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**Developing a Human Rights-Based Approach
to Addressing Maternal Mortality**

Desk Review

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EXECUTIVE SUMMARY

Introduction

The purpose of this Desk Review is to provide an evidence-based assessment of the potential of rights-based approaches for accelerating a reduction in maternal mortality. In particular, to identify how a rights perspective can increase the focus on equity and thus improve health outcomes for poor women.

The Desk Review is a supporting document for the DFID guidance note, *How to reduce maternal deaths: rights and responsibilities*¹. The *How to Note* provides practical guidance for DFID advisers and programme managers working on maternal health. It is by necessity concise and a starting point. This Desk Review complements the Note by providing more detailed analysis, and additional case studies and references. Together, these documents are one of the priority outputs identified by DFID's maternal health strategy document *Reducing Maternal Deaths: Evidence And Action*².

The argument developed in this Review is that carefully contextualised rights-based approaches can add a critical impetus to existing means of reducing maternal mortality. This can be achieved by enabling key policy actors in both government and civil society to recognise and find ways of directly addressing the economic, social, cultural and political forces that constrain poor women and their families from asserting their right to maternal health.

Why new approaches are needed

Although improving maternal health is one of the *Millennium Development Goals*, actual progress in reduction of maternal mortality remains limited. Too few countries have seen any noticeable reductions over the last 20 years.

Unacceptably high maternal mortality rates prevail, despite 15 years of the global Safe Motherhood Initiative. There are very few signs of progress. This lack of progress can be attributed to the status of women, the systematic violation of their basic human rights, and also to failing health systems that deny many women access to emergency obstetric care (EmOC). These dynamics are inextricably linked. Unless the underlying factors relating to women's human rights are addressed, the necessary conditions for ensuring significant investment in maternal care is never assured.

A fundamental shift in thinking and action is required if progress towards reducing maternal mortality is to be achieved. This shift requires a broadening of approaches to the problem of maternal mortality. The injustice inherent in the shockingly low percentage of women who have access to EmOC needs to be directly addressed through the systematic use of human rights values and principles to focus attention on underlying power dynamics that deny access to services that could save the lives of women experiencing obstetric complications.

Improving accessibility to both routine reproductive health services and EmOC requires serious attention to the systemic, institutional and political factors

¹ DFID (February 2005). *How to reduce maternal deaths: rights and responsibilities*. How to Note. London: Department for International Development.

² DFID (2004). *Reducing Maternal Deaths: Evidence and Action*. London: Department for International Development.

determining inequalities in access to these services. Rights-based approaches help to uncover the power dynamics that perpetuate these inequities, and suggest strategic interventions such as the reallocation of resources, changing accountability mechanisms within health systems and communities, and challenging existing hierarchies in health facilities.

Key elements of rights-based approaches

DFID's Target Strategy Paper on *Realising Human Rights for Poor People* highlights the need for:

- **Inclusion and non-discrimination**
- **Participation and empowerment** of women and men within communities as rights-holders and enabling their voices to be heard
- **Holding duty-bearers accountable for fulfilling their obligations** to respect and uphold rights

and

- **Progressive realisation of rights.** Progressive realisation of rights combines two disciplines. Firstly recognition that rights are exercised in different economic environments, and that progress is likely to be incremental, but should progress towards greater respect and protection of these rights. Secondly that prioritization for interventions, particularly with regard to resource allocation, should give priority to those interventions that are known to be most effective at reducing maternal mortality.

Value added of applying rights-based approaches at legal and policy levels

Evidence indicates that supporting maternal health services in an isolated way will not make much of an impact on maternal mortality rates as a whole. More systemic change is needed. Change will only occur by tackling health policy at a national level to influence resource allocation for improving health service delivery in general, and essential obstetric care (EOC) and emergency obstetric care (EmOC) in particular.

Rights-based approaches highlight the need to address policy and law beyond the health sector, to include, for example, education and age of marriage. There is great value in a multi-sectoral approach, as endorsed by WHO and their experience with developing a human rights tool. However, this approach requires careful attention to prioritizing the allocation of limited resources, especially in places where maximizing improvement in maternal health may not have prominent policy support.

Rights-based approaches promoting principles of 'constructive accountability' (Freedman, 2003) support women to claim their rights to maternal health, while supporting government to fulfill their obligations. The literature cited in this Review demonstrates how important national leadership is in directing attention to previously neglected areas of policy, e.g. girl's education, reproductive health and maternal health care. This in turn has had an impact on legislation and resource allocation. The most striking reductions in maternal mortality rates have occurred in countries that have made it a matter of policy to ensure basic and EmOC is universally available.

While this Review defines rights-based approaches in a broader way than the use of formal law based on treaties and conventions, treaty-based monitoring bodies still have an important role to play in the recognition of maternal mortality. Work with the treaty bodies forms part of the broader 'menu' of rights-based strategies at the legalframework level – an agenda being addressed by WHO.

Value added of applying rights-based approaches at health systems level

All literature reviewed indicates the key role that health services, and the health systems that support them, play in reducing maternal mortality. Maternal mortality rates will only fall when countries have well-functioning health systems providing quality care and supporting a referral system from community level through to facilities offering EmOC.

Rights-based approaches to improving health systems and services have focused on women's access to and use of quality EOC. A health systems analysis of the extent to which services are available, accessible, acceptable, and of the highest possible quality, as outlined in the UN General Comment on the Right to Health (See Annex 2) can be valuable in identifying problems and designing interventions that are rights-based. Within this context strategies have ranged from ensuring that EmOC services exist and are financially and physically accessible, to focusing on health providers and ensuring they are accountable to women who seek their care. The concepts of obligation and accountability provide entry points to influence both how decisions are taken about what services to finance (so that, for example, resources are prioritised more for EOC and not for traditional birth attendant (TBA) training) and to support providers so that they are able to provide a service that women want to use and can use.

A rights-based analysis of access to care, spotlighting non-discrimination and equity, would draw attention not only to those women who are not currently using services but also to the underlying social and cultural factors that perpetuate their inability to do so.

Value added of applying rights-based approaches at community level

Family and community-level decision-making related to obstetric care can be influenced through strategies and interventions that link global human rights principles and values with local contexts. However, rights-based interventions at the community level need to respond to local context, and resonate with locally recognizable and respected values. In some situations this may mean working on rights without explicitly talking about human rights. Participatory and empowering capacity building processes appear central to enabling local stakeholders to redefine and negotiate new norms and practices. However, these need to be done in parallel with programmes that help communities, and women in particular, to hold government and service providers to account.

Using a rights-based approach involves working with community and women's associations to advocate their rights be respected and protected, while also working with government and service providers to increase their capacity to uphold their obligation to provide health services of the highest possible quality.

The initial analysis undertaken when employing a rights-based approach to assess the reasons behind delays in seeking, accessing and receiving care can help to identify not only who the excluded are, and what particular problems they face when accessing maternal health services and especially EOC, but also the power dynamics and structures that maintain inequities in access to care. Further, a rights-based approach would oblige governments and their funding partners, as well as communities, to address the problems of poor referral systems. This is especially important for poor women living in remote communities who may be socially excluded from using even primary care facilities. Finally, analysing access issues

from a rights-based perspective has already led many to question the ethics of charging for pre-natal and obstetric care.

Conclusions

DFID must match its commitment to applying a rights-based approach to maternal mortality with a recognition of, and advocacy for, the benefits of doing so. For example, rights-based approaches can increase the focus on interventions that address the underlying injustices that prevent women accessing life-saving services they need. The political dimensions of rights-based work must be clearly acknowledged: a rights-based approach addresses powerful people's interest in maintaining the status quo. This carries the risk of alienating those who have vested interests in maintaining, for example, resource allocation and other existing agendas.

Other key elements that must be explicitly addressed include ensuring the political acceptability of the language used to promote and ensure rights-based concepts. The language should always be contextualized carefully within local values that mirror principles such as equity and non-discrimination. This helps to ensure that principles that derive their legal legitimacy from international human rights treaties resonate with rights as identified and defined at community level. It also helps to ensure that the principles form the basis for interventions that advance the rights of the socially excluded without compromising their security or increasing their vulnerability.

Rights-based approaches require a multi-sectoral analysis and response. This is to ensure that support can be mobilized across health, education and other sectors for the changes required to prioritize maternal health. This brings with it challenges related to prioritizing activities, and resource allocation and reallocation.

In reality, strategies that work at all levels are needed. For DFID, the challenge is now to:

- direct effort and funding towards not only what works programmatically, but also to building the critical mass of influence that will bring about much needed political and social change. Only through a combined approach will we turn the tide on maternal deaths.
- identify how to complement and add value to existing initiatives in rights-based approaches to reducing maternal deaths.
- identify gaps in the evidence base that need addressing.
- encourage the creation of a policy environment for rights-based approaches. This will involve supporting analysis at various levels that builds thinking based on human rights principles and values into problem identification and incorporating rights-based approaches into maternal health programmes.

SECTION 1: THE VALUE OF RIGHTS-BASED APPROACHES

1.1 Maternal Mortality: A Development Failure?

1. High maternal mortality and morbidity rates reflect one of the shameful failures of development. Despite the existence of the global Safe Motherhood Initiative since 1987, overall levels of maternal mortality appear to have barely changed over the past 15 years. More than 520,000 women die each year from complications of pregnancy and childbirth, and an estimated 300 million women suffer disabilities related to pregnancy and childbirth.³
2. As many as 99% of all maternal deaths occur in developing countries, with the highest maternal mortality rates in sub-Saharan Africa, followed by South and Central Asia. Recent findings by WHO, UNICEF and UNFPA show that during her lifetime a woman living in sub-Saharan Africa has a one in 16 chance of dying in pregnancy or childbirth. In Sierra Leone and Afghanistan one in six women will die from complications related to pregnancy and childbirth. (In the developed world, women have a one in 2,800 risk of dying in pregnancy or childbirth.)
3. Not only is there an enormous disparity between levels of maternal mortality between developed and developing countries but further disparities between different socio-economic groups within countries. Recent research using DHS data provides an important indication of the relationship between women's poverty status and survival during pregnancy and childbirth. With increasing poverty the likelihood of women dying of maternal causes increases significantly.⁴ Gender analysis has also revealed ways in which power imbalances enforced through culturally sanctioned ideas deeply damaging effects on women's health.⁵
4. While maternal mortality rates remain unacceptably high the actual determinants of maternal mortality are well known:
 - Women's status, starting with lack of education, which is linked to early marriage and childbearing; inability to take decisions regarding health care; low valuation of girls and women, particularly in the peak reproductive years, and poorer access to nutrition
 - Family and community beliefs which prevent early identification of problems related to pregnancy, or lack of awareness of pregnant women's needs
 - Women's lack of access to health care services due to inaccessibility, cost, or perceived poor quality
 - Poorly functioning health systems and a lack of skilled personnel, supplies, equipment, and adequate referral systems
 - A lack of a supportive and protective legal and policy environment, or where it exists poor enforcement of its provisions⁶

These determinants are often mutually reinforcing, and directly linked to poverty. Several of them can be redefined in terms of violation of women's rights to non-

³ Freedman L et al (2005) *Who's Got the Power? Transforming Health Systems for Women and Children*, UN Millennium Project Task Force on Child Health and Maternal Health.

⁴ Graham W et al (2004) *The Familial Technique For Linking Maternal Deaths With Poverty*, *The Lancet*, 363 (9402): 23-27.

⁵ Freedman L et al (2005) *Who's Got the Power? Transforming Health Systems for Women and Children*, UN Millennium Project Task Force on Child Health and Maternal Health.

⁶ WHO (2004) *Using Human Rights For Maternal And Neonatal Health: A Tool For Strengthening Laws, Policies And Standards Of Care*.

discrimination, health care and health protection, education, etc. – a rights-based analysis that points the way towards addressing some of the underlying issues that keep women poor, powerless and (unsafely) pregnant.

5. We know what works to avert the vast majority of maternal deaths. The need for increased access to an expanded range of reproductive health services is clear.⁷ Undesired fertility contributes directly to the level of maternal mortality. Yet each year 120 million unwanted pregnancies occur leading to an estimated 46 million abortions, with 20 million occurring in countries where the procedure remains unsafe and or illegal. (Unsafe abortions are estimated to account for more than 78,000 deaths each year, accounting for 13% of all maternal mortality.) Skilled management of deliveries with evidence-based practices and active management of third stage labour can help avert a significant portion of deaths. However, once a woman does experience a complication routine care will not save her. She must have access to quality EOC and EmOC.
6. Improving accessibility to technical interventions to both routine reproductive health services and EOC requires serious attention to the systemic, institutional and political factors determining inequalities in access to these services. EOC is part of an Essential Obstetric Care package. EOC can be categorised as ‘basic’ and ‘comprehensive’. The United Nations Process Indicators on Availability and Utilisation of EOC make use of these categories for needs assessment and monitoring levels of unmet need for EOC. The following table shows the specific functions provided by each of these categories.

Table 1: Categorising basic and comprehensive EOC facilities

Basic EOC Services	Comprehensive EOC Services
<ol style="list-style-type: none"> 1. Administer parenteral antibiotics 2. Administer parenteral oxytocic drugs 3. Administer parenteral anticonvulsants for pre-eclampsia and eclampsia 4. Perform manual removal of placenta 5. Perform removal of retained products (e.g. manual vacuum aspiration) 6. Perform assisted vaginal delivery 	<ol style="list-style-type: none"> (1-6) All of those included in Basic EOC 7. Perform surgery (caesarean section) 8. Perform blood transfusions

7. Freedman has argued that the reasons for the relative failures in responses to maternal mortality partly relate to the status of women - and systematic violation of their basic human rights, and to failing health systems – a problem particularly significant in relation to maternal mortality because of the strong evidence that access to EmOC is a critical factor in determining maternal mortality risks. These two elements are not separate. **Unless underlying factors relating to women’s human rights are addressed, the necessary conditions for ensuring significant investment in maternal care will not be attained.** Data collection using UN Process Indicators, which measure met need for EmOC, demonstrate the dimensions of the problem. In Mozambique fewer than 8% of the women who are estimated to have severe obstetric complications are receiving treatment at facilities that provide either Basic or Comprehensive EmOC (the recommended rate is 100%). The similar average rate in Nepal was 5.4%. In Senegal, the

⁷ WHO/UNICEF and UNFPA have produced Guidelines for monitoring the availability and use of obstetric services which describe a set of indicators to assess the availability and utilisation of EmOC. Data indicate that in six out of 13 countries surveyed less than 10% of health facilities offer basic EmOC.

proportion of women with serious obstetric complications who are treated at EmOC facilities is approximately 12%. Even if all facilities are included, only 19% of women estimated to have serious complications are treated.⁸

8. A rights-based approach has the potential to address some of the underlying factors that need to be tackled effectively if these figures are to be significantly reduced.

⁸ Bailey, P E, Paxton, A. (2002) Program note using UN process indicators to assess needs in emergency obstetric services. *International Journal of Gynecology & Obstetrics* 76: 299-305. Authors note: It is important to note that the three countries described in this feature were not selected because of the quality of coverage or performance of their maternity services, but because their programme managers were eager to share their findings with others in similar situations.

1.2 Introducing a Rights-Based Approach

9. When human rights are talked about in relation to health a distinction should be made between two related and complementary approaches. The **first approach** refers to **the use of human rights as a system of formal laws** based on treaties and conventions, and which draws on the **human rights standards** explicit in these conventions to set the parameters for interventions. These rights are mainly defined through international human rights law and confer obligations on national governments.
10. The basic characteristics of these human rights are that they are the rights of all individuals, they inhere in individuals because they are human and they are principally concerned with the relationship between the individual and the state. Human rights treaty monitoring bodies such as the Committee On The Elimination Of All Forms Of Discrimination Against Women (CEDAW) increasingly identify issues related to women's health as coming within their remit, and can provide useful mechanisms for exposing violations of human rights, and, more constructively, to add impetus to actions to improve maternal health. There is a value in joining international advocacy efforts to increase understanding of the human rights dimension of sexual and reproductive health in general, and of maternal mortality in particular.
11. The **second approach** sets out a broader framework for specifically addressing maternal mortality as a political, cultural, social, economic and development problem. This approach **uses human rights standards and principles to help deepen the description and analysis of the problem of maternal mortality, and to shape strategies to address maternal mortality**. This approach is not solely dependent on human rights analysis and uses other forms of analysis traditionally used by health and policy analysts. It involves, for example, as Freedman has argued, taking a concept like accountability, but moving away from an approach concerned mostly with identifying fault and apportioning blame, towards the concept of 'constructive accountability'; developing a dynamic of entitlement and obligation between people and their government that enables the building of "health systems that function for the benefit of people". This can only be done by increasing awareness by individual women and men of their entitlement to basic rights and increasing capacity of governments to fulfil their obligations, within a system that is not about recrimination and blame, but which seeks to set up and maintain accountability mechanisms within health systems and communities.
12. While such a process derives its legitimacy from human rights treaties traditionally focused on state actors or state obligations, it may be more applicable to the work of bilateral agencies such as DFID in that it takes human rights principles and values as integral to good development practice and has the potential to offer practical guidance on how a rights-based understanding of, and approach to, maternal mortality can strengthen country programmes concerned with health systems development. It also has the potential to begin the process of social and political change necessary to place priority on improving maternal health, and allocate resources accordingly. This second approach is the main focus of this Review, which draws upon work already undertaken within DFID on strengthening rights of the poor and the excluded.⁹

⁹Piron L-H, Watkins, F. (2004) DFID Human Rights Review: A review of how DFID has integrated human rights into its work. London, ODI.

13. Organizations such as Amnesty International have been successful in advocacy and programmatic interventions derived from the first approach, while Columbia University's Averting Maternal Death and Disability (AMDD) Programme is a good example of the second approach. Annex 1 provides a review of other organisations' approaches to applying a rights-based approach to maternal health.
14. Human rights activists have traditionally focused on civil and political rights. It is only relatively recently that economic, social and cultural rights, of which the right to health is one, have received similar attention as basic human rights. Although they are clearly established in law, their meaning is less clear-cut, as is the ability to assert them within national legislative frameworks. The **right to health** is articulated in article 12.1 of the International Covenant On Economic, Social And Cultural Rights, which states "The States Parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health". Valuable work in adding specific content and meaning to the right to health was recently undertaken by the Committee On Economic, Social And Cultural Rights and can be found in that Committee's General Comment 14 on the right to the highest attainable standard of health¹⁰ which has identified four key interrelated and essential elements within the Right to Health: availability, accessibility, acceptability and quality. Human rights cannot, by themselves, deliver health. But they can form a valuable basis for addressing underlying social and political forces that combine to keep maternal mortality unacceptably high. See Annex 2 for further details.

1.3 Framework for a Rights-Based Approach to Maternal Mortality

15. The conceptual framework for a rights-based approach to development was laid out by the UN in 2003 in the **UN agencies common understanding of a rights-based approach to development cooperation**¹¹: "In a human rights-based approach, human rights determine the relationship between individuals and groups with valid claims (rights-holders) and State and non-State actors with correlative obligation (duty-bearers). It identifies rights-holders (and their entitlements) and corresponding duty-bearers (and their obligations) and works towards strengthening the capacities of rights-holders to make their claims and duty-bearers to meet their obligations".¹² This UN Common Understanding in its turn takes as its starting point the principles outlined in the Universal Declaration of Human Rights and other international human rights instruments to guide programming in all sectors. See Annex 3 for further details.
16. We take as a starting point the DFID Human Rights Framework outlined in the Target Strategy Paper *Realising Human Rights for Poor People*. In this paper DFID's human rights strategy is defined as follows:

"The human rights approach to development means empowering people to take their own decisions rather than being the passive objects of choices made on

¹⁰ See also United Nations Human Rights Website - Treaty Bodies Database - Document - General Comments - <http://www.unhchr.ch/tbs/doc.nsf/MasterFrameView/40d009901358b0e2c1256915005090be?Opendocument>

¹¹ UN (2003) Report on the Second Interagency Workshop On Implementing A Human Rights-Based Approach In The Context Of UN Reform. Stamford, CT, USA, 5-7 May 2003.

¹² United Nations (2003) The Human Rights-Based Approach to Development: Towards a Common Understanding Among UN Agencies New York: UN p2

their behalf. The objectives of DFID's Human Rights Strategy is to enable all people to be active citizens with rights, expectations and responsibilities' and to 'claim their rights to the opportunities and services made available through pro-poor development'.

17. In the context of maternal mortality, the first task is to reach a consensus that death in pregnancy and childbirth is unacceptable.¹³ As stated earlier, patterns of mortality both within and between countries are rife with inequality, a situation that is amenable to change. Within a broad human rights framework key questions that need to be addressed are:

- Is maternal mortality recognised as an urgent and priority concern at international, national and local level? If not why not?
- Can groups of women who do not have access to EOC/EmOC be defined by different social, cultural or political characteristics such as race, class or religion?¹⁴ What produces these patterns of discrimination? What are the power dynamics within the community that preserve and sustain this inequity?
- Do women lack power in decision-making at community and family level on maternal health? If so, what factors are involved?

18. DFID identifies three key **operational principles** in applying rights-based approaches to development, set out in the Target Strategy Paper on *Realising Human Rights*¹⁵. These are fulfilling obligation (accountability), inclusion and participation.

Accountability: All too often accountability is used to mean blame or punishment. The concept of "**constructive accountability**" makes it clear that a rights-based approach to maternal mortality reduction is not primarily about finding fault, but about developing a dynamic of entitlement and obligation between people and their governments and within the complex system of relationships that forms the wider health system.¹⁶ Accountability may imply legal recourse. However, there are other ways of ensuring accountability that involve rights-focused monitoring and reporting systems, public debate and greater citizen participation in public service management.¹⁷ The core concept of accountability is the recognition that the rights of one party generally involves the **fulfilment of obligations** by another; this relates directly to DFID's principle of fulfilling obligations, and to the dynamic process of the claiming of rights, and the recognition of accountability that is crucial to the extent to which human rights are respected, protected and fulfilled.

The starting point of fulfilling obligation is the **human rights standards**, the international human rights framework, that apply to maternal mortality. The human rights most relevant to maternal mortality are defined in the following international conventions and covenants: *the International Covenant on Civil and Political Rights (ICCPR)*; *the International Covenant on Economic, Social and Cultural Rights (ICESCR)*; *the UN Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW)*; *the UN Convention on the Rights of the Child (CRC)*; and *the International Convention on the Elimination of all Forms of*

¹³ Freedman L (2001) Averting Maternal Death And Disability: Using Human Rights In Maternal Mortality Programmes – from analysis to strategy. *International Journal Of Gynaecology And Obstetrics*, 75:51-60.

¹⁴ Ibid

¹⁵ DFID (2000) Target Strategy Paper: *Realising Human Rights for Poor People*. London: Department for International Development.

¹⁶ op cit

¹⁷ Overseas Development Institute (1999) *What Can We Do With A Rights-Based Approach To Development?* ODI Briefings No 3: London ODI.

Racial Discrimination (ICEFRD). See Annex 2 for further details of these Covenants and Conventions, and how they relate to maternal health.

Inclusion and non-discrimination: An inclusive approach is one that ensures that there is equity of opportunity and access across all social groups. The concept of health equity includes “concerns about the achievement of health and the capability to achieve good health, not just the distribution of health care . . . [it includes] non-discrimination in the delivery of health care. . . and broader issues of social justice and overall equity”.¹⁸ In relation to maternal mortality, equity is particularly critical in relation to inclusive access to quality EOC/EmOC, across social groups and regions, and in practical measures to ensure high quality of care regardless of the poverty and social composition of the population served. The principle of inclusion implicitly includes non-discrimination, which demands an analysis of who is not included in the process, or is not using the service, processes that lead to that exclusion, and explicit efforts to address them.

Participation: The right to participate in health-related policy-making at community, national and international levels is now an integral part of the right to health as interpreted in formal human rights law.¹⁹ The Right to Freedom of Assembly and Political Participation is enshrined in the *Universal Declaration of Human Rights*. Evidence suggests that citizen participation initiatives must ensure social representation and inclusion, and give voice to women and the poor over a significant period of time.²⁰ Freedman suggests that key issues to be addressed in developing meaningful community participation include: who are the different groups of stakeholders; how should representatives be chosen; who from a facility or local government should be involved; what issue do they address and with what level of decision-making power; and how does the group relate to other political structures and power dynamics in the community? Within this conceptualisation of participation the key dynamic is entitlement and accountability. Participation is necessarily a political process, which directly challenges power structures and inequality, by explicitly placing a value on including and hearing different groups of stakeholders. While not easy to implement in practice, it is harder to maintain that a programme is rights-based if it has not demonstrated an explicit commitment to this principle.

Empowerment And Voice: Empowerment in the context of rights is important because it embodies the possibility that individual women and men – and groups advocating for them – can effect social and political change through demanding and directly claiming their rights. Effective rights focused education can empower people to assert their rights by making them aware of their rights, of the gap that often exists between their rights and the reality of their lives and encourage them to seek ways of closing that gap.²¹ In terms of health service provision, strategies for improving empowerment and voice can also give poor people a stronger say in how services are managed and delivered.

19. In addition to these operational principles, the notion of ***progressive realisation of rights*** is important in applying a rights-based approach. When working from a rights-based perspective, it is important to acknowledge that there are tremendous resource and capacity implications to fulfilling obligations. As such, for a rights-

¹⁸ Sen A (2001) Development As Freedom.

¹⁹ Freedman LP (2003) Human Rights, Constructive Accountability And Maternal Mortality In The Dominican Republic, *International Journal Of Gynaecology And Obstetrics*. 82:111-114.

²⁰ Thomas et al (2003) Citizen Participation And Voice In The Health Sector In Bangladesh. London: DFID/Options.

²¹ Hausermann J. A Human Rights Approach To Development. London: Rights And Humanity, 1998.

based approach to maternal mortality reduction to be useful, there must be prioritisation based on the evidence of what interventions are most important for achieving rights and in negotiation with users, advocates and government. For example, if the outcome to be achieved is a reduction in maternal mortality, and there is an absolute lack of essential obstetric care, then a rights-based approach should support this first before resources for 'community mobilisation' activities.²² See Annex 4 for further explanation.

20. The following case study (Box 1) provides a useful example of how the principles of equity/inclusion, participation, empowerment, accountability and progressive realisation of rights were used in a UNICEF programme that aimed to reduce maternal mortality in a socially excluded population in Peru.

Box 1: UNICEF And Rights-Based Approaches In Peru

Maternal mortality rates amongst indigenous women in Peru have been consistently higher than in other Peruvian women. Traditional programmes that considered the problem as strictly a health care problem were not making any headway in reducing maternal mortality rates in this group. UNICEF and its local implementing partners, used a rights-based approach that looked at disparities and exclusion in several sectors (health, education) and examined indigenous cultural rights and status of women in general. A causal analysis determined that the "principal reason for high maternal mortality amongst indigenous women was rampant gender inequality combined with social and cultural barriers to access health care facilities, which were culturally inappropriate and even offensive to indigenous women."

UNICEF, local NGOs and health workers worked together and first met with women to elicit their needs and preferences, and then met with State and local health officials, to design a health care delivery system that respected the women and their culture. "This dual approach: strengthening the capacity of the rights holder to understand that health care is a right and then helping them to design a strategy to assert and claim this right while simultaneously working with the duty bearers to improve their capacity to fulfil their obligations is the hallmark of the rights-based approach". UNICEF and its partners worked with local women's organisations on advocacy and awareness-raising campaigns, while facilitating meetings between Andean women and government health care officials. "Power dynamics were shifting: marginalized women were being 'heard' for the first time".²³

1.4 The Added Value of a Rights-Based Approach

21. Applying a rights-based approach to maternal mortality adds value at several levels.

At the **normative level** value is provided through a conceptual framework which sets out international standards. According to Mary Robinson, UN Commissioner for Human Rights, "A human rights approach adds value because it provides a normative framework of obligations that has legal power to render governments accountable".²⁴ At national levels, concepts of equality and non-discrimination focus attention on how to reach the poor and socially marginalized. A human rights framework can enhance accountability through building dialogue and coalitions within communities and between civil society, health care providers and government. The approach builds on the notion of a social contract which

²² Freedman L. (2004) Personal Communication

²³ UNICEF (2002) Peru Case Study: A Human Rights Approach. In: Interaction (2003) *An Introduction To The Concept Of Rights-Based Approach To Development*. Washington DC: Interaction.

²⁴ Robinson M (2002) in speech to World Summit, Johannesburg, 28.08.02

empowers citizens to claim their rights. Ultimately, this concept of ‘agency’ – stimulating the capacity of individual women and men to take action in pursuit of the changes needed to turn rights from theoretical entitlements into access to the range of services that will render them fulfilled – is a defining hallmark of a rights-based approach.

At the **analytical level** a rights-based approach can help to set programme objectives. For example, human rights principles can inform analysis of health sector reform and its impact on equitable access to EmOC. A rights-based approach provokes a different kind of analysis of poverty in terms of highlighting rights that are and are not realised. This means moving beyond the health sector, and also implies an analysis of power relations and underlying structures that determine maternal mortality outcomes – leading to interventions designed to bring about social and political change. Such an analysis necessarily involves, for example, challenging hierarchies in the staffing of health care services, and identifying and tackling vested interests that keep maternal health services out of the reach of the women who need them most.

At the **operational level** a rights-based approach shares the principles of what is currently considered to be ‘good development practice’, especially ensuring equity and stakeholder participation.²⁵ For example, human rights audits of health facilities can help identify ways to encourage non-discriminatory treatment of patients, their families and of providers. Principles, such as non-discriminatory treatment, can be also integrated into programmes at the community, clinical, facility management and national policy levels. Principles of entitlement and accountability can inform mechanisms of community participation designed to improve responsiveness and accessibility of health facilities (e.g. Patients’ Charters). The application of human rights principles to maternal mortality therefore helps to maintain a focus on good practice, with dignity, equity participation, accountability and non-discrimination at its centre.

22. Urban Jonsson has identified some of the critical **differences between needs-based and rights-based programming**, the most significant of which is the element of accountability.²⁶ In a needs-based approach, no one is identified with a duty to meet the need. He summarizes the key differences as follows:

²⁵ Piron L-H and Watkins F (2004) DFID Human Rights Review: A review of how DFID has integrated human rights into its work. ODI: London.

²⁶ Jonsson, U (2004) A Human Rights Approach To Development Programming, UNICEF, New York.

Table 2: Distinction between needs-based and rights-based approaches

The Basic Needs Approach	The Human Rights Approach
Needs are met or satisfied	Rights are realised (respected, protected, facilitated, and fulfilled)
Needs do not imply duties or obligations, although they may generate promises	Rights always imply correlative duties or obligations
Needs are not necessarily universal	Human rights are always universal
Basic needs can be met by goal or outcome strategies	Human rights can be realised only by attention to both outcome and process
Needs can be met through charity and benevolence	Charity and benevolence do not reflect duty or obligation
It is gratifying to state that “80% of all children have had their needs met to be vaccinated”	In a human rights approach, this means that 20% of all children have not had their right to be vaccinated
The government does not yet have the political will to enforce legislation to iodise all salt	The government has chosen to ignore its duty by failing to enforce legislation to iodise all salt

23. Jonsson further discusses the relationship between good programming practices and human rights approaches, maintaining that part of the added value of the human rights approach is that it demands adherence to the first – i.e. that it **makes good programming practices obligatory** rather than aspirational or optional. Annex 5 clarifies this relationship further.

SECTION 2: DEVELOPING THE EVIDENCE BASE

Section 2.1: Delay 1 – Delays in Seeking Care

➤ ***How can rights-based approaches contribute to analysing and addressing underlying factors related to maternal deaths?***

24. The first delay is the delay in seeking health care. The country examples of Mali and Nepal (see Boxes 2 and 3) provide a useful starting point for considering socio-cultural factors contributing to the delay in seeking health care. The United Nations has estimated the maternal mortality ratio in Mali at 630 per 100,000 live births with one in 19 women dying from pregnancy and childbirth related causes.²⁷ There are multiple factors that drive such high maternal mortality in Mali, but it is apparent that women's lack of power within the family, linked to deeper and broader gender discrimination, denies women many of their human rights.²⁸ A rights-based analysis of these factors helps to identify interventions that address these power dynamics, and have the potential to mobilize communities to demand better health services, because it starts with the premise that these patterns can be changed if the political will is there.

Box 2: Women's Health and Social Compromises in Mali

A poor Malian woman's life is characterised by child marriage²⁹, female genital cutting (FGC)³⁰, high fertility, vulnerability to domestic violence, and social values that define women according to their roles as mothers' and wives³¹. Within the family, women's status is fragile. The law states that a husband is the head of a household, and sanctions polygamy. Traditional attitudes and discrimination discourage women from working outside the home, early marriage prevents many girls from continuing their secondary education, leaving most women economically dependent on their husbands. Cultural beliefs expect women to keep working throughout pregnancy and to resume work shortly after childbirth. Social norms place women as the last to eat at mealtime even during pregnancy. Within this social and cultural context it is a woman's husband or mother-in-law who decides whether she seeks obstetric care and controls the household resources that pay for that care. For unmarried pregnant women and their families, the social stigma of pregnancy outside marriage adds to the complexity of deciding whether or not to seek medical attention. Anecdotal evidence gathered for this case study indicated that unmarried women, especially those having an unwanted pregnancy, are probably placed at even greater risk of maternal death.

25. DFID's Safer Motherhood Project in Nepal (NSMP) provides insight into the challenges of reducing maternal mortality in a poor country highly stratified by ethnicity, caste, gender, kinship and age (Box 3).

²⁷ op.cit

²⁸ For example, the right to non-discrimination and respect for difference, the right to life and survival, the right to liberty and security of the person (eliminating FGC), the right to freedom from inhuman and degrading treatment (protect women from domestic violence), and the right to marry and found a family (prevent early marriage).

²⁹ By the age of 17, 38% of women in Mali have already had one child or are pregnant.

³⁰ 94% of women in Mali of childbearing age are victims of FGC.

³¹ Centre For Reproductive Rights And Association Des Juristes Maliennes 2003. Claiming Our Rights: Surviving Pregnancy And Childbirth in Mali.

Box 3: Maternal Mortality in Nepal

Maternal mortality in Nepal is high, women's status is low and decision-making to seek obstetric care is typically made by women's husbands, their mothers-in-law or if neither of those are around, neighbours or respected members of the village.³² Silence and shame surround pregnancy and childbirth.³³ Perceptions that childbirth is highly polluting are common. For example, Bahun-Chhetri mothers giving birth cut the cord themselves because of the supposed highly polluting nature of the act.³⁴ Traditional explanations of the cause of illness by evil spirits and witches also apply to complications arising in pregnancy and childbirth, requiring spiritual remedies.³⁵

➤ ***How can rights-based approaches influence the power dynamics within the family and community to reduce delays in decision-making and the risk of maternal death?***

26. Evidence of the application of rights-based approaches in safe motherhood interventions at the community level is limited.³⁶ What we do know is that in many situations, providing information and raising awareness of the danger signs of pregnancy does not affect the social context of maternal health seeking behaviour, and has limited impact on reducing the delay in deciding to seek obstetric care.³⁷ Improved decision-making in the family in countries with high maternal mortality rates, such as Nepal and Mali, requires more than awareness-raising. For example, where good quality EOC is unavailable, families may be making a rational choice not to spend money on inadequate health services, despite being well aware of the dangers of pregnancy.

27. In Nepal, to influence family decision-making to seek obstetric care, NSMP is working with community change agents who are supported by local NGOs and community based organizations. One approach being tested is the use of key informant monitoring (KIM) to measure changes in the social context in which women experience pregnancy and childbirth.³⁸ See Box 4 below.

³² That said variation in women's autonomy exists between different ethnic and caste groups. Women are found to have greater autonomy and decision-making power among the Tharu and Magar tribal peoples than among Hindu caste groups

³³ Nepal Safe Motherhood Project, 2004. Options/DFID, <http://www.nsmmp.org>

³⁴ Mary Mandandhar. 2000. "Nepal Safer Motherhood Project. Social Research Literature Review for the IEC Strategy." Options/DFID.

³⁵ For example, traditional practices for childbirth complications include the woman drinking water in which her husband's underwear has been washed, bursting an egg over the woman's stomach, and making women work hard after childbirth to wash out impure blood.

³⁶ This could be due to language (many projects are possibly using rights principles without naming interventions as rights-based approaches) and our inability to access relevant documentation.

³⁷ Marjorie Koblinsky, 2003. *Mothercare Matters*, 2000.

³⁸ KIM is an adaptation of the participatory ethnographic evaluation and research method developed by Neil Price and Kirstan Hawkins (2000), <http://www.options.co.uk>

Box 4: Experience with Community Change Agents in Nepal

Key Informant Monitoring (KIM) is founded on the understanding that the wider social, religious, cultural, economic and political environment is important in shaping maternal health outcomes and maternal health seeking behaviour. The KIM methodology is based on local women and men collecting information from peers or key informants on their perceptions of how the social environment enables women to access care. The conversations are structured around three themes, reduced barriers to obstetric care, improved quality of care, and improvements in women's social status and mobility.³⁹ The KIM tool is a means through which communities can communicate their views and concerns to project staff, in this case NGO support staff, and participate in monitoring relevant social change.

The findings from use of the KIM tool in Nepal highlight barriers to change and the reasons why families are delaying the use of EmOC. For example, key informant researchers have recorded instances of health workers discriminating against low caste women, and the functional exclusion of extremely poor women from community emergency fund schemes – both practices antithetical to the project and also to Nepalese Government policy.

One of the key aspects of KIM has been its importance as an advocacy and social change tool. Local NGOs have facilitated meetings between key informant researchers and Village Development Committees on findings and recommendations of the research. The dialogue generated through this process has facilitated changes being made to improve quality of service delivery.

Further research on the benefits of the KIM tool is planned. Potentially the tool could be developed into a means of women holding project stakeholders accountable. One of the limitations of the application of the tool in Nepal has been its dependence on using local researchers (women and men from the community) that are literate, with the result that low caste groups and the extreme poor are badly represented. However participatory ethnographic evaluation and research has been used successfully with non-literate researchers in other contexts.⁴⁰

28. Looking beyond maternal mortality, there are lessons to be learned on how rights-based approaches can engage with and influence family decision-making processes from projects that have taken a rights-based approach to girls' education and to other violations of reproductive rights such as FGC.
29. UNICEF, and many of the NGOs working closely with UNICEF, strongly advocates a rights-based approach to education of girls. Girls' education is considered a main entry point for supporting vital aspects of women's well being later in life, including age of marriage, age at birth of first child and ability to be part of decision-making processes. UNICEF is combining working with communities, pressuring national leaders to commit to universal education for girls and intensifying its own programme of work to make education for girls more accessible in order to ensure rapid progress towards the *Millennium Development Goals* targets relating to education.⁴¹
30. Justifications for FGC are often based on social practice, religion, and subjugation of women's sexuality, agendas that are deeply rooted in the value

³⁹ Neil Price. May 2002. The Key Informant Tool For Monitoring Improvements In Social Access To Midwifery And Obstetrics Services.

⁴⁰ See <http://www.options.co.uk>

⁴¹ UNICEF (2004) State Of The World's Children: Girls, Education And Development. UNICEF: NY

systems and beliefs of respective societies. However, FGC is a violation of human rights and increases the risk of complications in childbirth.⁴²

31. An International Centre for Research on Women (ICRW) review of three FGC projects in Gambia, Senegal and Egypt⁴³ that had taken different rights-based approaches, identified several factors across the interventions that enabled communities to decide to stop FGC some of which could be applied to other rights-based community programming, including maternal mortality reduction (Box 5).

Box 5: Rights-Based Approaches to Female Genital Cutting/Mutilation (FGCM) In Gambia, Senegal and Egypt

In the Gambia, FGCM is part of a rite of passage for girls moving into womanhood. The community celebrates the ritual; offer gifts to the newly circumcised girls, and status and income to the circumciser and her assistant. The Foundation for Research on Women's Health, Productivity and the Environment (BAFROW) worked with community stakeholders to design a ceremony that continued to celebrate local culture without involving any cutting. BAFROW trained former circumcisers as promoters and facilitators of the new rite, built a site for the ceremony, and through advocacy and awareness raising mobilised the support of religious leaders, local government and former circumcisers.

Tostan, a NGO in Senegal, inspired over 100 villages to stop FGCM through its non-formal education programmes on human rights, problem-solving skills, basic hygiene and women's health. Working from the principles of participation and empowerment, Tostan trained village education facilitators to lead participants through processes of community discussion, providing safe environments in which to share knowledge and for reflection. An evaluation in 10 villages where Tostan had worked found women were no longer afraid to voice their views in village meetings and were confident in their ability to effect social change. Men were found to be aware of women's right to health and safety and agreed to end violence against women.

CARE's experience with integrating rights-based approaches into community based health projects targeting the prevention of FGCM⁴⁴ raises some important issues also relevant to maternal health. First, the language of international human rights treaties is removed and often inaccessible to everyday people. The application of rights-based approaches in the community need to start from the rights and responsibilities defined by the community: where meaning and relevance exists. Second, CARE's research found that different social contexts were better suited to direct or more indirect dialogue over human rights, reinforcing the need to adapt and apply rights principles to each context.

32. The ICRW review of FGCM found that human rights concepts when presented in practical terms in local and accessible language can be a powerful tools upon which rural women and men can hang universal concepts of dignity, and use this to recast their relationships, rights and responsibilities with their communities.
33. There is sufficient evidence to suggest that family and community level decision-making related to obstetric care can be influenced through strategies and interventions that provide a bridge between global human rights and local contexts. However, there are no blueprints. Rights-based interventions at the community level need to respond to the local context. They need to work intelligently around the concepts and understanding of rights and responsibilities

⁴² UNICEF (2000) Equality, Development, Peace. Beijing +5 2000.

⁴³ See Julia Masterson and Julie Hanson Swanson. 2000. "Female Genital Cutting: Breaking The Silence, Enabling Change."

⁴⁴ Susan Igras et al. August 2002.

in the community. In some situations this may mean working on rights without talking explicitly about human rights as such; appropriate reference points would include culturally resonant equivalents of human rights values such as fairness and equity that correspond to locally held values that can be celebrated, invoked and upheld. Participatory and empowering capacity building processes appear central to enabling local stakeholders to redefine and negotiate new norms and practices. However, these need to be done in parallel with programmes that do help communities, and women in particular, to hold government and providers to account.

Section 2.2: Delay 2 – Delays in Accessing Care

➤ ***What value does a rights-based approach bring to identifying the excluded, and analysing and addressing the reasons for such inequities in coverage and access to maternal health services?***

34. Physical and financial barriers delay women's access to life-saving obstetric treatment, and are important factors in family decisions over whether or not and when to seek care.⁴⁵ Considerable international experience exists of various approaches to increasing the physical and financial accessibility of hospital care, for example national health insurance (Bolivia), community transportation schemes, savings schemes (Bangladesh), emergency funds (Nepal), and maternity benefits for poor women (India). Evidence suggests that many of these interventions have failed to increase access to services for the most vulnerable because social discrimination, prevailing gender and power relations, and lack of information and capacity to demand entitlement is too often absent for the marginalized, and, the opportunity cost of applying for the benefit is often greater than the allowance.⁴⁶
35. A recent assessment of the performance, management, utilisation and sustainability of community based emergency funds under the NSMP in Nepal highlights the risk that interventions end up replicating the power relations of the community and fail to reach the most vulnerable. Dev Neupane (2004) found:
- Management of community funds tends to be dominated by village men although the fund members are primarily women
 - Those who are too poor to save are excluded from joining fund schemes based on savings and credit principles
 - *Dalit* (low caste) and ethnic minority membership of fund schemes is low. In some areas, high caste people will not allow *dalits* to join schemes. No specific interventions have been designed to ensure marginalized social groups feel entitled to participate in community schemes, and to counter the discriminatory attitudes and behaviour of higher caste groups
 - Coverage and utilisation of emergency funds is low. Members often use the fund as a last resort if a loan cannot be raised through other sources
36. The example of community funds in Nepal, and evidence from community health schemes in Bangladesh such as DFID's Public-Private-Partnership⁴⁷ highlight the tension created by overlaying a community managed health scheme with

⁴⁵ Abouzahr, 1997. Jahn and De Brouwere, 2001, MacDonagh, 2002.

⁴⁶ Jayalakshmi, K. et al. October 2003. Draft report "State Responsiveness to Poverty: A Comparative Study of Development Interventions in the Indian States of Andhra Pradesh and Madhya Pradesh"

⁴⁷ See Deborah Thomas. 2003. "Citizen Voice And Participation In the Health Sector In Bangladesh". Options and Bangladesh Population and Health Consortium for DFID.

inclusive objectives on a poor, unequal and divided social environment with weak social solidarity. In such settings it is to be expected that the elite will try to capture resources, benefits and power, and socially marginalized groups will be squeezed out. The added value of a rights-based approach is that it anticipates the playing out of existing power dynamics and forces attention on the need to protect and promote the right of vulnerable groups. In Nepal this would possibly mean targeted strategies to empower *dalit* and ethnic groups to join and use community funds, creating accountability mechanisms to monitor who is and is not joining the schemes, assessing who is and is not using the funds, and greater transparency in the management of funds.

37. Evidence shows that financial mechanisms created to increase poor women's access to hospital level obstetric care are only partly achieving their objective. Experience shows that much more effort has to be made in raising poor and vulnerable women's sense of entitlement to benefits if they are to be empowered to access funds. In the case of the Nepalese community funds, it seems that much more attention needs to be given to broad, community-wide participation in design and management, dissemination of information and transparency, and functional accountability mechanisms to hold fund managers accountable for discriminating practices. Experiments with targeted maternity vouchers for poor women may provide a more equitable mechanism for overcoming financial access barriers and should be designed and monitored from an inclusion and non-discrimination perspective.⁴⁸
38. One particularly complicated area of accessing care facilities has been the setting up of and support for referral systems that include emergency transport. It is vital to have the means of transferring women from a basic EOC facility to a comprehensive EOC facility. In parts of some countries the referral facility takes days to get to. Some countries have invested in the provision of comprehensive EOC at secondary and tertiary level, but continue to have appalling coverage of basic EOC at primary care level.⁴⁹
39. Donors tend to be reluctant to fund the necessary infrastructure to allow for emergency transportation of women suffering complications during labour, due to concerns about potential abuse of vehicles or sustainability issues relating to long-term vehicle maintenance.⁵⁰ Alternatives to providing emergency transport at sub-district level have included maternity waiting homes near district hospitals or radio links to health centres. However these often prove too costly, and waiting homes have also not been popular with pregnant women as they take them away from their families for long periods of time.
40. From the literature and our experience the initial analysis undertaken when employing a rights-based approach can help to identify who the excluded are, and what particular obstacles they face when accessing maternal health services, particularly EmOC. A rights-based approach would also oblige governments and their funding partners, as well as communities, to address the problems of poor referral systems, and would ensure that maternal mortality reduction is included on the agenda of, for example, ministries responsible for road and bridge construction. This is especially important for those women living in very remote communities, or who are socially excluded from using even primary care facilities.

⁴⁸ Large-scale experiments are planned in Bangladesh.

⁴⁹ Freedman L et al (2005) *Who's Got the Power? Transforming Health Systems for Women and Children*, UN Millennium Project Task Force on Child Health and Maternal Health.

⁵⁰ Carlson (1993) Planning documents for the Uganda Family Health Project. Kampala: CARE Uganda

Finally, analysing access issues from a rights perspective has already led many to question the ethics of charging for pre-natal and obstetric care represents an insurmountable financial barrier to many women.

Section 2.3: Delay 3 – Delays in Receiving Care

- ***Where is the scope for integrating a rights-based approach to reducing maternal mortality at macro, meso and micro levels in the health sector?***
- ***What value does a rights-based approach bring to identifying who the excluded are and analysing and addressing the reasons for such inequities in health care coverage?***
- ***How can a rights-based approach be integrated into the internal processes of health policy making, in addition to instruments used to expose rights violations.***
- ***How can a rights-based approach in policy making engage with and influence the power dynamics underlying decision-making processes?***

41. When using a rights-based analysis of the delays women face accessing and receiving care, the relative strength of health systems play an important role. As stated above, no other public health problem's solutions are quite so intrinsically linked to how well health systems function.
42. The concept of accountability is relevant here. The state as the duty-bearer for fulfilling women's right to health and to health care is also, in most countries with high maternal mortality rates, the only feasible provider of services. Developing the concept of constructive accountability would involve creating dynamics within communities that encouraged the articulation of rights, and demand that they be respected, protected, and, to the extent possible, fulfilled, while, at the same time, encouraging health service providers to put in place mechanisms of accountability that demonstrate that input and feedback from the community forms a valued element in service planning and provision.
43. Cook ⁵¹ provides a framework for analysing health systems and clinical care in the context of human rights, and the systematic barriers faced by women when seeking health care. These include:
- a lack of implementation of laws and policies;
 - low priority given to sexual and reproductive health in national resource allocations;
 - a lack of skilled health personnel capable of delivering a competent service;
 - a lack of adequate health information systems.
- These four areas are explored below.

Implementation of laws fulfilling women's right to health

44. As the picture of women's status in Mali clearly reflects, maternal mortality is related to the powerlessness of women and the inequities they face. Social discrimination also works to obstruct other vulnerable groups (adolescents, unmarried women, the extremely poor, marginalized ethnic and low caste groups) from their right to safe motherhood. The deep societal, structural and cross-sectoral causes of maternal mortality and the need to solve maternal mortality by

⁵¹ Cook R. 2003 Human Rights Relating to Women's Reproductive Health: Implications for Health Sector Reform in World Bank (2003) Globalisation, Health Sector Reform, Gender and Reproductive Health. Washington DC: World Bank

providing appropriate, quality obstetric care to women in danger means that an enabling policy and legal framework must exist both within and outside the health sector. Within the health sector, policies must encourage and enable equitable availability of appropriate services for all women who need care. Outside the health sector, more energy needs to be put into reducing the underlying conditions that increase women's risk of maternal complications (e.g. poor nutrition, early marriage and early childbearing, FGCM, violence against women). The policy environment also must nurture women and families to make decisions that promote and protect women's access to and use of care (access to resources, information, education, political voice, means of accountability, transparency etc.).

45. Tripathi ⁵² acknowledges that there are two ways for states and individuals to violate international human rights covenants. In *de jure* violations, wrongful discrimination is written into the text of the law itself. In *de facto* violations, a law that is neutral functions (or is implemented) in a way that creates wrongful discrimination. In analysing southern African countries' adherence to human rights covenants with regards to HIV/AIDS services, Klugman and Nkosidintsi ⁵³ found that in most countries *de facto* violations were the norm. For example, in Botswana and South Africa, the right to health is enshrined in the constitution, but levels of service provision could be seen to violate the constitution because of poor access to HIV care and EmOC. In terms of *de jure* violations, some countries, notably Lesotho and Swaziland, have laws that consider women 'minors' before the law.
46. A prime example of the difference changes to women's health that legislation can make is seen in analysis of the impact of changes in abortion law in Romania. Restrictive laws in abortion were passed in Romania in 1966 and from this date there was an inexorable rise in maternal mortality ratios from around 80 maternal deaths per 100,000 live births in 1964 to a high of 180/100,000 in 1988. Repeal of these laws in 1989 saw a dramatic drop in maternal mortality to around 40/100,000 in 1992.⁵⁴ The same study tracked deaths due specifically to abortion, and found that this mapped perfectly with patterns in maternal mortality, demonstrating a direct causal relationship.
47. Legalising abortion is an important step to saving women from unsafe abortion. Ensuring that women and providers understand, respect and claim entitlements is another matter. In India where abortion is legal, 50% of maternal deaths in 15-19 year olds result from unsafe abortion, due to problems of accessibility and confidentiality. Having the legal framework alone is necessary, but not sufficient. Knowledge of the law and activism to promote women's rights are instrumental in bringing about positive change (Box 6).

⁵² Tripathi V (1998) Applying a Human Rights Framework to the Provision of Abortion Care and Related Reproductive Health Services in India. Carolina papers in International Health and Development.

⁵³ Klugman B and Nkosidintsi (2000) Health and Human Rights in Southern Africa? EQUINET Policy Series No. 5. and Women's Health Project. Johannesburg: University of Witwatersrand

⁵⁴ World Bank (1993) World Development Report: Investing In Health.

Box 6: Public and Provider Knowledge of Abortion Law in Ghana

Abortion in Ghana is legally permissible under three conditions. Hospital based research has shown that unsafe abortion accounts for 30% of maternal deaths, and adolescents are particularly at risk. Public knowledge of the circumstances under which abortion can be provided is low. The African Women Lawyers Association (Ghana Chapter) has found widespread misconceptions among providers as to the legal basis of abortion services. Lack of public and provider knowledge of the law keeps abortion services clandestine. This encourages unsafe practices, constrains the access of women and girls seeking abortion within the boundaries of the law, and promotes high user charges. The covert nature of abortion services also excludes them from Government quality assurance controls, including the promotion and provision of contraceptives to women and girls that have had an abortion.

48. In Peru the *Movimiento Amplio de Mujeres* (Comprehensive Women's Movement) was able to invoke human rights treaties to advocate for new standards for accountability in service provision.⁵⁵ Particular attention was given by the Women's Movement to problems of coercion, informed consent and quality of care in family planning services in the country.
49. The Uganda Association of Women Lawyers has been a strong advocate of the rights of women enshrined in both international covenants and Uganda's own laws. The Association has made considerable progress in bringing local and national attention to the ongoing, illegal, practice of FGC in certain districts in the country. Their tactics have included highlighting cases in the national press where young women have contacted them asking for help to escape from ritual ceremonies, and ensuring that at local community level women are aware that they have the right to refuse FGC rituals.⁵⁶

Prioritisation of right to maternal health in policy and national resource allocation

50. An historical review of 'what works' in reducing maternal mortality in resource poor environments finds that countries that have succeeded in lowering maternal mortality rates to below 100 deaths per 100,000 live births have a number of common features. These include strong political support from health ministries and central government, as well as long term planning often using a 20 to 50 year time frame. The relevant health systems also had efficient co-ordination between all levels of care, from non-professional attendance to high-level medical care. Accountability to local officials, as in decentralised systems, appears to have played an important role in China and Malaysia, and free referral to specialist and EOC were features in Brazil, Malaysia and Sri Lanka.⁵⁷
51. Campbell further suggests that high level political advocacy for safe motherhood is possible where there is longer term political stability, mentioning the support to such initiatives by President Museveni and the First Lady of Uganda, President Rawlings in Ghana and President Mocumbi in Mozambique, all of whom "nurtured the social and economic conditions for sustained progress".

⁵⁵ Cited in Panis 2001

⁵⁶ Uganda Women's Law Association

⁵⁷ Campbell O. (2001) What are maternal health policies in developing countries and who drives them? A review of the last century. HSO&P 17:412-447

52. Where governments have signed human rights treaties, such legal change forms part of their obligations, to which they can be held accountable by both human rights treaty bodies, and equally importantly, by civil society (Box 7).

Box 7: The Right to Health Campaign, Nima, Ghana

The Legal Resources Centre (LRC), Ghana, has taken a multi-faceted approach to claiming people's right to health⁵⁸. This includes community mobilisation, documenting evidence of the denial of poor people's exemption from user fees, and the use of public accountability mechanisms such as public hearings, parliamentary questions to the Minister for Health, litigation against targeted health facilities, and a complaint to the Inspection Panel of the World Bank which was supporting Ghana's health sector budget. One outcome of LRC's advocacy and lobbying has been the establishment of a joint community/LRC/Ministry of Health Committee to deliberate on how to effectively implement the exemption scheme.

53. The theme of government accountability and support is further developed by a case study of the success of Honduras in reducing maternal mortality (Box 8).

Box 8: Rapid Reduction of Maternal Mortality Rates in Honduras⁵⁹

In the 1990s Honduras enjoyed a rapid reduction in its maternal mortality ratio, from 182/100,000 in 1990 to 108/100,000 in 1997. This rate of reduction parallels rapid reductions seen previously in Sri Lanka and Malaysia. This receptive policy environment translated into effective action for reducing maternal mortality.⁶⁰ The main areas of improvement that the Honduran Government focused on, and which have been proven to reduce maternal mortality rates in the literature, were:

- Improvements in infrastructure and personnel levels, as well as strategies to increase the use and improve the quality of care;
- The main push for improvements was made in those areas that were shown to have the highest mortality rates in the survey;
- Communities were encouraged to become more involved, through general policies aiming to decentralise the health system, so that they now use local community resources to build and maintain birthing centres and maternity waiting homes.

A number of interwoven factors are behind this decline:

- a) The Honduran Government (in the 1980s and 1990s) was receptive to Safe Motherhood initiatives as it was an active member in the international organisations pushing Safe Motherhood, especially PAHO. Also numerous staff members of these international organisations based in Honduras were Honduran nationals who migrated between working for international organisations and for the Ministry of Health.
- b) The Honduran political environment was receptive to Safe Motherhood messages as it was relatively politically stable, had developed a solid health infrastructure and had prioritised maternal health since the late 1960s.
- c) The drive for necessary changes in service delivery was not donor driven but were the result of shared decision making through a Honduran working group on Safe Motherhood that included representatives of the Ministry of Health, bilateral donors and the UN.
- d) While national and regional conferences continued to keep Safe Motherhood issues in the public eye, a Reproductive Age Mortality Survey published in 1990 revealed maternal mortality ratios to be more than three times higher than had originally been thought, spurring the Government to action.

⁵⁸ Legal Resources Centre, Community Action Towards A Human Right to Health, January 2002, Ghana

⁵⁹ Shiffman J, Stanton C and Salazar AP (2004) The Emergence of Priority for Safe Motherhood in Honduras. New York: Campbell Public Affairs Institute

⁶⁰ Koblinsky M (2003) Reducing Maternal Mortality. Washington DC: World Bank

54. A human rights approach based on gender equality and women's empowerment has value in both guiding the focus of legal and policy assessments, and highlighting participation, accountability and obligation as processes for facilitating change. To enable the reduction of maternal mortality, laws and policies need to be strengthened to promote:

- Gender equity and women's empowerment, requiring specific attention to laws and policy that directly target or exclude women such as age of marriage⁶¹ inheritance laws, violence against women and FGCM, female education, anti-discrimination laws and reproductive health laws and policies⁶²
- Women's access to resources critical to reaching EmOC, such as credit; power and transport systems
- Women's participation in governance systems and structures to create voice and hold policy-makers and providers accountable

55. Human rights fact-finding approaches to identifying and publicising rights violations are valuable sources of information, but are weak in creating national partnerships and consensus to correct those violations. The tool that WHO is currently piloting may go some way towards strengthening laws, policies and regulation related to maternal and newborn health from a human rights perspective (see Annex 1).

56. National laws and policies are a vital part of reducing maternal mortality rates. A rights-based approach, featuring notions of constructive accountability and progressive realisation can help support governments to fulfill their obligations to their population. Evidence shows that this is relatively straightforward when working with governments already attuned to notions of accountability to their people. This is more problematic when working with governments that, for whatever reasons, are not willing to engage in this debate. DFID's work on service delivery in difficult environments and drivers for change indicate the need for sensitive external leadership and continued engagement with 'difficult' governments to help progress towards a more rights friendly environment.

Prioritising right to maternal health in aid instruments

57. A further key dynamic related to addressing maternal mortality effectively relates to aid instruments linked to macro-economic and fiscal frameworks, including support to health sector reforms, SWAps, and aid mechanisms such as direct budget support which impact on health systems. A rights-based approach can inform these macro-economic and fiscal frameworks and aid instruments and improve maternal health outcomes. It can also complement a macro-economic perspective by drawing attention to the ways in which greater equity and fulfilment of entitlements contributes to pro-poor growth and development. A rights-based approach can also be used to assess the impact of specific policy reforms on, for example, women's access to services that directly and indirectly affect maternal mortality.

⁶¹ Despite international agreements that 18 should be the minimum age of marriage, many countries either continue to hold laws permitting younger marriages or fail to enforce national legal ages of marriage. In Mali, the legal age of marriage is 15. In Bangladesh the median age of first marriage is 14.7.

⁶² Including access to family planning and abortion care.

58. Poverty Reduction Strategy Papers (PRSPs), Sector Wide Approaches (SWAs) and terms of Direct Budget Support may provide real opportunities for advocating for greater attention to maternal mortality, through the use of incentives and monitoring tools attached to these strategies⁶³. None of these instruments has to date used a rights-based approach *per se*, though PRSPs do contain some of the core notions, particularly participation and inclusion. We found only one case of evidence of invoking rights to change government policy, which was then made part of the PRSP. In Tanzania civil society organisations, supported by international NGOs, claimed entitlement to free, universal primary education and persuaded the Government to redraft strategy documents and budgets accordingly.⁶⁴
59. To date, however, PRSPs do not go beyond providing basic statistics on maternal mortality.⁶⁵ High level political commitment to reducing maternal mortality, along with incentives for ensuring that commitment is made real in practice, could shift priorities in resource allocation, as has been seen to some extent in Ghana, Uganda, Mozambique.⁶⁶ A rights-based approach to reducing maternal mortality could fundamentally shift this dynamic by making Poverty Reduction Strategies (PRS) and SWAs focus more overtly on government obligations to fulfil rights more than they have to date by insisting on adequate investment in obstetric care. The PRS process, which obliges civil society participation, could also provide opportunities for education of people about their entitlements.
60. As indicated above, rights-based approaches could shift the decision taking process on health investment through SWAs. Health sector reforms can have a huge impact on maternal health service delivery (e.g. decentralisation, user fees) and linking reducing maternal mortality to SWAs at an early stage can mean that any proposals can be evaluated for the impact they would have on maternal health service delivery.⁶⁷ Invoking obligation at this stage could influence decisions towards policies and strategies that would reduce maternal mortality.
61. Furthermore, tracking of how health finances are disbursed through public expenditure reviews and beneficiary incidence analysis could provide a “maternal health investment” monitoring mechanism for government and donors. Unfortunately there do not appear to be researched, practical examples of where this has been attempted specific to maternal health, though one effort by the Mexican NGO Fundar has been cited where this monitoring has been tried.⁶⁸ Broader experience of monitoring funds could provide useful lessons (Box 9).

⁶³ For example, Benefit-Incidence Analysis associated with PRSPs monitors both tax and spending incidence with disaggregated data to measure how public revenue and expenditure impacts on the poor.

⁶⁴ Alonso i Terme, R. (2003) Tanzania Primary Education Case Study. Presented at Mozambique PRSP training, May 2003

⁶⁵ Dodd and Hinshelwood (unpublished) Poverty Reduction Strategy Papers – their significance for health. Preliminary Report. Geneva: WHO

⁶⁶ _AbouZahr C (2001) Cautious Champions: International agency efforts to get safe motherhood onto the agenda. *Studies in Health Services Organisation and Policy* 17:384-41

⁶⁷ _Goodburn E and Campbell O (2001) What can a health system delivery do if it can't deliver a baby?

BMJ

⁶⁸ Freedman L. (2004) personal communication

Box 9: The SEND HIPC Watch Project in Northern Ghana

The Social Enterprise Development (SEND) Foundation of West Africa has established a participatory scheme for community monitoring of the use of HIPC relief funding and the evaluation of its impact. SEND has created District HIPC Monitoring Committees (DHMC) drawn from focal community based organizations (CBO) and non-governmental organizations (NGO) in the district. Based on three indicators of good governance, accountability and equity, DHMCs gather and analyse information on the disbursement of HIPC funds and the execution of HIPC funded projects. The information gathered from monitoring is shared and discussed with key officials of the District Assembly. The information gathered and shared has enabled communities to hold project implementers accountable whilst ensuring their efficient execution.

Health provider rights – improving skills, attitudes and service quality

62. South Asian experience, amongst many others, demonstrates that nurse-midwives and lab technicians are the mainstay of clinical maternity services.⁶⁹ Improving the skills through training in agreed standard protocols and providing continuous updating through continuous professional development are key features of ensuring the technical quality of staff.
63. In the last decade professional organisations such as the International Federation of Gynaecologists and Obstetricians (FIGO), have set up partnership arrangements between members in developed countries with those in developing countries. Professional associations are important partners for promoting rights-based approaches (Box 10).

Box 10: FIGO's Partnership Work on Rights-Based Approaches

A project run by the Canadian Society of Obstetricians and Gynaecologists set up partnership projects with peer associations in Guatemala, Haiti and Uganda. The unique feature of this particular project was its focus on women's empowerment and reproductive rights. Activities included educating peer association members and other health professionals on the importance of taking a rights-based approach to women's health, as well as working in partnership with women's interest groups that share a common interest. The project was evaluated in 2002 and found that all partners, including the Canadian Society members, felt that they had improved their capacity to integrate rights-based approaches into their work.⁷⁰

64. In many countries with high mortality rates the percentage of women being attended by a specially trained health worker falls woefully short of the 60% target set by WHO.⁷¹ Many experts agree that greater attention needs to be given to the training of health care providers who have specific knowledge and skills in pregnancy and delivery care. While some argue that the evidence base for the impact of skilled birth attendants on reducing maternal mortality remains

⁶⁹ Ramachandran V (2003) Incorporating Women's Health Concerns in Health Sector Reforms: Key areas for strategic advocacy and citizen participation. In: Ford Foundation Globalisation, Health Sector Reform, Gender and Reproductive Health.

⁷⁰ Lalonde and Perron (2003) Integrating Women Empowerment and Reproductive Rights in the Work of Health Professionals: The experience of Ob/Gyn Associations. Paper at the FIGO 2003 conference.

⁷¹ Cook, Dickens, Wilson and Scarrow (2001) Advancing Safe Motherhood through Human Rights. Geneva: WHO

contentious⁷² some of this contention is based upon no agreed definition of skill birth attendants and partly because unequivocal evidence does not exist.⁷³ Koblinsky⁷⁴ makes a cogent argument for the value of having skilled attendants at birth based on ecological evidence that points to the positive impact of having skilled birth attendants attending any birth. However, a trained health worker alone cannot solve the problem as he/she must be equipped with the material and equipment to provide essential care.⁷⁵

65. In some contexts there are legal/structural barriers to certain skilled health personnel performing medical procedures (such as applying anaesthetic for caesarean section) or requirement of excessive qualifications for providers to give maternity care.⁷⁶ Ongoing work by FIGO with national professional organisations has sought to improve standards of service delivery and also review what level of skilled attendant is necessary within given resource constraints of several developing countries. Increasingly members of FIGO are advocating for midwives and other non-medical health care staff to have an increased role in delivery care.⁷⁷
66. Recent work in India has revealed that access to EMOC is seriously compromised in parts of rural India because of policies that restrict basic doctors from performing obstetric surgical procedures including caesarean section even in remote areas where there is no specialist obstetrician available, prevent para-medical staff such as auxiliary nurse midwives from managing obstetric emergencies in rural areas, and prohibit basic doctors from giving anaesthesia.⁷⁸ Reasons for these policy barriers include protectionism on the part of medical practitioners currently performing these tasks, and, ironically, a tendency to practice medicine conservatively due to the recently passed consumer protection act, which makes it easier to sue doctors. Open recognition of the operation of vested interests is often a critical part of rights-based work.
67. A familiar refrain about why women delay coming to health centres or hospitals, and why there may be delays in their care, revolve around health worker attitudes to, and treatment of, women and childbirth. Obvious physical abuse of women give clear and direct examples of human rights violations by service providers.⁷⁹
⁸⁰ International calls for cracking down on such overt violence is now more widespread, and such practice needs to be tackled both in the basic training of health workers as well as through good management of staff in health facilities.

⁷² Abouzahr C (2001) Cautious Champions: International agency efforts to get safe motherhood onto the agenda. *Studies in Health Services Organisation and Policy* 17:384-411

⁷³ Abouzahr and Wardlaw 2001 *Maternal Mortality at the end of a decade: signs of progress?*

⁷⁴ Koblinsky M (2001) *Reducing Maternal Mortality: Learning from Bolivia, China, Egypt, Honduras, Indonesia, Jamaica and Zimbabwe*. Washington: World Bank

⁷⁵ Panos Institute (2001) *Birth Rights*. London: The Panos Institute

⁷⁶ Freedman L (2001) Shifting Visions: "Delegation", Policies and the Building of a "Rights-based" Approach to Maternal Mortality. *JAMWA* 57(3): 154-158

⁷⁷ Lilijestrang J. (2003) Why midwives and not only doctors? Paper at the FIGO 2003 International Conference, Chile.

⁷⁸ Dileep V Mavalankar. Policy Barriers Preventing Access to Emergency Obstetric Care In Rural India. Public Systems Group Indian Institute of Management, Ahmedabad

⁷⁹ CLADEM and CRLP (1999) *Silence and Complicity: Violence against women in Peruvian Public Health Facilities* describes abuse meted out by staff to women giving birth in Peruvian hospitals, while Grossman-Kendall, Filippi, De Koninck and Kanhonou (2001) relate women's experience of birth from qualitative research they carried out in West Africa in "Giving Birth in Maternity Hospitals in Benin: Testimonies of Women" *Reproductive Health Matters* 9(17).

⁸⁰ D'Oliveira AFP, Diniz SG and Schraiber LB (2002) Violence against women in health care institutions: an emerging problem. *Lancet* 359: 1681-1685 reviews research findings from across the world about the level of violent abuse endured by women at the hands of health providers.

68. Beyond this, there are specific elements within the delivery of maternity services that can be addressed without substantial additional resources, including health staff re-training. One highly innovative programme carried out in South Africa sought to transform how health workers saw their own role and how they treated their patients, and women in particular (Box 11).⁸¹

Box 11: Health Workers for Change Training in South Africa

Health Workers for Change training was developed in direct response to women's complaints about how they were treated by health staff in clinics. The training is comprised of six workshops each of which explore the interpersonal component of quality of care. The workshops help participants to reflect on the various factors that hinder the delivery of quality care, and to formulate solutions to existing obstacles. The themes of the workshops were:

- Why Am I a Health Worker?
- How Do Our Clients See Us?
- Women's Status in Society?
- Unmet Needs?
- Overcoming Obstacles at Work?
- Solutions?

This process builds health workers' understanding of the impact of gender relations on health and health seeking behaviour. In exploring these issues both personal and institutional barriers to quality of care are identified. The workshops involve analysis and critique of current practice and the development of action plans that primary care workers and managers can use to improve health systems. Further research indicates that Health Workers For Change approach identifies problems in health systems and methods of addressing these problems. The model is designed to improve provider/client relations, promote problem solving by health workers, and promote gender mainstreaming.⁸²

69. To ensure training is effective, health staff also need proper infrastructure to support their work. The setting of obstetric care needs to encourage an atmosphere of dignity, privacy and confidentiality. Poor facilities, both in terms of infrastructure and materials, is a leading reason behind the frustration and distress that lead trained staff to leaving particular health service institutions.⁸³

Client participation and rights – improving service quality and responsiveness

70. At the community level, a rights-based approach to improving service quality needs to encourage community participation in monitoring and managing quality. "Most advocates agree that meaningful partnerships through a representative committee at the operational level not only enhances the quality of service delivery but also involves women at the design and planning stage to resolve issues of privacy and essential facilities such as a bathroom."⁸⁴

⁸¹ Fonn S (1999) The Transformation of Reproductive Health Services: Addressing Gender Equality in Health Programming. <http://www.reprohealth.org/reprohealthDB/doc/m1s5fonngenn.pdf>

⁸² *ibid*, pg 4.

⁸³ Jewkes, R., N. Abrahams and Z Mvo. Why Do Nurses Abuse Patients? Reflections From South African Obstetric Services. *Social Sciences and Medicine*, 1998, 47(11): p1781-1795.

⁸⁴ Ramachandran (ref 51) pg.74.

71. Supply side initiatives such as client rights charters and health workers' codes of ethics can give power to clients and define entitlements to quality care, alongside initiatives to satisfy the rights of the provider to deliver quality care. However, unless they are widely communicated and supported by mechanisms for clients to seek fair redress, they risk being empty gestures (see Box 12).

Box 12: The Patient's Charter and Code of Ethics in Ghana

The Patient's Charter and Code of Ethics for health workers were developed in 2002 in response to increasing patient complaints of the quality of health care to the Commission on Human Rights and Administrative Justice and through court cases, and an attempt to promote the image of the Ghana Health Service (GHS). Public and provider dissemination was limited to a short one-off mass media campaign. No new institutional mechanism was established to enforce or apply either the Patient's Charter or the Code of Ethics. In practice, the accountability mechanisms are poorly known by the public and providers. GHS recognizes the weaknesses of this approach and the lack of enforceability of the Patients' Charter. Unable to satisfy rights for the provider in a resource deficient health system, the CHS is not pushing the rights of the patient.

The right to count – strengthening health information systems

72. From a rights perspective, the importance of information is two-fold:
- Women who die in pregnancy and childbirth have the right to be counted
 - Information is a powerful tool in advocacy and influencing, in generating voice and demanding accountability. For example, UNICEF in Uganda used UN process indicator on EmOC to inform and influence the health sector review and SWAp. DFID may have a role in resourcing information systems that generate data relevant for monitoring maternal mortality.
73. Various experts have commented that there are fundamental problems with understanding the breadth and depth of maternal mortality in countries because of poor data gathering and interpretation.⁸⁵ ⁸⁶One primary reason for this is that maternal death is - in itself - a relatively rare event. The paucity of information relating to maternal death also poses real problems for measuring progress towards health information systems. Maternity related deaths fail to be counted for numerous reasons, including death due to illegal, unsafe abortion or complications in childbirth for an unmarried woman. Along the same lines, there are issues about whose death is counted. In general, data on maternal morbidity and mortality is not disaggregated to show differences in risk and death by social class or ethnicity. As a result "reasonable" rates of maternal and child mortality aggregated at a national level can mask underlying large scale differences within a country (as is seen in the USA between white, black and Hispanic groups).⁸⁷
74. Information systems are also key to monitoring equity and efficiency. In resource-limited settings, there will always be compromises to be made by policy makers and implementers. The natural tendency of those expected to implement targets is to find the path of least resistance, leading to distortions of effort and data

⁸⁵ Graham W. and Hussain J. The right to count. The Lancet 363(9402): 67-6

⁸⁶ Yamin A and Maine D (1999) Maternal Mortality as a Human Rights Issue: Measuring Compliance with International Treaty Obligations. Human Rights Quarterly 21: 563 - 607

⁸⁷ Sen A. (2001) Economic Progress and Health. In Leon D and Walt G (2001) Poverty, Inequality and Health. Oxford: Oxford University Press.

within health systems.⁸⁸ In the case of *Millennium Development Goal* targets, there is a danger that, in order to meet these aggregate targets, governments will focus on the more accessible majority, to the detriment of the harder to reach, and more costly to serve, minority.⁸⁹ A rights-based approach to reducing maternal mortality must focus on equitable access to services across all sectors of society and will need monitoring mechanisms that allow data to be disaggregated in order to monitor who accesses and who does not access services.

2.4 Summary of Evidence

75. Large amounts of resources (time, money and human) have been invested in tackling the three delays, primarily through the Safe Motherhood Initiative and associated programmes. However, this hasn't been translated into reductions in maternal mortality. While the evidence base for why this is remains slim, our literature review and case studies begin to point to a number of ways that rights-based approaches could help reduce maternal mortality rates.

- Good efforts have been made towards the participation and inclusion of women, and communities, in programmes targeting maternal mortality. Yet research, such as the 'citizen's voices' study, indicate that community voice can only achieve limited success on its own. Re-orienting work on participation with more emphasis on entitlement moves on the discussion from what is needed towards what women must have by right;
- Claims for entitlement are best heard when a critical mass of voice is achieved. Alliances between professional groups, civil society organisations and community groups have achieved some success in changing policy to be more inclusive and responsive to community priorities;
- Access to EOC, and its sub-set EmOC, needs to be seen as every woman's right. There are good examples of projects and programmes that have targeted improvements in EmOC that have helped local women. Rights-based approaches have been useful in bringing communities, government officials and providers together to explore what services need to be in place to assure a woman's right to health. This has also helped to achieve local political 'buy-in' to support on-going improvements in service delivery and holding service providers to account.
- Evidence indicates, however, that supporting such services in an isolated way will not make much of an impact on maternal mortality rates as a whole. More systemic change is needed, with greater emphasis on ensuring that the whole health system works more effectively. Change will only occur by tackling health policy at a national level to influence resource allocation for improving health service delivery in general, and EmOC in particular.

76. In Annex 6, we include a 'what if' scenario to bring home what difference a rights-based approach could make to maternal health outcomes, if applied holistically,

⁸⁸ Deming WE (1994) *The New Economics: For Industry, Government and Education*. 2nd Edition. Cambridge, MA: MIT Press. Quality improvement programmes in both private and public services have increasingly bought into Deming's thesis that targets don't increase quality in systems and that much more subtle and sophisticated systems thinking is needed to effect quality improvement.

⁸⁹ Freedman L et al (2005) *Who's Got the Power? Transforming Health Systems for Women and Children*, UN Millennium Project Task Force on Child Health and Maternal Health.

focusing on duty-bearers as well as rights-holders. This scenario uses a programme funded by DFID in the 1990s and implemented through CARE.

2.5 Implications for DFID

77. In reality, strategies that work at all three levels, family/community, health service and national policy, are needed. For DFID offices, in partnership with governments, civil society and other development partners, the challenge now is to direct effort and funding towards not only what works programmatically, but also to building the critical mass of influence that will bring about much needed political and social change. Only through a combined approach will we turn the tide on maternal mortality rates.
78. As indicated in Annexes 1 and 3, all UN agencies are adopting a rights-based approach to their work, in both advocacy and service delivery programmes. Considerable work has already been done to facilitate civil society initiatives to hold governments accountable to commitments under human rights covenants and conventions, including, for example, the preparation of shadow reports to UN treaty monitoring bodies. DFID may have a role to play in supporting such initiatives, since work in this area usually involves educating people about their rights in ways that are meaningful within the national setting and culture, relating relevant concepts such as entitlement and accountability to values that are resonant within the local culture.
79. DFID can place a value on its policy co-ordination work with other donors, including the World Bank, to ensure that the core human rights value it espouses – fulfilling obligation, inclusion and participation – also underpin their resource allocation and other programme decision-making processes, particularly because most donor agencies maintain that they are supportive of human rights-based approaches to development.
80. At national level, DFID can play an important role monitoring national policy to ensure that core human rights principles, including progressive realisation of rights, ensure that funding is allocated to interventions that are known to be more effective in saving lives. In terms of PRSPs, MDGs and other national-level development policy mechanisms, DFID may have a role in ensuring that broad policy objectives are rights-based. With regard to maternal mortality reduction, DFID could seek to ensure that access to EmOC is prioritized over other initiatives. As Lynn Freedman has pointed out, “all people have the right to adequate nutrition, and anaemia is certainly an important women’s health issue. But a major haemorrhage, untreated, will kill any woman, anaemic or not”⁸⁵.
81. Similarly, DFID could encourage health systems to adopt and adapt human rights obligations of government to respect, protect and fulfil rights, to their own obligations as health system providers, and, for example, put in place mechanisms that enhance the accountability of health service providers.
82. At community level, DFID could encourage rights-based initiatives which include contextualized rights education that encourages and supports women and men to claim their rights, demand high quality services, participate actively in identifying solutions related to maternal health problems experienced in their communities and demand accountability from local and national public and private authorities responsible for the provision of health care services.

SECTION 3: CONCLUSIONS

83. Achieving reductions in maternal mortality is technically feasible and financially within the reach of many countries in the world. The obstacles to making in-roads into maternal mortality rates are primarily related to political and socio-cultural factors, which are often inter-linked, and not only to economic and technical resource factors. Usually, maternal health programmes only focus on increasing economic and technical resources, ignoring the wider political and social context. As maternal mortality rates continue to stagnate or even get worse, such programme strategies must now be considered inadequate.
84. The evidence base for what works, or can work for tackling the socio-cultural and cross-sectoral factors through a rights-based approach is patchy. Most initiatives are small scale and attempt to tackle primarily women's entitlement to maternity care at a local level. In many cases there is no clear indication of efforts to address more systemic causes of rights violations amongst duty-bearers, hence making it difficult to differentiate between these 'rights' programmes and what has been established good development practice for the last 20 years. Programmes that focus on entitlement and empowering rights-holders inevitably hit the ceiling described in Thomas et al's study of citizen voice in Bangladesh, where the voice of rights-holders become 'trapped' at too low a level to have much significant influence.
85. Rights-based approaches to improving health systems and services have focused on women's access to and use of quality EmOC. Strategies have ranged from ensuring that such services exist; that they are financially and physically accessible to focusing on health providers and ensuring they are accountable to women who seek their care. The concepts of obligation and accountability provides entry points to both influence how decisions are taken about what services to finance (so that resources are prioritised for EMOC and not for TBA training, as an example) and to support providers, through training and equipping, so that they are able to provide a service that women want to use.
86. The evidence shows that rights-based approaches to legal and policy domains are vital. Countries that have been able to achieve dramatic reductions in maternal mortality rates have done so through a combination of long-term and high-level political commitment to fulfil state obligations to making such reductions happen and investment in essential obstetric care part of provision of the full range of maternal health services. In some places these efforts have been complimented by demand side work that helped women understand their entitlement to quality maternity care. The number of countries where these factors feature are very limited. A rights-based framework provides an entry point to leveraging both political will.
87. Risks and cautions associated with a rights-based approach to maternal mortality include issues related to the political acceptability of RBA language and concepts, the need to contextualize rights to the local culture and community, the need to identify stakeholder positions, to recognise that vested interests may be threatened by an explicit commitment to transforming power relations, to recognise the need for multi-sectoral analyses and responses, and to acknowledge the challenges that may be presented by the importance of prioritizing interventions and allocating (and reallocating) resources according to the impact that the proposed actions could potentially make to reducing maternal mortality.

88. Experience from work done in reproductive health and women's health more generally indicates that it is vital to build alliances with national groups, supporting them to make the drive for change. Not only will they be better able to understand, and therefore navigate, the political environment, but they are likely to have greater credibility with decision-makers. Where there is political support from the executive, the work is easier. Where there is little or no support from the top, then working with 'levers of change' within the country, including professional organisations (both health and legal) as well as community-based organisations and NGOs can help build momentum for change.
89. The next steps for DFID are to build on lessons learned so far by using the guidance note on *How to reduce maternal deaths: rights and responsibilities* to:
- meet its commitments to reducing maternal deaths;
 - support the creation of a normative environment for rights-based approaches;
 - promote the analysis that builds rights thinking into problem solving;
 - identify ways to put rights-based approaches into practice in its support to policy and programmes targeting the reduction of maternal mortality; and
 - document lessons learned to fill gaps in the current evidence base.

ANNEX 1: A SELECTED REVIEW OF CURRENT DEVELOPMENTS IN RIGHTS-BASED APPROACHES TO DEVELOPMENT, REPRODUCTIVE AND MATERNAL HEALTH AND AIDS

1. DFID

A recent review of DFID's work on integrating human rights into DFID funded policy and programmes found a large body of interesting and innovative work on human rights.⁹⁰ DFID has engaged with numerous international organisations in taking a rights-based approach while also supporting a range of research and policy development activities. At a country level, DFID staff have: used human rights analysis to inform strategy and set overall objectives; integrated human rights into programmes (such as pro-poor governance); and integrated human rights into strategic aspects of programme delivery (such as informing the use of budget support in Uganda).

DFID staff have piloted Participatory Rights Assessment Methodologies (PRAMs)⁹¹ in four country programmes (Malawi, Peru, Romania and Zambia)- PRAMs aims to facilitate:

- People's own identification and assessment of their rights;
- Understanding and agreement between stakeholders of the obstacles poor people face in accessing those rights;
- Identification of actions to support governments and other duty-bearers in the protection, promotion and realisation of human rights;
- Institutional change and the opening up of new channels of institutional engagement between citizens and duty bearers those who make and implement policy at national and local levels.

In Malawi PRAMs operationalised these aims by bringing together local communities, education and district officials to carry out Participatory Rights Assessment (PRAss) on education issues. This allowed officials to hear directly the concerns of local and marginalized communities. Using the tools offered by PRAss communities and officials are now working together on school improvement plans that have rights-based approaches embedded within them.

As in DFID's approach to other aspects of its work, the rights-based approach to maternal mortality needs to have an analysis of the structural features, institutions and individuals/organisations that make up the dynamics leading to the compromise of progress in reducing mortality rates. DFID has also used its Institutional Strategy Paper with UNICEF to develop closer relationships between country offices of DFID and UNICEF and have looked at undertaking an evaluation of working with human rights-based approaches at country level.

DFID is not alone in pursuing rights-based approaches to addressing maternal health. Rights-based approaches have clearly gained currency in the last decade, as more and more organisations have integrated rights language into their central policy and thinking. Once the domain of human rights organisations and a few NGOs, rights language is now used more and more by bilateral and multi-lateral organisations.

⁹⁰ Piron LH (2004) DFID Human Rights Review. London: DFID.

⁹¹ See PRAMS resources on <http://www.swan.ac.uk/cds/research/PRAMS.htm>

2. World Health Organisation/Harvard University

In collaboration with the International Health and Human Rights Program of the Francois-Xavier Bagnoud Centre for Health and Human Rights at Harvard University's School of Public Health, the World Health Organization has developed a Tool designed to strengthen legislation, policies and standards of care. The purpose of the Tool is to help countries to use a human rights framework to identify and address legal, policy and regulatory barriers to women's access to, and use of, maternal and newborn health care services, and to the provision of quality services. The tool helps national and regional organisations to:

- Review and address legal, policy and regulatory barriers to maternal and newborn health
- Engage health sector and non-health sector stakeholders to help eliminate barriers to maternal and newborn health

and

- Monitor, review and document government efforts to respect, protect and fulfil rights and progress toward achieving international development goals and targets – including the *Millennium Development Goals* and targets - relating to maternal and newborn health⁹²

The Tool consists of both a process and an instrument. Following human rights principles, the process is participatory in nature, and must involve many different stakeholders. The instrument links governments' commitments to international human rights treaties, conventions and consensus document targets to existing national and, if appropriate, provincial legislation and policies, and to selected service delivery and health outcome indicators associated with maternal and newborn health.

The Tool specifically assesses human rights relating to: life, survival and security; health and maternity; information and education; and non-discrimination. Successful use of the Tool – its participatory process and instrument – will help governments to:

- Demonstrate leadership and commitment to improving maternal and newborn health
- Realise their national human rights obligations related to maternal and newborn health
- Involve other health sector and non-health sector actors for the improvement of maternal and newborn health

and

- Reduce legal, policy and regulatory barriers in the short to medium term for improving access, utilization and quality of maternal and newborn health, especially for the poor and most vulnerable

The 'results' of the Tool will ultimately be measured by the degree to which newly prioritized actions to reduce barriers are implemented. Implementation, like use of the Tool, requires sustained commitment, interest and political will. The Tool is a facilitated methodology to assist governments. Action for change ultimately rests with the government itself, with support to the extent possible from United Nations agencies such as WHO, and from bilateral or multilateral donors.

⁹² Personal communication to consultation team from Mindy Roseman, FXB Centre For Health And Human Rights.

3. Columbia University

The AMDD Program (Averting Maternal Death and Disability: Improving Life-Saving Obstetric Services In Developing Countries) was established in 1999. The Program brings together developing country ministries of health, NGOs, and United Nations Agencies with the express intention of improving quality, availability and utilization of EmOC. The AMDD Program combines a focus on making emergency obstetric care available with a human rights perspective that argues for a woman's right to appropriate and quality care. This human rights perspective challenges all governments and healthcare providers to guarantee women access to timely and quality treatment, information, privacy, and respect. It also promotes respect for the rights of healthcare providers regardless of gender, level of training, and ethnicity⁹³.

AMDD seeks to give concrete expression to human rights principles by advocating that countries use United Nations process indicators (see Table 1 below) when they report on progress in implementing international conventions, and by incorporating principles such as dignity, accountability and participation into field activities.^{94 95} One of the most important lessons from AMDD is the way in which rights-based approaches to maternal mortality can connect with the other kinds of existing rights-based work being carried out in country, such as women's groups in communities working on political participation.

Table 1: United Nations Process Indicators Used in AMDD Rights-Based Programmes

Indicator	Acceptable Level
1. Amount of essential obstetric care: <ul style="list-style-type: none"> • Basic essential obstetric care (EOC) Facilities • Comprehensive EOC Facilities 	For every 500,000 population, there should be: <ul style="list-style-type: none"> • At least four basic EOC facilities • At least one comprehensive EOC facility
2. Geographic distribution of facilities	The minimum level in Indicator 1 for the amount of EOC should be met in sub-national areas (e.g. facilities must be well distributed at the provincial or district level to be within reach of women in emergency situations.
3. Proportion of all births in basic EOC and comprehensive EOC facilities	At least 15% of all births in the population should take place in either basic or comprehensive EOC facilities
4. Met need	All women (100% estimated to have obstetric complications are treated.
5. Caesarean sections as a percentage of all births	Caesarean sections should account for not less than 5% nor more than 15% of all births in the population
6. Case fatality rate	The case fatality rate among women with obstetric complications is less than 1% at the facility.

4. UNICEF

UNICEF has made a rights-based approach to its work with women and children central to its policy and programming. In outlining the various ways that UNICEF can

⁹³ Caro D, et al. (2004) Evaluation of the Averting Death and Disability Program. Cultural Practice.

⁹⁴ AMDD/UNFPA (2003) Making Safe Motherhood A Reality In West Africa, New York: UNFPA

⁹⁵ <http://cpmcnet.columbia.edu/dept/sph/popfam/amdd/about.html>

begin to operationalise human rights within its programmes, a framework of four key 'how tos' have been developed:

- The process of developing comprehensive Human Rights National Plans of Action should pursue a holistic approach, promote cross-sectoral interventions, foster active involvement of civil society and set benchmarks to be achieved in a given time period
- Human centred policies should be adopted, and systematically assessed for their impact on the enjoyment of human rights
- Effective national monitoring systems should be developed, based on the collection of accurate and reliable data This data should include indicators to reflect trends, assessment of disparities and identify levels of vulnerability, and should be widely disseminated to inform policy making, to foster social change and to promote popular participation and public scrutiny
- Serious consideration should be taken over reporting systems to human rights treaty bodies, both to portray a realistic picture of the national reality and to ensure a serious follow up to the concluding observations and recommendations by each committee concerned – including through technical assistance programmes ⁹⁶

UNICEF South Asia office has developed a five-step procedure for rights-based programming in maternal health, as initial guidance to its own office⁹⁷. These steps are:

Step 1: Develop a vision, mission and goal – a call to action – put women's right to life and development, and their autonomy and participation to the fore

Step 2: Create a values framework to help develop thinking and motivation for a rights-based approach

Step 3: Develop strategies for change to articulate what needs to be done, capturing UNICEF's three key project components of rights, management and technology

Step 4: Use a 'systems' approach to service delivery to look at how to link with traditional government systems to strengthen services and open possibilities to operationalise strategies at scale

Step 5: Measure progress and change with the six standard indicators that measure the availability and use of EmOC (see Para 20 above)

The Peruvian case study in Box 1 (Section 1) of this Review provides one example of how UNICEF has applied rights-based approaches, working with partners. Other areas of work for UNICEF have included promoting girls' rights to education and the strengthening of child protection within child labour legislation. UNICEF has also developed a number of training initiatives for staff and others. One initiative of note is training in child rights-based approaches in emergencies. With the steps outlined above, UNICEF promotes the use of child rights as a framework for situation analysis and conflict analysis, understanding children's rights and human rights within a humanitarian context and building strategies around the concept of "children as a zone of peace."⁹⁷

⁹⁶ Pais M (1999) A Human Rights Conceptual Framework For UNICEF. Florence, Italy: UNICEF.

⁹⁷ UNICEF (accessed 2004) Introduction to a rights-based approach to complex emergencies. http://www.Coe-dmha.org/UNICEF/HPT_IntroReading02 .

5. UNFPA

UNFPA programme and policy language is steeped in rights and rights-based approaches. While calling for greater recognition and adherence to reproductive rights as outlined in the International Conference on Population and Development Programme of Action (1994)⁹⁸, UNFPA also promotes a call to action to redress imbalances in power between men and women. At government levels, UNFPA states that women's empowerment implies the extension of all full social, economic and political rights to women. At an individual level, empowerment implies women gaining the power to express and defend their rights and gain greater self-esteem and control over their own lives and social relationships.⁹⁹

In its *State of the World's Population 2004* Report UNFPA notes that:

During the past decade, NGOs in many countries have become increasingly involved in monitoring reproductive rights and using the reporting procedures for international human rights instruments that their governments have ratified. Many submit "shadow reports" to complement those submitted by the government and attend sessions of the relevant monitoring committee when the report of their country is being examined. In some countries such as India, Indonesia, Malaysia and Nigeria, human rights commissions can play an important role in ensuring that reproductive rights are observed and can provide redress in cases of violations. Other countries have ombudsmen or other mechanisms that civil society groups can use.

An example of UNFPA's approach to rights-based programming is found in its Stronger Voices For Reproductive Health Programme. At an international level the Programme's aims include increasing the understanding of the role of informed demand in efforts to improve the quality of reproductive and sexual health care provided in state and non-state facilities. The Stronger Voices Programme in Nepal aims to:

- Facilitate participatory approaches in the provision of reproductive health
- Enhance the ability of service providers to provide appropriate, sensitive reproductive health care for women

and

- Better integrate reproductive health concerns and improve the quality of care delivered through community involvement in a range of activities

6. Lessons learned from rights-based approaches to AIDS

Some of the world's most effective use of rights-based campaigning and programming has been seen in the field of HIV/AIDS¹⁰⁰ Rights-based approaches to the AIDS epidemic have yielded results by:

⁹⁸ The Programme of Action defines reproductive rights as: "Reproductive rights embrace certain human rights that are already recognised in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. In the exercise of this right, they should take into account the needs of their living and future children and their responsibilities towards the community. The promotion of the responsible exercise of these rights for all people should be the fundamental basis for government- and community-supported policies and programmes in the area of reproductive health, including family planning."

⁹⁹ UNFPA (2004) Protecting Reproductive Rights. <http://www.unfpa.org/rh/rights.htm>

¹⁰⁰ UNAIDS. 2004 Report On The Global AIDS Epidemic. Geneva: UNAIDS, 2004.

Enhancing public health outcomes and protecting a person's right—particularly a person living with HIV—to achieve the highest attainable standard of physical and mental health has brought about increased confidence in health systems. In turn, this has led more people to seek and receive relevant information on HIV prevention, counselling and care.

Ensuring a participatory process linking patients and care providers, which has improved the relevance and acceptability of public health strategies.

Fostering non-discriminatory programmes that include marginalized groups more vulnerable to HIV infection. For example, the Stopping HIV/AIDS through Knowledge and Training Initiatives project in Bangladesh, and the Sonagachi project in Kolkata, India, have integrated the rights of people in sex work by ensuring that sex workers are part of planning, implementing and assessing all relevant AIDS programmes.

Scaling up the AIDS response through empowering people to claim their rights to gain access to HIV prevention and care services. Several countries in Latin American, including Brazil, Costa Rica, El Salvador, Mexico, and Panama have entrenched this by providing free access to treatment and other related health services for many people living with HIV.

Enhancing the accountability of States through people seeking redress for the negative consequences of health policies. Legal action based on human rights has been a vehicle to enforce people's right to gain access to health care, including antiretroviral treatment. For example, in South Africa, the Treatment Action Campaign (TAC) won a court ruling that required the Government to supply the antiretroviral drug nevirapine to HIV-positive pregnant women at public health facilities, within a phased roll-out of a comprehensive national programme to prevent mother-to-child HIV transmission. TAC's human rights work is rooted in community mobilization. According to TAC founder-member Zackie Achmat:

“The MTCT case demonstrates that court action alone is insufficient. Public mobilisation on a large scale accompanying litigation led to whatever success there has been in the rollout of this programme. Undoubtedly the court was swayed by the strength of legal argument-- much of it prepared by ordinary TAC members and health-care workers without legal training-- that the programme would be effective, life-saving and cost-saving. But other important socio-economic judgments have also been made by the Constitutional Court with limited effect on implementation of government policy because the associated civil society mobilisation was missing or muted”.

7. CONCLUSION

This brief review of various agencies' policies on rights-based approaches and how they are operationalised raises some observations and also concerns. Despite this greater currency, the translation of rights-based approaches from policy to programmes is less evident. Numerous explanations have been put forward for this, including poor understanding by implementing staff of what a rights-based approach is, perhaps not helped by lack of clarity from institutions themselves as to how they actually intend rights-based approaches to be used.

Many organisations have chosen to focus more on the 'rights holder' side of the equation, putting effort into promoting well-informed and empowered demand. However, the literature around rights-based approaches indicates that this may

simply be another way of working on the path of least resistance, and that the fundamental changes needed will not occur unless those who design and also implement policy are supported and held to account. Few organisations have documented how they have done this and what impact such approaches have had.

ANNEX 2: INTERNATIONAL COVENANTS AND AGREEMENTS RELATED TO MATERNAL HEALTH

Human Rights in International Law

Human rights are enshrined in treaties that have the status of international law, which protect individuals and groups against actions that interfere with fundamental freedoms and human dignity.¹⁰¹ Human rights encompass what are known as civil, cultural, economic, political and social rights, and are principally concerned with the relationship between the individual and the state.

While human rights thinking and practice has a long history, the importance of human rights for governmental action and accountability was first widely recognised only after World War II. Agreement between nation-states that all people "are born free and equal in dignity and rights" was reached in 1945 when the promotion of human rights was identified as a principal purpose of the newly created United Nations (UN 1945). The United Nations Charter established general obligations that apply to all its member states, including respect for human rights and dignity. In 1948, the Universal Declaration of Human Rights was adopted as a common standard of achievement for all peoples and all nations (UN 1948). The basic characteristics of human rights are that they are the rights of individuals, which inhere in individuals because they are human; that they apply to people everywhere in the world; and that they are principally concerned with the relationship between the individual and the state. In practical terms, international human rights law is about defining what governments can do to us, cannot do to us, and should do for us.¹⁰²

Countries that are members of an international human rights convention are obligated to report on a periodic basis to the respective treaty monitoring body to provide information on their national performance. In this context it should be noted that the declarations and programmes of action generated by United Nations conferences, such as the International Conference on Population and Development *Programme of Action*, are non-binding consensual policy documents, although, as Rebecca Cook has argued, they do add "content and meaning" to the human rights articulated in the treaties.

Under international human rights treaties (and often also their national constitutions and regional human rights treaties), governments have different kinds of general legal obligations to implement human rights. These have been defined in the following way:

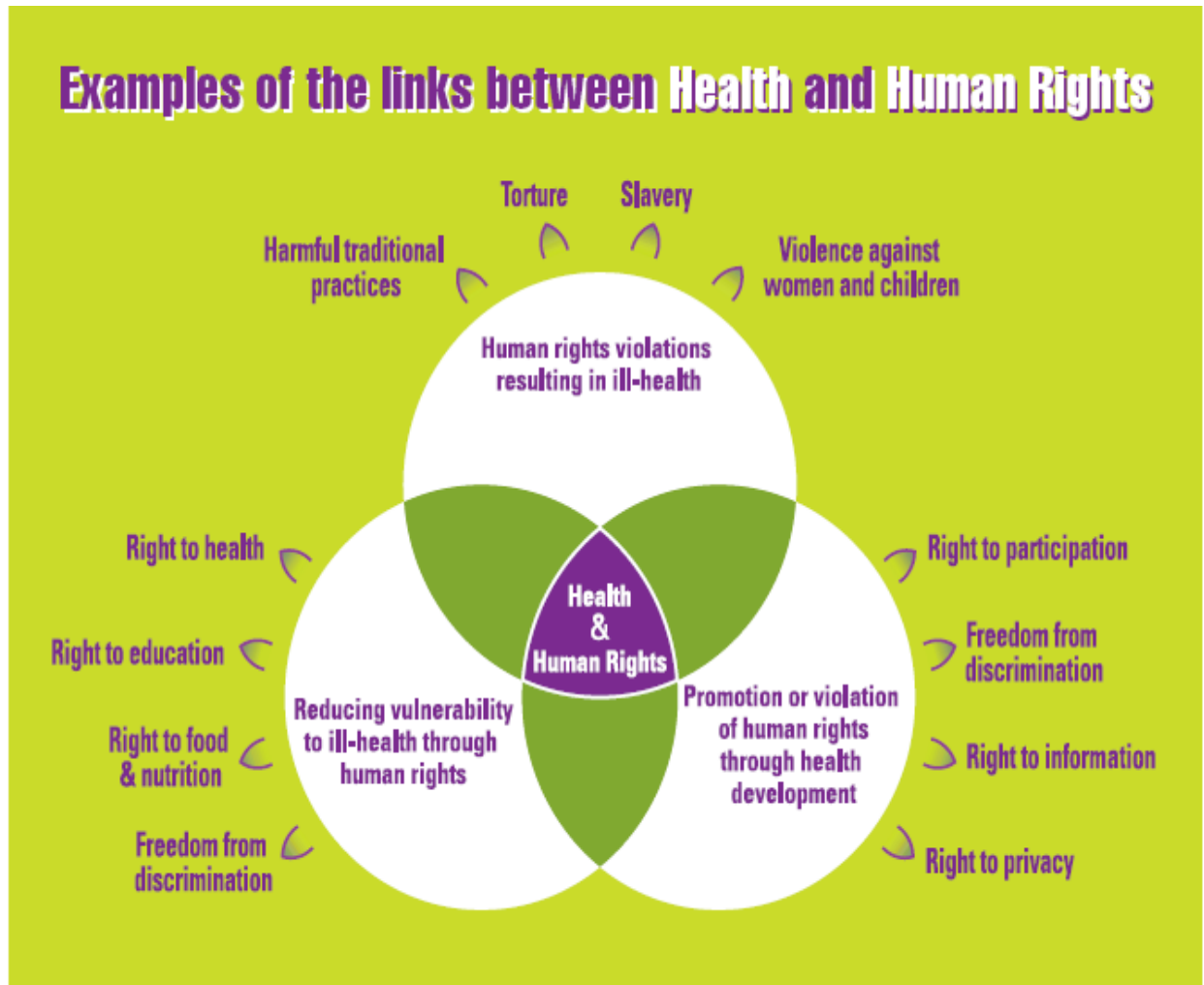
- The obligation to **respect** rights, which requires states to refrain from interfering with the enjoyment of rights
 - The obligation to **protect** rights, which requires states actively to prevent violations of human right by third parties
- and
- The obligation to **fulfil** rights, which requires states to take appropriate governmental measures toward the full realisation of rights

¹⁰¹ Human Rights: A Basic Handbook For UN Staff issued by UNHCR and the UN Staff College Project, 1999, p3.

¹⁰² Gruskin S, Tarantola D, "Health And Human Rights", Oxford Textbook On Public Health, eds. R Detels, R Beaglehole (OUP 2001).

Human Rights and Health

WHO has identified the following links between health and human rights.¹⁰³



In 2000 The Committee on Economic, Social and Cultural Rights (CESCR) issued General Comment 14 on The Right to the Highest Attainable Standard of Health (Article 12)¹⁰⁴ which states that governments must take “appropriate measures” towards the “progressive realisation” of the rights, and must do so to the “maximum of available resources”.

General Comment 14 notes that “while the Covenant provides for progressive realisation and acknowledges the constraints due to the limits of available resources, it also imposes on States parties various obligations which are of immediate effect. States parties have immediate obligations in relation to the right to health, such as the guarantee that the right will be exercised without discrimination of any kind (art. 2.2) and the obligation to take steps (art. 2.1) towards the full realisation of article 12. Such steps must be deliberate, concrete and targeted towards the full realisation of the right to health.”¹⁰⁵

¹⁰³ World Health Organization. 25 Questions And Answers On Health And Human Rights, Geneva: WHO, 2002.

¹⁰⁴ CESCR, General Comment 14, UN Dec. E/C.12/2000/04, 11 August 2000.

¹⁰⁵ CESCR, General Comment 14, para 30.

The General Comment can be used as a tool to hold governments accountable for promises they have made to respect, protect and fulfil the right to health, and also contains relevant criteria for developing rights-based approaches for the design and delivery of health care services.

Human Rights and their Application to Maternal Mortality

The human rights most relevant for maternal mortality ¹⁰⁶ are defined in the following international covenants and conventions:

The International Covenant on Civil and Political Rights

The International Covenant on Civil and Political Rights contains the rights to life, which can be applied to the “preventable death” that constitutes such a large proportion of maternal mortality. Other rights in this covenant include the right to liberty and security of person and the right of men and women of marriageable age to marry and to found a family. This covenant also contains the provision that no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.

The International Covenant on Economic, Social and Cultural Rights

The International Covenant on Economic, Social and Cultural Rights, as well as containing the Right to the highest attainable standard of health, also contains articles specifying that special protection should be accorded to mothers during a reasonable period before and after childbirth, and that during such period working mothers should be accorded paid leave or leave with adequate social security benefits. This Covenant also recognises the right of everyone to enjoy the benefits of scientific progress and its applications.

Valuable work in adding specific content and meaning to the Right to Health was recently undertaken by the Committee on Economic, Social and Cultural Rights and can be found in that Committee’s General Comment 14 on the Right to the Highest Attainable Standard of Health. The General Comment outlines four key elements of the right to health:

(a) **Availability.** Functioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party. The precise nature of the facilities, goods and services will vary depending on numerous factors, including the State party’s developmental level. They will include, however, the underlying determinants of health, such as safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs, as defined by the WHO Action Programme on Essential Drugs.

(b) **Accessibility.** Health facilities, goods and services have to be accessible to everyone without discrimination, within the jurisdiction of the State party. Accessibility has four overlapping dimensions:

- *Non-discrimination:* health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds.

¹⁰⁶ See ACPD. The Application Of Human Rights To Reproductive And Sexual Health: A Compilation Of The Work Of International Treaty Bodies <http://www.acpd.ca/compilation/contents.htm> (Marcy 2002)

- **Physical accessibility:** health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS. Accessibility also implies that medical services and underlying determinants of health, such as safe and potable water and adequate sanitation facilities, are within safe physical reach, including in rural areas. Accessibility further includes adequate access to buildings for persons with disabilities.
- **Economic accessibility (affordability):** health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.
- **Information accessibility:** accessibility includes the right to seek, receive and impart information and ideas concerning health issues. However, accessibility of information should not impair the right to have personal health data treated with confidentiality.

(c) **Acceptability.** All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.

(d) **Quality.** As well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires, *inter alia*, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.

The UN Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)

The CEDAW General Recommendation on Women and Health explains that states are obliged to change laws or policies that require women to seek the authorization of their husbands, parents or health authorities to obtain health services, because such laws or policies obstruct pursuit of women's pursuit of their health goals.¹⁰⁷ The General Recommendation suggests that studies that show high rates of maternal mortality and morbidity, or large numbers of couples who would like to limit their family size but lack access to contraception, provide important indications about possible breaches of duties to ensure women's access to health care.

The UN Convention on the Rights of the Child

The Convention on the Rights of the Child, contains provisions relevant for the right

¹⁰⁷ The Recommendation also states that the Women's Convention may be infringed by "laws that criminalize medical procedures only needed by women and that punish women who undergo those procedures." (Para 14). The General Recommendation further observes that "the obligation to protect rights relating to women's health requires states parties, their agents and officials to take action to prevent and impose sanctions for violation of rights by private persons and organisations." (Para 15)

of the child to the enjoyment of the highest attainable standard of health including appropriate measures to develop preventive health care, guidance for parents and family planning education and services. There are also articles relating to State obligations to ensure appropriate pre natal and post natal health care for mothers.

The International Convention on the Elimination of All Forms of Racial Discrimination

The International Convention on the Elimination Of All Forms Of Racial Discrimination contains articles on State obligations to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, including in the enjoyment of rights relating to security of person and protection by the State against violence or bodily harm, whether inflicted by government officials or by any individual group or institution; the right to marriage and choice of spouse; the right to public health, medical care, social security and social services; and the right to education and training.

Table 3: Classification of five basic kinds of rights highlighting issues particularly relevant for maternal mortality¹⁰⁸

<p>1. Rights relating to life, survival security and sexuality</p> <p>a. The right to life and survival</p> <ul style="list-style-type: none"> • Essential obstetric care <p>b. The right to liberty and security of the person</p> <ul style="list-style-type: none"> • Confidentiality <p>c. The right to be free from inhuman and degrading treatment</p> <ul style="list-style-type: none"> • Denial of abortion services (including following rape) <p>2. Rights relating to reproductive self-determination and free choice of maternity</p> <p>a. The right to decide the number and spacing of one’s children</p> <p>b. The right to marry and to found and plan a family</p> <ul style="list-style-type: none"> • Marriageable age <p>3. Rights relating to health and the benefits of scientific progress</p> <p>a. The right to the highest attainable standard of health</p> <ul style="list-style-type: none"> • Available resources and their fair allocation <p>b. The right to the benefit of scientific progress</p> <p>4. Rights to non-discrimination and due respect for difference</p> <p>a. Sex and gender</p> <p>b. Marital status</p> <p>c. Age</p> <p>d. Race and ethnicity</p> <p>e. Health status/disability</p> <p>5. Rights relating to information and education and decision-making</p> <p>a. The right to receive and to impart information</p> <p>b. The right to education</p> <p>c. The right to freedom of thought, conscience and religion</p>

¹⁰⁸ Cook R, et al. Reproductive Health And Human Rights: Integrating Medicine, Ethics And Law, Oxford: OUP, 2003.

The table above is an indication of ways in which specific issues related to maternal mortality have been related to specific human rights. There are other classifications, and the specific right under which particular issues are addressed is less important than the realisation that the way that these rights have been articulated allows for issues related to maternal mortality to be addressed as legitimate human rights issues. Health advocates have succeeded in bringing issues such as these to the attention of human rights treaty bodies, and their concluding observations have obliged governments, when they subsequently report to those treaty bodies, to explain how they have addressed these problems. The Human Rights Committee, which monitors the UN Covenant on Civil And Political Rights, has discussed illegal and unsafe abortion as a violation of Article 6, which articulates the Right to Life, and has made the link between illegal and unsafe abortions and high rates of maternal mortality.¹⁰⁹

¹⁰⁹ Center For Reproductive Rights 2003. Bringing Rights To Bear: An Analysis Of The Work Of UN Treaty Monitoring Bodies On Reproductive And Sexual Rights. Center For Reproductive Rights and University Of Toronto International Programme On Reproductive And Sexual Health Law.

ANNEX 3: STATEMENT OF COMMON UNDERSTANDING AMONG UN AGENCIES ON THE HUMAN RIGHTS-BASED APPROACH TO DEVELOPMENT (2003)

In May 2003, a UN Interagency Workshop on a Human Rights-Based Approach in the Context Of UN Reform issued a Statement of Common Understanding in reference to a human rights-based approach to development cooperation and development programming by UN agencies¹¹⁰. This identified three core elements, and set out the programmatic implications that flow from them. The core elements:

1. All programmes of development co-operation, policies and technical assistance should further the realisation of human rights as laid down in the Universal Declaration of Human Rights and other international human rights instruments.
2. Human rights standards contained in, and principles derived from, the Universal Declaration of Human Rights and other international human rights instruments guide all development cooperation and programming in all sectors and in all phases of the programming process.
3. Development cooperation contributes to the development of the capacities of 'duty-bearers' to meet their obligations and/or of 'rights-holders' to claim their rights.

Implications of a human rights-based approach to development programming of UN Agencies

Experience has shown that the use of a human rights-based approach requires the use of good programming practices. However, the application of "good programming practices" does not by itself constitute a human rights-based approach, and requires additional elements.

The following elements are *necessary, specific, and unique* to a human rights-based approach:

- a) Assessment and analysis identify the human rights claims of rights-holders and the corresponding human rights obligations of duty-bearers as well as the immediate, underlying, and structural causes of the non-realisation of rights.
- b) Programmes assess the capacity of rights-holders to claim their rights, and of duty-bearers to fulfil their obligations. They then develop strategies to build these capacities.
- c) Programmes monitor and evaluate both outcomes and processes guided by human rights standards and principles.
- d) Programming is informed by the recommendations of international human rights bodies and mechanisms.

¹¹⁰ UN (2003) Report on the Second Interagency Workshop On Implementing A Human Rights-Based Approach In The Context Of UN Reform. Stamford, CT, USA, 5-7 May 2003. See also United Nations (2003) The Human Rights-Based Approach to Development: Towards a Common Understanding Among UN Agencies New York: UN p2

Other elements of *good programming practices* that are also essential under a HRBA, include:

1. People are recognised as key actors in their own development, rather than passive recipients of commodities and services
2. Participation is both a means and a goal
3. Strategies are empowering, not disempowering
4. Both outcomes and processes are monitored and evaluated
5. Analysis includes all stakeholders
6. Programmes focus on marginalized, disadvantaged, and excluded groups
7. The development process is locally owned
8. Programmes aim to reduce disparity
9. Both top-down and bottom-up approaches are used in synergy
10. Situation analysis is used to identify immediate, underlying, and basic causes of development problems
11. Measurable goals and targets are important in programming
12. Strategic partnerships are developed and sustained
13. Programmes support accountability to all stakeholders

ANNEX 4: PROGRESSIVE REALISATION OF RIGHTS

Progressive realisation of rights is a significant principle in the understanding of government human rights obligations, and has a particular significance for maternal mortality because it is known that some interventions are more effective than others in preventing morbidity and mortality.

The Covenant on Economic Social and Cultural right, in which the Right to the Highest Attainable Standard of Health is articulated in Article 12 itself specifies in Article 2 *inter alia* that:

Each State Party to the present Covenant undertakes 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 realisation of the rights recognised in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.

The States Parties to the present Covenant undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

The concept of progressive realisation embodies two concepts; firstly that there must be continuous progress towards the achievement of the right, and secondly that resources should be allocated in ways that best facilitate the realisation of the right.

Freedman has argued that “When it comes to applying this standard to maternal mortality, we know from health research and experience that not all interventions are equal. All pregnant women may want to have a smooth delivery in the hands of a caring attendant; but training TBAs will not save the life of a woman with a potentially fatal complication...In short, if the human right in question is the right not to die an avoidable death in pregnancy and childbirth, then the first line of appropriate measures that will move progressively toward the realisation of the right is the implementation of EmOC. In a human rights analysis, EmOC is not just one good idea among many. It is an obligation”⁸⁵.

The principle of progressive realisation underlines the importance of the need to prioritize, within the context of a local situation analysis which identifies key areas of change that are needed in order to address maternal mortality and morbidity effectively.

ANNEX 5: RELATIONSHIP BETWEEN GOOD PROGRAMMING AND HUMAN RIGHTS-BASED PROGRAMMING

Urban Jonsson¹¹¹ explains how part of the added value of the human rights approach is that it makes good programming practices obligatory rather than aspirational or optional. The table below draws out the distinctions between the two approaches.

Good Programming	Human Rights-Based Approach to Programming (HRBAP)
<p>1. People cannot be developed; they must develop themselves. People, including people who are poor, should be recognised as key actors in their own development rather than passive beneficiaries of transfers of commodities and services.</p>	<p>In a human rights approach, people, including people who are poor, are subjects of rights. It is therefore logical to recognise people who are poor as key actors in their development by empowering them to claim their rights. Human rights programming entails the building of community capacity for people to understand their rights, to claim their rights, and to make meaningful contribution to realising these rights.</p>
<p>2. Participation is crucial, both as an end and a means. Participation, however, should not only be seen as “they” participate in “our” programme or project, but rather that “we” behave in such a way that we are allowed and invited to participate in “their” development efforts.</p>	<p>Participation, including children’s and women’s participation is a human right enshrined in many conventions; a right often violated. In a human rights approach, participation is both a necessary outcome and a necessary part of the process. Facilitating participation in societal decision-making is an objective in itself.</p>
<p>3. “Empowerment” is important, but is not a strategy. Empowerment and dis-empowerment are aspects of any strategy, such as advocacy, capacity building, or service delivery. Empowerment means “the replacement of the dominance of circumstance and chance over people’s choices with the dominance of people’s choices over circumstance and chance.”</p>	<p>Human rights imply dignity and respect for the individual. This means self-esteem and equality. Circumstance and chance should not dominate people’s lives. An HRBAP implies a people-centred approach to development in which outside support should be catalytic and supportive to people’s own efforts.</p>
<p>4. Monitoring of both outcome and process and actual use of information for decision-making at all levels of society is very important.</p>	<p>An HRBAP implies accountability of those with duties or obligations. Both the obligations of conduct/effort and the obligation of result must be constantly checked. This requires monitoring at all levels of society and the use of the information to design new actions to respect, protect, facilitate, and fulfil human rights.</p>

¹¹¹ Jonsson, U (2004) A Human Rights Approach To Development Programming, UNICEF, New York.

Good Programming	Human Rights-Based Approach to Programming (HRBAP)
5. Role or stakeholder analysis is very useful for social mobilisation, programme development, and evaluation because it identifies clear accountabilities in the community and society.	Most stakeholders, although not all, are duty-bearers. An important step in a HRBAP is to identify key relations between all claim-holders and all duty-bearers. Such an analysis is similar to, but goes beyond, stakeholder analysis.
6. Programmes and projects should respond to basic needs of people, with a focus on vulnerable groups. Local ownership is important, and development support from outside should always build on existing capabilities. Poverty reduction/eradication and disparity reduction should be overriding, long-term goals in all development efforts.	The right to development implies disparity reduction. While the ultimate goal is poverty eradication, resource endowment and different baselines may require different goal setting. The goal of disparity reduction and equity demands action to eliminate the worst manifestations of human rights violation in each context (commensurate with the country's socio-economic baseline).
7. Pure top-down approaches should be rejected, because they deny the principle of "people as actors." Pure bottom-up approaches should be rejected because they are utopian. It is not either/or; it is both. Synergy between appropriate top-down and bottom-up approaches should be promoted.	A human rights approach to programming requires respect for local knowledge and the dignity of people. A HRBAP implies a people-centred approach to development in which outside support is only catalytic and supportive to people's own efforts. But in many communities human rights values need to be promoted "from above" because they are not yet internalised.
8. Programmes should be developed on the basis of a situation analysis that identifies priority problems and their immediate, underlying, and basic causes, which should be addressed either simultaneously or in sequence.	An HRBAP requires an understanding of causes at all levels—immediate, underlying, and basic. The internalisation of human rights values makes it inescapable that the basic or structural causes be addressed. The indivisibility of human rights also emphasises simultaneous attention to causes at all levels.
9. Goal setting is important. The necessity for scaling-up needs to be considered at the planning stage. Efforts should be made to ensure that positive changes are sustainable and sustained. This includes environmental sustainability.	The realisation of human rights requires both the achievement of desirable outcomes and achieving them through a process that reflects human rights values. A HRBAP calls for simultaneous attention to outcomes and processes.
10. All possible partnerships should be explored with strategic allies, including donors and NGOs/CBOs. Through linkages to other development efforts it is often possible to leverage additional resources.	A country's human rights realisation must come from within, and be supported from outside. The UN has an obligation to promote human rights. The UN Reform emphasises this challenge and the need for co-operation in choosing among strategies to achieve goals. UNDAF is therefore of particular importance.
11. Good programming includes the identification and pursuit of a specific agency's comparative advantages.	No single agency can, or should attempt to, do everything. Cost-effectiveness and cost-efficiency are as important in an HRBAP as they are in other approaches. An agency's comparative advantage should decide what action the agency should address and support.

ANNEX 6: DETERMINANTS OF MATERNAL HEALTH OUTCOMES IN UGANDA

In 1993 CARE in Uganda won the tender to design, and then eventually to implement, a three district programme. The purpose of the programme was 'To raise the reproductive health status in Mbale, Pallisa and Kapchorwa Districts'. The programme had three outputs for achieving its purpose:

- **Increased** awareness about and demand for reproductive health services
- **Improved** access to acceptable and effective reproductive health services
- **Improved** decentralisation systems, structures and capability for planning and management of district health services.

The project was designed by a multi-disciplinary team who spent several weeks in the three programme districts collecting information, interviewing key district management and health staff about their perception of needs in this area, as well as community organisations to ascertain their needs. The design phase culminated in a three day participatory planning workshop involving all stakeholders in the programme, using a ZOPP methodology. A project logical framework and proposal was developed on the basis of the outputs of the planning workshop, and subsequent revisions were made in negotiation with ODA (DFID) regional staff.

A few of the indicators signposting achievement of the project's outputs were related to obstetric care, and included:

- Deliveries attended by trained health unit or TBA increased from 46% to 80% by end of project
- Percentage of people knowing at least four danger signs and risk factors in pregnancy and delivery increased to 80% at the end of the project
- 10 mid-level referral facilities offering quality basic EOC services by the end of the project
- Four hospitals offer quality comprehensive EOC services by end of project
- 80 primary health units have at least 2 trained staff by the end of the project
- At least five trained TBAs per sub-county offer quality safe-delivery services an appropriate referral advice for RH by end of project

An innovation of this project was the strong emphasis on strengthening district management systems, not only within the office of the District Medical Officer, but of district managers as a whole. As the project was being set up during the first phase of effective decentralisation in Uganda, it was deemed necessary by project planners to ensure district systems as whole were improved in order to support and hold accountable health services. There was also a strong emphasis on the role of community health management committees that were to be set up and trained to monitor health centre administration, especially the use of user fees (another new policy at the time).

The project started in 1995 and was evaluated in 2001.¹¹² The findings of the evaluation were mixed. Key achievements were the strengthening of many district systems that were nascent at the beginning of the project period, with an emphasis on the training of district level staff in various management and supervision systems.

¹¹² DFID Health Systems Resource Centre (2001) Uganda Family Health Project: Final Evaluation Report, London: DFID HSRC.

The main disappointment about project results was that, despite huge investment in rehabilitating and re-equipping health centres, and in training staff, little in road was made in attracting women to health units for delivery, despite high attendance for antenatal care and despite the fact that an Evaluation of Quality of Care at service facility level found high standards of facility cleanliness, client handling, individual patient management, reproductive health facilities and infection control. The evaluation found that critical features of EMOC remained unaddressed, including having operating theatres and equipment, having trained anaesthetic assistants and the provision of post-operative in-patient facilities. There was also a high turnover of staff at all levels, but especially at district hospitals, meaning that staff trained by the project often quickly moved on elsewhere. Above all, referral systems were not addressed at all by the project.

This project was set up and implemented along classic needs-based lines, working from the health problem identification to be addressed through strategies and actions to be undertaken during the project lifetime. The project was designed and implemented with a strong emphasis on principles of participation and equity. And, as with many projects like it, it failed to achieve gains in the processes and outputs that would lead to reductions in maternal mortality. So how would a rights-based approach have made this different? The following is purely conjectural, but attempts to take existing knowledge and experience and translate it into meaningful action.

- a) There was no initial rights-based analysis done at the beginning of the project that allowed an understanding of family, community and state level power structures that were of relevance to tackling reproductive health problems in general, and maternal mortality specifically. The evaluators of the project posited that tradition and culture were behind women not using health facilities for birth, but this may be too simplistic an explanation. Teasing this question out from the beginning could have made a difference in how district, health and project staff all worked with communities to increase the demand for using health facilities for obstetric care.
- b) A further reason given for women not wishing to use health facilities was the fact that these facilities charged for services through a cost-sharing programme. During the design phase it was argued that reproductive health services, and especially pregnancy and delivery care, should be exempted from cost-sharing programmes, as there were concerns then that cost sharing would reduce access to services. These arguments were discounted by both donor and district authorities. A rights-based approach would work with duty-bearers (both donors and state/non-state providers in this case) to ensure that quality pregnancy and delivery care is available to all women, even if this means ending cost-sharing schemes.
- c) A great deal of project energy went into training and equipping TBAs. A total of 560 TBAs were trained as a result of this programme. However effective EmOC capacity remained undeveloped by the end of the project and systems of referral of women having difficult labour from TBAs to Basic EOC and Comprehensive EOC facilities was not well established. Freedman has argued that this type of prioritisation could be seen as a violation of rights as it can be seen as a misdirection of scarce resources away from proven efficacious services.¹¹³
- d) A further finding in the evaluation is that, even though the project was very successful in increasing the number of trained staff and equipped facilities, and was successful in ensuring an equitable distribution of trained staff and facilities through targeting the least well served areas, staffing remained problematic due to high turn over and low incentives for staff to remain in remote centres or even

¹¹³ Freedman (2004) Personal Communication.

district hospitals. Various external constraints experienced by the project, such as the fact that the districts were unable to maintain their annual budget allocations and disbursements even at project Year 1 levels contributed to staffing problems. Again, in using a rights-based approach national and district level authorities would be engaged in discussion about the level of commitment needed in both financial and human resources to fulfil their obligation for ensuring a women's right to health and health care.