Empowering communities to ensure women's rights to safe motherhood in El Salvador

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Background

While the number of annual maternal deaths globally has declined from 500,000 to 358,000 per year between 1990 and 2008 according to the latest estimates, the burden of mortality has not changed, with 99% of maternal deaths continuing to occur in developing countries.[1] Women in developing countries are also more likely to suffer acute or chronic illness as a result of pregnancy or childbirth, as an estimated 20 women suffer morbidity due to maternal causes for each death.[2] Nearly every maternal death is avoidable and much of maternal morbidity is preventable or treatable as medical solutions to the majority of problems related to pregnancy and birth are known and even routine in the developed world. In response to these observations of inequity represented by the distribution of maternal mortality and morbidity, the Office of the United Nations High Commissioner on Human Rights issued an historic statement denouncing preventable maternal mortality and morbidity as violations of women's rights to health, life, education, dignity and information.[3]

The maternal mortality ratio (MMR) in the Latin American and Caribbean region is estimated at 85/100,000, a ratio which is significantly higher than the 14/100,000 MMR found in developed countries. As almost every maternal death is an avoidable tragedy, the MMR in the Latin American region indicates that many women are not attaining their rights related to maternal health. El Salvador, the most densely populated Latin American country, continues to struggle to guarantee women's rights to safely experience pregnancy and childbirth despite commendable action at the national level. The government of El Salvador has exhibited a strong commitment to achieving the Millennium Development Goals (MDGs), including MDG 5 to reduce by three-quarters the maternal mortality ratio (MMR). However, in spite of the progress which has been made in reducing the MMR from 200/100,000 in 1990 to 110/100,000 in 2008, the country is not on track to reach this goal. While a 5.5% annual rate of decline has been necessitated to achieve MDG 5, only a 3.2% annual decline has been observed to date. The MMR of El Salvador remains one of the higher ratios in the Latin American and Caribbean region. Moreover, a woman in El Salvador continues to face a 1 in 350 lifetime risk of death due to maternal causes, compared to the 1 in 490 lifetime risk of the average woman living in the Latin American and Caribbean region, which is still a much greater risk that the 1 in 4,300 lifetime risk of a woman living in an industrialized country.[4]

[1] WHO, UNICEF, UNFPA and the World Bank (2010). Trends in maternal mortality: 1990-2008. Geneva: World Health Organization.
[2] Naanda G, Switlick K, Lule E. Accelerating progress towards achieving the MDG to improve maternal health: a collection of promising approaches. Washington, DC: World Bank; 2005.
[3] UN Human Rights Council. Report of the Office of the United Nations High Commissioner for Human Rights on preventable maternal mortality and morbidity and human rights. United Nations General Assembly; 2010.
[4] WHO, UNICEF, UNFPA and the World Bank (2010). Trends in maternal mortality: 1990-2008. Geneva: World Health Organization.

Providing skilled attendance at birth is now widely considered as one of key interventions for reducing maternal and neonatal mortality, as most deaths occur on the day of or in 24 hours following delivery.[5] In El Salvador, the leading causes of maternal death are pre-eclampsia/eclampsia (44%) and haemorrhage (28%), both of which can be treated medically. Based on this observation, it is reasonable to assume that achieving skilled attendance at birth is a critical component of assuring women's rights related to maternal health in El Salvador. The challenge of reaching quality health services for skilled care at birth is especially burdensome for women living in rural regions, constituting 39.9% of the population.[6]

In 2004, the government of El Salvador outlined a national strategy to reduce maternal and perinatal mortality within the context of achieving the MDGs. This comprehensive national strategy is constituted of four primary components: (1) to make quality maternal and newborn health services universally available according to population needs ; (2) to reinforce and extend the maternal and perinatal mortality epidemiological surveillance system; (3) to increase women's, families' and communities' demand of quality maternal and newborn health services, improve community level care practices of pregnant women and newborns and promote community participation in activities to reduce maternal and perinatal mortality; and, finally, (4) to reinforce transparency and monitoring of political, legal and institutional bodies that facilitate actions contributing to the reduction of maternal and perinatal mortality at the national and local levels.

Within this overarching national strategy, the World Health Organization's framework for working with Individuals, Families and Communities (IFC) was adopted as the primary approach to address the third component of the strategy. The principal goals of the IFC framework are to empower women, men, families and communities to increase their capacities to improve maternal and newborn health and to increase access to quality maternal and newborn health services. This is achieved through a combination of community- and health services-level interventions. The following four priority areas form the basis of interventions within the IFC framework: (1) developing capacities to stay healthy, make healthy decisions, and respond to obstetric and neonatal emergencies; (2) increasing awareness of the rights, needs and potential problems related to maternal and newborn health; (3) strengthening the linkages for social support between women, men, families and communities and with the health delivery system; and (4) improving quality of care, health services and interactions with women and communities.[7] Fundamental requisites of the framework are active community participation at every stage of programme development and strong interagency and intersectoral collaboration. These conditions optimize the potential of programme success and sustainability.

The IFC framework was initially incorporated in the Pan American regional strategy to reduce maternal mortality and morbidity outlined at the 26th Pan American Health Conference in 2002. In 2003, the Pan American Health Organization (PAHO) elaborated the framework to be validated and implemented in four countries: Bolivia, El Salvador, Honduras and Paraguay. While the 2005 inclusion of the framework in the national strategy of El Salvador envisions its

[5] Campbell OM, Graham W. Strategies for reducing maternal mortality: getting on with what works. The Lancet. 2006 Oct;368(9543):1284-1299; WHO. Skilled care at every birth. Geneva: World Health Organization; 2005
[6] United Nations Population Division, 2005.
[7] WHO. Working with individuals, families and communities to improve maternal and newborn health. Geneva: World Health Organization; 2010.

eventual scale-up to guide programmes throughout the country, eight rural municipalities were initially selected for piloting the framework based on the existence of certain fundamental pre-conditions to programme implementation: high levels of maternal and neonatal mortality, the existence of community organizations and the possibility of collaboration between the Ministry of Health and civil society.

Implementation of the IFC framework

In El Salvador, the national Ministry of Health took the leading role in managing the IFC programmes in the eight municipalities of the Sonsonate, Chalatenango, Morazan and San Salvador departments. One of the first steps in programme implementation was establishing interagency and intersectoral IFC committees at the national level. This committee is led by the national Ministry of Health and Ministry of Education and includes the participation of PAHO, WHO and Enfants du Monde, a Swiss non-governmental organization (NGO). This committee selected the municipalities for implementation and enlisted the participation of regional and local Ministries of Health and the Concertacion Educativa de El Salvador (CEES), a local NGO platform composed of 11 organizations. Once these collaborative structures were established, the participating organizations began developing the instruments to be used in conducting community participatory assessments (PCAs).

These PCAs were designed to allow community members in each municipality to identify priority maternal and newborn health needs in each of the four IFC priority areas, barriers to quality health services access and potential solutions. Complete PCAs were conducted in two municipalities while validation workshops to test the applicability of the results were conducted in the remaining six municipalities. Following the PCA or validation workshop, an action plan including activities from each of the IFC priority areas was developed with the close cooperation of community representatives and leaders, thereby tailoring each action plan to individual municipalities.

The following activities from each of the four IFC priority areas were planned with communities:

- *Developing capacities to stay healthy, make healthy decisions, and respond to obstetric and neonatal emergencies:* Developing a health education plan for women and families that include birth and emergency preparedness and address other specific needs identified in the PCA; mobilising health promoters and midwives to provide health education to women and families
- *Increasing awareness of the rights, needs and potential problems related to maternal and newborn health:* Developing training on maternal health rights; developing training on community organization and participation in maternal and child health epidemiological surveillance systems under the coordination of health promoters and other actors.
- *Strengthening the linkages for social support between women, men, families and communities and with the health delivery system:* Strengthening system referring pregnant women to health facilities; strengthening the network between the community and primary and tertiary level health facilities; meeting with local transport workers to negotiate with them to transport pregnant women to health facilities; developing a better relationship between the community and health services
- *Improving quality of care, health services and interactions with women and communities:* Training facility-based health personnel in technical and administrative skills; training

facility-based personnel to improve their interpersonal and intercultural skills; training health care providers on human rights and on including partners and families during antenatal care, delivery and postnatal care; implementation mechanisms to include diverse actors and sectors, including the community, in defining and monitoring quality of care

After elaborating the programme, a baseline study was conducted in each of the eight intervention areas. The programmes were then implemented and monitored under the management and support of each local IFC coordinating group.

Program results

The results of programme evaluations strongly suggest that community participation and empowerment are effective strategies in assuring women's rights related to maternal health. A crowning transformation has been the unprecedented participation of multiple groups in favour of assuring women's maternal health rights. At the national and coordinating level, various actors have come together to contribute to improving maternal and newborn health, including those not traditionally involved in this area, such as the Ministry of Education and some to the organizations belonging to CEES. This shift has also been striking at the community level as many groups of people not previously involved have started to play a role in maternal health.

Before the intervention, men were little involved in maternal issues and rarely accompanied their wives to health facilities for antenatal care visits. Since programme implementation, men have become much more common companions for their partners during these visits. Additionally, actors involved in maternal and newborn health begun to work more cohesively, with traditional birth attendants and community leaders working collaboratively with health care personnel, capitalising on the strengths of each group to work in a collective manner toward the common goal of improving women's health. In order to overcome transportation barriers to health services access, transporters in different sectors, including the police, have engaged in providing transportation services for pregnant women needing to reach health facilities.

Utilisation of health services has increased significantly in the intervention areas. At baseline, 58.7% of women benefited from at least one antenatal care visit from a qualified health professional. At the evaluation, 93% of women had at least one antenatal care visit. The percentage of births taking place in a health facility increased from 75% to 90%. No maternal deaths were reported in the intervention area throughout course of program implementation.

Communities have become much more involved in health services and monitoring their quality. Community groups, accorded legitimacy by the Ministry of Health, carefully monitor services to verify that they are of adequate quality, assuring that they are appropriately staffed, providers are available during opening hours and facilities are more appropriately equipped. If the community group recognises that services are not being provided as expected, they notify the Ministry of Health. The Ministry of Health supports this community-led system of monitoring as it facilitates accountability of the health system and prevents the wasting of limited resources. Community groups having been empowered to demand the services that they need. For example, in the municipality of Nahuizalco, the community recognized that women had no access to a gynaecologist. They took steps at the national level to demand that gynaecological services be

provided to pregnant women in their community and were successful in obtaining a gynaecologist.

Discussion

The results of the experience of the IFC framework in El Salvador suggest that the approach has been effective in improving women's capacities to assume their rights related to pregnancy and childbirth. Community participation throughout all programme phases, including planning, implementation and monitoring evaluation has been particularly instrumental in developing a programme capable of addressing the maternal and newborn health needs and barriers to health services access specific to each municipality. As communities have participated in identifying priority needs and potential solutions, they have taken ownership of the problems and their adequate solutions. Such an approach not only increased programme success by responding directly to community needs but also bodes well for sustainability as local actors take the lead programme roles.

Community empowerment, central to the framework, has proven to be especially effective in assuring women's rights related to maternal health. Through the programme, communities have come to view maternal health as a concern belonging collectively to the community rather than limited in scope to the women in question. Many different groups are playing a role in maternal health, from men becoming more active in accompanying their partners to antenatal care visits to those groups providing transportation for pregnant women to health facilities. As these groups have become involved, they have been empowered to respond directly to health problems that exist in their municipality. Their involvement has also created an environment in which women are empowered to make positive choices related to care-seeking behaviour, which has been instrumental in increasing the use of skilled care before, during and after birth.

Community involvement in monitoring the quality of care has served to ensure accountability in the health system as well as to improve the quality of care. Before the initiation of the programme, community opinions on care provided were not taken into consideration and there was a lack of accountability in the health system. By involving the community in monitoring services, they have been empowered to demand the quality that is necessary and have also been able to demand the augmentation of services and their quality. The Ministry of Health has been a crucial force in enabling this monitoring system, as they have given legitimacy to these groups and work as a partner with them, responding to their demands.

Finally, the involvement of multiple actors at different levels, from the local level to the national level, has guaranteed that women's maternal health rights are given the attention that they deserve. Women's rights have become an important concern at many levels with different actors working to assure that these rights are attainable for even the most disadvantaged women in El Salvador.

While the results of the programme are highly encouraging, it is essential to note that it has been supported and complemented by a positive political environment. Recently the government of El Salvador has accorded more attention to maternal and newborn health and has adopted new policies favourable to the rights of these groups. The effect that such high level changes may have in assuring women's rights related to maternal health cannot be overstated, and these reforms have likely facilitated the success of the programme.

Conclusion

Ensuring access to the resources, including knowledge and health services, that make motherhood safe to all women is essential to ensuring women's basic human rights, as reproduction should be an experience not only survivable but satisfying to women regardless of residence or socioeconomic status. The results of the IFC programme in El Salvador strongly suggest that a rights approach based on community empowerment and participation is an effective practice in ensuring women's rights related to maternal health.