

International

Empowerment through Education: Recommendations for the Integration of a Human Rights Based Approach to CIDA's MNCH Strategy

Kieran Bergmann and Emma Kenyon

At the G8 Summit in Muskoka, Canada in June 2010, Prime Minister Stephen Harper announced the Canadian government's desire to lead a global effort to reduce maternal and infant mortality and improve the health of mothers worldwide. To date, however, the Millennium Development Goals relating to maternal, newborn and child health (MNCH) remain far from being realized. In an effort to rectify this situation, this paper recommends integrating a human rights based approach to the Canadian International Development Agency's maternal, newborn and child health strategy. In particular, it will propose including education as a fourth pillar in the strategy, updating the requirements for data collection and monitoring and developing a broader set of indicators for tracking progress on maternal and child health. Doing so will not only improve the effectiveness of Canada's MNCH strategy, but will have far reaching implications for the social, economic and political status of the most marginalized women in the world.

Introduction

More than 500,000 women die each year due to complications of pregnancy and childbirth, and millions more suffer from injuries, infections, diseases and disabilities (Khan 2009, 123). As reflected in the Millennium Development Goals and various global and international commitments, the international community has made improving maternal and child health a key priority. The Canadian Government, with the Canadian International Development Agency (CIDA) at the forefront, has taken a leadership role on this issue, announcing the Muskoka Initiative at the G8 Summit in June 2010 and co-chairing the Commission on Information and Accountability for Women's and Children's Health. CIDA's maternal, newborn and child health (MNCH) strategy, however, has not sufficiently addressed key human rights issues—including gender discrimination, women's low socio-economic status,

Kieran Bergmann and Emma Kenyon recently earned their Master's degrees in Public and International Affairs from the University of Ottawa. Kieran is a Policy Research Analyst at Cancer Care Ontario and the 2012 Google Policy Fellow at the Citizen Lab, Munk School of Global Affairs, University of Toronto. Emma is a Policy Analyst at the Correctional Service of Canada.

the denial of sexual and reproductive rights, a lack of decision-making power, and early marriage and pregnancy—that greatly contribute to these preventable deaths. This paper will propose the integration of a more explicit human rights orientation within CIDA's MNCH strategy, and will make specific recommendations on how to better apply human rights principles to CIDA's programming in this sector.

Context

CIDA's MNCH strategy focuses on three paths: i) supporting national plans and priorities regarding MNCH; ii) filling gaps in health systems (for example, by training more health workers, increasing access to health facilities, ensuring health facilities and personnel are sufficiently equipped, and implementing monitoring and evaluation mechanisms); and iii) expanding access to services (CIDA 2012). These paths primarily address the supply needs of MNCH and not important human rights considerations despite substantial evidence that such considerations are crucial to improving maternal health.

In June 2009, the United Nations Human Rights Council issued resolution 11/8, which states that there are a wide range of human rights directly implicated by maternal mortality, namely: the right to life; to be equal in dignity; to education; to be free to seek, receive and impart information; to enjoy the benefits of scientific progress; to freedom from discrimination; and to enjoy the highest attainable standard of physical and mental health including sexual and reproductive health (Human Rights Council 2009). These rights are enshrined in various international and regional human rights treaties including the International Covenant on Civil and Political Rights; the International Covenant on Economic, Social and Cultural Rights; and the Convention on the Elimination of All forms of Discrimination against Women. Parties to these treaties have a duty to respect and ensure that their population can enjoy their rights regarding MNCH. As a party to those treaties, Canada also has an obligation to take effective measures to reduce maternal mortality rates and improve maternal health in countries receiving official development assistance (Human Rights Council 2010, 6).

The case for a human rights based approach

The use of a human rights based approach for MNCH would enable CIDA's interventions to contribute to more sustainable long-term results, and to increase the adoption of MNCH related human rights by local populations. The seven core principles of the human rights based approach are equality and non-discrimination, empowerment, participation, transparency, sustainability, international cooperation and accountability (Human Rights Council 2011, 4). CIDA's MNCH strategy has already integrated some of these principles, but would benefit from a more systematic integration of the first three principles (equality and non-discrimination, empowerment and participation). The inclusion of these principles in CIDA's strategy could have a multiplier effect on MNCH and other related issues as well.

The rates of maternal and child death and disability in CIDA's ten countries of focus for MNCH¹ are often highest in the most marginalized and vulnerable communities (Kuruvilla et al. 2012, 153). Evidence suggests that maternal mortality is primarily a result of gender inequality, discrimination, health inequity and governments' failure to guarantee women's human rights (IIMMHR 2010, 6). The principles of equality and non-discrimination are fundamental elements of the right to health (Hunt and Bueno de Mesquita 2010, 11). The systematic integration of equality and non-discrimination in MNCH programming would enable CIDA to focus its interventions on the groups that are most at risk of maternal mortality and to better identify the gaps in protection, participation and accountability that they are facing (Ibid.). In addition, the inclusion of these principles in the design of CIDA's MNCH programs would ensure it targets the social, economic and political barriers to women's wellbeing in its programming (Kuruvilla et al. 2012, 160). For example, instead of only providing family planning, commodities, and essential medicines, the use of a human rights based approach would also address the specific reasons behind the inability of certain groups of women to gain access to these services.

The integration of gender equality and women's empowerment into CIDA's programming would allow its interventions to take into consideration the broader social context and determinants of MNCH instead of only focusing on very specific and technical goals (for example, the number of doctors per capita). Health systems are more than just mechanical structures delivering services to the population; they are also core social institutions (Kuruvilla et al. 2012, 156). In certain contexts, increasing the number of health workers will not necessarily help to reduce maternal and child mortality if women's rights to access sexual and reproductive health information and services are not also integrated into health systems (Human Rights Council 2011, 7). While improving the quality of health care systems, CIDA should also develop programs that will contribute to gender equality and women's empowerment across all sectors (DFID 2010, 21). Gender equality and women's empowerment often contribute to greater demand by women for family planning services, antenatal care and safe delivery, and to women's freedom to choose whether, when and how many children to have, and to enjoy a healthy sex life (Kuruvilla et al. 2012, 157). Finally, the empowerment of women can encourage them to participate in locally driven activities to change "accepted" social practices including physical and sexual violence in the home (DFID 2010, 22).

Participation in the context of MNCH means granting women access to relevant information and including them in the decision-making process. The Special Rapporteur on the right to health has noted that "in the context of reducing maternal mortality and morbidity, the right to health includes an entitlement to participate in health policymaking ... [because this] will help develop more effective and sustainable programmes, reduce exclusion and

1. Afghanistan, Bangladesh, Ethiopia, Haiti, Malawi, Mali, Mozambique, Nigeria, Sudan and Tanzania

enhance accountability” (Human Rights Council 2010, 15). CIDA’s programming should therefore aim at increasing the participation of women and adolescent girls, especially those living in poverty, in health policymaking at the local, national and international levels. In order to do so, it is important to first place the emphasis on women and adolescent girls’ participation and on marginalized communities in general (Yamin 2009, 13). To counter the problem of community “consensus” when organizing consultation sessions or group activities, CIDA must determine who represents the women in the community and if there are power dynamics shaping who is invited to participate (Hunt and Buena de Mesquita 2010, 12). CIDA should also ensure that women have a voice when they are participating. For example, some important issues will not be raised at the community level because they are taboo or because men will take the lead in the discussions. Often it is not a problem to raise the issue of maternal mortality or morbidity, but rather to talk about important practices such as abortion.

Education: A fourth path

In order to better integrate the three human rights principles noted above, and the human rights based approach in general, CIDA should consider adding education as a fourth path to its MNCH strategy. Doing so could bolster CIDA’s current technical- and service-focused strategy. Education offers concrete and measurable results in the field of maternal health, including: lower rates of adolescent pregnancy; increased prenatal visits with a skilled health practitioner; higher rates of contraceptive use; smaller families; and the adoption of similar safe sexual and reproductive practices by the next generation (The Economist, 2009).

The ability of girls and women to access education is increasingly the centrepiece of female empowerment initiatives, which aim to increase female participation in the workforce and in politics, thus enabling women to have their voices heard on a range of issues in public and private forums. Initiatives that facilitate women’s access to stable employment and competitive wages, participation in political decision-making, and an equal voice in household decisions increasingly include an education component (Cueva Beteta 2006, 228-230). It is widely recognized that girls’ education promotes safe sexual practices and can delay motherhood from adolescence to adulthood (Murphy and Carr 2007, 2). This has important consequences for the number of mothers and newborns at risk of serious medical complications and death, and can therefore drastically improve development when integrated into strategies like Canada’s MNCH initiative.

Simply keeping girls in school longer delays motherhood by several years. Adolescent pregnancy increases the risks of medical complications, due in part to the continuing physical development of adolescents, as well as the resistance of many adolescents to visit a skilled health practitioner. Newborn mortality rates are twice as high for adolescent mothers than for adult mothers, and while adolescent pregnancies constitute just 11% of

pregnancies worldwide, 95% of adolescent pregnancies occur in developing countries (World Health Organization 2009). While many of the complications that arise during adolescent pregnancy are treatable, and will be addressed in the current MNCH strategy, the fact remains that adolescent pregnancy is itself preventable. When girls remain in school long enough to receive a primary education, pregnancy is delayed, often by years (Murphy and Carr 2007, 2). Moreover, contraceptive use among adolescents and women with a secondary education increases fourfold, pregnancy is delayed until adulthood and is more likely to be the result of family planning. Where women have little or no education, and this is particularly true among rural women, there has been no increase in contraceptive use (Ibid.).

Adolescence is a key risk factor in maternal and newborn health, and adolescent pregnancies could be reduced through an effective MNCH education strategy. According to the Millennium Development Goals 2010 Report, the regions with some of the highest rates of adolescent pregnancy were largely successful in their efforts to reduce these rates between 1990 and 2000, coinciding with efforts to ensure more girls entered and remained in school. Since 2000, rates of adolescent pregnancy have either slowed or increased, again coinciding with similar negative movements in girls' primary education (United Nations 2010, 20-34).

Education delivers long-term positive effects in the field of women's health. As a preventive tool, education is particularly successful among girls and women as it empowers them to make choices about their reproductive future and to cultivate identities outside of the household and motherhood. Women with basic education not only delay motherhood, but they also limit the size of their families (Hadden and London 1996, 39).

Sexual and reproductive education

Girls' education is a promising tool in efforts to promote maternal health. Sexual and reproductive health education can yield even better results. A 2010 study by the University of Washington found that nearly one in five maternal deaths was related to HIV (Institute for Health Metrics and Evaluation 2010). Education about sexually transmitted infections (STIs), preventable diseases, antenatal nutrition, and postpartum care is known to reduce deaths among women and children. Studies in Canada have shown that sex education, combined with the provision of better access to contraceptives, can cause a significant decrease in adolescent pregnancies (McKay 2004, 70). Increasingly, experts are advocating for sex and reproductive education to begin in primary school.

Women and girls who are able to seek and receive a basic sexual and reproductive education can make choices to safeguard their health and the health of their families. For example, education about the spacing and timing of birth can contribute to safer reproductive practices. USAID considers spacing and timing to be essential maternal health

interventions: “Short birth-to-pregnancy intervals are associated with significant increased risk of neonatal, infant, child and under-five mortality; low birthweight and preterm births; infant/child malnutrition in some populations; and stillbirths, miscarriages, and maternal morbidity” (USAID 2012). Empowering women to participate in important family-planning decisions by educating them on issues such as the dangers of short birth-to-pregnancy intervals, will enable women to better control the outcomes of family planning discussions with their partners. Without this education, women are less likely to argue in favour of their own health and the health of their babies.

Sexual health education initiatives may also bridge the communication divide between pregnant adolescents and health providers. Long-term sexual health education can destigmatize the field of women’s health and forge personal, community-level relationships between health practitioners and girls and women (Sen and Ostlin 2007, 93). An education-focused MNCH strategy could reduce the stigma and provide an incentive for girls and women to take care of their sexual and reproductive health.

Empowerment through education: Effects on reproductive health

Women who are educated on their basic health and reproductive rights can demand access to the tools that make them safe, potentially prompting changes to health policy, service access, and a re-orientation of government positions on women’s health.

When women’s status is low, families are large and overall family health decreases. According to the United Nations Population Fund, “reproductive health programmes are more effective when they address the educational opportunities, status and empowerment of women. When women are empowered, whole families benefit, and these benefits often have ripple effects to future generations” (United Nations Population Fund). Education-based female empowerment initiatives can have ripple effects throughout society. For example, girls’ education results in increased participation of women in the health sector and a greater emphasis on women’s healthcare training. Gender sensitivity training programs have strengthened women-centred health provisions in several communities throughout developing countries, such as in India, Pakistan and Bolivia (Sen and Ostlin 2007, 73). In addition, women with a basic knowledge of their health rights can demand increased accountability from their health care providers. Community women’s groups in Bangladesh and Peru have successfully lobbied hospitals and local governments for larger supplies of contraceptives, more doctors and increased accountability of doctor performance (Ibid., 76).

Education enables girls and women to enter and participate in the political sphere, which in turn leads to an increased awareness of and emphasis on women’s issues. Female parliamentarians in Africa and Asia have established continent-wide committees and developed agreements to address women’s empowerment and reproductive issues in their

home countries (World Health Organization 2007, 4). Education enables women to make maternal health and women's health issues a policy focus at the household, community and national level.

In order to improve maternal and child health and ensure that reduced rates of mortality and injury amongst mothers and expectant mothers are sustained, countries must take an integrated approach that addresses not just the programming and delivery of health services, but of education as well. The improvement of maternal and child health is inextricably linked to the promotion of and access to education, and CIDA's efforts to address MNCH must be as well. A focus on the right to education in developing countries, and specifically the right of girls and women to basic education, has a measurable effect on the reduction of early and unplanned pregnancy. Sexual and reproductive health education bolsters this effect, and also reduces preventable complications that result from STIs, medical issues and pregnancy spacing.

Recommendations

The following are specific recommendations for the inclusion of a human rights based approach to CIDA's MNCH strategy.

1. Include education as a fourth path to CIDA's MNCH initiative.

CIDA should promote universal access to education within its MNCH initiative, especially education for girls and women. In its programming, CIDA should include measures to help its countries of focus review and update school curriculum to ensure the inclusion of MNCH and sexual and reproductive health education. Within the Strategic Policy and Performance Branch, the MNCH Team should collaborate with the Education Team to update the MNCH strategy to include the fourth path of education, and should work closely together in the future to ensure effective implementation.

2. Update requirements for data collection and monitoring within the MNCH strategy.

The MNCH Team should work with various thematic sectors to promote better monitoring and data collection by countries of focus. Information on maternal and child mortality remains inaccurate and incomplete in many countries around the world. Many governments fail to properly record births, deaths or disability, or the causes of death and disability, inside and outside of health facilities (Khan 2009, 142). In addition, the information that is available is often not sufficiently disaggregated to illustrate the impact of poverty, geographic location, race, ethnicity or age on maternal health. While the Commission on Information and Accountability for Women's and Children's Health (2012) has stressed the importance of strengthening countries' capacity to monitor progress, to establish a system for registration of births, deaths and causes of death, and to have a well-functioning health information

systems that combine data from facilities, administrative sources and surveys, it does not require that data collected be disaggregated. It is therefore likely that efforts to reduce the incidence of maternal mortality and disability will not take into account the unique realities of these different groups of women and will continue to be improperly targeted. Promoting the collection of disaggregated data by countries of focus will allow CIDA to effectively monitor changes in rates of maternal mortality that are likely to have been impacted by empowerment and education initiatives.

3. Include a broader list of indicators for tracking progress on maternal and child health.

In order to successfully tackle maternal health, the range of indicators must be broadened to include those which address the goals of equity and human rights.² First and foremost, education indicators should be included as these contribute to the improvement of other determinants of maternal health. Education indicators include net enrolment in primary and secondary education, the proportion of students who finish primary and secondary school, and the proportion of students receiving sexual education (United Nations 2008). These indicators should be disaggregated by gender, ethnicity, socio-economic status and geographic location.

A range of other indicators should also be included as they promote gender equality, non-discrimination and women's empowerment, which are key to improving maternal health. These include: the proportion of women in paid employment; the percentage of seats in national parliaments held by women; the prevalence of early and forced marriage, female genital mutilation and violence against women, including sexual violence; and the use of contraception. Where appropriate, all indicators should be disaggregated by socio-economic status, geographic location, race, ethnicity and age.

Conclusion

The benefits of mainstreaming gender and integrating a human rights approach into CIDA's MNCH strategy will be far-reaching. CIDA will be able to have a greater impact on maternal and child health and will also see an improvement in women's social, economic and political positions which will, in turn, benefit families and communities exponentially. Based on the evidence provided in this paper, CIDA should include education as a fourth path to its MNCH strategy, improve its requirements for monitoring and data collection, and adopt an updated list of indicators that go beyond the health sector. Doing so will address the root causes of maternal and child mortality and disability and ensure solutions are more targeted and therefore more effective.

2. CIDA's MNCH strategy recommends that countries use two indicators to track their progress in maternal and child health: i) total health expenditure by financing source, per capita; ii) total reproductive, maternal, newborn and child health expenditure by financing source, per capita.

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