

HUMAN RIGHTS- BASED APPROACHES TO MATERNAL MORTALITY REDUCTION EFFORTS



 **IIMMHR**
INTERNATIONAL INITIATIVE
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AND HUMAN RIGHTS

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IIMMHR is the first civil society human rights effort aimed at reducing maternal mortality. For more information, visit www.righttomaternalhealth.org.

PREFACE

More than 500,000 women die every year from complications of pregnancy and childbirth. Most of the time these tragic and preventable deaths are the culmination of human rights violations against women and girls in many aspects of their lives and at all levels of health decision-making. Ending these human rights violations is essential for preventing maternal death. Women have the right not to die needlessly in pregnancy or childbirth. Governments have an obligation to ensure the provision of pregnancy-related care in a way that respects the dignity and rights of all women and families, and respects the principles of non-discrimination, equity, transparency, accountability, and participation.

IIMMHR embarked on three in-country field projects from October 2008 to October 2009 in order to increase understanding of how to integrate human rights principles and approaches into maternal mortality reduction efforts at the national and local levels. Our projects in India, Kenya, and Peru highlight the positive experiences of applying a human rights-based approach to maternal mortality reduction efforts, and further demonstrate valuable lessons learned - in line with the UN Human Rights Council Resolution on Preventable Maternal Mortality and Morbidity and Human Rights (A/HRC/11/L.16/Rev.1) and the subsequent Report of the Office of the United Nations High Commissioner for Human Rights on preventable maternal mortality and morbidity and human rights (A/HRC/14/39)- from which others may build.

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The UN Human Rights Council Resolution on Preventable Maternal Mortality and Morbidity and Human Rights (A/HRC/11/L.16/Rev.1, 16 June 2009)

(Recognizes) that the unacceptably high global rate of preventable maternal mortality and morbidity is a health, development and human rights challenge, and that a human rights analysis of preventable maternal mortality and morbidity and the integration of a human rights perspective in international and national responses to maternal mortality and morbidity could contribute positively to ... eliminating preventable maternal mortality and morbidity

requests States to give renewed emphasis to maternal mortality and morbidity initiatives ... as well as to integrate a human rights perspective into such initiatives, addressing the impact that discrimination against women has on maternal mortality and morbidity.

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Maternal Mortality as a Human Rights Issue

“Human rights are not just about prisoners of conscience, they are also about prisoners of poverty. Human rights are not just about torture, they are also about avoidable deaths from preventable health conditions.”

- Paul Hunt, former UN Special Rapporteur on the Right to Health¹

Worldwide, far too many women die each year from complications of pregnancy and childbirth. Of all the Millennium Development Goals, Goal 5 (to reduce maternal mortality) has seen the least progress toward realization. The majority of these deaths can be prevented if women's basic human rights are guaranteed.

Fueled by inadequate funding of health systems, lack of awareness among health-care providers, and lack of empowerment of women at the community level, serious human rights violations: ranging from denial of quality care to delayed or negligent care, abusive and discriminatory treatment, and disrespect for indigenous women's culture and beliefs - are routinely perpetrated against women by the very people who were supposed to ensure their health and well-being. These include violations of the rights to life and health; the rights to equality and non-discrimination; the right to be free from torture and cruel, inhuman, or degrading treatment; the right to dignity; the right to information; the right to privacy and family; and the right to redress - rights that are enshrined in international and regional human rights treaties and conventions and many national constitutions.² These human rights abuses contribute directly to high maternal mortality and morbidity rates, not only through the sub-standard care that women receive during pregnancy and childbirth, but also because ill-treatment discourages women from seeking skilled reproductive health care in the first place.

1. Statement by Paul Hunt, "Panel on Maternal Mortality and the Human Rights of Women," June 5, 2008, UN Human Rights Council, available at http://www2.essex.ac.uk/human_rights_centre/rth/pressreleases.shtm.
2. For example-the Universal Declaration on Human Rights; the International Covenant on Civil and Political Rights; the International Covenant on Economic, Social and Cultural Rights; the Convention on the Elimination of All Forms of Discrimination against Women; and the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

If we hope to see real and sustained reductions in maternal mortality rates, the core of the problem must be addressed, and not just the symptoms - in other words, concrete action in favor of women's human rights is necessary in order to effectively and sustainably reduce maternal injury and death.

Why is it so important to ensure women's human rights in order to eliminate preventable maternal death and injury? There are a number of reasons:

1. Maternal death is not inevitable; women have a right to lifesaving care. Governments are obliged to respect, protect, and fulfill human rights related to universal access to good quality health services that help prevent maternal mortality and morbidity.
2. The poorest and most vulnerable women face the greatest barriers to care. Affordable, accessible, acceptable and quality obstetric and reproductive health services are the right of all women, including women living in poverty and marginalized women.
3. To save women's lives, health-care providers must respect women's dignity and rights. Good-quality obstetric and other reproductive health services administered respectfully are the right of all women.
4. Ensuring women's right to determine the number and spacing of their children and to autonomy in their sexual and reproductive lives is essential to reducing maternal mortality. Autonomy in sexual decision making and access to comprehensive reproductive health services are the right of all women.
5. Women must be able to enjoy their right to participate in public life and decision making. Governments have a responsibility to ensure that women are empowered to take part in the formulation and implementation of policies and programs, and that appropriate, effective dialogue and negotiation spaces to that end are institutionalized at all levels of health care management.
6. Maternal health must be made a budgetary priority. Governments must allocate and effectively spend increasing and sustained resources to strengthen their health systems and make them available, accessible, affordable and acceptable.

For more information on the human rights dimensions of maternal mortality, consult our publication *No More Needless Deaths: A Call to Action on Human Rights and Maternal Mortality*, available at www.righttomaternalhealth.org.

APPLYING A HUMAN RIGHTS APPROACH AT THE LOCAL LEVEL

Given that preventable maternal mortality represents a violation of women's human rights, it follows that our on-the-ground efforts to combat maternal death should incorporate human rights principles (see box). This is key if our ultimate goal is to lead to more effective interventions and sustainable results. A rights-based approach entails transforming existing policies so that women's rights and well-being are placed at the center and so that government policies conform to the principles of meaningful participation, non-discrimination, inclusion, and accountability.

What's a human rights-based approach all about?

If you are a maternal health advocate interested in implementing a rights-based approach in your work, the very real question remains: What exactly does a human rights approach to maternal mortality reduction efforts involve? It is worth mentioning once again that every local context is different and therefore deserving of a unique approach that may not work elsewhere. However, several key recommendations

Key human rights related to maternal mortality

- **Right to life.** The majority of maternal deaths are preventable. Governments must take positive steps to protect individuals from preventable losses of life, including preventable maternal death.
- **Right to health.** Women's access to health care must be ensured, as well as the conditions necessary to attain good health. Women must have access to the full range of reproductive health services related to safe pregnancy and childbirth.
- **Equality and non-discrimination.** Governments must refrain from acts of discrimination against women, and health-care services must be provided free from discrimination on the basis of sex, marital status, age, socioeconomic background, and other status.
- **Right to reproductive self-determination.** Women should be able to decide freely and responsibly whether and when to have children. Protecting a woman's right to reproductive self-determination means ensuring that she has access to a range of reproductive health information and services.
- **Right to participation.** The community should be able to participate in health-related decision making at the community, national, and international levels.

should be integrated by anyone intending to do this work, anywhere. The following list of recommendations was adapted by a document prepared by the United Nations Population Fund (UNFPA) and the Harvard School of Public Health as part of a training manual for UNFPA staff worldwide.³ It is a useful tool for any maternal health advocate seeking to use a rights-based approach on the ground.

- **Emphasize the processes as well as the outcomes of programming.** For example, a human rights-based approach looks not only at the increased number of deliveries in a hospital but also at how women were treated during childbirth.
- **Focus on the most marginalized populations.** These groups include, for example, women living in extreme poverty, adolescents, women living with HIV, minorities and indigenous women, women living with disabilities, and refugees and internally displaced women.
- **Work towards equitable service delivery.** Although you may start by focusing on the most vulnerable populations, your goal should be to eventually ensure equitable access for all women.
- **Ensure meaningful participation of affected communities.** Rights-holders should play a role in discussing, reforming, and advocating around the services that are aimed at them. For example, it is important to include the participation of the most excluded groups at all stages of your programming. Duty-bearers should demonstrate accountability and responsiveness to people's demands and needs.
- **Ensure local ownership of any initiative/program.** A rights-based approach to maternal mortality reduction efforts ensures local ownership because of its insistence on such principles as participation, inclusion, and accountability, and because of its focus on developing the capacities of both duty-bearers and rights-holders and bridging the communication gap between them.
- **Seek to strengthen the accountability of all actors.** Accountability at all levels should be a core focus of any initiative - that means

3. UNFPA and Harvard School of Public Health, A Human Rights-Based Approach to Programming: Practical Information and Training Materials, 2010, available at <http://www.unfpa.org/public/publications/pid/4919>.

everyone from health-care providers to health institutions to the national government. For example, ensure that your process builds transparency and accountability into all stages of its programming cycle.

Implementing a human rights-based approach in your work will not replace any of your existing efforts but rather reinforce them.

A Closer Look at Rights-based Approaches: IIMMHR's Three Field Projects

IIMMHR embarked on three in-country field projects from October 2008 to October 2009 in order to increase understanding of how to integrate human rights principles and approaches into maternal mortality reduction efforts at the national and local levels. Our projects in India, Kenya, and Peru highlight the positive experiences of applying a human rights-based approach to maternal mortality reduction efforts, and further demonstrate valuable lessons learned from which others may build.

While each project focused on a particular aspect of maternal mortality reduction, they all shared some common characteristics:

- They offered **innovative approaches** to using human rights in programs aiming to reduce maternal mortality.
- They focused on **disadvantaged groups**, promoting empowerment and active dialogue with duty-bearers, and/or seek to address issues of inequity.
- They strengthened our understanding of a **human rights framework** and practice.
- They had specific **advocacy strategies** and the potential to influence policymakers and other actors in order to better incorporate a human rights approach to maternal mortality.
- They developed **strategic alliances** with key actors to ensure sustainable efforts and results.
- They promoted **accountability of duty-bearers** hence strengthening good governance within the health sector and governments.

INDIA: Voices from the Ground

The country context

Uttar Pradesh (UP) is one of the least developed states in India, with a population of over 200 million. UP's maternal mortality ratio is estimated to be 440 deaths⁴ per hundred thousand live births, compared to the national average of 254. According to national survey data from 2007-08, a high percentage of women in UP give birth at home (75%), and the rate of safe delivery is 30%.⁵



The UP government has promised that all maternal health services will be provided free of cost. In addition, under the national Mother's Protection Scheme (called the Janani Suraksha Yojana⁶), local women health volunteers are paid to motivate pregnant women to register with the local auxiliary nurse midwife and to attend institutions during childbirth. But whether this will be effective in safeguarding maternal health is doubtful, since UP's health facilities cannot currently provide basic maternal care or tackle obstetric complications that may arise.

According to the 2007 Facility Survey of UP, of the primary health centers that are "24 x 7 PHC" only 5% had a gynaecologist, 5% had a doctor trained in skilled birth attendance and 4% had nurses trained in skilled birth attendance. Only 5% of First Referral Units surveyed had a doctor or gynaecologist trained in emergency obstetric care, while 3% had nurses skilled in birth attendance. Only 15% had a functioning blood storage refrigerator, despite widespread anaemia among pregnant women in India. Ironically, 81% of them had functioning equipment for female sterilization!

4. Sample Registration Survey 2005-2006 of the Registrar General of India. The SRS 2001-2003 estimates were 517 per hundred thousand live births, which was also higher than the national average at that time.
5. According to the District Level Household Survey 2007-2008; more recently the "coverage evaluation survey" (UNICEF '09) with a sample of 1135 suggests higher proportions of women may be attending institutions.
6. Considering home childbirths to be a main reason for high mortality rates, the government of India has launched a program to encourage pregnant women to deliver in institutions through a conditional cash transfer.

Since UP is estimated to have around 5.5 million childbirths each year, the promotion of institutional childbirth for every pregnant woman runs the risk of overloading health providers (and health facilities) to the extent that they are unable to give adequate attention to complicated cases or obstetric emergencies that really require medical intervention. Often the very real lack of skilled personnel and equipment or supplies leads providers to turn women away in fear of a maternal death on the premises.

Health facilities frequently fail to provide a proper referral system for women in emergency situations. Women in labor are then compelled to go through repeated referrals since the families lack information about which institution can provide appropriate level of care. Yet no one is held accountable, and the lack of responsive government services often compels the poor women to seek expensive private care, which they cannot afford. The inaccessibility of health services to the rural population is compounded by costs borne due to transportation and seeking private care. It is estimated that 34% of the population falls below the poverty line in UP as a result of hospital costs.

Rights-based frameworks have the potential to improve maternal health outcomes enormously through enhanced accountability towards women users. This form of vertical accountability is important as it recognizes the unequal power relations that exist between users and providers of health services. However, institutionalized accountability cannot work effectively without recognition of women as a “class” of rights-claimants. This in turn would require bringing center-stage women's own perspectives, preferences and experiences, as articulated by women's rights organizations at all levels.

About SAHAYOG

SAHAYOG is an Indian NGO working to promote gender equality and women's health from a human rights framework.

Its key activities include advocacy and strengthening partnerships. SAHAYOG believes that socially marginalized individuals and groups - such as poor rural women, youth, non-literates, Dalits, tribals, and minorities - must participate in decision making that affects their lives. SAHAYOG works at the community level in partnership with local NGOs to build capacities and provide information so that the marginalized can

exercise their rights and access services. In Uttar Pradesh state, local NGO partners of SAHAYOG are involved in facilitating community-based organizations of poor and marginalized women into a collective called the Mahila Swasthya Adhikar Manch (Women's Health Rights Forum or MSAM). This organization has been set up in 2006, and mobilizes thousands of women across ten districts of UP.

SAHAYOG has been advocating on various issues of women's rights locally, nationally and globally. With SAHAYOG's regular research, documentation and evidence base, SAHAYOG reaches out to organizations, educational institutions, state actors and the media, as well as anchors campaigns and advocacy efforts in partnership with other organizations and individuals.

Project Overview

SAHAYOG chose to work in this IIMMHR field project through an ongoing effort at studying poor women's experiences of attempting institutional delivery. SAHAYOG had facilitated a collective of NGOs working in selected blocks of six states in India, and some volunteer advisors, to work together on capacity building of field researchers, and conducting the study with a common research design and data coding frameworks.

The project enabled these documented case studies of poor women's experiences in attempting institutional delivery, as "Voices from the Ground", to be used by civil society to present the "user perspective," as feedback to national policy actors. Additionally, the case studies were used locally by the women leaders of MSAM to negotiate with local health managers for more responsive maternal health care.

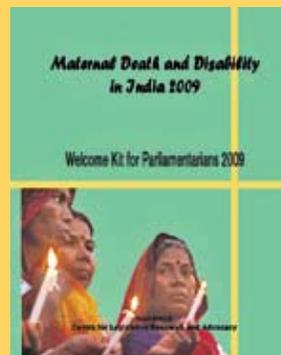
Applying rights-based approaches, **Voices from the Ground** attempted to address the exclusion of women's experiences and voices from policy making and program design for maternal mortality prevention in Uttar Pradesh (UP), and in India. The project builds the argument for incorporating a human rights dimension in maternal mortality prevention through greater inclusion, participation and accountability. Further it contrasts the top-down bio-medical model of maternal mortality prevention by demonstrating how the "voice" of the directly affected community can be strengthened in claiming their rights to quality maternal health services.

Project Implementation

SAHAYOG implemented its project activities by addressing national actors as well as working locally within two districts of Uttar Pradesh state. The project was carried out in just under a year from November 2008 - September 2009.

SAHAYOG, in collaboration with NGOs and researchers from several other states that had collaborated in the study, planned a formal national presentation of the case studies and findings from the study. The qualitative research illuminated the extremely adverse experiences of poor and marginalized rural women in seeking maternal health-care services promised by the state. This national event, "**Glimpses of institutional maternity care: Some food for thought,**" was held in New Delhi in April 2009. It was attended by close to 100 participants from 13 states of India, and included the Planning Commission of the Government of India,⁷ human rights groups, donors and technical agencies, UN agencies, academics, women's groups, and NGOs; and for many in the audience, they were hearing this kind of programmatic feedback for the first time.

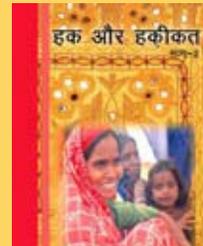
Following the event, in partnership with a legislative advocacy group, SAHAYOG and the partner organizations produced a policy brief and a policy booklet. The study findings and recommendations were used to sensitize the newly elected Members of Parliament on the issue of preventable maternal mortality. This briefing kit was launched by a Minister of Health in the presence of many new MPs in July 2009, and copies were given to the President and Vice-President of India. In addition, the group that had worked together on the study formed a **National Alliance on Maternal Health and Human Rights** in India that brings together activists, lawyers and researchers from several states as well as individuals and experts (<http://namhhr.blogspot.com>).



7. A council of experts that advises the government on the financial allocation for development programs in the country.

Locally, SAHAYOG worked with two partner NGOs and with the Women's Health Rights Forum (MSAM) an organization of poor rural women leaders in the two intervention districts, Azamgarh and Mirzapur in Uttar Pradesh.

Drawing on the findings of the study in these two districts, SAHAYOG compiled a booklet in simple Hindi called **Haq aur Haqeeqat-2**, or "Rights and Reality Part 2." The booklet provided readers with simple information on the basic entitlements around health services in Uttar Pradesh, and presented ten cases that described poor women's contrasting experiences in using maternal health services. The field staff of the partner NGOs received capacity building inputs on using Paulo Freire's "Conscientization methodology" for adult participants. For six months in 2009, during community meetings of the MSAM women members in the villages, women read out the cases and information in this booklet, and the field staff of the NGOs facilitated analytical discussions on why poor women are unable to access quality maternal care, and what should be done to remedy the situation.



The discussions also helped the MSAM women and the local NGO to develop an advocacy action plan and recommendations for women-friendly program and policies. After several months of discussing the cases in the booklet, and identifying many other similar cases, the MSAM and the partner NGOs organized a Public Hearing on the quality of maternal health services in Azamgarh in August 2009. Several testimonies were presented of maternal death, severe complications with denial of care, harassment for money or referral to private providers leading to indebtedness. The Hearing was attended by hundreds of MSAM women from the intervention districts, government health officials, eminent personalities and the media. In 2010, the Policy Recommendations from this event were presented by a delegation of rural women leaders of MSAM to the Minister of Health of Uttar Pradesh.

Project Outcomes

At the end of one year, the film *Voices from the Ground*⁸ documented

8. The shorter version of the documentary film is available at <http://www.youtube.com/watch?v=4pAoJY2sk9g>.

the processes by which organized women users address program managers and by which women human rights advocates address policy actors-in both cases to improve human rights focus in maternal mortality prevention.



The policy brief and booklet for members of parliament continues to be used as resource material, and the Hindi booklet Haq Aur Haqeeqat-2 or "Rights and Reality" is a useful tool for facilitating community analyses of maternal health care.

This brief intervention also led to processes of changes in the following areas:

With affected communities: increased voice, agency and participation of the women leaders of MSAM in two districts of UP. Poor rural women themselves analyzed and presented their experiences to health program managers, and their recommendations to the Health Minister of the state.

Among human rights defenders: within the group of NGOs working on maternal health, better mutual understanding and ability to work together for realization of rights, and establishment of a mutually agreeable framework to view maternal rights and their violation. This group has now coalesced into the National Alliance for Maternal Health and Human Rights with members in eight states. The Alliance has continued to work together on maternal health and rights issues in India.

With duty-bearers: at the local level, increased responsiveness to service requirements for women users. At state and national level, there is now greater awareness of the gaps in service design and the lack of accountability mechanisms.

"It is clear from the presentations that access to the conditional cash transfer, JSY, means that people spent a lot of money, and they had to share the JSY money with the providers...The voices that speak from the ground and speak the truth are always discounted, as being too dramatic by the system and seeing the darker side of things... The system needs a major thrust and major corrections."

[Ms Syeda Hameed, Member, Planning Commission, Government of India, after hearing the presentation of the study findings on poor women's experiences with accessing maternal health services during labor]

Voices from the Ground

Report of Meeting at Village Indranagar, Kolan Basti (Mirzapur) on 21 March 2009, women's statements on discussing some of the case-stories in the booklet Haq aur Haqeeqat 2

Rajkumari said, *"If the person was well off and belonged to a good caste, then the doctor would treat them well. If we have to buy medicines from outside and pay for facilities, then what kind of a government hospital is it?"*



Champa said that all the wrong doings of the staff at the hospital should be reported. She went on to say that they should all go together to the PHC and protest and if the staff did not take these protests seriously, then they should go to the CMO and report the matter to him. Rajkumari stated that a lack of information also compels us to bear with the existing situation and it prevents us to voice our demands. There should be a list at the PHC which should state exactly what is supposed to be given by the hospital to a woman during her delivery and her stay there.

At the Public Hearing in August 2009, Azamgarh



Ramiya, an MSAM leader, said that she had joined the MSAM in the year 2006. She said that the members were aware of the fact that they would have to fight at various levels-the village level, the block level, the district level and even at the state level-if they wanted their voices to be heard. She added that the voice of a single person was not given importance, but when the women raised their voices

in unison it was heard. At times the women have traveled a distance of 50 kms to reach the block office where they have to create a commotion in order to be heard by the officials.

National Alliance for Maternal Health and Human Rights

The NAMHHR was set up in January 2010, based on the urgent need for women's organizations, health organizations, groups working on law and human rights, and mass-based organizations to come together on this issue, given the sheer scale of the problem at seventy to eight thousand women dying each year in India of preventable causes related to maternity.

The Alliance believes that strong rights-based strategies are needed to build greater accountability for these thousands of preventable deaths among women in India. It sees maternal health and maternal mortality as an issue of social inequity, faced by the most marginal communities and women in vulnerable situations.

Maternal mortality is also the one-point indicator on the quality of primary health services, and poor health systems that fail to provide healthcare for low income communities. It is affected by many social determinants affecting women's health including gender discrimination, social exclusion and discrimination, displacement, violence, conflict, and the lack of basic necessities such as nutrition, livelihoods, safe water and sanitation.

The Alliance is concerned about several factors that contribute to poor maternal health, including the weakening of health systems and persistent lack of skilled human resources, sufficient drugs or supplies, leading to lack of available services at PHC and CHC level; quality of care, as well as discrimination and social exclusion.

The Alliance is concerned about the current vertical program approach focusing exclusively on childbirth in institutions, that has led to neglect of the continuum of care from pregnancy to the post-partum stage, safety of home-delivery and services for abortion or post-abortion complications.

The Alliance advocated for accountability and surveillance systems to prevent maternal mortality; as well as accessible grievance redressal systems. It also calls for social security for pregnancy and childbirth; nutrition for women and girls throughout the life-cycle, and the right to food.

KENYA: Right to Care

The country context

More than 20 years after the global Safe Motherhood Initiative was launched in Nairobi, maternal mortality remains an urgent public health challenge in Kenya, and each year, approximately 7,700 women die of pregnancy-related causes.⁹ Available data from Kenya suggests that maternal health has steadily been worsening during the past two decades. For example, use of skilled maternity care during childbirth has declined from 50% of all births in 1989 to 42% in 2003 and 44% in 2009. Similarly, the proportion of women aged 15 to 49 with at least one antenatal care check-up by a skilled provider during pregnancy decreased from 95% in 1993 to 88% in 2003.¹⁰



Also of concern in Kenya are inequities in access to and use of such care. Nationally, approximately 25% of women in the lowest two wealth quintiles deliver with a skilled attendant, compared to over 65% of women in the highest two wealth quintiles. Women who have completed primary education are more than three times more likely to deliver with a skilled practitioner compared to women with no education, and more than one and a half times more likely than women who did not complete primary education.¹¹

A range of social, economic, and geographic factors contribute to low use of skilled maternity care during childbirth and poor maternal health outcomes in Kenya, especially for poor women, including women's low social status and education levels; their lack of information about health and rights, autonomy, decision-making power, and access to resources;

9. World Health Organization, *Maternal Mortality in 2005: Estimates Developed by WHO, UNICEF and UNFPA*, 2007.

10. Central Bureau of Statistics, Ministry of Health, ORC Macro, *Kenya Demographic and Health Survey 2003*.

11. Central Bureau of Statistics, Ministry of Health, ORC Macro, *Kenya Demographic and Health Survey 2003*.

and cultural norms that encourage home birth or discourage the use of facility-based care. Equally important, however, are a range of health system factors. Kenya has an extensive network of public, private, and mission health facilities and sound policies on reproductive health, including maternal health. However, the health sector is inadequately resourced, with serious gaps in the availability and quality of maternity care, shortages of skilled health workers, and stock-outs of essential drugs and supplies. These gaps are particularly acute at primary care health facilities, which are the most geographically and financially accessible to the majority of the population.

As a result of these community- and health facility-level factors, too many women in Kenya lack access to quality maternity care - care that is essential for their health and survival during pregnancy, childbirth, and the postpartum period. They live too far from health facilities where skilled providers equipped with the essential drugs, equipment and supplies are



available, and they cannot afford the costs of accessing and obtaining such care, even when it is nominally provided free of charge.

About Family Care International (FCI) Kenya

FCI Kenya is an NGO that works with the Ministry of Health and a range of national and international partner organizations to improve maternal health, increase adolescents' access to sexuality information and youth-friendly sexual and reproductive health services, and reduce the spread of HIV/AIDS. FCI Kenya advances its work by (a) strengthening commitment and resources for people-centered policies and programs, and encouraging action through the exchange of information and experience, and (b) building the capacity of partners to design, implement, and evaluate national strategies and model programs.

Project Overview

Right to Care used a human rights approach to transform communities from passive recipients of government social services to engaged

citizens able to claim their rights, and health staff from potential or inadvertent abusers of women's right to maternal health into active protectors and guarantors of these rights. FCI Kenya conducted a variety of sensitization activities and workshops for various community and religious leaders, as well as a wide range of health-care professionals. Participants explored how health generally, and maternal health in particular is an issue of human rights; how the right to maternal health can be compromised on various levels; and ways to protect and ensure women's right to maternal health within the health facility. It had a special focus on low-income and rural women.

Project Implementation

FCI Kenya's project team began implementation by arranging various meetings with government actors:

- (1) with national level partners at the Ministry of Public Health and Sanitation to inform them of the proposed project and solicit their feedback on proposed project strategies and approaches;
- (2) with the Gender and Technical Working Group of the Ministry of Health; and
- (3) an orientation meeting with Yatta District Health Management Team to introduce the project to and ensure their support in implementing the project activities.



FCI then developed two sets of tools for this project. One set of tools was aimed at sensitizing health facility staff (clinical and non-clinical staff) to women's right to go through pregnancy and childbirth safely, while the other set of tools was aimed at sensitizing community leaders and civil society partners about women's right to maternal health.

Once the tools were developed, FCI Kenya organized a technical review meeting with representatives from the Ministry of Public Health

and Sanitation, the Kenya National Commission on Human Rights, the Kenya Federation of Women Lawyers, and the Health Rights Advocacy Forum, to solicit feedback.

With support from both National and district-level Ministry of Health partners, FCI Kenya conducted a number of workshops for health facility staff and community leaders: it held three training sessions for selected health facilities, which included health facility staff and health facility management committee members; and nine training sessions for 169 community leaders.

At the end of each training, participants worked together to develop action plans which included activities to identify protective and accountability measures to ensure that women's rights to maternal health are not violated as well as to mobilize communities around women's right to maternal health. Follow-up visits were conducted after the trainings to assess progress and implementation.

Project Outcomes

The objectives of Right to Care were fulfilled with the development of a set of tools for engaging health staff and community leaders in exploring human rights dimensions of maternal health and identifying priority actions needed to ensure these rights.



These tools were reviewed and approved by key members of the Ministry of Health as well as other key human rights stakeholders at the national level.

The outcome of the project was an increased knowledge of and attention to women's human rights as they relate to pregnancy and childbirth among health providers and community members.

After the training sessions had been conducted, the project team found that over two thirds of the protective measures identified in the action plans were either completed or were in progress.

PERU: No Woman Behind

The country context

Peru's maternal mortality rate is among the highest in the Americas. In 2000, it was 185 maternal deaths per 100,000 live births, which in absolute numbers represents more than 1,250 maternal deaths per year. However, national averages shadow a discriminatory situation: there is an unacceptable gap between wealthy and poor regions. Maternal mortality ratios that same year in Puno and Huancavelica regions were 361 and 302 maternal deaths per 100,000 live births, respectively.



In Peru, there are serious regional and local disparities in access to health services that are accessible, acceptable, appropriate and of good quality. Community-based maternal health care is weak, and there is a lack of women's participation in the formation and implementation of policies. Maternal mortality estimates provide a telling indicator not only of the social exclusion faced by rural women, but also of the structural deficiencies and inequities that should be addressed within the health system.¹²

Diverse studies highlight the unacceptable inequities present within Peruvian regions and their consequences for women's health.¹³ Moreover many women are reluctant to use formal health services due to (a) the clash between the "western" characteristics of the services offered and the expectations of rural women, and (b) frequent episodes of ill-treatment in health facilities. Although the Ministry of Health launched national guidelines in 2006 to promote access to vertical birth delivery with cultural appropriateness, this norm is not respected in rural health facilities.

12. Physicians for Human Rights. Deadly delays: maternal mortality in Peru. A rights-based approach to safe motherhood. 2007. <http://physiciansforhumanrights.org/library/report-2007-11-28.html> (accessed May 10, 2010).
13. D. Cotlear, ed., A New Social Contract for Peru: An Agenda for Improving Health, Education and the Social Safety Net; A World Bank Country Study, January 2006; Amnesty International, Peru: Poor and Excluded Women; Denial of the Right to Maternal and Child Health, July 2006; Physicians for Human Rights, Deadly Delays: Maternal Mortality in Peru; A Rights-based Approach to Safe Motherhood, 2007.

Focusing on the reduction of economic barriers to health-care access for poor women and children, the Ministry of Health implemented "public health insurance" (known as SIS), which is essentially a reimbursement of the actual provision of health care to those prioritized groups. Although this system has been in place for twelve years, the existence of an under-resourced public health provider, frequent delays in reimbursements from the SIS to health facilities, and unequal power relations amongst poor rural women and health providers create barriers for access to effective health services. Civil society participation is greatly needed, not just to influence the way public policies are implemented, but also for citizenship building. Only informed and collective voices will effectively combat these unjust processes.

About CARE Peru

CARE International has worked in Peru for 40 years. CARE tackles underlying causes of poverty so that people can become self-sufficient. Recognizing that women and children suffer disproportionately from poverty, CARE places special emphasis on working with women to create permanent social change.



CARE operationalizes its rights-based approach through six program principles: promote empowerment and more equal power relations; work in partnership with others; ensure accountability and promote responsibility; address discrimination; promote the non-violent resolution of conflicts; seek sustainable results. There is a strong focus on working in partnership with a wide range of stakeholders to address both immediate and underlying causes. In particular, CARE stresses the importance of addressing power imbalances as a core component of a rights based approach.¹⁴ To do this, a series of processes are developed:

- Identification of those with less power and those who have the power to determine the allocation of resources or make decisions;
- Implementation of strategies to promote better information and

14. Frisancho, A., Gayle, H., Goulden, J (2010) Operationalizing Rights-Based Approaches to Health: The Case of CARE in Peru, Beracochea, E., Evans, D., Weinstein, C.(Edits) Rights-Based Approaches to Public Health, Springer Publishing Company, LLC New York, pp 271-291.

understanding of human rights amongst poor and excluded people;

- Facilitation of empowerment processes;
- Provision of technical assistance and advocacy to support organizational environments for the inclusion of those traditionally excluded in the design and, implementation of policies.
- Work with both rights-holders and duty-bearers to promote human rights and good governance processes at different levels;
- Technical assistance to Ministry of Health and regional governments to promote better understanding of good governance processes;
- Technical assistance to national and regional governments to institutionalize new rights-based mechanisms.

Project Overview

No Woman Behind used an actor-oriented approach to promote women's health rights and accountability. The project strengthened citizen surveillance initiatives that have been implemented since 2008 by CARE Peru through its Participatory Voices project (DFID-CARE International UK), at the Andes highlands' provinces of Azangaro & Ayaviri in Puno, the region with the highest maternal mortality.



The project developed capacity-building workshops, technical assistance, and alliance building to strengthen the capacities of local civil society networks to implement effective citizen surveillance mechanisms for the quality of maternal health services. The process also strengthened the accountability of duty-bearers through dialogues with community leaders on the findings of the citizen oversight and analysis of the improvement proposals. This resulted in increased understanding of and respect for women's health rights. Finally, it implemented culturally adapted social communication strategies to raise awareness among and inform rural women of their rights.

Project Implementation

CARE Peru began its project implementation by constructing strategic alliances with ForoSalud, the main civil society network in Peru; grassroots organizations Las Manuelas (Ayaviri) and Las Micaelas

(Azángaro), who served as vigilantes; and Puno's Ombudsperson.

The rural leaders of grassroots organizations participated in capacity-building workshops on citizenship and citizen participation; entitlements within social programs; sexual and reproductive rights; health services user's rights; and how rights could be claimed within the health system. After attending a series of capacity-building workshops, each vigilante received accreditation by the Ombudsperson and planned their visits to health facilities. Afterwards, the supporting committee (CARE Peru, ForoSalud and Ombudsman) presented the selected vigilantes to the regional authorities, explaining the initiative and its implementation.



At first, the vigilantes visited health center officers and explained the mechanism to health providers. The vigilantes visited the health facilities in pairs two or three times a week. They made direct observations based on the criteria agreed on during the training. They spoke to patients in their native language, asking how long they had to wait, whether they had been told about their health condition in a way they could understand (including native language), whether they were treated with respect, whether they received free health care, the procedures and medicines they were entitled to, and so on. Most of the time, the respondents mentioned unavailability of services, disrespect of culture, discrimination, ill-treatment to those women entitled to free health care through the Integral Health Insurance, under-the-table payments, being charged for medicines and services that were meant to be free, and so on.

On the basis of their findings indicating why women are deterred from utilizing services, the vigilantes produced regular reports and analyzed them every two months with the regional Ombudsperson officers, CARE Peru, and ForoSalud. They prioritized the findings, both negative and positive, to construct a "dialogue agenda" which was presented to the health-care networks/hospital directors and health team, to agree on commitments for improvement. This process aimed to develop a sustained dialogue between health service users and providers, leading to an increased awareness of the rights and responsibilities, and consequently, an improvement in the quality of health care.

The project designed and produced social communication materials (such as radio programs) to inform rural women of their sexual and reproductive rights as well as their rights to health services.

Project Outcomes

With respect to human rights defenders, the "voice" and internal organization of rural women's groups and civil society networks was strengthened. These organizations were able to create better mutual understanding of each other's work and build strategic alliances in order to work together for the realization of women's rights. Rural women show an increased awareness of their rights and public health service entitlements. The project team also documented an increased knowledge of women's rights among health providers, ombudsperson officers and local authorities. Preliminary data indicates increased satisfaction of rural women with health services provision and increased rates of childbirth in health facilities. In addition, positive changes were seen at health facilities where citizen surveillance was implemented, when comparing variations before and after the intervention (2007-09), and comparing intervened health facilities and control facilities. A special trend analyzed was the increase in access to culturally appropriate birth delivery within health facilities where citizen surveillance was implemented. Since 2010, CARE Peru has continued promoting citizen surveillance, together with ForuSalud, with support from CARE UK/DFID and the European Union.



An important outcome is the positioning and institutionalization of citizen surveillance: currently, the National Health Policy Guidelines recognize it as an important mechanism to improve the quality of health care services. The training tools and guidelines developed by CARE during the project have been the basis for the scaling-up of the citizen surveillance initiative. In 2010, CARE provided technical assistance to the Ministry of Health for the participatory construction of National Policy Guidelines to promote and support the implementation of mechanisms for citizen surveillance of the quality of health services. In 2010, the Ministry launched National Policy Guidelines to Promote Citizen Surveillance.

Lessons Learned

From the specific context of each field project, we extracted several key elements and broader lessons learned that can be applied to other national and local efforts.

Creating accountability mechanisms. Institutionalized accountability - whether through courts, national human rights commissions, or health audits, for example - enable governments to monitor adverse outcomes and, in turn, be better informed on how to improve health services. Hand in hand with accountability mechanisms goes the empowerment of communities and local leadership structures with knowledge of their rights, which leads them to question violations and demand accountability.¹⁵ However, institutionalized accountability cannot work effectively without recognition of women as a "class" of rights claimants; in this regard, it is equally important that women's agency and participation be strengthened.

Building community participation. Community leaders as an organized unit have a great potential in improving health service delivery. Building citizens' participation through local leadership has the potential of utilizing local capacities and enhancing the right to participate. It is therefore important to bring together various community leaders and provide them with the opportunity to work together on maternal health rights. In addition, communities at large can be engaged and their voices amplified through mechanisms such as public hearings, or through the documentation of women's direct experiences with the health system (which, in turn, can be used to sensitize advocates, health workers, and policymakers). Furthermore, it is critical to identify a "common language" on health rights and responsibilities, and the existing mechanisms and legal norms through which citizen participation can be demanded. Finally, citizen participatory spaces should be catered to the specific local context in which they take place, in order to make the most of communities' voices.

15. Budget analysis is one example of how civil society can be empowered to hold their governments accountable. For more information, see *The Missing Link: Applied Budget Work as a Tool to Hold Governments Accountable for Maternal Mortality Reduction Commitments*, available at www.righttomaternalhealth.org.

Promoting rights-based approaches within the health system.

Promotion of rights-based approaches within the health system must target both health workers and the communities that utilize the health system, or the message is not thoroughly effective. Targeting health workers while excluding communities may leave the enjoyment of rights by communities at the mercy of health workers. Alternatively, targeting communities alone may lead to confrontations with health workers once communities begin to demand their rights. In addition, sufficient time should be allocated to human rights training, and the training should include the identification of concrete actions to protect communities from violations.

Getting government buy-in. It is critical to get the buy-in and support of the government (for example, the Ministry of Health) before launching any activities regarding health and human rights. Government administration officials at the local level are necessary partners in realizing meaningful change on the ground, given their leadership role in the community. If possible, it is also effective to incorporate official government documents into project activities (or use official documents as the framework), as this promotes acceptance of the project by government officers and enforces the need for accountability.¹⁶

Building bridges among human rights, public health, and women's rights groups. Strategic alliance building and partnerships is essential for sharpening advocacy efforts around maternal health. Additionally, global initiatives, such as the MDGs, can play an important role in positioning local efforts. When bringing together various groups, it is ideal to create dialogue spaces that enable decision making and identification of solutions in order to be fully constructive; it is also important to establish "rules of the game" to avoid unequal power relations.

Monitoring and evaluating rights-based approaches to maternal mortality reduction. Conducting follow-up visits to assess the implementation of action plans provides opportunities not only to understand progress achieved but also to further strengthen communities and facility staff in their efforts to protect human rights related to maternal health. Joint follow-up of the project with the district, regional, and national health managers provides joint ownership of outcomes and challenges. At the local level, the monitoring of project interventions beyond the project period can be best sustained by local government officials.

16. For example, FCI Kenya's project, Right to Care, used a matrix that created a link between the Kenya Ministry of Health Service Charter and the international and regional human rights instruments. The matrix helped in promoting acceptance of the human rights project within the health system. It also made the health workers obliged to uphold human rights related to maternal health.

Challenges

It is important for maternal health advocates to understand some of the obstacles that may be out there; depending on a particular country context, they might also encounter a variety of different challenges. Below are a few of the challenges encountered by our field projects.

Voluntary grassroots engagement. In any maternal health project, it is critical to engage actors at the grassroots level. However, oftentimes facilitating a peer group in which everyone is voluntarily engaged is a test of patience and tact. Even if everyone is committed to the cause, they likely have many other personal and/or professional commitments, and output timelines cannot always be maintained. Nonetheless, the outcomes can be worth the struggle, as information gleaned from small-scale workshops or studies is almost inevitably a valuable tool for national-level advocacy. Any maternal health initiative should incorporate this challenge into its design process. Another important issue to take into account is the need to encourage women's empowerment in both the public and private spheres.

Negative reactions from government. Challenging government policies or practices could be regarded as confrontational, and advocates must tread a fine line between criticism of and engagement with the government. Each particular country context will determine the best way to constructively criticize maternal health policies and programs. Sometimes the "name and blame" approach gets positive results. Other times the best approach is to seek government buy-in from the onset of a project, engaging public officials in a manner that draws upon their expertise and makes use of existing government documents and frameworks in order to develop sustainable tools and approaches.

High turnover among key stakeholders. When trying to sensitize and engage government actors around maternal health issues, it is often practical to engage with officers who are most "connected" to the issue and who are closer to the ground. However, these positions can also involve high turnover, and can stand in the way of advocates' efforts to create real change within the mindsets of government actors. Therefore, it is wise to engage policymakers at all levels when possible—both the higher-ups and the ones on the ground.

Buy-in from health-care providers. Sometimes those who provide maternity care are stuck in the middle: they are the ones responsible for caring for women's health and thus protecting women's human rights in the process; but they also often work under extremely difficult conditions without adequate protections for their own rights. For example, health-care providers may face pressure to improve services without being given the resources to do so. As a result, they may be reluctant to support changes to existing policies and programs. Advocates must find ways to seek their buy-in and support.

Conclusion

While every local context is different and deserves its own unique approach, concrete action in favor of women's human rights is essential for effectively and sustainably reducing maternal injury and death. The lessons learned and recommendations presented above can be usefully integrated by anyone intending to do this work, anywhere. In order to effectively reduce maternal mortality, women's human rights must be put at the center of the equation.

For more information about our field projects, as well as other resources on human rights and maternal mortality, visit www.righttomaternalhealth.org.



Governments are obliged to respect, protect and fulfill human rights related to universal access to health services that help prevent maternal mortality and morbidity.

Affordable and quality obstetric and reproductive health services are the right of all women, including women living in poverty and marginalized women. Good-quality obstetric and other health services administered in a respectful way are the right of all women. Autonomy in sexual decision-making and access to comprehensive reproductive health services are the right of all women.

Governments have a responsibility to ensure that women are empowered to take into their own hands the struggle against maternal death and injury.

Governments must allocate and effectively spend increasing and sustained resources to strengthen their health systems and make them available, accessible, and affordable.



The International Initiative on Maternal Mortality and Human Rights is the first civil society effort aimed at reducing maternal mortality. We seek to ensure that the policies and practices of key stakeholders successfully address maternal mortality as a human rights issue.

Steering Committee:

- Averting Maternal Death and Disability Program, Columbia University
- CARE
- Center for Justice and International Law
- Center for Reproductive Rights
- Equinet, the Regional Network on Equity in Health in Southern Africa
- Family Care International
- Health Equity Group
- Human Rights Center, University of Essex
- International Budget Partnership
- The Kvinna till Kvinna Foundation
- Likhaan
- Physicians for Human Rights
- SAHAYOG

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