

# Summary Reflection Guide on a Human Rights-Based Approach to Health

*Application to sexual and reproductive  
health, maternal health and under-5 child health*

# HEALTH WORKERS



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# INTRODUCTION

Health workers<sup>1</sup> have a critical role to play in preventing maternal and child mortality and morbidity, and in assisting health system users to enjoy their human rights. In fulfilling this role, an essential starting point is the recognition that patterns of maternal and child mortality and morbidity are not inevitable: they are the result of indifference, discriminatory laws and practices, and institutional arrangements that compound poverty and inequalities, which are fundamental issues of rights and justice.





## INTENTION OF THIS GUIDE

This quick reference guide is intended to contribute to the efforts of health workers to effectively and meaningfully implement a human rights-based approach (HRBA) to sexual and reproductive health, maternal health<sup>2</sup> and under-5 child health.<sup>3</sup> It complements other tools and builds from the two technical guidance documents of the Office of the High Commissioner for Human Rights on a human rights-based approach to the reduction of preventable maternal mortality and morbidity and under-5 mortality and morbidity,<sup>4</sup> which were both welcomed by the United Nations Human Rights Council.

## WHAT IS A HUMAN-RIGHTS BASED APPROACH?

An HRBA identifies who has rights (rights-holders) and what freedoms and entitlements they have under international human rights law, as well as the obligations of those responsible for making sure rights-holders are enjoying their rights (duty-bearers). An HRBA empowers rights-holders to claim their rights, and encourages duty-bearers to meet their obligations. Importantly, an HRBA recognizes that health workers have responsibilities to uphold human rights as duty-bearers, but also are entitled to have their rights respected as rights-holders. Promotion of accountability for meeting obligations is continuous in an HRBA; the “circle of accountability”<sup>5</sup> throughout the policy cycle helps to ensure that policies and programs are responsive to the needs of rights-holders, including health system users. In its simplest terms, accountability ensures that those charged with

protecting and fulfilling health rights actually meet these obligations at different points in the policy cycle, and if they do not or cannot, mechanisms exist both to lodge and receive a response to a complaint.

In addition to accountability, an HRBA also analyzes a policy cycle through a framework of human rights principles of equality and non-discrimination, participation, indivisibility, and the rule of law<sup>6</sup>, as well as the “AAAQ” framework, which identifies availability, accessibility, acceptability and quality of health-care facilities, goods and services as essential components of the right to health. In the case of children, an HRBA also requires that “best interests of the child”<sup>7</sup> is a primary consideration in the design and implementation of policies which will affect children. Applying an HRBA is complementary to adhering to standards of medical ethics.

## PURPOSE OF THIS GUIDE

The purpose of this guide is to support health workers in applying an HRBA and to offer reflective questions to assist actions to protect the rights of women and children, starting with interactions between the provider and the health system user, through facility, district and national levels. It is one of a series of reflection guides targeted to specific stakeholder groups.

In building on the two technical guidance documents, this guide uses reflective questions to stimulate group discussion on the application of an HRBA to sexual and reproductive health, maternal health, and under-5 child health.



It is essential that this group reflection includes frank and open discussion of what problems are happening to whom and where; why they are happening; and who or what institution is responsible for taking action. It is equally essential that corrective (remedial) actions based upon the diagnoses then be taken, because if they are not, it is not a meaningful HRBA, or accountability for the fulfillment of rights. As contexts vary dramatically, the questions in this document are illustrative only; they are not meant to be a comprehensive guide. Nor are they meant to be a checklist, as checklists do not always capture the actual practice of health workers.

Meaningful change requires both technical knowledge and capacity regarding an HRBA to health. But overcoming political and organizational obstacles to change also requires collective deliberation on the part of health workers regarding their roles in protecting and promoting the rights and health of women and children and how to overcome the obstacles that these individuals face. The following questions are meant to be used as points of departure for those ongoing conversations and reflections, and to spur collective deliberation on necessary changes in policy and practice that will lead to effective implementation and measurement of an HRBA.

## SCOPE AND ORGANIZATION OF THIS GUIDE

The guide is organized in 3 sections which correspond to the levels of health care:

**1 Service provision** – a health worker’s direct interactions with health system users and their families, as well as facility level arrangements.

**2 Local/District level** – implementation of national policies, budgeting and management for local health service delivery.

**3 Linking health workers and the national level** – laws, policies and guidelines, and plans of action, that support or impede human rights.

Under each section, there are three types of questions/comments.

## CONSIDER

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*This is a question designed to trigger reflection on various aspects of an HRBA.*

## FOR EXAMPLE

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*This is an example to illustrate some of the various elements that one might consider in addressing the question at hand.*

## HRBA REFLECTION

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*This is an insight into why this issue matters from a human rights perspective.*



The guide covers sexual and reproductive health, maternal health and under-5 child health, in line with the continuum of care. In particular, maternal health is understood within the broader framework of sexual and reproductive health, and requires attention not only to women, but also to adolescents. While under-5 child health can be closely linked to maternal health, it also requires explicit attention to child rights. Applying an HRBA to health will sometimes require similar actions in sexual, reproductive and maternal health, and under-5 child health respectively, and will sometimes require explicit attention to the particularities of women's rights or children's rights. Where appropriate, this guide provides separate considerations and examples on sexual, reproductive and maternal health, and under-5 child health, in order to highlight where different dimensions will need to be factored in. These are identified by pictograms.



As an accompaniment to this guide, a list of resources is also available, with additional materials on an HRBA.

## ACKNOWLEDGEMENTS

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## PHOTO CREDITS

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## NOTES

- 1 Health workers are “all people engaged in actions whose primary intent is to enhance health.” World Health Organization, *World Health Report*, p. 1 (2006). This includes physicians, nurses and midwives, but also laboratory technicians, public health professionals, community health workers, pharmacists, and all other support workers whose main function relates to delivering preventive, promotive or curative health services. This Reflection Guide is primarily intended for those health workers interacting directly with health service users to advise on or deliver preventive, promotive or curative health services.
- 2 Center for Reproductive Rights and United Nations Population Fund, *Reproductive Rights: A Tool for Monitoring State Obligations Law* (2013); Harvard School of Public Health and United Nations Population Fund, *A Human Rights-Based Approach to Programming* (2010); Office of the United Nations High Commissioner for Human Rights, *Human Rights in Budget Monitoring, Analysis and Advocacy Training Guide* (2011); International Initiative on Maternal Mortality and Human Rights, *A Framework on Applying Human Rights-Based Approaches to Maternal Mortality and Morbidity* (2014).
- 3 Committee on the Rights of the Child, General Comment No. 15 on the right of the child to the enjoyment of the highest attainable standard of health (art. 24) (2013); International Institute For Child Rights and Development, *CREED-PRO Child Rights Curriculum for Health Professionals* (2008).
- 4 Technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality, UN Doc. A/HRC/21/22 (2012); Technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce and eliminate preventable mortality and morbidity of children under 5 years of age, UN Doc. A/HRC/27/31 (2014).
- 5 Alicia Ely Yamin, Toward Transformative Accountability: A Proposal for Rights-based Approaches to Fulfilling Maternal Health Obligations, *Sur: An International Journal* 7(12): 95-122 (2010); Alicia Ely Yamin and Rebecca Cantor, Between Insurrectional Discourse and Technical Guidance: Challenges and Dilemmas in Operationalizing Human Rights-based Approaches in Relation to Sexual and Reproductive Health, *Journal of Human Rights Practice* 6(3): 451-485 (2014); Alicia Ely Yamin, Applying Human Rights to Maternal Health: UN Technical Guidance on Rights-based Approaches, *International Journal of Gynecology and Obstetrics* 121(2): 190-193 (2013).
- 6 United Nations Development Group, *The Human Rights Based Approach to Development Cooperation: Towards a Common Understanding Among UN Agencies* (2003).
- 7 States are urged to place children’s best interests at the center of all decisions affecting their health and development. The best interest of the child is based on their physical, emotional, social and educational needs, age, sex, relationship with parents/guardians, and their family and social background. See Committee on the Rights of the Child, General Comment No. 15 on the right of the child to the enjoyment of the highest attainable standard of health (art. 24) (2013).





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# SERVICE PROVISION

Identifying problems, and who is responsible for resolving them (duty-bearer), is necessary for effective realization of rights and accountability.

**YOU, AS HEALTH WORKERS**, play an important role in creating environments conducive to the realization of rights for women and children. You can do this through your own actions as well as by identifying obstacles to the enjoyment of rights at the facility or other levels. Establishing professional accountability and respecting medical ethics ensures quality of care and prevents negligence, abuse and malpractice. Equally, monitoring and evaluation of what is actually going on in a health facility, including treatment of health workers and respect for their human rights (e.g., working conditions), is essential to correcting systemic failures and creating a responsive health system that contributes to the enjoyment of human rights.

## CONSIDER

### COMMUNICATING WITH HEALTH SYSTEM USERS

*Health workers should treat health system users with respect and dignity, and adopt a people-centered care approach. This means that health system users should be treated courteously in a way that respects and protects their rights and autonomy. Similarly, the parent(s)/guardian(s) of children should be treated with dignity.*

## FOR EXAMPLE

### INTRODUCTIONS AND EXPLAINING COMPLEX ISSUES

How do you greet people when you first meet them, and when you see them afterwards? Do you wear a name tag that clearly displays your name and title? Do you introduce yourself to health system users, children and their parent(s)/guardian(s), as they may not be able to read?

How do you communicate sensitive or complex information with health system users, including those who may have different literacy levels or language knowledge? For instance, about diagnoses, or procedures. How do you address adolescents seeking sexual and reproductive health services, including contraception in different social and cultural contexts?

### INVOLVING AND RESPECTING CHILDREN



How do you greet children coming for care when you first meet them, and when you see them afterwards? Do you make an effort to put them at ease or do you speak exclusively to the parent or guardian accompanying the child? Do you try to respect the time of parent(s), guardian(s) and children by attending to them as quickly as possible?

## SERVICE PROVISION

### HRBA REFLECTION

#### DIGNITY AND AUTONOMY

Think about the way you would want to be treated, or your spouse, child or grandchild. You would want to be greeted with respect, you would want to be made to feel at ease, and you would want to have procedures explained clearly and simply, respecting your right to make informed decisions about your health, or the health of your young child, and enabling you to exercise that right. The way you would like to be treated is the way people entering your care should be treated.

While young children are dependent on their parents for seeking health care, speaking directly to children not only affirms their dignity, but helps to reduce their fears, build trust and thus accept your treatment. Children may find waiting stressful and boring, or disruptive to their sleep schedule, such that undue waiting is not in their best interests.

### CONSIDER

#### DISCUSSIONS WITH HEALTH SYSTEM USERS

*Health system users, as rights-holders, are entitled to refuse treatment, and have freedom from any interference with their body that they do not want. Children and adolescents also have the right to respect of their physical integrity, and to be involved in decisions about their health care, in accordance with their evolving capacities, which increase with age and maturity.*

### FOR EXAMPLE

#### EXPLAINING OPTIONS AND RISKS



How do you approach a situation where a pregnant woman would like to have a vaginal delivery after having a previous caesarean, or a fistula? Do you ask them what their preference is? If not, why not? How do you explain their options to them and the relative risks?

How do you approach a discussion about contraception with a woman who is HIV-positive?

What if a sex worker is seeking contraception? How do you deal with it if the sex worker is accompanied by his/her child?

#### INVOLVING CHILDREN AND PROTECTING THEIR BEST INTERESTS



How do you communicate to the child what you plan to do and why? Do you use language or gestures that he or she can easily understand? What do you do if the child is fearful? Do you take the time to talk to children in your care, and listen to their concerns?

## SERVICE PROVISION

What do you do if a parent/guardian refuses consent for his/her child to be vaccinated or receive a particular treatment? Are you aware of your Government policy in these circumstances? Do you explain how treatment will protect the child from illness and death, and how such protection is in the child's best interests?

### HRBA REFLECTION

## BODILY INTEGRITY AND INFORMED CONSENT

Health workers should also not assume they know best for the individuals who come to them for care. It can be difficult when someone disagrees with your professional opinion about what is best for him or her and difficult to overcome parents' reluctance to consent to their child's treatment, when you know that treatment is in the child's best interests. Applying an HRBA means respecting an individual's autonomy to make decisions about his/her health, not touching or operating on anyone without his or her consent, and refraining from actions which would compromise his or her bodily integrity. There are only a few emergency circumstances where a practitioner can override an individual's refusal or choice of treatment.



Decisions about health care of a child must involve both the child and parents/guardians who are legally responsible for the child's well-being. However as a child gets older, and in accordance with the laws on age of consent in your country, he/she will have increased capacity to make decisions about his/her health and well-being, including sexual and reproductive health, without the involvement of parents/guardians. Respecting children's right to be informed requires presenting information in child-friendly language or gestures (for the non-verbal child), giving children the time to reflect on the information provided, and working with parents/guardians to ensure that the child's best interests are intentionally considered and supported when making health-care decisions.

### CONSIDER

## PATIENTS' RIGHTS CHARTERS



*Each facility should post a charter of patient rights, which explains health system users' rights when they come to a facility. These are usually produced at national level.*

## CHARTERS FOR CHILDREN



*The facility should also post charters for children, distinct from a patients' rights charter for adults, as treatment of children, given their age, limited maturity and autonomy, requires special considerations.*

### FOR EXAMPLE

## KNOWLEDGE AND AWARENESS OF RIGHTS

Have you ever seen a patients' rights charter or a charter for children in your facility? Do you know who is responsible for giving these to health system users and parents/guardians of children and for explaining the content? Is/are the charter(s) posted in all languages spoken in the community your health center serves?

## SERVICE PROVISION

<b>DETAILS OF PATIENTS' CHARTER</b> 	<b>DETAILS OF CHILDREN'S CHARTER</b> 
<p>In the context of sexual, reproductive and maternal health, a patients' rights charter should include, at a minimum, the following rights:</p> <ul style="list-style-type: none"><li>- a right to be free from harm, violence and ill treatment,</li><li>- a right to information, informed consent and refusal,</li><li>- a right to privacy and confidentiality,</li><li>- a right to be treated with dignity and respect,</li><li>- a right to equality and non-discrimination in enjoyment of rights related to sexual and reproductive health,</li><li>- a right to autonomy and self-determination, as well as freedom from coercion,</li><li>- a right to the highest attainable standard of health.</li></ul>	<p>A child rights charter should include, at a minimum, the following rights for children:</p> <ul style="list-style-type: none"><li>- a right to preventive and curative care,</li><li>- a right to be listened to and have his/her views taken seriously,</li><li>- a right to information,</li><li>- a right to privacy,</li><li>- a right to have their parents/guardians with them at all times in accordance with their evolving capacities,</li><li>- a right of children and parents/guardians to be informed on health status and treatment options in a manner appropriate to age and understanding.</li></ul> <p>The charter for children should also recognize that children admitted for treatment will not forfeit their rights to play, education and other rights required for their holistic development.</p>
<b>HRBA REFLECTION</b> <b>ACCOUNTABILITY REQUIRES AWARENESS</b>	
<p>Realizing rights requires awareness among health system users, children, and their parents/guardians. It is important that they are told what their rights are and that changes are made in the facility to ensure the conditions necessary for these rights to be realized. A children's charter further serves to remind health workers of their obligations to each child, and that children have multiple rights, which facilities dedicated to realizing the right to health must respect.</p>	

**CONSIDER**  
**INVOLVING FAMILY MEMBERS**

*The degree to which any person wishes to have family involved in their care should be respected, including the decision to not involve family, taking into account the influence of family power dynamics on individual health decisions.*

**FOR EXAMPLE**  
**FAMILY PRESENCE AND PARTICIPATION IN DECISIONS**

Are families or close friends allowed in rooms of health system users? If families are not allowed in because of overcrowding, is this justified and can solutions be identified?

How do you manage delicate situations, such as breaking bad news? Do you include or exclude family members from these conversations? How do you balance confidentiality with including families for support?

**ASSURING CONFIDENTIALITY  
FOR WOMEN AND  
RESPONDING TO VIOLENCE**



What if a woman is (or a deceased woman was) HIV-positive and her family is not aware of this situation? How do you manage this situation, and how do you communicate with her partner, who may or may not have infected her?

What if a woman is seeking contraception and her husband is against it? How do you manage this situation?

What if a woman appears to have been physically abused by her husband or partner?

**ASSURING THE BEST INTERESTS  
OF THE CHILD AND  
RESPONDING TO VIOLENCE**



Do you speak only to the child's parents/guardians? How do you decide whether to include the child in these conversations?

What if an adolescent is seeking contraception, and her family is not aware?

What do you do if you suspect that a child in your care has been abused by his/her parents, or by other family members? What if you manage to confirm this in a confidential conversation with the child, but he/she is adamant that the information be kept private? What guidance have you received as a health worker for reporting cases of suspected violence, abuse or neglect of a child?

**HRBA REFLECTION**  
**RESPECT FOR CHOICE OF INDIVIDUAL HEALTH SYSTEM USER**

In an HRBA, health system users are entitled to choose their care and determine the involvement of family members in their health decisions, and health workers should be supportive of their wishes.

## SERVICE PROVISION

It is almost always in a child's best interests, especially for young children, to have their parent, guardian or family members present when receiving health care and treatment, as the child will be less anxious and thus better able to cope. When children are old enough to express an opinion, they should be consulted on their treatment and whether the parents'/guardians' presence is wanted/needed, with their views taken into consideration.

For adolescents and women, the involvement of family members can be a source of great support, or it can undermine the individuals' ability to make independent choices. Determining family involvement should take account of the fact that in many contexts, family members can interfere with women's and girls' enjoyment of their sexual and reproductive health and rights. In ensuring adolescents' and women's access to services, their right to privacy must be protected and shielded from parental or spousal action which would undermine their enjoyment of sexual and reproductive health and rights.

If you suspect that an individual in your care is a victim of domestic violence, by their spouse, parents, guardians or other family members, insist that your facility provide you with direction on how to handle such delicate cases.



### CONSIDER

#### WHO DOES NOT HAVE ACCESS

*Certain groups of individuals may face barriers in accessing health care, including barriers related to discrimination. These obstacles to accessing health care may be related to residency, to socio-economic status, or membership in groups that may suffer discrimination, including on the basis of race, ethnicity, language, physical or intellectual disability, age, sex, religion, sexual orientation and gender identity, migrant status, marital status, health status, or other grounds relevant in your national context. Health system users should not receive a lower level of care because of one of these factors.*

### FOR EXAMPLE

#### BARRIERS

Does your facility refuse to provide a service to people who cannot pay, because they are poor? Are you aware of your Government policy in these circumstances?

Is it difficult for people in rural communities to access your facility? Does your facility offer outreach to these communities through, for example, community health workers who provide health education, counseling, vaccination and other promotive and preventive health services, as well as pneumonia, diarrhea and malaria treatment to children? What else may be done to help remote populations (which are often the poorest) access health care?

When a person, or a parent, does not speak your language, how do you talk to them about their diagnosis and treatment, or that of their child? Do you arrange for an interpreter to be present when you speak to them, or does a member of the family translate for you? How do you ensure confidentiality? Having a family member translate is much better than not being able to communicate with a health system user at all, but this can potentially create some problems between the practitioner and the individual concerned.

When the health system user has an intellectual or physical disability, how do you manage that situation? For example, if a child or the parent/guardian accompanying him/her is blind or unable to walk due to paralysis, do you go to where the child is waiting with his/her parent/guardian? Do you arrange for assistance or take extra steps to ensure health system users get the treatment or support that they need? If not, why not? What would enable you to ensure that, for example, disabled women are helped to ambulate to avoid blood clots during labour? Or, what would enable you to ensure that intellectually disabled women are helped to communicate?

### HRBA REFLECTION

#### NON-DISCRIMINATION

An HRBA aims to shine a light on who is excluded, and draw attention to removing obstacles to equal access to health care. **Accessibility** is an important part of the AAAQ framework. Because of this, a facility or health worker:



## SERVICE PROVISION

- (i) must not deny care to vulnerable members of a society or discriminate against certain groups of people;
- (ii) should consult with disadvantaged groups to find out how best to provide culturally sensitive services and provide such services;
- (iii) should actively take steps to provide services to people who are marginalized or disadvantaged.

Consider the types of actions that you can take, as a health worker, to ensure that people from these groups receive care and treatment at your facility. At the facility level, it could be useful to obtain data about the socio-economic and ethnic make-up of the community, which can be compared with facility records, to see if any population group is underserved. Another potential action could be advocating for the establishment of a team of community health workers able to extend the facility's services into remote areas, and increase access for marginalized women and children.

### CONSIDER

#### STIGMATIZED POPULATION GROUPS

*Certain population groups may face judgmental or negative attitudes of health workers because of their membership in a particular group which is stigmatized or characterized by harmful stereotypes in a given societal context. Special measures will be required by health workers to ensure that these individuals have access to health-care services without discrimination.*

### FOR EXAMPLE

#### BARRIERS DUE TO STIGMATIZED STATUS

When a sex worker or a lesbian, gay, bisexual or transgender (LGBT) person seeks care, how do you manage that situation? Do you take extra steps to ensure that they get the treatment that they need, and to ensure that they are able to freely communicate their health concerns? If not, why not?

#### STEREOTYPING

When providing promotive, preventive or curative care to a child or a woman from a very different cultural or economic background than your own, do you find you make assumptions about that child, woman or family based on your experience of providing health care to others from that same background? Have you known stereotyping, and the lack of respect which accompanies it, to result in a family or a woman refusing to return to the health facility? What can be done to combat stereotyping?

## SERVICE PROVISION

### HRBA REFLECTION

#### EXAMINING ATTITUDES AND ADDRESSING STIGMA

So that each individual can enjoy his/her right to health equally, health worker attitudes about certain population groups should be examined to ensure that stereotyping or stigmatization does not reduce access to and quality of care, and to encourage provider acceptance and non-judgmental approaches. The importance of ensuring confidentiality takes on added significance when delivering services to individuals whose status is criminalized (e.g., LGBT individuals, sex workers, persons living with HIV, women who have undergone illegal abortions).

### CONSIDER

#### MANAGING CONFIDENTIALITY

*Health system users have a right to have their own health data treated with confidentiality. Children, even those too young to fully understand the implications of privacy, also have that right. It is the responsibility of health workers to keep health information confidential. Such information may only be disclosed to the individual to whom it pertains or to parents/guardians of that person, provided that person is without a sufficient level of maturity to act on the information in an autonomous way. Such information must be denied to those with no right or need to know, or who lack explicit permission from the health service user and/or his/her parent/guardian.*

### FOR EXAMPLE

#### RECORD KEEPING AND CONSULTATION

How do you make sure that written notes about an individual's case are not easy to access by non-health-care professionals? Are case notes kept in a safe place in your facility, or are they kept where anyone can read them?

When a family of a woman who has died a maternal death requests her medical records, are they immediately provided with them? If not, why not?

#### PRIVACY AND DISCLOSURE

When you are examining an individual, and there are other people present in the room, what do you do to improve privacy? Can you use things like screens to shield health system users when you are examining them? If not, why not?

If you have to tell someone that they have a certain illness, such as HIV, and it might be sensitive for others people in the room to overhear, can you take them to a different room? Do you know of any other ways that health workers try to keep information private?

## SERVICE PROVISION

Do you take the time to help young children in your care feel safe by letting them know that what they tell you about how they feel, emotionally and symptomatically, is private information, which you will only share with their parents/guardians, where appropriate? Do you listen and respond to young children's questions about privacy?

### HRBA REFLECTION

## PRIVACY AND CONFIDENTIALITY ARE HUMAN RIGHTS

Confidentiality is the duty of the health worker to keep private the information they receive from health system users. The right to privacy of health system users pertains to informational, physical and decisional privacy.

It is easy to unintentionally disclose confidential information to other people, especially when there are many people around. Health workers should minimize the chance of revealing private information, such as HIV status, marital status, and employment status, wherever possible. It is also important to take steps to improve confidentiality at the facility level – for example, by reducing overcrowding to make it easier for staff to have confidential discussions with health system users, or through keeping written case files out of sight of visitors. Integrating sexual and reproductive health services into primary health care is one way that greater privacy has been afforded to adolescents and unmarried women.

Keeping personal health information confidential is the right of the **health system user**, not the health worker. Therefore, the health system user has a right to his/her records whenever he/she wants, as do the survivors of a deceased woman or child.

Although children may be too young to make decisions for themselves, and are largely dependent on their parents, they still have a right to have information about their health status kept private from anyone other than those directly involved with their care, especially in cases where there is a risk of stigmatization.

In the event that a child has indicated to a health worker that he/she is suffering abuse at the hands of a family or community member, the child's right to confidentiality needs to be weighed against the child's best interests and the risk of remaining in a dangerous situation. You should explain to the child the limits of confidentiality and why it may not always be possible to respect it if the child is in danger, and refer the case to child protection authorities in your area for further investigation.

## SERVICE PROVISION

### CONSIDER

#### IMPLEMENTING NATIONAL POLICIES AT THE FACILITY LEVEL

*Facilities must be in a condition to implement evidence-based national public health policies. Some of these relate to treatment protocols, others relate to financing, others to health promotion and education.*

### FOR EXAMPLE

#### FREE HEALTH SERVICES AND AVAILABILITY OF GOODS

Are there policies in your country calling for free maternal and child health care? Can individuals access maternal and child health care without charge in reality in your facility, or do they still have to pay some money? If so, why? How might this be changed?

Do you ever have to personally pay to buy supplies for the facility to give to persons in need?



Is the full range of contraceptive methods recommended in government policies provided to health system users? Are you aware of what is recommended?



Is the full range of recommended preventive health services and essential drugs provided to children served by your facility? If not, why not? Is this a facility problem, or a problem with supply from the local, district or central level? (See *Local/District level, below*)

#### FAILURES IN IMPLEMENTATION

Are there any gaps where policies and laws are not being implemented in your facility? Are treatment protocols and guidelines readily available and understood? Are health-care providers adequately trained on the use of guidelines and protocols?

#### HEALTH PROMOTION



Do you take advantage of the time a child and his/her parent spend with you to explain the benefits of the procedure and to share your knowledge of newborn and under-5 child care, feeding, hygiene and health practices? How do parents/guardians access the information necessary to participate meaningfully in decisions about their child's health? If your facility does not provide regular health promotion services for the education of parents/guardians, why is this? Is it due to lack of resources, time, or the lack of a policy?

## SERVICE PROVISION

### HRBA REFLECTION

#### IDENTIFYING GAPS BETWEEN POLICY AND PRACTICE

Think about whether the “official” government policy concerning free maternal and child health care is implemented in your facility so that women, children and their families receive the services to which they are entitled.

Under the right to health, financial **accessibility** (from the AAAQ framework) is very important. The right to health says that people living in poverty must not be forced to bear disproportionate health-care costs, and States must remove barriers that make it difficult for women and children to access health-care services (for example, through fees for service). For this reason, many States have made maternal and child health care free, or have introduced laws banning out-of-pocket payments, to improve access to services.

Health workers have the right to information as well as to supplies and working conditions (including locally competitive salaries) needed to effectively carry out their job. They also have a *responsibility* to ensure that their management of health system users is of high quality and respects human rights principles. If you are having problems delivering a good service, think about where the root of the problem lies (e.g., facility management, district problems, etc.) and what you might do to help alleviate such problems.

### CONSIDER

#### HEALTH WORKER TRAINING PROGRAMMES

*Under the right to health, States and facilities are obliged to provide adequate training and support for health workers providing care at community, primary, secondary and tertiary levels of the health system. There should also be opportunities for performance evaluation in your facility, so that practitioners can constantly improve their standards of care.*

### FOR EXAMPLE

#### QUALITY AND AVAILABILITY OF TRAINING

Does your facility have training programmes about protecting the right to confidentiality, privacy, informed consent and autonomous decision-making, as well as the prohibition of discrimination?



Do you receive training in detection and treatment of sexual and physical abuse or intimate partner violence?



Do you receive training and guidance in respecting the child’s privacy, and in what actions to take if you suspect a child is being abused? What about training in applying the principle of best interests of the child in decisions related to his/her treatment and care?

## SERVICE PROVISION

Does your facility have training programmes about appropriate and respectful treatment of health system users: e.g., not hitting or slapping people, or touching them without consent or in a disrespectful manner, or training programmes about child-friendly communication and involving children in decisions about their care and treatment?

Are you trained in how to obtain informed consent from individuals who are illiterate, who do not speak the same language as you, or who have intellectual disabilities?

Does your health facility conduct annual reviews of your performance, including on how respectfully you interact with health system users, including children in your care?

### HRBA REFLECTION

#### MEETING THE NEEDS OF THE POPULATION

Both training programmes and evaluations are necessary to ensure that enough health workers are recruited and trained to give quality care in meeting the needs of the population, and that they have the supervision and oversight which ensures that health system users are treated with dignity and not with disrespect and abuse. The national and/or district government is responsible for providing the requisite training budget.

### CONSIDER

#### COMPLAINT AND MONITORING MECHANISMS

*Accountability is a vital part of the right to health. Accountability has many dimensions including social, political, administrative, professional and legal accountability. One way that people are held accountable is through monitoring mechanisms.*

### FOR EXAMPLE

#### COMPLAINTS ABOUT HARM TO HEALTH SYSTEM USERS OR STAFF

Is there a complaint mechanism that staff can use to report incidents where health system users were harmed or nearly harmed, or to report things like drug stock-outs which impact the quality of care you can provide?

What mechanisms are available to you to complain about violations of your human rights as a health worker? These include labour rights and other rights. Can you complain if a health system user or other staff member abuses you, or if you are not paid properly? What about if you are not provided with gloves to protect yourself while you are working?

Is there a policy in place at the health facility requiring reviews of each maternal or child death? Who conducts these maternal or child death reviews? Are the findings used? If so, are they used to institute policy and programming changes based on the findings? Or are they used to scapegoat providers?

## SERVICE PROVISION

Are health system users, children, and their parents/guardians provided with accessible information about how to use complaint mechanisms? Can health system users safely and confidentially complain about physical or verbal abuse by a staff member, without fear of attacks or reprisals? Are these complaint mechanisms child-sensitive?

Is there a community health committee with the capability to work with facility staff to help improve outcomes for health system users, and ensure services maintain a certain standard of performance? Does the committee help you and community members to advocate when performance falls short, such that facility and district managers are held to account and remedy shortcomings? Does the community health committee have access to public information such as budget allocation and expenditure?

### HRBA REFLECTION

#### IMPROVING THE QUALITY OF CARE AND ENSURING ACCOUNTABILITY

A facility must ensure that health-care professionals are not punished for reporting deaths or other problems; rather, steps should be put in place to ensure identified problems do not recur, and correct systemic failures. Monitoring and complaint mechanisms should be available for staff and health system users to provide feedback to managers of a facility, who can use this information to improve care, and provide compensation if harm occurs. There should also be mechanisms in place to record maternal and child deaths, and identify “structural” factors that contribute to these deaths.

It is not enough to have monitoring mechanisms in place – complaints filed with these mechanisms must be acted upon. Complaints should be analyzed to identify patterns of problems so that these can be addressed system-wide. If complaints are not acted upon, there is a lack of meaningful accountability for the realization of rights.

It is equally important for health workers to be able to complain about violations of their rights – for instance, being physically or verbally abused by a health system user, parent of a child in health care, or colleague. Community health committees can help both health system users and health workers claim their rights and ensure accountability.

# LOCAL/DISTRICT LEVEL

Health workers have an important role to play in influencing traditional authorities at community level, and policy-makers at district levels to respect the HRBA to health, improve health-care delivery, and help people to realize their right to health, including by promoting healthy practices. Health workers can also have a role in raising community and district awareness of the importance of realizing rights related to the right to health, such as rights to an adequate standard of living, to water and sanitation and to protection from violence and abuse.

**YOU, AS HEALTH WORKERS**, and depending upon your role within the health system, can do this on your own, as well as through collective associations and community health committees and/or groups.

## CONSIDER

### COMMUNITY ENGAGEMENT

*How have you been able to work with communities to improve enjoyment of human rights related to sexual and reproductive health, maternal health and to under-5 child health?*

## FOR EXAMPLE

### TRADITIONAL AUTHORITIES, WOMEN'S GROUPS

What efforts have been made to facilitate discussion and debate with traditional authorities about sensitive issues, such as the prevention of female genital mutilation? Can you play a role in convening these discussions?

How can you create space for women's groups to discuss and identify priority problems? How can you support them in advocating for local solutions to improving sexual and reproductive health, maternal health and under-5 child health?

## HRBA REFLECTION

### PARTICIPATION AND INCLUSION

Ensuring enjoyment of human rights requires the participation and engagement of communities. Since many human rights concerns related to sexual and reproductive health, maternal health and under-5 child health are integrally related to social and cultural norms, social dialogue at the community level, including marginalized members of the community, is essential for enhanced human rights protection. In addition, locally identified priorities and solutions often have the benefit of being more sustainable.



**CONSIDER**  
**DISTRICT BUDGETING PROCESS**

*Budgeting under an HRBA should involve a range of ministries and departments, and involve communities, together with their traditional authorities, in determining budgetary priorities. The budget process should be transparent and open to scrutiny from civil society, including community health committees. Health workers should also be involved in making budgetary decisions, to help, for instance, in identifying needs of health system users, providers, and facilities – even in settings where resources are scarce. The salaries allocated for given facilities within a district should also be made available to the public.*

**FOR EXAMPLE**  
**PARTICIPATION AND MONITORING OF BUDGET PROCESS**

Were health workers permitted to participate in the formulation of the district health budget? Were they able to use their knowledge of local health disparities to influence budgetary allocations? If so, at what point? How were their views as to different needs taken into consideration?

Were health workers at your facility asked to hold meetings with traditional authorities, community members, the community health committee, youth-led organizations, or women’s groups to identify budget priorities? Is this something you could do on your own initiative? If such consultations took place, how were the communities’ priorities reflected in the district budget?

Do health workers participate in monitoring the execution of the budget? For example, how the budget money is actually spent at facility level, by health area, where leakage is identified?

Is the budget assigned to your facility, including the portion allocated for salaries, posted so that the public can participate in monitoring its execution, including through the community health committee, if one exists?

**HRBA REFLECTION**  
**ENSURING TRANSPARENT PROCESSES**

In an HRBA, those who will be affected by budgetary allocations should be able to express their views when priorities are set, as well as when funds are spent. As resources make rights real, participation in budget processes is essential, and transparency is key to effective participation. Helping to ensure that the public, including health system users, has the knowledge and capacity to engage in this process is a critical role that health workers can play.

**CONSIDER**

**ENSURING ADEQUATE GOODS AND SERVICES**

*Even where there are severe resource constraints, some goods and services for sexual and reproductive health, maternal health and under-5 child health are considered “essential” and a State will be in breach of international law if it fails to provide these. This is an example of **availability** under the AAAQ framework.*



*Essential maternal health goods and services include a range of contraceptive methods, oxytocics, anti-convulsants, including magnesium sulphate, and all appropriate antibiotics.*



*Essential under-5 child health goods and services include vaccines against six childhood diseases, micro-nutrient supplementation, as well as oral rehydration salts and antibiotics for treatment for the two top killers of children under 5 years of age.*

*Facilities must provide these essential goods and services, even when budgets are stretched. Under an HRBA, no budgetary decision should result in people’s rights being denied.*

**FOR EXAMPLE**

**IDENTIFYING FAILURES IN ACCOUNTABILITY**

Are “essential” goods and services consistently budgeted for in your district, and in particular, your facility? If not, why? Is it a problem in your facility alone, or a district-wide problem?

Have you noticed or is there data to suggest that other districts seem to provide better services to health system users? For example, are services better in the capital and other major urban centers than in your district? Why is this?

Do posting and transfer policies ensure continuous and quality care for all health system users? If not, why not? Do they respect rights of health workers? If not, how might changes be made?

Has your district instituted a system for promoting and monitoring health services by use of mobile phone technologies such as text messaging? What about using these technologies to inform authorities about a stock-out of essential drugs?

**HRBA REFLECTION**

**FIXING FAILURES TO PROVIDE ESSENTIAL SERVICES**

Health workers are vital in reporting failures to provide essential goods and services, and determining whether it is only an issue in their own facility, or a district or even a nationwide problem, possibly tied to policies of international donors. Multiple methods, including information technologies solutions, could be used in order for health workers to realize this reporting function. It is essential to work out **who** in the circle of accountability is responsible, so that when failures are identified, there is some feedback mechanism through which problems can be fixed.

## LOCAL/DISTRICT LEVEL

Think about what you can do, individually or collectively, to put increasing pressure on your district or local government to provide essential goods and services. If you made their failures public, there may be negative consequences for you, hence it is important for health workers to think through ways to change the situation collectively, and so mitigate risks to any one person.



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# LINKING HEALTH WORKERS AND THE NATIONAL LEVEL

National governments have certain obligations under international law – for example, they must create health-care plans that include sexual and reproductive health, as well as the health of children, and consider children’s best interests in the plan’s related policies and budgets. Many decisions that affect the facility level are actually taken at national level.

**YOU, AS HEALTH WORKERS**, and depending on your role within the health system, can play an important role in monitoring implementation at the facility level, and ensuring that governments are held accountable for any failure to fully consider sexual and reproductive health, maternal health and under-5 child health.

## CONSIDER

### NATIONAL HEALTH PLAN FOR SEXUAL AND REPRODUCTIVE HEALTH, MATERNAL HEALTH AND UNDER-5 CHILD HEALTH

*Under international law, States must develop, in consultation with the public, national public health strategies and plans of action (“national plans”) to guarantee the right to health. These plans must be evidence-based, comprehensive, and include an analysis of sexual and reproductive health needs, maternal health needs and under-5 child health needs as well as health system capacities in the country.*

## FOR EXAMPLE

### AWARENESS OF NATIONAL POLICIES

How do you find out what the “official” national policy is on sexual and reproductive health, maternal health and under-5 child health, and check whether your practice is based on this policy?

### DISAGGREGATION, BENCHMARKS AND EXPANDING SERVICES

Is the national plan based on disaggregated data showing disparities in access to health services across the country and responsive to those inequalities in access? Are there explicit benchmarks and targets for improving sexual and reproductive health, maternal health and under-5 child health? How does the plan foresee the expansion of health services into under-served or unserved areas?

## LINKING HEALTH WORKERS AND THE NATIONAL LEVEL

### SEXUAL, REPRODUCTIVE AND MATERNAL HEALTH NEEDS



Does your national plan for health address safe birthing facilities, access to skilled birth attendants, and antenatal care, but exclude issues such as elimination of mother-to-child transmission of HIV (“EMTCT”)?

Does your country’s sexual and reproductive health plan include the issue of domestic and intimate partner violence? Does it include the issue of reducing maternal deaths from the complications of unsafe abortions? Does it include the need for comprehensive sexuality education? Women’s sexual and reproductive health is also dependent on power relationships within homes and communities, as well as the effects of law as a social determinant, not just biological mechanisms.

### UNDER-5 CHILD HEALTH NEEDS



Does your national plan on reducing child mortality address death caused by diarrhea through parental education, training of health workers and supply of oral rehydration salts, but exclude explicit attention to ensuring safe drinking water and sanitation?

Does the national plan set targets for reducing pneumonia in children, another top cause of death, but may not have a policy authorizing community health workers to administer antibiotics? The national plan must be comprehensive if it is to contribute to the progressive realization of the right to health.

### HRBA REFLECTION

### REVEALING ACCOUNTABILITY GAPS

Health workers can use national plans to identify whether there are gaps in accountability. In particular, a national plan should reveal whether there is enough funding for operating, stocking and staffing facilities; for training (including human rights training); and, whether better accountability mechanisms are needed, to ensure all people in the country can realize their rights relating to sexual and reproductive health, maternal health and under-5 child health. If there is no national plan, or if the plan does not include a comprehensive approach to sexual and reproductive health, maternal health and under-5 child health, the government cannot identify what steps to take to move toward guaranteeing everyone the right to health, and can be held to account for this failure to progressively realize the right to health.

## LINKING HEALTH WORKERS AND THE NATIONAL LEVEL

### CONSIDER

#### EVIDENCE-BASED PUBLIC HEALTH MEASURES

*Under international human rights law, States must adopt evidence-based public health measures, including essential interventions, services and medicines.*

### FOR EXAMPLE

#### POLICIES ON APPROPRIATE DRUGS OR PREVENTION OF HIV TRANSMISSION

Are there policies concerning appropriate drugs used in managing pregnancy and childbirth? Are there policies concerning prevention of mother-to-child transmission of HIV?

#### INAPPROPRIATE POLICIES FOR WOMEN



#### INAPPROPRIATE POLICIES FOR CHILDREN



Are women pushed to deliver at facilities even when such facilities cannot deal with obstetric emergencies? Are there requirements that medical practitioners provide information on, for instance, the side effects of certain sexual and reproductive health services, which are not backed by medical evidence?

Is there inappropriate information and marketing of breast-milk substitutes to pregnant women and mothers at facilities? How is this regulated so as not to undermine initiation of exclusive breastfeeding after birth?

### HRBA REFLECTION

#### ACCOUNTABILITY FOR PRACTICES THAT VIOLATE RIGHTS

Health workers are directly involved in enforcing State public health measures, and are often best informed about the latest developments in public health interventions. For both of these reasons, as part of the circle of accountability it is important for them, individually or collectively, to be aware and to call attention to practices and/or policies that are not evidence-based, and that should be changed.

## LINKING HEALTH WORKERS AND THE NATIONAL LEVEL

### **CONSIDER** TASK SHIFTING OR SHARING

*To what extent does the government policy encourage task shifting or task sharing?*

### **FOR EXAMPLE** MID-LEVEL HEALTH WORKERS, NURSES AND MID-WIVES

Are there regulations and protocols establishing the possibility to shift tasks related to the provision of basic sexual and reproductive health services to mid-level health-care workers, nurses and midwives?

Have mid-level workers received appropriate training to perform these tasks? Has this training included knowledge and guidance on the delivery of services in accordance to quality of care and human rights standards?

### **HRBA REFLECTION** INCREASING ACCESSIBILITY

One of the many barriers to accessible, equitable and high quality sexual and reproductive health, maternal health and under-5 child health services is a shortage of trained providers. Task shifting and task sharing are cost-effective interventions that can increase accessibility to basic health services without compromising on the quality and safety of these services. In order for task shifting and task sharing to contribute to the achievement of more equitable health outcomes in those places where services are most needed, mid-level health-care workers, nurses and midwives should receive appropriate training and guidance to be able to perform those tasks. This training should include guidance on the delivery of services in accordance with quality of care and human rights standards, including respect for the right to privacy, informed consent and freedom from coercion.

While task shifting is an important temporary measure to ensure accessibility to basic sexual and reproductive health services, it should not be used as an excuse to avoid health system strengthening and the progressive realization of the right to the highest attainable standard of health.

## LINKING HEALTH WORKERS AND THE NATIONAL LEVEL

### CONSIDER

### LAWS AND POLICES TO PROTECT SEXUAL, REPRODUCTIVE, MATERNAL AND UNDER-5 CHILD HEALTH

States are obliged to introduce and implement laws that promote and protect the health rights of women and children. Laws and policies alone are not sufficient to guarantee sexual and reproductive health, maternal health or under-5 child health, but they are **necessary**, because otherwise there are no standards or institutional mechanisms that individuals can use to claim their health rights.

#### LAWS IMPORTANT FOR GENDER EQUALITY



Are there laws supporting female education, even where girls become pregnant?

Does the law prohibit access to certain services by women or adolescents, or require them to obtain permission from third parties, including parents or spouses, in order to obtain such services?

Are there laws prohibiting harmful traditional practices, such as early marriage or female genital mutilation (FGM)?

#### LAWS IMPORTANT FOR CHILD RIGHTS



Are there laws providing a statutory entitlement to essential under-5 child health and related services, including birth registration and other social services?

Are there laws protecting children from violence and abuse?

Is there a law requiring that all salt sold in the country be iodized?

### HRBA REFLECTION

### EFFECT AND IMPLEMENTATION OF LAWS AND POLICIES

Certain laws undermine the enjoyment of human rights and would need to be reformed or repealed. Other laws may uphold human rights in principle, but lack effective implementation. Health workers can individually or collectively lobby governments to introduce laws supporting health-related rights, or hold governments to account where laws are not properly implemented or enforced.



LINKING HEALTH WORKERS AND THE NATIONAL LEVEL



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