How to reduce maternal deaths: rights and responsibilities

About this note

DFID's strategy for *Reducing maternal deaths*[1] recognises the importance of achieving women's rights in order to accelerate equitable progress towards *the* **off-track maternal health Millennium Development Goal (MDG 5).**[2] This note provides **guidance** on how to put a human rights-based approach into practice. It includes examples, issues to consider and references. Further analysis and case studies are provided in the supporting *Desk Review.*[3]

This note is primarily for DFID advisers and programme managers working on maternal health. It aims to help them **bring a rights and equity perspective** to work with partners in Government, civil society and international development agencies. It demonstrates how a rights-based approach adds value to public health and health systems approaches. It recognises that reducing maternal deaths is not a purely technical action, but one that challenges the political and social *status quo* and requires actions within and beyond the health sector.

A rights-based approach to maternal health is new and evolving, for DFID as well as many of its partners. There are still large gaps in the evidence base. This note is a **starting point** to help think through how to use human rights to strengthen analysis, policy and programmes to reduce maternal deaths. Country-specific tools may need to be developed, particularly for fragile states.

This note (page 3 onwards) outlines ways to:

- strengthen policy and political support for maternal health;
- apply a rights perspective to strengthening health systems;
- increase women's entitlement and access;
- increase state accountability for maternal health; and
- integrate a rights perspective into aid instruments.

The case for a rights perspective

Over half a million women die unnecessarily in pregnancy and childbirth every year worldwide. There are marked disparities by social group in women's access to skilled birth attendance and to essential obstetric care. Behind these deaths is a failure to assure women's rights: women's low status and lack of power, poor access to information and care, restricted mobility, early age of marriage, and the low political priority and resources given to their health. Related factors include poorly functioning, inequitable health systems; weak legal and policy frameworks; and community beliefs that 'hide' pregnancy and childbirth. **Achieving MDG5 more equitably will require political, social, legal and economic actions as well as scaling up technical strategies. Traditional public health and health systems approaches must therefore be combined**

with a human rights-based approach.[4] This means that development partners can work with governments, civil society, service providers and communities to:

- increase political commitment to and accountability for maternal health – within and outside the health sector, drawing on the state's obligations to meet internationally agreed human rights standards and principles;
- build capacity of those with duties to fulfil women's rights that impact on maternal health;
- strengthen women's voices and their ability to claim their right[5] to maternal health;
- transform the distribution of power and resources that maintain inequalities across society, in families, communities, health systems and government;
- identify which groups of women are furthest from the maternal health MDG, highlight their plight and remove the multiple barriers they face; and
- place accountability, inclusion and equity at the heart of health policy, and to strengthen the links between supply and demand-side factors within health systems.

Describing a human rights-based approach

In recent years, two distinct but complementary approaches have evolved. The first is a **legal approach**. This uses human rights *standards*, the formal system of international human rights law, to emphasise legal obligations to respect, protect and fulfil rights. The second is a broader **development-centred approach**. This draws on the *standards* and *principles* of human rights and demands adherence to 'good development practice' such as participation and inclusion. DFID more commonly uses this second approach.[6]

Human rights **standards** relevant to maternal health[7] include,[8] but are not limited to:
- the right to life and survival;[9]
- the right to the highest attainable standard of health;[10]
- the right to decide freely the number and spacing of one's children;[11] and
- the Convention for the Elimination of Discrimination Against Women (CEDAW).[12]

The use of *internationally* agreed human rights standards gives legitimacy to and a legal basis for women's claims to maternal health. At the *national* level, human rights are protected in constitutions, which can also contain 'directive principles of state policy', that is, statements that guide the implementation of economic and social rights.[13]

DFID's *Target Strategy Paper*[14] prioritises three human rights **principles** to guide programming: **Participation**: Actions to empower women to recognise and voice their claim to maternal health and to access information for decision-making. **Inclusion**: Actions to reduce inequalities and discrimination that put specific groups of women at greater risk of maternal death. **Fulfilling obligation**: Actions to strengthen the state and others with responsibility for reducing maternal deaths to fulfil that duty and to strengthen their accountability to women. **This note focuses on how commitment to these principles can be used to strengthen analysis, planning and implementation.**

Governments that have ratified the right to health have a duty to take concrete steps, to the maximum of their available resources, and with the support of development partners, towards the **progressive realisation**[15] of the right not to die an avoidable death in pregnancy and childbirth.

This acknowledges that both a short and a long-term agenda are needed for realising rights. Progressive realisation requires the state and its development partners to monitor and account for progress towards fulfilling their responsibilities for reducing maternal deaths without discrimination. Planners can use this approach to justify prioritising resources for those measures that will be most effective in saving women's lives, particularly emergency obstetric care.

Applying a human rights-based approach

The practical application of a rights perspective will always depend on **country and local contexts**. The following dimensions – both the current position and trends – should be considered to decide the most appropriate application of the approach:

- the scale, social and geographical distribution, and causes of maternal deaths;
- the status and empowerment of women and girls;
- the legal status of maternal health-related rights and discrepancies with treaties;
- links between the various rights that relate to maternal health;
- the social and cultural context of access to obstetric care and patterns of discrimination;
- capacity and constraints of the existing health systems;
- local meaning given to human rights and the capacity of citizens to claim their rights;
- the nature of the relationship between the state and its citizens, and the strength of accountability mechanisms;
- opportunities for donor harmonisation and partnership; and
- mix of available aid instruments.

Local context will determine the **language** DFID uses. In some contexts legalistic human rights language may be alienating and unhelpful. Language that partners use and understand – about concepts such as participation, empowerment, inclusion, gender equity, equality, and accountability – is likely to have more impact and resonance at policy level. Similarly, at community level, rights-based approaches need to build on local understanding of rights and responsibilities. In Bangladesh, for example, this means talking with people about their daily lives and practices, building on local values that chime with human rights principles.[16]

Strengthening policy and political support for maternal health

National development policies can be a starting point for turning state ratification of international human rights treaties into plans and action. Development partners and civil society can contribute through dialogue and advocacy. In some countries, national poverty reduction strategies (PRSs) are a chance to combine the various policy objectives (for example, maternal health, gender and social equity, and public accountability) and participatory processes (public hearings and consultations, broad government-wide participation and enhanced donor co-ordination) needed to address the multiple causes of maternal deaths, and to promote the principles of human rights.

A rights perspective helps legitimise prioritising women's health. Strong **political support and national ownership** are essential to create enabling health policies, to attract resources for safe motherhood, and to ensure those resources reach groups with the highest maternal mortality.

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The case of Honduras

In the 1990s Honduras enjoyed a rapid reduction in its maternal mortality ratio, from 182 to 108 per 100,000 live births between 1992 and 1997. Interwoven factors contributing to this success were: (i) a stable political environment, (ii) strong political commitment to safe motherhood and participation in international safe motherhood for a, (iii) national technical leadership in safe motherhood programming, (iv) solid health infrastructure, and (v) power of evidence to spur the Government into action. All this put the Ministry of Health in a position to secure additional resources for safe motherhood, and to target resources and efforts to those regions with the highest maternal mortality ratios.[17]

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Looking at **health policy from a human rights perspective**, it is important to ask in whose interests policies are made, and is that policy appropriate to fulfil women's rights. Development partners can support national governments in review and revision of laws and policies by drawing on international health standards and research, and by working with civil society groups and professional associations representing the interests of women and their families. In India – unlike many other countries – only a specialist obstetrician can perform a caesarean section. Such restrictions, fuelled by the interests of politically strong doctors' associations and councils, severely limit access to life-saving care in rural and remote areas.[18] Female-dominated associations, such as the Trained Nurses Association of India, have limited power to advocate.

Issues to consider

- *Is there consensus among stakeholders on the importance of reducing maternal deaths, and if not, how can this consensus and commitment be developed?*
- *What evidence is there to link maternal mortality, women's empowerment, social inclusion and poverty? How can evidence be used to generate political commitment and support planning?*
- *Does the government's national development processes, such as the PRS, create opportunity for greater multi-sectoral commitment to reducing maternal deaths?*
- *Are there restrictive policies and practices that compromise the interests of women and their families? How can development partners support government, professional associations (especially women health workers) and civil society to remove such obstacles?*

Applying a rights perspective to strengthening health systems

Addressing inequality

A rights perspective on the supply of maternal health services focuses attention on social, economic and geographical inequalities in the provision and impact of maternal services.[19] A rights perspective helps legitimise the targeting and empowerment of excluded groups by emphasising social justice alongside public health need.

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Universal coverage and the targeting of excluded groups

The Nepal Safer Motherhood Project adopted an 'all inclusive' approach with the aim of saving the maximum number of women's lives. In 2004, a study measuring the utilisation of emergency obstetric care (EmOC) found that the principal users of services were high caste Brahmin/Chettri women. In one district, the rate of use per 1000 population was over four times greater for the higher caste women than for all other women. This has called attention to the need to target resources so that lower caste groups and Janajatis (ethnic groups) can use EmOC services at the same rate as that attained by the Brahmin/Chettri women – both to save maximum lives and to be truly inclusive.[20] The cost of providing services for the poorest and socially excluded will be higher than for the more accessible, high caste women. While this calls for difficult political choices, it may also allow informed defensible choices. It also highlights the need to monitor who benefits.

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Reallocating resources to address inequalities can be politically difficult. Human rights standards and principles can be powerful advocacy tools in supporting more equitable delivery of maternal health services. Public expenditure reviews, benefit incidence analysis and gender budgeting[21] often reveal inequitable biases in public expenditure. Budget allocations based on poverty and vulnerability measures rather than service provision norms per capita may better target resources to the most disadvantaged. For example, in Ghana, institutional deliveries are free in the three poorest regions, which also have the worst maternal mortality indicators.

A rights perspective can also help ***human resource allocation*** by highlighting:
- the distribution and make-up of human resources within the country, particularly the gender balance, and promoting fairer access to services for excluded groups; and
- the interests of professional groups and their gender and power relations within the health sector that support or conflict with increasing access to essential obstetric care (as above).

Increasing participation in planning and managing services

Strengthening the accountability of health providers to citizens can lead to more responsive services.[22] Experience shows that:
- dialogue between providers and the community on the limitations of the health system can focus public expectations and encourage the community to fill gaps;[23]
- citizen participation in planning and monitoring services can stimulate positive provider behaviour,[24] including improved attendance; and
- local community voice needs to be heard by managers with the authority to make financial and human resource decisions

Quality of care

Rights to privacy, confidentiality and sensitive care are often missing where staff and funds are very limited. Hospitals and health centres often struggle to balance increasing patient loads and stagnant resources and it is usually quality of care that suffers. Marrying a rights-based approach with action to secure more resources is vital to fulfil both clients' and providers' rights.

A rights perspective adds value by addressing the underlying social inequalities and discrimination at play between service providers and users. **Women-friendly services** tailored to the local social and cultural context increase women's confidence in the formal health system. This means:

- reducing the social and cultural differences between providers and users;[25]
- working with local allies trusted by the community to promote equitable access to skilled attendance and emergency obstetric care;[26] and
- responding to women's preferences such as female providers and women-only services.

A rights perspective also spotlights **discrimination** in the delivery of services, including discriminatory attitudes and abusive practices of health providers, both towards clients and fellow providers. Practices that deny women and their families respect and dignity also discourage their use of services, and contribute to maternal deaths.[27] Approaches to address discrimination include:

- 'appreciative inquiry' tools that empower all levels of health facility staff, regardless of social and cultural status, to work together to improve attitudes and skills;[28,29]
- quality improvement processes to set and monitor quality standards;
- integrating user satisfaction into health facility-based performance measurement;
- continuing professional development and reinforcement of medical ethics; and
- establishment of client rights and institutional mechanisms to seek redress.

Supply side initiatives such as **client rights charters** can give power to clients and define entitlements. However, unless they are widely communicated and supported by mechanisms for clients to seek fair redress, they risk being empty gestures. A human rights approach also draws attention to the **rights of providers**. Governments and non-state employers have a responsibility to provide the financial, legal, technical, managerial, and logistical support that providers need to perform their duties of providing high quality, responsive care.[30]

Monitoring and evaluation

Many maternal deaths are not counted, for example deaths at home or in facilities with poor records, and deaths due to illegal, unsafe abortion.[31] Explaining maternal deaths and 'near misses' is vital to understanding why women die and what can be done to prevent further deaths. *Beyond the numbers* is a WHO guide on methods for doing this.[32] From a rights perspective, it is also important to know whose death is counted,[33] and who is excluded from access to life-saving services. Progress reports, including those using UN process indicators and MDG5 indicators,[34] often only present aggregated data that can mask important disparities. **Disaggregated data** showing which social groups access services and resources such as user fees exemptions, and which are most at risk of maternal death can be used to address inequalities and discrimination.

Public access to this information, through official or civil society channels, can improve accountability for maternal deaths. In China, provincial governors have to report publicly on the maternal mortality ratio in their province each year, and in turn hold local officials accountable for township, county and provincial performance.

Issues to consider

- *Are maternal health services used by and accessible to all social groups? What action is being taken to reach socially excluded women and what more can be done?*
- *What constraints in the health system – financial, institutional, and human resources – affect quality of care and access to services for the excluded? What is being done or could be done in the short and long term to address these constraints?*
- *What incentives and disincentives exist for policy makers and service providers to reallocate resources to promote fairer access to services for excluded groups?*
- *What discriminatory practices affect the delivery of maternal health services and how? How can these be changed and by whom?*
- *Partnerships between providers and users can improve quality of services. What has worked in the local context? How can partnerships be strengthened or created?*
- *Do health information systems disaggregate data on maternal deaths and service access by poverty status, geography, age, ethnicity, caste, etc? What gaps in the evidence base need filling?*
- *To what extent do governments, communities and civil society (including media) use the evidence base to demand accountability for maternal deaths? What more can be done?*

Increasing women's entitlement and access

Increasing women's **knowledge of their rights**, and the knowledge of family members who make decisions about care-seeking, leads to better maternal health. Knowledge alone has varying but often limited impact on behaviour. But information introduced and reinforced in ways appropriate to the social context can lead to healthier behaviour.[35]

Social mobilisation, such as woman-to-woman peer support, personal testimonials of local people, engaging respected traditional practitioners, and building on benign traditional practices can increase the priority communities give to pregnancy and childbirth, and their sense of responsibility and obligation. It can promote women's active participation in decision-making, and increase demand for safer motherhood from women and men.[36] Including men and local leaders, the traditional holders of power, in galvanising community action can ensure women's voices are heard, and improve women's access to services.[37]

Community-managed support systems, such as transportation schemes and emergency funds, are signs of communities recognising and meeting social obligations. Such systems can reduce delays in seeking care. They can also build bridges between traditional practice and norms and formal medical care. External safeguards and resources may be needed to ensure inclusion.

Issues to consider

- *Is sufficient attention being paid to increasing demand for maternal health and to barriers to accessing services for currently excluded groups? What support systems could be strengthened or created? What local values and allies (such as women's groups and religious leaders) can be used as a starting point for discussion and support?*
- *What mechanisms currently support community action? What more could be done? Which partners are best placed to take this forward (such as village councils, women's groups)?*

- *What communication strategies exist to promote women's entitlements? Which partners are best placed to take this forward to fill any gaps (such as mass media and community-based organisations)?*
- *How can men and other local holders of power be involved in actions to increase women's entitlement and voice?*

Increasing state accountability for maternal health

Using the law to improve maternal health policy and practice

Governments that have signed and ratified international human rights treaties have undertaken to respect, protect and fulfil the rights contained in the treaties, and to introduce these into national legislation. These states also undertake to report regularly to **international treaty monitoring bodies** (TMB). However compliance could be significantly improved. '**Shadow reports**' to bodies such as the Committee for the Elimination of Discrimination Against Women (CEDAW) and the Committee on the Rights of the Child (CRC) are one way that individuals or groups can present an alternative account of state progress. TMBs issue recommendations that they require states to respond to in subsequent progress reports. Some TMBs[38] have complaints procedures for individuals or groups who have exhausted domestic channels. Decisions of TMBs help define the meaning of rights.

The right to health is included in many national constitutions as a Directive Principle of State Policy. This is not itself legally enforceable but guides policy, and is a standard for measuring government performance and for advocacy. Directive principles can be used to argue for the recognition of an individual's rights through the courts. Opportunities for promoting maternal health through **litigation** will depend on the national legal framework. In Ghana, where the right to health is a directive principle, litigation has focused on the right of the poor to user fee exemptions, which is covered in legislation, rather than the right to health, which is not. Litigation has stimulated the Ghana Health Service to develop a set of patient rights.

National laws, policies and regulatory mechanisms may support or contravene human rights standards and principles. WHO is currently working with countries on a tool to assess and strengthen laws, policies and standards on maternal and newborn health to comply with human rights.[39] WHO's mandate for technical standard-setting makes it a potentially important partner for supporting a rights-based approach to maternal health, and DFID will track this innovation.

In many instances, laws exist but are not implemented, often because they are not known about.[40] In some countries, laws related to reproductive and maternal health are major barriers to reducing maternal deaths.

The impact of abortion law on maternal mortality in Romania

Legislation can save women from unsafe abortion. Restrictive abortion laws were passed in Romania in 1966. There was a dramatic rise in maternal mortality ratios from around 80 deaths per 100,000 live births in 1964 to 180 in 1988. After the repeal of these laws in 1989 the maternal mortality ratio fell, to around 40 deaths per 100,000 live births in 1992. This fall was almost entirely due to fewer deaths from abortion.[41]

Civil society advocacy and monitoring can increase collective accountability for maternal deaths. Legal provisions for public access to information enable civil society to monitor performance of different actors.[42] Governments and development partners can also support civil society by initiating public debate on maternal health, and public participation in policy-making and programme planning. Sector-wide programmes, as in Cambodia, can include meaningful citizen participation during sector reviews and bring civil society into policy level decision-making.

Institutional reform processes that strengthen public accountability, transparency, and participation in governance, may be vehicles for broadening responsibility for maternal health.

Decentralisation in Nepal

In Nepal, the Local Self Governance Act (2002) created local governance structures that were harnessed to support safer motherhood through: enlisting district administrators onto safe motherhood coordination committees, linking those committees to the new governance structures, and building relationships with emerging district leaders.[43] Decentralisation also improved collaboration across line ministries and encouraged district development financing of safe motherhood activities from outside the health line ministry budget.

Issues to consider

- *Which formal laws do or could promote maternal health? These may include age of marriage, reproductive health legislation, law relating to gender violence, anti-discrimination law, and also provision of available and accessible quality health care.*
- *Is the country a party to the relevant human rights conventions? Are there any reservations that make ratification meaningless? How can development agencies support civil society advocacy efforts to promote ratification, and support government to ratify and remove reservations (for instance, harness national technical expertise to strengthen the legal framework).*
- *Does the country fulfil its reporting obligations? How can reporting be improved and how can practice respond to the formal observations and comments made by UN human rights bodies?*
- *Which legal processes are effective: litigation, complaints to treaty bodies, parliamentary and public advocacy, Human Rights Commissions or health service commissions?*
- *How can customary laws of local leaders be used to promote women's rights?*
- *How can civil society (including media) information dissemination, monitoring and advocacy be supported to improve implementation?*
- *How can governance structures and processes be used to mobilise elected politicians, officials and civil society representatives to take action on maternal health, and used to broaden responsibility for maternal health beyond the health line ministry?*

Integrating a rights perspective into aid instruments

The optimal mix of aid instruments for integrating a rights perspective to maternal health will need to facilitate engagement with both government and civil society.[44] For example:
- investment of time in informal dialogue about maternal health rights, policy and practice;

- budget support that includes incentives to promote rights principles within national priorities on maternal health;
- funds to support civil society for policy advocacy and monitoring, social mobilisation, and promoting accountability for maternal deaths;
- multi-donor funded projects that carry more weight in applying human rights principles and standards than single-donor funded ones; and
- promoting the use of disaggregated maternal mortality related indicators to track progress and performance of aid instruments.

Multi-donor budget support in Ghana

The Ghana Poverty Reduction Strategy (PRS) framework, supported by multi-donor budget support (MDBS), brings together institutional and governance reforms and pro-poor health sector objectives, which is conducive to discussing rights and accountability and safe motherhood services. The policy-matrix has a strong emphasis throughout on reaching the poor. The specific target to expand maternity exemptions to the districts with the highest maternal mortality rates is reinforced by broader targets that promote an equitable, inclusive health system.

Issues to consider

- *What mix of aid instruments do or could allow development partners to support both governments and civil society in the reduction of maternal deaths?*
- *What aid instruments permit support to civil society advocacy and 'watch-dog' initiatives for more responsive services? Are they well used for this or is other support needed?*
- *If budget support is an option, what government actions for reducing maternal mortality are used or can be used for measuring performance? How do or can performance measures reflect a rights perspective, such as by disaggregating data to track equity?*
- *How can PRSs be used to link poverty reduction policy with parallel country-owned processes to implement human rights obligations, such as CEDAW, and agreements made at Cairo and Beijing?*

Conclusion

For any organisation, a move to and sustaining a rights-based focus requires strong internal commitment and long-term vision. To continue learning how a rights-based approach can reduce maternal deaths, we need to document the stories, evaluate the evidence and improve our practice. We need to do this with national governments, civil society organisations, UN agencies, WHO, and other development partners. To discuss this paper and how DFID can meet its commitments **contact Reproductive and Child Health Team, Policy Division,** RCH@dfid.gov.uk. This note is also at http://www.dfid.gov.uk/pubs/maternal-how.pdf

Notes and references

Background on maternal health

[1] *Reducing maternal deaths: Evidence and action*, 2004, DFID, http://www.dfid.gov.uk/pubs/files/reducmaternaldeath.pdf. See also DFID's *Sexual and reproductive health and rights* position paper, 2004, http://www.dfid.gov.uk/pubs/files/sexualreprohealthrights.pdf

[2] MDG5: To improve maternal health. Target: reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio. http://millenniumindicators.un.org/unsd/mi/mi_goals.asp

[3] *Developing a Human Rights-Based Approach to Addressing Maternal Mortality – Desk Review*, 2004, Kirstan Hawkins, Karen Newman, Deborah Thomas, Cindy Carlson. DFID Health Resource Centre. http://www.dfid.gov.uk/pubs/maternal-desk.pdf

[4] Freedman, L. et al., 2005, *Who's Got the Power? Transforming Health Systems for Women and Children*. UN Millennium Project Task Force on Child Health and Maternal Health. http://unmp.forumone.com/eng_html_02.html

Background on human rights-based approaches and human rights

[5] Jonsson, Urban, 25 June 2004, *Draft – A Human Rights Based Approach to Programming*, UNICEF. See further discussion of the difference between needs-based and rights-based approaches in Desk Review. See also Participatory Rights Assessment Methodologies: http://www.swan.ac.uk/cds/research/PRAMS.htm

[6] See also *DFID Human Rights Review: a review of how DFID has integrated human rights into its work,* Piron, L. and Watkins, F., ODI, July 2004, http://www.odi.org.uk/PPPG/publications/papers_reports/dfid/issues/rights01/DFIDRightsReview07.04.pdf

[7] See Annex 2 in the Desk Review for a list of key human rights standards relevant to maternal health.

[8] For a fuller discussion see Cook, Rebecca et al. 2001. 'Advancing Safe Motherhood through Human Rights', WHO: Geneva, http://www.who.int/reproductive-health/publications/RHR_01_5_advancing_safe_motherhood/RHR_01_05_table_of_contents_en.html

[9] International Covenant on Civil and Political Rights, Article 6(1), http://www.unhchr.ch/html/menu3/b/a_ccpr.htm

[10] International Covenant on Economic, Social and Cultural Rights, Article 12, http://www.unhchr.ch/html/menu3/b/a_cescr.htm

[11] International Covenant on Civil and Political Rights, Article 17(1), http://www.unhchr.ch/html/menu3/b/a_ccpr.htm

[12] CEDAW http://www.un.org/womenwatch/daw/cedaw/

[13] See note 5.

[14] For a fuller discussion of human rights principles see Desk Review and *Realising Human Rights for Poor People*, 2000, DFID Target Strategy Paper, http://www.dfid.gov.uk/pubs/files/tsphuman.pdf

[15] See Annex 4 in the Desk Review for fuller discussion on the concept of progressive realisation.

[16] See Box 5 'Rights-based Approaches to FGC/M' in Desk Review for more on using the 'rights' language.

Strengthening policy and political support for maternal health

[17] Koblinsky, M., 2003, *Reducing Maternal Mortality.* Washington DC: World Bank, http://www-wds.worldbank.org/servlet/WDSContentServer/WDSP/IB/2003/06/06/000094946_0305280402518/Rendered/PDF/multi0page.pdf. See also Box 8 'Rapid reduction of maternal mortality rates in Honduras' in Desk Review.

[18] Mavalankar, D.V., undated, 'Policy Barriers Preventing Access to Emergency Obstetric Care in Rural India', Indian Institute of Management, Ahmedabad, http://www.iimahd.ernet.in/publications/data/2001-11-02Mavalankar.pdf

Applying a rights perspectives to strengthening health systems

[19] International evidence has shown the relationship between poverty status and increased maternal mortality.

[20] Nepal Safer Motherhood Project and Institute of Medicine, Nepal, 'Will a social justice approach to safe motherhood also meet the public health objective of maximising lives saved?' November 2004.

[21] See Desk Review.

[22] *Making Services Work for Poor People.* World Bank World Development Report, 2004, http://econ.worldbank.org/wdr/wdr2004/text-30023/

[23] Naripokkho, 2003, *Ensuring Accountability of the Local Health Authorities and Health Service Providers to People, Specially Women in Bangladesh*. Dhaka, http://www.iued.unige.ch/information/publications/pdf/yp_9pouvoirs-r.sengupta.pdf

[24] Thomas, D, A.H. Sarker, H. Khondker, Z. Ahmed and M. Hossain, 2003, *Citizen Participation and Voice in the Health Sector in Bangladesh*, Report to DFID and Bangladesh Ministry of Health, London: Options and Dhaka:

Partners in Health and Development,
http://www.lcgbangladesh.org/HealthandPopulation/reports/Final%20report.doc

[25] Deborah Thomas, Don Messerschmidt, Liesl Messerschmidt KC, *Increasing Access to Essential Obstetric Care. A Review*, 2004, Nepal Safer Motherhood Project, Options/DFID,
http://www.nsmp.org/increasing_access/index.html

[26] Countries such as Malaysia that have successfully moved from the use of traditional birth attendants to skilled birth attendants (SBAs) sought to include TBAs as partners and allies in the process, and constructively used their social status and relationships in the community to promote the use of SBAs.

[27] See Box 11 'Health Workers for Change in South Africa' in Desk Review.

[28] See for example: Bushe, G.R. (1998) Appreciative inquiry with teams. *Organization Development Journal,* 16:3, 41-50. Bushe, G.R. (1995) Advances in appreciative inquiry as an organizational development intervention. *Organization Development Journal,* 13:3, 14-22, http://www.gervasebushe.ca/aiteams.htm.

[29] Hodgson, R., K. Badu, C. Kati and M. Parajuli, 2003, *'Artistry of the Invisible' – Evaluation of 'Foundation for Change': A Change Management Process*, Kathmandu: Nepal Safe Motherhood Project, http://www.nsmp.org/pdf/Artistry-of-the-Invisible--Evaluation-of-Foundation-for-Chan.pdf.

[30] See Box 12 'Patients' Charter and Providers' Code of Ethics in Ghana' in Desk Review.

[31] See Desk Review for further discussion.

[32] WHO, 2004, Beyond the Numbers. Reviewing maternal deaths and complications to make pregnancy safer. Geneva. http://www.who.int/reproductive-health/publications/btn/btn.pdf

[33] Graham, W. and Hussain, J. The Right to Count. *The Lancet* 363 (9402): 67-68, http://pdf.thelancet.com/pdfdownload?uid=llan.363.9402.editorial_and_review.28253.1&x=x.pdf.

[34] See Desk Review, Annex 1, section 3 for UN process indicators. See note 2 for MDG5 indicators.

Increasing women's entitlement and access

[35] See Desk Review.

[36] CEDPA, 2003, *Igniting Change! Accelerating Collective Action for Reproductive Health and Safe Motherhood*, Baltimore: The Enable Project, http://www.dec.org/pdf_docs/PNACW636.pdf

[37] See Box 4 'Key Informant Monitoring and Community Change Agents' box in Desk Review.

Increasing accountability

[38] Such as CEDAW, http://www.un.org/womenwatch/daw/cedaw/, International Convention on the Elimination of All Forms of Racial Discrimination, http://www.unhchr.ch/html/menu3/b/d_icerd.htm, and regional human rights charters and conventions.

[39] See Desk Review for further details. And http://www.who.int/reproductive-health/

[40] For example, widespread misconception of the abortion law in Ghana amongst health providers and the public keeps abortion services clandestine, which in turn encourages unsafe practices. See Desk Review for more details.

[41] See World Bank (1993) World Development Report: Investing in Health, http://www-wds.worldbank.org/servlet/WDSContentServer/WDSP/IB/1993/06/01/000009265_3970716142319/Rendered/PDF/multi0page.pdf

[42] See Box 9 'SEND tracking of HIPC funds, Ghana' in Desk Review.

[43] Whiteside, G., 2003, *Partnership Review of NSMP's Increasing Access Component,* Kathmandu: NSMP, http://www.nsmp.org/pdf/Partnership-Review-NSMP.pdf.

Aid instruments

[44] See note 5.