A HUMAN RIGHTS-BASED APPROACH TO PROGRAMMING FOR MATERNAL MORTALITY REDUCTION IN A SOUTH ASIAN CONTEXT

A review of the literature
A HUMAN RIGHTS-BASED APPROACH TO PROGRAMMING FOR MATERNAL MORTALITY REDUCTION IN A SOUTH ASIAN CONTEXT

A review of the literature
FOREWORD

This literature review by the UNICEF Regional Office for South Asia (ROSA) synthesises relevant information for applying a human rights-based approach to programming to the urgent task of reducing maternal mortality and morbidity. Information was gathered on maternal mortality, especially in South Asia, and on the human rights-based approach to programming, particularly as applied within UNICEF.

Since the human rights-based approach to programming is evolving, the sources used are quite recent, and some are still in draft form. Each point presented carries a reference. The literature chosen is by no means exhaustive, but is hopefully sufficiently representative to make this review useful for the task and to be a reference source for policy makers, programmers and advocates within South Asia. For those in other regions, where the reduction of maternal mortality and morbidity remains a priority, it provides an important resource to supplement global policy documents and programme guidance.

The resulting material is organised in three sections of text according to the main themes, plus a fourth section of annexes. Section I deals with the concept of ‘Human Rights and Development’ and attempts to reveal the range of possibilities to be tapped by applying the human rights treaties. It examines the relationship of the human rights-based approach to other development approaches and the value to be gained from this approach. Section II deals with the ‘Challenge of Maternal Mortality in South Asia’. The present situation is alarming, yet there is considerable understanding of the causes of this appalling state. Even though the means to save women’s lives are known, there are numerous challenges to applying this knowledge. Each of these challenges is discussed in detail. In Section III, the knowledge gained on the human rights-based approach is applied to the particular issue of the reduction of maternal mortality. It follows the process of assessment and analysis, strategies and priority setting, through to monitoring and evaluation. A summary of the findings is given in the conclusion. The bibliography is the first of the annexes, followed by important material to supplement the text in the main chapters.

In all of this, there is but one aim – to ensure that all women exercise and enjoy the fulfillment of their human right to life and health and to survive pregnancy and childbirth. They have the right, the privilege and must take the risk of bearing the next generation of humanity. All of society has a duty to ensure that they do not perish in the endeavour.

Special thanks go to DFID’s Asia Regional Poverty Fund, for supporting the preparation and production of this document, which we all hope will be of benefit to those committed to reducing maternal mortality and morbidity the world over.

It is my sincere hope that policy makers, practitioners, programmers, social change makers, communicators and advocates in South Asia and beyond would find this source book useful.

Sadig Rasheed
Regional Director
UNICEF Regional Office for South Asia
August, 2003
## CONTENTS

### SECTION 1

**HUMAN RIGHTS AND DEVELOPMENT**

<table>
<thead>
<tr>
<th>CHAPTER 1  Setting The Stage</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Maternal Mortality: A Social Injustice</td>
<td>3</td>
</tr>
<tr>
<td>1.2 Vision of a Better Future</td>
<td>3</td>
</tr>
<tr>
<td>1.3 Understanding Human Rights</td>
<td>5</td>
</tr>
<tr>
<td>1.4 Human Rights Related to Safe Motherhood</td>
<td>5</td>
</tr>
<tr>
<td>1.5 Rights Regime</td>
<td>6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CHAPTER 2  Human Rights</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 Key Concepts of the Nature of Human Rights</td>
<td>8</td>
</tr>
<tr>
<td>2.2 Values Inherent in Human Rights</td>
<td>8</td>
</tr>
<tr>
<td>2.3 Key Principles of A Human Rights-Based Approach</td>
<td>9</td>
</tr>
<tr>
<td>2.4 Key Principles Derived from Particular Treaties</td>
<td>11</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CHAPTER 3  Human Rights And Development</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 History of the Human Rights Based Approach to Development</td>
<td>13</td>
</tr>
<tr>
<td>3.2 Outcome and Process</td>
<td>13</td>
</tr>
<tr>
<td>3.3 Needs and Rights</td>
<td>14</td>
</tr>
<tr>
<td>3.4 Responsibility and Accountability</td>
<td>22</td>
</tr>
<tr>
<td>3.5 Participation</td>
<td>17</td>
</tr>
<tr>
<td>3.6 Empowerment</td>
<td>20</td>
</tr>
<tr>
<td>3.7 Sustainability</td>
<td>21</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CHAPTER 4  Overview Of A Human Rights-Based Approach to Programming</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1 Key Elements of A Human Rights-Based Approach</td>
<td>22</td>
</tr>
<tr>
<td>4.2 A Human Rights-Based Approach and Human Development</td>
<td>24</td>
</tr>
<tr>
<td>4.3 Value Added</td>
<td>25</td>
</tr>
</tbody>
</table>

### SECTION 2

**THE CHALLENGE OF MATERNAL MORTALITY**

<table>
<thead>
<tr>
<th>CHAPTER 5  Understanding Maternal Mortality</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1 Present Situation</td>
<td>31</td>
</tr>
<tr>
<td>5.2 Definitions</td>
<td>31</td>
</tr>
<tr>
<td>5.3 Investigation of Maternal Deaths</td>
<td>32</td>
</tr>
<tr>
<td>5.4 Causes of Maternal Deaths</td>
<td>32</td>
</tr>
<tr>
<td>5.5 Roles and Responsibilities</td>
<td>37</td>
</tr>
<tr>
<td>5.6 Lessons</td>
<td>40</td>
</tr>
<tr>
<td>5.7 Management</td>
<td>45</td>
</tr>
<tr>
<td>5.8 Information, Education and Communication (IEC)</td>
<td>45</td>
</tr>
<tr>
<td>5.9 Essential Values</td>
<td>45</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CHAPTER 6  Challenges</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1 Discrimination</td>
<td>46</td>
</tr>
<tr>
<td>6.2 Poverty</td>
<td>46</td>
</tr>
<tr>
<td>6.3 Gender</td>
<td>47</td>
</tr>
<tr>
<td>6.4 Gender-Based Violence Against Women</td>
<td>50</td>
</tr>
<tr>
<td>6.5 Health and Rights</td>
<td>51</td>
</tr>
<tr>
<td>6.6 Emergency Situations</td>
<td>51</td>
</tr>
<tr>
<td>6.7 Economics</td>
<td>52</td>
</tr>
<tr>
<td>6.8 Imperative for Change</td>
<td>54</td>
</tr>
</tbody>
</table>
APPLYING THE HUMAN RIGHTS-BASED APPROACH TO PROGRAMMING FOR MATERNAL MORTALITY REDUCTION

CHAPTER 7  Assessment and Analysis
7.1 Moving from Theory to Practice 57
7.2 Through a Human Rights Filter 57
7.3 Types of Analysis 58
7.4 Steps in Analysis 58
7.5 Community Capacity Analysis 62
7.6 Applying A Human Rights-Based Approach to Assessment and Analysis of Maternal Mortality 63

CHAPTER 8  Strategies and Priorities
8.1 Through a Human Rights Filter 67
8.2 Capacity Development 68
8.3 Priority Setting 70
8.4 General Principles Related to Maternal Mortality Reduction 72
8.5 Managing Change 79
8.6 Building Partnerships 81

CHAPTER 9  Monitoring and Evaluation
9.1 Through a Human Rights Filter 84
9.2 Types of Monitoring 85
9.3 Indicators 86
9.4 Monitoring Methods for Maternal Mortality 86
9.5 Evaluations 88

CHAPTER 10  Summary and Conclusions

ANNEXES

REFERENCES
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAT</td>
<td>Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment</td>
</tr>
<tr>
<td>CCA</td>
<td>Common Country Assessment</td>
</tr>
<tr>
<td>CCD</td>
<td>Community Capacity Development</td>
</tr>
<tr>
<td>CCM</td>
<td>Convention on Consent to Marriage, Minimum Age for Marriage and Registration of Marriages</td>
</tr>
<tr>
<td>CEDAW</td>
<td>Convention on the Elimination of All Forms of Discrimination Against Women</td>
</tr>
<tr>
<td>CRC</td>
<td>Convention on the Rights of the Child</td>
</tr>
<tr>
<td>CSO</td>
<td>Civil Society Organisation</td>
</tr>
<tr>
<td>DEVAW</td>
<td>Declaration on the Elimination of Violence Against Women</td>
</tr>
<tr>
<td>EmOC</td>
<td>Emergency Obstetric Care</td>
</tr>
<tr>
<td>HRBAP</td>
<td>Human Rights-Based Approach to Programming</td>
</tr>
<tr>
<td>HRBA</td>
<td>Human Rights-Based Approach</td>
</tr>
<tr>
<td>ICCPR</td>
<td>International Covenant on Civil and Political Rights</td>
</tr>
<tr>
<td>ICPD</td>
<td>International Conference on Population and Development Programme of Action</td>
</tr>
<tr>
<td>ICERD</td>
<td>International Convention on the Elimination of All Forms of Racial Discrimination</td>
</tr>
<tr>
<td>ICESCR</td>
<td>International Covenant on Economic, Social and Cultural Rights</td>
</tr>
<tr>
<td>IEC</td>
<td>Information, Education and Communication</td>
</tr>
<tr>
<td>IFI's</td>
<td>International Financial Institutions</td>
</tr>
<tr>
<td>IHL</td>
<td>International Humanitarian Law</td>
</tr>
<tr>
<td>MDCR</td>
<td>Maternal Death Case Review</td>
</tr>
<tr>
<td>MMR</td>
<td>Maternal Mortality Reduction</td>
</tr>
<tr>
<td>MPC</td>
<td>Maternity Protection Convention (Revised)</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Government Organisation</td>
</tr>
<tr>
<td>PFA</td>
<td>UN Fourth World Conference on Women Platform for Action</td>
</tr>
<tr>
<td>PRSP</td>
<td>Poverty Reduction Strategy Paper</td>
</tr>
<tr>
<td>RAMOS</td>
<td>Reproductive Age Survey</td>
</tr>
<tr>
<td>SWOT</td>
<td>Strengths, Weaknesses, Opportunities and Threats</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>UNCT</td>
<td>United Nations Country Team</td>
</tr>
<tr>
<td>UNDAF</td>
<td>United Nations Development Assistance Framework</td>
</tr>
<tr>
<td>UDHR</td>
<td>Universal Declaration of Human Rights</td>
</tr>
<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Fund for Population Activities</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children's Fund</td>
</tr>
<tr>
<td>UNOCHR</td>
<td>United Nations Office of the High Commissioner for Human Rights</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
“... no woman should have to struggle for equality and respect. No woman should have to shoulder the disadvantage of being denied an education. And no girl or woman should die in the process of giving birth.”

Carol Bellamy
Executive Director, UNICEF
7 March, 2003
Section 1

HUMAN RIGHTS AND DEVELOPMENT

CHAPTER 1 Setting The Stage
CHAPTER 2 Human Rights
CHAPTER 3 Human Rights And Development
CHAPTER 4 Overview of A Human Rights-Based Approach to Programming
1.1 Maternal Mortality: A Social Injustice

In South Asia every three minutes one woman dies from complications of pregnancy and childbirth.¹

These women succumb, their lives ending in pools of blood, in the throes of convulsions or even in the agony of their bodies being torn apart.

Those who survive, live with complications that range from discomfort to situations of indignity. At the extreme is the woman who drips urine constantly as an abnormal passage is created by the head of the baby pressing down too hard for too long to be released through a path that is not wide enough. She is associated with a smell that makes her company undesirable leading to her being abandoned by husband and cast out by society.

For three out of four of the babies whose mother dies, her death is the beginning of their death. Without breast milk, they waste away on a diet of flour and water or very diluted milk and die of pneumonia or diarrhoea.²

Estimating maternal mortality is difficult, as records of the cause of death do not always mention the pregnancy. So current estimates are likely to err on the side of being too low. However, deaths are relatively easy to estimate. Further, for every woman who dies, an estimated 30-100 women suffer complications that result in debilitating conditions. This means that while approximately 155,000 women die, between 4.6 million and 15.5 million women suffer permanent disabilities each year in South Asia alone. The tragedy is that most of these deaths and disabilities are avoidable with appropriate treatment.³

The likelihood of maternal death varies between rich and poor countries: a lifetime risk of 1 in 8,700 for Canadian women compares with 1 in 42 for women in Bangladesh or 1 in 30 in Bhutan. Within any given country, it also varies greatly between rich and poor women.⁴

The failure to address preventable maternal disability and death represents one of the greatest social injustices of our times. A human rights approach shows that women’s maternal mortality and morbidity result not simply from their disadvantages but frequently from cumulative denials of their human rights; that is, failure to address their preventable death and sickness is a result of injustices that women experience.⁵

Mabelle Arole noted that South Asian women are conceived in violence, unwanted in birth, discriminated against throughout life and must struggle for their very existence. They are stripped of their human rights and treated as property, mere chattels. They work, they serve, they please. Yet they are raped, they are abused, they are even burned.⁶ In some places they are also stoned. The challenge is to create a better future by applying human rights principles so that all women can live in dignity and health.⁷

1.2 Vision of a Better Future

At the end of the Second World War, there was a determination to prevent a recurrence of the
devastation that occurred then. With the formation of the United Nations, there came a greater understanding of the inherent dignity of each human being and from this was born the Universal Declaration of Human Rights (UDHR). The UDHR has been enhanced since then by a series of conventions and treaties which further elaborate on the provisions contained in the Universal Declaration.

According to the UN Charter, human rights are about respecting, protecting and fulfilling the inherent dignity of the individual as well as promoting the ability of each individual to reach his or her full potential, in the context of equality, self-determination, peace and security. Along with the Charter, the collection of international human rights instruments constitutes a clear and compelling development agenda both for individual countries and for the UN system. 13

Human rights are necessary for the enjoyment and safeguarding of human life, the achievement of human progress, the protection of human dignity and the advancement of human security. They are formulated to promote tolerance, solidarity, peace and human dignity and subjectivity. 14

Freedom from fear and freedom from want15 enshrined in the human rights treaties are not only idealistic rhetoric. By ratifying such treaties, governments commit themselves to the progressive realisation of these rights.

Implicit in a growing ‘culture of rights’ is a historical shift from state and subject relationships based on clientelism and patronage, to state and citizen relationships based on political, civil, economic, social and cultural rights with associated sets of rules governing mutual obligations. 16

These mutual obligations are observed in a series of claim-holder – duty-bearer relationships. Claims gather legitimacy through the growing recognition that they are not claims to privilege but rather a matter of rights; that is, society recognises their denial as an injustice. Governments must recognise that avoidable maternal mortality is a denial of human dignity constituting an injustice, and that they are obliged to prevent such maternal deaths. For the advancement of safe motherhood through human rights, society in each country must realise that maternal mortality is unjust by their own standards of fairness, in response to which their governments have subscribed to international standards by their free consent, in the exercise of their sovereignty. 17

Box 1: The Facts in South Asia

- Nearly once every three minutes a South Asian woman or girl dies from complications of pregnancy and childbirth. This translates into an estimated 425 deaths each day and 155,200 deaths annually, 30% of all maternal deaths world-wide. 8 It is currently estimated that India alone has the greatest number of maternal deaths of any country in the world, 130,000 deaths every year. 9

- For every woman who dies, an estimated 30-100 women and girls suffer complications that result in debilitating conditions. This means that between 4.6 and 15.5 million South Asian women and girls suffer permanent disabilities each year. Most of these deaths and disabilities are preventable.

- The survival of infants and young children is directly linked to the survival of their mothers. Nearly 8.1 million infants die each year, many as a direct result of poorly managed pregnancies and deliveries. 11 A mother’s death is particularly damaging for the survival of girl children.

- An estimated 74 million South Asian women are “missing” as a result of violence, sex selective abortion, female infanticide, dowry deaths and honour killing. As a consequence, the female-male ratio is the lowest in the world. 12

Please pause for a moment to acknowledge and reflect on these facts.
As the stories in “Small Efforts Can Make a Difference” illustrate, there is a growing recognition in South Asia that maternal mortality is not only a social injustice but one that demands a response from society at many levels. Governments in South Asia have subscribed to the new vision proposed by the Women’s Right to Life and Health Initiative so that it now represents a shared vision across the region.

**Imagine our Vision:** The self-determination and dignity of all women are universally valued, and this value is reflected in each woman’s realisation of her right to a safe, life-enhancing pregnancy and birth.¹⁹

### 1.3 Understanding Human Rights

To understand how a human rights-based approach can further efforts to reduce maternal mortality and to ensure the vision outlined above, it is important to understand human rights, the principles underlying them and the values they embody.

*Human rights are commonly understood as being those rights which are inherent to the human being. Human rights are legally guaranteed by human rights law, which consists of the treaties as well as declarations, guidelines and principles that have been agreed under the auspices of the United Nations since 1945. A treaty is an agreement by states to be bound by particular rules. General principles of human rights law, to which most states would agree, are often stated in declarations, proclamations, standard rules, guidelines, recommendations and principles. These documents include the Declarations and the Programmes of Action agreed at major UN World Conferences. They represent a broad consensus on the part of the international community on actions required to implement those rights and have a strong moral force on the practice of states. The human rights framework provides a basis for both legal measures to promote institutional change and interventions to create consensus around the values and norms they represent.*²⁰

Since these human rights instruments are above all human instruments, they are continuing to evolve in their application to present day reality. The Universal Declaration of Human Rights was further elaborated in the two Covenants, the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights. The United Nations has always insisted that both Covenants are equally important but this did not meet political acceptance.²¹ The inseparability of the two sets of rights was agreed in Vienna in 1993.²² To further clarify the concept of equality and dignity of all persons proclaimed in the UDHR, three further Conventions were proclaimed - the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD), the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the Convention on the Rights of the Child (CRC). Each of these conventions has a committee which monitors the realisation of human rights according to the particular treaty. These committees also issue Recommendations on particular issues to provide greater clarity.

Other Conventions relevant to safe motherhood include those on age at marriage (CCM), maternal protection at work (MPC), and on inhuman treatment (CAT). The International Conference on Population and Development Programme for Action (ICPD) and the Platform for Action from the Fourth UN World Conference on Women (PFA) in Beijing and their follow-up conferences five years later have been very influential on women’s rights, particularly in promoting their rights to health. There is a difference between the legal obligations of ratification of human rights instruments and political commitments made at global conferences or summits. These two sets of commitments are mutually reinforcing.²³

### 1.4 Human Rights Related to Safe Motherhood

“The movement for human rights has focused more on the right to survival against oppression than to the quality of life, to which health is central. Maternal death has been accepted as part of the natural order, rather than as an avoidable consequence of women’s ill health resulting from unjust disadvantage.”²⁴ This change in focus leads to an examination of the human
rights instruments to reveal the social injustices which contribute to avoidable maternal deaths. “Once an issue is recognised as a human right, there is a legal obligation to take steps that are ‘deliberate, concrete and targeted toward realisation of the right.”25

Reduction of maternal mortality is a threshold objective in a comprehensive strategy to ensure a woman’s right to a life-enhancing pregnancy and childbirth. “The right to survival is founded on the inherent value of every woman - as a human being - not only as a mother, daughter or wife.”26 WHO has produced a treatise “Advancing Safe Motherhood through Human Rights”27 on the articles in the various international and regional treaties which underpin this right. Clarification of the obligations and implications of the treaties has been made by the committees which monitor the observance of the various treaties.

The obligations have been grouped under:

1. Rights relating to life, survival and security;
2. Rights relating to maternity and health;
3. Rights relating to non-discrimination and due respect for difference; and
4. Rights relating to information and education.

An additional category of human rights28 that gained recognition at the Vienna World Conference on Human Rights is the special right of women to physical integrity. Another important category is the right to participation.29 This right ensures that women have the right to influence policy, legislation and their implementation affecting all aspects of their lives, including the reduction of maternal mortality. The implications of these obligations are provided in more detail in Appendix 2. The list of countries of South Asia and their status in relation to the relevant treaties is provided in Appendix 3, and a list of documents relevant to women’s right to health and safe motherhood is provided in Appendix 4.

This wide range of rights related to safe motherhood reinforces the importance of human rights realisation for maternal mortality reduction. By ratifying the relevant treaties, the states accept their obligation to implement these treaties and to be accountable for meeting the rights and the needs of their people. Finally, ratification requires states to align their domestic laws with treaty provisions and to ensure that steps are taken to make structures in society, at national and sub national level, respond in a way consistent with the letter and intent of the law.30

1.5 Rights Regime

These globally accepted human rights did not arise from a vacuum. They came from the consciousness of human beings living in particular contexts. They are both a reaction to prevailing negative experiences and an articulation of desired reality. The transition from the negative to the desired situation begins with examining the underlying situation in relation to human rights.

In discussing how rights may be incorporated into development strategies for livelihood security, Moser and Norton are careful to distinguish the various ways in which rights may be understood. They summarised the conceptualisation of rights as follows.31

Rights as legitimate claims: Rights are widely characterised as legitimate claims that give rise to correlative obligations or duties. Rights regime: A rights regime is a system of rights which derive from a particular regulatory order or source of authority. In a given society several may co-exist – all with distinct normative frameworks and means of formulation and enforcement, for example customary law, religious law and statutory law.

Individual rights: These are a subset of rights-obligations relationships where the right-holder is an individual person; group rights would not fall within this subset of rights.

Universal human rights: These can be characterised as an individual right with a universal domain – that is, an individual right that applies to all human beings equally, irrespective of their membership of particular families, groups, religions, communities, or societies.
To ensure that all people enjoy their human rights, it is important to examine whether universal human rights have been incorporated in all levels of a rights regime. These levels may include:\(^{32}\)

- International human rights law
- Regional law
- Constitutional law
- Statutory law
- Religious law
- Customary law
- Living law

Rights regimes are implemented through the operation of the legal system and the allocation of resources and administration of services. Capacity to make claims and influence rights regimes depends on social identity and the authority and power that this confers – e.g., gender, caste, class.\(^{33}\)
2.1 Key Concepts of the Nature of Human Rights

As the understanding and application of human rights has evolved, the nature of human rights has been described as universal, indivisible, interdependent and interrelated.\(^{34}\)

**Universality**

The first document, by its very name, Universal Declaration of Human Rights, announces universality. “Universality means that all people have the right to claim agreed economic, social and cultural, civil and political entitlements. Universality also means that all people have equal rights.”\(^{35}\)

**Indivisibility, Interdependence and Inter-relatedness**

These three aspects describe the relationship of one human right to another. The absence or presence of one human right affects the quality of enjoyment of another human right. Consequently, human rights cannot be prioritised. There is no hierarchy of rights.\(^{36}\) Hence, all rights have equal status as rights and it is necessary to look at the full range of human needs: physical, psychological, developmental and spiritual.\(^{37}\)

In the literature reviewed, the concept of interdependence was used in two senses. However, when applied to human rights, interdependence of human rights refers to the fact that “the realisation of civil and political rights is interdependent with the achievement of economic, social and cultural rights. All rights are equally important as a means of ensuring that all people can live a life of freedom and dignity.”\(^{38}\)

In the implementation of programmes, the interdependence of people and programmes must be recognised, acknowledged and incorporated into practice if human rights are to be realised. “Systems characterised by dependency threaten the rights and potential for self-expression of everyone involved. In contrast, interdependence suggests a mutual reliance on one another.”\(^{39}\)

The 24-hour availability of quality EmOC services in the hospital depends on many people. Recognising and respecting the diversity of the hospital staff enables the facility to benefit from the diverse contributions made. It is commonly experienced that women and their families receive care and assistance from housekeeping staff and ward attendants. These contributions are most often not formally recognised.....Genuine appreciation for and recognition of the contributions made by all levels of hospital personnel builds trust, team spirit and understanding that results in the provision of quality services 24 hours a day.\(^{40}\)

2.2 Values Inherent in Human Rights

Article 1 of the Universal Declaration of Human Rights states: “All beings are born free and equal in dignity and rights.” The second article clarifies that everyone is entitled to all the rights without distinction of any kind, such as race, colour, sex, language, religion, or other status e.g., political, social or geographical.
These articles enshrine the essential values of the dignity of every human being and the principle of non-discrimination.

Dignity

“In essence, every person – every woman, man and child – simply by virtue of being human is entitled to be treated with dignity.” This value must not only be reflected in the choices made about what to do but also must be preserved by how choices are made and implemented. “Human dignity is not only about material well being (e.g. adequate food, shelter, health); it is also about the ways in which we interact in society.” Dignity in health is not only being free of avoidable disease but also concerns the process of obtaining and maintaining a standard of health.

“Everyone is entitled to the human rights that allow them dignity, physical integrity and safety. These rights are inherent in being a human being. In defining dignity and bodily integrity it is essential to respect the perspective, the self-determination, of those whose rights are being considered.”

Non-discrimination

Belief in the inherent dignity of every human being naturally flows from the premise that all people must be included without discrimination. This is easier to state than to realise. “Non-discrimination as a right is also defined as inclusion or social justice. Women and girls frequently encounter discrimination on the basis of gender. This discrimination cuts across other characteristics, poverty and caste. Women within these marginalised groups are likely to suffer even greater discrimination.”

Promotion of all human rights for all people necessitates the building of socially inclusive societies, based on the values of equality and non-discrimination. Non-discrimination has implications for all levels of activity (e.g., community schemes available to all women, equal access to services and resources for all, including the poor, hospital procedures to hear and respond to the voice of every client and every worker). Governments have obligations to address social discrimination through efforts to promote rights awareness and attitudinal change as well as reform of legislation and policies.

The practical implications of the inherent values of dignity and non-discrimination have produced a number of working principles.

2.3 Key Principles of A Human Rights Based Approach

The practical implications of the inherent values of dignity and non-discrimination have produced a number of working principles.

DFID, in working towards the elimination of poverty, identified three operational principles (participation, inclusion and fulfilling obligations) which apply to the achievement of all human rights. Moser and Norton, in their treatise on claiming rights for sustainable livelihoods, list the key normative principles that can be derived from human rights as follows: human freedom; universality and equality; the multi-dimensional character of well-being; participation, transparency and empowerment; responsibility and accountability; and sustainability.

The Women’s Right to Life and Health Initiative has adopted five human rights principles as core values for the initiative. These values are human dignity, non-discrimination, right to life and development, participation and accountability.

From these models, key principles for the human rights approach may be identified. Some have already been included: universality, or an essential value, dignity and non-discrimination. However, there remain other key operational principles; including responsibility and accountability, participation, transparency and empowerment, and sustainability.

Responsibility and accountability

States voluntarily acknowledge and accept obligations when they ratify human rights treaties. They must be proactive in efforts to implement provisions to ensure
rights. Some rights must be immediately realised; others may be progressively realised but to the fullest extent of available resources. However, in all cases, States are called to respect, protect, and fulfil human rights. All people are rights-holders and have corresponding obligations to ensure others enjoy their human rights. The international obligation to ensure the human rights of all transcends national boundaries. It is an endeavour which humanises us all.

**Participation**

Participation is seen here as an operational principle, but it has come to be recognised as a right in itself. At the Alma Ata International Conference on Primary Health Care it was stated that “the people have the right and duty to participate individually and collectively in the planning and implementation of their health care.” Further, it is identified as a strategy for implementation and sustainability. “The participation of civil society in the development and monitoring of action plans and targets at national and local levels further increases the responsiveness of the state to the needs and perceptions of citizens.”

Participation means enabling people to realise their rights to participate in, and access information relating to, the decision-making processes which affect their lives. “The concept of participation is shifting from beneficiary participation in state-delivered programmes to an understanding of participation as a means of holding the state accountable. New means of strengthening this approach include participatory policy research, participatory budgeting and citizen monitoring and evaluation.” “Valuing the participation of women, means listening to and respecting their opinions and views. The practical application of this value requires support for decentralisation of decision-making in both public and private spheres.”

**Transparency**

Being able to access information related to decision-making processes calls for transparency. The operational principle of transparency is also related to accountability, in that information must be available to ensure that claim-holders can hold duty-bearers accountable. “Access to information, and transparency are both critical factors in ensuring that services are delivered and standards are met.” “The principles of transparency, participation and empowerment can help to ensure that development institutions are responsible and accountable.”

It has been suggested that the development of information systems for transparency should include:

- There should be a clearly specified right of public access to information.
- Information should be available at each level where there are interested stakeholders.
- Information should be available at each level at which relevant decisions are made.
- The burden of information collection should be at the level of information use.
- There should be agreement on the domain and burden of information collection.
- Indigenous information / knowledge is at least as valuable as that from other sources.
- There should be a right to present and a responsibility to feedback information.
- Those presenting information must be mandated by those whom they claim to represent.

**Empowerment**

The principle of empowerment is related to that of responsibility and accountability. Unless claim-holders are empowered, they will not hold duty-bearers responsible and accountable.

*Human rights are rooted in historic, prestigious and authoritatively endorsed national constitutions and laws, and international treaties and documents. Many individuals find human rights empowering because they provide means by which individuals can*
legitimately assert their interests. Governmental agencies can employ human rights to advance social justice among the people they lead and serve, and individuals and groups can employ human rights to require governmental agencies to observe standards of conduct to which they have committed themselves. Human rights, expressed in national and international laws, are tools that direct government agencies, individuals and institutions towards the appropriate shaping of their own policies and practices, and equip them with the principles and language to urge improvements in the policies and practices of others.60

Sustainability

The principle of sustainability is a reminder that realising human rights is not a one-time activity, but rather the constant backdrop to all activity, both now and in the future. It also calls on the present generation to respect the rights of future generations. As Amartya Sen argues, sustainability means “development that promotes the capabilities of people in the present without compromising the capabilities of future generations.”61

Sustainability can also be related to the concept of the progressive realisation of rights. “Rights may be universal but they are perceived as expensive.”62 States are expected to realise immediately some rights (e.g., the right to freedom of expression). However, in poor countries, budget constraints prevent fulfillment of the rights of all. These States are required to ensure the progressive realisation of rights. Programmes which are not sustainable mean that an initial gain is followed by a regression, rather than progressive realisation.

“The progressive realisation of human rights requires policies of pro-poor growth, which increase the amount of resources available, as well as good governance which ensures that those resources are used efficiently.”63 This entails strategic planning with clear target setting and local benchmarks to indicate progress, as well as resources for medium and long-term action.

2.4 Key Principles Derived from Particular Treaties

The Convention on the Rights of the Child (CRC) and the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) have special importance to maternal mortality reduction. The CRC is UNICEF’s guiding frame of reference and CEDAW is the other underpinning of the organisation’s mandate and mission. Both are at the core of UNICEF’s Human Rights-Based Programming Approach. They provide further key human rights principles.

2.4.1 Four foundation principles of the CRC64

The CRC Committee has identified four CRC articles as ‘foundation’ principles underpinning all other articles. They are:

- Non-discrimination (article 2)
- Best Interests of the Child (article 3)
- Right to Life, Survival and Development (article 6)
- Views of the Child (article 12)

In essence, these principles derive from the inherent dignity of each child and the principle of nondiscrimination. They are also operational principles guiding choices made in programming and adding emphasis. Best interests of the child and right to life, survival and development refer to desirable outcomes, while non-discrimination and respect for the views of the child focus on process.65

Best Interests of the Child is “a primary consideration” in CRC, but in CEDAW, it is a “principle of paramount consideration”. It means having a child-centered approach to resolve conflicts between competing rights, and is the basis for evaluation of laws and practices for protection.66 “The best interests of the child must reflect a balance between both the
child’s short term and long term interests.” 67 In the treaty, the upper age of childhood is defined as 18 years, but there is no lower limit mentioned. “Account needs to be taken of children’s evolving capacities during adolescence, when access to information, for example on reproductive health, emerges as a vital issue.” 68

The right to life, survival and development raises the issues of accessibility to basic services for all, and is based on distributive justice. “As articulated in several human rights conventions, the right to life and development establishes the legal obligation of signatory governments to ensure the availability of and access to emergency obstetric care (EmOC) and other services that enhance a women’s health and ensure her survival.” 69

2.4.2 Additional principles derived from CEDAW

“Human rights provide the values, principles and standards essential to safeguard that most precious of all rights – the right to be human, of which the right to be a woman is an essential and integral component.” 70 CEDAW applies to females of all ages since no specific age group is mentioned. CEDAW addresses discrimination against women, but does not specifically mention violence. However, in response to a Recommendation from the CEDAW Committee, the UN General Assembly proclaimed the Declaration against the Elimination of Violence Against Women. From these two documents come two further principles,

- Gender justice
- Prohibition of violence against women.

Gender justice

CEDAW requires states to establish effective legal protection of women against any act of discrimination and provides justification for affirmative action to redress past injustices. To attain its goals, CEDAW is based on a set of interrelated strategic principles. These strategic principles include the following:

- Gender-based disparities must be identified and eliminated.
- Necessary temporary measures must be taken to overcome the social injustices due to unfair construction of gender roles.
- Practices that demean women are to be prohibited.
- There must be facilitation of services to safeguard the well-being of women as women.
- Priority action must be taken to improve the quality of life of deprived women and to facilitate equitable development of vulnerable children.
- Women’s participation must be facilitated in all spheres of life. 71

“Within the dimensions of rights and gender justice, access to emergency obstetric care for all women is an essential goal.” 72

Prohibition of violence against women

While not legally binding, the Declaration on the Elimination of Violence Against Women represents a moral commitment on the part of member states to introduce a number of immediate and progressive measures to address gender-based violence against women. 73 Conventionally, responsibility for fulfilling these duties falls on the State. However, as a result of the breakthrough made by women in gaining recognition of their human rights, it is now recognised that the duties attach as well to non-state actors (e.g., in domestic violence against women). 74
3.1 History of the Human Rights-Based Approach to Development

Development theory and practice has passed through various phases. With the adoption of the International Bill of Human Rights, the objective of development as human well-being became more acceptable. It is a tribute to the quest of the human spirit for excellence that development has come to include more and more dimensions of being human. The approach to development has moved from purely economic growth to economic growth with equity plus sustainable human development. The human development approach has three important components: (1) capability to be well nourished and healthy, (2) capability for healthy reproduction, and (3) capability to be educated and knowledgeable. The human rights-based approach to development goes beyond this by recognising the existence of duties and obligations. Beginning with his ‘Programme for Reform’, the Secretary-General has stressed that human rights is a cross cutting issue which is at the center of all work of the United Nations in peace and security, in humanitarian relief and in development. Accordingly, the Secretary-General has called for the integration of human rights into all principal United Nations activities and programmes and has signaled that human rights are to be considered a priority objective of the United Nations.

The human development approach and the human rights-based approach (HRBA) complement and enrich each other as the human development approach provides guidance in setting priorities within a human rights approach and vice versa. While a human development approach focuses on the ‘outcome’; a human rights approach focuses on both the ‘outcome’ and the ‘process’. Rights-based programming may not always affect WHAT we do, but it does affect HOW we do it. A human rights-based approach affirms that people are rights-holders, not objects of charity.

3.2 Outcome and Process

Human rights are indivisible. The vision is holistic and so the process used to fulfil human rights must respect and protect other human rights. Hence in a human rights-based approach to programming, attention must be paid to the process to ensure it is in keeping with human rights values and principles. This approach is also concerned with results or outcomes, as the desired outcome of any programme activity is that it promotes human rights. There is an ethical dimension to the what, the how and the why of activities in a human rights-based approach.

Process goals outlined in the UN Charter include participation and equality, to which transparency, accountability and effectiveness have been added. As already seen, empowerment is needed for effective participation of the disadvantaged, and to be truly effective a programme must be sustainable.

Monitoring is essential for the success of any programme. In holding people accountable in a HRBA, it is necessary that both process and outcome are assessed. The indicators for meaningful participation, empowerment, transparency and process are not as yet as well developed as those for outcomes.
3.3 Needs and Rights

“Although rights cannot be realised if needs are not met, simply meeting needs is not enough. The problems facing vulnerable women and children have immediate, underlying and structural causes and many have common roots....Rights cannot be separated from needs.”

Table 1 exemplifies some differences between the two approaches to programming.

The previous chapter identified the key operational principles of responsibility and accountability, participation, empowerment and sustainability and described them briefly. In the following sections of this chapter, each principle will be explained in greater depth.

3.4 Responsibility and Accountability

Human rights are inalienable entitlements or interests that are agreed as necessary claims for people based on their human nature, needs and aspirations. To convert a rights regime into a human rights regime involves identifying those who have legitimate claims, those who have the duty to ensure these claims are fulfilled, and what redress claim-holders may have against duty-bearers. These questions must be asked and answered at different levels of society.

In respect of human rights, all persons are claim-holders, except for very small children, and all are also duty-bearers. For the realisation of human rights, duty-bearers must be identified and made accountable. Claim-holders, according to age and ability, are

<table>
<thead>
<tr>
<th>Table 1: Differences between Basic Needs Approach and Human Rights Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Basic Needs Approach</strong></td>
</tr>
<tr>
<td>Needs are met or satisfied.</td>
</tr>
<tr>
<td>Needs do not imply duties or obligations although they may generate promises.</td>
</tr>
<tr>
<td>Needs are not necessarily universal.</td>
</tr>
<tr>
<td>Basic needs can be met by goal or outcome strategies.</td>
</tr>
<tr>
<td>Needs can be ranked in a hierarchy of priorities.</td>
</tr>
<tr>
<td>Needs can be met through charity and benevolence.</td>
</tr>
<tr>
<td>It is gratifying to state that “80% of all children have had their needs met to be vaccinated.”</td>
</tr>
<tr>
<td>It is an excuse to state that the “government does not yet have the political will to enforce legislation to iodise all salt.”</td>
</tr>
</tbody>
</table>
responsible for seeing that enjoyment of their rights respects the rights of others. As a duty-bearer, each person is accountable to the community.

However, the state is recognised by law as the primary duty-bearer and is under obligation to ensure human rights. These obligations are of three types: the obligation to respect, protect and fulfill. The obligation to fulfill contains obligations to facilitate (promote) and provide.  

- “The Obligation to Respect requires States to refrain from interfering directly or indirectly with the enjoyment of the right.
- The Obligation to Protect requires States to take measures that prevent third parties from interfering with enjoyment of the right.
- The Obligation to Fulfil (Facilitate) requires States to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realisation of the right.
- The Obligation to Fulfil (Provide) requires States to directly provide assistance or services for the realisation of the right.”  

Obligations may also be divided into obligations of conduct and obligations of result. “While civil and political rights are mostly associated with an obligation of result, social, economic and cultural rights are much more associated with an obligation of conduct.” A group of experts developed new guidelines on violations of social, economic and cultural rights (ICESCR) recommending that more of the obligations related to ICESCR should move from obligations of conduct to obligations of results. Obligation of conduct means in the area of health, for example, the adoption and implementation of a plan of action to reduce maternal mortality. The obligation of result, however, would require states to achieve the goals agreed upon in 1994 Cairo ICPD.  

“Article 29 of the Universal Declaration makes clear that human rights are not just a matter of citizen-state relations. Everyone has a duty to the community. All people must exercise their rights responsibly and respect the rights of others.” Human rights contained in the various treaties and conventions not only engender legally enforceable duties on governments and their agents but also make various agencies, officers and others morally accountable for their duties.

The fulfilment of duties depends on capacities. For a person to be held accountable, four conditions must be satisfied.

1. The person must be aware of the problem and the specific claim-duty relationship.
2. The person must expressly, implicitly or from assuming a role, accept the responsibility to carry out the duty.
3. The person must have the authority to carry out the duty.
4. The person must have access to and control of resources required for meeting the obligation.

“Someone can only be held accountable if he/she is aware of the problem, feels that he/she should act; that he/she may act; and that he/she can act.”  

“The ‘global architecture’ of UN conventions, declarations and world conference documents provides an internationally legitimised set of agreements on social, economic and political issues. These agreements set out the basis for global action to promote the well-being of all by creating an international consensus around a set of values based on human dignity, equality and social justice. In the international arena, social justice means “states also have international obligations to promote human rights globally.” This entails strengthening institutions and policies which ensure that obligations to protect and promote the realisation of all human rights are fulfilled by states and other duty-bearers.  

“The identification of duty-bearers and the extent of their accountability is crucial to a human rights approach to programming.” It is states that ratify the human rights treaties. However, globalisation has generated a significant debate concerning the extent to
which non-state actors (corporations, NGOs, international bodies) also should be subject to human rights laws.95 “Society no longer accepts the view that the conduct of global corporations is bound only by the laws of the country they operate in. By virtue of their global influence and power, they must accept responsibility and be accountable for upholding high human rights standards.”96

One key value is non-discrimination. In examining the relative positions of government and NGOs in terms of non-discrimination and accountability, there are obvious differences, as shown graphically in table 2.97

Progressive realisation of human rights requires states to move as expeditiously as possible towards the realisation of the rights and not to defer indefinitely efforts to ensure full realisation. On the contrary, all state parties have the obligation to begin immediately to take steps to fulfil their obligations under the covenant.98

An enduring challenge in advancing human rights is the lack of understanding of how to invoke human rights to prevent wrongs. The options are to approach human rights reactively or proactively. However, the two approaches are actually complementary and reinforce each other. A reactive approach concentrates on violations, by imposing sanctions on the violator, or by securing redress, relief and rehabilitation for the victim. Violations may be used to mobilise awareness, indignation and concern of others so as to motivate them to adopt a proactive approach. A three-pronged proactive approach includes education on human rights, strengthening of the mechanisms to protect human rights and using development programmes to fulfil these human rights.99 In a violations approach “lawyers and tribunals tend to approach applications of human rights to achieve remedies or preventive outcomes in the context of particular complaints.”100

Each individual woman’s avoidable death may be evidence of multiple kinds of failures within the health care system. In thinking about accountability for those failures and the implications for policy making, it is first useful to distinguish between an individual malpractice case and a human rights violation. ...An individual avoidable death becomes a human rights issue when that death is evidence of a wider, more systemic failure of the government to adequately address structural problems that result in a pattern of maternal mortality.101

Just as duty-bearers are found at every level, so too are the mechanisms for accountability. However, for claim-holders to be able to hold governments to account, it is necessary to address discrimination in legislation, policies and society so that excluded people have more control over their lives.102 It is necessary to develop a set of best practices for reducing preventable causes of maternal deaths and to show how these practices are in compliance with human rights obligations. Lawyers can then work with health care providers to identify whether human rights have been violated and which agencies are obligated to provide remedies. At the national level, the possibilities for seeking redress include ombudsmen, alternative dispute resolution, professional associations and licensing authorities, national human rights commissions and courts of law. Under the regional international human rights treaties, there are monitoring procedures and complaint and enquiry procedures.

<table>
<thead>
<tr>
<th>Table 2: Differences in Government and Non-government</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-discrimination</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Accountability</strong></td>
</tr>
</tbody>
</table>
At the local level, there is often a lack of accountability. “Poor people may prefer, or have no choice but, to use traditional and customary systems. While such informal systems are often closer to the lives and concerns of poor people, they may be based on authority structures, practices and values which do not comply with human rights norms.” Stakeholder committees are often ineffective, as they are not truly participatory but rather they are governed by the elites. Education on human rights helps claim-holders to ensure duty-bearers are accountable.

A good exposition on the various methods of ensuring accountability is given in “Advancing Safe Motherhood Through Human Rights”. For example, a proactive approach would involve taking an agreed set of best practices for reducing preventable causes of maternal mortality, and showing Governments that these practices are required for compliance with human rights obligations found in national laws and regional and international human rights treaties. In this way, “Providers and their professional associations may invoke laws, particularly human rights laws, to advocate for better reproductive health services on behalf of their patients.” A rights-based analysis provides a valuable entry point to analyse the process by which claims are made and to gain legitimacy as a guide to identification of strategic operational entry points.

This proactive approach can be used to strengthen the movement towards socially responsible business and to encourage development organisations to work in ways that strengthen the accountability of governments to people living in poverty. It also means that development agencies should be subject to the same standards of transparency as government. Within the government itself, bureaucratic actors have a role as enablers of rights by constructing a system of rights and entitlements.

3.5 Participation

Participation may be variously described as a right, a process and a strategy. As such it calls for a change in the way assessment, analysis, planning and monitoring are done. For participation to be realised as a right, special attention must be paid to those who are often excluded, especially the poor, women and children. For their voices to be heard, it may require capacity building to enable them to speak and for the duty-bearers to hear and respond. Rights to participation are interrelated with information rights, including the right to freedom of opinion and expression, the right to receive and impart information and ideas through any medium regardless of frontiers.

3.5.1 Participation as a right

Recognition of participation as a human right is vital to its realisation as participation requires resources and capacities and entails costs and time. This right carries with it the familiar duties to respect, protect, promote and fulfil. The duty to respect rights of participation would involve both transparency and removal of obstacles to participation. The duty to protect participation involves a watchdog role on the part of the state. The duty to promote participation will involve capacity-building, creation of procedural opportunities and an enabling environment. The duty to fulfil involves the obligation to take steps to build capacities as well as to provide opportunities for participation. It is important to stress, therefore, that the correlative duties are both immediate and progressive, and may involve either positive or negative acts. There are obligations of conduct as well as obligations of result.

“Violations of the right to participation need to be conceptualised as including exclusion, denial, discrimination as well as other forms of violations. In addition to monitoring violations of the right to participation, it is important to monitor progressive realisation as well. This will enable determinations to be made with regard to both obligations of conduct as well as obligations of result.”

In considering the obligation of result, it is now interpreted from formal human rights law that the right to participate in health-related policy making at the community, national and levels is quite explicitly an integral part of the right to health. For this to be meaningful, steps must be taken to decentralise and...
devolve decision-making. “Decentralisation may increase the participation of marginalised people, but only if it takes place within the context of a political framework which promotes the equal rights of all people.” In their paper on realising the human rights of poor people, DFID highlighted some of the difficulties associated with the right to participation.

“There is no single prescription for effective citizens’ participation. The right to participation requires that people should have the opportunity to choose their level of involvement in decisions and actions which affect their lives. Participatory decision-making may reveal previously hidden problems and conflicts of interest. A rights approach does not provide easy solutions or prescribed answers. It forces us to recognise difficult issues and provides a framework for trying to resolve existing conflicts through processes and institutions which protect the interests of the poorest and most marginalised.”

“Both governmental and non-governmental actors have roles to play in promoting awareness of the importance as well as the opportunities for participation. Both governmental and non-governmental organisations have roles to play in implementation of the right, especially with regard to capacity-building for participation.”

### 3.5.2 Participation as process

Effective participation requires effective dialogue. For some, such as UNICEF, dialogue will demand developing a ‘listening culture’ in order to become an effective partner. This is a change from a needs-based approach to programming where the primary purpose of communication is to initiate changed behaviour in local people. In an applied human rights-based approach, the purpose is to facilitate empowering processes within communities and between communities and outside stakeholders. A shift to empowering processes implies a move beyond the project cycle to longer term relationships with communities, in which rights-holders invite duty-bearers to participate in their development agenda, rather than vice versa.

Building the capacity of both claim-holders and duty-bearers is essential to realising the right to participation. In situations where duty-bearers have the political will to listen, the focus should be on building the capacity of duty-bearers to respond, if necessary at many levels of the chain of rights-holders. If there is no political will to listen, empowering rights-holders to claim their rights may be frustrating or even dangerous. Where there is no political will to listen to rights-holders, advocacy for political development is required before human rights programming is possible.

### 3.5.3 Participation as strategy

Difficult as participation may be in practice, it is still recognised not only as a right but also as an essential strategy. At the Symposium on Development and Human Rights, Terence Jones, the UNDP resident representative to Malawi, noted that “participation is in many ways the key to release the power of fusion between development and human rights.” Belief in the effectiveness of participation as a strategy is prompted by findings in the social sciences. For instance, “complexity theory suggests that optimum connectivity, in which each individual communicates intensively with four to six others, can lead to the spontaneous creation of new ideas, approaches or processes to help a community define its goals and move towards them.”

Fruits expected from participation include:

- Inclusion of the marginalised such as women and children
- Ownership of programmes
- Empowerment
- Sustainability
- Better coordination of programmes at community level.
Strategies necessary to gain these benefits include:

- Inclusion of women, children, and poor
- Discussion with communities and individuals
- Development of genuine modes of partnerships and participation
- Inclusion of local communities and associations as full actors
- Moving beyond community participation to community management.\(^\text{125}\)

“From a human rights perspective, poor people must be recognised as the key actors in their own development rather than the beneficiaries of commodities and services provided by others.”\(^\text{126}\) This respect for the community taps into the wisdom of a community which has already done its own assessment and analysis of the situation\(^\text{127}\) using traditional knowledge, emotional intelligence and experiential knowledge.

Organisational learning approaches such as Appreciative Inquiry can play a key role. These approaches build the confidence and energy of rights holders. They also help duty bearers understand the complete reality of a community, ensuring that traditional or experiential knowledge is respected and included in decision-making.\(^\text{128}\)

This “widens the realm of communication from a rational or information-based knowledge system (the comfort zone of duty-bearers) to a knowledge system that incorporates spiritual, emotional and cultural values (the reality of rights-holders in communities).”\(^\text{129}\) More equal communication between duty-bearers and claim-holders will often meet resistance from people with vested interests in the status quo. Yet this type of intervention is vital to realising human rights.\(^\text{130}\)

This will necessarily lead to “analysing the interactions between people’s ‘voice’ and the institutional structures that enable their priorities, views and perceptions to be translated into real outcomes.”\(^\text{131}\) It is important to detect tokenism and to foster genuine modes of partnership and participation in which communities and local associations are full actors in development, not participants of projects planned and managed elsewhere.\(^\text{132}\) “When people examine problems together and agree on the causes, they are more likely to agree on the actions to resolve them.”\(^\text{133}\) They are also more likely to understand their own role in realising the rights of women and children.\(^\text{134}\) Having agreed on a programme to realise the human rights of all, the community is then empowered to claim their concrete entitlements, thus increasing accountability.\(^\text{135}\)

Urban situations present the challenge of defining the communities and recognising their structure. For concerted and sustained action, especially on behalf of the marginalised, it is important to have a high level of connectivity within the community.

Within communities, there is a need for:

- Increased connectivity
- Defining goals
- Creation of ‘safe spaces’ to discuss issues and reach consensus
- Participation of the normally voiceless in decision-making.

Between community and duty-bearers, there is need for:

- Increased connectivity
- Creation of ‘non-threatening’ communication channels
- Imaginative use of media to improve participation.\(^\text{136}\)

Improved connectivity produces unpredictable results, but unpredictability is consistent with a human rights approach to programming, in which a large number of rights-holders set the development agenda rather than a small number of duty-bearers or others who hold power.\(^\text{137}\)
The benefits of partnerships for saving women’s lives and upholding women’s rights include:

- Creating dynamic contact networks to influence and engage the community and policy makers
- Replacing conflict with cooperation, thus aligning priorities, needs and the roles of each actor and leading to synergy of efforts to reduce maternal mortality
- Providing possibilities for sharing specific knowledge, skills and competencies to address common problems
- Assisting in the mobilisation of resources and action for critical needs.\(^{138}\)

### 3.6 Empowerment

Not all people are aware of their inherent dignity and equality by virtue of their humanity. This is manifest in social inequalities recognised as power differences. These power differences translate into and perpetuate the social injustices of our world, including avoidable maternal deaths.

*Human rights are undoubtedly about power and empowerment. The Czech author, Milan Kundera, reminds us that “the struggle of man over power is the struggle of memory over forgetting”. Human rights are about power and emphasise “right not might”. Human rights are about memory: and remind us of our dignity, our identity, our very humanity.*\(^{139}\)

As a result of empowerment, rights-holders learn to define who they are and visualise where they would like to go, and hence can interact with duty-bearers on an equal basis.\(^{140}\) DFID maintains that empowering people to take their own decisions is inherent in a human rights-based approach to development. Empowerment means individuals acquiring the power to think and act freely, exercise choice, and to fulfil their potential as full and equal members of society.\(^{141}\) The objective of DFID’s Human Rights Strategy is to enable people to be active citizens with rights, expectations and responsibilities.\(^{142}\)

An analysis of claim-holder – duty-bearer relationships reveals that fulfilling the rights of one claimholder is a prerequisite for that person’s fulfilling the rights of another for whom they are a duty-bearer. To fulfil the rights of a child (the primary claim-holder) the parents are the primary duty-bearers, but the parents are in turn secondary claim-holders against other secondary duty-bearers.\(^{143}\)

This series of claim-holder – duty-bearer relationships is called a pattern of rights. In looking to empower claimholders, it is important to understand the series of power relationships involved in the pattern of rights. “The definition, interpretation and implementation of rights are therefore dynamic processes that are inherently political in their nature.”\(^{144}\)

The political nature of human rights initiatives is related to their challenge to the status quo from which vested interest groups currently benefit. Hence decisions on development initiatives are more often based on interest group power rather than on technical information.\(^{145}\) This is true also at the international level, where the governments of poorer countries continue to have concerns about the use of human rights as a means of increasing conditionality or as weapons in international trade negotiations.\(^{146}\)

However, human rights instruments provide internationally accepted standards and facilitate the recognition of social injustice. As Lynn Freedman points out, “If we approach human rights as a tool for transforming a system – transforming a set of power relationships that keep unacceptable things as they are – then a rights-based approach can make a meaningful difference for the decision makers compelled to make a real policy choice.”\(^{147}\)

In social theory power is seen as essentially any form of asymmetry in human relations. Political sociology emphasised structural power and the coercive capacity of the state, but more recent perspectives have emphasised the ways in which power relations can be disguised and coded in most aspects of everyday life (language, bureaucratic cultures and procedures, etc.).\(^{148}\) The very pervasiveness of the exercise of power means that human rights needs to inform all levels of interaction, from the family to the international
arena. Building socially inclusive societies requires a focus on relations of power that lead to discrimination and inequality and calls for integrated approaches which address both legislation and policy across development sectors. This, in turn, requires multi-disciplinary work within and between development organisations.149

“Community plays a critical role in empowering or disempowering individuals (subjects) to claim their rights.”150 “The key challenge is to ensure that actions to increase citizens’ participation in decision-making processes empower the poor and not just local elites.”151 It is in examining a particular social injustice that the extent of power imbalance and its effects are revealed. The empowerment of one necessarily means the disempowerment of another, not a welcome idea to those in power. In Nepal the new focus on the most disadvantaged runs counter to ingrained patterns of discrimination, both institutional and conventional.152 In examining the right to participation, it was seen that empowerment of the voiceless rights-holders is essential for them to claim their rights. “It is not simply that women’s lives and health are devalued; it is the intersection of such gender discrimination with imbalances of power by race/ethnicity, class and age, within households, across societies, and between countries, that shapes the patterns of maternal mortality.”153

3.7 Sustainability

Just as there is a symbiotic relationship between participation and empowerment, the same is true of sustainability and human rights. One cannot be realised without the other. “Sustainable human development means expanding all people’s choices and creating the conditions for equality so that they may realise their full potential. This goal is unrealisable if all human rights – economic, social, cultural, civil and political – are not promoted, preserved and defended.”154 Likewise, it is recognised that “Without imbuing management with values and rights-based principles, there will be no sustainable change.”155

“In order for human rights conventions to form a sustainable foundation for development, innovative strategies and interventions must be developed to translate ethical and legal principles into practical programme activities with verifiable results.”156

“Sustainable development requires the management and maintenance of different sorts of ‘capital’ which support human well-being:

- Created capital: including physical infrastructure, buildings, machinery and equipment
- Natural capital: the environment and natural resources
- Human capital: human skills and capacity
- Social capital: strong social relationships and institutions.”157

Sustainability refers especially to the economic, social and cultural rights of all. In the face of limitations of resources, the challenge is to ensure distribution is based on human rights principles. “Generating results, consolidating gains and sustaining results are among the major programming challenges in South Asia. Many factors influence sustainability of programme results – shared values, technical capacity, financial resources, political commitment. Above all, ownership and management that address the deeper and more critical, subtle issues are key.”158 From shared values will flow political commitment and ownership.

“Political commitment will be strengthened when civil society shares the ownership and commitment to maternal mortality reduction and exerts enough influence.”159 Only with ownership and commitment will people (rights-holders) demand the necessary services, hold the duty-bearers accountable and be empowered to ensure sustainability.
OVERVIEW OF A HUMAN RIGHTS-BASED APPROACH TO PROGRAMMING

4.1 Key Elements of A Human Rights-Based Approach

UNICEF was the first UN agency to transform its country programming into an exclusively full-fledged human rights-based process. Following lengthy and intensive consultations within the organisation, the Executive Director, Carol Bellamy, formally issued on 21 April 1998, the guidelines for “A Human Rights Approach to UNICEF’s Programming for Children and Women” as Executive Directive 04/1998.160

This is an authoritative guidance to country offices in particular, and the organisation in general, detailing what this approach is; the changes it will bring; the relationship between need, rights and development; the key guiding human rights principles – particularly with reference to the CRC and CEDAW; and the general and specific programme implications and methodology for applying the approach. It ends with other implications of human rights programming for the work of UNICEF, such as human rights programming and UN reform and advancing the human rights agenda with the international financial institutions (IFIs). Ever since, UNICEF has been applying this approach and learning valuable lessons through the process.

At a workshop attended by a number of UN agencies in Princeton in 2001, the key elements of a human rights based approach were delineated.

A human rights approach to development: 161

- “Focuses on people as holders of rights and as active participants rather than passive beneficiaries in development
- Focuses on duties and responsibilities of governments, people (both individuals and groups), and the international community
- Applies the fundamental principles of non-discrimination on the basis of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status
- Prioritises the most vulnerable, disadvantaged, excluded or neglected groups in society
- Reiterates that development is a human right and not merely a matter of need or charity
- Recognises that the realisation of human rights is both a legal and developmental imperative
- Is directed towards the goal of poverty eradication and addresses structural inequalities that cause poverty
- Adopts the normative legal framework of human rights contained in the core human rights treaties and other UN human rights instruments
Reiterates that human rights is a holistic concept and recognises all – civil, cultural, economic, political and social – rights as universal, indivisible, interdependent and interrelated

Draws upon human rights information generated by UN human rights mechanisms, procedures and institutions

Necessitates full national ownership, consistent with the above principles, of all development plans, programmes and activities

Requires a step-by-step raising of awareness, at all levels, within the UN system and all development partners, of the above elements

Requires a long-term commitment to human rights, at the highest level, for its attainment

Most importantly, seeks to put into practice the human rights norms and principles of freedom (in terms of enlarging people’s choices and capabilities), dignity, security of persons and resources, transparency and accountability

Is based upon an analysis and understanding of the human rights situation in the country

Adopts a human rights perspective in identifying and addressing development challenges and priorities in the country.”

Among the UN agencies, “there is, as yet, lack of agreement as to a single common approach (e.g., how to incorporate the goals and targets of the Millennium Declaration in a human rights approach).” Among these goals is the reduction of maternal mortality by three-quarters by the year 2015.

At the first UN Interagency Workshop on the human rights mainstreaming held in Princeton, NJ, in January 2001, key challenges for a human rights-based approach were identified as:

“Differences in understanding among agencies regarding human rights-based approaches to development

Diversity of practices regarding human rights in development calls for recognition of common goals (e.g., prioritising those most in need)

A human rights approach must be multi-sectoral, creating the need to bring together the contributions of the various relevant professionals in an interdisciplinary manner

Failure to recognise the human rights mandates of UN agencies and programmes

Absence of a culture of human rights and pockets of resistance to mainstreaming human rights in development

Strategic differences as to whether a human rights approach should be explicit or implicit

Difficulties in securing (and measuring) national ownership

Donor requirements and expectations regarding products, outcomes, impact and process

Dearth of relevant materials on implementation of a human rights-based approach to development

Lack of criteria for prioritisation

Differences among agencies in programming practices and processes

Inadequacies of conceptual and methodological development, e.g., with regard to measuring progress and impact; to building subjective dimensions of human development into indicators; and to ensuring against manipulation of development data for political purposes

The establishment of interplay between national human rights commitments and treaty obligations; the accountability of non-state, as well as state, actors for their actions affecting human rights

While an initial focus, of both introspection and training, will indeed be on the UN, there is a clear need to move to examining how the UN system and
UNCTs can assist government and national partners to mainstream human rights

- UNDAF is not an end in itself but rather a process to achieve specific objectives, a means to establish an effective country team, and an opportunity to move from theory to practice on a human rights-based approach.”

In the two years since the Princeton Workshop, significant progress has been made by both the UN agencies individually and collectively through UN country teams (UNCTs) in addressing some of these challenges. This was evident in the Second Inter-Agency Workshop, held in May 2003, where the UN agencies adopted the Statement of Common Understanding of the Human Rights Based Approach to Development Cooperation and Programming outlined in Box 2.164

4.2 A Human Rights-Based Approach and Human Development

The relationship between the Human Development Approach and the Human Rights-Based Approach to programming was examined in the Human Development Report 2000. These two approaches share the common purpose and motivation of human freedom. Drawing on the strengths of the movements for human rights and for human development forges a broader alliance and releases a reciprocal exchange of creative energy.165

This symbiosis of development activity has related to the growing international support for democratic principles and human rights. With modern communications technology, the world has become a virtual village and recent civil conflicts, wars and acts of genocide have become globally shared experiences. This has elicited strong international calls in defense of human rights and a renewed demand for public sector accountability, good governance and the realisation of human rights as the ultimate purpose of development efforts.166

Human development is a process of enhancing human capabilities – of expanding choices and opportunities so that each person can lead a life of respect and value.

A rights-based approach introduces the following additional important considerations:

- The notion of the legal and moral obligation and accountability of the state and its institutions with regard to meeting the basic needs of its people;

- The affirmation that children and women are subjects of rights (rights-holders), not objects of charity; this change in attitude also initiates a process whereby children, within the context of their evolving capacities, participate in the processes and decisions that concern them and affect their lives;

- The principle that benevolent and charitable actions, while good, are insufficient from a human rights perspective. A rights approach is based on the premise that there are shared

Box 2: Statement of Common Understanding

1. All programmes of development cooperation, 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.
interests between rights-holders and those working to help realise rights. In a rights approach, it is accepted that the state is normatively required to work consistently towards ending denials or violations of human rights and that the empowerment of rights holders is in itself an important result of various processes. A rights-based approach, therefore, better guarantees the sustainability of development programmes.167

Development is about people. A human rights approach changes the concept of people from simply beneficiaries to a much more complex pattern of people as priorities, as beneficiaries, as rights-holders and as duty-bearers. “Clearly, rights-based programming is also about values, to ensure that society values women and children, protects their rights and responds positively to their entitlements.”168 Concern for those who suffer discrimination enables a priority focus on the disadvantaged, the vulnerable – those most in need. This changes not only how assessments are made but also how development indicators measure impact on human well-being and the realisation of human rights.169

Whilst human rights cannot be prioritised, scarcity of resources and institutional constraints demand that actions to realise rights must be prioritised. This often means policy choices. A human rights approach to programming does not help in such choices. This is where a human development approach becomes more useful.170

4.3 Value Added

The value added to programmes using a human rights-based approach comes from the very nature of human rights. Since human rights are enshrined in internationally accepted legal documents they have acquired global legitimacy.171 However, not only are they based on a legal foundation, human rights also are indivisible, interdependent and interrelated. Since they encompass all people, the human rights-based approach has a mandate to respect the dignity and equality of all people by the principles of non-discrimination, participation, accountability, empowerment and sustainability.

4.3.1 Value added by global legitimacy

The legal basis of human rights has set a valuable standard which gains its legitimacy from its universality. It is over fifty years since the Universal Declaration of Human Rights was ratified. Such a long duration has also increased legitimacy. In the case of safe motherhood, this means reviewing and modifying laws and policies so that they protect women’s health interests, as well as ensuring that health services and information are provided in a way that respects human rights.172

Human rights instruments also provide a starting point of common ground for negotiations between governments and donors. The dialogue between governments and donors then is aimed at enabling governments to keep their promises to respect, protect and fulfil human rights. It becomes a process to understand the different factors affecting the realisation of rights and to explore the specific priority actions needed in each country in order to promote them.173

4.3.2 Value added by indivisibility, interdependence and interrelatedness

The indivisible relationship among human rights gives impetus to address specific problems in a multi-sectoral manner.

The failure to address preventable maternal disability and death represents one of the greatest social injustices of our times. A human rights approach shows that women’s maternal mortality and morbidity result not simply from their disadvantages but frequently from cumulative denials of their human rights; that is, failure to address their preventable death and sickness is a result of injustices that women experience. A human rights approach to safe motherhood identifies forums to acknowledge the wrongs women suffer through the neglect of their basic health care needs as denials of their human rights, and seeks means by which these denials can be remedied.174
A human rights approach allows health care providers and administrators to participate with colleagues in their own, related and different fields in determining how best to advance safe motherhood through human rights. Once people from different sectors become involved in overcoming one problem related to unfulfilled human rights, the same basic causes may be found for a number of problems, such as lack of capacity and gender discrimination. So addressing these basic causes may result at the same time in enabling the solutions of a number of problems.

Addressing the factors underlying women’s lack of access to health services leads to addressing the way some of these same factors lead to violence against women. Upholding the rights of women to survive pregnancy also upholds the rights of children and husbands, whose mothers and wives are otherwise lost.

Thus maternal mortality reduction is both an output and an entry point for addressing key strategic issues associated with women’s rights issues, such as violence. A human rights perspective helps to identify entry points and associated instruments at each level of society.

4.3.3 Value added by non-discrimination

The whole human rights endeavor, with human dignity as its core value, is also meant to inspire profound and fundamental change in the most everyday interactions of life. In families, this means that girls and women are no longer discriminated against in terms of food, education and health care. At the public policy level, strengthening of the human rights content creates stronger and more equitable public, civil and community institutions.

A human rights-based approach has prompted the shift from a welfarist, needs approach to putting greater onus on states to fulfill rights. Women and children are not charity cases but rights-holders whose rights duty-bearers are obliged to address. This also encourages governments to think more comprehensively about services to be provided, especially beyond the health setting.

4.3.4 Value added by participation

Participation is a right but it is also a strategy. In both cases, it leads to greater ownership and sustainability. A human rights-based approach to programming includes participation in all phases of the programme cycle: assessment, analysis and action. It is this which gives the added value.

4.3.5 Value added by accountability

Since States have ratified the human rights treaties, they can also be held accountable. The legal processes are established. However, in the wide range of human experience, the full implications of these treaties are still evolving. The usual process is to take test cases and apply the principles. “It is the accretion of specific cases using rights principles to address concrete situations – rather than repeated declarations of broadly stated entitlements – that will drive the steady development of a meaningful rights-based approach to health.”

The full value of governments’ accountability is not yet realised but the potential is there for people to use. NGOs may feel they do not have sufficient standing, and professionals employed by the government may feel uneasy about confronting the government. However, on the issue of safe motherhood, they can begin negotiations with the government by pointing out that maternal deaths are not mere unavoidable misfortunes but rather social injustices that society is obliged to remedy. Governments may then begin to understand their responsibility.

4.3.6 Value added by empowerment

“Rights matter and a framework that focuses on rights helps policymakers to understand the power dimensions of development processes.” A human rights-based approach examines the social and political processes that determine whether people’s claims are being recognised as rights.
It seeks to:

- Identify social characteristics related to empowerment
- Understand how power impacts on poverty and insecurity and different levels of authority
- Understand the means for realisation of rights through the legal system, the allocation of resources and the administration of resources, as well as through political processes.  

A human rights-based approach has both normative and analytical components, which when combined, constitute a basis for mainstreaming empowerment in development agencies' work. 

4.3.7 Value added by sustainability

UNICEF has found that a rights-based approach improved both the sustainability and quality of its programmes. This is an added value from a human rights-based approach. However Amartya Sen has expanded the understanding of human rights in his concept of sustainability. “Sen’s conceptualisation of sustainable development as pertaining to inter-generational equity of capabilities provides a powerful linkage with the human rights agenda. A moral argument that recognises equity between the rights of present and future generations is a powerful step towards developing an approach to development, which is sustainable in such terms.”
“Women and girls are the key. If we fail them, we fail their children, we fail their communities, and we fail the very idea of human progress”

Carol Bellamy
Executive Director, UNICEF
7 March, 2003
Section 2

THE CHALLENGE OF MATERNAL MORTALITY

CHAPTER 5  Understanding Maternal Mortality

CHAPTER 6  Challenges
5.1 Present Situation

In 1987, global attention was drawn to the neglected issue of maternal mortality through a conference at which the Safe Motherhood Initiative was launched. At that time, maternal mortality rates were not even estimated for most developing countries. However, it was known that “globally, maternal mortality ratios present the largest discrepancy in any public health statistics between developed and developing countries.” There has been progress in the past 15 years:

- Maternal mortality reduction is now on the development agenda
- Research has been done on causes of maternal mortality
- Conceptual frameworks have been developed
- Various programme options have been tried and evaluated
- The need for a multi-sectoral approach has been recognised.

For a long time maternal deaths were seen as an “unavoidable and natural disadvantage of pregnancy.” But now it is recognised that “most maternal deaths are avoidable, and thus unacceptable.”

5.2 Definitions

While it is important to liberate maternal mortality from being solely a medical concern, it is still useful to know the precise meaning of some of the terms used. Some of the important terms are defined below.

**Maternal death** refers to the death of a woman while pregnant or within 42 days of the termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by pregnancy or its management but not from accidental or incidental causes.

**Late Maternal Death** is defined as the death of a woman from direct or indirect obstetric causes occurring more than 42 days but less than one year after the termination of pregnancy.

**Maternal Mortality Ratio:** the number of maternal deaths per 100,000 live births. This measure indicates the risk of maternal death among pregnant and recently pregnant women.

**Maternal Mortality Rate:** the number of maternal deaths per 100,000 women aged 15 – 49 per year. This measure reflects both the risk of death among pregnant and recently pregnant women and the proportion of women who become pregnant in a given year.
5.3 Investigation of Maternal Deaths

Figures for maternal deaths are difficult to establish with accuracy. Large population samples are needed and the relationship between pregnancy and death has to be established. This is particularly difficult in cases of abortion-related deaths. Hence maternal deaths may be under-reported or misreported. Due to the inaccuracy of any vital registration systems, new methods have been developed to estimate maternal mortality, including household surveys, the Sisterhood Method and the Reproductive Age Survey (RAMOS), however each is costly and time-consuming.

There are several methods for investigating the causes of maternal deaths. They include verbal autopsy and maternal death case review.

Verbal autopsy is ‘a method of finding out the medical causes of death and to ascertain the personal, family or community factors that may have contributed to the death in women who died outside of a medical facility.’ It consists of interviewing people who are knowledgeable about the events leading to the death. This technique provides information beyond the immediate cause of death, which can point to possible interventions to prevent similar situations in the future.

While figures for South Asia indicate that most maternal deaths occur at home, for deaths which occur in a health facility there is a need to identify the combination of factors at the facility and in the community that contributed to the death and which ones were avoidable. ‘Maternal Death Case Review (MDCR) is ‘a qualitative, in-depth investigation of the causes and circumstances surrounding maternal deaths occurring at health facilities.’

The MDCR “process begins at the health facility but also traces events back to the community... If it is conducted in a participatory and culturally sensitive manner, the investigative process often has the advantage of strengthening links between health facilities and communities.”

The Confidential Enquiry into Maternal Deaths, a more elaborate technique undertaken at a national level, investigates individual maternal deaths to identify flaws in the healthcare system and to recommend positive changes in practice, rather than punitive action.

5.4 Causes of Maternal Deaths

Maternal death is the result of a sequence of three events:

- A woman becomes pregnant, voluntarily or involuntarily
- She suffers one or more complications caused or aggravated by pregnancy and/or childbirth
- The complications are not treated or are not treated properly.

Since most of these complications of pregnancy cannot be prevented or reliably predicted, the points of intervention are the first and the third events in this sequence. Responsible planning of family size and birth spacing will decrease the total number of pregnancies, but adequate treatment of complications is needed to avoid death related to pregnancy. The measures taken to treat complications are referred to as emergency obstetric care (EmOC).

The incidence of complications in pregnancy is given in box 3.

**Box 3: For Every 100 Women Who Become Pregnant**

- 40 will experience some complication during pregnancy, childbirth or the postpartum period
- 15 will develop life-threatening complications, mostly at the time of or soon after childbirth
- 5 will require a surgical intervention, usually a Caesarean section

If the Caesarean rate is below 5 per cent, this indicates that many women are being denied access to essential life-saving surgery.
It is important to emphasise that every pregnant woman is at risk of a complication. A review conducted by WHO found that the strategy of risk assessment has not been effective in preventing maternal deaths. Some women identified as being at risk have no complication, whereas women identified as being low risk are ignorant of what needs to be done in the event of a complication. 206 “The problem is that low-risk women do develop complications and there are so many of these women in the population” 206

5.4.1 Medical causes

The five direct obstetric causes of maternal death – haemorrhage (bleeding), hypertensive disorders (eclampsia), infection, obstructed labour and complications of unsafe abortion – are common among women worldwide. These five obstetric complications account for 80% of all obstetric causes of maternal death (Figure 1). 207

Time is a critical element in relation to pregnancy related complications. These complications may occur during the pregnancy, during the delivery of the baby or after the birth.

The estimated average intervals from the onset of major complications to death are given in table 3. 208

The time between onset and death is reflected in the distribution of maternal deaths according to the stage of pregnancy and childbirth as shown graphically in figure 2. 209

5.4.2 Three delays model

Obviously the most dangerous time is the first 24 hours after delivery. When planning activities to improve access to medical treatment for obstetric emergencies, it is useful to think in terms of time. There are three steps to life saving care:

- Decide to seek medical care
- Reach an appropriate medical facility
- Receive adequate care at that facility 210
A delay at any one of these stages may cause death. The factors affecting utilisation of EmOC and hence leading to maternal death are shown in figure 3. Furthermore, delay at the first stage is often compounded by delays at the other two as well.

In looking at the causes of maternal death from a human rights perspective, it is important to consider the factors that have been identified as contributing to the delays which ultimately deny a woman her right to life. The inequality of girl children and women is the transcending risk factor, related to lower status and significance of women in their communities.211

“Maternal death is most likely to occur in families where girls learn they have a lesser right to food and education than boys, and where women believe that their health is less important than that of other family members.”212

The first of the three delays is in making the decision to seek care. This delay may be divided into two elements: the delay in recognising the need for medical care and the delay in deciding to seek care.213 Maternal death is “most likely in cultures where maternal illness, suffering and death are viewed as natural, inevitable and part of what it means to be a
Even if the complication is recognised as something for which there is a remedy, the next barrier to action to save a woman’s life is her value within the family. “Maternal death is more likely in communities where women hold the least economic and political power and yet carry a heavier physical work-burden,”215 A study conducted in Nepal demonstrates that the husband is the most frequent decision-maker in whether to seek hospital care.216

The decision to seek care is also influenced by the expected outcome. “Women’s utilisation of health services, for emergency obstetric care or for treatment of injuries resulting from violence, is highly influenced by the manner in which their dignity is respected.”217 Confidentiality is a major issue. “Women sometimes refuse to seek health services because they believe that their medical confidentiality will not be respected,”218 especially in relation to complications of unsafe abortion, which is a leading cause of maternal death. This may be due to social stigma or prevailing laws.219 A further barrier to women seeking care is the need for authorisation. In some cultures women requesting health services must obtain their husbands’ authorisation or adolescent girls seeking health services must obtain parental authorisation.220 As shown in figure 4,221, a study in Bangladesh revealed a number of reasons why women failed to seek care. Situations of civil unrest also impact negatively on women’s access to health care, with particularly negative consequences for minority groups.222

The time taken to reach a facility is related to the availability, accessibility and quality of the services. Maternal death is “more likely in nations that give little priority to health services for women – including maternal care.”223 Health regulations and policies may demand unnecessarily high qualifications for health service providers of routine obstetric care. This may obstruct access and availability because of limits of facilities, personnel or women’s financial means.224

The third delay in receiving adequate, appropriate treatment at the facility depends on the functioning of the facility.225 To save women’s lives, quality EmOC must be available 24 hours a day, 365 days a year. It depends on the management of the internal systems and processes of the facility to ensure:

- Availability and willingness of competent staff
- Availability of necessary equipment, supplies and infrastructure
- Technical competence
- An environment where women feel comfortable with the way they are treated.226
However, the situation in South Asia is in stark contrast to the requirements. Delays in the facility are related to lack of appropriate management resulting in low staff morale, insufficient teamwork, a lack of adequate services, and negative interactions between women and health personnel. The quality of care given by a particular facility is spread by word of mouth. A study in Bangladesh found that decisions on whether to use a facility or not were often based on hearsay, but then there was a good functioning team, the use of the facility increased five-fold. However, “suspicion and fear of improper practices may persist long after they have been eradicated.” Lack of supportive national policies contributes to delays in decision making, in reaching the facility and in receiving adequate, appropriate care.

Beyond the medical causes of maternal deaths, health systems, laws and policies affect availability, accessibility and quality of reproductive health services. Existing challenges include:

- Establishing transparency in the health system
- Rationalising human, physical and financial resources
- Creating women friendly environments
- Establishing high standards of care

**5.4.3 Factors underlying the medical causes**

While complications cannot be predicted, certain conditions are known to be associated with a higher incidence of complications. Globally, “teenagers account for an estimated 25% of the 600,000 maternal deaths each year – many of these could have been avoided if these adolescents had better access to family planning information and counseling. Each year, women experience 75 million unwanted pregnancies, approximately 20 million of which end in unsafe abortion.” Sexual activity and childbearing early in life carry significant risks for young people all around the world.

**Box 4: The Situation**

South Asia has the technical expertise to provide emergency obstetric services, yet most women fail to get the life-saving care that they need.

- The national and sub-national budgets for EmOC are inadequate.
- There is little political or administrative commitment to women’s rights and health needs.
- Many facilities do not provide 24-hour emergency obstetric services. They are poorly staffed and lack basic EmOC supplies and equipment.
- Standard protocols for EmOC services are scarce.
- Many health personnel are insufficiently trained and supported to provide EmOC services, to manage those services and to deal with clients appropriately.
- Staff guidance and supervision need to be strengthened, as do systems for acknowledging commitment, innovation and leadership to save women’s lives.
- The low status of women is reflected in the way women - both clients and staff – are treated.

Teen mothers face twice the risk of dying from childbirth than do women in their twenties. Underlying socio-legal conditions such as lack of enforcement of minimum age of marriage laws, and lack of alternatives to early marriage and childbearing for adolescent girls also influence the incidence of maternal death.
Early marriage for young girls in South Asia is linked to poverty and fear of rape. Early marriage to a much older man becomes a survival strategy for the family, and may even be seen to be in the girl's best interest. Marriage as a young girl is seen as the best way for a woman to gain status in the community, and averts pregnancy out of wedlock. Consequently, more than 40% of girls in South Asia give birth before the age of 20. At least 50% of girls in Bangladesh and 44% of girls in Nepal are married in their teens.

Because of perceptions that young girls will end up as "another family's property," they are too often regarded as economic burdens, not worth a parent's investment. With such low social and economic status, their access to education, nutrition and economic resources for health care is limited. Lack of access to information and decision-making power consigns many women to a life of repeated childbearing. The preference for sons over daughters has reportedly led to a significant increase in the abortion of female foetuses. This suggests that anti-female biases are still deeply entrenched in society. Excessive physical work coupled with poor diet also contributes to poor maternal outcomes. Poor nutrition before and during pregnancy results in conditions such as stunting, anaemia, severe vitamin A deficiency, and other micronutrient deficiencies, which contribute to poor maternal health, obstetric problems, and poor pregnancy outcomes.

There is a clear relationship between girls' access to education and literacy and reduced maternal mortality. Girls and young women often lack access to formal education and opportunities that would enhance confidence and decision-making skills to delay marriage and fertility and to refuse unwanted sex. Literacy and education contribute to safe motherhood by increasing women's autonomy, providing information on pregnancy-related topics and correcting misconceptions.

Cultural practices contribute to maternal deaths: in some communities women must deliver in livestock sheds since blood lost during delivery is considered impure. Tetanus still accounts for a significant number of maternal deaths. Misconceptions about the cause of complications include the belief that spirit possession causes eclampsia. Evidence from several studies suggests that pregnancy is associated with an increased incidence of domestic violence, including homicide. Studies show that women in India are subject to increased risk of violence for producing a child of the 'wrong sex'. The stigma of rape, pregnancy outside marriage or dowry problems are suggested as the cause of suicides and homicides. Such cases amounted to 6% of maternal deaths in one area of Bangladesh. A review of a paper on 65 verbal autopsies of maternal deaths was done by two women activists in Bangladesh. This revealed that 14% of maternal deaths were due to violence. Many of the factors influencing delays in pregnant women seeking treatment for complications also affect women who have been abused. When a woman is both subject to violence and pregnant she is doubly vulnerable.

The gains made in reducing maternal mortality in Sub-Saharan Africa have been overturned by the AIDS epidemic. In India, the HIV/AIDS epidemic continues to shift towards women and young people, with half the new infections in those below 25 years. States such as Andhra Pradesh, Karnataka, Maharashtra, and Manipur are reporting high levels of infection among young pregnant women (between 1-2 %), with an accompanying increase in vertical transmission and pediatric AIDS.

5.5 Roles and Responsibilities

A vital concept in a human rights based approach is the recognition of duty-bearers and a participatory approach to holding them accountable. "As correlative duties apply at all levels, it is not only governments that have to account for their roles in the realisation of child rights. Non-governmental and community-based organisations, extended families, nuclear families, households, individuals, the private sector and the international community in the region all bear duties to respect, protect, facilitate and fulfil the rights of the child and those of women."

In a society where women see themselves as having little value, they are less likely to claim their rights. "In women-friendly societies, husbands, parents-in-law,
other family members, neighbours, communities and nations all actively encourage women to protect and improve their health and to use maternal health services. For duty-bearers to meet their obligations, they must be aware of their duty, accept the responsibility, have the authority to do what is required and have the resources to do it. In other words, ‘should’ must be preceded by ‘can’ – it is otherwise utopia. ‘Morality must march with capacity’.

5.5.1 Family level

The well-being of women is heavily determined by what happens in the private spheres of their lives, within their families, households and communities. To ensure that women have the care they need for safe motherhood, it is necessary to improve the way families and communities care for women. Care refers to the support provided to women by the family and to practices within the household, such as the allocation of household food. In addition, care includes the utilisation of health services and water and sanitation systems to create a healthy micro-environment.

Specifically in relation to a woman’s right to surviving pregnancy, at the family level it is essential that all women and family members can identify dangerous signs during pregnancy and childbirth, know where to seek help and have access to quality maternal care. Another major issue is the willingness to donate blood. Often the reason why family members do not want to donate blood is the misconception that it makes one weak and affects one’s well-being. To ensure that women survive, families need to donate blood if required, and communities need to organise blood donor networks.

5.5.2 Community level

Economic status has been identified as one of the factors influencing the decision to seek care. Transport to distant health facilities affects the delay in reaching the facility. A further delay in receiving care may occur if blood donors are not available. All these situations call for a response from the community to save the woman’s life. If the sequence of awareness, responsibility, authority and resources are applied at community level, it is seen that “members of these communities have the capacity to develop themselves to lay the foundation for their security and well-being.”

For awareness, “advocacy and mobilisation are necessary to facilitate social interdependence and solidarity to realise human rights.” Awareness of the role and responsibility of the community in preventing maternal deaths will be grasped first by a few champions for change.

They will:

- Mobilise family and community accountability for saving women’s lives
- Foster a sense of accountability for women’s life and health, which demands quality EmOC

Their effectiveness will be enhanced by identifying strategic allies. Strategic allies are those people who share the same values in relation to all or a subset of human rights such as gender discrimination or lack of basic health care. Identification of these people or groups of people and linking them together with support to realise certain rights will increase the pool of human rights-conscious people and achieve increased participation in societal decision-making.

Non-governmental organisations and local community workers have important roles in advocacy and in

<table>
<thead>
<tr>
<th>Country</th>
<th>Percentage of Births Attended by Skilled Health Personnel 1990-2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afghanistan</td>
<td>15*</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>13</td>
</tr>
<tr>
<td>Bhutan</td>
<td>15</td>
</tr>
<tr>
<td>India</td>
<td>42</td>
</tr>
<tr>
<td>Maldives</td>
<td>90</td>
</tr>
<tr>
<td>Nepal</td>
<td>9</td>
</tr>
<tr>
<td>Pakistan</td>
<td>18</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>94</td>
</tr>
</tbody>
</table>

enabling the poor and the illiterate to have a voice in community endeavours.260 They have a crucial role in monitoring governmental agencies’ discharge of their duties to respect, protect and promote human rights relevant to safe motherhood.261

Access to skilled birth attendants is vital for a woman’s survival of a pregnancy complication. Yet, “in parts of Asia and Africa, there is only one midwife for every 300,000 people, meaning one midwife for every 15,000 births. The recommended ratio is one midwife for every 5,000 people.”262 “The confrontation with failing health care systems challenges those who support a ‘rights-based approach’ to health to consider how a human rights perspective can help health policy makers respond to the very real resource constraints and resulting policy dilemmas they face. This is as much a challenge for human rights advocates as it is for health policy makers”263

5.5.3 Health facility level

At the health facility level, the first requirement is 24-hour availability of quality emergency obstetric care services that are acceptable and affordable to the women who need them. In addition, it is necessary to create a women-friendly environment for all women to uphold their rights and to build and sustain accountability in the health facility.264 Accountability includes individuals and teams, as well as the facility as a whole.

In the context of EmOC, two key human rights values are human dignity and non-discrimination. These human rights values are relevant to all the human interactions that happen in a facility, whether patient – provider, or among providers and staff.265 The progressive realisation of women’s rights will require the facility to build partnerships that are accountable for reducing maternal deaths. Partners champion change for women within the hospital – both women health personnel and women clients – regardless of their caste, class, religion and ethnicity, by demanding, influencing and participating in the creation of the desired environment.266

Health professionals have a role as advocates for women’s human rights to officials and legislators, as educators of their patients, students and communities on human rights related to safe motherhood, and as collaborators with professionals of other disciplines such as lawyers.267 “Human rights education and training of clinicians and health service administrators equip them to advocate for the relief of unsafe motherhood in terms familiar to government officers and legislators, and to the lawyers who advise them on the principles to be observed by responsible governments and countries.”268

5.5.4 District level

For the reduction of maternal mortality, stakeholders include anyone who has a stake in an action for saving a woman’s life.269 Since their actions influence the realisation of a woman’s right to survive, they are also duty-bearers. “As a stakeholder at the district level, one may be local union leader, a community leader, a local NGO member, a woman’s rights activist, a health worker or a religious leader....A district stakeholder can bring the community closer to the health services and make the health services accountable to community needs.”270

District managers, are by their leadership role, in a position to influence policies and laws to ensure quality, equitable EmOC services and safe motherhood for women. They are in a particularly crucial and strategic place to form the bridge between civil society and government health services.271 Negotiations for changes in policy to ensure women’s rights may begin with local levels of government and ultimately move to national level to achieve more widespread change.272

The challenge is to put women’s rights and all that it entails permanently on the agenda at the national and district levels and to work steadily to advance the concerns of women across all sectors. In light of the value of participation and respect for the dignity of women, this calls for listening to women and taking their views into account when deciding on appropriate action.273
5.5.5 National/sub-national level

National duty-bearers include not only government officials but also other stakeholders who advocate for safe motherhood, such as members of professional bodies and NGO leaders who link government to women. Together they seek to promote and ensure safe motherhood.

Health care officials may refer to human rights of sexual and racial non-discrimination in implementing and advocating for health sector reforms that give substance to the right to equality in access to health care, including health services necessary for safe motherhood. Initiatives may range from the financial management of short-term budgeting, through longer-term financial and personnel planning. These could transform ethical, constitutional and legal commitments to human rights into prevailing realities of everyday life, reflected in the justified expectation that women will survive pregnancy and that families will rear their children in good health.

Promoting safe motherhood as a human right lays the foundation for an integrated, inter-sectoral approach to maternal health by relating factors underlying safe motherhood to fundamental rights enshrined in international conventions and national constitutions.

In developing policy to achieve the realisation of women’s rights, explicit attention must be given to:

- The links between a given policy and the realisation of rights
- Consistency between policy and rights principles
- Whether policy is a sound basis for ‘progressive realisation of rights’
- Whether there is effective participation of rights-holders in the process of policy making.

5.5.6 International level

“Article 28 of the Universal Declaration states that everyone is entitled to a social and international order so that their rights can be realised.” The international clarion call to advance safe motherhood in 1987 has now been subsumed into the Millenium Development Goals. In 1986 the Declaration on the Right to Development states that “the right to development is an inalienable human right by virtue of which every human person and all peoples are entitled to participate in, contribute to, and enjoy economic, social, cultural and political development, in which all human rights and fundamental freedoms can be fully realised.”

“The Right to Development sets out the need for an environment of international co-operation which enables the development of all countries of the world.” Such cooperation calls for national governments to take seriously women’s right to safe delivery as an obligation to provide effective life saving services and for donors to share this obligation. Indicators are needed to check that the poorest women are using such services. The international community has a role not only in supporting those governments that are taking their obligations seriously but also in encouraging other governments to follow suit.

Macroeconomic policies of international financial institutions have been documented as adversely affecting the health of whole populations. Imposition of user-fees has impacted on patterns of maternal mortality and hospital use. However, a woman’s right to life should take precedence over such administrative impositions. These institutions have the same duty as national governments to ensure that policies do not affect adversely the progressive realisation of human rights. “International co-ordination in integrating human rights into development requires both a shared analysis and a common commitment to shifting from rhetoric to sustained practice.”

In deciding on their activities, UNICEF and other development agencies are responsible for ensuring their programmes of cooperation:

- Influence governments and other actors to make choices which do not violate rights
- Directly support actions to help realise rights of women and children
Empower poor people and especially children to claim rights, and help stakeholders to meet their obligations.

International development organisations have developed a number of approaches to promote human rights by building the capacity of rights-claimers especially the poor, directly or indirectly, to have a voice in policy dialogue and to make claims, and by advocacy at local, national and international levels.

5.6 Lessons

Lessons have been learned in the 15 years since the Safe Motherhood Initiative was launched. These lessons relate not so much to the medical techniques needed to save a woman’s life but more to the conditions needed to ensure that she receives life-saving care. The following factors are critical to reducing maternal mortality:

- Reducing gender inequality, especially related to nutrition and education
- Improving nutrition
- Promoting professional delivery care
- Building effective referral systems
- Ensuring maternal care for all women
- Developing district-level planning and community participation
- Using process indicators to evaluate progress.

In South Asia, the Women’s Right to Life and Health Initiative has recognised that saving women’s lives will require service providers, policy makers, systems managers, families and women themselves to act in new ways. The challenge is to motivate the health care personnel to assume responsibility and accountability for saving women’s lives. This will require a shift in values and a commitment to doing things differently. Actually at all levels of society, a shift in individual values and cultural norms is required to ensure that women have access to services. This recognition adds to the lessons learned:

- Need for skilled birth attendance
- Management skills needed to ensure 24-hour EmOC
- Need to address misconceptions and dangerous practices
- Importance of a values-based transformation
- Importance of supporting champions of change.

5.6.1 Reducing gender inequality

Safe motherhood is primarily a matter of women’s empowerment and access to social justice. Changes in service delivery and accessibility are necessary but on their own will not be sufficient to bring a dramatic reduction in maternal mortality. Too often the high incidence of maternal death is the outcome of a combination of discriminatory practices against girls and women that leave them inadequately educated, poorly nourished and with low self-esteem.

5.6.2 Improving nutrition

There is a general assumption that women who enter pregnancy well nourished and in good health are more likely to survive an obstetric emergency. It is known that stunting from protein/calorie malnutrition in early life leads to short women who are at greater risk of developing obstructed labour. This points to the need of improving girls diets long before pregnancy as well as meeting their specific nutritional needs during pregnancy.

“Evidence is growing that malnutrition, particularly certain vitamin and mineral deficiencies, are linked to the high incidence of maternal illness and death in developing countries.” These deficiency states include anaemia, stunting and deficiency of vitamin A, zinc, iodine, calcium or folate. These deficiencies increase the risk of complications being fatal e.g.,
haemorrhage or infection. Calcium deficiency may contribute to pre-eclampsia. While supplementation of specific micronutrients would correct deficiency states, there are as yet no international standards for a multivitamin/mineral supplement. However, there have been some suggested formulations and some trials are being carried out in the field.

5.6.3 Professional delivery care

There is a direct correlation between the percentage of professionally attended births and maternal mortality ratios. "Professional and good quality delivery care for home births and in institutional settings is essential for the reduction of maternal mortality. Most complications occur at the time of childbirth or soon afterwards, and the presence of a well-trained nurse, midwife, doctor or other health worker is crucial for the urgent action that will save lives." A huge investment was made in the training of the traditional birth attendants. However, this has apparently had little impact in reducing the risk of maternal death, although it has had some positive benefits in reducing neonatal deaths due to tetanus.

5.6.3.1 Emergency obstetric care

The lesson which cannot be repeated too often is that emergency obstetric care is needed to save lives. The concept of emergency obstetric care only refers to those measures taken if a complication occurs. However, obstetric care includes other interventions such as prenatal care and postnatal care. Whether professional services for delivery care will save lives depends on a functioning health system.

"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 measure 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." Maternal health programmes must ensure that all women have access to essential obstetric care.

Access to health services is not a simple concept. It implies not only that the facilities exist, but

- That people have the information they need to use them properly
- That the facilities can be reached by the people who need them
- That the cost of care is reasonable
- That the supplies and equipment are adequate
- That services are provided in a manner acceptable to patients and families.

5.6.3.2 Family planning

"Reducing maternal and child mortality cannot be achieved without better addressing the unmet demand for family planning." UNICEF has long viewed the responsible planning of family size, especially birth spacing, as an essential part of maternal and child health (MCH) services. "As a matter of policy, UNICEF does not advocate any particular method of family planning, as such issues are more appropriately decided by individuals, using information and services available to them in their countries and communities, and in accordance with their development policies and social, religious and cultural values."

5.6.3.3 Prenatal care

"Investments in antenatal care have brought limited results in maternal mortality reduction due to the unpredictable nature of the obstetric emergencies that occur around the time of delivery." Arguments for the continued investment in prenatal care include patient education, treatment of existing conditions, treatment of complications and screening for risk factors. It is believed that "prenatal care also provides an important entry point for women into the health care system. Good quality care in the prenatal period builds positive relations between providers and women and encourages women to seek further help during..."
At **Comprehensive EmOC facilities**, all of the services provided at Basic EmOC facilities (as above), plus the following services are provided:

- Surgery (cesarean section)
- Administration of blood transfusion

At **Basic EmOC facilities**, the following services are provided:

- Administration of parenteral antibiotics
- Administration of parenteral oxytocic drugs
- Administration of parenteral anticonvulsants for pre-eclampsia and eclampsia
- Manual removal of placenta
- Manual removal of retained products
- Assisted vaginal delivery
- Referral and transport arrangements

Obstetric First Aid provided at selected health centres, includes the following services:

- Administration of parenteral antibiotics
- Administration of parenteral oxytocic drugs
- Administration of parenteral anticonvulsants
- Administration of intravenous (IV) fluids
- Referral and transport arrangements

At **family and community level**, the following activities support prompt access to EmOC services:

- Community education
  - recognition of obstetric complications
  - when to seek medical care
  - where to go for medical care
- Community mobilisation
  - arrange transport and referral and financial support
  - arrange for blood donors

---

**Box 5: Levels of Emergency Obstetric Care**

---

delivery, the postnatal phase and for their children. Poorly delivered care usually has the opposite effect. Thus the quality of prenatal care is vital. Poor quality leads to ill informed women and families who have a false sense of security. Good quality prenatal care is an adjunct to increasing women’s access to emergency obstetric care. The best-case scenario is when “linkages between emergency obstetric care services and antenatal care services cultivate a climate of co-operation within health facilities and into the surrounding communities.”

### 5.6.3.4 Postnatal care

“Half of all maternal deaths take place within one day of delivery, and 70% of maternal deaths occur within the first week.” The danger signs of a complication of childbirth should alert the family to the need for care; however, postnatal care, particularly if given at home, provides an opportunity to detect and manage any problems early. To achieve this may require policy changes and additional training for appropriate health workers.

### 5.6.3.5 Functioning health system

Maternal mortality is different from other major maternal and child health problems in at least one important respect: A functioning health care system must be at the center of the solution. No amount of information and education or community mobilisation or even poverty reduction will make a major dent in maternal deaths in high-mortality countries unless it is accompanied by a health system that makes emergency obstetric care widely available and accessible.

Within the health system there are a number of interrelated and interdependent established systems, which work synergistically to reduce maternal death and disability. To ensure that 24-hour quality services are
available every day requires well-functioning support systems:

- Service Delivery
- Planning and Review
- Financing
- Management Information System
- Drugs and Logistics
- Human Resource Development: Technical and Managerial
- Stakeholder Groups
- Information, Education and Communication

5.6.4 Referral system

Referral systems start from the home of the woman with the complication. To ensure that women reach a suitably functioning facility in time, the actual functioning status of the facilities will determine the referral linkages. "Effective health care in rural areas depends on team-building and strengthening links between community health care workers and the formal health system. Establishing a maternal health team is part of this process." 311

Strong links for effective referral between community-based skilled birth attendants and hospitals depend on:

- Good communications
- The availability of appropriate transportation
- Timely decision-making. 312

5.6.5 Ensuring emergency maternal care for all women

Since all pregnant women are at risk of sudden, life-threatening complications, maternal health programmes must ensure that all women have access to essential obstetric care. 313

5.6.6 District-level planning with community participation

“It has been demonstrated time and again that interventions that do not incorporate active involvement by communities are destined to fail." 314 Decentralisation promotes the involvement of communities. In the Women's Right to Life and Health Initiative, external stakeholder involvement is key to sustainability at all levels. National support is being given to the district as the unit for planning, implementing and monitoring of implementation. 315

The purpose of participation by stakeholder groups is to create sustained high quality, responsive, rights-sensitive services. This is done by encouraging a community to feel ownership and responsibility for a facility, and by encouraging the facility to see itself as needing to account to the community it serves. This influences the key dynamic of entitlement and accountability, even beyond the facility and community levels. 316

“Building partnerships and revitalising existing ones is an essential strategy for establishing and strengthening EmOC services, as well as for increasing acceptance of and access to services by women” 317 The involvement of both facility and community in the process of planning for safe motherhood is in itself a form of advocacy.

5.6.7 Using process indicators

"Measuring maternal mortality is extremely difficult and costly." 318 The alternative is to monitor processes which are aimed at reducing maternal mortality. Seven standard indicators are being utilised to measure the availability and use of obstetric services:

- Number of Basic EmOC facilities
- Number of Comprehensive EmOC facilities
- Geographical distribution of EmOC facilities
- Proportion of all births in Basic and Comprehensive EmOC facilities
Met need for EmOC: Proportion of women estimated to have complications who are treated in EmOC facilities

Caesarian sections as a percentage of all births

Case fatality rate.

“However, diverse social, political and economic factors contribute to the ongoing injustice of maternal death in South Asia and additional indicators are being explored to measure progress in regard to these factors.”

5.7 Management

In most countries of South Asia, programme evaluations - including programmes for maternal mortality reduction - at national, sub-national and facility level, show that management and leadership are the most critical factors affecting the programmes negatively. Among the key areas that require immediate attention are systems of accountability, participation of stakeholder (both internal and external to the health system), teamwork, and combining innovation with commitment to results.

The development of leadership requires investing in people through an ongoing process of human resource development. Leaders committed to doing things from a human rights perspective both guide and drive change.

5.8 Information, Education and Communication (IEC)

Efforts to reduce maternal mortality must include not only making EmOC services accessible, affordable and acceptable to the women who need them but generating an awareness of the rights of women at home, in communities, in hospitals and throughout society. Information, education and communication (IEC) campaigns can be used to promote awareness of healthy behaviours and danger signs. They take many forms, including strategic use of the media to raise the public’s awareness of social and cultural obstacles and identify ways of overcoming them. The media can promote the need for accessible, high quality health and nutrition services, document successful projects, and encourage family members to recognise their important role in supporting a woman during childbirth. IEC activities are only effective when they are supported by strong interventions to improve services. These need to be backed by participatory programmes that engage communities in promoting positive change.

A central message of all community mobilisation and communication initiatives must be that maternal mortality and morbidity are social injustice, that they are avoidable, and that women and families should not accept them as inevitable outcomes of pregnancy. Women need to be encouraged to exercise their rights to life and health promoting services. The support of families and communities is critical for such efforts to have an impact on health and legal systems.

5.9 Essential Values

The support of families for women during pregnancy and childbirth is critical to save women’s lives. In examining the value system underpinning the human rights-based approach to maternal mortality reduction, the Women’s Right to Life and Health Initiative consulted religious scholars.

Religious scholars...challenged us to expand the values framework to include two additional values from the religious traditions - compassion and interdependence. These two values go beyond the human rights principles to explicitly address the manner in which we approach our relationships with others, individually and collectively.

The value added is that “compassion drives action and accountability. It motivates us to do whatever possible to save women’s lives and thereby uphold women’s rights.”
6.1 Discrimination

If there were no discrimination by race, sex, age, ethnicity or any other status, then there would be no need for a human rights-based approach. Discrimination strikes at the heart of the dignity and equality of all human beings. Discrimination:

- Limits or negates access to resources
- May be from legal inequalities in status and entitlements
- May be enshrined in social values and norms affecting all levels of implementation from policy making to communities and household
- May ultimately lead to conflict.

The very pervasiveness of discrimination is the greatest challenge. “In many countries, people receive differential treatment from government officials because of their class, religious identity, disability, age, ethnicity or skin colour.” This is true of developed and developing countries. It is equally true of government and non-government agencies, public and private institutions and businesses.

Seeking to redress this situation calls for systematically incorporating social analysis into development work to identify excluded persons. It necessitates programme activities to create greater cohesion and integration in a community or society. It also means challenging those civil society organisations which work to promote human rights to ensure they develop inclusive approaches so as to represent the rights of the disadvantaged.

6.2 Poverty

Poverty is relevant to South Asia, to women and to maternal mortality:

- 39% of the people who live in extreme poverty are in South Asia
- Almost 70% of those are women
- The burden of unsafe motherhood is borne predominantly by women in poor families, communities and countries
- Poor people generally lack access to public provision of health services, and to legal systems to remedy this injustice.

At times, the link between poverty and maternal mortality has been used not only to explain the high levels of maternal deaths but also to excuse the lack of change in this highly unacceptable situation. Now, maternal mortality reduction has been located in the International Development Targets for poverty elimination. These milestones, against which progress towards the goal of poverty elimination can be measured, include a 75% reduction in maternal mortality by 2015.

Work by Amartya Sen challenges the view that poverty is irrelevant to the characterisation of fundamental freedoms and human rights. Since well-being includes
living with substantial freedoms, human development is also integrally connected with enhancing certain capabilities – defined as the range of things people can do and be in leading a life. Sen spells out the added value of a rights-based approach to development in terms of claims. He argues that human rights represent the claims that individuals have on the conduct of individual and collective agents, and on the design of social arrangements to facilitate or secure these capabilities and freedoms. 335

Poor people are defined as poor because they lack material resources. The poor consider themselves to be powerless and lacking influence over the key decisions which affect their lives. 336 Their choices for action are constrained by social, political and cultural factors as well as economic factors. 337 In an effort to bridge the gap between the aspirations of the UDHR and the reality of the lives of many people in poorer countries, 338 development agencies see making empowerment of the poor an explicit objective. However, without the full participation of the beneficiaries, development will be elusive and human rights simply an aspiration. 339

Effective pro-poor advocacy institutions are characterised by commitment to empowering particular social groups, by a capacity to adapt to their priorities and realities, and an ability to work at the same time on many levels on the same issue. 340 Poor people, in their efforts simply to survive, are adept at the learning process of Assessment, Analysis and Action (Triple A) as they constantly try to improve their capability to cope and manage. 341 This is the wisdom they bring to strategies for community capacity development. Such a strategy needs to be supported by advocacy, mobilisation and capacity development at all levels of society. 342 At a policy level, strategies successful in cutting poverty include sustained and equitable economic growth, accompanied by strategies aimed at meeting the health and education needs of the very poorest. 343

The capacity of the poor and relatively disempowered to make their claims stick at higher levels may always be weak. For them the fulfillment of economic and social rights will probably occur largely through the evolution of the state’s policy instruments to take account of a changing sense of obligation to its citizens. 344 Civil society often looks to the international community to encourage the voices of the poor to be heard in multilateral institutions and meetings. 345 Hence, there is a need for a poverty focus to the work of the Treaty Monitoring Bodies and commissions and the international organisations, which are responsible for setting standards. 346 “Without external assistance the poorest and most marginalised will generally lack the capacity to negotiate effectively for their rights.” 347

For poor people, making claims effectively requires a number of complementary strategies and elements including:

- Access to information
- Group solidarity
- Development of skills and capabilities
- The help of allies to advocate at other levels
- Access to a ‘fair regulator’ competent to assess competing claims without succumbing to elite groups. 348

Monitoring from a human rights perspective includes ensuring that there is no discrimination in access to services. However, experience has shown that evaluation teams can have difficulty in determining whether the poorest village members are reached by initiatives. 349

6.3 Gender

6.3.1 Status of women

Ours is a gendered society: that is, roles and responsibilities have been determined by the gender roles assigned to men and women. While there are biological differences, it is mainly the socially constructed differences which lead to discrimination against women. This discrimination is related to power, as women are often seen as being of lower status. The low status of women exerts a profound influence on the way societies, communities, families and women
themselves respond to their needs. It influences not only who makes the decision about a woman’s health needs but also levels of investment in maternal health services and the quality of care women receive through that system. Poor women are frequently doubly disadvantaged (because of their poverty and because of their gender) in access to services, in access to and control over economic resources and in participation in public life.

The value placed on a woman’s life at home, in the community, society and in hospitals, all impact on women’s utilisation of health services. The failure of health workers to respect their dignity means indigenous women, impoverished women and others from ethnic minorities and their families are sometimes reluctant to use existing health services.

Another major issue related to gender is gender-based violence against women. Violence contributes significantly to the death of women of childbearing age, including pregnant women. In much of South Asia cultural norms make violence against women acceptable and may lead women to believe that violence is deserved. Many types of discrimination occurring together may compound feelings of powerlessness. Even when laws protecting women’s rights do exist, the vulnerability of poor women means they are less likely to use them – whether against an exploitative employer or a violent partner.

Maternal mortality is also related to this deep discrimination against, and powerlessness of, women. If all pregnant women are to have prompt access to high quality emergency obstetric care, a broad, deep transformation is required. While it is not expected that such a transformation can be achieved immediately, it is considered essential to initiate this change in order to achieve the goal.

Donor countries which support women’s equality have sometimes been accused of seeking to impose their own values on others. While respect for people’s culture is a right, so too is respect for the human rights of women. Both are recognised in the Universal Declaration of Human Rights. Women have been oppressed and treated unequally in all cultures, and in all cultures this is an abuse of human rights. An underlying guiding principle in addressing attitudes and social values is the importance of moving forward at a pace, and in a direction, determined by women themselves.

This raises the important principle that strategies and actions in a human-rights based approach to programming should model those human rights values and principles. As Mahatma Gandhi said, We are the change, we are the message and we are the messenger. This principle implies empowerment. So often decisions about women’s lives are made without listening to the women themselves. However, it is also known that the oppressed collude in their own oppression.

Discrimination against girls and women is reproduced through families and communities. Mothers may show preference for sons over daughters – a prejudice that can be exhibited even before birth with the induction of female foetuses. Cultural beliefs about health and illness, about pregnancy and childbirth, about gender, work, education, health and other social services all have a bearing on the development of girls and women, and ultimately on maternal health.

6.3.2 Gender and rights

This cultural heritage represents learned attitudes and behaviours, and as such is open to change. Human rights instruments set standards and endorsed values which have been crafted by a global consensus. The preamble to CEDAW specifically says that the state parties are “concerned, however, that despite these various instruments extensive discrimination against women continues to exist, recalling that discrimination against women violates the principles of equality of rights and respect for human dignity.” A series of international conferences have further elaborated the results to be achieved for women by the application of these human rights instruments.

Within the UN system, a number of mechanisms and offices have been established to encourage the implementation of women’s human rights. The most important of these are:
6.3.3 Women’s empowerment

Women’s empowerment and gender justice require a social transformation which will change relations between women and men, as well as in the ideologies and institutions that preserve and reproduce gender inequality. The power dynamics in such relationships will not be based on power of one over others but on a mutual development of creative human energy. This must flow into institutions, incorporating new norms and rules that support egalitarian and just relations between women and men. The United Nations Development Fund for Women (UNIFEM) includes the following factors in its definition of women’s empowerment:

- Acquiring knowledge and understanding of gender relations and the ways in which these relations may be changed
- Developing a sense of self-worth, a belief in one’s ability to secure desired changes and the right to control one’s life
- Gaining the ability to generate choices and exercise bargaining power
- Developing the ability to organise and influence the direction of social change to create a more just social and economic order, nationally and internationally.

The obligation of conduct is expressed as equality of opportunity. This means that women should have equal rights and entitlements to human, social, economic, and cultural development, and an equal voice in civil and political life. The obligation of result or equity of outcomes means that the exercise of these rights and entitlements leads to outcomes which are fair and just, and which enable women to have the same power as men to define the objectives of development.

A full understanding of what is required to promote gender equality and women’s empowerment will require a deeper analysis of these factors, and a recognition that women’s own development aspirations are likely to reflect their diversity. Efforts to ensure gender equality must be ongoing. Income level is not directly related to gender equality, which is more dependent on political will for its realisation.

6.3.4 Key actors for gender equality

Since gender equality is a human right and a public good, bringing benefits to all, governments must not only be committed to equal rights and opportunities but ensure they are delivered. Organisations and groups in civil society, both formal and informal, national and international can:
- Provide focal points for debate and advocacy
- Support activities and programmes
- Lobby governments and private sector
- Assist and empower citizens to call governments to account.  

The private sector may respond to regulation by governments and international bodies, but in the end, a commitment to social responsibility and the maintenance of ethical standards must come from within.  

The donor community is far from homogeneous and each development partner has a slightly different role to play; these are additional challenges to face in strengthening its contribution to the achievement of international gender equality goals. UN funds, programmes and specialised agencies help to deliver the global, normative framework for development set down by the various UN conferences and conventions. DFID’s strategy aims at mainstreaming women’s empowerment and gender equality in all development activities.

### 6.3.5 Women’s equality and empowerment framework for gender disparities (WEEF)

In trying to overcome gender inequalities, it is helpful to have a conceptual framework. The framework used by UNICEF is called the Women’s Equality and Empowerment Framework (Figure 5). Its five levels represent different dimensions of the development process that ought to always be part of a process to overcome gender inequality.

The gender framework supports the rights-based strategy and should be used at all stages in analysing, planning, implementing, monitoring and evaluating programmes. The gender framework views women’s development in terms of five levels of equality:

**Welfare** – regarding the material well-being of women, compared with men, e.g. their vulnerability to poverty and its relationship to maternal health

### Figure 5: Women’s Equality and Empowerment Framework

<table>
<thead>
<tr>
<th>Levels of Equality</th>
<th>Increased Equality</th>
<th>Increased Empowerment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conscientisation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Welfare</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Access to resources** – differences in women’s access to productive resources such as land, credit, labour and services compared with men, and the connection between these and maternal health

**Awareness** – including the extent to which maternal illness and death is perceived as part of what it means to be a woman, the knowledge women and families possess about maternal well-being

**Participation** – the extent to which women are involved in decisions concerning their maternal health, includes their participation within families, in communities, through local authorities and at a national level

**Control** – the level of equality between men and women in their ability to influence their own destinies, and in particular to improve their own health.

### 6.4 Gender-Based Violence Against Women

Violence against women is defined as any act of gender-based violence that results in or is likely to result in physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty whether occurring in public or in private life. “Gender violence is a complex social phenomenon, deeply rooted in existing gender power relations, sexuality, self-identity and the structure of social institutions.” It is related to maternal mortality as both a cause of death and as originating from many of the same underlying causes which deny women life-saving care.
Violence contributes significantly to deaths among women of childbearing age. Pregnant women are at increased risk of violence. In some areas of South Asia, the proportion of women dying as a result of violence is greater than the proportion of women dying of obstetric complications.  

“Pregnancy can often be a trigger for violence, and is a risk factor for abuse due to added stress in relationships or because it makes women vulnerable to abuse.” A feminist analysis of a paper on Verbal Autopsies of Maternal Deaths in Bangladesh revealed that 14% of maternal deaths were due to gender-based violence. The prevalence of violence against women is usually under-estimated as there are cultural norms that make violence against women acceptable and may lead women to believe that violence is deserved. This attitude may be found in laws which condone or neglect violence against women.

Violence has numerous negative consequences for maternal health and infant health and survival. These include: unwanted pregnancies, unsafe abortions, miscarriage or foetal damage, physical injuries, mental disorders and adding to maternal morbidity and mortality.

"Women are subjected to violence due to attitudes and beliefs that underpin patriarchy. Violent behaviour reflects the lack of both self-regulation and respect for self and others.” For many women subjected to violence, the only place they may go is to a health facility. For pregnant women, pre-natal visits are one such possibility. However, compared with women who are not abused, women who are abused are three times more likely to delay registering for prenatal care. “Women subjected to violence often share the same urgent need for care that is experienced by women with obstetric complications.” At the hospital they need compassionate care, which is linked with social welfare and legal assistance. Gender violence is further compounded by cultural practices related to the belief that blood is impure and that the woman determines the sex of the child. These beliefs and other misconceptions also contribute to maternal death and disability.

6.5 Health and Rights

The Committee for the ICESCR has issued a General Comment which explains the minimum core obligations of Article 12 on the right to the highest attainable standard of health. These include:

- Access on a non-discriminatory basis
- Access to basic minimum essential food
- Access to basic shelter, housing, safe potable water and sanitation
- Equitable distribution of health facilities, goods and services
- Implementation of a national public health strategy and plan of action for the whole population that is evidence-based, devised and reviewed by a participatory and transparent process, uses right to health indicators and benchmarks for close monitoring and gives particular attention to the most vulnerable.

6.6 Emergency Situations

6.6.1 Conflict and humanitarian law instruments

The Geneva Conventions, which are concerned with the protection of non-combatant persons and
vulnerable groups, are almost universally ratified. Of the four Conventions, the Fourth Convention addresses the protection of civilian persons in time of war. Articles common to all four conventions (Common Article 3) make provisions for armed conflicts of a non-international character; all other articles refer only to international conflicts. In 1977 two Protocols were added. Protocol I strengthens provisions for civilians, notably women, children, the elderly and sick in international conflicts. Protocol II develops Common Article 3 into a legal document, extending the provisions to situations of internal armed conflict. In the Protocols, there are frequent provisions referring to women, children and family rights, concerning the care and aid of children and women. These are elements of international humanitarian law. However, in various circumstances, human rights law and refugee law may also be used to help women and children.

Ongoing confrontations and conflict in the region have been part of South Asia’s history. As a consequence, thousands of families have crossed borders to take refuge in neighbouring countries. Hence, in looking at how human rights instruments can be applied to the reduction of maternal mortality, it is necessary to know something of the provisions available for their protection and well-being. For instance, The Fourth Geneva Convention guarantees the free passage of medical consignments and of foodstuffs, clothing and special items intended for children under fifteen, expectant mothers and women in labour. These emergencies adversely affect the quality of lives of most people, especially children and women. Most human rights law continues to apply in emergency and conflict situations and it is critical that this be taken into account in emergency preparedness and responsiveness phase of programme planning. International Humanitarian Law (IHL) also applies in most conflict situations and this provides programme planners with additional tools, particularly in terms of advocacy and other actions for protecting women and children from the effects of conflict and for negotiating access to women and children.

Conflicts can be divided into at least four categories of conflict: international conflict and three categories of internal conflicts. The nature of these principal groups of conflict and the corresponding applicable instrument of humanitarian law are synthesised in table 5.

6.6.2 Refugees

In 1951, the Convention (and later the Protocol) Relating to the Status of Refugees set the minimum standards of treatment of refugees. It establishes that states have the primary responsibility to protect refugees within their borders. However the definition of refugee does not recognise people internally displaced. Globally, the number of internally displaced people exceeds those who are internationally displaced.

Internally displaced persons are people who flee their homes without leaving their country of nationality. A set of Guiding Principles on Internal Displacement developed by the Representative on Internally Displaced Persons in 1992 incorporates elements of the three branches of public international law into a single document: international humanitarian law, human rights law and refugee law.

6.7 Economics

Economic considerations related to the reduction of maternal mortality may be divided into different perspectives: the perspectives of the woman, the family, the provider, the policy makers and the donors. Since so many women in South Asia have been socialised to see themselves as having little or no value and to endure suffering as their lot, they are unlikely to demand the services needed as their right, but instead try to avoid incurring any expense for the family. The family that nurtured this woman gave her these ideas and the family of her husband belongs to the same society. This blatant denial of the woman’s dignity indicates the importance of a human rights approach. Even families that want to take women for EmOC, must find funds for transport, accommodation and supplies as well as cope with the loss of income due to earning members being at the hospital rather than at work.

Health care providers in much of South Asia have to
Table 5: Types of Conflicts and Relevant Humanitarian Law Instruments

<table>
<thead>
<tr>
<th>Nature of Conflict</th>
<th>Humanitarian Law Instruments that Apply Nature of Conflict</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>International Conflict</strong></td>
<td>The four Geneva Conventions and Additional Protocol I</td>
</tr>
<tr>
<td><strong>Internal Conflicts</strong></td>
<td>Relatively detailed treaty rules are applicable under Protocol II, covering government and non-government forces</td>
</tr>
<tr>
<td>(i) Armed conflict between government and dissident forces, where the latter control part of the &quot;High Contracting Party’s&quot; territory, enabling them &quot;to carry out sustained concerted military operations and to implement this Protocol&quot; (P.II1)</td>
<td>Common Article 3 of the Geneva Conventions applies</td>
</tr>
<tr>
<td>(ii) Armed conflict between government and dissident forces, with dissident forces not having control over part of the territory nor being able to implement Protocol II</td>
<td>Not covered by Protocol II or other humanitarian law; human rights law applies, but is derogated in these situations (although on the limitations of derogation and note the CRC is non-derogable)</td>
</tr>
<tr>
<td>(iii) Conflicts of a lower intensity, classified as internal “tensions and disturbances” (“riots, isolated and sporadic acts of violence and other acts of similar nature”, as defined in P II, 1.2)</td>
<td></td>
</tr>
</tbody>
</table>

Manage with inadequate resources – both personal and institutional. The average salary of government medical officers is such that they have to have an additional source of income, most frequently private practice. This leads to pressure to ensure a clientele for their own needs and leads to diversion of patients from public hospital facilities to private chambers. Often this is further compounded for the patients by the ordering of unnecessary tests and doing unnecessary caesarean operations. However, even conscientious health care providers in public hospitals are faced with the dilemma of how to distribute limited resources and how to care for poor women.395

In such a situation, the issue of user fees is raised. The concern is that user fees will be a further deterrent to women needing emergency obstetric care. This in turn leads to considering insurance schemes. However, if such schemes are private or employment-related, they will leave the majority of women unprotected.396 In Bolivia after insurance schemes provided free care for pregnant women, prenatal coverage increased by 80%, hospital-based deliveries by 48% and care for emergency cases by 90%.397 Since governments are obliged to ensure the progressive realisation of women’s rights, they have to grapple with the problem of economic barriers to women’s access to life-saving procedures.398

Policy makers look for facts on which to base decisions. However, a study on safe motherhood in 1999 reported that there is a paucity of information on costs at a global level, let alone at local level.399 A finding in a World Bank study, however, has ‘estimated that providing a standard ‘package’ of maternal and new-born health services would cost approximately $3 [U.S.] per person per year in a developing country; maternal health services alone could cost as little as $2 per person.”400 This same study noted that responsible planning of family size and maternal health services are the most cost-effective governmental health interventions, in terms of death and disability.
prevention, and investing in them leads to significant savings.\textsuperscript{401}

“WHO estimates that an investment of US $3 per person per year can prevent the overwhelming majority of maternal deaths, half of infant deaths, and the painful and often life-long disabilities that millions of women suffer in low-income, developing countries. This amount includes basic antenatal care and nutrition for pregnant women, assistance at delivery by a health professional, neonatal care, the promotion of family planning during the postnatal period, and special care in case of complications.”\textsuperscript{402} In Bangladesh, the total cost of providing essential obstetric care in a district was estimated to be US $2.75 per birth for 50,000 births per year.\textsuperscript{403}

Donors recognise that expenditures on human development are both sound economic investments and necessary conditions for the enjoyment of human rights.\textsuperscript{404} A broad coalition of partners is moving towards a human rights-based approach to programming. UNICEF, by collaborating with international financial institutions – especially the World Bank, has a strategic opportunity to advance rights-based development.\textsuperscript{405} Three factors within the World Bank are facilitating the potential for a rights-based approach. Through the overarching goal of poverty alleviation, the World Bank has moved from rigid sectors to an approach to facilitate cross-cutting issues such as gender discrimination. Decentralisation gives the World Bank greater scope for flexibility. The Country Assistance Strategy is developed in substantial measure at the country level.\textsuperscript{406} The international community has a crucial role to play in funding the necessary research to ensure the best possible interventions in poor countries.\textsuperscript{407}

Dr. Kan Tun, WHO Representative in Sri Lanka, stated: “Investing in health makes good economic sense; investing in women’s health makes more sense.” This is specially true given that gender based inequalities adversely affect women’s health and 40% of maternal deaths are due to lack of essential obstetric care. He emphasised the importance of making quality health care facilities accessible to all of the women of the world.\textsuperscript{408} Women need more than treaties; they need urgent action to save their lives. For this they need investment in their health by their families, their governments and the international community.

6.8 Imperative for Change

Time and again it has been noted that reality does not reflect human rights. The development of a human rights based approach has challenged this state of affairs. This approach highlights the fact that human rights are not only the basis of sustainable development, but governments and their peoples are under obligation to make the necessary changes to ensure human rights are realised.

In this region, where women are often treated as inferior and as resources and certainly not as equal subjects of human rights, the change that is needed is enormous. However, though change must begin in the individual, there must also be an environment which supports change. “Health is profoundly driven by the social and cultural contexts in which it exists, and that context ranges from the most intimate spaces of daily life to the macro-economic policies of international financial institutions. In a world increasingly linked together, for better or for worse, by globalisation, we need ways to speak and think and act on our shared (and our differing) understandings about what human well-being is and how to achieve it.”\textsuperscript{409}

Ultimately, the fulfillment of human rights surrounding pregnancy and childbirth will require transformation in all spheres: in households and communities, in health facilities, and in national and international policies. It will also require the dedication of a broad range of social actors including health professionals, advocacy groups, women’s groups and other community-based movements.\textsuperscript{410}

Two key strategies are necessary: investing in people and supporting risk-taking champions of innovation and change. Leaders and managers themselves must undergo personal transformation to be effective agents of change.\textsuperscript{411} The effects of these changes will be seen in the way policy makers allocate resources to women’s issues, health providers act, and communities and families support the health-seeking behaviour of women themselves.\textsuperscript{412}
Section 3

APPLYING THE HUMAN RIGHTS-BASED APPROACH TO PROGRAMMING FOR MATERNAL MORTALITY REDUCTION

CHAPTER 7  Assessment and Analysis
CHAPTER 8  Strategies and Priorities
CHAPTER 9  Monitoring and Evaluation
CHAPTER 10 Summary and Conclusions
7.1 Moving from Theory to Practice

To bring the theory of a human rights-based approach to practical implementation is a huge challenge. It is a challenge which strikes at the very heart of individuals, relationships, governments and development agencies. It begins with a process of internalisation of the human rights values and principles by a significant number of people who become the champions of change, infusing energy and enthusiasm. This requires an ethical stance that respects the dignity and the equality of all people.

A holistic approach to problems in society requires recognition of both its scientific and ethical aspect. Science deals with what can be done, while ethics deals with what should be done. Science is objective, whereas ethics is normative or intersubjective. Science mostly advances through observation and logical deduction. Ethics, in contrast advances by reaching consensus through dialogue, reflection and enquiry.413

Human rights offer a normative framework for this ethical dialogue. The values of dignity and nondiscrimination and the principles of participation, accountability, empowerment and sustainability must inform the processes used to move from policy to implementation. The indivisibility of human rights calls for more inherently integrated, cross-sectoral and decentralised activities, and for participatory approaches involving both rights-holder and duty-bearers.414

Implications of a human rights-based approach for programming culled from UNICEF415 and other UN416 agencies include:

- Objectives and strategies of programmes are to be informed by general principles of human rights
- Indicators for assessment are to be disaggregated by gender, age-group, physical location, ethnic group etc. to reveal disparities
- Indicators should provide a basis for capturing the rights to participation, protection and sustainability
- Design of the assessment is to facilitate an intersectoral analysis consistent with indivisibility and interdependence of rights
- General principles of human rights influence and strengthen mechanisms for coordination, oversight and monitoring.

The continuous cycle of Assessment, Analysis and Action is called the Triple A Approach (figure 6). It is a mental construct for rational decision-making in society and is a process of ‘learning-by-doing.’ Caution must be exercised because information can be collected as myths, and mis-information can result in inadequate or wrong decisions.417 By establishing which of the components of the Triple A process needs strengthening, programme resources may be used more efficiently.418

7.2 Through a Human Rights Filter

To make an assessment with a human rights filter, it is important to examine the indicators used to ensure they are rights-sensitive. A Monitoring and Reporting Process of CRC and CEDAW Committees exists, and
the process can yield valuable information. Whatever process is used, it must be in keeping with human rights-based approach principles, especially participation and empowerment.  

One vital filter is that of non-discrimination. For this, data is disaggregated by sex, geographic origin, age and ethnicity in order to expose disparities, which are too often concealed by averages.

Outcome is often easy to measure, but as ‘good process’ has seldom been defined, there is an urgent need to develop appropriate indicators for criteria such as participation, women’s empowerment and sustainability, among others. Women must be involved in the assessment at all stages. Respect for participation rights is vital from a rights perspective.

This will involve gathering the community information and feeding it into an information system which will serve first and foremost the needs of the community. If the benefits of information are experienced by the community and the demands from outside are small and manageable, then the information needs for assessment become self-sustaining.

7.3 Types of Analysis

For a full analysis from a human rights perspective, broad participation is needed so that both duty bearers and claim-holders can work together to understand the situation and come to a consensus on how it may best be improved. The analysis begins a three-step process of problem analysis.

Three steps of problem analysis are:

**STEP 1** Causality Analysis – different kinds and levels of causes

**STEP 2** Role Analysis / Pattern Analysis

**STEP 3** Resource Analysis

To these steps are added two crucial areas of analysis:

**STEP 4** Analysis of Behaviours and Cultural Patterns

**STEP 5** Analysis of Prevailing Norms and Legal System

---

**Figure 6: Triple A Process**

Assessment → Analysis → Action

i. Legislation

ii. Tradition as a Factor of Resistance to Change

iii. Tradition as a Factor of Change

In areas where there is the possibility of an emergency, either from conflict or natural disasters, it is important to include in the overall analysis:

**STEP 6** Vulnerability Analysis

This will allow the development of strategies to strengthen the capacity of vulnerable populations to cope.

7.4 Steps in Analysis

7.4.1 STEP 1: Causality analysis

Before anything can be done with a problem, the problem must be recognised as such at some level of society. If not, a Step 0 is necessary to raise awareness about the problem. When people are adequately aware, the first step is to identify the immediate, underlying and basic levels of causes. Without consensus on the causes, it is difficult to reach a consensus on how to solve the problem.
Ideally actors at all levels of society should be involved in the analysis. It is important to recognise that people at all levels already assess and analyze their situation. An explicit conceptual framework may improve existing processes by helping to identify what to look for. The causality analysis will, therefore, result in a list of rights that are either violated or at risk of being violated, together with the major causes of their violations.429

7.4.2 STEP 2: Role analysis/pattern analysis

A human rights-based approach focuses on accountabilities and identifies specific duty-bearers and their capacities.430 It involves an analysis of the pattern of duty-bearer/claim-holder relationships. This means looking at the many relationships and roles among various actors and institutions at community, district or country level, which are essential for the realisation of rights.431 It is needed to guide our understanding of why and how various individuals and institutions have failed in their duties to rights-holders.432

The purpose of the role/pattern analysis is thus to arrive at a list of the most crucial claim-duty relationships for each particular set of selected rights violations. The role/pattern analysis should involve all levels, from government to family, in a participatory manner. Thus the role analysis itself becomes a learning process as the members of the communities start to appreciate the roles of certain actors, how these roles may be shared, and the real and perceived roles of the inherent structures within the community.433

Role analysis carried out by dialogue at the community level may well reveal key actors not perceived by outsiders. There are primary duty-bearers who in turn are secondary rights-holders with claims on secondary duty-bearers. Appreciative Inquiry is a useful method to encourage and empower primary duty-bearers to identify these secondary duty-bearers.434

It is important to analyse the capacity of the duty-bearer to fulfill the rights-holder’s claim. For this it is necessary to assess whether the duty-bearer is aware of and accepts responsibility of the duty, and has both the authority and the resources to fulfill the duty.435 However, a human rights-based approach should focus on progress as well as problems.436 “Some individuals accept responsibilities far beyond what may be expected and provide leadership.”437

Focusing on a specific priority problem will also help to reduce the role/pattern analysis to a limited set of claim-duty relationships that are likely to be most critical in the given situation. In a human rights perspective, the key question for each right is: Who are the duty-bearers? The analysis will result in a list of duty-bearers, with their anticipated duties at different levels.

These may be summarised using a table such as table 6:

<table>
<thead>
<tr>
<th>Right</th>
<th>Claim-holders</th>
<th>Women</th>
<th>Household</th>
<th>Community</th>
<th>Facility</th>
<th>District</th>
<th>National</th>
<th>International</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duty-bearers</td>
<td>Household</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Community</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Facility</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>District</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>National</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>International</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The next step is to analyse why the duty-bearers do not seem to be able to perform their duties as expected. Some relevant questions must be explored in relation to critical elements needed for capacity to perform their duties. (See Appendix 14). Different duty-bearers who need to join together to address important problems may have different capacity gaps. If programmes are properly focused to address critical capacity gaps in identified groups of duty-bearers, then it is both possible to design the capacity building activities more appropriately and also to assess if the support leads to the expected actions.

Capacity, including the availability and control of human, economic and organisational resources at any given point in time, are results of historical processes. Different forms of disparities, poverty, inequities, etc., are constantly reproduced in society.

7.4.3 STEP 3: Resource analysis

Role analysis identifies the duty-bearers; resource analysis shows the resources available for duty-bearers and capacity analysis shows the gaps which prevent duty-bearers from meeting their obligations. Problems and their causes are often directly linked to how resources are allocated and who controls them. This means that resources are not just a question of wealth or poverty but also of who has decision-making powers at the national, community and household levels. The vulnerable, including women and the poor, should participate in the whole process of development of a strategy. A major concern remains that a critical analysis is likely to show that a very limited proportion of resources actually empowers the most vulnerable segments of the population.

Resources are classified in different ways. Those mentioned may be shown schematically as in figure 7.

**Figure 7: Classification of Resources**

Resources

Existing

Potential

Human

Knowledge

Skill

Time

Self-confidence

Will to take action

Economic

Means of Production

Credit

Income

Organsational

Extended family

Kinship groups

Civil Society orgs.

Government orgs.

Formal/ non-formal institutions
Human rights commitments remain abstract principles until governments allocate resources to particular sectors and define the levels and standards of provision that all citizens can expect.\textsuperscript{445} From a human rights perspective, it is necessary to examine the extent to which national resources are used to advance human rights and human development. The level, distribution, efficiency and effectiveness of the resources devoted to women and children should be examined as to whether they meet the standard of “maximum extent of available resources.”\textsuperscript{446} Resources are key in determining both short-term and long-term development possibilities.\textsuperscript{447}

Every society has a maximum potential of production and an existing social organisation and relations which determine the realisation of this potential and the distribution of the results of production. The potential and social organisation of society are inter-related and interactive. Neither has a full meaning without the other.\textsuperscript{448} This is where the analysis should start.\textsuperscript{449} The potential of society includes the following:

- Ecology, including climate and soil
- Other natural resources
- People with their knowledge and skills
- Technology.

The social organisation and relations represent the relationships among individuals or groups of individuals. They include:\textsuperscript{450}

- Ownership of the means of production
- Class and caste
- Gender relationships
- Power relationships
- Other political factors, including political power, legal system and other rule systems
- Other ideological factors, such as culture, religion, habits and traditional legal systems.

### 7.4.4 STEP 4: Analysis of behaviours and cultural patterns

Situation Analysis must look at societal, behavioural and cultural patterns in order to understand their interactions.\textsuperscript{451} Change of societal values is a long-term proposition. Therefore, strategic analysis of opportunities to set change in motion is important. Hence there is need to understand factors influencing current social values and behaviours and how to influence these over time.\textsuperscript{452} “A specific programme objective should be to influence attitudes towards children and women so as to contribute to the development of a culture of respect for their rights.”\textsuperscript{453}

### 7.4.5 STEP 5: Analysis of prevailing norms and legal system

Human society is structured in many ways, both formal and informal. There is a formal legal system and in many cases, an informal system of traditional law and entitlements. Traditional law may govern the lives of the majority in some countries.\textsuperscript{454} In a human rights-based approach, it is necessary to look at both national legislation and increasingly, decentralised government structures for their compliance with CRC and CEDAW.\textsuperscript{455} “Where human rights are not legally protected or recognised in the policies and practices of service providers, people are unable to claim entitlements, even where resources are available.”\textsuperscript{456}

The legal framework of a country should be assessed for its conformity with human rights treaties. Laws and policies also need to be examined to see how they regulate women’s health care, affect the allocation of scarce health resources and govern women in their personal, family and public lives.\textsuperscript{457} Even if the laws are adequate, it is also important to look at decentralised government structures and mechanisms that enable women to claim their entitlements and rights. Traditional law should also be considered from a human rights perspective, since it may govern the lives of the majority in some countries.\textsuperscript{458}

It is necessary to dialogue with traditional or customary law supporters. These types of law need to be
examined too, and customs that are incompatible with the CRC and CEDAW must be identified and ways to change negative aspects addressed collectively. 459

“Rather than being governed by, and identifying with, one set of values and institutions, people will utilise whichever mechanisms are most accessible and offer least ideological resistance to their interests.” 460

Tradition can be an asset, especially if the positive aspects are recognised and promoted. “Analysis may need to compare modern and traditional norms in ways that help to revive and protect positive traditional practices.” 461 “Socio-political structures that create a strong sense of social cohesion can help to promote human rights and the recognition of basic needs.” 462 Therefore, it is important to identify, analyse and preserve aspects of traditional society promoting social cohesion for the benefit of children and women. 463

7.4.6 STEP 6: Vulnerability analysis

“A Vulnerability Analysis will consider actual and potential hazards, the likelihood of their occurrence, determine the population that will be affected, and their ability to cope.” 464 Any human rights based situation analysis should identify those who are excluded from basic services, are experiencing higher morbidity and mortality, are exposed to neglect, abuse or infectious diseases, or who drop out of the education system. 465 It adds crisis scenarios to the regular situational analysis. As such, it is concerned with trends affecting women as well as threats which may emerge. 466

“The social trends ultimately determine the capacity of individuals, households, communities and other actors at higher levels of society.” 467 They are the result of the constant interaction of the potential of society and the society organisation/relations being transmitted through social, economic, political and cultural processes in society. 468 Societal trends include production, distribution, unemployment/employment, exploitation/non-exploitation, exclusion/inclusion, discrimination/non-discrimination, alienation/non-alienation, corruption/non-corruption, dis-empowerment/empowerment, dictatorship/democracy, war/peace. Most of these trends are interrelated, some in a synergistic way. 469

7.5 Community Capacity Analysis

Development efforts must focus on building the capacities of communities, since development is for people, all of whom live in communities. 470

A community is an organised group of people who share a sense of belonging, beliefs, norms and leadership and who interact within a defined geographical area. Some communities share common goals and common interests are mutually supportive and are distinguishable by what they do. 471

Some duty-bearers live in the community, others live outside the specific community, often having roles at higher levels of the society. Hence a HRBAP focuses both on communities and the relationships between the community and higher levels of society. 472 It is imperative to recognise fully and build upon already existing community capacities. The six step-process for assessment and analysis is applied at the community level.

It is important during assessment to identify existing capacity in the community. Factors to be assessed include:

- Sense of responsibility and commitment to protecting human rights
- Existing formal or informal, traditional or non-traditional authority
- Existing human and organisational resources
- Participation in decision-making within the community and between the community and the wider society
- Whether macroeconomic and social sector policies and programmes are consistent with the general principles of human rights and provide a sound basis for the progressive realisation of rights.

In many communities one finds members who work together against external threats to the community
(e.g., floods, criminals) but they may be more reluctant to intervene in more private matters like family conflict or neglect. Authority structures in a community must be assessed, as religious leaders and traditional birth attendants are recognised as respected authorities on specific issues related to their social and cultural roles. In assessing community resources, it is important not to overlook that poor communities often have existing human and organisational resources.

"Participation in Capacity Analysis is very important, as it is often only through a dialogue among the actors themselves that the real constraints will emerge in a proper perspective." Participation by the community in the wider society and within the community must be assessed with particular attention to whether resources for community capacity development empower the most vulnerable segments of the community. Any capacity-building gap that is identified must be addressed as highest priority in a HRBAP.

Often different members of a community will articulate causality differently. Measures must be taken to ensure that women, children and especially adolescents and the marginalised, are able to voice their opinions in an enabling environment. Anyone who enters into a community should be open minded enough to listen to all of the community’s problems and not just the selected issue (e.g. HIV/AIDS). Outsiders may help a community to make linkages between problems and to perceive an issue in a different light.

7.6 Applying a Human Rights-Based Approach to Assessment and Analysis of Maternal Mortality

In assessing and analysing the situation in relation to maternal mortality in a human rights-based approach to programming, the principles of non-discrimination and participation must be respected. The process follows the six steps mentioned.

7.6.1 Non-discrimination

When this is applied to the reduction of maternal mortality, it raises questions such as:

*If there are groups not using the facility, why not and where, if anywhere, are they going? What are the barriers that prevent them from using the facility? How can such barriers be addressed and the health facility change to serve the entire population?*

Another vital issue for assessment at a health facility is to examine each area and process to see if the dignity of each person is respected. This complements the assessment related to technical competence of each area and process.

7.6.2 Participation

Ensuring the participation of women reveals unsuspected causes of lack of access to EmOC. In Peru, after numerous consultations with Andean women and health workers, UNICEF and its partners understood that to overcome cultural barriers, a number of the women’s concerns had to be taken into account to increase the use of health centers and thereby reduce the high maternal mortality rates. In applying a human rights-based approach, it is imperative that questions about women’s participation are raised, including: 1) Do women participate in decision-making at the level of the family, community, district and nation? 2) What is the connection between maternal health and women’s participation in decision-making, particularly in vulnerable populations? UNICEF can play an important role in ensuring the participation of women and women’s organisations in policy development and implementation, particularly as advocates of women’s rights and women-friendly health services.

7.6.3 STEP 1: Causality analysis

Scientifically based analysis is a key tool to identify the immediate, underlying and basic causes of maternal death. It is important to understand the causes of problems and the linkages between problems. The analysis should start at the ultimate outcome and continue down the hierarchy of causes (focused analysis). A focused analysis will help to limit the analysis to only those causes that actually influence the selected outcome in the situation at hand, and will therefore not include all possible determinants.
and processes in society. Only then can appropriate interventions be identified for reducing maternal mortality.\textsuperscript{488} The framework for assessing and analysing maternal death (see figure 8) shows:

- Immediate causes as complications of pregnancy
- Intermediate causes as the nutritional status of women, the health status of women, and the use of services influenced by knowledge attitudes and behaviour health and maternal rights
- Underlying factors such as the status of girls and women in society.\textsuperscript{489}

In any given country or community, the relative weight of these causes may vary. One must understand causes clearly to have clear objectives to guide a multi-disciplinary approach to reducing maternal mortality.

7.6.4 STEP 2: Role analysis/pattern analysis

Faced with appalling rates of maternal death practically unchanged over the years, a human rights-based approach to maternal mortality policy must be grounded in a careful critique of the workings of power that have permitted this situation.\textsuperscript{491} At a workshop with representatives from the South Asia region, participants identified seven levels that impact upon the life and health of women in South Asia: household (including individual women and men), community, facility, district, national (including sub-national), regional and international. Duty-bearers may indeed have obligations at several different levels at the same time or at different times. Each level constitutes a tool for analysis and actions, which to be effective often must link across levels. As we move from the household to the international level, decisions are made more and more remote from the place at which they have their impacts.\textsuperscript{492}

The approach to human rights advocated here seeks to encourage policy makers and program managers to focus their analysis, prioritise their efforts, and confront the most serious barriers to reducing maternal mortality by confronting the power dynamics that have precluded widespread access to EmOC in any given setting.\textsuperscript{493}

Unlike infant and child mortality, where the primary health care model has been effective in lowering mortality rates, maternal mortality only changes when EmOC is available and accessible to women suffering complications of pregnancy. This depends on having functioning health care systems. In the face of health systems failing to deliver EmOC, it is essential to have a strategic focus on the health care system itself. This means analysis of the current dynamics of health care systems.

7.6.5 STEP 3: Resource analysis

It is important to look critically at the use of resources and expected outcome. Any serious attempt to address maternal mortality must look not just at numbers of trained personnel but also at their distribution. This entails looking at whether the resources allocated match the responsibility that has been assigned at a sub-national level. It also means looking at what outcome (increase in met need for EmOC) can be expected from the investment of resources in training personnel of various cadres in vital techniques.\textsuperscript{494} In the analysis of resources, it is also important to distinguish inability from unwillingness.\textsuperscript{495}

Conviction in and commitment to our values support us to make decisions and undertake actions that save women’s lives.\textsuperscript{496} A human rights-based approach also seeks to identify and support those who are risk-takers and champions of women’s right to safe motherhood, as it is leadership that both guides and drives change.\textsuperscript{497}

7.6.6 STEP 4: Analysis of behaviours and cultural patterns

At the community level, social science research is needed to identify social or behavioural practices that might inhibit, or advance, safe motherhood.\textsuperscript{498} “Both the health services and the women who need them exist in political space. Many different social, economic, cultural, political forces have combined to prevent widespread implementation of EmOC and to prevent the conditions that make universal access to it possible.”\textsuperscript{499}

Lack of knowledge is one of the principal underlying
Figure 8: Framework for Assessing and Analysing Maternal Health

MATERNAL MORBIDITY, MORTALITY OR SURVIVAL

Complications of Pregnancy Including
- Haemorrhage
- Infection
- Pregnancy Induced Hypertension
- Obstructed Labour
- Unsafe Abortion
- Others

Nutritional Status of Women
Including equal access to food, and micro-nutrient deficiencies from childhood, through adolescence and child-bearing years

The Health Status of Women
Including vulnerability to HIV/AIDS and other STDS as well as diseases like malaria

Knowledge, Attitudes and Behaviour
that influence female health including
- Participation of women in decision-making
- Attitudes towards pregnancy and childbirth including adolescent pregnancies
- Harmful practices such as female genital mutilation and vulnerability to violence and abuse

Use of services depends mainly on availability, cost and the quality of care

Reproductive and Maternal Health Rights
Including:
- Family Planning
- Prenatal Care
- Delivery Care
- Essential Obstetric Care
- Postnatal Care
- Screening for STDs, HIV/AIDS, cervical and breast cancer

The Status of Girls and Women in Society
Legal rights of women based on national constitutions and international human rights treaties
- Girl’s access to education
- Work burden on girls and women
- Women’s access to equal employment with maternity rights
- Women’s vulnerability to poverty
- Equal participation of women in political decision making
causes of maternal death – particularly when women and their families fail to recognise danger signs, do not realise the importance of swift action, and do not know where to go to seek help. Attitudes towards girls and women influence their status in society, their ability to receive education and make their own decisions about seeking health care. Custom often dictates what woman should and should not eat during pregnancy, how she should give birth, what she should wear during delivery and who should be present at the birth.500

“In some parts of Nepal, for instance, women are expected to give birth alone.”501 Violence is accepted in many communities and contributes significantly to maternal deaths. Actions due to misconceptions about the causes of complications and other cultural practices also threaten women’s health and survival.502

7.6.7 STEP 5: Analysis of prevailing norms and legal system

The provisions in the international human rights treaties which promote safe motherhood and protect a woman’s right to life have been identified.503 In light of the differences in context from country to country, “a local assessment is a desirable first step in applying human rights to advance safe motherhood.”504 “Legal research addresses how laws:

- Regulate women’s health care, such as regarding provider-patient relations
- Affect the allocation of scarce health resources
- Govern women in their personal, family and public lives.”505

Besides ensuring that the system of formal law is in keeping with the treaties at national level and that governments are held accountable, human rights work includes using the values and principles of human rights to shape programmes and policy.506 Careful review of national law, and policies is necessary, particularly related to family planning, adolescents and children, regulation of practice, delegation of authority and barriers to access.507 Access to services by women and girls is often affected more by religious and customary laws which also need to be analysed.

7.6.8 STEP 6: Vulnerability analysis

Pregnant women are all vulnerable to life-threatening complications, which need prompt treatment if they are to survive. The “three delays model” helps in understanding where a particular hazard may affect women’s survival. The vulnerability analysis examines what are likely hazards and threats, who is most at risk, what is the local capacity for response, what causes this vulnerability and how existing mechanisms can be strengthened to cope.508 Deterioration of the national economy leads to a steady decline in quality of health care and decline in women seeking care.509
CHAPTER 8

STRATEGIES AND PRIORITIES

8.1 Through a Human Rights Filter

Planning is about making choices. It is choosing where to invest resources to ensure maximum short-term and long-term benefits. The process of strategy development will reveal a multitude of needs and diverging priorities. A human rights-based approach has an inter-sectoral vision of development. The goals and objectives are:

- Longer term
- Process and outcome focused
- More difficult to quantify
- Focused on basic structural causes as well as manifestations
- Focused on rights fulfillment and empowerment.

The context is social, political, macroeconomic and policy-oriented.

The human rights-based approach aims at achieving ethically chosen goals/outcomes which reflect human rights values, through a process that fully involves claim-holders and focuses on strengthening duty-bearers’ capacities. It has been operationalised in Zimbabwe, among others, by taking Community Capacity Development (CCD) as the core ‘process method’ for implementation of projects. While implementing a HRBAP, other lessons learned in Zimbabwe include:

- Holistic and multisectoral work is unavoidable in a HRBAP
- Decentralised and community work become necessary
- The need to expand partnership with civil society is increased.

Human rights work for reducing maternal mortality includes not only the use of formal legal mechanisms, both international and domestic, but also happens at multiple levels in society.

It works at the individual level where it speaks to the ways in which individual people – patients and providers – are treated. It works at the institutional level where community participation and the dynamics of accountability can help the health facility to function better. Human rights principles also work at the larger systemic level, for example by addressing the impact of international actors and global forces.

The transition to a human rights-based approach implies an important change in values and principles of the entire society. Within UNICEF offices, it implied important changes in the strategic orientation of the program, the working methodologies and the demands on the staff. It also meant new and different relations with a variety of actors. As is the case with any process entailing profound change, fear and resistance were encountered along the way.

From examining the causes of maternal mortality, it is known that saving women’s lives in pregnancy and childbirth requires a shift in individual values and cultural norms at all levels of society. Service providers, policy makers, systems managers, families and women themselves are required to act in new ways. For instance, health personnel and managers have to be
motivated to be responsible and accountable for saving women’s lives.\textsuperscript{518} To initiate, diffuse and sustain change in organisations requires management support for a learning process.\textsuperscript{519}

8.2 Capacity Development

The new concept of capacity development increasingly dominates as a strategy of technical cooperation with its emphasis on sustainability, ownership and process.\textsuperscript{520} The term ‘capacity development’ has replaced ‘capacity building’, as in almost all instances considerable capacity already exists. The challenge, therefore, is to further strengthen and develop capacities rather than to ‘build’ something new.\textsuperscript{521} Capacity development is relevant for individuals, households, communities, organisations, formal and non-formal institutions, government institutions, NGOs and society as a whole. From a human rights perspective, since all individuals have both rights and duties, all need capacity both to claim their rights and to meet their duties.\textsuperscript{522}

According to a UNDP/UNICEF Workshop in 1999, capacity development requires:\textsuperscript{523}

- Effective processes (functions, roles, responsibilities, tasks) for identifying problems as issues, and formulating and realising goals
- Appropriate actors (individual and collective) who have the motivation, knowledge, skills and resources to perform effectively
- Effective structures for accountability, management and collective voice
- Supportive ‘rules’ or norms (formal and informal, economic, social, political) at all levels of society (public, private, civil society).

This is a systems thinking approach in which relations are as important as the components.\textsuperscript{524}

8.2.1 Community capacity development

One approach to human rights-based programming is that of community capacity development, in which the analysis begins with the capacity of the community and then examines other levels according to how they influence the community level. Its aim is community empowerment. The need to recognise the relationships between the community and higher levels of society is also important in poverty alleviation.

*Realistic action plans need to be based on the perspectives of poor people as well as clear analysis of the capacity and resources of governments. Action plans need to feed into the policy and budget processes in order to ensure that human and material resources are mobilised.*\textsuperscript{525}

The following components are seen as essential for such capacity development:\textsuperscript{526}

a) Awareness of both rights and duties

b) Responsibility/motivation/commitment/leadership means acceptance and internalisation of a duty, for some, leading to strong commitment and a leadership role

c) Authority to take action

d) Access and control of resources including human resources, economic resources and organisational resources

e) Communication capability to access information and communications systems crucial to their responsibilities and to establish a network among key actors

f) Capability for rational decision-making and learning requires evidence-based assessment and a logical analysis of causality, action based on analysis and a cycle of reassessment, reanalysis and improved action based on lessons learned from experience.
One challenge of this approach is that many communities such as villages are very heterogeneous and it is often difficult to reach agreement on sharing responsibility and resources, especially for what are considered ‘private matters’. However, community action and responsibility are necessary for any reasonable degree of realisation of the human rights of resource-poor and marginalised people.527

Efforts to improve capacity should aim at helping actors to address the basic political, economic, social and cultural constraints, thereby facilitating an empowerment process.

The duty-bearers have to agree on how to share accountabilities in a constructive manner. This dialogue should involve the claim-holders, who should be encouraged and learn how to claim their rights.528

8.2.2 Role of communication

The effectiveness of participation in community capacity analysis and decision making depends on a rights-holder’s capability to communicate and their relative position of power. Groups that cannot communicate effectively, such as women or adolescents, become marginalised within a community. They develop coping strategies that allow them to survive, but do not reach their full potential as individuals. Marginalisation may affect not only individuals or groups of individuals but also whole communities within a national framework.529

Techniques and methodologies are needed to overcome these communication barriers within a community and between communities and duty-bearers outside the community. New technologies need to be harnessed to create a two-way exchange. Often development activities are planned outside and communication techniques are used to inform the community of what they should do.

The challenge for ‘outsiders’ is how to both listen and to enable the community members to discover that issues they did not regard as problems at all suddenly are perceived in different light and linkages are established between these problems and what communities originally table as their key concerns.530

8.2.3 Identification of candidate actions and strategies531

The steps of analysis will result in a set of rights (violated or at risk of being violated) and the corresponding duty-bearers. The specific gaps in the necessary capacity of each duty-bearer will be listed. The objectives for interventions are to:

1. Empower claim-holders to claim their rights
2. Reduce or close capacity gaps of duty-bearers
3. Address the basic/structural causes of the problem.

This analysis may well produce a very large number of candidate actions and strategies. Strategies to achieve the realisation of human rights may be grouped as:

- Advocacy and Social Mobilisation
- Information
- Education
- Training
- Service Delivery.

Programming is about making strategic choices. Everything is not of equal importance or urgency. Needs, the political economy of priorities, cost and sustainability all influence strategic choices. All this must be discussed in the community and not decided by people outside the community. The dialogue between the community and those outside the community should lead to a consensus about priorities.

Candidate activities are clustered by level and by the objective of intervention. Some will reach across several levels. This produces a structured list to fill capacity gaps. When alternative actions or strategies appear to exist, the selection may be helped by cost-effective and cost-efficiency analysis, and sometimes by strengths, weaknesses, opportunities and threats (SWOT) techniques.
8.3 Priority Setting

Rights are not prioritised but actions to address specific problems need to be ranked in order of priority. Evolving human rights practice is meant to assist states in moving expeditiously towards fulfillment of the substantive rights. A rights-based approach requires finding effective ways of influencing outcomes at the family and community level, as well as through institutions and administrative arrangements of the state, at local and national levels.

“What principle do we use to move from analysis to strategy, from the complex web of social and economic determinants exposed by elaborating the full spectrum of human rights provisions to a strategic decision about how to address these problems?” The difficulty in answering this question may explain the perception that the rights-based approach is proving difficult to operationalise.

8.3.1 Priority and political struggle

The International Development Targets (now the Millenium Development Goals) provide a vehicle for focusing the resources and energies of international development efforts on the rights and needs of the poor. The primary responsibility for securing rights for all people, however, rests with individual governments and their citizens. Official donor agencies are challenged by the process of political struggle over priorities and access to resources. A human rights perspective on development reveals these competing claims and legitimises excluded peoples’ efforts to strengthen their voice in the political process. The importance of political struggle is also highlighted from a gender perspective.

A major lesson for empowerment of women is that little can be achieved in the long term by focusing only on small-scale activities. While these bring direct benefits to many people, they rarely bring about lasting, strategic change unless they are linked to, and complement policy development... Lasting change is best brought about through interventions which focus on major policy reforms, changes to laws and regulations, the reallocation of financial and other resources, and the promotion of changes in attitude through public debate.

The political nature of priority setting is recognised by UNICEF in its directive that a rights perspective for programming requires:

- Good skills in public policy analysis and formulation
- A keen sense of political processes shaping change
- Creating alliances with other organisations with similar purposes/mandates (especially in volatile situations).

8.3.2 Prioritising activities using causality analysis

A conceptual framework for causality examines the immediate, underlying and basic causes of problems. Some of the criteria for choosing which problems to examine in depth are:

- The number of children and women affected
- The problems affecting the poorest and most marginalised
- The scope and severity of the problem
- Trends
- The likelihood of the problem affecting realisation of other human rights.

The identification of specific causes, often referred to as a ‘problem tree’, helps to identify programmatic choices and to design specific interventions, as illustrated in figure 9.
In this scenario, Problem 1 and Cause A might be a good choice to be addressed. By resolving Cause A, both immediate causes of Problem 1 are fully or partially addressed. In contrast, tackling Cause X might be less practical, as it itself is caused by three more underlying causes, and the resolution of Cause X only marginally contributes to resolving Problem 2. For this example, Problem 1 and Problem 2 are considered of equal significance.

As for each selected cause an associated objective and a set of interventions are developed, the problem tree indicates whether the sum of the proposed interventions will be sufficient to adequately address the problem.543 “Although integrated programmes are more complex, when effectively planned and managed they address a broad range of problems and produce more sustainable results.”544

8.3.3 Priorities and time

During assessment and analysis from a human rights perspective, it is found that the underlying causes of several problems are a lack of realisation of human rights. In a rights approach, it is necessary to situate short-term programme objectives in the context of longer-term goals that seek to fundamentally change deeply rooted conditions that perpetually undermine the full implementation of human rights treaties.545 The challenge is to find the right balance between activities that ensure survival in the short-term and those that will bring the transformation necessary for sustained fulfillment of rights.546

8.3.4 Process and outcome

“A human rights approach to programming implies an ethical dimension on both what should be done (outcome) and how it should be done (process).”547 Human rights are based on the belief that all persons are equal in dignity and rights. “Questions of process and interaction are also deemed to be critical attributes of social and economic rights, such as the right to health.”548 Participation, local ownership, empowerment and sustainability are essential characteristics of a high quality process. Level of outcome and quality of process define a two-dimensional space for social action. This is illustrated in figure 10.
The ideal is to move from an existing bad process producing bad outcome (A) to the desired good outcome from a good process (D). However, there is a risk of being caught in a good outcome from a bad process (B) e.g., lack of sustainability; or in a good process from a bad outcome; e.g., one that could never be taken to scale (C). Economists tend to emphasise outcome, whereas many NGOs have high-quality but highly expensive processes. The process is as important as the outcome, but not more important. The principle of ‘low cost - high impact’ may at times be rejected in a human rights-based approach, as priority may be given to gross violations of the rights of a few rather than the addressing the less severe violations of a large number. “Morality sometimes leads to a different set of priorities, than what, for example, cost-benefit analysis does.”

8.4 General Principles Related to Maternal Mortality Reduction

8.4.1 From a human rights perspective

The indivisibility of human rights seems to challenge the concept of programming for the reduction of violations of one particular right. However, closer examination of the right to safe motherhood is seen to give evidence of the indivisibility of rights, as the fulfillment of this right depends on the fulfillment of a number of other related human rights. In UNICEF programming, reduction of maternal mortality is part of the overall strategy for Early Childhood Development. This illustrates that the rights of one person are often dependent on the fulfillment of the rights of another. It also points to another of the challenges of human rights-based programming. Duty-bearers are also rights-holders and there can be conflict of rights (e.g., the health team have a right to family life, which can conflict with the right of women to 24-hour quality EmOC).

The Women’s Right to Life and Health Initiative adopted five human rights principles as core values for the initiative, namely human dignity, non-discrimination, right to life and development, participation and accountability.

The well-being and survival of women during pregnancy and childbirth depend on respect for their dignity and right to life within families, communities and health facilities. Concern for human dignity means respect for the perspective and self-determination of not only women clients but also men and women who work at the hospital. Non-discrimination means that all women have the same right to life and health. In practice this means positive support to poor, vulnerable and marginalised people by acknowledging and addressing their needs at a national level as well as by community initiatives.

The practical applications of participation include ensuring that women are included in decision making processes, decentralisation of decision-making in both public and private spheres, and ensuring that the marginalised have a voice in all stakeholder committees. “Active participation and accountability of stakeholders from throughout civil society are essential to achieving – and sustaining – a substantial reduction in maternal mortality.”

Since women have a right to the highest attainable level of physical and mental health, including the right to special health services during and after pregnancy and childbirth, governments are legally obliged by the treaties to ensure access to EmOC and other services necessary for their survival.

To save women’s lives from complications of pregnancy, it is necessary to have a functional health care system providing EmOC. Initiatives for safe motherhood, for
example by WHO, focus increasingly on health care system performance and so open the way for more inventive human rights approaches. Interventions at many levels have a rational basis for reducing maternal mortality. However, in the face of massive deprivation of fundamental rights, human rights principles compel us to act strategically and press for those interventions most likely to lead to the rearrangement of power necessary for change in each time and place.\(^{559}\)

There are two basic goals articulated in relation to the human rights of women during pregnancy and childbirth. One is the reduction of maternal mortality and the other is safe motherhood. This may well be an example of how in a human rights-based approach, priority may be given to gross violations of the rights of a few rather than addressing the less severe violations of a large number.

However, the long-term goal is to ensure the progressive realisation of every women's right to health, including safe motherhood.

*We need simultaneously to create and maintain a grand vision about the meaning and importance and ideals of our work, while still valuing and prioritising the concrete, grounded, sometimes even plodding, steps of health programming. We need to expand and deepen our understanding of the ways in which large-scale economic and social forces influence maternal mortality, yet not allow the complexity of our analysis to detract from the clarity and directness of our strategy. We need to see the big picture but to do focused actions.\(^ {560}\)*

### 8.4.2 Options for reduction of maternal mortality

When the choices of focused actions are made, then, for the goal of preventing maternal deaths, the activities are scrutinised using three basic questions:

- Will it affect the incidence of pregnancy?
- Will it affect the incidence of complications among pregnant women?
- Will it affect the outcome of obstetric complications?

Unless the answer to one of these three questions is “yes”, then the proposed activity cannot reduce maternal deaths.\(^{561}\)

Even so there are many programme options. “In evaluating which interventions are likely to be most effective in reducing maternal deaths, what is needed is not to consider various options as mutually exclusive, but to estimate their relative importance and potential for reducing maternal mortality.” \(^{562}\) The options available were analysed using the model shown in figure 11.

Proposed programme options to decrease maternal mortality and how they may be expected to reduce maternal mortality are summarised below: \(^{564}\)

- Responsible planning of family size (this reduces number of pregnancies but apparently has little effect on the risk of maternal death)
- Improve socioeconomic status (historical evidence suggests that improving socioeconomic status in the absence of effective care of complications of pregnancy does not reduce complications of pregnancy does not reduce maternal mortality. This

---

**Figure 11: Analytical Model of Maternal Mortality**\(^ {563}\)

<table>
<thead>
<tr>
<th>Distant Factors</th>
<th>Intermediate Factors</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Socioeconomic Status</td>
<td>Health and Reproductive Behaviour</td>
<td>Pregnancy</td>
</tr>
<tr>
<td>Health Status</td>
<td>Access to Health Services</td>
<td>Complications</td>
</tr>
<tr>
<td>Unknown Factors</td>
<td>Maternal Mortality</td>
<td></td>
</tr>
</tbody>
</table>

---
argument does not address the question of access to effective care by those in lower socioeconomic strata)

- Provide prenatal care (the proposed benefits are limited by the fact that all women are at risk of developing life-threatening complications, which cannot be predicted. To be effective, prenatal care needs the backup of emergency obstetric care. Education to improve health status and birth preparedness does not have to be confined to the time of antenatal care. It is not known whether treatment with iron tablets will lead to a significant reduction in maternal deaths)

- Improve emergency obstetric care (since most complications cannot be predicted or prevented, all pregnant women need to be able to access emergency care to save their lives)

- Train traditional birth attendants (only if their training gives them skills in first aid for obstetric emergencies will training TBAs reduce maternal deaths. Even so, they will need effective linkages to higher levels of care)

- Inform and mobilise the community (this is effective in reduction of maternal mortality if it changes behaviour in order to improve utilisation of health services for treatment of complications).

In light of the above, the priorities suggested by Deborah Maine are listed below.565

**Priority 1:** Ensure Access to Medical Treatment for Obstetric Emergencies

- Improve emergency treatment for obstetric complications in existing referral facilities

- Upgrade peripheral facilities to provide obstetric first aid

- Inform the community about danger signs during pregnancy and delivery

- Work within the community to improve access to emergency care

**Priority 2:** Reduce Exposure to the Risks of Unwanted Pregnancies

- Responsible planning of family size

**Priority 3:** Establish and Improve Other Maternal Health Services

- Establish and equip community maternities

- Train birth attendants to treat women with complications and refer

- Improve prenatal care services

- Establish maternity waiting homes.

Priority 1 relates to the all-encompassing term ‘access’. There are many barriers to women’s access to emergency obstetric care, beginning within the woman herself, who has been socialised not to claim her rights, and extending to the national and international policy makers who do not include reduction of maternal mortality as an important aspect of development policy. Access is hampered by the low socio-cultural status of girls and women in their homes, communities and civil society.566

It is not enough to have the technical capacity in health facilities. To ensure that all pregnant women have access to high quality emergency obstetric care – that is both acceptable and affordable to them – requires a broader, deeper transformation. While it is not expected that such a transformation can be achieved immediately, it is considered essential to initiate this change in order to achieve the goal.567

**8.4.3 Operating principles for reduction of maternal mortality**568

Through a participatory approach to the development of its strategies, the Women’s Right to Life and Health Initiative has articulated its operating principles for implementation of strategies to reduce maternal mortality. The first essential element is sharing the vision of women’s right to life and health, based on shared values and integrating the three components of human rights, technology and management. Other elements include:
Commit to a continuous learning of new competencies and skills, in order to achieve a transformation of the inner being and outer actions of individuals and groups. The acquisition of competencies and skills is founded upon equal access to information and knowledge, enhancing equal, informed participation. Actions and behaviours embody what has been learned supporting the shift in value systems.

Build leadership and management that embody the transformed values and principles, and support initiative, innovation, quality and results.

Develop internal and external systems for working that reflect the transformed values, attitudes, behaviours, and work processes. Maintain a focus on the vision to guide our individual and collective actions, such that synergy of efforts and clear performance goals and strategies generate accountability for results.

Establish structures and processes of decision-making that reflect values that support equal participation of all. The voices of individual women and men and of groups (e.g., nurses, doctors, marginalised women) are accorded equal value. Promote active, equal participation to facilitate development of individual and collective responsibility and accountability for achieving the vision.

Commit to adequate resource allocation for achievement of the vision.

A phased intervention has been drafted that begins with community stakeholder supportive participation at hospital/district level. Once EmOC services are established, convergence with more vulnerable groups in the community should be ready to begin. Country projects need to identify partners who can facilitate community stakeholder supportive participation. They can become champions of change.569

### Table 7: Phases of Delay and Their Strategies

<table>
<thead>
<tr>
<th>Phases of Delay</th>
<th>Strategies</th>
</tr>
</thead>
</table>
| **1st Delay**
  Deciding to Seek Care                                                      | ● Mobilise men, women, family and community
  ● Build partnerships to reduce maternal deaths
  ● Invest in people
  ● Support risk-taking champions of innovation and change                      |
| **2nd Delay**
  Identifying & Reaching a Medical Facility                                    | ● Link community to facility
  ● Build partnerships to reduce maternal deaths
  ● Invest in people
  ● Support risk-taking champions of innovation and change                      |
| **3rd Delay**
  Receiving Adequate, Appropriate Treatment at the Facility                   | ● Provide 24-hour quality EmOC services
  ● Champion women’s rights
  ● Build & sustain accountability
  ● Invest in people
  ● Support risk-taking champions of innovation and change                      |

Lack of supportive national policies and action contributes to all delays
8.4.4 Strategies derived from the “Three Delays Model”

The outcome of obstetric complications is subject to the nature of the complication and the time taken to receive adequate and appropriate treatment. Since time is of the essence, especially in the case of haemorrhage, any delay can be fatal. Strategies to reduce maternal mortality may be linked to the Three Delays Model described in Section 5.4.2 (table 7). These strategies are broad brush strokes, each one of which encompasses many elements requiring actions at different levels of society. All activities are designed to produce a change from the status quo in which women are denied their right to life.

Interventions or strategies to reduce maternal mortality must be directed towards preventing these delays by transforming the way individuals, communities and facilities respond to complications of pregnancy and childbirth. The transformation required is across the whole of society. Risk taking champions of innovation and change are necessary at every level and as the leaders of this transformation, they need to be supported in their efforts.

Creating convergence between hospital and communities over time is social justice. To make this a reality, resource groups are required to move rights into action. We need to build hospital and community accountability. Accountability for action must be linked to a sense of urgency among all stakeholders that ensures availability and readiness of EmOC services and a prompt response to obstetric emergencies in the community and at the facility.

8.4.4.1 Strategies to reduce delays in deciding to seek care

In South Asia, the majority of births still occur in the home, so the decision to seek care is made in the household. Women have no voice over the use of medical facilities, often resulting in the delay or failure to access life-saving services. A study on maternal mortality and morbidity carried out in three districts of Nepal revealed that the husbands and the family of the husband were the most frequent decision-makers (81.6%) regarding women’s use of health facilities. The fact that 67.4% of the women in this study died at home reflects a lack of understanding and care for women’s needs among the household’s primary decision-makers.

The delay in deciding to seek care has been divided into two: delay in recognising the need to seek care and delay in deciding to seek care. Recognising the presence of a complication depends on knowing the danger signs and whether the person present has this knowledge. However, the recognition of the complication does not necessarily translate into a decision to seek care. Barriers to deciding to seek care include cost, restriction of women’s mobility, and strong preferences for home births, among others. In Bangladesh, a community mobilisation programme which promoted birth preparedness, set up community support schemes, and worked at the nearest facility to improve quality of care found that while upgrading facilities increases utilisation rates, combining upgrading with community mobilisation increases them even more.

8.4.4.2 Strategies to reduce delays in reaching care

The delay in reaching care depends on the distance to the nearest available care. In South Asia, only 28% of births are assisted by trained health personnel. “Providing skilled attendants able to prevent, detect, and manage the major obstetric complications, together with equipment, drugs and other supplies essential for their effective management, is the single most important factor in preventing maternal deaths.” Skilled attendants are exclusively people with midwifery skills (for example, doctors, midwives, nurses) who have been trained to proficiency in the skills necessary to manage normal deliveries and to diagnose and treat or refer obstetric complications. Ideally, skilled attendants live in, and are part of, the communities they serve. At the onset of complications, they perform essential interventions, start treatment, and supervise the referral of mother and baby if necessary. Those skilled attendants located at the community level, either in the home or in low-level facilities with minimal equipment, provide obstetric first aid. If this care is
viewed as an alternative to hospitalisation in an emergency, this would be counter-productive and dangerous for mothers and infants.581

The delay in identifying and reaching a medical facility that provides needed care is related to the availability and accessibility of facilities. There are existing EmOC facilities. However, their geographical distribution influences the delay in reaching an EmOC facility. Undertaking mapping at the district level (covering populations between 100,000 and 200,000 people) can help to ensure efficient case loads at all available and potentially available facilities.582 Terrain and the availability of transportation also affect this delay. In Nigeria, a village transport workers’ union now provides transportation to health facilities for women with obstetric emergencies. Drivers were sensitised to women’s needs for emergency transport and good transport care. Communities established a revolving ‘emergency fuel fund’ to pay the drivers if the women are too poor.583 In Nepal, Safe Motherhood Action Groups (SMAG) proved to be an effective way of motivating the women of the community to ensure pregnant women received appropriate care during pregnancy and childbirth. They also established an emergency fund and built stronger linkages with agencies outside the community.584

8.4.4.3 Strategies to reduce delays in receiving care

The EmOC provided must be of high quality. Studies in Bangladesh have shown that many more women attended facilities with well-motivated and active staff.585 Quality of care encompasses not only the technical competencies and logistic support of EmOC, but also the manner in which care is provided.586

The quality desired is described as “women-friendly”. Such health services should:

- Be available, accessible, affordable and acceptable
- Respect technical standards of care by providing a continuum of services in the context of integrated and strengthened systems
- Be implemented by staff motivated and backed up by supervisory, team-based training, and incentive-linked evaluation of performance
- Empower users as individuals and as a group by respecting their rights to information, choice, and participation.587

At the service delivery point, it is important to take a systems approach to service delivery. This involves looking at the different levels of implementation and their linkages. For the Women’s Right to Life and Health Initiative, “interventions are being implemented at three levels: 1) national, provincial and state governments and donors, 2) district management and hospitals, and 3) individual men, women and communities. External stakeholder involvement is the key to sustainability at all levels.”588

Within the whole system, traditional hierarchical relationships need to be replaced by relationships that acknowledge interdependence and interrelatedness. “If hospital facilities are to show the way to the path of health, it is not only doctors and nurses but also the labourers and cleaners, who should show respect for women’s lives.”589 The transformation required demands strategies which incorporate a shared vision for women’s right to life and health, integrating the three components – rights, technology and management – with the shared values.590

8.4.4.4 Strategies to reduce delay due to lack of political commitment

Initiatives at the community level are aimed at overcoming the barriers to deciding to seek care as well as those affecting travel to an EmOC facility.

However, no amount of information and education or community mobilisation or even poverty reduction will make a major dent in maternal deaths in high-mortality countries unless it is accompanied by a health care system that makes emergency obstetric care (EmOC) widely available and accessible.591
Long-term political commitment is an essential prerequisite. When decision-makers at the highest levels are resolved to address maternal mortality, the resources needed will be mobilised and the essential policy decisions will be taken. Fostering governmental compliance with human rights obligations to advance safe motherhood can be approached by a variety of different procedures at national, regional and international levels. Pressure on governments and their agencies to fulfil their obligations may be brought to bear through legal action, political pressure (including the media and religious institutions) and at times by force of public opinion. The long-term commitment of politicians, planners, and decision-makers to safe motherhood programmes depends on popular support. Input from a wide range of groups and individuals is therefore essential, including community and religious leaders, women’s groups, youth groups, other local associations and healthcare professionals. UNICEF may encourage the establishment of a broad group of agencies inside and outside government to lobby for policy changes in favour of safe motherhood.

8.4.5 Options for safe motherhood

After an examination of the human rights treaties and their application to issues related to safe motherhood, Cook and associates recommended three general strategies:

- Education and training to reinforce safe motherhood as a human right
- Negotiation for improved maternal health services and for other enabling conditions for improvement in maternal health
- Implementation of accountability for safe motherhood at national, regional and international levels.

Applying human rights to maternal health, including safe motherhood, is recognised as a new paradigm. At the International Conference on Population and Development (ICPD) there was a strong emphasis on women’s empowerment, and the rights agenda was seen to move society from a negative preventive stance towards health to an affirmative one. Thus, the goal reaches beyond a sustained reduction in maternal mortality and related disability to become the more comprehensive one of total well-being. Ensuring that all women have access to quality EmOC is a critical first step in strategies for safe motherhood. Programming for safe motherhood looks at the whole framework for assessing and analysing maternal health and not simply the last step between complications and maternal morbidity, mortality or survival. It highlights the importance of the underlying factors, including women’s status from childhood as well as in pregnancy in terms of health, nutrition, access and use of services, and attitudes of their families and communities.

This broader approach necessarily includes all the strategies to ensure that all women have access to EmOC, as is seen in the list of the key operational strategies:

- Assessing the scope of maternal illness and death, identifying populations at risk and using the Triple A Approach to develop, implement and monitor programmes for safe motherhood
- Using a rights-based approach to leverage resources for improving maternal health
- Building broad-based multi-sectoral partnerships for safe motherhood
- Applying a gender focus to all programme activities
- Making strategic use of mass communications to promote safe motherhood
- Involving adolescents, women, men and communities in participatory efforts to build women friendly societies
- Using process indicators to monitor changes in maternal health

Areas of intervention applying a human rights approach include improving nutrition, care during pregnancy and childbirth, attention to maternal and neonatal health during emergency situations and building linkages with programmes that address other reproductive health issues, teenage pregnancy, HIV/AIDS and gender
violence and discrimination. A range of strategies and interventions to promote safe motherhood needs to be based on the analysis of the situation in each country or region. Safe motherhood is more than a question of health. It requires changes at many levels of society, and in many systems – health, legal, political, educational and cultural. It requires strong partnerships between government and communities.

8.5 Managing Change

8.5.1 Change inherent in a human rights-based approach

A human rights-based approach to programming necessarily involves doing things differently. The change includes examining the values and attitudes underpinning decision-making processes, the focus of strategies and the time frame. The rights approach is a long-term process that applies the principles and standards of international human rights instruments and focuses on both rights-holders and duty-bearers, especially prioritising the disadvantaged and excluded. A human rights-based programme aims at increasing people’s capacity to claim their rights and to fulfil their duties.

The category of behaviour change communication (BCC) is less relevant within a human rights framework. Rather than developing communication strategies to convince marginalised rights holders to change their behaviour, help them to assert their rights so that they can define a future that is relevant to their situation. Behaviour change will then occur as a result of empowerment and changed circumstances. This may prove to be more successful.

“Studies of large-scale programmes reveal that addressing subjective attitudes and beliefs of individuals is essential to achieving programme results. Teamwork and cooperation are key to programme success.”

Human rights-based programmes call for inter-sectoral programming. However, “it is sometimes, or perhaps always, harder to talk across disciplines than across cultures.” Yet, attempts to do so can produce a kind of creative tension.

Those who already share human rights values and commitment should not change, but others who have not yet internalised these values need to change. Strategies for such changes must be developed and work processes adapted accordingly.

In challenging the status quo, the husband and the policy maker face opposition. They face risks. It is acknowledged that the individuals who are willing to challenge the status quo - risking criticism, marginalisation and even their security – require support for their willingness to model new behaviours and lead change.

In the community capacity development model, the role of communication is one of opening up dialogue between rights-holders (especially the marginalised) and duty-bearers so that they can influence decisions and development plans which affect their lives.

This calls for a change in the strategies used. To make a human rights approach to communication operational, strategies include:

- Recruiting staff who can work with communities of marginalised rights holders as well as being able to sensitise duty-bearers
- Sharing of knowledge among partners at all levels
- Helping partners take successful techniques to scale
- Using community radio to improve connectivity
- Using appreciative inquiry to create the positive energy needed to build a positive future.
- Creating methods to ensure non-confrontational communication between duty-bearers and rights-holders
- Developing techniques to enable rights holders to share their whole reality with duty-bearers, including traditional knowledge and emotional intelligence.

Strategies need to support actors who work at the community level, especially mobilisers and facilitators.
Mobilisers are highly motivated people of the community, who are links between the community and service delivery, as well as animators of community actions. For optimum benefit there should be one trained mobiliser per 10 - 20 households. Facilitators are normally staff of some government service or NGO and are paid. Ideally for every 10 - 20 mobilisers, there is one facilitator who plays a supportive and problem-solving role for the mobilisers. They may also be the trainers of the mobilisers.611

Social mobilisation often assumes a development approach in which rights-holders do not empower themselves, but are mobilised by outsiders in support of externally developed goals.612 Far more important than the development of messages and materials is the development of communication channels to help rights-holders express themselves, and to help duty-bearers listen and respond. These channels are essential pre-conditions to the realisation of rights.613 Information that is received by the community is usually discussed to obtain greater clarity. Effective mobilisers and facilitators facilitate understanding as well as providing feedback from the community. Typical facilitator/mobiliser chains include dispensary staff working with village health workers and traditional birth attendants. Strategies to enhance Triple A processes at the community level need to be channeled through such linkages for the five ‘generic’ strategies: advocacy/social mobilisation, information, education, training and provision of essential services.614

8.5.2 Change necessary to reduce maternal mortality

The need for change at all levels to ensure women’s survival is clear. “Behavioural change is needed as much to improve the quality of care as it is to eliminate harmful practices, whether these are traditional (such as female genital mutilation) or ‘modern’ (such as “routine” episiotomy).”615 While female genital mutilation is not a problem in South Asia, there are such harmful practices as trying to dispel the evil spirit by beating women who have convulsions.616

Establishment of women friendly hospitals will explicitly address and support processes for initiating these changes, creating environments that encourage women to seek care... The aim is not only to transfer skills that will save women’s lives, but to cultivate a transformation for healthcare staff and managers, women and their families.617

To initiate, diffuse and sustain change in organisations requires learning, both individual and organisational. Efforts to save women’s lives require widespread changes. These changes, and the learning that is needed, require management support.618

Good management and leadership that are committed to guiding and driving change demand investment in people – an ongoing process of human resource development.619 It is essentially the filling up of capacity gaps that have been identified. “Profound change requires investment of time, energy and resources. Genuine commitment is absolutely essential to bringing about positive change and results.”620

8.5.3 Appreciative inquiry as a strategy for change

In a human rights-based approach to programming it is necessary to have a method that will sustain the necessary change as well as satisfy the demands of good process. Appreciative Inquiry is one of several methods which has the potential to bring about sustainable change. The appreciative inquiry process releases our creative energy and commitment at every level – to sustain financing, technical support, political will and the interest of civil society.621

Appreciative Inquiry is comprised of four steps:622

- Discovery: a process of appreciating (“what gives energy”)
- Dream: envisioning (“what might be”)
- Design: co-constructing (“what should be”)
- Destiny: sustaining results (“what will be”)

The whole-site approach to management – through a process of appreciative inquiry – is an essential
strategy. This methodology promotes active participation in decision-making and ownership of results among facility staff, as ownership is a crucial element for sustainability. Again, the focus is on creating an enabling or facilitative learning environment that fosters a personal transformation in values as well as acquisition of the necessary skills and competencies to champion for women’s rights in the facility, provide 24-hour quality EmOC, and services for women subjected to violence. In this manner, motivation and capacity are developed hand in hand.  

“A key element of the appreciative inquiry process in EmOC facilities is the promotion of working teams that enlist support and participation of external stakeholders, particularly women.” This approach is an appropriate strategy for a process of change. “Risk is minimised when everyone in the workplace participates in the change initiative.” It begins by recognising the successes of each person and so captures the energy which can be channeled to create a plan of action to achieve the dream, the desired goal.

While it is recognised that transformation and sustainable change are only possible through individual transformation, the cumulative effect of individual transformations is a change in the norms and structures of the collective worldview. “Conviction in and commitment to our values support us to make decisions and undertake actions that save women’s lives.” In the Women’s Right to Life and Health Initiative, the whole issue of the underlying values and ethical principles supporting this dream is expressly addressed using the work of Ken Wilbur to align values and actions. In this process attention is paid to both individual and collective values and the actions by which these values are expressed. “Dreaming together involves communication of the vision to others, not just in words but through actions that are consistent with the vision.”

“Through a community based process of appreciative inquiry, personal transformation and community participation is built to generate a shared ownership of and accountability for every woman’s realisation of her right to a safe, life-enhancing pregnancy and birth.” Many of the factors influencing a woman’s access to EmOC are imbedded in society. “Societal evolution is the result of deterministic reproduction and unpredictable changes. These changes depend a lot on innovations by individuals and groups of individuals.”

New processes of accountability regarding women – for their health and survival, their development, participation, dignity and care – at all levels must evolve to generate and sustain change. These processes are dependent upon those who are responsible and accountable for implementing them. Without individual transformation the cumulative changes that result in widespread change do not occur.

Our mission is to nurture a transformation within individuals and throughout civil society that motivates individuals to take a stand, to do things differently, to do what it takes to honour women and save their lives.

8.6 Building Partnerships

The range of women’s rights is too broad to be dealt with by any single actor working in isolation. The crucial issue is to ensure that the roles of UNICEF and others are complementary.

8.6.1 Mandate within the UN system

Within the Secretary General’s Reform Programme for the UN system, human rights is a cross cutting theme integrated in all activities. Even so, the question of how to translate human rights policies and guidelines into practical action remains. The UN agencies have identified three priority tasks in relation to the human rights-based approach:

- Strengthening human rights capacities of UN staff and of national counterparts, both governmental and non-governmental
- Conducting participatory national assessments of current realisation of human rights
- Ensuring meaningful, active and effective participation in all developmental decision-making and developing ways for measuring this participation.
To address these tasks, action is needed in relation to the following themes:

- Taking leadership by system-wide promotion and commitment to human rights-based approach
- Building capacity for human rights-based programming at country level
- Inter-agency cooperation
- Development of methods and approaches for mainstreaming and sharing of lessons learned
- Updating and sharing of training materials to mainstream human rights
- Improving documentation by disaggregation of UN data on the basis of non-discrimination and by standardising definitions, and creating and sharing a central data base of practices, indicators and tools. 636

8.6.2 UNICEF’s programme approach

A human rights-based approach to programming is intersectoral. Within UNICEF, this means that for the reduction of maternal mortality, linkages with other UNICEF programmes that have a relationship to maternal mortality, including anaemia, malaria, HIV/AIDS, violence against women, mental health, education, hygiene and sanitation must be established. 637

Some of the directives for programming in UNICEF include:

- Ensuring that country programmes of cooperation and global activities specifically support the implementation of the CRC
- Finding effective ways to link its situation assessment and analysis with the State’s process for reporting to the treaty bodies
- Building public and private partnerships in working both with governments and civil society for effective realisation of human rights
- Influencing public policy and policy formulation to realise the human rights of women and children
- Influencing budgets and the use of resources by examining how resources are used to advance human rights
- Working much more intersectorally to ensure greater cohesion and integration in society. 638

In formulating the country programme, it has been suggested to UNICEF offices that they should:

- Define different strategies at different levels of society 639
- Identify resource-relevant strategies and actions to be taken from household to national level, with an emphasis on the most efficient and effective in building capacity
- Incorporate three fundamental strategies for UNICEF to address immediate, underlying and basic (structural) causes:
  - advocacy
  - capacity building
  - service delivery
- Choose strategies based on core competencies and comparative advantages of UNICEF
- Accent partners, participation and empowerment.

UNICEF’s strengths are influencing public policy, developing partnerships and advocacy. Programmes of cooperation must contribute in observable ways to making the participation of women and children possible, especially in family and community activities that affect them. 640 UNICEF must give priority to those who are deprived, usually the poor. 641 Country programmes should aim to build strong communities moving beyond community participation to community management of programmes and services. 642

Another challenge for all organisations is how they will organise themselves in human rights-based programming given that a multi-sectoral approach is needed. Currently the recommendation within UNICEF is that the country offices continue to have resource
sections (health, education etc) which ensure a long-term availability of specialised staff.643

8.6.3 Partnerships

An important feature of human rights-based programming is conscious alliance-building and broadening of partnerships.644 Safe motherhood is more than a question of health. It requires changes at many levels of society, and in many systems – health, legal, political, educational and cultural. It requires strong partnerships between government and communities. The following actions are key:

- Applying the provisions of human rights instruments
- Encouraging governments to make sustained social investments
- Helping establish women-friendly health services
- Helping communities to become women-friendly
- Encouraging the formation of women's groups.645

In Bangladesh, the main agencies providing for women’s health are government, NGO, private sector and development partners. ‘Future Search Conferences’ brought on board the ‘non-health’ allies and generated action among the various society bodies for reducing maternal mortality. These allies include women, women’s organisations, service providers, policy makers, police, lawyers, donor agencies, media and other influential groups.646 The National Strategy for Maternal Health explicitly makes the inter-sectoral linkages which are needed for promoting and protecting the rights of girls and women throughout the life cycle.647

In a human rights-based approach, partners should understand and share human rights principles.648 The principles governing partnerships are not so clearly defined. A workshop organised by the Institute of Development Studies examined accountability through participation, especially experience on the development of workable partnership models of community participation in health. Criteria that enhance partnerships were suggested as including:

- Agreement on a shared vision
- Transparency of information and resources
- Agreed roles and responsibilities
- All interests represented
- Agreed mechanisms for conflict resolution.

Issues of transparency emerged as a crucial factor in partnerships with considerable imbalance of power, such as between government and community. Donors were seen as having a role in facilitating transparency and multilateral partnerships rather than such unbalanced dyads.649

The joint statement on the reduction of maternal mortality made by WHO, UNFPA, UNICEF and the World Bank points out that each agency implements the interventions described in the statement in accordance with the principles and policies of each agency and within the scope of its mandate.650 UNICEF needs to learn what it can do best and what it should persuade others to do. Critical self-examination of its own competencies is necessary as well as understanding of the intentions and capabilities of other organisations.651 It is important to recognise that UNICEF is just one of the actors in development assistance. In countries where maternal mortality is high, UNICEF can use its influence to build a coalition for safe motherhood among its partners. Such a coalition can help reduce duplication, and strengthen consensus on priorities and most effective actions.652 Discussions with key partners will result in an agreement on ‘who will do what.’ Organisations need to prioritise areas and actions for cooperation according to their own capacities and resource availability, their expertise and accumulated experience, their established organisational priorities and their common understanding of the prevailing situation of children and women.653
MONITORING AND EVALUATION

9.1 Through a Human Rights Filter

By their ratification of human rights treaties, governments are accountable for respecting, protecting, promoting and realising the human rights of all people in the country. The four most common ways of ensuring enforcement of conventions are monitoring by a committee of experts, periodic reports to the committee, a complaint to the committee made by one state against another, and individual complaints made to the committee. To enforce the various conventions, the relevant UN commission may establish working groups or appoint special rapporteurs to work on a particularly urgent human rights situation.

Since a human rights approach to development is focused on promoting equity and reducing disparity, it is important to understand that this approach seeks to measure progress towards (i) an explicit standard against which to measure performance; (ii) fulfillment by duty-bearers (institutions and people); (iii) the capacity and progress of the rights-holder to exercise and realise rights; and (iv) mechanisms of delivery.

Performance standards enable courts and treaty monitoring bodies to determine whether governments are meeting their obligations to respect, protect and fulfil rights related to safe motherhood. The CEDAW treaty uses the goals agreed at the Cairo and Beijing conferences as performance standards. “Human rights set the standard against which to evaluate actions; health disciplines supply the technical rationale for applying the standard.” Benchmarks, codes of conduct or citizens’ charters and report cards have been used to clarify entitlements, increase accountability and empower citizens in relation to public organisations. These approaches may be more effective if monitoring and mechanisms for redress are invested in higher level institutions.

The CEDAW Committee is very comprehensive in its General Recommendation on Women and Health. It requires that states report on how policies and measures on health care address the health rights of women from the perspective of women’s needs and interests and how they address distinctive features and factors which differ for women in comparison to men, such as:

a) Biological factors – their different reproductive function as well as increased risk of exposure to sexually transmitted diseases

b) Socio-economic factors such as unequal power relationships between men and women leading to poor nutrition, sexual abuse, unwanted pregnancy and harmful traditional practices

c) Psychological factors including depression in general and post-partum depression in particular

d) Lack of confidentiality affects both men and women but is more likely to deter women from seeking care for reproductive health-related or violence-related conditions.

The Committee also notes that states parties are obliged to take all appropriate measures to ensure women’s health and that the studies showing high maternal mortality and morbidity rates may indicate violations of this duty. These obligations are to be
met to “the maximum extent of their available resources.” The challenge is, therefore, usually to ensure that the term ‘available resources’ is viewed as ‘total available resources’, and not just those currently allocated to the social sector.

The General Recommendation obliges states to report on what measures have been taken to ensure appropriate services related to pregnancy, delivery and postpartum. The reports should indicate reduction in maternal mortality and morbidity for the country in general and for vulnerable groups, regions and communities in particular. These provisions among others provide adequate scope for linkage between monitoring and reporting processes of CEDAW and the situation analysis. For this, “particular attention should be given to:

- Fulfillment of reporting obligations to the CRC and CEDAW committees
- Implementation of recommendations of the CEDAW and CRC committees
- The impact of policy or legal reform on the provision of maternal health services, and maternal health, should also be assessed.

A human rights-based approach is concerned with both process and outcome. “Accountability for nondiscrimination means we must ensure that the poor and marginalised populations have access to health services, and that the indicators we use track utilisation by these populations.” Participatory monitoring supports important human rights values. For accountability, stakeholder participation ensures maximum transparency and ownership of monitoring processes.

If stakeholders select the indicators and do record keeping at the community level, participation is enhanced and the process is empowering in itself. Recognition by stakeholders of the multi-sectoral impacts/effects of programming underscores the indivisibility of human rights. Monitoring the differential impacts and involvement is critical to ensure processes and systems are responsive to the special needs of populations.

9.2 Types of Monitoring

Monitoring is a process of tracking or measuring what is happening and includes situation monitoring and performance monitoring. Situation monitoring measures change in a condition or a set of conditions (or lack of change), while performance monitoring measures progress in achieving specific objectives and results of the implementation of plans. Learning and accountability are two primary purposes of monitoring and evaluation. Wider learning requires participation and dialogue whereas accountability requires impartiality: these requirements may be seen to be in opposition to each other.

In the Triple A approach of decision-making, the information flow from assessment to analysis, actions and re-analysis (monitoring) fuels the process. “The extent to which information can be synthesised to generate more comprehensive understanding or knowledge is dependent upon how, when and with whom information is shared and used.” When data are carefully collected, analysed and interpreted, and when the findings are released and turned into messages, they become an important means for promoting human rights. “Access to information, and transparency, are both critical factors in ensuring that services are delivered and standards are met.”

9.2.1 Situation monitoring

“Monitoring the situation of children and women is necessary when trying to draw conclusions about the impact of programmes or policies. It also includes monitoring of the wider context, such as early warning monitoring, or monitoring of socio-economic trends and the country’s wider policy, economic or institutional context.” Situation monitoring draws attention to emerging children’s and women’s rights issues.

9.2.2 Performance monitoring

Performance monitoring ideally contributes to learning at the level at which it is collected as well as at programme management levels, and feeds into short-term adjustments to programmes. “Capturing
evidence of impact is not only important in pointing the way forward to further work, but also provides a vital incentive to continue to pursue the policy objective with commitment and vigour. 677

9.3 Indicators

Monitoring depends on the use of indicators. Indicators in a human rights-based approach have certain characteristics. Their goal is the production of information to guide policy on how better to realise human freedoms. They use measures of outcomes as well as inputs, measures of averages and disaggregations both global and local—to reveal information at many different levels. They place a greater emphasis on data that are disaggregated – by gender, ethnicity, race, religion, nationality, birth, social origin and other relevant distinctions. Such indicators assess the dignity and freedom of people as well as the fulfillment of obligations by critical actors. They focus on human outcomes and draw attention to policies and practices and the conduct of public officials. 678

Indicators for human rights need to be explored for four interlocking objectives:

- Asking whether states respect, protect and fulfil rights – the overriding framework of accountability for the role of the state
- Ensuring that key principles of rights are met – asking whether rights are being realised without discrimination, and with adequate progress, participation and effective remedies
- Ensuring secure access – through the norms and institutions, laws and enabling economic environment that turn outcomes from needs met into rights realised
- Identifying critical non-state actors – highlighting which other actors have an impact on realising rights and revealing what the impact is. 679

These principles need to be applied to women’s rights, in particular to safe motherhood. “UN agencies have developed indicators that are used to give a general overview of the reproductive health situation in particular settings. They include, but are not limited to:

- Health status indicators, such as measures of maternal mortality and morbidity
- Health service indicators that show the availability and the accessibility of services, such as the percentage of births attended by skilled birth attendants
- Health policy indicators, such as laws and policies favourable to adolescent health, or the degree of enforcement of a legal age of marriage.

Some of these indicators are more developed than others, the health policy indicators being the least well developed. 680 Developing and using indicators has become a cutting-edge area of advocacy. 681

9.4 Monitoring Methods for Maternal Mortality

“As experience with implementing safe motherhood programmes has grown, it has become increasingly clear that the traditional indicator of maternal health status – the maternal mortality ratio – is not an appropriate indicator for monitoring progress in the short term. 682 Few developing countries have comprehensive systems of vital registration. Even in countries with high maternal mortality ratios, maternal deaths are relatively rare events.

“Relative infrequency of maternal deaths in a short period (such as 1 - 2 years) has important consequences for monitoring maternal mortality.” 683 This infrequency means large populations must be studied, thus increasing the expense and limiting the ability to detect statistically significant changes over time. The ‘sisterhood method’ needs a smaller population sample but produces estimates of maternal mortality that refers to a period of time about 12 years before a survey. 684
9.4.1 Process indicators

Collecting data is not in itself a goal; its aim is to find ways to reduce maternal mortality. Faced with the difficulties of measuring maternal mortality, WHO, UNICEF and UNFPA worked on developing indicators which would measure the essential elements of emergency obstetric care. These process indicators focus specifically on monitoring whether women who develop serious obstetric complications receive the services they need.

They ask six questions in relation to accepted benchmarks.

1. Are there enough health facilities providing life-saving care for women with obstetric complications?
   *Benchmark:* Four Basic EOC facilities and one Comprehensive EOC facility per 500,000 population

2. Are these facilities equitably distributed across the population?

3. Are pregnant women using these facilities?
   *Benchmark:* 15% of pregnant women deliver in EOC facilities

4. Are pregnant women with complications using these facilities?
   *Benchmark:* 15% of estimated number of pregnant women have complications

5. Are these facilities providing enough life-saving surgery to meet the needs of the population?
   *Benchmark:* Caesarean section rate is between 5 and 15 percent of births

6. Is the quality of these services adequate?
   *Benchmark:* Case fatality rate is less than 1%

"Initiation of these standardised indicators is critical and the information generated must be integrated into planning and review processes."

The chief advantages of process indicators are that they:

- Are less expensive to use and therefore can be applied more frequently
- Can be used for an initial situation analysis as well as to monitor progress.

9.4.2 Indicators of process and outcome

A human rights-based approach to programming is concerned about both process and outcome. The process indicators give an indication of the outcome; however, indicators are needed to monitor the process at all levels.

When we recognise that rights programming also implies that society commits to a set of values and perspectives – such as human dignity and social justice – then the structures of accountability need to include not only governments, but also civil society, UN agencies, NGOs, corporate sectors, families and communities. A very crucial factor for the next decade is how we are going to have more structures and processes for all parts of society to be accountable. Involving stakeholders from different walks of life in the management of facilities, in developing the perspectives required for a sound health system, are steps towards this accountability.

Concerns for non-discrimination and participation of women raise questions such as “Do stakeholder groups have women? Does the hospital management committee have women? How is the voice of women, especially marginalised women and women subjected to violence, brought into the decision making sphere? Do women at home have a voice in decisions that affect them?”

WHO is currently working to develop indicators to determine how fully the substantive elements of the right to health services, namely their availability, accessibility, acceptability and quality, are satisfied.

In the Women’s Right to Life and Health Initiative, the linkage of human rights, technology and management has revealed the need for more indicators. The initiative is currently developing indicators to monitor:

- National policy support
Resource allocation

Quality of care

24-hour functionality of EmOC facilities

Whole-site approach to management

Stakeholder involvement at hospital level

Stakeholder involvement at village level

Individual knowledge, attitudes and practices.

“These additional indicators will encompass new dimensions, such that they measure – and therefore drive – changes in the values and norms, behaviours and civil structures and processes that ensure women’s survival and uphold women’s rights.”

9.4.3 Indicators related to safe motherhood

Besides the process indicators for the availability and use of Emergency Obstetric Care, other indicators are commonly used to monitor and evaluate safe motherhood. They include:

- Percentage of births with skilled attendance
- Percentage of pregnant women attending antenatal care at least once
- Percentage of women immunised with tetanus toxoid
- Percentage of women receiving postnatal care
- Time interval from onset of complication (or arrival at facility) to treatment at referral site
- Ratio of complicated obstetric admissions

All these factors have been shown to correlate with maternal mortality.

9.5 Evaluations

“Evaluation is a process that attempts to determine as systematically and objectively as possible the worth or significance of an intervention, strategy or policy.” The aim of an evaluation is to provide credible information to influence decision-making on the basis of lessons learned. Programme evaluations contribute to improvements in implementation methods and to significant changes in programme design, as well as providing the necessary rigour to advocate for scaling-up of successful pilot projects.

The use of a human rights-based approach to programming is still in its early stages. UNICEF has been a pioneer in this approach and has evaluated how it is being operationalised in various countries. Key findings have included the following:

- Human rights-based programming provides a better grounding and clearer focus for working with government and other partners to realise the rights of children.
- It is essential to work together with partners, including other UN agencies, bilaterals, NGOs and CSOs in the HRBAP process.
- Concrete, practical HRBAP training of both staff and partners is essential.
- The HRBAP process helps UNICEF staff and partners to identify gender issues as an integral part of human rights-based programming.
- A HRBAP demands a stronger advocacy, communication, information and social mobilisation capacity.
- Results-based programming with time-bound goals and objectives for measuring progress can be related to human rights-based programming.
- Adopting human rights-based approaches is a gradual, time-consuming process, requiring continuous advocacy with government and other partners, sensitivity, intensive dialogue, consensus building and compromise.
The concept of a human rights-based approach to development is increasingly being embraced by development partners. However, the translation of the concept into practical strategies to realise human rights is still evolving. This literature review was undertaken to explore and document the experience to date on using this approach and its application to the reduction of maternal mortality. Section I begins by showing that avoidable maternal deaths are a social injustice and a violation of human rights. It then examines human rights, their underlying values and principles and the relationship between human rights and development. Section II looks at the situation of maternal mortality in South Asia and the challenges to reducing the present unacceptably high levels. Section III looks at the programme process and how it is informed by a human rights-based approach.

Many women in South Asia are condemned to die during pregnancy and childbirth from complications which can be treated. The failure to ensure their access to the necessary care that would save their lives is a major social injustice and violation of their human rights. Maternal mortality reduction is a threshold objective for the realisation of women’s rights. Conversely, realisation of women’s rights is an important strategy for maternal mortality reduction. These rights include those related to life, survival and security, to maternity and health, to non-discrimination, to information and education, and to participation.

Human rights were first articulated in the Universal Declaration of Human Rights, and subsequent human rights instruments have sought to clarify the implications of these rights. These human rights treaties have been ratified by governments, who accept the responsibility to ensure these rights for all their citizens and who are held accountable by the treaty monitoring bodies. This ratification must be translated into laws, policies and practices which are in keeping with the spirit and the letter of the treaties. By nature, human rights are universal, indivisible, interdependent and inter-related. They enshrine the values of respect for human dignity and non-discrimination. The key principles for applying a human rights-based approach to programming (HRBAP) are responsibility and accountability, participation, transparency and empowerment, and sustainability. The principles of the best interests of the child and of gender justice are among the principles related to CRC and CEDAW.

Governments are obliged to respect, protect, promote and fulfil human rights. They have an obligation of conduct, which for maternal mortality reduction (MMR) means implementation of plans for MMR; but they also have an obligation of result, which would mean achieving the goals of MMR set at the Cairo conference. While those held accountable for fulfillment of human rights are primarily governments, there is a whole series of duty-bearers with obligations. In an HRBAP, there is an ethical dimension which results in a concern for process as well as outcome. Process goals include participation and equality, transparency, accountability and effectiveness, empowerment and sustainability.

Addressing needs is optional, a political or a charitable choice; realising rights is obligatory and universal. People are seen as rights-holders, not objects of charity. Rights-holders have a claim on duty-bearers. Identification of duty-bearers and the extent of their accountability for ensuring human rights is essential.
For a duty-bearer to be held accountable, the person must be aware of the duty and accept the responsibility, and have the necessary authority and resources to act. An effective approach includes a healthy balance of two approaches, reactive (responding to violations) and proactive (programming to fulfil rights). The value added to development efforts by an HRBAP comes from the global legitimacy of human rights and the application of the underlying values and principles. For instance, indivisibility means that a multi-sectoral approach is essential and linkages between programme elements must be made. Empowerment demands that unequal power dynamics and the political nature of development be addressed.

Research into the causes of maternal mortality has shown that while the direct causes are medical, either directly related to pregnancy or incidental, the underlying and basic causes are often social. WHO has established that the risk assessment strategy is ineffective, as complications are unpredictable. Once a complication has developed, time is of the essence in ensuring that a woman gets the necessary life-saving care. In the “Three Delays” model, the first delay is in deciding to seek care, the second is in reaching a facility giving care and the third delay is in receiving adequate care in the facility. Discrimination against girls and women is at the base of many of these delays. A maternal death often marks the end of a lifetime of neglect and discrimination. From infancy, girls are given less care, less food and education. Women lack information and freedom of movement; they have limited decision-making power but fear disrespect for their wishes at health facilities. Other predisposing factors are teenage pregnancies, usually due to child marriages, son-preference and gender-based violence.

To save women’s lives, individuals and groups from the family to the international level have roles and responsibilities. Families’ role is to care for the pregnant women and to initiate the process of seeking care. Communities’ role is to support families in caring for women, especially those from poor and marginalised families. It is important that higher levels, including government planners and donors, assess the communities’ awareness and acceptance of responsibility, resources and authority to act for women, and assist them in filling capacity gaps. Health facilities must provide quality obstetric care with EmOC services 24 hours every day and do so in a woman-friendly way which respects human dignity with no discrimination. Stakeholders and planners need to cooperate at district and national level to ensure maximum benefit from resources and for effective monitoring. From the right to development comes the duty of the whole international community to respect, protect, promote and realise human rights. Donors must not only fulfil their own duties but also ensure that programmes they support are in keeping with the values and principles of human rights.

Important lessons learned include the need for a multi-sectoral, multi-level approach which aims to reduce gender inequality and to ensure the availability and use of EmOC and other related services by all women. For this, advocacy, district planning, a functional health system including a referral system, and excellent monitoring are necessary. The challenges to this include entrenched discriminatory practices, poverty and gender imbalance. Gender inequity and gender based violence are rights issues and key actors (both government and non-government) are required to address them. UNICEF uses the Women’s Equality and Empowerment Framework for this task. Emergency situations including conflicts and refugees are other challenges for maternal mortality reduction (MMR). Economic considerations are raised at every level mentioned. The prevailing situation which contributes to maternal mortality demands a concerted effort at all levels to bring about a change which supports women’s rights.

Programming with a human rights-based approach begins with the internalisation of human rights values and principles so that they inform every phase of the process used. Participatory processes involving both rights-holders and duty-bearers must be used to develop integrated, cross-sectoral and decentralised activities. A human rights filter means that the indicators used for assessment are disaggregated to reveal disparities, such as those due to ethnicity, geographical location, economic status. There are six steps to the assessment and analysis. Step 1 is a scientifically based Causality Analysis which reveals immediate, underlying and basic causes. Step 2 is a Role/Pattern Analysis which identifies the duty-bearers
and their capacity to fulfil their duty. Step 3 is a Resource Analysis, looking at both potential and existing human, economic and organisational resources. Step 4 is an Analysis of Behaviours and Cultural Patterns, and Step 5 is an Analysis of Prevailing Norms and Legal Systems. In areas subject to conflict and natural disasters, Step 6 is a Vulnerability Analysis. When working at the community level, maternal mortality may not be recognised as an issue. In this case there is a Step 0 which is needed to raise awareness of the problem.

The quality of the analysis will determine the quality of the action. Planning means making choices. The essence of an HRBAP is setting priorities to reach those most in need. The disadvantaged need to be empowered to claim their rights in the political process which determines priorities. HRBAP has to find the right balance between activities for survival in the short term and those for transforming society for a sustained fulfillment of rights. Both process and outcome are important in developing the capacity of duty-bearers to fulfill their duties. Community capacity development is a key strategy in HRBAP and is based on the premise that the focus for development is people, who all live in communities. The challenge is that communities are heterogeneous and members are often reluctant to work together on 'private matters.' For the marginalised in a community, access to and use of information, including rational decision-making, is vital to identifying appropriate candidate actions and strategies. Many such actions may be suggested, but not all are of equal importance or urgency. Gross violations of the few may call for a bigger investment than the lesser violations of many, a change from the ‘low cost - high impact’ approach. This concept may be translated to put priority on interventions to save lives rather than on improving maternal well-being.

To prevent maternal deaths, activities are needed that will affect the incidence of pregnancy and the incidence and outcome of complications of pregnancy and childbirth. Assessment includes identifying populations with a higher incidence and analysis of the factors influencing the greater incidence. For a successful outcome from a complication, all women with complications must have access to the necessary EmOC. Access means that EmOC is available to all women without discrimination; respects women's dignity; is of good quality technically; is culturally appropriate and affordable. A strategy imbued with human rights values and principles includes evidence-based technology and excellence in management that is whole-site and involves the whole system. Providing free care is essential for the very poor. Surviving pregnancy and childbirth means that the delays in seeking and reaching care have been addressed so that women are recognised as having a right to EmOC; the danger signs are recognised and prompt urgent action is taken; and the community has the capacity to respond. Community participation is needed to prevent bad practices, to remove misconceptions and to provide transport and blood donors. In short, a women-friendly society is created. A human rights-based approach overcomes the overarching delay due to lack of supportive national policies by reminding governments of their obligations. Accountability to rights-holders is a hallmark of HRBAP and is done in a participatory manner at every level.

 Provision of EmOC directed at the immediate cause of maternal death is a threshold activity in the progressive realisation of a woman's right to safe motherhood. To overcome the underlying and basic causes, a gender focus must be given to all programme activities to ensure equitable access to food, education, and information that includes responsible planning of family size. Services for women's health must include addressing violence against women, improving micronutrient status, prevention and treatment of malaria and HIV/AIDS. Antenatal care is an opportunity to provide information and care for a number of issues, including birth preparedness, danger signs, nutrition and HIV/AIDS.

A HRBAP is about change, and deliberate strategies must be engaged to facilitate change. Appreciative Inquiry is one such methodology as it supports the dignity of each person and empowers each one to have a voice during planning and monitoring whether at community or facility level. Generating and sustaining change calls for leadership and for the cultivation of a strategic partnership of individuals and groups with the same values. These champions of change need to be supported and enabled to invest in creating a critical mass of committed people. Partnerships need to be
strengthened at every level – within the donor community, between government departments, within facilities and among community groups both government and non-government.

Measuring change is important, as it also drives change. Measurement of maternal mortality is difficult and expensive. Process indicators give an indication of progress of availability and utilisation of EmOC. Other indicators must be developed to monitor process, to ensure that the process used supports the principles of participation, empowerment and sustainability, and to measure the changes in quality of care.

A human rights-based approach to programming is very much a work in progress. UNICEF has a distinct advantage in that it has been using this approach for some years and already has monitored countries’ experience with this approach in a series of case studies. The whole process of programme development has been institutionalised, and in South Asia all countries have used it to design their current programmes.

Reduction of maternal mortality demands attention to the human rights of girls and women. It will also be the mark of success of a multi-sectoral endeavour reflecting concerted effort by governments and communities, professionals and family members committed to the values and the principles enshrined in UN treaties which define what it means to be human.
Section 4

ANNEXES
BIBLIOGRAPHY


Department For International Development, Poverty elimination and the empowerment of women, Strategies for achieving the international development targets, Papers, September 2000.

Department for International Development, Realising human rights for poor people, Strategies for achieving the international development targets, Papers, October 2000.


Overseas Development Institute. *What Can We Do with a Right-Based Approach to Development*, Briefing Paper, September 1999.


Appendix 1: A Summary of Human Rights


Human rights necessary for survival and dignified living include:

- The rights to life and liberty
- The right to a standard of living adequate for health and well-being of the individual and his/her family
- The right to social protection in times of need
- The right to the highest attainable standard of physical and mental health
- The right to work and to just and favourable conditions of work
- The right to food and housing
- The right to privacy and family life

Human rights also cover rights and freedoms related to human dignity, creativity and intellectual and spiritual development, for example:

- The right to education and access to information
- Freedom of religion, opinion, speech and expression
- Freedom of association
- The right to participate in the political process
- The right to participate in cultural life

Human rights also include rights necessary for liberty and physical security, for example:

- Freedom from slavery and servitude
- The right to security of person (physical integrity)
- The right to be free from arbitrary arrest or imprisonment
- Freedom from torture and from cruel, inhuman or degrading treatment or punishment
Appendix 2:
Human Rights Affecting Safe Motherhood

The following is a summary of the rights mentioned in Appendix 1 plus the major articles quoted.

1. Rights relating to life, survival and security

These include:

The right to life and survival: ICCPR 6(1)
- Most obvious right to protect pregnant women
- Requires government to address avoidable deaths by taking positive measures
- Includes increasing the rate of births attended by skilled birth attendants

The right to liberty and security of person: ICCPR 9(1)
- Supports women’s free choice of maternity
- Holds governments accountable to provide conditions for safe motherhood
- Requires clinic policies and law that ensure women’s care and confidentiality
- Requires positive measures to ensure respect for women at particular risk

The right to be free from inhuman and degrading treatment: ICCPR 7
- Requires states to provide health services when their denial would constitute inhuman treatment.

2. Rights relating to maternity and health

These include:

The right to maternity protection: ICESCR 10(2), CEDAW 5(b), 12(2), UDHR 25(2) CRC 24(d)
- Obligates states parties to provide free maternity services if necessary

The right to maternity protection during employment: ICESCR 10(2), MPC 1, 4(1)(3)
- Requires paid maternity leave plus health care without discrimination

The right to marry and found a family: ICCPR 23, ICESCR 10(1), CEDAW 16
- Covers full and free consent to marriage, minimum age for marriages
- Includes right of children and husbands to family life with mother/wife

The right to free choice of maternity/the right to private and family life: CEDAW 16(1), ICCPR 17(1)
- Includes the right to decide freely and responsibly on the number and spacing of children
- Right to have access to the information, education and means to enable women to exercise these rights

The right to the highest attainable standard of health: ICESCR 12
- Includes essential features such as availability, accessibility, acceptability, and quality

Available resources: obliges states to take appropriate budgetary, economic and other measures to the maximum extent of resources

Economic access: requires governments to give services free if necessary

Transparency and fairness in the allocation of resources: protects women from being arbitrarily denied resources or services

The right to the benefits of scientific progress: ICESCR 15(1)(b)
- Requires that recent advances be made available to women
3. Rights relating to non-discrimination and due respect for difference

States parties obligations include: ICCPR 2(1),26
- States parties are obliged to change laws and policies which discriminate on the face (e.g. women, not men, need spousal consent for health services) and in effect (e.g. everyone must pay equally discriminates against the poor)

- Women have distinct interests in safe pregnancy and childbirth, which if not protected would constitute discrimination

Issues to be considered include:
- Sex and gender
- Sex and gender non-discrimination in the family: CEDAW 1
- Sex and gender non-discrimination in health: CEDAW 12
  - Particular mention of adolescents sexual and reproductive health education

Marital status: ICCPR 2(26)
- Requires that there is no discrimination in services offered to married and single women

Age: CRC 2, 14(2)
- Requires governments to provide reproductive health care to adolescents and to take into due account the "evolving capacities of the child"

Race and ethnicity: ICERD 1
- Requires that attention is given to the distribution of resources to districts with different racial composition

Other status
- Includes rural residence, poverty
- Different forms of discrimination often overlap.

4. Rights relating to information and education

These include:

The right to receive and to impart information: ICCPR 19
- Requires governments to provide information about how to save lives of women before, during and after delivery

The right to education: ICESCR 13
- Relates to safe motherhood as girls education is linked to decreased maternal mortality, probably due to informed choice on timing and number of pregnancies, awareness of pregnancy complications and removing misconceptions about pregnancy and childbirth

There is also recognition of the right to specific educational information to help ensure the health and well-being of families.

5. Rights relating to physical integrity

These include:

The right to be free from torture, cruel, inhuman or degrading treatment or punishment: UDHR 5, ICCPR 7, CRC 37a, CAT 12

The right to be free from medical or scientific experimentation against one’s will: ICCPR 7

The right to be protected from violence against women: CEDAW General Recommendation 12, DEVAW

The right to protection in situations of armed conflict: PFA 144b, DPWCEAC 4 requires states to protect women from rape, forced prostitution, persecution, torture, degrading treatment, violence and any other form of assault and sexual slavery

The right not to be forced to return to a country where one may be in danger of torture: CAT 3
6. Rights relating to participation

These include:

- The right to vote in all elections and public referenda CEDAW 7a
- The right to participate in the formulation and implementation of government policy CEDAW 7b
- The right to participate in development planning and implementation CEDAW 14.2.a
- The right to participate in all community activities CEDAW 14.2.f
- The right to participate in non-governmental organisations and associations CEDAW 7.c
- The right to represent their government at the international level and to participate in the work of international organisations CEDAW 8
### Appendix 3:
Ratification of Relevant Rights Documents by South Asian Countries (May 2003)

<table>
<thead>
<tr>
<th>Country</th>
<th>CRC</th>
<th>CEDAW</th>
<th>ICESCR</th>
<th>MPC**</th>
<th>ICERD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afghanistan</td>
<td>R</td>
<td>R</td>
<td>R</td>
<td>R</td>
<td>R</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>R</td>
<td>R</td>
<td>R</td>
<td>R</td>
<td>R</td>
</tr>
<tr>
<td>Bhutan</td>
<td>R</td>
<td>R</td>
<td>R</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>India</td>
<td>R</td>
<td>R</td>
<td>R</td>
<td>R</td>
<td>R</td>
</tr>
<tr>
<td>Maldives</td>
<td>R</td>
<td>R</td>
<td>R</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>Nepal</td>
<td>R</td>
<td>R</td>
<td>R</td>
<td>R</td>
<td>R</td>
</tr>
<tr>
<td>Pakistan</td>
<td>R</td>
<td>R</td>
<td>R</td>
<td>R</td>
<td>R</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>R</td>
<td>R</td>
<td>R</td>
<td>R*</td>
<td>R</td>
</tr>
</tbody>
</table>

R = Ratification
S = Signature
Source: http://www.unhchr.ch

** Ratifications as of May 31, 1997, Source: International Women’s Tribune Center, Rights of Women, page 129

# Ratification as of December 31, 1998, Source: http://www.unesco.org

** Acronyms:**

- **CRC**: Convention on the Rights of the Child
- **CEDAW**: Convention on the Elimination of All Forms of Discrimination against Women
- **ICESCR**: International Covenant on Economic, Social and Cultural Rights
- **MPC**: Maternity Protection Convention (Revised)
- **ICERD**: International Convention on the Elimination of All Forms of Racial Discrimination
## Appendix 4:
### Documents Relevant to the Rights Related to Women’s Health

<table>
<thead>
<tr>
<th>Document</th>
<th>Relevant Articles/Mentions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Universal Declaration on Human Rights</strong></td>
<td>Articles 2, 3, 5, 16, 25</td>
</tr>
<tr>
<td><strong>International Covenant on Civil and Political Rights</strong></td>
<td>Articles 2, 6, 7, 9, 17, 23</td>
</tr>
<tr>
<td><strong>International Covenant on Economic, Social and Cultural Rights</strong></td>
<td>Articles 2, 10, 12, 15</td>
</tr>
<tr>
<td><strong>Convention on the Elimination of All Forms of Discrimination Against Women</strong></td>
<td>Articles 1, 2, 3, 5, 6, 10, 11, 12, 14, 15, 16</td>
</tr>
<tr>
<td><strong>Convention on the Rights of the Child</strong></td>
<td>Articles 6, 16, 19, 24, 34, 37</td>
</tr>
<tr>
<td><strong>International Convention on the Elimination of All Forms of Racial Discrimination</strong></td>
<td>Article 5</td>
</tr>
<tr>
<td><strong>UN Fourth World Conference on Women Platform for Action</strong></td>
<td>See paragraphs 89-130; 259-285.</td>
</tr>
</tbody>
</table>

**CEDAW** General Recommendation No. 12 or 19 on Violence Against Women states that the Committee considers gender-based violence to be a form of gender discrimination, and therefore outlawed by CEDAW.

**CEDAW** General Recommendation No. 14 on Female Circumcision states the Committee’s view that appropriate and effective measure must be taken to eradicate female genital mutilation.

**CEDAW** General Recommendation No. 15 on HIV/AIDS requires states parties to include information on AIDS and its effect on women and recommends certain national-level action to address such effects.

**CEDAW** Recommendation No 21. on Equality in Marriage and Family Relations outlines the Committee’s views on the importance of women’s basic rights within the family.

**CEDAW** General Recommendation No. 24 on Women and Health affirms the obligation of State parties to ensure women’s access to health care as a basic right.
Appendix 5: Conceptual Framework for Assessing and Analysing the Situation of Children and Women from a Rights Perspective
## Appendix 6: Good Programming and Human Rights Programming

<table>
<thead>
<tr>
<th>Good Programming</th>
<th>Human Rights Programming</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. People can not be developed; they must develop themselves. People, including</td>
<td>1. In a human rights perspective, people, including people who are poor, are subjects of</td>
</tr>
<tr>
<td>people who are poor should be recognised as key actors in their own development,</td>
<td>rights. It is therefore logical to recognise people who are poor as key actors in their</td>
</tr>
<tr>
<td>rather than passive beneficiaries of transfers of commodities and services.</td>
<td>development, by empowering them to claim their rights. Human rights programming entails</td>
</tr>
<tr>
<td></td>
<td>the building of community capacity for people to understand their rights, to claim their</td>
</tr>
<tr>
<td></td>
<td>rights and to make meaningful contribution to have these rights realised.</td>
</tr>
<tr>
<td>2. Participation is crucial, both as an end and a means. Participation, however,</td>
<td>2. Participation, including children’s and women’s participation is a human right enshrined</td>
</tr>
<tr>
<td>should not only be seen as ‘they’ participate in ‘our’ programme or project, but</td>
<td>in many conventions; a right often violated. In a human rights perspective, participation</td>
</tr>
<tr>
<td>rather that ‘we’ behave in such a way that ‘we’ are allowed and invited to</td>
<td>is both a necessary outcome and a necessary aspect of the process. The facilitation of</td>
</tr>
<tr>
<td>participate in ‘their’ development efforts.</td>
<td>participation in societal decision-making is an objective in itself.</td>
</tr>
<tr>
<td>3. ‘Empowerment’ is important, but is not a strategy. ‘Empowerment’ and ‘dis-empower</td>
<td>3. Human Rights imply dignity and respect for the individual. This means self-esteem and</td>
</tr>
<tr>
<td>ment’ are aspects of any strategy, such as advocacy, capacity building or service</td>
<td>equality. Circumstance and chance should not dominate one’s life. A HRBAP implies a</td>
</tr>
<tr>
<td>delivery. ‘Empowerment’ means ‘the replacement of the dominance of circumstance</td>
<td>people centered approach to development, in which outside support should be catalytic and</td>
</tr>
<tr>
<td>and chance over people’s choices with the dominance of people’s choices over</td>
<td>supportive to people’s own efforts.</td>
</tr>
<tr>
<td>circumstance and chance.’</td>
<td></td>
</tr>
<tr>
<td>decision-making at all levels of society is very important.</td>
<td>Both the obligations of conduct/effort and the obligation of result must be constantly</td>
</tr>
<tr>
<td></td>
<td>checked. This requires monitoring at all levels of society and the use of the information</td>
</tr>
<tr>
<td></td>
<td>for the design of new actions to respect, protect, facilitate and fulfil human rights.</td>
</tr>
<tr>
<td>5. Role or stakeholder analysis is very useful for social mobilisation, programme</td>
<td>5. Most stake-holders, although not all, are duty-bearers. An important step in a HRAP</td>
</tr>
<tr>
<td>development and evaluation, because it identifies clear accountabilities in the</td>
<td>is the identification of key relations between the child as a claim-holder and all duty-</td>
</tr>
<tr>
<td>community and society.</td>
<td>bearers. Such an analysis is similar to, but is more than, a stake-holder analysis.</td>
</tr>
<tr>
<td>6. Programmes and projects should respond to basic needs of people, with a focus</td>
<td>6. The right to development implies disparity reduction. While the ultimate goal is</td>
</tr>
<tr>
<td>on</td>
<td>poverty eradication,</td>
</tr>
<tr>
<td>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).</td>
<td></td>
</tr>
</tbody>
</table>

7. 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. On the other hand, in many communities, human rights need to be promoted ‘from above’ because they are not yet internalised. |

---

| 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. It is the synergism between appropriate top-down and bottom-up approaches that should be promoted. |  

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. It is the synergism between appropriate top-down and bottom-up approaches that should be promoted. |

---

| Programmes should be developed on the basis of a situation analysis that identifies priority problems and their immediate, underlying and basic causes. Immediate, underlying and basic causes should be addressed, either simultaneously or in sequence. |  

8. Programmes should be developed on the basis of a situation analysis that identifies priority problems and their immediate, underlying and basic causes. Immediate, underlying and basic causes should be addressed, either simultaneously or in sequence. |

---

| Goal setting is important. The necessity for scaling up needs to be considered at the planning stage. Efforts should promote that positive changes are sustainable and sustained. This includes environmental sustainability. |  

9. Goal setting is important. The necessity for scaling up needs to be considered at the planning stage. Efforts should promote that positive changes are sustainable and sustained. This includes environmental sustainability. |

---

| All possible partnerships should be explored with strategic allies including donors and NGOs/CBOs. Also through the linkages to other development efforts, it is often possible to leverage additional resources. |  

10. All possible partnerships should be explored with strategic allies including donors and NGOs/CBOs. Also through the linkages to other development efforts, it is often possible to leverage additional resources. |

---

| Good programming includes the identification and pursuit of UNICEF’s comparative advantages. |  

11. Good programming includes the identification and pursuit of UNICEF’s comparative advantages. |
Appendix 7a: Conceptual Framework for Child Survival, Development and Participation

Child Survival, Development and Participation

- Nutritional Status
- Health Status
- Cognitive/Emotional Status
- Food/Water Energy
- Basic Social Services
- Care Practices

Responsibility, Authority and Resources

Action
Analysis
Assessment

HRs

CAPACITY
## Appendix 8: Different Perspectives on Women’s Development

### Type of Project Goal

<table>
<thead>
<tr>
<th>Concept of the Problem</th>
<th>Concept of the Solution</th>
<th>Examples of Type of Developmental Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Welfare</strong></td>
<td><strong>Women's poverty</strong></td>
<td><strong>Build maternity clinics</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Women’s special needs</strong></td>
<td><strong>Promote health clinics</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Women as vulnerable group</strong></td>
<td><strong>Immunisation</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Women’s lower socio-economic status</strong></td>
<td><strong>Health education</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Women as underemployed, unproductive, dependent, lacking in productive skills</strong></td>
<td><strong>Nutrition education</strong></td>
</tr>
<tr>
<td><strong>Economic Self-Reliance</strong></td>
<td><strong>Women as previously overlooked resource in development planning</strong></td>
<td><strong>Income generating projects for women: women's clubs, soap-making, rice field, school uniform making, etc.</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Women as underdeveloped human capital, in need of skills training and improved access to resources</strong></td>
<td><strong>Increase women's access to factors of production: provision of credit and marketing facilities; extension advice for women farmers; appropriate technology for more efficient utilisation of women's labour</strong></td>
</tr>
<tr>
<td><strong>Efficiency</strong></td>
<td><strong>Women's actual productive roles and recognise the gender division of labour, improve women's access to skills training, technology and any necessary productive resources</strong></td>
<td><strong>Affirmative action to promote equal opportunity</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Identify women's actual productive roles and recognise the gender division of labour, improve women's access to skills training, technology and any necessary productive resources</strong></td>
<td><strong>Revise development planning so women are equally participants and beneficiaries in development process.</strong></td>
</tr>
<tr>
<td><strong>Equality</strong></td>
<td><strong>Equality of opportunity for women in schooling, access to the factors of production</strong></td>
<td><strong>Grassroots projects</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Structure of inequality</strong></td>
<td><strong>Support for women's collective action Projects concerned with democratisation and political action</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Discrimination against women in schooling, credit, access to land, etc.</strong></td>
<td><strong>Women's participation in the development process for gender equality in control over productive resources using strategies of conscientisation, mobilisation for collective action.</strong></td>
</tr>
<tr>
<td><strong>Empowerment</strong></td>
<td><strong>Unequal gender power relations</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Male dominated society</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Social and political resistance – both male and female</strong></td>
<td></td>
</tr>
</tbody>
</table>

---

710 Source: [UNDP Women's Development Report](https://www.undp.org/content/dam/undp/library/women/0607/060702wb-01.pdf)
Appendix 9: Relative Costs of Implementing the Mother-Baby Package (WHO 1997)
Appendix 10: Needs Assessment of Rights Issues related to Safe Motherhood

Nutrition
- What is the nutritional status of girls and women, especially in areas of high maternal mortality?
- Are there gender differences in access to nutrition among infants, children, adolescents and adults?

Health Services
- Do Women have access to health care?
- What is the quality of care?
- How do these issues relate to areas of high maternal mortality and to age, ethnicity, income and location?

Environment
- What is the relationship between access to potable water and maternal health?
- Are potable water and sanitation services available close to where women live and in health facilities?

Education
- How does maternal health relate to girls’ enrollment and retention rates in primary and secondary education?
- Do government policies and customary practices support girls’ education?
- Are politicians and communities aware of the significance of girls’ education for development in general and maternal health and infant survival in particular?
- What are school policies on girls who become pregnant?
- Is health education relevant to girls’ lives?

Cultural Practices
- Do any cultural practices inhibit access to safe motherhood – such as female genital mutilation, early marriage, forced marriage ad heavy household work burden?
- What kinds of attitudes exist towards health services and schooling?
- Is there any gender bias in use of these services?

Media Representation
- How are girls and women and the issues affecting them presented in the media?
- Is gender bias in any such presentations compounded by other discrimination such as poverty, race, ethnicity, location of residence and religion?

Participation
- Do women participate in decision-making at the level of the family, community, district and nation?
- What is the connection between maternal health and women’s participation in decision making, particularly in vulnerable populations?

Violence and Abuse
- How does the incidence of violence and abuse vary according to ethnicity, location or other factors?
- Is there any correlation between these findings and trends in maternal and neonatal health and survival?

Economic Issues
- Does any relation exist between women’s control, or lack of it, over economic resources and maternal health?
- Is there any relation between the physical work burden on women and maternal health?
- Can women afford maternal health care?
- Do women have equal access to employment?
- What are the laws and practices governing the treatment of women in the workplace during pregnancy?

Are maternity rights respected?
- What are the consequences for women and families of any failure to respect maternity rights?

Legislation
- What international conventions and conditions that have been signed by the government?
– Has the government taken appropriate measures to implement key international conventions, specifically CEDAW and CRC?
– Do any laws within the constitution or other policies promote rights that could be applied to safe motherhood?
– Do any existing laws or policies contradict any of the rights guaranteed by signed international agreements or national constitutions?
– Are systems in place to monitor compliance with national and international agreements?
– Are Family Law experts engaged in dialogue with Ministry of Health and academic health institutes?

Social Change
– How are trends in migration, economic development and political conflict affecting women?
– Is there any increase in poverty, gender violence, the break-up of families that is negatively affecting women, for example by reducing their access to social services?
– Are these or similar factors affecting maternal and neonatal health?
Appendix 11: Critical Questions on the Capacity of Duty-Bearers

Awareness
- How aware of the problem are the community and what do they understand to be the cause?
- How aware are rights-holders of their rights?

Responsibility / Motivation / Leadership
- To what extent have the duty-bearers accepted and internalised the responsibility to act?
- Do their basic values support assuming such a responsibility?
- Do the duty-bearers show clear motivation to act according to their responsibilities?
- Does the duty-bearer provide leadership in moving towards a more general acceptance of this responsibility?
- Are there some people in this category of duty-bearers who go beyond their duties (typical strategic allies)?

Authority
- What is the legal status of the duty-bearer?
- Is it socially, legally, politically and culturally legitimate to act in accordance with this particular duty?
- What would it take to establish such authority?
- If the duty-bearer lacks authority, what are the sanctions to fear if they do take action?
- If the authority exists, who makes them accountable?

Resources
- An assessment should be made of the human, economic and organisational resources available and controlled by the duty-bearer to meet his/her obligations.

Human resources
- Does the duty bearer have the time and the skills to address the problem in hand?

Economic resources
- For the poor, what long term solutions are needed to improve their economic resource base?

Organisational resources
- Are there any formal or informal structures that can assist in individual crisis situations?
- What ‘networks’ exist to help the poor to cope with crisis?

Capability to make informed decisions and to learn from results
- How are decisions made in a community (household)?
- What is the quality of the assessment that is made?
- What is the basis for the analysis of the situation e.g. scientific or misconceptions?
- What is the quality of the relationship between actors involved in decision-making?
- What is the quality of reassessment and learning from the impact of the action?

Communication analysis
- Communication is a reflection of structural and systemic realities and an integral part of the development process rather than simply as a set of techniques or tools for ready application to a variety of circumstances. Communication analysis is essentially about how to access, share, and use information. A method of communication assessment/analysis needs to be developed.
- What are the systems for generating, collecting and analysing information?
- How do these contribute to the capacity development of the community?
- Do all duty bearers have the access they need to the relevant communication and information systems?
- To what extent are community members equipped to process, share and apply the information they receive?
- Will more information produce a more informed community or will more sharing of information be the more useful strategy?
Appendix 12: Aligning Values and Actions

<table>
<thead>
<tr>
<th>Subjective</th>
<th>Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual</strong></td>
<td><strong>Collective</strong></td>
</tr>
<tr>
<td><strong>Intentions / Attitudes</strong></td>
<td><strong>Culture / Norms</strong></td>
</tr>
<tr>
<td>“I value......”</td>
<td>“We value......”</td>
</tr>
<tr>
<td>- self-awareness</td>
<td>- non-discrimination</td>
</tr>
<tr>
<td>- self-regulation</td>
<td>- human dignity</td>
</tr>
<tr>
<td>- motivation</td>
<td>- participation</td>
</tr>
<tr>
<td>- empathy</td>
<td>- life and development</td>
</tr>
<tr>
<td>- social skills</td>
<td>- caring and compassion</td>
</tr>
<tr>
<td></td>
<td>- accountability</td>
</tr>
<tr>
<td></td>
<td>- interdependence</td>
</tr>
<tr>
<td><strong>Behaviour / Skills</strong></td>
<td><strong>Systems / Structures</strong></td>
</tr>
<tr>
<td>“My actions embody......”</td>
<td>“In our actions we strive toward......”</td>
</tr>
<tr>
<td>- respect for the inherent value of others</td>
<td>- provision of 24-hour quality EmOC</td>
</tr>
<tr>
<td>- respect for the voice of others</td>
<td>- facility and stakeholder accountability</td>
</tr>
<tr>
<td>- self-determination</td>
<td>- commitment to human resource development</td>
</tr>
<tr>
<td>- non-violence</td>
<td>- development of leadership</td>
</tr>
<tr>
<td>- commitment and perseverance</td>
<td>- recognition of risk-taking champions of innovation and change</td>
</tr>
<tr>
<td>- individual accountability</td>
<td>- participation of external stakeholders</td>
</tr>
<tr>
<td>- compassion and caring</td>
<td>- adequate resource allocation</td>
</tr>
<tr>
<td>- men and women as champions of the rights of women</td>
<td>- strengthening of systems</td>
</tr>
</tbody>
</table>

“Service providers, policymakers, systems managers, families and women themselves will have to act in new ways in order to save women’s lives. Our actions and behaviours stem from our intentions and attitudes. This framework for aligning values and actions is useful in examining exactly what steps, what changes are required in the household, community, hospital and at national level in order to save a women’s life when she encounters an obstetric emergency.”
Appendix 13: Indicators and Issues

Indicator 1: Number of Basic EmOC facilities
At least 4 Basic EmOC facilities for every 500,000 population

Indicator 2: Number of Comprehensive EmOC facilities
At least 1 Comprehensive EmOC facility for every 500,000 population

Indicator 3: Geographical distribution of EmOC facilities
Minimum level for amount of EmOC services is met in sub-national areas.

Indicator 4: Proportion of all births in Basic and Comprehensive EmOC facilities
At least 15% of all births take place in either Basic or Comprehensive EmOC facilities.

Indicator 5: Met need for EmOC: Proportion of women estimated to have complications who are treated in EmOC facilities
100% of the women estimated to have obstetric complications are treated in EmOC facilities.

Indicator 6: Caesarean sections as a percentage of all births
As a proportion of all births in the population, caesarean sections account for not less than 5% nor more than 15%.

Indicator 7: Case fatality rate
The case fatality rate among women with obstetric complications in EmOC facilities is less than 1%.

Eight additional quantitative and qualitative indicators and tools are under development for the following issues that impact upon efforts to save women’s lives and uphold women’s rights.

Indicator A: Individual knowledge, attitudes and practices

- Women know the danger signs that mean a woman requires immediate emergency obstetric care
- Men know the danger signs that mean a woman requires immediate emergency obstetric care
- Women have access to financial resources that they can use for themselves
- Women and men know what determines the sex of the child
- Women and men would donate blood
- The sense of responsibility and accountability for women within the family, demand for quality health services, and responsibility for appropriate health support and action
- Qualitative assessment of the broader issues surrounding pregnancy complications, access to and use of emergency obstetric care, value of women, misconceptions and harmful practices and differential access

Issues:

- The need to value the woman in her own right, irrespective of her class, caste, creed and ethnicity
- The need to value the woman’s opinion and provide her opportunities for voice and self expression
- The need to value the woman’s life and to take appropriate action to ensure her survival
- The need for women and their families to have correct information on which to act.
- The need for families to take responsibility for preparedness, to understand urgency and to demand quality EmOC services
- The need to develop social and cultural beliefs and perceptions that are based on scientific knowledge, discarding traditional perceptions and practices that are harmful, including those based on a patriarchal value system that marginalises women
The need to acknowledge the value of different roles and responsibilities within and outside the family, recognising the importance of what nurtures every child and human being, both spiritually and physically
The need to have women receive the same quality of caring and nurturing that they provide so readily to children, adults and the sick in their families
The need to have families responding through informed demand for quality health services

**Indicator B: Stakeholder involvement at village level**

- Villages have a functioning scheme for providing emergency transport to women with obstetric emergencies
- Villages have a functioning scheme for providing emergency financial assistance to women with obstetric emergencies
- Qualitative assessment of the active participation of women, especially marginalised women, among stakeholders and the extent to which it works in the interests of marginalised women in the community
- Qualitative assessment of responsibility and accountability for women in the community, for supporting the health system and for demanding quality health care
- Qualitative assessment of the support given to risk-takers who act for innovation and change at the community level

**Issues:** As above individual issues, plus,

- The need to create opportunities for women’s self-expression
- The need to understand about health systems’ management and quality
- The need to understand the interdependence of all members of the community
- Lack of responsibility by the poor and marginalised in communities, including lack of understanding and of opportunity to voice their concerns
- Lack of responsibility for the poor and marginalised in communities
- The need to address the comfort of the status quo
- The need to support and acknowledge risk-takers, who act for innovation and change, within families and community organisations

The need to influence the perception that the government should provide health and medical care, and that individuals and communities do not have any responsibility for health care or quality medical services
The need for communities to realise that the health system and facilities are supposed to serve the community and should be accountable to them as clients
The need for stakeholders to work with hospitals to develop direct pathways for clients requiring EmOC
The need for stakeholders to work with hospitals to develop an affordable package of EmOC services (e.g., reducing over-medicalisation and practicing rational drug use)
The need to have responsible community members who demand quality health care, take responsibility for their friends and neighbours, and take responsibility for appropriate health support and action

**Indicator C: Stakeholder involvement at the hospital**

- Hospitals that have an active mechanism for accountable external stakeholder participation in hospital management (who understand and promote the values and rights of each individual, every woman, including the marginalised within the hospital; and who support the establishment of quality health care for all)
- External stakeholders who have a mechanism to acknowledge risk-takers who act for innovation and change

**Issues:**

- The need to take shared responsibility for services that save women’s lives
- The need to interact constructively in the decision-making process at the hospital
- The need to advocate support for the needs of women, including marginalised women
- The need to understand a patient’s right to information, and to promote communication between the provider and client, and to establish or strengthen direct pathways for clients to receive EmOC care as and when required
The need to support an affordable EmOC package for all women

The need to understand the spirit and components of quality health care, including both technology as well as caring and compassion; and to promote an acknowledgement system for the same

The need to develop an appreciation of the roles and responsibilities of all categories of staff, recognising that a well-functioning hospital is the result of individual and team effort at all levels.

The need to have a special sensitivity and responsiveness to the needs of women, including women staff members

The need to understand and be responsive to a woman’s health and other needs throughout the life cycle

The need to understand EmOC and how skilled delivery attendance saves women’s lives.

The need to know about the different ways in which timely and safe blood bank services can be supported and to initiate action on that

**Indicator D: Whole-site approach to management**

- Hospitals that have an active, participatory whole-site approach to management
- Hospitals that have a mechanism to acknowledge risk-takers who act for innovation and change.
- A qualitative assessment of the management process

**Issues:**

- The need to understand and appreciate the interdependence of each of the hospital systems
- The need to recognise and appreciate the roles and responsibilities of each member of the staff
- The need to understand and value the personal needs and expectations of each staff member, particularly the needs of women staff
- The need to understand the importance of building a shared vision in the workplace
- The need to understand the necessity of investing in the development of staff members as individuals and as a team, with respect to technology, management and gender aware sensitivity and action
- The need to provide a platform for all categories of staff (including women and junior staff, irrespective of class, caste, creed and ethnicity) to participate and have a voice in the management of the hospital
- The need to recognise and encourage initiative, innovation and new leadership to save women’s lives.
- The need to foster a sense of accountability for women’s lives by practicing gender-sensitive action in one’s personal and professional life in a way that upholds women’s rights

**Indicator E: Hospital 24-hour functionality**

- Hospitals that perform at least x % of relevant comprehensive and basic EmOC services between 8 p.m. and 8 a.m.
- Qualitative assessment of achievements and challenges to achieving 24-hour EmOC functionality in the hospital

**Issues:**

- The need to have adequate infrastructure, supplies and blood bank services to provide quality EmOC around-the-clock
- The need to have adequate and appropriately skilled staff to operate services and provide quality EmOC to clients around-the-clock
- The need to build a sense of responsibility and accountability for fully functional services to be available around-the-clock in order to save women’s lives
- The need to build commitment within the hospital team to maintain around-the-clock services by developing compassion as health care providers
- The need to value and reward risk-taking champions of innovation and change within the hospital team who are ready to work night duty or to be on-call in order to provide around-the-clock services
- The need to value and endorse young leaders who are enthusiastic and foster an ethics- and values-based approach within the hospital team
- The need to foster an understanding of the interdependence of each function involved in around the-clock services, including rostering of skilled maternity staff, a surgeon and anesthetist on call, blood and blood typing available, emergency drugs, oxygen cylinders filled, resuscitation units working, surgical sets complete and sterilised, etc
**Indicator F: Quality of care**

- Hospitals that meet technical standards in provision of EmOC care
- Hospitals that have drug schemes for patients and that provide emergency drugs at wholesale prices
- Women who have episiotomies, induced labour, caesarean section
- Qualitative assessment of quality of care from the provider’s perspective
- Qualitative assessment of quality of care from the client’s perspective

**Issues:**

- The need to build the responsibility and accountability of staff for meeting quality of patient care standards within the hospital
- The need to put clients’ (women patients’) needs, interests and well being at the centre of service delivery, regardless of caste, religion and economic status
- The need to imbue a sense of integrity in the health care providers as professionals providing quality EmOC to save women’s lives
- The need to ensure that staff who are trained in EmOC are actually stationed in the EmOC unit of the hospital
- The need to maintain stock and to provide the required EmOC drugs and supplies at wholesale prices
- The need to provide blood that has been properly screened for HIV and hepatitis B
- The need for mechanisms to monitor the use of episiotomy, induction of labour and caesarean sections
- The need to reward risk-taking individuals and groups who work to improve standards of care and services
- The need to learn from near misses and not punish when genuine efforts have been made to save a woman’s life
- The need to provide an element of privacy to the woman patient with screens, curtains and delivery beds not facing the doorway
- The need to speak to women in a way that you would like to be spoken to as a patient
- The need to communicate rightful information to the women patient and her family, regardless of education, social or economic status

**Indicator G: Resource allocation**

- Incremental comprehensive and basic EmOC costs that are met through government funding (disaggregated for urban-rural and state-provincial)
- Individual hospital incremental EmOC costs met from government and other sources

**Issues:**

- The need for finance allocation to be based on need
- The need to take on the responsibility and be accountable to the public and to women to address unmet need for EmOC services
- The need to know the amount of unmet need so that resources can be raised to meet it
- The need to have the courage to take risks to ensure that there is equal and equitable distribution of EmOC facilities
- The need to allocate resources for appropriately skilled staff to be trained and available for hospital duty

**Indicator H: National policy support**

- Qualitative assessment of laws, regulations, policies and directives relating to EmOC

**Issues:**

- The need to be responsible and accountable to the women and families of the nation by ensuring that adequate EmOC policy is in place; policies are rights-based and aligned with the vision, mission, goal and strategies for saving women’s lives
- The need to acknowledge risk-taking champions of innovation and change who defy the status quo to bring new policies for improved EmOC services
- The need to take pride in the position of the policymaker to ensure policies that support women’s life and health are addressed
- The need to reform existing regulatory and other mechanisms that provide access to life-saving procedures to women (e.g., the procedures that can be performed by various cadres of staff)
• The need for commitment from policymakers to ensure that more women are involved at the policy level
• The need to understand that without accountable national level policy-makers, all other levels becomes less accountable

• The need to apply what is known about the diverse factors contributing to maternal death (e.g., technology, management and rights) through policy and programme design
Appendix 14: Making a Difference

“What Can I Do?” National or a District Manager?”

National and district managers are leaders in policy development and implementation in their countries. They are in positions of power to influence by example, advocate and facilitate the institution of policies, laws and systems of administration that promote and ensure safe motherhood and quality, equitable EmOC services for women. District managers are in a particularly crucial and strategic place to form the bridge between civil society and government health services.

The challenge is to put women’s rights and all that it entails permanently on the agenda at the national and district levels – in all plans, policies, meetings and events – and to work steadily to advance the concerns of women across all sectors. The following is a checklist of practical steps one can take to ensure a reduction of maternal deaths and address women’s rights.

**National Policy-maker**

Clear objectives for maternal mortality reduction, including the standard indicators, are stated in the national policy document:

- Budget allocation is adequate
- A minimum standard for 24-hour quality EmOC services in the private, NGO and public sectors is defined and maintained. This standard is rights- and values-based and technologically sound. Delivery of 24-hour quality EmOC services is ensured through participatory, accountable, facilitative management and leadership
- Human resource development – investment in people – is recognised and prioritised as a core strategy, including new leadership and management techniques
- Policy is values-based as reflected in the vision, mission, goal and strategies for saving women’s lives. It addresses the rights of the clients and the service providers, as integral to all action and measurement of progress
- Incorporates standard protocols for blood banking, anesthesia, surgical interventions, medical interventions (anaemia, malaria, eclampsia), infection prevention, waste management and physical infrastructure
- Rationalises existing regulatory and other mechanisms that ensure availability of life-saving procedures for women (e.g. reform of what procedures different cadres are allowed to perform)
- The elements are obligatory for all donors as well as for health sector reforms
- Selected issues relating to violence against women are addressed
- Establishes clear guidelines for external stakeholder groups and risk-taking champions of innovation and change
- Establishes an annual policy and programme implementation review

**Invest in people to cultivate individual intrinsic power:**

- Prioritise and invest in ongoing programs for learning and change that are facilitative
- Invest in learning processes that challenge entrenched patriarchal attitudes and behaviours
- Celebrate and acknowledge individual and organisational learning that is values-based

**Champion women’s rights in the facility:**

- Ensure adequate and gender-balanced staffing of EmOC facilities
- Ensure an empowering environment for women staff so that they are able to participate in hospital decision-making processes, express their opinions
- Respond to their particular needs (e.g., adequate staff quarters, membership on appropriate hospital management committees)
Ensure that women patients and their families regardless of their caste, class, religion and ethnicity are treated with respect, provided information, and that their needs and concerns are met (e.g., their need for privacy, waiting rooms for their children)

Institute gender training and learning opportunities with annual follow-up for all staff

Institute medical treatment and support services (e.g., shelters, legal aid, and police protection) for women who have been subjected to violence, to ensure their safety and wellbeing

Encourage external stakeholder and community involvement in hospital management to champion women’s needs and rights

Encourage leadership to save women’s lives

Build and sustain accountability in the health facility:

- Ensure adequate personnel policies and actions that reflect equitable, impartial and gender-sensitive and balanced recruitment and transfer policies, based on relevant and required competencies and skills
- Ensure performance based systematic career development of all staff to provide incentives and generate commitment
- Encourage the use of cutting-edge and innovative human resource development and management technologies to mobilise the health sector – individuals, teams and the facility – to be committed to and accountable for saving women’s lives
- Encourage and promote leadership and innovation to save women’s lives at all levels
- Acknowledge and institute systems for rewarding persons who have taken risks to save women’s lives and uphold their rights

Build stakeholder accountability to reduce maternal deaths:

- Ensure alignment of all activities to reduce maternal deaths and disability at the national level, including those of the government, INGOs and NGOs
- Ensure alignment of donor involvement and funding
- Design national IEC strategies to create awareness regarding the unacceptability of maternal deaths and disability and violence against women, on causes and prevention, as well as on misconceptions and harmful practices that contribute to these deaths

Champion women’s rights in society:

- Encourage community initiatives to prepare for emergencies
- Promote a positive, caring and sharing role model for men by practicing and serving as an example
- Ensure that laws and policies uphold women’s rights and that they reflect women’s perceptions, needs and interests
- Ensure the enforcement of laws against violence, early marriage and those that uphold women’s rights (e.g., laws relating to property rights and inheritance, abortion, etc)
- Encourage financial independence and mobility for women by promoting a self-determining and empowered womanhood
- Ensure women’s representation at the policy level

Support risk-taking champions of innovation and change:

- National level champions are publicly and privately recognised and supported for their commitment to and advocacy for change.
- Mechanisms for public acknowledgement and support for champions are institutionalised.

District Management Officer

Provide 24-hour quality EmOC services:

- Ensure that for every 500,000 people there are 4 Basic EmOC facilities and 1 Comprehensive EmOC facility
- Ensure that relevant health facilities provide 24-hour EmOC services
- Ensure maintenance and improvement of hospital infrastructure and all equipment
- Ensure adequate supply of drugs
- Ensure a 24-hour blood bank service
- Ensure practice according to standardised technical protocols related to EmOC service delivery
- Ensure adequate staffing (both technically competent and caring) of EmOC facilities
Invest in people to cultivate individual intrinsic power:
- Prioritise and invest in ongoing programmes for learning and change that are facilitative.
- Invest in learning processes that challenge entrenched patriarchal attitudes and behaviours.
- Celebrate and acknowledge individual and organisational learning that is values-based.

Champion women’s rights in the facility:
- Ensure that staff at all levels of the district management and at the hospital know what it means to have a women-friendly work atmosphere and a women-friendly hospital.
- Create a women-friendly environment for women staff by:
  - providing them with opportunity to participate in decision-making and to express their opinions (e.g. membership on appropriate management committees, committee to review blood bank services, infection prevention, etc.)
  - meeting their needs (e.g. adequate staff quarters, crèches for children, etc.)
- Create a women-friendly environment for women patients and their families regardless of their caste, class, religion and ethnicity by:
  - treating them with respect, listening to their illnesses and concerns with attention and meeting their needs (e.g. their need for privacy, waiting rooms for their children, etc.)
  - providing them with adequate information on their health and complications, the course of treatment and options (if they are available), and encouraging them to ask questions.
- Ensure compulsory gender training and learning opportunities for all staff at all levels and institute an annual follow-up process.
- Ensure that services are available to women sufferers of violence through medical care, legal help, police protection, dialogue with the woman’s family, and rehabilitation.
- Involve stakeholder groups in championing women’s needs and rights both in the facility and in the community.
- Ensure a balanced representation of women from all classes, castes and relevant ethnicities of the district in all district management committees.
- Provide support and acknowledge women and men who have challenged or defied norms or the status quo to uphold women’s rights and save women’s lives.

Build and sustain accountability in the health facility:
- Develop a hospital environment that supports change and builds accountability in individuals, teams and facility by:
  - involving all staff to create a common vision for the hospital, to enroll them and create a sense of ownership in the future of the hospital.
  - instituting an annual process to revisit the vision to strengthen commitment and enroll new staff.
  - encouraging membership of all staff in appropriate management and review committees.
  - encouraging all staff to set goals and take steps to achieve those goals this strengthens commitment and sets a process for learning by doing.
  - encouraging gender sensitivity and team spirit.
- Develop processes, systems and an environment that produces results:
  - collectively embark on a process to define the results expected from individuals, teams and the facility, respectively.
  - identify challenges and take steps to overcome those challenges generate breakthroughs or change (e.g. taking steps to make the facility infection free, celebrating the birth of a child, girl or boy).
- Create a process of reflection for individuals, teams and the facility:
  - institute a regular procedure for reviewing case management of major morbidities to examine how interventions were made, how these responded to the particular needs of women patients and upheld their rights, as well as what could be done to improve or facilitate the care.
  - acknowledge and encourage leadership, commitment, and good work to save women’s lives and provide regular feedback.
- Acknowledge and institute systems for rewarding individuals, teams and institutions that have taken risks to save women’s lives and uphold their rights.
Build stakeholder accountability to reduce maternal deaths:

- Ensure stakeholder participation on the district and hospital committees and that their views and insights are included in plans, policies and changes made in action plans
- Work with local stakeholder groups to create awareness and mobilise action on the misconceptions and harmful practices that contribute to women’s deaths during pregnancy and childbirth
- Create a social movement to prevent the deaths of women, whether during pregnancy and childbirth or from violence, by mobilising the whole district
- Urge the police and lawyers to play a leading role in preventing the violent deaths of women
- Align all activities related to EmOC service delivery within the district to create synergy

Champion women’s rights in society:

- Create awareness about the vast and unacceptable numbers of maternal deaths and disability, the availability of treatment and the danger signs: WOMEN DO NOT HAVE TO DIE
- Educate and mobilise families and communities to be prepared for emergencies. They need to identify the nearest facility providing EmOC and arrange transport, funds and blood donation in advance
- Create a functioning referral system from the community to the health facility
- Provide support systems for women and men in the community who have challenged the norms to uphold women’s rights and save women’s lives
- Promote action against misconceptions and harmful practices

Support risk-taking champions of innovation and change:

- Mechanisms for public acknowledgement and support for champions are institutionalised.
- Facility management committees review and acknowledge the efforts of personnel when women’s lives are saved
- Families, communities, stakeholder groups and facilities share a sense of pride in their champions of change

Making a Difference: “What can I do as a stakeholder at the national or the district level

As a stakeholder at the national and the district level, one can champion and lead the process of change in the family, community and society for saving women’s lives. As a national stakeholder, one may be a member of a professional body (e.g., obstetrics and gynaecological society, nurses association) a NGO leader, a women’s rights activist, a lawyer, a well-known personality. This is a strategic place to advocate and lobby for policies, laws and systems of administration that promote and ensure safe motherhood through quality and equitable EmOC services for women, which uphold their rights.

As a stakeholder at the district level, one may be local union leader, a community leader, a local NGO member, a woman’s rights activist, a health worker or a religious leader. In addition to the above, a district stakeholder can bring the community closer to the health services and make the health services accountable to community needs.

The challenge will be to put women’s rights permanently on the agenda at the national and the district levels in all plans, policies, meetings and events and to work steadily to advance the concerns of women across all sectors.

The following is a checklist of practical steps one can take to ensure a reduction of maternal deaths and address women’s rights. You can influence and act as a pressure group to:

National Stakeholder

Ensure national policy support and commitment to 24-hour quality EmOC services:

- Ensure that reduction of maternal deaths and disability is high on the list of priorities of the government
- Ensure that health policies include specific goals for reducing maternal deaths and disability
- Ensure that the commitment to maternal mortality reduction is reflected in budgetary allocations, in infrastructure management and in human resource development
Ensure that for every 500,000 population there are 4 Basic EmOC facilities and 1 Comprehensive EmOC facility

Ensure that protocols for standardising the practice of EmOC and guiding service provision at each level of the health service are established

Ensure that health facilities provide quality EmOC services 24 hours a day that respond to women’s needs and uphold their dignity

Ensure that appropriate drugs and equipment are available at the health facilities, including a fully functional 24-hour blood bank service

Ensure proper monitoring and evaluation of all EmOC-related health programmes at the national and sub-national level

Ensure periodic national review of policy, directives and action related to the provision of EmOC services

Invest in people to cultivate individual intrinsic power:

- Prioritise and invest in ongoing programmes for learning and change that are facilitative
- Invest in learning processes that challenge entrenched patriarchal attitudes and behaviours
- Celebrate and acknowledge individual and organisational learning that reflects the project values

Champion women’s rights in the health facility:

- Ensure adequate and gender-balanced staffing of EmOC facilities
- Ensure an empowering environment for women staff that encourages their participation in hospital decision-making and meets their needs (e.g., adequate staff quarters, membership in appropriate hospital management committees)
- Ensure that women patients and their families regardless of caste, class, religion and ethnicity are treated with respect, provided information, and that their needs and concerns are met (e.g. their need for privacy, waiting rooms for their children)
- Encourage gender awareness and institution of gender training and learning opportunities with annual follow-up for all staff
- Ensure medical treatment and support services (e.g., shelters, legal aid and police protection) for women who have been subjected to violence etc

Build stakeholder accountability to reduce maternal deaths:

- Ensure alignment of all activities to reduce maternal deaths and disability at the national level including those of the government, INGOs and NGOs
- Ensure alignment of donor involvement and funding
- Participate in IEC strategies to create awareness regarding the unacceptability of maternal deaths and disability and violence against women, on causes and prevention, as well as on misconceptions and harmful practices that contribute to these deaths
- Promote the commitment to and creation of an enabling environment for all women and men irrespective of their status, class, caste and ethnicity
- Promote understanding of quality care that includes skills of medical staff and care for patients’ needs and interests, including their right to information and informed choice

Champion women’s rights in society:

- Promote community initiatives to prepare for emergencies
- Promote a positive, caring and sharing role model for men by practicing and putting one’s own self forward as an example
- Promote self-determining and empowered womanhood
- Ensure that laws and policies uphold women’s rights and that they reflect women’s perceptions, needs and interests
- Ensure the enforcement of laws against violence, early marriage and those that uphold women’s rights (e.g., laws relating to property rights and inheritance, abortion, etc)
- Ensure women’s representation at the policy level

Support risk-taking champions of innovation and change:

- National level champions are publicly and privately recognised and supported for their commitment to and advocacy for change
- Mechanisms for public acknowledgement and support for champions are institutionalised.
- Families, communities, stakeholder groups and facilities share a sense of pride in their champions of change
Sub-National/District Stakeholder

Provide 24-hour quality EmOC services:

- Provide constructive support to the hospital management process by:
  - acknowledging systems that are effective and supporting systems that need to be strengthened (e.g. providing support to strengthen blood bank services by mobilising donors from the community, establishing an effective referral system or link from the community to the facility.)
  - creating a sense of ownership for the health and wellbeing of all in community – good health services are not just a matter for government

Invest in people to cultivate individual intrinsic power:

- Prioritise and invest in ongoing programmes for learning and change that are facilitative
- Invest in learning processes that challenge entrenched patriarchal attitudes and behaviours
- Celebrate and acknowledge individual and organisational learning that reflects the project values

Champion women’s rights in the health facility:

- Champion change for women within the hospital (both women health personnel and women patients) regardless of their caste, class, religion and ethnicity, by demanding, influencing and participating to create an environment that:
  - respects women’s voice and meets their needs (e.g., if there are adequate staff quarters, crèches for staff children, if the right to privacy of the patient is respected, if there are waiting rooms for patients’ children)
  - respects the women patients’ right to information and encourages informed decisions and choices, wherever possible
  - is gender sensitive
- Constructively participate in hospital and district stakeholder committees to bring the views and needs of your community to the committee, particularly the needs of the poor and the marginalised, as they represent the most vulnerable and those whose needs are most likely to be met with indifference
  - suggest ways that would facilitate the incorporation of these needs into action within the hospital
  - make sure that the committee is gender balanced (equal numbers of men and women) and represents all the different classes, castes and ethnicities (as much as possible) within your community and as well as different categories and levels of hospital staff members

Champion women’s rights in society:

- Make it unacceptable that a woman should die in your community of something so preventable as complications of childbirth and pregnancy
- Create awareness about the availability of emergency treatment if complications arise during pregnancy and childbirth: WOMEN DO NOT HAVE TO DIE
- Educate each and every family in your community about the danger signs of complications so that they are able to identify these and act in a timely manner to save women’s lives
- Educate each and every family in your community about the need to be prepared for an emergency in order to avoid delay in getting a woman to an appropriate health facility. They need to find out about the nearest EmOC facilities and arrange emergency transport, funds and blood donation in advance
- Organise a community plan for emergencies for all members of the community, particularly for the poor and marginalised sections as they might have not had the means to be prepared for an emergency. For example, organise a revolving fund, transport to take women to the hospital and blood donation
- Create awareness on what it means to have quality care. Quality involves not only the skills and competencies of health workers, but also the quality of interaction between staff and the patient – the caring and nurturing that the patient needs to feel at the hands of the health staff
- Create awareness on the patients’ right to information and informed choice
- Create awareness related to misconceptions and
harmful practices that contribute to women’s deaths during pregnancy and childbirth, and make it socially unacceptable and a cause for shame within the community

- Break the myths and practices regarding impurity of menstrual blood, blood donation, eclampsia and spirit possession, early marriage, son preference, etc., by practicing and putting oneself forward as an example
- Create awareness regarding the important and varied roles and responsibilities that women undertake in society: at home and outside of home, in the field, in the office, in the community
- Create awareness about the importance of the caring and nurturing roles that women undertake and the importance of men sharing in these roles
- For men, practice nurturing and caring by:
  - being a supportive husband by acknowledging that when your wife works at home and takes up work outside, they are both full time jobs and just as or even more demanding than what you do
  - doing your share of the housework – setting aside time to cook, clean and care for the children and elders
  - giving your wife time to rest, go out to the market or see her friends
  - being a loving father to your daughters, by making sure that they get the same education and care and grow up with the same freedoms and opportunities as your sons, by supporting their dreams whatever they be
- Respect and promote a self-determining and empowered womanhood
- Acknowledge and support women and men in the community who have taken risks to save women’s lives
- Create awareness that it is wrong to use violence against anyone to get one’s way.
- Acknowledge that men often use violence against women. Make this unacceptable in your family and community. Promote ways that are non-violent to mediate differences discussion within the family; mediation by neighbours, friends, and even the community panchayats

Support risk-taking champions of innovation and change:

- Sub-national and district-level champions are publicly and privately recognised and supported for their commitment to and advocacy for change
- Mechanisms for public acknowledgement and support for champions are institutionalised
- Facility management committees review and acknowledge the efforts of personnel when women’s lives are saved
- Families, communities, stakeholder groups and facilities share a sense of pride in their champions of change

Making a Difference: “What can I do as a hospital superintendent?”

The following is a checklist for making health facilities women-friendly and providing quality and equitable EmOC services to women, regardless of their class, caste, religion and ethnicity

Provide 24-hour quality EmOC services:

- Ensure that the hospital provides prompt, quality EmOC services, 24 hours a day, 365 days per year
- Ensure maintenance and improvement of hospital infrastructure and all equipment
- Ensure adequate supply of drugs
- Ensure a 24-hour blood bank service
- Ensure practice according to standardised technical protocols related to EmOC service delivery.
- Ensure standards for cleanliness are practiced
- Ensure adequate staffing – both technically competent and caring – of EmOC facilities

Invest in people to cultivate individual intrinsic power:

- Prioritise and invest in ongoing programmes for learning and change that are facilitative
- Invest in learning processes that challenge entrenched patriarchal attitudes and behaviours
- Celebrate and acknowledge individual and organisational learning that is values-based
Champion women’s rights in the facility:

- Ensure that staff at all levels of the hospital know what it means to have a women friendly hospital
- Create a women-friendly environment for women staff by:
  - providing them with opportunity to participate in decision-making and express their opinion (e.g., membership in appropriate management committees, including committees to review blood bank services, infection prevention, etc)
  - meeting their needs (e.g., adequate staff quarters, crèches for children, etc)
- Create a women-friendly environment for women patients and their families regardless of their caste, class, religion and ethnicity by:
  - treating them with respect, listening to their health concerns with attention and meeting their needs (e.g., their need for privacy, waiting rooms for their children, etc)
  - providing them with adequate information on their health and complications, the course of treatment and options (if they are available) and encouraging them to ask questions
- Ensure compulsory gender training and learning opportunities for all staff at all levels and institute an annual follow-up process
- Ensure that services are available to women sufferers of violence through medical care, legal help, police protection, and dialogue with women’s families and rehabilitation.
- Involve external stakeholder groups through the hospital stakeholder committee. Elicit the health needs and concerns of women, their families and communities, and incorporate these into hospital action plans

Build and sustain accountability in the health facility:

- Develop a hospital environment that supports change and builds accountability in individuals, teams and the facility by:
  - involving all staff to create a common vision for the hospital, to enroll them and create a sense of ownership in the future of the hospital
  - instituting an annual process to revisit the vision to strengthen commitment and enroll new staff
- encouraging membership of all staff in appropriate management and review committees
- encouraging all staff to set goals and take steps to achieve those goals; this strengthens commitment and sets a process for learning by doing
- encouraging gender sensitivity and team spirit
- Develop processes, systems and an environment that produces results:
  - collectively embark on a process to define the results expected from individual teams and from the facility, respectively
  - identify challenges and take steps to overcome those challenges, generate breakthroughs or change (e.g. taking steps to make the facility infection-free, celebrating the birth of a child, girl or boy)
- Create a process of self-reflection for individuals, teams and the facility:
  - institute a regular procedure for reviewing case management of major morbidities to examine how interventions were made, how these responded to women patients’ particular needs and upheld their rights, as well as what could be done to improve or facilitate the process
  - acknowledge and encourage leadership, commitment, good work to save women’s lives and provide regular feedback
- Acknowledge and institute systems for rewarding individuals, teams and institutions that have taken risks to save women’s lives and uphold their rights

Build stakeholder accountability to reduce maternal deaths:

- Ensure stakeholder participation on hospital committees and that their views and insights are included in plans, policies and changes made in action plans
- Use stakeholder committee to create awareness and mobilise action locally on misconceptions and harmful practices that contribute to women’s deaths during pregnancy and childbirth: impurity of blood, need for blood donation, sex preference of the child, eclampsia and spirit possession, teenage pregnancy, and violence against women
Use stakeholder committee to build a functioning referral system from the community to the hospital.

Encourage community to take responsibility for proper functioning of health services by acknowledging their contribution in the stakeholder committee – health services are not just the responsibility of the government.

**Support risk-taking champions of innovation and change:**

- Facility champions are publicly and privately recognised and supported for their commitment to women’s rights and advocacy for change.
- Mechanisms for public acknowledgement and support of champions are institutionalised.
- Facility management committees review and acknowledge the efforts of personnel when women’s lives are saved.
- Families, communities, stakeholder groups and facilities share a sense of pride in their champions of change.

**Manage change through operating principles and processes for a new way of working:**

- Develop a **shared vision** integrating the three components of the project rights, technology and values-based management.
- Commit to a **continuous learning** of new competencies and skills, to transform the inner being and outer actions of individuals and groups.
- Build **leadership and management** that embody the transformed values and principles, and support initiative, innovation, quality and results.
- Develop **internal and external systems** for working that reflect the transformed values, attitudes, behaviours, and work processes.
- Establish **structures and processes of decision-making** that reflect values that support equal participation of all.
- **Measure change**, assessing accountability for saving women’s lives from a values-based perspective.
Appendix 15: 
Resources needed to improve essential obstetric care\textsuperscript{717}

- Adequate Financing
- Health Services
  - Appropriate policies
  - Evidence-based guidelines
  - Skilled staff providing 24 hr. coverage
  - Supportive Management
  - Appropriate infrastructure and equipment
  - Supplies of drugs and blood
  - Reliable logistics support
  - Monitoring
- Referral Services
  - Transport
  - Communications
  - Improved availability, accessibility, use, and quality of care
- Community Services
  - Information and education to promote health-seeking behavior
  - Reduction in maternal Deaths
### Appendix 16:
Capacity Analysis Matrix

#### The Right to Basic Education

<table>
<thead>
<tr>
<th>Claim-Holders</th>
<th>Duty-Bearers</th>
<th>Children</th>
<th>Parents</th>
<th>School</th>
<th>Community</th>
<th>District</th>
</tr>
</thead>
</table>
| Parents       | Parents      | ● positive attitude  
                ● non-discrimination  
                ● allow time for study  
                ● pay school fees  |         |         |          |          |
| School-Teachers | School-Teachers | ● provide good quality teaching  
                             ● be present  
                             ● be role-models  
                             ● establish child-friendly schools  
                             ● not allow child labour |         |         | ● establish PTAs  
                             ● encourage parents to bring girls to school |          |
| Community     | Community     | ● encourage schooling  
                             ● explain to parents why girls should go to school |         |         |          |          |
| Mobilisers    | Mobilisers    |          |         |        | ● assist in building classrooms  
                             ● encourage PTAs |          |
| District      | District      |          |         |        |          |          |
| Officials     | Officials     |          |         |        | ● allocate adequate funds  
                             ● supervise and train |          |
| Facilitators  | Facilitators  |          |         |        | ● assist in re-training of teachers |          |

---

718 The Right to Basic Education
<table>
<thead>
<tr>
<th>Claim-Holder</th>
<th>Children</th>
<th>Parents</th>
<th>School</th>
<th>Community</th>
<th>District</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Government</td>
<td>ministry of education</td>
<td>ministry of finance</td>
<td>parliament</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ministry of Education</td>
<td></td>
<td></td>
<td></td>
<td>prepare curricula</td>
<td></td>
</tr>
<tr>
<td>Ministry of Finance</td>
<td></td>
<td></td>
<td>ensure adequate salaries for teachers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parliament</td>
<td>legislate on free and compulsory basic education</td>
<td></td>
<td>allocate adequate funds for basic education</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The analysis below is far from complete but shows one way to systematically assess and analyse the capacity-gaps to claim rights.719

**Capacity Gaps of Parents to claim their rights in relation to Children's Right to Education**

<table>
<thead>
<tr>
<th>Capacity</th>
<th>Children</th>
<th>Community</th>
<th>District</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responsibility</td>
<td>believe that teachers should decide everything</td>
<td>most poor parents are not aware of that their children have a right to basic education</td>
<td></td>
</tr>
<tr>
<td>Authority</td>
<td>accept the authority of teachers</td>
<td>follow leaders uncritically</td>
<td></td>
</tr>
<tr>
<td>Resources</td>
<td>many parents have no education, some are illiterate</td>
<td>poor parents do not have the courage to question district authority</td>
<td></td>
</tr>
<tr>
<td>AAA</td>
<td>many parents fail to understand the positive long-term impact of girls' education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication</td>
<td>parents do not understand the teachers' ‘language’</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Capacity Gaps of Parents meeting their duties in relation to Children's Right to Education

<table>
<thead>
<tr>
<th>Capacity</th>
<th>Children</th>
<th>Parents</th>
<th>School /Community / District / Government</th>
</tr>
</thead>
</table>
| Responsibility | • do not see the value of basic education  
               • no motivation to educate girls |                                                                                                  | • do not see the value of PTAs            |
| Authority | • mothers want to bring their girls to school but have no authority |                                                                                                  |                                           |
| Resources | • need children to work at home                                           |                                                                                                  | • no money for school fees and textbooks   |
| AAA        | • some decision influenced by superstition                                 |                                                                                                  |                                           |
REFERENCES

5. Ibid, p 5
6. UNICEF Rosa, Saving Women’s Lives A Call to Rights Based Action, 2000, p 49
7. Cook et al., op.cit., p. 4.
11. Ibid.
15. For further elaboration see Appendix 1
18. Hoque, Uzma, Small Efforts Can Make a Difference, UNICEF ROSA
24. Cook et al., op. cit., p. 5.
29. More details are given in Appendix 2.
32. Ibid., p. 23.
33. Ibid.
40. Ibid.
42. Ibid., p. 55.
43. UNICEF ROSA, Saving Women’s Lives A Call to Rights Based Action, 2000, p. 12.
44. Ibid., p. 11.
46. UNICEF ROSA, Saving Women’s Lives A Call to Rights Based Action, 2000, p. 11.
48. Ibid., p. 7.
126 Ibid.
130 Ibid, p. 20.
133 Ibid., p. 27.
134 Ibid.
137 Ibid.
139 Dias, C.J., op. cit., p. 3.
141 DFID, Poverty elimination and the empowerment of women, 2000, p. 11.
142 Moser & Norton, op. cit., p. 2.
145 Ibid.
149 DFID, Realising human rights for poor people, 2000, p. 25.
156 UNICEF, Human rights for children and women, June 1999, p. 27.
158 UNICEF ROSA, Saving Women’s Lives A Call to Rights Based Action, 2000, p. 54.
159 Ibid.
162 Ibid., p. 3.
163 Ibid., p. 5.
167 Ibid., p. 9.
168 Ibid., p. 12.
172 Cook et al., op. cit., p. 1.
174 Cook et al., op. cit., p. 4.
175 Ibid., p. 5.
178 Ibid., p. 49.
179 Freedman, op. cit., p. 53.
182 Cook et al., op. cit., p. 69.
183 Moser & Norton, op. cit., p. x.
184 Ibid., p. viii.
185 Ibid., p. 18.
189 Cook et al., op. cit., p. 3.
191 UNICEF ROSA, Saving Women’s Lives A Call to Rights Based Action, 2000, p. 3.
193 Ibid.
194 Ibid., p 12
195 Ibid.
198 Cook et al., op. cit., p. 11.
199 Ibid.
435  Ibid., p. 66.
439  Ibid., pp. 71-73.
440  Ibid., p. 74.
441  Ibid., p. 76.
442  Ibid., p. 52.
450  Ibid.
451  Ibid.
453  Ibid.
454  Ibid.
455  Ibid.
456  Ibid.
458  Cook et al., op. cit.
461  Moser & Norton, op. cit.
463  Ibid.
464  Ibid.
466  Ibid., p. 2.
467  Ibid., p. 4.
469  Ibid., p. 52.
470  Ibid., p. 53.
472  Ibid., p. 77.
473  Ibid., p. 76.
477  Ibid., p. 79.
480  Ibid., p. 82.
481  Ibid., p. 83.
482  Freedman, op. cit., p. 57.
483  Ibid.
484  Rios-Kohn, The Case of Peru, March 2002, p. 34.
491  Ibid., p. 17.
492  Freedman, L, Shifting Visions, op. cit., p. 3.
494  Freedman, L, Shifting Visions, op. cit., p. 3.
495  Ibid.
497  UNICEF ROSA, Saving Women’s Lives A Call to Rights Based Action, p. 11.
498  Ibid., p. 19.
499  Cook et al., op. cit., p. 16.
500  Freedman, L.P., op. cit., p. 52.
501  Ibid.
503  Cook et al., op. cit., pp. 26 – 66.
504  Ibid., p. 6.
508 UNICEF, Program, Planning and Procedure Manual, Chap. 6, p. 4.
513 Ibid., p. 11.
514 Freedman, L.P, op. cit., p. 56.
515 Ibid.
516 Lewin, op. cit., p. 29.
517 Ibid., p. 12.
518 UNICEF ROSA, Saving Women’s Lives A Call to Rights Based Action, 2000, p. 15.
519 Ibid., p. 41.
521 Ibid.
522 Ibid.
523 Ibid.
524 Ibid.
525 DFID, Realising human rights for poor people, 2000, p. 27.
527 Ibid., p. 59.
528 Ibid., p. 76.
529 Ibid., p. 62.
530 Ibid., p. 63 ff.
531 Ibid., p. 84 ff.
532 Freedman, op. cit., p. 55.
537 DFID, Realising human rights for poor people, 2000, p. 16.
538 Ibid., p.18.
539 DFID, Poverty elimination and the empowerment of women, 2000, p. 21 ff.
543 Ibid.
669 Ibid, p. 106.
675 Ibid., p. 106.
676 Ibid.
677 DFID, Poverty elimination and the empowerment of women, 2000, p. 21.
679 Ibid., p. 92.
680 Cook et al., op. cit., p. 62.
684 Ibid.
685 Cook et al., op. cit., p. 19.
687 Cook et al., op. cit., p. 64.
690 UNICEF ROSA, Saving Women’s Lives A Call to Rights Based Action, 2000, p. 50.
691 Ibid.
692 Cook et al., op. cit., p. 43.
697 Ibid.
698 Ibid., p. 106.
703 CCM Convention on Consent to Marriage, Minimum Age for Marriage and Registration of Marriages
CEDAW Convention on the Elimination of All Forms of Discrimination Against Women
CRC Convention on the Rights of the Child
DEVAW Declaration on the Elimination of Violence Against Women
DPWCEAC Declaration on the Protection of Women and Children in Emergency and Armed Conflict
ICCPR International Covenant on Civil and Political Rights
ICPD International Conference on Population and Development Programme of Action
ICERD International Convention on the Elimination of All Forms of Racial Discrimination
ICESCR International Covenant on Economic, Social and Cultural Rights
MPC Maternity Protection Convention (Revised)
705 Cook et al., Advancing Safe Motherhood Through Human Rights, Appendix 4.
710 Longwe, Clarke and Assoc., Reading #2, p. 4.
714 UNICEF ROSA, Saving Women’s Lives A Call to Rights Based Action, 2000, p. 16.
715 UNICEF ROSA, Saving Women’s Lives A Call to Rights Based Action, 2000, p. 84.