



THE WELLBEING FOUNDATION AFRICA SUBMISSION TO THE OHCHR: TECHNICAL GUIDANCE APPLICATION OF HUMAN RIGHTS APPROACH TO MATERNAL MORTALITY - The WBFA IMNCH PHR© Based Approach.

This submission by The Wellbeing Foundation Africa is based on 8 years experience of working on the frontline in within communities Africa, particularly in Nigeria. It draws upon the views and experiences of multiple stakeholders across the MNCH sector.

The submission is sectioned into 3 parts that include the following:

1. Organisational Profile – The Wellbeing Foundation Africa
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1. The Wellbeing Foundation Africa Profile

The Wellbeing Foundation Africa (WBFA) is a Nigerian founded charity seeking to create real and sustainable change for families by working with communities across the continent by building capacity and empowering women. Through projects such as the IMNCH Personal Health Record©, and the product WBFA Mama Kits we give people the ability to seek better health outcomes for themselves and improve quality of lives in communities.

We are focused on contributing to the achievements of the UN Millennium Development Goals, in particular goals three, four and five through the partnership ethos embed in goal eight. These MDGs are

- 3 - Promote gender equality and empower women
- 4 - Reduce child mortality
- 5 - Improve maternal health
- 8- Global partnership for development

Currently, sub-Saharan Africa is failing to meet these goals. The region still has the highest levels of under-five mortality - one in eight children die before the age of five, nearly twice the average in developing regions overall and



nearly 18 times the average in developed regions. Due to rapid progress in other regions, the disparity between sub-Saharan Africa and the rest of the world is growing.

Maternal death rates have declined just 26% since 1990 and currently stand at 640 per 100,000 births, well short of the 218 per 100,000 2015 target. Together, sub-Saharan Africa and Southern Asia accounted for 87% of all such deaths globally in 2008.

The UN Millennium Development Goals Report 2011 concluded that the 2015 targets will only be achieved through sustained and accelerated action. We undertake a grassroots approach by partnering community groups with the private sector to introduce the best global practices while taking account of local variants.

2. WBFA's Human Rights Based Approach

WBFA has three focus areas for addressing maternal, child and newborn health: frontline education and training, practical tools and advocacy & action. Each area and programme/ intervention within is designed to further the rights of mothers and children.

WBFA recognises maternal and child mortality and morbidity is often a direct result of women and children being unable to access health and education. Therefore, in situations where mothers endure gender-based violence/discrimination; have no major economic power, lack decision-making power and/or social participation; interventions designed to reach them actually fail in impact due to these barriers.

The right to health could often mean the right to medical care; however health encompasses much broader principles than just quality medical care. It is the right to attain holistic well-being. (OHCHR and WHO) This implies that a child has a right to physical, mental and social development. A child should not be subjected to discriminatory treatment. Their rights should be protected by all means by State parties and all interventions and programmes designed to implement their rights must be supported and executed by both state and non-state actors.

Children's right to health is undoubtedly linked to women's right to life. According to the WHO (Maternal and New Born Health, 2011), if more than one third of all child deaths occur within their first month of life; then addressing mother's access to well-being has never been more crucial. The underlying value of the health service delivery system is to ensure that equity is achieved at all times. In this regard, an equitable and holistic health service delivery system hinges on the protection of women's and children's rights (a vulnerable group in our societies); the provision of preventive and primary health care, with effective referral systems which ensures un-delayed access to efficient secondary health care services. This implies that no individual; mother or child should be denied or delayed care



because of cost, gender or age; hence, putting the child and mother's best interests first, in ensuring a child's survival and development.

Maternal and child health as part of the MDGs is being addressed by various international organisations. However, what has been evident over the past few years is that grassroots organisations are where the real changes are; bottom-up, effective and comprehensive community participation/development, empowerment of women and children; arming them with the 'tools' to identify their own issues locally, as well as their rights and empower them to claim them.

2.1 Access to Primary Healthcare

The primary healthcare approach was introduced by the WHO for the purpose of increasing accessibility to healthcare, public participation, health promotion, multi-sectorial cooperation and availability of appropriate technology, with a focus on reducing the need for curative and rehabilitative care (5). The primary healthcare approach, although aimed at addressing existing inequities in health service delivery, remains scarcely implemented in many resource-poor settings. Preventing illness and reaching women and children with health promotion and education programmes are often faced with major challenges. Such barriers include geographical access or distance; financial barriers; socio cultural, language and ethnicity-related barriers; and lack of knowledge and awareness, which can together lead to low demand for and use of services, particularly by the poor.

Public participation implies that clients should be involved in the services made available to them. However, particularly in maternal health care services, our experience shows that women endure very low quality of care, less participation in their health care as they are subjected to lack of people skills by staff, inconvenient and dilapidated facilities and long waiting times at the centres. Low quality of care and various stages of delay in health service delivery contribute to the increasing rates of maternal mortality. Low quality of health care highly contributes to the lower survival rates among poor children and results to greater poverty. This suggests that although there are available cost-effective interventions in resource-poor settings, coverage is still very low, particularly among the poor (4).

2.1.1 The IMNCH Personal Health Record©

The IMNCH Personal Health Record© (IMNCH PHR©) was introduced by The Wellbeing Foundation to address the abysmal inequality of access to healthcare among poor mothers in sub-Saharan Africa. It has been widely reported that weak referral systems contribute to the morbidity of the health system, with secondary and tertiary health centres being submersed with patients and cases that can be treated at the primary care level. The PHR reduces gaps in information and ensures that women are empowered and participate in the decision making for their own and their children under 5 years old health via the comprehensive health records; ensuring that therapeutic regimens are



harmonised across personnel and facilities. It facilitates transparency and accountability as it provides adequate information for the caregiver and health professionals on the state of mother during pregnancy, birth, postpartum and the child 's health up to the age of five including immunisation.

The IMNCH PHR© applies a new level of accountability in healthcare by reforming the record keeping process in the health sector, presenting two simultaneous methods of information capture and storage at a low per capita outlay; a hard-copy (paper) record, with key data pages recordable as multi-leaf carbon format as well as easy electronically captured version using the key information pages, which are pre-designed for computer readability.

The Personal Health Record, commonly referred to as the “Health Passport”, addresses some of the major problems plaguing the health sector in Sub-Saharan Africa which include poor access to effective healthcare. Mothers and children under five are the most vulnerable members of society where access to timely health care is concerned. Paradoxically they are the least able to meet the out-of-pocket fees for registration and treatment at point of care. The PHR when embedded into costed healthcare programmes for sustainability, guarantees the holders non-discriminatory access to effective timely health service which can be tracked and evaluated at the point of care or at any other time for impact analysis. This has been implemented in a number of states in Nigeria, most notably Kwara State where nearly 10,000 copies have been distributed over 18month. The IMNCH PHR© has also been adopted by the National Primary Care Development Agency, Nigeria through their midwives services scheme, with nearly 290,000 of the health records in circulation.

Experience has shown that the weak referral systems further compounds the burden of morbidity on the health system with secondary and tertiary health facilities being inundated with cases that can be very adequately handled at the primary peripheral centres. With its checklist system the IMNCH PHR© ensures that a standardised operating practice is maintained by whoever is available to deliver service. It reduces gaps in information and ensures that therapeutic regimens are harmonised across personnel and facilities. Overall, it is a home/healthcare provider-custody health record, service delivery resource, health education, hard copy data collation tool, and electronic data capture system designed to address the key challenges impacting upon maternal and child morbidity and mortality in Nigeria and other African countries.

The book details the health indices at every stage of pregnancy and the early stages of the child's life until the age of five. It provides a health history utilisable by health workers and professionals for informed decisions or referrals. A concrete strategy towards the attainment of MDG's 4, 5 and 6, it produces measurable and verifiable impact on key indicators to track achievements until 2015.

The IMNCH PHR© aims to address the inequality of access to both public and private healthcare provision suffered by these vulnerable groups, it can create a practical linkage between primary, secondary, and tertiary healthcare by



promoting effective two-way referral procedures, and create a verifiable cost effective database. It also empowers the mother in appropriate health-seeking behaviour when deployed as part of an effective package of healthcare solutions and interventions, ensuring their participation in their own health and their child's. This process minimises delays right from the first potential point of delay - decision-making in the home.

2.2 Lessons learned

Local capacity building is pivotal to realising a mother's and child's right to health. To put into practice policies and programmes, state actors must largely support and participate with non-state actors in their efforts. The efforts of grass root organisations to educate, empower, develop and save women and children in their communities should not be underestimated but rather promoted. Many of these organisations will be more effective with further support, as they understand the context and the people with which they are working. This implies that they are capable to develop comprehensive situation analyses and locally sourced solutions, hence, partnerships with these groups/organisations could be very beneficial. This has been the experience of WBFA in our community-based work.

Cultural beliefs and traditions is the greatest barrier to achieving gender equity in our communities. And although gender equity is often addressed in various policies, we must ensure that we employ the bottom-up approach to ascertain that the affected population fully understand the principle enough to embrace it and put it into practice. On the other hand, the state should ensure a gender-responsive and equity-based guidance to maternal and child health policies and others appropriately. We must ensure that trained professionals and leaders are put in place; who will assume accountability throughout implementation and the achievement of set goals.

Particular attention must be paid to the needs and rights of specific groups, such as children who belong to minority/indigenous communities, and particularly, young girls and adolescent girls, who in many contexts are prevented from accessing a wide range of services, including health care. State parties should prioritise the health conditions affecting poor mothers and children; WBFA has been able to support these activities with orphaned and vulnerable children in Kwara State, Nigeria.

Programmes and interventions should ensure that 'gatekeepers' - fathers, husbands, and elders - are fully involved in the health care of their women and children. By increasing multi-sectoral approach we are ensuring that key groups; i.e. religious leaders are further involved and educated about the crucial importance of prompt women/children's access to health care services, the ills of young girls' early marriage. Men must be encouraged to play a more positive role in the health-seeking behaviours of their women and children, by developing sustainable outreach programmes designed to penetrate the barricades formed by decades of belief systems and traditions.



It has been reported that with policies in place, implementation and financing remain the challenge (Maternal and New Born Health, 2011). The emphasis on strengthening our health systems has never been more crucial. State parties should train health professionals state-by-state and fully equip them as well as the facilities for equitable distribution to all areas. Furthermore, applying a human-rights based framework, to health service delivery will further serve as guidance to health service professionals.

Finally, to promote national accountability, we must strengthen our health information system; data collection, analysis and monitoring and evaluation of programmes. It is important that we recognise our challenges and opportunities in addressing maternal and child health as we approach the 2015 deadline set to achieve the MDGs.

3. Conclusion

From the ongoing discussion, it can be deduced that achieving equity and gender-responsive health systems is a challenge in resource-poor settings. From the viewpoint of equity and protection of women and child's right, the state and health systems have largely neglected the principles of health as a human right. There is need to develop comprehensive situation analyses to reflect precisely the conditions of vulnerable populations in their communities. The implementation of women and child policies requires systemic planning, political commitment down to the level of execution. To accelerate this process intervention tools such as the IMNCH Personal Health Record© can help build and entrench systems and best practices to facilitate women and children's access to health care. Further still, such a tool also provides a source of valuable information for situational analysis, tracking and accountability.

References

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