionnaires distributed that underlying at the root of maternal mortality is the status and place of women in the society. Mothers are invaluable component of the societal network, their death have plural effects on the immediate and extended family and future of the household they have left behind.[203]

Further general recommendations

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and Specialist Hospital, College of Medicine Addis Ababa University and Chief Medical Director
Heman Maternal and Child Centre Addis Ababa.

201 W Masadomi 'Niger takes delivery of NGN800 million worth of hospital equipment' *Vanguard Newspapers* 27 October 2009 available at <http://www.vanguardngr.com> (accessed 27 October 2009.)

202 B Winikoff et al 'Assessing the role of family planning in reducing maternal mortality' (1997) *Studies in Family Planning* 18;128-143; corroborated in an interview with Dr Solomon of Engender
Health Ethiopia, a nongovernmental organisation working for improved health.

203 DFID 'Reducing maternal deaths: Evidence and action. A strategy for DFID' (2004) 6-7 For more
on the link between the status of a woman and her health, see E Royson & S Armstrong '*Preventing*
*maternal deaths'b*f (1989) 45-73.

i) Synergised intervention of health and social services that reach the poor wherever they maybe. This includes water, basic education, and women participation in government, sanitation, nutrition and integrated rural development.

ii) Improving road network and transportation system. This will open up the hard to reach areas and overcome the third tier of the three delay model.[204]

iii) Removing all financial and socio cultural barriers to antenatal, delivery and post natal care.

iv) Professionalising birthing care services.

v) Efficient data collation and health information system.

5.4 Recommendations peculiar to Nigeria

i) Corruption

Nigeria is scored a mere 27% in the 2008 Transparency International Corruption Perception Index (CPI.)[205] This is an improvement from previous ratings, but 27% is far from impressive. It pervades all sectors of the country. In other to make any meaningful progress in the health sector the incidence of high corruption must be tackled, otherwise it would be an endless vicious circle for which women pay with their lives. Stringent measures should be taken against persons found guilty of fraudulent activities. A top politician and former chairman of the Nigerian Ports Authority Chief Olabode Goerge was recently convicted for fraud and sentenced to 28 years imprisonment without an option of fine.[206] Actions as this are encouraged. Not only will the effect of interventions be easily felt and evaluated, it will sanitise the entire health system and the country in general.

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204 C Hoestermann 'Maternal mortality in the main referral hospital in The Gambia, West Africa' (1996) 1 *Tropical Medicine and International Health* 5715.

205 U Ukpong 'Anti-corruption war: Nigeria still below pass mark –T I ...Scores 27% in 2008' *The Sun Newspapers* 24 September 2008. Available at http://www.sunnewsonline.com/webpages/news/national (accessed 27 October 2009.)

206 A Abdulah et al 'Surprise, shock as Olabode George, others land in jail' *Vanguard Newspapers* 27 October 2009 available at http://www.vanguardngr.com accessed 27 October 2009. See also 'N1bn Fraud: ICPC Arrests Education Ministry Staff' *Thisday Newspapers* http://www.thisdayonline.com/nview (accessed 27 October 2009.)

ii) Work ethic

In other to regain public confidence, health workers in Nigeria need a complete reorientation and paradigm shift. There is need to treat patients with care and respect.[207] This is what B Lanre-Abass[208] called 'care ethics', where she argued persuasively for and made a strong liaison between medical practices, our shared human capacity to care and the importance of many missed opportunity by Nigerian health workers.

5.4.1 Recommendations peculiar to Ethiopia

i) Malnutrition

Ethiopia is a country known for incessant famines. This impacts greatly on the nutritional state of women,[209] which is worse for pregnant women. The staple food *injera* is balanced diet when eaten with the adequate accompaniments such as eggs, meat, and vegetable. Government should engage in mechanised farming in fertile regions of the country to diminish the effects of famine in the arid north.

ii) Remuneration for service

The Ethiopian government needs to increase her remuneration for public servants. During the research for this work, it came out as a caring fact that medical personnel are far from being adequately paid. A paediatrician described the situation as 'working for free'.[210] This would go a long way to retain highly skilled staff and motivate them for greater commitment to maternal reduction and a healthier Ethiopia.

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207 Communiqué issued at the Nigerian National Health Conference November 2006 para 7.

208 Lanre- Abass (n 115 above.)

209 UNICEF '*Efants et Femmes D'Ethiopie Rapport de situation'* (1993) 55-56 ; 103.

210 Dr Berhamu Gudetta, associate professor of paediatrics Tikuru Anbessa Specialist and General Hospital, College of Medicine Addis Ababa University and director John Hopkins University Technical Support for Ethiopia on Anti Retroviral Treatment.

5.6 Conclusion

From chapters 2 to 5, this dissertation has answered the research question. Thus, it can be said that the causes of maternal deaths are as a result of medical, socio economic and cultural factors. It can be reduced by a continuum of accessible and efficient maternal care. The solution lies in a comprehensive and multi sectoral approach to provide health and social services. The burden seats squarely on the shoulders of both Nigeria and Ethiopian governments to rise to their national and international obligations and realise the rights of their women. It is a matter of urgency, a survival right, not merely a right to be progressively realised: it is a right to life and health.

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Uchenna Nnamani Chairman, Ujodo Development Council

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ANNEXURE 1 Introductory letter from Addis Ababa University

አዲስ አበባ ዩኒቨርስቲ
ሕግ ፋኩልቲ

ADDIS ABABA UNIVERSITY
FACULTY OF LAW

Date: October 1, 2009
Ref No. Ls/OH/2002/09

To Whom It May Concern

Letter of Reference

Uchechukwu Victoria Okwor is an exchange student at the Faculty of Law of Addis Ababa University. She is enrolled in the 2009 Master of Laws (LL.M) Programme in Human Rights and Democratization in Africa at the Center of Human Rights of the University of Pretoria. Addis Ababa University is one of the partners of the Center. Uchechukwu is currently undertaking her dissertation on the topic of ***"Where are the mothers? Interrogating Maternal Mortality as a Violation of the Rights to Life and Health: a Nigerian and Ethiopian Perspective.*** Therefore, we kindly ask you to provide information Uchechukwu by way of interviews and furnishing her materials relevant to the issue.

With regards,

Dr. Fikremarkos Merso
Dean

☎ +251-11-123 97 57/ + 251-11-123 98 00 Ex.108, Fax. +251-11-1 24 36 97, 1176

ANNEXURE 2 Letter for field research assistance

AFRICAN UNION
الاتحاد الأفريقي

UNION AFRICAINE
UNIÃO AFRICANA

Addis Ababa, ETHIOPIA P. O. Box 3243 Tel: (251-11) 5517700 Fax: (251-11) 5517844

20 October 2009

Dear Sir,

Subject: **FIELD RESEARCH ASSISTANCE**

Uche Okwor is a Masters Student from the University of Pretoria and an intern with Humanitarian Affairs, Refugees and Internally Displaced Persons Division of the Department of Political Affairs at the Commission.

For her thesis, she is researching into women's health rights, in particular, maternal mortality in Ethiopia. Sequel to this, she wishes to join the maternal and child health team of your ministry on a field work to Nazareth.

Your assistance in this regard will be appreciated.

Yours sincerely,

AFRICAN UNION COMMISSION * COMMISSION DE L'UNION AFRICAINE * ADDIS ABABA

Dr Mamadou Dia,
Ag Director, Political Affairs Department
African Union Commission

Dr. Keseteberhan Admassu
Director General
Health Promotion and Disease Prevention
Ministry of Health
Addis Ababa, Ethiopia

21 OCT 2009
ሙ/ጠ33/1/44/38

በኢትዮጵያ ፌዴራላዊ ዲሞክራሲያዊ ሪፐብሊክ
የፌዴራል ጤና ሚኒስቴር
Federal Democratic Republic of Ethiopia
Ministry of Health
ስልክ ቁጥር / Tel 51 70 11
ፖ.ሳ.ቁጥር / P. O. Box 1234

To Adama Health Center

Aama

Subject: **Field Research Assistant**

Uche Okwor is a masters student from the university of Pretoria and an intern with Humaneterian Affairs, Refugees and Internally Displaced Persons Division of the Department of Political Affairs at the Commission.

For her thesis, she is researching in to women's health rights, in particular, maternal mortality in Ethiopia. Accordingly She needs to visit Adama health Center for her assessment. There fore, we kindly request your esteemed office to assist and support her as usual. Thank for your genuine cooperation.

With regards,

for

Kes[illegible]berhan Admassu Berhane (Dr.)
[illegible]alth Promotion and Disease
Prevention General
Directorate Director General

C.C

Oromia Regional Health Bureau

Addis Ababa

Health Promotion and Disease Prevention General Directorate

MOH

Annexure 3 Letter to Adama Hospital Nazret, Oromia Region

ኢጣ33/1/44/38

27 OCT 2009

በኢትዮጵያ ፌዴራላዊ ዲሞክራሲያዊ ሪፐብሊክ
የ... ሚኒስቴር
Federal Democratic Republic of Ethiopia
Ministry of Health

ስልክ ቁጥር / Tel 51 70 11 ፖ.ሳ.ቁጥር / P. O. Box 1234

To Adama Hospital

Aama

Subject: **Field Research Assistant**

Uche Okwor is a masters student from the university of Pretoria and an intern with Humaneterian Affairs, Refugees and Internally Displaced Persons Division of the Department of Political Affairs at the Commission.

For her thesis, she is researching in to women's health rights, in particular, maternal mortality in Ethiopia. Accordingly She needs to visit Adama health Center for her assessment. There fore, we kindly request your esteemed office to assist and support her as usual. Thank for your genuine cooperation.

With regards,

for

...seteberhan Admassu Berhane (Dr.)
Health Promotion and Disease
Prevention General
Directorate Director General

C.C

Oromia Regional Health Bureau

Addis Ababa

Health Promotion and Disease Prevention General Directorate

MOH