Via Electronic Mail

United Nations High Commissioner for Human Rights
Office of the United Nations High Commissioner for Human Rights (OHCHR)
Palais des Nations
CH 1211 Geneva 10, Switzerland

February 7, 2016


Dear Hon. Zeid Ra’ad Al Hussein,

I am writing with respect to the request for information on how the “Technical Guidance On The Application Of A Human Rights-Based Approach To The Implementation Of Policies And Programmes To Reduce Preventable Maternal Mortality And Morbidity” (Technical Guidance) has been applied by States and other actors to support your report to the Human Rights Council regarding maternal mortality and morbidity. The International Initiative on Maternal Health and Human Rights, an international network currently anchored by a Secretariat in SAHAYOG, India, welcomes the opportunity to further the work of the OHCHR by providing independent information on the implementation of the technical guidance.

Please find below a short submission that outlines the work of the IIMMHR in the promotion of the Technical Guidance. We hope you find it useful in the context of your report to the Human Rights Council.

Please do not hesitate to get in touch with us in case you require any further information.

Thank you,

Yours sincerely,

Jashodhara Dasgupta, Convenor,

On behalf of the IIMMHR
Background

The International Initiative on Maternal Mortality and Human Rights or IIMMHR is a civil society platform active since 2007, comprising members from many regions, and includes practitioners, academicians, and feminist and human rights organizations, several of whom work in the global South. Its advisory body draws together many experts in the field of health, women’s rights and human rights. Since its inception, IIMMHR has been working to promote and advance the understanding that preventable maternal mortality and morbidity is a violation of a woman’s most fundamental human rights, including the rights to life, health, equality and non-discrimination; and that the realization of these rights requires effective accountability mechanisms at every level.

Responses to the Note Verbale (WRGS/LOH/Res27/11)

IIMMHR’s work on the Technical Guidance 2014-2016

Since 2012, IIMMHR has been deeply engaged in the processes of the OHCHR that led to the development of the Technical Guidance (TG), and is fully committed to its promotion. IIMMHR believes that the TG provides specific indications on how to implement human rights-based approaches (HRBAs) which are crucial for upholding the human rights to dignity and survival for all pregnant women and girls. While HRBAs in themselves may not immediately reflect in changed health outcome indicators, IIMMHR believes they will impact upon adverse outcomes and enhance women’s participation, empowerment, enjoyment of all related social, economic, sexual and reproductive rights and ultimately contribute to reducing maternal mortality and morbidity.

While IIMMHR upholds the responsibility of state parties in the promotion, protection and fulfilment of rights, we see an important contribution by other stakeholders such as civil society organizations in different countries. National civil society platforms and indigenous NGOs do work with issues affecting the most marginalized populations, and these are the groups that often fall through the cracks of even well-managed health systems. As such IIMMHR is pleased to provide below our efforts to promote the implementation of the Technical Guidance Note both internationally, as well as in specific middle-income country settings, where maternal mortality still remains a problem.

i. Dissemination of supplementary practice-oriented materials:

Towards promoting the use of human rights based principles in maternal mortality reduction strategies, IIMMHR members have developed a supplementary publication called "A framework for applying human rights-based approaches (HRBA) to prevent maternal mortality and morbidity". This publication is useful as a Supplement to the Technical Guidance and explains how the human rights principles can be applied in action, illustrating these with concrete examples from countries around the world. This has been widely disseminated in soft copies and hard copies at the Human Rights Council (September 2014), at the Global Health Systems Research Conference, Cape Town (Oct 2014), at the Global Maternal Newborn Health Conference, Mexico (October 2015), at the NORAD Seminar on Operationalising a rights-based approach to health: reorienting health and measuring impact (December 2015) and several other opportunities.
In addition, simplified or adapted forms of the Technical Guidance and other locally appropriate materials have been developed by the IIMMHR partners to make the TG more easily understandable to various audiences. For example, in Peru, a Regional Workshop *Knowing and implementing the TG within Peru* was held on 28th of November 2014 in collaboration with the Ombudspersons and the Regional Public Health authority. During this workshop the main components of using a rights based approach in advocacy were reviewed, including analyzing the examples mentioned in the simplified version of the TG.

ii. **Upholding human rights based approaches (HRBAs) to accountability in the post-2015 agenda:**

The invited spaces for discussing the post-2015 agenda included consultations on the Secretary General’s new Global Strategy on Women, Children and Adolescents’ Health (GS-WCAH). IIMMHR members participated in consultative processes around the Human Rights and Accountability work-streams and contributed inputs upholding HRBAs as advocated in the Technical Guidance.

iii. **Dissemination of our experiences with promoting the Technical Guidance:**

At the Global Maternal Newborn Health Conference, Mexico (October 2015), IIMMHR partners and advisor Alicia Yamin conducted a well-attended panel discussion on applying human rights-based approaches to prevention of maternal mortality: ‘Applying Human Rights Based Approaches to Preventing Maternal Mortality and Morbidity: Strategies, Challenges and Lessons from Civil Society Experiences in Four Countries’ - Tuesday, 11:00-12:30 | Doña Socorro | Track 2 [http://www.globalmnh2015.org/concurrent-sessions-group-3/]

iv. **Country-based interventions with different stakeholders:**

In 201, IIMMHR received, a grant from NORAD to work on promoting the Technical Guidance through a project entitled *Promoting the inclusion of rights based frameworks in programmes for preventing maternal mortality and morbidity*. The project aimed to inform a variety of stakeholders in four middle income countries, **India, Mexico, Peru and South Africa**, about the Technical Guidance to incorporate human rights-based approaches (HRBA) in the way they are planning, budgeting, implementing, monitoring and evaluating their programmes for reduction of maternal mortality and morbidity (MMM). In India the project addressed parliamentarians, in Mexico the project worked with frontline medical social workers in Jalisco, in Peru the indigenous women and regional Ombudsperson were addressed, and in South Africa it was with the midwives and the Ministry of Health.

Also the four country projects addressed entirely different stakeholders they generated a considerable range of experiences and learning about how human rights may be applied to different aspects of policy and programmes for maternal mortality prevention. An underlying challenge was that they were all led by civil society organizations (CSO), working in collaboration with state actors, guardianship institutions, and in some cases UN agencies. The capacity of CSOs is restricted by the available resources and the extent to which their collaborative efforts can move state actors to implement HRBAs. Moreover, in all these countries a major challenge was to translate an international human rights document into guidance that health managers, politicians and health providers or frontline workers could comprehend and implement, especially those that work in the provinces or states.
Nonetheless, the four case studies led to some degree of achievements in promoting the implementation of human rights-based approaches, drawing from different sections of the Technical Guidance, reinterpreting the UN document in their own contextual realities, and in one case expanding even further upon what could be included within rights based approaches to budgeting for maternal health. Some details of these four country interventions are given below.

A. In India: Advocating with parliamentarians towards human rights-based budgets for maternal health (TG Para 44-52)

**Background**: The IIMMHR partner in India is SAHAYOG which worked in partnership with the National Alliance for Maternal Health and Human Rights, a national network. An examination of budgetary provisions for maternal health in India shows an endemic problem of insufficient resources for primary health care, as India has among the lowest public spending on health in the world (1.2% of the GDP). Considerable maternal health spending is on a conditional cash transfer to induce women to come into hospitals during labour (JSY scheme - Janani Suraksha Yojana); as opposed to improving the availability and quality of maternal health services being provided. Budgets for reproductive health services get disproportionately spent on incentives for female sterilization as opposed to a choice of methods and skilled service provision. Although the marginalized social groups (indigenous tribes and Dalit castes) are meant to have special ear-marked budget allocations¹, these are almost never spent appropriately, and participation of these groups is not elicited on setting budget priorities.

**Strategy**: The intervention draws from sections of the Technical Guidance (TG) that explain human rights based budgeting, notably: ‘…In … the case of high-burden countries, the principle of progressive realization under human rights law means that the budget for maternal health programmes would be expected to increase unless there is public justification to the contrary [TG, Para 47 (a)] and ‘… reducing budgets for programmes directed at low-income and marginalized women may constitute retrogression under international law …’ [para 47 (d)]. Going ahead from the guidelines provided in the TG, the IIMMHR partner added the need for budgets to promote and fulfil women’s reproductive rights, include comprehensive family planning information and services.

The annual budget of the Ministry of Health & Family Welfare (MOHFW) in India has to undergo scrutiny by a Parliamentary Standing Committee (PSC²) mandated specifically on Health and Family Welfare. Using the accountability mechanism of Parliamentary Oversight, SAHAYOG and allies provided relevant materials and technical inputs so that the Chairperson and Members of the PSC could make recommendations based on these human rights principles to the MOHFW.

Recent incidents that received wide media coverage, such as the deaths of 13 young women following sterilization surgery in one state of India (November 2014) were used to focus attention on how budgets had neglected women’s reproductive rights. A spate of maternal deaths among women from indigenous tribes were reported on and additional data

¹ Special Component Sub-plan earmarked for marginalized and indigenous populations (Scheduled Castes/dalits and Scheduled tribes respectively) be utilized to improve their health status and other social determinants

² Composed of Members of Parliament (MP) from all the political parties, constituted for five years after the elections, and rotational chairing by an MP who is not from the party currently in power in government
provided to show that these marginalized social groups did not benefit from the additional special budget components earmarked for their welfare, and have high rates of maternal deaths. The Members of Parliament (MPs) were provided with research and fact-finding reports, policy recommendations, expert briefings and data, in order to promote human rights-based oversight of the health budget, including raising questions on maximum available resources, budget equity and promotion of reproductive rights.

**Achievement so far:** The PSC on Health and Family Welfare has provided budget oversight on the departmental Demand for Grants 2015-16 that upholds the human rights principles of equity and non-discrimination. They have given strong recommendations for overall increase of health budgets, as well as for safeguarding special budget allocations for indigenous tribal populations (within the Scheduled Tribes’ Special Component). Consequently the MOHFW has increased the Special Component earmarked for marginalized indigenous populations (Scheduled Tribes): To minimize the effect of budgetary cuts on the Tribal Sub-plan, it is informed that against the desired contribution of 8.2% of the total outlay for Scheduled Tribe Sub-Plan (STSP) in the Financial Year 2015-16,… has been earmarked for STSP, i.e. 11%.” The PSC has also strongly recommended that health budgets end the practice of setting numerical targets and providing incentives for terminal contraceptive methods aimed at women, towards promoting a gender-sensitive and ‘reproductive rights approach’ in the health budget.

**B. In South Africa: Promoting rights-based approaches with midwives as key providers of maternal health services (TG Para 20,39 and 66)**

**Background:** The IIMMHR partner was the Society of Midwives of South Africa (SOMSA). Although South Africa permits midwives to run Midwife-Operated Units (MOUs) close to larger hospitals, and they can independently manage and conduct deliveries, yet midwife training and registration was under the overall legal provision for general nurses. This according to SOMSA was a major barrier in giving enough attention to the special role played by midwives in sexual and reproductive health, notably reducing maternal mortality. At the same time midwives were unaware of what would constitute a human rights-based approach to midwifery and this was a gap in their capacity building.

**Strategy:** The objective of the SOMSA intervention was to build on sections of the Technical Guidance that speak of the rights of health workers (Technical Guidance para 39 and para 66”), and the roles that health workers have to play in ensuring available, accessible, acceptable and quality health services (ibid, para 20”). The two are inter-related and quality services can certainly not be provided through an under-valued and unsupported health workforce: ‘Ensuring adequate working conditions and treatment of health workers, including salary and benefits, disciplinary processes and voice, is necessary to respect their rights and, in turn, to promote health system effectiveness in addressing maternal mortality and morbidity.’

In specific terms, SOMSA hoped to highlight the special role of midwives as distinct from general nurses, and ensure separate training, registration and management for midwives in South Africa. At the same time SOMSA intended to educate midwives about their responsibilities in providing human-rights based respectful services to pregnant women, in a less medicalized environment that enabled women to make their own choices. SOMSA’s strategy was to influence, through engagement with various midwifery structures and all
relevant stakeholders, the process of separation or clear distinction of a midwife from the nurse from education, regulation and policies that impact on the Midwifery practice. The key stakeholders that they worked with were midwives and the Ministry of Health.

Initially, the Technical Guidance (TG) from the OHCHR was reviewed and adapted. The executive members of the SOMSA were exposed to workshops on the key concepts of a human right based approach so that they could advocate to claim their space as autonomous professionals. Besides, SOMSA also produced a Trainers Handbook on Applying Human rights-based approaches to midwifery. The participants were tasked with piloting the Trainers’ Handbook with the advanced students within their training institutions. The assumption was that the trained SOMSA members will then educate midwives in their institutions as well as women/mothers on their rights.

Achievements so far: This handbook has been piloted in the Advanced Training Course with 30 midwives in Free State and Western Cape, who subsequently apply rights-based approaches in their clinical practice during their six month practicum. Two of the midwifery trained educators managed to conduct the workshops. One used the tool using Appreciative Enquiry (a paper on this was presented in the 12th SOMSA Congress, August 2015) The other one combined the tool with information on the Sexual Reproductive Health Policy of the country.

Some SOMSA members were tasked with advocacy activities aimed at improving the state of midwifery. During training, a number of questions were prepared for various stakeholders such as the Regulatory Body, Ministry of Health as well as other professional unions. The sharpened advocacy was aimed at the possibility of a new Act that include midwifery. The issue was strongly raised at the 12th SOMSA Congress and finally, the SOMSA through advocacy with the National Department of Health and the Minister of Health, got the South African Nursing Act changed into become the South African Nursing and Midwifery Act 2015. This is the biggest breakthrough in that midwifery is now independently recognized in South Africa, which means eventually midwives will have an influence on planning and management of midwifery training as well as the practice of their profession, as opposed to being dictated by nursing or assumed to be the same as nursing. Therefore the next stage of advocacy will be to have a desk or strong presence of midwifery in the Regulatory Body to influence training and quality of midwifery practice, looking at the rights of both mothers and the midwives who serve them.

C. Citizen participation and Social Accountability: Monitoring of maternal health services by indigenous women in Peru [TG para 56, 63, 67 and 74 b)]

Background: The IIMMHR Country partner was initially CARE Peru and later Ayni Desorollo, both working through the health rights civil society network Foro Salud, the largest in Peru. The report on maternal health and human rights in Puno and Huancavelica regions of Peru by Physicians for Human Rights, Deadly Delays (2007) brought to light the lack of participation of the rural indigenous women (‘campesinas’), the limited respect for their rights in health care provision and the devaluing of their cultural difference by the health system, which were major barriers to seeking life-saving care.

Consequently, in 2008 in Peru, indigenous women community leaders of Quechua and Aymara groups engaged with ForoSalud, CARE Peru and regional office of the Human-
Rights Ombudsman in the Puno Region, to monitor women's health rights, particularly the right to good quality, appropriate and culturally respectful maternal health services. The civil society groups supported the women vigilantes in raising the issue of respectful and responsive quality care for the health needs of the especially marginalized groups, like the indigenous highland populations, acknowledging that: ‘Lack of cultural sensitivity and acceptability of care at facilities, including language and provision for traditional birthing customs also leads to a reluctance to seek care.’ (TG, Para 56) The platform ForoSalud created leverage at the national level to promote the idea that social accountability, through popular participation of indigenous women, should be part of institutional mechanisms to ensure quality of care.

**Strategy:** The intervention by IIMMHR partners in Puno draws from the sections of the Technical Guidance that speak of the importance of gender-sensitive and culturally appropriate care as a human right of all pregnant women (Technical Guidance, Para 56, ibid); the need for local documentation and deliberation to identify barriers to care-seeking faced by marginalized women (Para 63, ibid); the importance of making women from marginalized populations aware of their entitlements (Para 67vi) and use of social accountability mechanisms to institute local oversight of health services (Para 74[b]vii).

Thus the **objective** of the IIMMHR partners’ intervention in the region of Puno was to promote the role of the indigenous community women leaders or vigilantes for ‘the meaningful participation of affected communities ... in particular of women from marginalized and vulnerable groups and health workers, in ... identify(ing) problems, causes and ... and in prioritizing remedial actions and solutions.’ (Para 63) This was intended to increase respect for women’s rights within health facilities and using the findings of the vigilantes to build a discourse on human rights principles amongst health authorities and health providers.

The strategy was to ensure that regular ‘citizen monitoring’ by the indigenous women of the quality of care at health facilities could be presented as findings to the local guardianship institution namely the Ombudsperson’s office in Puno, and to the health officials3. The intention was to propel greater awareness and political will to progressively implement key contents of the TG within Puno’s local health system. Regional (sub-national) workshops were conducted in collaboration with the office of the Ombudsperson and health authorities on Citizen Participation, Rights-based Approaches and the existing gaps within health care at the local level. The findings from the women also provided lessons regarding the implementation challenges while applying HRBA in maternal health services. Since the Ombuds office is mainly composed of lawyers who do not have any specialized understanding of the internal dynamics in public health systems, the intervention provided an opportunity to provide technical assistance to the Regional Ombudsman Officer and team.

**Achievement so far:** The project has led to the activation of a human rights guardianship institution for human rights in relation maternal health accountability, namely the Ombudsperson of Peru, and the Ombuds in the state of Puno. The Ombudspersons have formally recognized the important role played by a social accountability mechanism, the Citizen Initiative in Puno. The Citizen Initiative has increased also the accountability of public health facilities as a result of regular monitoring by indigenous women, who are now able to

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3 For example the Integral Health Insurance Program Officers who have become allies in the effort to ensure quality health care
present their monitoring findings to the Ombuds officers. This intervention has strengthened the advocacy of Peruvian civil society actors around rights-based quality health services for indigenous people within Ministry of Health efforts to implement Universal Health Coverage.

D. In Mexico: Sensitizing Local Level Social Workers to Rights Based Approaches in the State of Jalisco (TG para 56, 63)

Background: The IIMMHR partners were the National Committee for the Promotion of Safe Motherhood (CPSM), the Simone de Beauvoir Leadership Institute (ILSB), who worked in close collaboration with the Office of the High Commissioner for Human Rights (OHCHR) Mexico. In June 2014 it emerged that although not a poor state, Jalisco still showed unexpectedly high numbers of maternal deaths (18 deaths in six months). Therefore the intervention focused on Jalisco. IIMMHR partners implemented a twofold strategy: advocating with the Health Ministry in Jalisco and conducting a rights-based budget analysis of maternal health budgets to be used for further advocacy on the one hand, and sensitizing health service providers from all around the state on a HRBA. This second strategy proved to be more successful.

Strategy: Drawing from the sections of the Technical Guidance that speak of the importance of gender-sensitive and culturally appropriate care as a human right of all pregnant women (Technical Guidance Para 56\textsuperscript{viii}) and need for local documentation and deliberation to identify women’s barriers face by marginalized women in seeking care (Para 63\textsuperscript{ix}) the objective of the IIMMHR partners’ intervention in the state of Jalisco was to promote the role of Social Workers in hospitals to become aware of the human rights based approach and support women’s human rights in maternity care, as they are the frontline and first point of contact for pregnant women and adolescent girls. While themselves adopting HRBAs, the Social Workers could also detect and document any incidents of human rights violations of pregnant women that they observe.

In specific terms, the project enabled the ILSB and the CPSM to build capacities of 55 Social Workers from all over Jalisco state, in short two-day sessions over six phases. The training was backed up by a mentoring process for these women. The training consisted of a first module dedicated entirely to women’s right to health and gender perspective. The module focused on introducing key concepts of human rights and gender to social workers and how they can be used to strengthen health service delivery. During this session the Technical Guidance Note was presented as well as the shorter adapted version created by ILSB and the CPSM. A later module was around building documentation skills, so that Social Workers could create evidence of any human rights violations in the maternity wards.

Achievements so far: The training was effective in addressing some of the prejudices that the Social Workers held earlier about the indigenous women being ignorant and foolish in not coming to health centres on time; they realized that these women are alienated by the way they are treated in the hospitals and health systems have to be more understanding and open about different cultural practices. Similarly the Social Workers earlier considered that adolescent girls had loose morals and that was why they became pregnant, but now they realize that lack of sexual education, a changed situation with households and no access to contraceptive methods is what leads to unwanted adolescent pregnancies. Some statements by Social Workers after the sessions:
• “I have realized that I have to guarantee that women’s reproductive health rights are protected at all times”

• “I have realized that I have to do my job without making any value judgments nor letting my own personal beliefs get in the way of what my obligations are, in terms of respecting women’s rights.”

Nonetheless, the Social Workers themselves cannot denounce human rights (HR) violations: they are at the bottom of the health system hierarchy, so any evidence they generate may or may not be taken up seriously by the officials in charge. There are at present no clear or effective complaint mechanisms to denounce HR violations, and their documentation may also make them vulnerable. Additionally, abortion is not a legal right in Mexico outside of Mexico City: the legislation on sexual rights in Jalisco is restrictive (abortion is a crime in most instances). One of the duties of a Social Worker is to notify authorities whenever a woman arrives to a health facility due to a miscarriage, and this means they cannot uphold and protect women’s sexual and reproductive rights at the same time.

Endnotes

1 Budgeting (Para 44-52)
44. The identification of budgetary needs requires the involvement of a range of ministries and departments; for example, adolescent pregnancy must be addressed in conjunction with the Ministry of Education and will require adequate budgets for both health and education sectors.

45. The State must devote the maximum available resources to sexual and reproductive health. The establishment and sustainability of an adequate fiscal envelope to afford the maximum available resources is critical to a rights-based approach; where structural imbalances exist between expenditures and revenues, strengthened and rationalized revenue collection should be undertaken before cuts are made to critical health areas, including sexual and reproductive health.

46. The budget should ensure that financing is not borne disproportionately by the poor. Out-of-pocket costs cannot impede accessibility of care, irrespective of whether services are provided by public or private facilities.

47. Addressing maternal health as a human rights issue in budget formulation confers added protection for resources allocated to related programmes at both the national and subnational levels:
(a) If the overall available budget increases, resources for maternal health should increase accordingly insofar as significant need in that area remains. In particular in the case of high-burden countries, the principle of progressive realization under human rights law means that the budget for maternal health programmes would be expected to increase unless there is public justification to the contrary;
(b) “Maximum available resources” under international law include resources from international assistance and cooperation; however, increased resources from external sources should not replace governmental funding of sexual and reproductive health programming unless publicly justified and based on an impact assessment;
(c) If the overall budget of the State decreases, resources for sexual and reproductive health programmes should not be decreased unless the Government demonstrates that it has taken all reasonable measures to avoid such reductions;
(d) As reducing budgets for programmes directed at low-income and marginalized women may constitute retrogression under international law, Governments bear a special burden in demonstrating the need for such cuts.

48. Both national and sub-national governments should establish participatory processes, such as public hearings, during budget formulation. Citizens, civil society organizations, academics and health service providers should be able to contribute meaningfully to budgeting discussions, including by identifying needs, and be aware of decision-making criteria.

49. Budgets earmarked for sexual and reproductive health should not be reassigned, diverted or underspent during the fiscal year. In decentralized health systems, budgets should be allocated and funds distributed to the regions and districts in a timely and equitable manner.

50. In order to implement budgets effectively and ensure that they are properly spent, annual work plans that clearly allocate responsibilities at all levels of government should be used.
51. The human rights principles of transparency and accountability call for both allocated and spent budgets on sexual and reproductive health to be disaggregated by functional and programmatic classifications and on the basis of regional reporting. Sexual and reproductive health spending should be clearly identifiable in the overall budget and available in a format readily accessible to the general public.

52. Budgets should include provisions for ensuring effective accountability, including monitoring, access to justice for the poor, and both judicial and non-judicial accountability mechanisms to facilitate timely redress.

ii 82nd Report on Demands for grants 2015-16 (demand no. 48) of the Department of Health and Family Welfare (Ministry of Health and Family Welfare), Rajya Sabha Secretariat, New Delhi Department-Related Parliamentary Standing Committee on Health And Family Welfare (24th April 2015) para 1.1.5, 2.6, 2.7, 2.9, 3.13 etc

iii 89th Report on Action Taken by the Government on the Recommendations/Observations contained in the 82nd report on Demands for Grants 2015-16 (Demands no. 48 & 50 of the Department of Health and Family Welfare, Rajya Sabha Secretariat, New Delhi Department-Related Parliamentary Standing Committee on Health And Family Welfare (22nd December 2015) para 1.2 in Chapter I, Part B (NHM)

iv Para 39 - The national plan should specify capacity-strengthening measures for the health workforce and requirements for the number and distribution of health workers while ensuring respect for health workers’ rights, including their labour rights. Where the conditions of work for health workers are a concern, the plan should specify measures to improve them.

Para 66 - Full respect for the rights of both health system users and health workers is fundamental to a rights-based approach. Any form of abuse, neglect or disrespect of health system users undermines their rights. Institutions need to be organized and managed to facilitate respect for women’s sexual and reproductive health rights, such as provision for privacy and confidentiality. Systematic education is required for policymakers, planners, health system administrators and providers to ensure that women’s access to care is treated as a right and that all duty-bearers understand their corresponding obligations of conduct. Moreover, in a health system, health workers are rights-holders as much as duty-bearers. Ensuring adequate working conditions and treatment of health workers, including salary and benefits, disciplinary processes and voice, is necessary to respect their rights and, in turn, to promote health system effectiveness in addressing maternal mortality and morbidity.

v Para 20- Ensuring women’s sexual and reproductive health rights requires meeting standards with regard to health facilities, goods and services:
(a) Availability of both the underlying determinants of health, as well as hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs;
(b) Accessibility in four overlapping dimensions: physical, economic (affordable), non-discrimination, and regarding information;
(c) Acceptability in terms of respect for medical ethics and of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned;
(d) Quality, including skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation;14 respectful care for women using health services is a critical dimension of both quality and acceptability.

vi Para 67 Effective accountability also requires individuals, families and groups, including women from vulnerable or marginalized populations, to be aware of their entitlements with regard to sexual and reproductive health and are empowered to make claims grounded in them.

vii Para 74 (b) Social accountability calls for civil society and public participation at all levels of decision-making regarding sexual and reproductive health, and throughout the project cycle. Community-based oversight of facility staff, finances and quality of care at facilities, such as “community scorecards”, “community-based local
administration” of health facilities and accompaniment of women by family and community members can all contribute to social accountability and should be implemented according to context.

Para 56 The first step is to analyse the cause of delays and failure to seek care. A human rights-based approach places responsibility on the State for ensuring available, accessible, acceptable and quality facilities, goods and services to address life-threatening delays. Delays in the decision to seek care or opting out of the health system entirely are treated not as idiosyncratic, personal choices or immutable cultural preferences but as human rights failures. They are affected by the inequitable and sometimes discriminatory distribution of health-care facilities, goods and services that makes emergency obstetric care both unavailable and physically inaccessible, as well as by a lack of awareness of the emergency signs among family and community members and the lack of empowerment of women to make decisions about their own well-being. Delays in arrival can also be attributable to out-of-pocket costs, lack of transportation or communications, and/or poor infrastructure. Lack of cultural sensitivity and acceptability of care at facilities, including language and provision for traditional birthing customs also leads to a reluctance to seek care. If abortion laws are overly restrictive, responses by providers, police and other actors can discourage care-seeking behaviour. Lastly, when the population perceives that care quality is poor – even if not directly related to sexual and reproductive health – including lack of respectful treatment at facilities, it also affects decisions to seek care and undermines the health system as a core social institution.

Para 63 The deliberation process itself is critical to understanding the complexities of addressing maternal mortality and morbidity and the responsibilities of duty-bearers, as well as to developing effective and sustainable solutions that are legitimate to the public. Local diagnoses will be conducted by an array of actors in contextually contingent ways, and not all of them will involve all stakeholders. Nevertheless, the meaningful participation of affected communities is essential, in particular of women from marginalized and vulnerable groups and health workers, in efforts to identify problems, causes and duty-bearers, and in prioritizing remedial actions and solutions.