

REPRODUCTIVE HEALTH AND HEALTHY MOTHERHOOD

Aligning National Legislation with International Human Rights Law



Pan American
Health
Organization



World Health
Organization
REGIONAL OFFICE FOR THE Americas

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with International Human
Rights Law



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REGIONAL OFFICE FOR THE
Americas

Washington, D.C., 2014

Also published in:

Spanish (2013): Salud reproductiva y maternidad saludable. Legislación nacional de conformidad con el derecho internacional de los derechos humanos

ISBN 978-92-75-31777-8

Portuguese (2013): Saúde Reprodutiva e Maternidade Saudável Legislação nacional em conformidade com o direito internacional dos Direitos Humanos

ISBN 978-92-75-71777-6

PAHO HQ Library Cataloguing-in-Publication Data

Pan American Health Organization.

Reproductive Health and Healthy Motherhood: Aligning National Legislation with International Human Rights Law. Washington, DC : PAHO, 2014.

1. Reproductive Health – legislation & jurisprudence. 2. Human Rights – legislation & jurisprudence. 3. International Law. 4. Americas. I. Title.

ISBN 978-92-75-11777-4

(NLM Classification: WA301 DA1)

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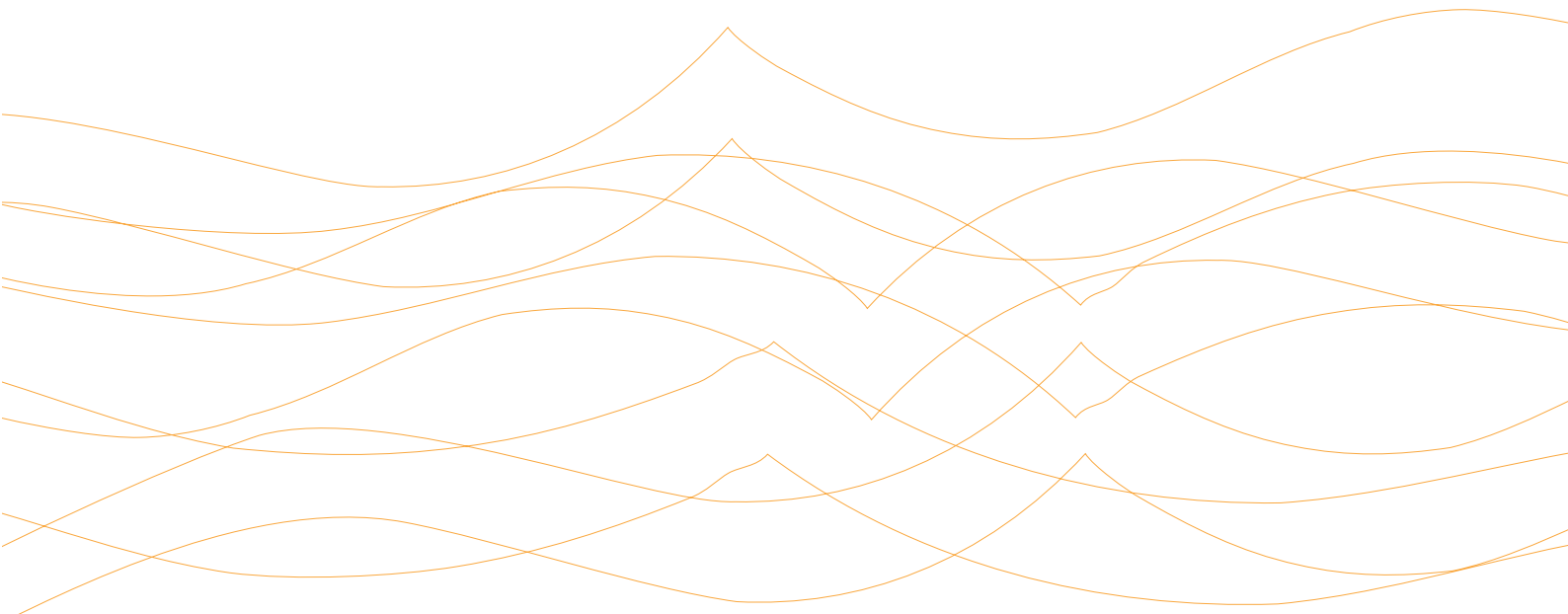
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This publication was made possible by financing from the Spanish Agency for International Development Cooperation (AECID).

Graphic design: Trilce García Cosavalente

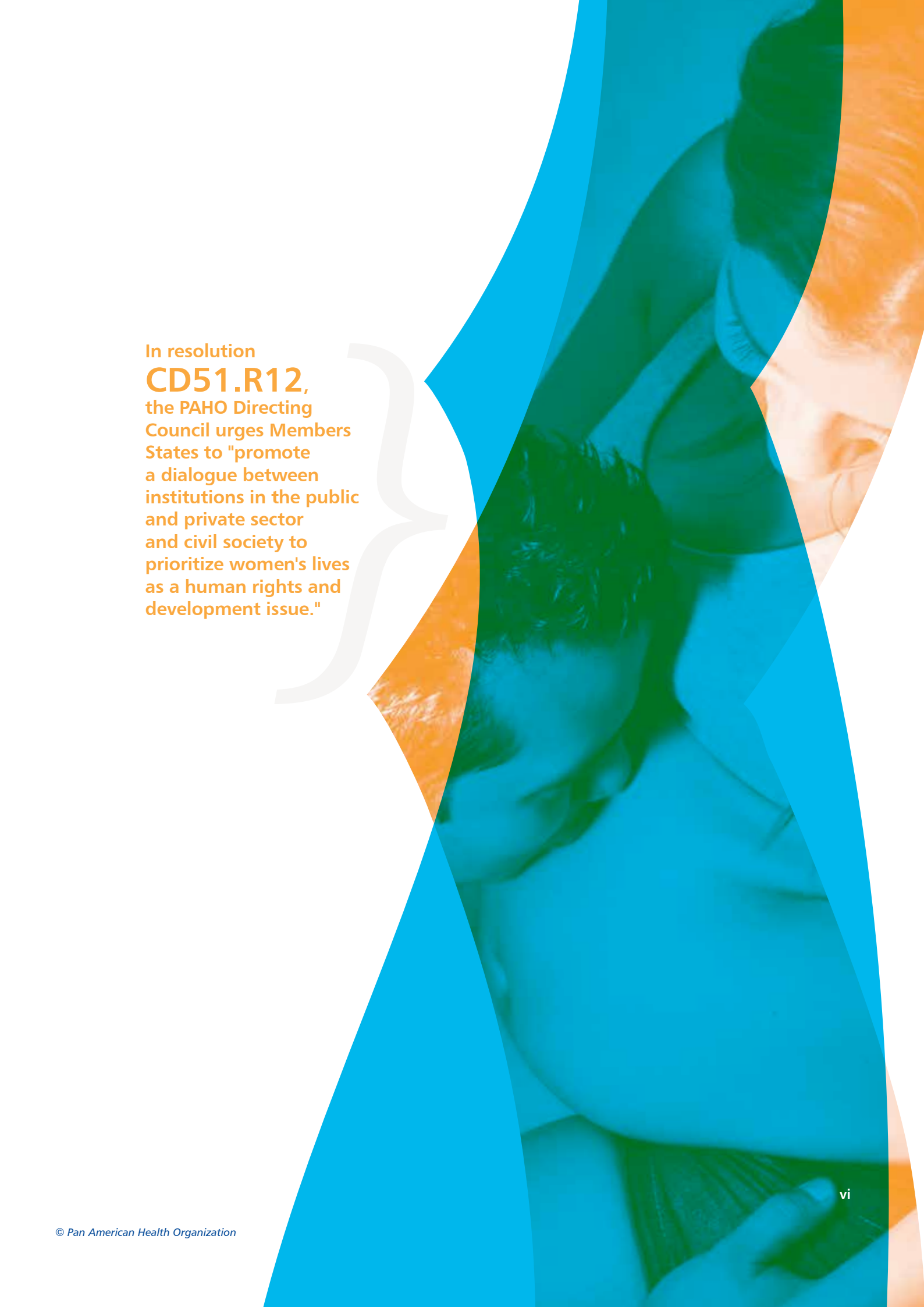
Photographs: Pan American Health Organization and Trilce García Cosavalente





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In resolution
CD51.R12,
the PAHO Directing
Council urges Members
States to "promote
a dialogue between
institutions in the public
and private sector
and civil society to
prioritize women's lives
as a human rights and
development issue."

FOREWORD

With the declaration of Millennium Development Goals (MDGs) in the year 2000, the international community and governments of Latin America and the Caribbean renewed their commitment to reducing avoidable maternal mortality. Given the recognition that healthy motherhood requires access to reproductive health care, and in the context of the MDG target of reducing maternal mortality by three-quarters between 1990 and 2015, a second target for the same year is universal access to reproductive health care.

In light of the slow progress, after the deliberations the Secretary-General of the United Nations launched the Global Strategy for Women's and Children's Health in 2010 and prepared an accountability framework based on the fundamental right of every woman and child to achieve the highest attainable standard of health, and on the urgent need to achieve both equity in health and gender equality.

In 2011, the Member States of the Pan American Health Organization/World Health Organization (PAHO/WHO) adopted a *Plan of Action* to accelerate the reduction of maternal mortality and signed a resolution calling for the promotion of a dialogue between institutions in the public and private sector and civil society to prioritize women's lives as a human rights and development issue.

In order to facilitate dialogue—and in accordance with the Technical Guidance on the application of a human rights-based approach to the implementation of policies and programs to reduce preventable maternal morbidity and mortality, approved by the United Nations Human Rights Council in July 2012—PAHO/WHO convened a regional meeting to review the international legal framework, the regional situation and case studies, and the elements of a model law that would serve as guidelines for the preparation of national legal frameworks to guarantee women's right to reproductive health, healthy motherhood, and other related human rights. Participants in this meeting included representatives of ministries in the social sector and agencies tasked with ensuring respect for human rights, lawmakers, and representatives of civil society and international agencies.

The Pan American Health Organization presents this document as a contribution to the analysis, deliberation, and decision-making processes under way in each country of the Region to effectively guarantee the right to reproductive and maternal health as key to achieving universal health coverage (UHC).

Matilde Pinto

*Senior Advisor, Health Economics and Planning
Department of Family, Gender, and Life Course*

**History of
Maternal Death.**
**Reproductive Health
Observatory (OSAR)**

Petén, Guatemala,
2009

“... a woman arrived at the hospital in labor (after four hours on the road). She patiently stood in line with eight other women. Leti (let’s call her that) was seen at 10 p.m.

Her husband waited outside with two men who shared his anxiety. The announcement that a baby boy had been born calmed him down. “Everything is fine,” said a nurse in a worn-out uniform. The man waited impatiently for an eternity until the nurse came out again, unsmiling, and said: “Sign these papers. Your wife died of exhaustion.”

Died? Yes, just like that.

After a thorough investigation, it turned out that Leti had bled to death after giving birth.”

Dr. Carissa F. Etienne
**Director, Pan American Health
Organization**

Inaugural address, 31 January
2013

“Giving birth can be one of the most joyous events in a woman’s life, but it can also be one of the most dangerous. Every day, women around the world die from preventable causes related to pregnancy and childbirth. We cannot tolerate maternal mortality in this modern world. Every mother, every child, and every family must be cared for.”



ACKNOWLEDGMENTS

The Pan American Health Organization/World Health Organization (PAHO/WHO) would like to thank the experts who took part in the meeting on Reproductive Health and Healthy Motherhood: Aligning National Legislation with International Human Rights Law, held in Santo Domingo, Dominican Republic, on 11-12 March 2013.

The technical expertise and sectoral perspective of each of them enriched the conversation on how to protect reproductive health and healthy motherhood. This publication benefits from their comments, thoughts, and contributions.

Thanks, also, to the Reproductive Health Observatory (OSAR) in Guatemala for preparing the first draft of the chapter on the civil society experience in drafting and passing the Healthy Motherhood Act in Guatemala.

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ACRONYMS

CAIMI	Center for Comprehensive Maternal and Child Care
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CMPMS	Multisectoral Committee on Healthy Motherhood (Guatemala)
CNE	National Epidemiology Center (Guatemala)
ENMM	National Study on Maternal Mortality
ENSMI	National Survey of Maternal and Child Health
EOC	Emergency oral contraceptive
IGSS	Guatemalan Social Security Institute
LAC	Latin America and the Caribbean
MDGs	Millennium Development Goals
MIFIN	Ministry of Finance
MMR	Maternal mortality ratio
MSPAS	Ministry of Public Health and Social Welfare
OSAR	Reproductive Health Observatory (Guatemala)
PAHO	Pan American Health Organization
PEC	Extended coverage program
PHCC	Primary health care center
RMNCH	Reproductive, maternal, neonatal, and child health
SEGEPLAN	Secretariat of Planning and Programming of the Presidency of Guatemala
SIGSA	Health Management Information System
UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Fund
USAC	University of San Carlos (Guatemala)
WHO	World Health Organization



International human rights law includes fundamental commitments of States to enable women to survive pregnancy and childbirth (1).

Links between maternal health policy/legislation and human rights:

- Legislation helps achieve policy goals;
- Legislation is a mechanism for putting human rights obligations into practice;
- Legislation enforces the right to maternal health (pregnancy, delivery, postpartum services, etc.).

I. REPRODUCTIVE AND MATERNAL HEALTH: A DEVELOPMENT AND HUMAN RIGHTS ISSUE

1. Background

Reproductive health and healthy motherhood¹ have been recognized both globally and regionally as a human development issue involving the right to the enjoyment of the highest attainable standard of health and other related human rights.

The links between maternal mortality and the right to health underscore the importance of taking this right into account in strategies to reduce maternal mortality and also highlight the role that the human rights community can play in reducing maternal mortality (2).

In June 2009, the United Nations Human Rights Council adopted a historic resolution explicitly recognizing preventable maternal mortality as a human rights issue and emphasizing the important role that could be played by treaty monitoring bodies and special procedures (3). Following this resolution, based on the recommendations of a study conducted by the Office of the United Nations High Commissioner for Human Rights in July 2012, the Human Rights Council drew up specific Technical Guidance for policymakers and program designers working to reduce maternal mortality and morbidity, taking a human rights-based approach (hereinafter the Technical Guidance) (1).

Binding international instruments and human rights standards have been agreed to by the States; their application would facilitate the achievement of Millennium Development Goals (MDGs) 4 and 5.² However, despite the existence of a widely-known set of clearly effective strategies and interventions of proven cost-effectiveness and the fact that most Latin American and Caribbean (LAC) countries are parties to these policies, programs, and treatment protocols, every year more than 9,000 women die from maternity-related causes, and 70,000-80,000 children die in their first 28 days of life—60% of them under circumstances preventable with timely care (premature birth, asphyxiation, and infection).

Given this situation, countries need legislation that guarantees compliance with health policies, plans, programs, and treatment protocols. Such legislation should be aligned with international and regional instruments that protect human rights and the basic freedoms associated with the sexual and reproductive health of women and adolescents. Interventions should target the different stages of the reproductive process that contribute to healthy motherhood, beginning prior to conception and continuing through pregnancy, childbirth, and the postpartum period, as described in the Technical Guidance.

Lawmakers have begun to recognize the role they have to play. The resolution adopted at the 126th Inter-Parliamentary Union Assembly in April 2012 urges parliaments to: “introduce or amend legislation to guarantee equal access to health services for all women and children without discrimination, and to provide free essential health services for all pregnant women and children” (5).

Children who lose their mother at birth have a higher risk of dying before the age of two, dropping out of school, suffering from malnutrition and family violence, experiencing early pregnancy, becoming the victims of child labor, and continuing the cycle of poverty (4).

¹ Healthy motherhood includes the mother and newborn: Following the life course approach, action taken prior to conception and onward is aimed at protecting the health of both.

² MDG 4 calls for a two-thirds reduction in infant mortality between 1990 and 2015; MDG 5, a three-quarters reduction in the maternal mortality ratio in the same period.

In view of the delay in achieving the MDG related to women's health (MDG 5), at the 51st PAHO Directing Council of the Pan American Health Organization (PAHO/WHO) in September 2011, the Ministers of Health approved the *Plan of Action to Accelerate the Reduction in Maternal Mortality and Severe Maternal Morbidity* (hereinafter the *Plan of Action*) (6). The *Plan of Action* states that around 95% of maternal mortality in LAC could be prevented with the knowledge that the countries have today, and recognizes that avoidable maternal mortality and morbidity are an expression of inequity, inequality, and a lack of women's empowerment.

The *Plan of Action* has the following general objectives:

- To accelerate the reduction in maternal mortality;
- To prevent severe maternal morbidity; and
- To strengthen surveillance of morbidity and mortality.

Resolution CD51.R12 (Annex I), which accompanies the *Plan of Action*, urges the PAHO/WHO Member States to take action that goes beyond the ministries of health into the field of public policy, by:

- Adopting national policies, strategies, plans, and programs that increase women's access to high-quality health services;
- Considering offering all these services free of charge to the most vulnerable populations;
- Prioritizing women's lives as a human rights and development issue;
- Promoting the empowerment of women and the participation and shared responsibility of men in sexual and reproductive health; and
- Advocating for specific, strategic public funding.

In public policy, recognition of the right to reproductive health and healthy motherhood has been achieved through a collaborative effort at the global and regional levels.

The *Plan of Action*, based on human rights treaties and standards, was prepared within the framework of the stated commitment of the Member States to work to guarantee the right to the enjoyment of the highest attainable standard of health and other related human rights, found in Resolution CD50.R8 of 2010 (Annex II), adopted by the PAHO Directing Council after a decade of work utilizing international norms and human rights treaties in public health.

The WHO Commission on Information and Accountability for Women's and Children's Health (7), convened by the United Nations Secretary General as one of the initiatives for implementing the Global Strategy for Women's and Children's Health (8), seeks to enhance the effectiveness of resources allocated to reproductive, maternal, neonatal, and child health (RMNCH). It also helps reduce inequities and promote progress toward gender equality and interculturalism, and proposes a framework of accountability aligned with the International Covenant on Economic, Social, and Cultural Rights (9), the Convention on the Elimination of All Forms of Discrimination against Women (10), and the Convention on the Rights of the Child (11). In LAC, the American Convention of Human Rights (12) and the Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women (Convention of Belém do Pará) (13) are also applicable.



2. Maternal Mortality in Latin America and the Caribbean

Maternal mortality was reduced by 44% in the Region between 1990 and 2010, meaning that more than 6,000 maternal deaths were prevented in that period. While some countries have seen a sharp decline in maternal mortality, the Region as a whole still needs an additional 31% reduction if it is to reach MDG 5 by 2015. The profound inequities in the majority of the countries are an additional hurdle. For example, only 40% of women in the bottom income quintile are attended by skilled personnel during pregnancy, childbirth, and the postpartum period, while nearly 100% of women in the top quintile receive skilled care. These data are even more dramatic in countries with large indigenous, Afro-descendant, and rural populations.

Avoidable maternal mortality and morbidity are an expression of inequity, inequality, and lack of empowerment of women.

The *Plan of Action* states that, according to the basic health indicators for 2010, there were 9,500 maternal deaths in Latin America and the Caribbean, for a maternal mortality ratio (MMR) of 88.9 per 100,000 live births at the regional level. These figures are trending downward, in both the data that the countries have reported to PAHO and the maternal mortality estimates that different groups have produced (excluding the United States and Canada). The maternal mortality ratio varies widely from country to country: in 2011 Uruguay reported a MMR of 6.4, while Haiti had an estimated 350 (with an interval of 210-610) (14).

The leading causes reported are:

- Hypertension (26%)
- Hemorrhage (21%)
- Medical complications from abortion under dangerous conditions (13%)
- Obstructed labor (12%)
- Sepsis (8%)
- Other direct causes (15%)

Based on existing knowledge,

95%
of maternal mortality is preventable if a woman receives timely high-quality care.

This denotes inequity in the Region, and the fact that the existing avoidable maternal mortality and morbidity is an expression of inequity and inequality and a lack of women's empowerment (6).

Adolescent pregnancy

Adolescent pregnancy poses a high risk to both mother and baby. Some studies have shown that the likelihood of maternal death quadruples in adolescent mothers under the age of 15 (15). In 2007, maternal death was among the four leading causes of death in young women aged 15-24 (16).

Although adolescent fertility and birth rates have fallen sharply in recent decades, the rates in LAC remain high. According to the most recent data, the estimated fertility rate for adolescents aged 15-19 in roughly half of the countries in the Region is above 71 per 1,000 women, ranging from 45 in Haiti to 111 in Nicaragua. In comparison, the adolescent fertility rate is 12 in Canada and 33 in the United States.

Early pregnancy limits a girl's personal development and her ability to achieve her potential. For example, adolescent mothers (aged 10-20) are more likely to drop out of school than mothers aged 20-24. Early pregnancy also affects employment: studies have shown that adolescent mothers (age 10-20) are less likely to be employed than mothers aged 20-24.

The *Plan of Action* contains the following strategic areas aimed at reducing the barriers and inequities observed in the LAC region:

(1) *Prevention of unwanted pregnancies and resulting complications:* Increase the use of modern contraceptive methods by women of reproductive age, with an emphasis on adolescents;

(2) *Universal access to affordable, high-quality maternity services within the coordinated health care system:* Ensure that high-quality maternal health care services are offered as part of integrated health systems;

(3) *Skilled human resources:* Increase the number of skilled personnel in health facilities for preconception, antenatal, childbirth, and postpartum; and

(4) *Strategic information for action and accountability:* Strengthen information systems and maternal and perinatal health monitoring and vital statistics.

Legislative action that Member States have committed to in the Plan of Action

- Draft and/or adopt national laws and regulatory frameworks to guarantee universal access to modern contraceptive methods (section 1.5)
- Draft and adopt national laws and regulatory frameworks for universal access good quality maternity services (section 2.9)

By approving the *Plan of Action*, the LAC countries have made specific commitments to legislation aimed at guaranteeing healthy motherhood.

3. Legislative Barriers and Access to Health

The *Plan of Action* reports that many maternal deaths are the result of unwanted pregnancies attributable to limited access to contraceptive methods—a situation especially common in the adolescent population. Although there is a relationship between unmet contraceptive needs and limited access to health services, the existence of geographical, cultural, and economic barriers over and above the legislative and practical barriers should be borne in mind.

PAHO/WHO studies and workshops in 18 Member States of the Region (17), have identified the following challenges with respect to reproductive rights and healthy motherhood:



It is necessary to provide ongoing training on the use of international and regional human rights instruments and how to integrate them into policies, plans, and laws in the countries that have ratified them.

- Lack of sexual and reproductive health policies and legislation consistent with the obligations spelled out in international human rights instruments, both at the global level (United Nations) and the regional level (Organization of American States);
- Limited awareness of the human rights instruments applicable to sexual and reproductive health, especially among health workers and judges;

- Lack of mechanisms to enable human rights ombudsmen to protect human rights associated with sexual and reproductive health and ensure that they are respected; and
- Legal provisions that restrict human rights, such as the dissemination of confidential information on reproductive health; restricted access to emergency oral contraceptives (EOC) and family planning methods; and a lack of protocols for therapeutic abortion.

Interparliamentary action and the establishment of subcommittees on healthy motherhood are essential for lending visibility to the issue and finding solutions.

In light of the growing role of national legislatures and the courts in decision-making on sexual and reproductive health (e.g., access to family planning methods, information about sexual health, access to therapeutic abortion, the ability of young people make decisions and give consent for medical examinations and treatment), it is essential for multidisciplinary teams to work together to identify gaps and opportunities for drafting policies and laws to guarantee reproductive rights and other related human rights.

In addition to the barriers faced by the adult population, adolescents face other obstacles: some are related to the health services themselves and to the behaviors of health workers, while others are imposed by the legal framework.

These include:

- Failure to respect young people's right to confidentiality and privacy;
- Insufficient safe, confidential, institutional services for sexual and reproductive health that offer information, counseling, and the interruption of pregnancy;
- Limited family counseling services and parent education programs;
- Lack of access to family planning, including EOCs for adolescents, and lack of protocols for the therapeutic interruption of pregnancy; and
- Lack of mechanisms to enable human rights ombudsmen to protect human rights, including visits to adolescent health services and other national agencies that protect young people's human rights.

Legal and institutional barriers must be removed to allow adolescents access to sexual and reproductive health care.

4. Obligations Deriving from International Human Rights Law

Human rights are a necessary tool in the effort to develop legal and programmatic frameworks consistent with respect for personal dignity.

It is a very valuable strategy to use international human rights instruments to change stereotypes regarding the so-called “natural order” that have led to the idea that it is normal for women to die during childbirth or that women are inferior beings.

International human rights law helps reduce the maternal mortality ratio in three ways, by:

1. *Establishing an alternative regulatory framework to counter stereotypes about women, mothers, and maternity;*
2. *Focusing attention on disparities in health care; and*
3. *Clarifying the obligations of all actors—not only States, but also civil society—in the effort to reduce preventable maternal mortality.*

The legal obligations surrounding human rights establish basic equality for all people. In this regard, Article 1 of the Universal Declaration of Human Rights establishes that “all human beings are born free and equal in dignity and rights...”.

The Member States have recognized the importance of international human rights law as a mechanism for accountability, surveillance, transformation, and empowerment (19).

The Program of Action of the International Conference on Population and Development, held in Cairo in 1994 (18), marked a change with regard to the recognition of women’s sexual and reproductive health as a fundamental human right. It stated that the objective of family planning programs should be for “couples and individuals to decide freely and responsibly the number and spacing of their children.” The Cairo Conference also emphasized the importance of access to information and the means for obtaining it, as well as guaranteeing informed choices based on a wide range of safe and effective methods.



Legislation should take several binding international human rights instruments into account:

- *The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) (10).*
This is considered the definitive international treaty on women's rights. Article 12 of the Convention expressly urges to States to eliminate discrimination against women in the field of health care in order to ensure access to health care services, including those related to family planning.
- *The International Covenant on Economic, Social, and Cultural Rights (9).*
This instrument protects the universal right "to the enjoyment of the highest attainable standard of physical and mental health." As a part of the right to health, States must adopt measures to prevent, treat, and control diseases with appropriate medical services for women. The right to health includes the obligation to adopt "measures to improve child and maternal health, sexual and reproductive health services, including access to family planning, pre- and post-natal care, emergency obstetric services and access to information, as well as to resources necessary to act on that information."
- *Convention on the Rights of the Child (11).*
Article 13 of the Convention enshrines freedom of expression, which includes the "freedom to seek, receive, and impart information and ideas of all kinds," which implies the right to receive sex education and have access to information on scientific advances useful in protecting their health. Moreover, Article 17 firmly establishes children's right to receive information from various sources that promote their "social, spiritual, and moral well-being and physical and mental health."



II. NATIONAL LEGISLATION WITH AN IMPACT ON HEALTHY MOTHERHOOD

Legislation is a mechanism for implementing policies designed to raise minimum levels, secure financing, help resolve conflicts, create societal change, promote education, and guarantee the exercise of reproductive rights, healthy motherhood, and other human rights.

Role of lawmakers

- *Include the human rights recognized by treaties and conventions in legislative proposals;*
- *Draft legislative proposals that eliminate discrimination;*
- *Include the right to access to reproductive and maternal health services for all; and*
- *Include accountability and monitoring mechanisms.*

1. Principles

Lack of timely equitable access to high-quality services is the root cause of maternal and neonatal mortality. It is therefore important for legislation to apply principles conducive to reducing inequities and protecting the right to reproductive health and healthy motherhood.

These principles include guaranteed universal and timely access to high-quality health facilities, comprehensive health services, and goods and technologies tailored to the needs and geographic access of the population. Within this framework, free access and public funding eliminate financial barriers and ensure sustainability.

2. Health Care Components

Legislation should guarantee access to a set of interventions identified as cost-effective for the protection of reproductive, maternal, and neonatal health throughout the life course (20). Beginning in adolescence, this includes access to sexual and reproductive health services to prevent unwanted pregnancies and prepare for healthy pregnancies. During pregnancy, childbirth, and the postpartum period women should receive care that minimizes risks, and newborns should receive timely essential treatment for neonatal morbidity.

3. Financing and Insurance Systems

The availability of financial resources is necessary but not sufficient for a health system to produce a set of interventions that protect reproductive health and healthy motherhood throughout the life course. It is also necessary to consider how resources are generated and allocated (avoiding situations in which access to care depends on one's ability to pay) and how effectively and efficiently they are used.

Accordingly, the Commission on Information and Accountability for Women's and Children's Health urges countries to "regularly review health spending (including spending on reproductive, maternal, newborn, and child health) and relate spending to commitments, human rights, gender, and other equity goals and results."

In addition to the availability of resources, consideration should be given to:

- *Nonregressive tax collection mechanisms;*
- *Equitable allocation of resources; and*
- *Efficient and effective implementation.*

It is essential that financing policies employ mechanisms to eliminate financial barriers to access, such as point-of-care charges, including the cost of drugs (and transportation where geographical conditions so require). Moreover, the allocation of resources should be based on prioritize spending aimed at serving vulnerable populations, since this is where the widest gaps are found in terms of access to health services—and the worst results in terms of maternal and neonatal mortality and morbidity.

Public policy on health care revenue and spending plays a key role in reducing in the inequalities and inequities concealed in the calculation of average figures for the progress made.

In Resolution CD51.R12, the ministers of health call on the Member States to advocate for dedicated public budgets, based on strategic results, aimed at improving the coverage and quality of care for women and children, and to provide these services free of charge to the most vulnerable populations. (Sections 2.c and 2.h)

It is also urgent to improve efficiency in health care delivery processes. The WHO estimates that 20-40% of total health spending is wasted through inefficiency and asserts that all countries, regardless of income level, can take steps to reduce inefficiency after determining its nature and causes (21).

The Technical Guidance points out that addressing maternal health as a human rights issue should be paired with added protection for resources allocated to related programs at both the national and subnational levels. Therefore these budgets should be protected against cutbacks in the public budget, as well as receive a more than proportional share of any increase in total available resources (Section 47 of the Technical Guidance).

In countries that have reduced their maternal mortality ratio by more than the regional average, progress is associated with expanded coverage accompanied by restructured financing and better management of reproductive and maternal health services. Higher public spending (through tax revenues or loans from development banks) has been accompanied by results-based budgeting and the use of more efficient procurement mechanisms.

Reproductive health care and healthy motherhood, like the health system as a whole, receive mixed financing that, in different proportions, combines resources generated by four systems:

- Tax revenues
- Contributions to social security and mutual funds
- Private insurance
- Out-of-pocket or direct payment by users

Jointly funded systems—based on general tax revenues, social security premiums, and even mutual funds—are the preferred mechanisms. First of all, they avoid direct out-of-pocket payments at the point of service delivery, thus keeping low-income families from incurring catastrophic costs and falling into poverty. Secondly, joint funding includes mechanisms for redistributing income from higher-income to lower-income people. Finally, in addition to redistributing income, social security systems also operate on the premise of solidarity: from healthy people to the sick and from young people to the old.



Contributory systems, however, have limited capacity to serve the informal sector of the economy, which includes indigenous women and rural populations. As a result, several countries have used public funds to extend social security coverage to vulnerable populations. Furthermore, regulations in some countries oblige other insurance schemes, such as savings cooperatives, mutual funds, and private insurance plans, to include maternal services such as childbirth and emergency obstetric services in their health plans.

Meanwhile, some countries have begun the transition from traditional public budget allocations to territorial, results- and product-based budgets. This means that resources are allocated according to the size of the priority population and the respective reproductive and maternal health indicators.

4. Strategies for Adopting Policies and Legislation

For the obligations arising from international and regional human rights instruments to be integrated into national policies and legislation, States must adopt strategies and priorities—in collaboration with stakeholders—to determine what action is necessary and who should carry it out in the short, medium, and long term.

With this objective, the following actors could be considered:

- Health authorities in the various ministries involved, especially the national health authority (e.g., ministry/secretariat of health);
- Other ministries and secretariats (e.g., finance, women’s affairs, and education);
- Legislative bodies (parliaments and parliamentary commissions) and parliamentarians;
- The judicial branch, including the courts;
- Civil society groups, activists, users of health services, and nongovernmental organizations that work to protect the human rights of women and adolescents; and
- Universities.

Such strategies must take into account the potential role of human rights committees, treaty bodies of the United Nations and Inter-American systems, and specialized United Nations agencies.

Table 1. Potential short-term actions (by actor)

ACTORS	ACTIONS
Health authority	Boost the technical capacity of the health authority by providing training and raising awareness about healthy motherhood and reproductive health, using international and regional human rights instruments, especially those that protect women and adolescents.
Ministry of education	Make sexual and reproductive health part of the adolescent curriculum. Prepare training modules in conjunction with the ministry of health.
Parliaments/ parliamentary commissions	Understand the importance of reproductive health and healthy motherhood and hold sessions with civil society groups to determine whether existing legislation is sufficient or needs to be amended or new legislation needs to be introduced.
Judicial branch/ courts	Familiarize judges and magistrates with the international human rights instruments that protect women and adolescents.
Civil society groups	Try to raise awareness and educate the media about reproductive, maternal, and neonatal health.
Universities	Adapt the curriculum to include information about international human rights instruments.

Strategies:

- Identify someone in each country who is a leader in promoting healthy motherhood and sexual and reproductive health;
- Identify an actor to promote initiatives in parliaments;
- Create parliamentary subcommittees for healthy motherhood;
- Continue to build strategic partnerships for raising awareness and obtaining technical support from regional and global agencies, such as the Latin American Parliament (PARLATINO), the Parliamentary Confederation of the Americas (COPA), and the Inter-Parliamentary Union (IPU), as well as national legislatures in the Region;
- Harmonize positions within countries, including those of the ministries of economy and finance;
- Raise awareness in the media, courts, secretariats, and human rights ombudsmen’s offices;
- Seek the support of universities and partnerships with professional associations; and
- Work on changing the university curriculum for health workers to include universal and regional human rights regulations and standards.

Tables 2 and 3 provide a summary of strategies, actors, and implementation mechanisms.



Table 2. Short-term strategies

ACTION	OBJECTIVE	STAKEHOLDERS	IMPLEMENTATION
Convene a multidisciplinary forum	Disseminate information and provide training on the binding human rights instruments and standards to which the country has committed itself	High-level health officials, judges, human rights ombudsmen, finance officials, professional associations, academics, civil society organizations, social protection officials, cabinet ministers	Formal request by parliament and associations. Requires legislation and monitoring.
Map the actors, draft a proposal, create a support group	Strengthen commitments	All members of parliaments who chair specialized committees (health, women's committees, etc.)	Interdisciplinary working groups
Send a letter of commitment on the issue of maternal and child health to everyone in the country's health system	Raise awareness about the importance of the issue; forge strategic partnerships	All professionals in the health system (including senior management)	Formalized by the president/government
Implement monitoring and surveillance mechanisms through the office of the public ombudsman, United Nations human rights treaty committees, and civil society initiatives	Promote public administration Consultations with ministries of foreign affairs and ministries of health facilitated by PAHO	Human/civil rights ombudsmen and ministries of foreign affairs UN treaty committees (Committee on the Rights of the Child, CEDAW, etc.)	Civil society petitions to ombudsmen regarding human rights violations that jeopardize maternal and neonatal health Ministries of health, PAHO, and ministries of foreign affairs collaborate in the preparation of reports to UN treaty committees and Inter-American committees

Table 3. Medium- and long-term strategies

ACTION	OBJECTIVE	STAKEHOLDERS	IMPLEMENTATION
Include a specific training module in judicial studies	Education, training, and awareness-raising	Students of the judiciary	Inclusion in the curriculum
Make the media more effective	Raise awareness about the issue: include business	Civil society, business, and the media	Through the relevant people
Maternal health observatory: university medicine	As part of medical training, students, and professors investigate and delve more deeply into the issue; Promote research, especially on childhood and adolescence	Universities, civil society leaders, government officials	Ministry of Health budget line
Professional associations (educators, nutritionists, lawyers, doctors, nurses)	Multidisciplinary efforts by professional groups regarding the issue	Professional associations (educators, nutritionists, lawyers, doctors, nurses)	Preparation of technical reports as requested by civil society organizations, universities, and government



III. PROPOSED MODEL LAW ON REPRODUCTIVE HEALTH AND HEALTHY MOTHERHOOD

A PAHO/WHO interprogrammatic group prepared model law for the prevention and reduction of maternal and neonatal mortality. This model is grounded in equity, freedom of choice, elimination of risk behaviors, exercise of the right to reproductive health and other related human rights, access to information, the reduction of inequities in access to health products and technologies, and the reduction of violence.

Interdisciplinary working groups were formed to review the proposal and study the original text, taking the following into account:

- Relevance of the components in terms of reflecting national needs, effectively ensuring the right to reproductive health, and reducing maternal and neonatal mortality;
- Comprehensiveness of the text and aforementioned actions to effectively address the issue;
- Importance of the “Whereas” clauses to reflect national situations and the global context of the issue;
- Relevance and scope of the “Principles” that guide the actions related to reproductive health and healthy motherhood; and
- Proposal’s potential to integrate and find common ground among the different stakeholders in the issue.

The text presented below took the input of the working groups into account. Its purpose is to furnish guidelines for the advocacy process and the preparation of possible national legislation aimed at guaranteeing healthy motherhood.

Model framework for legislative text on REPRODUCTIVE, MATERNAL, AND NEONATAL HEALTH³

Whereas⁴

(Name of the country) has signed and ratified the following international human rights instruments applicable to reproductive, maternal, and neonatal health:

Whereas

The Constitution of (name of the country) recognizes

Whereas

The United Nations High Commissioner for Human Rights issued the document *Technical guidance on the application of a human rights-based approach to the implementation of policies and programs to reduce preventable maternal morbidity and mortality* in order to help those responsible for and involved in policy-making to improve health, promote women’s rights, and strengthen accountability processes.

Whereas

The countries of the Region made the commitment to reduce maternal mortality by 75% by the year 2015, based on 1990 figures (MDG 5) and, only three years before that date, the regional rate has been reduced by 44%, with a 31% gap remaining.

Whereas

In (insert the name of the country and data on annual number of maternal deaths, maternal mortality ratio, and inequity in conditions of access—including ethnic group, income, education, and other data relevant to the country).

Whereas

To improve the health of women and newborns, it is necessary to have a functional health system that guarantees access without financial, geographical, or cultural barriers to a set of interventions at the different stages in the life course, and with respect for human rights and basic freedoms, including reproductive rights, national, cultural, linguistic, ethnic, and racial identity, and the values and customs of each community.

³ Includes the comments made by the working groups at the meeting on reproductive health and healthy motherhood (Aligning national legislation with international human rights law), held in Santo Domingo, Dominican Republic, on 11-12 March 2013.

⁴ This model law uses “whereas” clauses; however, in many countries, legal practice requires preliminary recitals. The content of the information used to construct the clauses presented here can also be used to prepare preliminary recitals.



Whereas

The international community has issued a call for dialogue between the public and private sectors and civil society in order to prioritize women’s and children’s health as a component of human development.

Whereas

The Member States of the Pan American Health Organization have approved Strategies and Regional Plans of Action for the performance of health systems—in particular, for reproductive, maternal, and neonatal health—based on international human rights law, which should be considered in national policy-making, plans, legislation, and programs.

CHAPTER I GENERAL PROVISIONS

Article Objective. This Law seeks to guarantee protection of the right to reproductive health and the prevention and reduction of avoidable maternal mortality, serious maternal morbidity, and neonatal morbidity and mortality through universal, timely access to high-quality health facilities, comprehensive health services, and appropriate products and technologies.

Article ... Scope. This Law covers all levels of health care services operated by the Ministry/Secretariat of Health (or national health authority, as appropriate), the social security system and other public sector institutions, for-profit or nonprofit private institutions, and nongovernmental organizations that provide reproductive, maternal, and neonatal health services.

Article ... Leadership. The Ministry/Secretariat of Health (or national health authority, as appropriate) shall be the regulatory body for actions to which this Law applies, including the development of strategic plans and policies and regulatory frameworks, as well as the monitoring of results, the evaluation of the Law’s impact on equity, and intersectoral coordination.

Article ... Guiding principles. Reproductive, maternal, and neonatal health shall be protected through application of the following principles:

- a) **No charge:** for any reproductive, maternal, and neonatal health-related action taken in the public health services.
- b) **Equity:** guaranteeing access to reproductive, maternal, and neonatal health services to bridge gender gaps and inequalities among geographical areas, ethnic groups, and poverty levels.

- c) **Nondiscrimination:** ensuring access, *de facto* and *de juris*, to facilities, goods, health services, and appropriate technologies without distinction of gender, ethnicity or race, language, religion, political or other opinions, economic condition, place of birth, disability, health status (including HIV/AIDS), or sexual orientation, that would, by design or result, invalidate or undermine the equal enjoyment or exercise of the right to health.
- d) **Availability:** of a sufficient number of facilities, goods, public services, and health care centers, as well as sexual and reproductive, maternal, and neonatal health programs.
- e) **Access:** guaranteeing that all sectors of the population have access to reproductive, maternal, and neonatal health services with a broad geographical, cultural, and economic scope. Particular emphasis shall be placed on groups living in conditions of vulnerability.⁵
- f) **Acceptance:** ensuring that all health facilities respect the culture of individuals, minorities, peoples, and communities, and are sensitive to gender equality and the needs of adolescents.
- g) **Sustainability:** ensuring specific, sufficient, and permanent public financing for ongoing reproductive, maternal, and neonatal health care.
- h) **Quality:** guaranteeing that reproductive, maternal, and neonatal health services provide evidence-based services and have a sufficient number of trained health workers and reliable, effective equipment.
- i) **Participation:** in which the community, organized civil society, and local authorities collaborate with the health sector in the drafting, implementation, and evaluation of policies, plans, legislation, programs, and actions for reproductive, maternal, and neonatal health, in order to guarantee the right to the enjoyment of the highest attainable standard of health.
- j) **Accountability:** establishing mechanisms for the monitoring, evaluation, and social distribution of the impact of implementing policies, plans, programs, and legislation for reproductive, maternal, and neonatal health.

Article ... Interinstitutional coordination. Action under this Law shall be taken in coordination with the ministries/secretariats of Education, Women, Labor, and Social Development, and other institutions with relevant responsibilities.

⁵ Each country shall define vulnerability according to its own epidemiological and population profile and the structure of its health services network.



CHAPTER II ACTION ON REPRODUCTIVE HEALTH

Article ... The exercise of reproductive rights. The full exercise of reproductive rights includes universal, timely access to high-quality family planning services, including counseling and education to allow free and informed decisions about sexual and reproductive activity.

Article... With a view to ensuring access to family planning services under the terms established in the preceding article, the Ministry/Secretariat of Health (or national health authority, as appropriate) shall undertake initiatives with the education sector and other relevant entities aimed at *(Note: follow the strategic areas established in the PAHO/WHO Plan of Action to Accelerate the Reduction of Maternal Mortality and Severe Maternal Morbidity):*

- a) Comprehensive education of adolescents on their human and reproductive rights and their responsibilities in the care of their health and sexuality, and the prevention of early and unwanted pregnancy.
- b) Counseling and education that help women and men make informed decisions about fertility.
- c) Counseling and education for the spacing of pregnancies.
- d) Facilitating access to modern contraceptive methods, even for adolescents.
- e) The prevention of sexually transmitted infections (STIs), including HIV/AIDS at all levels of the national education system.

CHAPTER III ACTION ON MATERNAL AND NEONATAL HEALTH

Article ... On maternal and neonatal health care. Maternal and neonatal health care includes the following areas (*follow the strategic areas established in the PAHO/WHO Plan of Action to Accelerate the Reduction of Maternal Mortality and Severe Maternal Morbidity*):

- a) Care for women in the preconception period, pregnancy, childbirth, and the postpartum period.
- b) High-quality delivery and newborn care, including immediate identification and contact with the mother and specific preventive practices.
- c) Assessment of fetal growth and specific requirements, with individualized attention to these requirements.
- d) Immunization and Integrated Management of Childhood Illness (IMCI), as well as treatment of HIV, congenital syphilis, and other pathologies.

Article ... Respectful treatment during reproductive, maternal, and neonatal health care. Reproductive, maternal, and neonatal health care shall be provided with full respect for the dignity and rights of individuals. To this end, health teams should receive training on sexual and reproductive rights. Mechanisms shall exist for users to lodge a complaint if these rights are violated.

Article ... During Preconception. Health services that fall within the scope of this Law shall include counseling to enable users to make informed decisions about pregnancy, prepare for healthy pregnancy, including nutritional and vitamin supplements, or prevent unwanted pregnancies through family planning.

Article ... During Pregnancy. Health services that fall within the scope of this Law shall include the following interventions:

- a) Prenatal care, including the detection of HIV and syphilis, and treatment for women and their partners.
- b) Ensuring the availability and provision of drugs and supplies for health care during pregnancy.
- c) Understandable information about action in obstetric emergencies.



- d) Identifying and reporting situations of physical, psychological, or sexual violence to which a pregnant woman may be exposed, and actions to prevent and respond to such situations.

Article ...During Childbirth. Health services that fall within the scope of this Law shall include the following necessary actions to create a referral system in the health care network, guaranteeing safe and supportive childbirth:

- a) Provide health care equipment for childbirth; this shall include access to a safe blood supply of sufficient quantity and quality, and equipment for the delivery and care of the newborn.
- b) Promote emotional support for women during childbirth.
- c) Emergency obstetric care and newborn care at the time of delivery shall include the basic services required by the World Health Organization standards.
- d) Health care in childbirth shall be provided by skilled workers with support services operating 24 hours a day.

Article ... During Postpartum. Until at least 42 days after delivery, the health services that fall within the scope of this Law shall include the following necessary actions:

- a) Postpartum care.
- b) Detection of and information on emotional problems related to childbirth, family planning, and the prevention of cervical and breast cancer.
- c) Promotion and support of sustained breastfeeding.
- d) Monitoring of newborn health.
- e) Prevention of complications and information on how to care for newborns at home after leaving the health care facility.
- f) Identification and treatment of the problems of prematurity, low birthweight, and neonatal morbidity.
- g) In the case of home births: a visit by a skilled health worker in the first 24-48 hours after birth.
- h) Protocol for the prevention of mother-to-child transmission (PMTCT) for newborns exposed to HIV or syphilis.

CHAPTER IV FINANCING REPRODUCTIVE, MATERNAL, AND NEONATAL HEALTH SERVICES

Article ... Financing reproductive, maternal, and neonatal health services. To correct inequalities and guarantee access to reproductive, maternal, and neonatal health services a specific budget line will be allocated to this end. The budget allocation shall prioritize the geographical areas with the highest maternal and neonatal mortality and cannot be reduced as a result of financial crises.

CHAPTER V COMPLEMENTARY PROVISIONS

Article ... Human resources. The health services shall have sufficient skilled health workers to provide health care to women in the preconception period, pregnancy, childbirth, and the postpartum period.

Article ... Free health services. Reproductive, maternal, and neonatal health services shall be free of charge at the point of care in public health facilities. Emergency obstetric care shall be free of charge in all health institutions within the scope of this Law, without prejudice to the applicable interinstitutional reimbursement processes.

Article ... Accountability/evaluation. In order to monitor compliance with the objectives of this Law and the respective standards and procedures for reproductive, maternal, and neonatal health, a monitoring and evaluation system shall be created with the participation of the community, the health sector, and other stakeholders. For this purpose, the pertinent international standards and recommendations shall be used to develop indicators, and the information obtained shall be in the public domain.

Article ... Promotion of research. Research should be promoted on the incidence and transmission mechanisms of HIV/AIDS and other STIs in different population groups, including newborns.

Article ... Protection of the rights of pregnant women in support of maternal and neonatal health. No one may prevent a pregnant woman from visiting a health facility to receive appropriate care.



CHAPTER VI SANCTIONS

Article ... Will be penalized by.... *(each country shall establish sanctions in accordance with its domestic legislation)*. This should include penalties applicable to partners or third parties who, for cultural or other reasons, prevent a pregnant woman from visiting health facilities.



IV. PASSAGE OF THE HEALTHY MOTHERHOOD LAW IN GUATEMALA: A CIVIL SOCIETY UNDERTAKING⁶

Civil society organizations are important democracy-building institutions in the countries. Civic engagement and the exercise of civil rights enable citizens to: i) express their needs, knowledge, and demands; ii) follow and scrutinize the work of decisionmakers; iii) encourage transparency and accountability on the part of government authorities; and iv) foster the conditions to guarantee the sustainability of the policies adopted.

One example is the case of Guatemala, where civil society engagement has enabled the sectors charged with making healthy motherhood a reality to reach a consensus, with civil society assuming a key role in monitoring and maintaining accountability. This chapter presents an analytical account of the experience of Guatemalan civil society in the drafting, negotiation, and passage of the Healthy Motherhood Law and the lessons learned that can inform other groups committed to women's and children's health concerned about developing a comprehensive public policy approach. *This experience shows that while passing the Law was a milestone, the work of drafting and approving the regulations to operationalize it and monitor compliance must go forward.*

In 2008, civic groups comprised of indigenous, nonindigenous, professional, and academic women concerned about the country's high maternal and neonatal mortality rates⁷ and about the fact indigenous and rural women account for the majority of these deaths, began taking a proactive stance to reduce death and injury to mothers and newborns and began reviewing the information from a technical standpoint in the search for potential solutions to these problems.

⁶ This chapter is based on the working document *Sistematización del proceso para la promulgación de la ley para la Maternidad Saludable en Guatemala: una experiencia desde la sociedad civil* [Systematization of the Process for Passage of the Healthy Motherhood Law in Guatemala: a Civil Society Undertaking], produced by the Reproductive Health Observatory (OSAR) of Guatemala. It was reviewed at a meeting attended by representatives of the organizations that had collaborated in the different stages of the process, which culminated in the passage of the Healthy Motherhood Law currently in force. Participants: Dr. Karin Slowing, former Secretary of SEGEPLAN; Dr. Elizabeth Porras, NGO; Dr. Linda Valencia, AGOG; Dr. Romeo Menéndez, AGOG; Dr. Alfredo Moreno, University of San Carlos of Guatemala; Ms. Patricia Borrayo, University of San Carlos of Guatemala, IUMUSAC; Dr. Marisela de Cruz, USAID Cooperation; Dr. Alejandro Silva, UNFPA Cooperation; Dr. Vinicio del Valle, Medical Association of Guatemala; Dr. Daniel Fradde, PAHO/WHO Cooperation; Dr. Roberto Escoto, PAHO/WHO Cooperation; Ms. Myrna Ponce, Congress of the Republic; Ms. Zury Rios de Weller, Congress of the Republic; Ms. Manuela García, *Organización de mujeres indígenas de Guatemala* [Organization of Indigenous Women of Guatemala]; Ms. Ana Victoria Maldonado, *Organización de mujeres indígenas de Guatemala*; Dr. Rossana Cifuentes, Guatemalan Association of Women Physicians; Ms. Carolina Vásquez Araya, Columnist, and Ms. Olga Villalta, journalist.

⁷ The National Study on Maternal Mortality 2007, conducted in 2011-2012, revealed that maternal deaths are concentrated among poor indigenous women without social security coverage who live in rural areas with no access to health services. In 2009, 380 maternal deaths were reported (more than one per day), 33% of which were attributable to the deficient skills of health workers or lack of supplies and equipment, meaning that women who manage to reach a health service do not receive the timely, good quality care mandated in the health care protocols, a constraint known as the "fourth delay."

Building on knowledge of the strategies for developing legal frameworks that support the right to health and the commitments assumed by the States, they decided to draft a bill to operationalize the provisions on motherhood found in national legislation and submit it to the Congress of the Republic: "Motherhood is protected by the State, which shall guarantee strict enforcement of the rights and obligations deriving therefrom;" "The life and health of mothers and children are a public good; healthy motherhood is therefore a matter of national urgency. Actions to effectively reduce maternal and infant mortality rates shall be promoted, supported and implemented."⁸

Recognition of the aforementioned inequities called attention to the need for targeted efforts in the six departments that in the past eight years had had MMRs above the national average of 153/100,000 live births (ranging from 211 to 174). Furthermore, the evidence that 60% of maternal deaths occur in the home or in transit supported the argument for specific, easily implemented legislation that would yield results that could be evaluated in the short term.

A cross-cutting element in the proposal is the defense of indigenous peoples through respect, inclusion, and the adaptation of the health services to ensure that they are culturally appropriate.

Passage of the Healthy Motherhood Law and approval of its regulations were the culmination of a three-year dialogue in which civil society groups organized, prepared, and took action, lobbying government entities in order to:

- i) gradually raise awareness among decisionmakers about maternal mortality and its societal consequences;
- ii) design, draft, and reach consensus on a bill with multisectoral participation at the national and departmental level;
- iii) engage in robust advocacy campaigns and political dialogue using official maternal mortality data, which resulted in the passage of the Healthy Motherhood Law; and
- iv) monitor compliance with the Law.

⁸ Article 52, Political Constitution of the Republic of Guatemala, 1985.



DRAFTING AND PASSAGE OF THE HEALTHY MOTHERHOOD ACT

1. Conceptualization

Given the maternal mortality situation in Guatemala, social organizations consider it necessary to put the following on the public policy agenda:

- Understanding of the harm that maternal death causes in terms of its repercussions on the family and society through analysis of the information provided by the Ministry of Public Health and Social Welfare (MSPAS);
- Knowledge that a country's MMR accurately reflects the inequity in society's response to women's health care needs during the preconception period, pregnancy, childbirth, and the postpartum period; and
- Analysis of the indicators, which show the vast differences among population groups depending on place of residence, ethnicity, and poverty level.

In order to draft the Law, it was decided to:

- Make the right to health the general framework, giving the Law a constitutional mandate and the backing of government institutions as guarantors and citizens the possessors of that right;
- Consider the need to declare the alarming maternal and neonatal mortality rates a critical problem; and
- Declare that, in light of this situation, the State should and must guarantee access by all pregnant women and their children to comprehensive services appropriate to their ethnicity, geographic location, and social group in order to ensure **free and ongoing comprehensive, equitable, intersectoral maternal and neonatal care.**

An operational bill containing multicultural guidelines and regulations tailored to the country's needs was drafted to turn this situation around via legislation, since maternal and neonatal deaths are largely preventable and avoidable, and maternal and child health are essential to national development.

It was decided that the bill should at the very least stipulate:

- The institutions involved;
- The responsibilities of each institution;
- Their institutional, financial, and legal scope; and
- Mandates requiring the stipulated action be taken in the health systems, involving national and local government agencies and civil society organizations in the process.

The initial group discussions and analysis led to the conclusion that guaranteeing healthy motherhood required:

- i) the commitment of national and local policymakers;
- ii) recognition of the country's identity, history, and culture;
- iii) recognition that motherhood has cultural and political implications and is not simply a biological process that affects the individual and the family; and
- iv) understanding that women's lives are affected by the gender roles that society assigns to them.

2. Design/drafting

Factors for legal analysis of the protection of motherhood in Guatemala

Legislation has a role to play in reducing unnecessary, avoidable, and unjust health inequalities. The majority of maternal deaths in Guatemala are preventable; many of them occur among poor indigenous women in rural areas—a reflection of the impact of unequal access to education, services, and information. Current domestic and international law recognizes the priority and societal nature of motherhood and sets goals and targets to protect it and reduce the risk of women suffering harm from pregnancy and childbirth. However, no binding instrument stipulates specific interventions for protecting motherhood in the country.

Recognition in Guatemala that women must be protected during pregnancy, childbirth, and the postpartum period is found in a variety of domains:

- a. *International agreements ratified by the Government of Guatemala***, wherein the States Parties commit to improving maternal health and reducing the MMR. These commitments also acknowledge the need to protect motherhood as a matter of societal interest and state that pregnancy should not be used as an excuse for discriminating against women. These agreements spell out the targets and goals to be met by each country and issue general recommendations on how to address the problem; however, they do not mandate any specific interventions.
- b. *National legislation, such as the Constitution***, the peace accords, the Social Development Law and other laws that refer to the protection of motherhood and the Guatemalan population's right to health. These instruments recognize the societal nature of motherhood and make it a national priority. However, they do not require any particular action by the State or health institutions.
- c. *Labor rights***. Women employed in the formal sector are protected by a package of services stipulated in the Labor Code, as well as the regulations of the Guatemalan Social Security Institute.⁹ Working women have the legal right to demand these benefits. Women not employed in the formal sector (the majority of cases in Guatemala, 80%) do not enjoy these benefits or the protection of motherhood enshrined in labor rights.

⁹ Social Security in Guatemala, 1954, mandatory membership of workers.



d. Service delivery. The MSPAS is constitutionally mandated to provide health promotion, disease prevention, recovery, rehabilitation, and other services to ensure the most complete physical, mental, and social well-being of the population. The health code makes no specific mention of motherhood. The constitutional mandate refers generally to the protection of motherhood.

e. Healthy motherhood plans, standards, and protocols. These instruments are used in MSPAS services; however, they are neither “legal” nor binding mandates but technical directives for care in the health services that are subject to change at the discretion of the government in office.

The first draft of the bill took four months to prepare. When it was finished in 2009, it was distributed to Guatemalan experts who were members of the Reproductive Health Observatory (OSAR) (see Annex 3) for opinions about its content, feasibility, and viability. It was also distributed to indigenous and nonindigenous women’s groups and international cooperation agencies, whose contributions were included in the bill.

Under the Guatemalan Constitution’s definition of motherhood as a public good, health legislation must create the means to “effectively” put health services within the reach of all women, not only under conditions of equality but within the framework of distributive justice grounded in the need to provide care commensurate with each situation.

3. Negotiation

The consensus-building and negotiation among the different stakeholders that occurred during the drafting of the legislative initiative must be noted. The stakeholders included:

Civil society: medical associations, with their clinical approach; women’s associations, with their social and rights approach; conservative groups wishing to eliminate the post-abortion care covered under the term “care for hemorrhage in the 1st trimester” (abortion being a cause of maternal death); indigenous groups concerned about respect for their culture, world view, traditional midwives, and maternity homes.

Local organizations: The Law was enriched by the contributions of departmental networks and organizations, whose local concerns and experiences were included—for example, maternity homes as a strategy to bring women into the health services; cultural appropriateness in prenatal care and childbirth; local government involvement in financing; and the experience working with midwives in different locations around the country, which was used as a framework to contextualize the initiative and foster local acceptance.

The political situation in 2010 created a window of opportunity with the passage of laws against femicide and other forms of violence against women and of the freedom of information Law. These laws buttressed the negotiations for passage of the Healthy Motherhood Law, which was promoted within the framework of legislation to support respect for women’s rights.

Congress: The identification of political operatives within Congress—in this particular case, the female deputies, who played a key role in publicizing the bill, lobbying, and fostering consensus among the 158 lawmakers. By the time the initial proposal had been sent to the Committee on Women for its opinion, several changes had been introduced, among them, the addition of a multisectoral healthy motherhood commission¹⁰ as the monitoring and oversight body, and the designation of OSAR as supervisor of the Law's implementation.

4. Passage

Civil society organizations drew up an advocacy or lobbying plan that began with a review of the official statistics on the number of maternal deaths at the time. This led to the holding of an “Information Flows for Measuring Maternal Mortality” forum in February 2009, opened by the President of the Congress, who stated his commitment to legislating and financing programs for reducing maternal mortality. Legislators and representatives of civil society attended the event, which was widely covered by the media. Representative Zury Ríos, fifth Secretary of the Congressional Executive Committee, declared that the Guatemalan State must have a legal framework for regulating procedures and designing the protocols necessary to tackle the issue of maternal mortality, stating that she would submit the bill for passage by the full Congress. In addition, OSAR prepared a fact sheet on methods for calculating maternal mortality that was distributed at the forum. This information was released to the media, making it possible to objectively question and document government statements indicating a reduction in the indicator for the MMR.

The organizations remained in constant contact with Congress, especially with deputies and the Executive Committee, several chairs and members of the Committees on Women, Health, and Indigenous Populations, and some congressional advisers. OSAR members also held meetings to lobby the Committee on Women to make it well-acquainted with the provisions of the initiative and would support its submission by the fifth Secretary of the Congress. It should be noted that civil society has no standing to propose legislation.¹¹

Finally, on 22 October 2009, Congress took up the bill, recorded as No. 4117, sending it to the Committee on Women for its review and opinion. This legislative office requested a number of changes to satisfy legal requirements. The Committee on Women endorsed the bill and issued a favorable opinion, No. 02-2009, for submission to the full Congress.

In order to keep the topic on the public agenda, in early July 2010 OSAR issued a press release with the headline “No woman should die giving life” in one of the more widely circulated newspapers, requesting the full Congress to pass the Healthy Motherhood bill. ALIANMISAR (see Annex 4), which was also one of the organizations involved and had provided input during the review of the initiative, sent letters to the members of the congressional Committee on Women and e-mails to the deputies representing their departments of origin. The messages urged unfettered support for passage of the Law.

¹⁰ Article 23, creation of the Multisectoral Committee for Healthy Motherhood (CMPMS). Cooperation agencies could participate in this committee; OSAR would monitor implementation of the Law.

¹¹ Art. 174, Political Constitution of the Republic.



OSAR, ALIANMISAR, and ISMD met to devise a more forceful advocacy plan defining the responsibilities of each organization and its respective networks in the departments. At the same time, encouraged by civil society organizations, concerned women legislators convinced of the need for a law of this type began lobbying other legislators, securing the necessary support for passage of the Law after three readings before the full Congress. It should be noted that the local and national media (print, television, and radio) voluntarily and free of charge provided ample coverage of the event and published OSAR's demands.

The third reading of the initiative took place on *9 September 2010*, the date the Law was unanimously passed by means of Decree No. 32-2010 and sent to the Executive Branch for official publication. The Decree-law was signed by the President of the Republic for publication in the official gazette on *7 October 2010*.

On *17 December* of that same year, the Multisectoral Committee on Healthy Motherhood was officially installed at the *Palacio de la Cultura*. Present at the ceremony were the Vice President of the Republic, the Minister of Health, a representative of international cooperation, and official delegates from the institutions represented in compliance with the Law.

In mid-2011, the Guatemalan Association of Women Physicians (ATM) requested international cooperation funds to publish 5,000 illustrated copies of the Law. The object was to promote its distribution and use among associations of health professionals, civil society organizations, health services, and members of the press. This material was also sent to the candidates who had run for office during the last election.

5. Drafting and approval of the regulations operationalizing the Act

Nineteen months passed between the passage of the Law and the publication of the regulations operationalizing it. The regulations were approved by Government Agreement No. 65-2012 in March 2012.

Civil society participated in the drafting of these regulations. With technical assistance from international cooperation agencies, an initial proposal was prepared and submitted to the MSPAS, later to be transmitted to the Office of the Attorney General and the General Secretariat of the Presidency, which sent it to the institutions mentioned therein as responsible for its implementation.

The regulations indicate the facilities that will provide services to pregnant women, with special emphasis on CAIMI, CAP,¹² and the maternity homes, defining their geographical coverage and functions. They also detail the profiles of the personnel that will be working in these facilities and the responsibilities of the MSPAS and training schools. They likewise describe the monitoring and surveillance system and its institutional responsibilities, which include the development of indicators.

¹² CAIMI: *Centro de Atención Integral Materno Infantil* (Center for Comprehensive Maternal and Child Care) (round-the-clock care; surgical delivery). CAP: *Centro de Atención Permanente* (Center for Round-the-Clock Care) (round-the-clock care; normal delivery).

During this process, civil society organizations systematically lobbied the authorities responsible for publishing the regulations. Essential to the process was knowing the approval procedure, the government entities involved, and their role (approval, consultation, transmittal), and identifying whom to lobby. Having obtained this information, the organizations sent letters requesting publication of the regulations to the President, the Attorney General, the General Secretariat of the Presidency, the Minister of Health, the Office of the Human Rights Ombudsman (PDH), and deputies.

6. Groups and stakeholders in the debate

a) Civil Society

Civil society was mobilized throughout the process by means of its organizations, among them *Instancia Salud Mujer* (Women's Health Organization) (ISDM);¹³ OSAR, with its departmental networks; ALIANMISAR;¹⁴ and Red de mujeres por la construcción de la paz (Women's Network for Peace) (REMUPAZ).¹⁵ Most of these organizations are national and local in scope. In addition, medical associations, including the Association of Gynecology and Obstetrics (AGOG), the Association of Women Physicians, and the Medical Association of Guatemala, actively participated.

b) Congress

The 19 women lawmakers forged a cross-party alliance to promote legislation to protect women: the Femicide and Other Forms of Violence against Women Law (April 2010) and the Healthy Motherhood Law (September 2010). The deputies who had sponsored the Law, the Health Committee, the Committee on Women, the Committee on Indigenous Affairs, and the Executive Committee were effective political operatives for building consensus around the proposal and accelerating the approval process.

c) The media

The media (columnists), also known as the 4th estate, played a critical role in molding public opinion and putting daily issues on decisionmakers's agendas. The media were part of an alliance and publicized the benefits, status of the proposal, and the actual maternal mortality situation.

d) International cooperation

At the request of the civil society organizations, various cooperation agencies furnished technical assistance and shared experiences on how the issue is handled in other countries, offering information on advances in evidence-based public health and opening a dialogue with health authorities and the national government.

¹³ ISDM- An organization that coordinates activities to promote women's health and development, officially established in June 2006. ISDM is comprised of 17 organizations of women and men interested in guaranteeing respect and enforcement of sexual and reproductive rights in Guatemala. A member of OSAR since 2008, it has provided technical assistance to the Observatory since 2009.

¹⁴ Alianza nacional de mujeres indígenas por la salud, nutrición y educación (National Alliance of Indigenous Women for Health, Nutrition, and Education) (ALIANMISAR). In June 2008, it began to tackle the issue of health, focusing on aspects of sexual and reproductive rights, such as the right to healthy motherhood, family planning, and care for children, calling for quality services, respect for the dignity of indigenous women and their customs – the right to receive treatment in their own language, respect for their modesty and customs, and care in childbirth that reflects their traditional ancestral practices (different types of vertical delivery). This network has partnered with different government entities – ministries of health and education, ombudsman for indigenous women, office of the human rights ombudsman, secretariat for food and nutrition security.

¹⁵ REMUPAZ. A feminist organization founded in May 2000 that includes 10 women's organizations.



CARE GUARANTEED BY THE ACT

The Law includes guarantees and opportunities for women and their children and buttresses Guatemala's general legislation and international commitments with respect to motherhood.

a) The right to health: healthy motherhood

- This Law makes motherhood a matter of national urgency and targets the most vulnerable populations (indigenous, rural, and poor populations);
- It provides universal access to maternal and neonatal health services and timely quality care. The fact that the universality of these services is part of the right to health undoubtedly puts enormous pressure on all government institutions to engage in joint efforts;
- It promotes the *involvement of institutions outside the MSPAS*, such as the development councils system, municipalities, civic organizations, and business, thereby fostering interinstitutional action;
- It makes State institutions the guarantors and families and citizens the possessors of that right. Recognizing health as a right (a social right) obliges the State to guarantee conditions that will enable every individual to exercise his or her rights and to reduce existing inequalities and asymmetries among social groups;
- It furthermore obliges the State and its institutions to provide free care to all women during pregnancy, childbirth, and the postpartum period, as well as to newborns, beginning the process of universal coverage in the health services;
- The Law requires decisionmakers to prioritize these services over other programs, despite a limited budget; and
- It provides civil society with advocacy tools to ensure that the Ministry enforces the Law.

The Law extends beyond the package of care, affecting behaviors and cultural practices that adversely impact women's health.

The cultural appropriateness policy will represent the start of the inclusion of this approach in other MSPAS programs, bearing in mind that Guatemala is a nation with a wealth of cultures.

b) Culturally appropriate services

This is first legislation requiring cultural appropriateness or interculturalism in the health services, in recognition of the guiding principles of cultural accessibility and respect for interculturalism. The regulations define cultural appropriateness and how to monitor it.

The creation of maternity homes, which before were isolated facilities created out of goodwill in some services, is mandated under the regulations, requiring national and local decisionmakers to forge partnerships and strategies to ensure compliance. This mandate benefits pregnant rural and indigenous women living in remote areas far from the health services, improving access when they arrive with their families from their distant homes seeking care in childbirth. Maternity homes also provide a place where pregnant women and their families can stay overnight if they are turned away by service providers because the birth is not imminent.

The Law officially acknowledges the role of traditional and community health care providers at the first level of care, honoring the principle of interculturalism; this represents a sea change in the culture of the health services.

This legislation is an important tool for promoting programs and actions with intercultural characteristics, which it defines as:

- a. Care provided to users of the services in their native language;
- b. Accompaniment of the woman in labor by a family member or trusted person (who can be a midwife) during a normal delivery;
- c. Delivery position based on the woman's preference; and
- d. Home visits to the woman within the first 24-48 hours postpartum and to the newborn within first 24 hours in the case of a home birth.

The Law names the MSPAS, IGSS, and NGO-PEC the institutions responsible for guaranteeing access to services and states that the services provided must be culturally appropriate, with no discrimination at the three levels of care, promoting social and community participation.

Considering the principle of interculturalism and the provisions of its other articles, the Law states that second- and third-level personnel must know, accept, respect, and include indigenous practices that are not life-threatening.

c) Quality of the services

The Law explicitly states a series of factors essential to the delivery of services during pregnancy, childbirth, and the postpartum period, important among them:

- Quality-of-care standards, whose definition and analysis will bolster the institutional capacity of the MSPAS; the issue of referral and the availability of transportation for users between the levels of care, which will improve the quality of the services; the availability of needed supplies, which will put pressure on the services but can also be used by the MSPAS in budget negotiations with Congress, since failure to allocate resources becomes a crime; special care for pregnant girls and adolescents; counseling on family planning and interculturalism, which are now explicit legal guarantees;



- Visits to the newborn within first 24 hours postpartum are officially mandated. The remaining interventions appear in the MSPAS regulations, but involve improving the monitoring of compliance in the institutions covered by the Law; and
- As one of the conditions for healthy motherhood, the Law mandates counseling and education to prevent unwanted pregnancies and promote healthy ones; it also promotes adequate nutritional status and the administration of food and vitamin supplements.

d) Civic monitoring and engagement

- Surveillance and monitoring
- Spending effectiveness
- Auditing and financing

The regulations creating the Multisectoral Committee on Healthy Motherhood (CMPMS), drafted with the participation of medical associations (Guatemalan Association of Women Physicians and the Guatemalan Association of Gynecology and Obstetrics), will help ensure that the technical rules and regulations governing implementation of the healthy motherhood strategy and the reduction of maternal mortality are cost-effective and based on scientific evidence and the recommendations of domestic and international institutions specializing in the field.

Participation by the members of the Congressional Committee on Health will enable these lawmakers to monitor and scrutinize the MSPAS activities mandated in this legislation. Their participation is likewise expected to raise awareness among other lawmakers to forge the political will to authorize funding during the negotiations on Guatemala's national budget and thereby guarantee compliance with the Law.

The provision explicitly delegating surveillance and monitoring of the Law's implementation to OSAR demonstrates the lawmakers' determination to ensure social participation with direct civil society intervention, thereby promoting the exercise of citizenship to enforce the rights spelled out in this legal framework, which is protected by the Political Constitution of the Republic of Guatemala and the country's international treaty commitments. Having lawmakers and civil society serve as committee members could prevent future budget cuts for this policy, regardless of the government in power.

Supplementary provisions include the amendment of Decree 21-2004, under which 15% of the revenues from the tax on alcoholic beverages shall be allocated to reproductive health, family planning, and alcoholism programs, and that 30% of that percentage shall be allocated exclusively to the procurement of contraceptives. The amendment also provides for the creation of a specific budget line in the MSPAS budget for that purpose. All of this will facilitate monitoring of the funds allocated to meet the demand for contraceptives and guarantee the population's right to make decisions about reproduction. This provision will also reduce the likelihood that funds for this category will be diverted to other programs.

Prioritizing funding for action in locations with higher MMRs and regions that are more vulnerable owing to poverty ensures that the interventions will have a positive impact on the prevention of maternal mortality.

“In January 2013, the hospital in Suchitepéquez attended a 17-year old primipara with a diagnosis of pre-eclampsia. Her 35-year old husband refused to allow a caesarean section (“...in my family they always have children the normal way ...”); however, because of the penalty article of the Healthy Motherhood Law, the couple agreed to the procedure. Within two hours, a healthy baby and a post-operative mother were the beneficiaries of this legal framework.”

–OSAR narrative, Suchitepéquez, February 2013.

e) Penalties

The penalty provisions are based on the penal code and special laws governing the matter for government officials and health service personnel responsible for maternal and neonatal care and provide for the indictment of individuals who commit acts that constitute a crime, associating it with revocation of their license to practice.

Under the Law, the woman’s life partner will be penalized if he does not permit, promote, and facilitate the woman’s access to maternal and neonatal health services. This regulation derives from the fact that many such individuals oppose treatment for problems related to pregnancy and childbirth in the health services, and it attempts to legislate in this regard; notwithstanding, intercultural issues, physical access to the services, and the limited resources of many households must also be considered.

LESSONS LEARNED

a. Progress can be made in developing legislative frameworks to guarantee healthy motherhood

While all national laws provide substantial legal protection for women and help prevent maternal mortality, there are still some legal gaps with respect to the content of the services that should be provided to pregnant women and the identification of who would be responsible for providing them. With the passage of the Healthy Motherhood Law and its associated decree, the State declared its interest in improving the health and quality of life of women and newborns. The Law promotes human development by ensuring healthy motherhood through free and timely universal access to quality information and services.

b. Legislative proposals must be specific, feasible, and measurable

Basing their proposal on the high maternal mortality indexes and their causes and consequences, civil society organizations, with international cooperation assistance, drafted an operational law defining and guaranteeing health service packages for the preconception period, pregnancy, childbirth, and the postpartum period that also include interventions for the newborn. Analysis of the political context became essential for passage of the Law.



c. Inclusive proposals

Complementary visions produce specific and legitimate responses through consensus-building and negotiation. Within this context, civil society's exercise of citizenship and the participation of experts from multiple disciplines, indigenous women's organizations, local organizations, and feminist groups added value to the proposal. In this process, *multicausal analysis of maternal death* allowed the various sectors to state their arguments and offer proposals (the social view of the problem, its sequelae in communities and families, the need for basic interventions to handle obstetric emergencies) given the current maternal mortality situation (strategic information), identifying specific cost-effective actions that can be monitored and mandated for specific institutions.

d. Civil society participation, exercise of citizenship

One of the Law's greatest contributions is that it enables and regulates the involvement of social groups in local maternal surveillance committees and high-level multisectoral hospital committees—all of which fosters greater accountability. Some 50% of births in Guatemala take place in the home, attended by *comadronas* (traditional birth attendants), whom are a critical and essential link in the strategy for reducing maternal deaths. This Law allows *comadronas* to participate in the drafting of a national midwifery policy and creates a transitional process for the training of skilled midwives (nurse-midwives or midwives) as necessary human resources for the care of pregnant women.

e. Healthy motherhood becomes women's empowerment

Since women's empowerment is a construct that covers much more than health—and involves access to goods and services, the right to information, and the right to make reproductive decisions—it is critical to monitor both the action taken under this Law and, especially, women living in poverty, offering them real opportunities to improve their education and training so that they can enter the job market on a competitive basis.

f. Information and knowledge lead to more compassionate care in childbirth and service delivery

In a hospital emergency service, a 12-year old girl in her 39th week of pregnancy and in active labor is covered by the surveillance protocol for pregnant women, whereby instances of a girl under the age of 14 who is pregnant or has a child must be reported to the Office of the Attorney General (PGN)¹⁶ (as a victim of sexual violence) and receive special treatment in the health service (accompaniment by a relative, psychological counseling, caesarean delivery). Furthermore, in such cases, the social protection system (social benefits, education) and justice system (reporting, trial) must become involved. This procedure, developed by an interministerial/civil society body, is part of the adolescent pregnancy care and prevention provided for in the Law.¹⁷

¹⁶ Office of the Attorney General, responsible for the protection of children.

¹⁷ *Ruta de denuncia y derivación de embarazos en menores de 14 años* (Procedure for reporting and referring pregnant girls under the age of 14), prepared by the Ministries of Health, Education, and Social Development under the initiative of the Secretariat to Combat Sexual Violence, Exploitation, and Human Trafficking. Procedure facilitated by OSAR.

PENDING MATTERS FOR EFFECTIVE IMPLEMENTATION

The Healthy Motherhood Law has been in force since September 2010 and its Regulations, since May 2012. Nevertheless, challenges to the implementation of this Law remain, among them: securing the necessary funding; lack of specialized technical personnel in rural areas (professional development in the cities); upgrading of the skills of health service providers; the guarantee of health care supplies; and the need for a process to monitor compliance with the Law in the field (health services).

Under the constitutional mandate and legal instruments, the MSPAS is responsible for the negotiation, design, regulation, implementation, monitoring, oversight, evaluation, and funding of all activities for the protection of pregnant women. It is the MSPAS' responsibility to:

- Strengthen the organizational, economic, human resource, and leadership capacity necessary to discharge the responsibilities imposed on it by this legal framework;
- Plan and implement the strategy for publicizing the Law among the families and women who use the services, health service providers, lawmakers, staff of the Guatemalan justice agency, and civil society and private sector organizations. If the training is for indigenous women, it should be provided in their native language;
- Print copies of the Law in order to publicize its content. These materials should be illustrated and adapted for easy understanding;
- Encourage monitoring and lobbying by committed national and local civil society stakeholders to ensure that the programs of the institutions designated in the Law comply with the regulations;
- Continue to pursue good media relations by releasing information on the progress, challenges, and impact achieved through compliance with the Law, using official data and data from the monitoring of the services;
- Interest private enterprise in collaborating in the implementation of the Law and in forging partnerships with civil society organizations that engage in lobbying and political dialogue as part of the exercise of their citizenship in health; and
- Maintain the collaboration and assistance from international cooperation agencies to continue their technical and financial support for civil society activities.



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VII. ANNEXES



PAN AMERICAN HEALTH ORGANIZATION
WORLD HEALTH ORGANIZATION



51st DIRECTING COUNCIL
63rd SESSION OF THE REGIONAL COMMITTEE

Washington, D.C., USA, 26-30 September 2011

CD51.R12 (Eng.)
ORIGINAL: SPANISH

RESOLUTION

CD51.R12

**PLAN OF ACTION TO ACCELERATE THE REDUCTION IN MATERNAL
MORTALITY AND SEVERE MATERNAL MORBIDITY**

THE 51st DIRECTING COUNCIL,

Having reviewed the *Plan of Action to Accelerate the Reduction in Maternal Mortality and Severe Maternal Morbidity* (Document CD51/12);

Taking into account the proposed international mandates in the Regional Plan of Action to Reduce Maternal Mortality in the Americas (Document CSP23/10 [1990]); the resolution *Population and Reproductive Health* (CSP25.R13 [1998]); the Regional Strategy for Maternal Mortality and Morbidity Reduction (Document CSP26/14 [2002]); the Strategy and Plan of Action for the Elimination of Mother-to-Child Transmission of HIV and Congenital Syphilis (Document CD50/15 (2010)); Resolutions WHA55.19 (2002), WHA57.13 (2004), and EB113.R11 (2004) on reproductive health, adopted by the World Health Assembly and the WHO Executive Board, respectively; the forums of Nairobi, Kenya (1987), Cairo, Egypt (1994), and Beijing, China (1995); the Millennium Declaration (2000); and the Health Agenda for the Americas 2008-2017;

Taking into account Resolution R11/8 of the Human Rights Council of the United Nations (2009), Resolution CD50.R8 of the 50th Directing Council of PAHO (2010) and the technical document *Health and Human Rights* (CD50/12), as well as the high degree of complementarity between this plan and other objectives established in the *PAHO Strategic Plan 2008-2012, Amended* (Official Document 328 [2009]);

Considering the Global Strategy for Women's and Children's Health launched by the United Nations Secretary-General in 2010 and the recommendations of the Commission on Information and Accountability for Women's and Children's Health;

Mindful of the need for scaling up the management of non-communicable diseases (NCDs) and risk factors (diabetes, hypertension, obesity, smoking) in maternal health care protocols, as discussed in the High Level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases;

Emphasizing that maternal mortality is a manifestation of inequity that affects every country in the Region, and that there are cost-effective interventions within the sector to effect the desired reduction that are capable of having a real impact within a short timeframe;

Considering the importance of having a plan of action that makes it possible for Member States to respond effectively and efficiently,

RESOLVES:

1. To approve the Plan of Action to Accelerate the Reduction in Maternal Mortality and Severe Maternal Morbidity and to further its consideration in policies, plans, and development programs, as well as in proposals and discussions of national budgets, allowing them to address the issue of improving maternal health.
2. To urge the Member States to:
 - (a) consider the Health Agenda for the Americas 2008-2017 and the call by the United Nations Secretary General in 2010 to implement a plan to help reduce maternal mortality;
 - (b) adopt national policies, strategies, plans, and programs that increase women's access to culturally appropriate, quality health services adapted to their needs, including, in particular, promotion and prevention programs based on primary health care provided by skilled personnel; that integrate preconceptional (including family planning), pregnancy, delivery, and postpartum care (including prevention and treatment of HIV infection); and that also take into consideration the provision of these services free of charge to the most vulnerable populations;

- (c) promote a dialogue between institutions in the public and private sector and civil society to prioritize women's lives as a human rights and development issue;
- (d) promote the empowerment of women and the participation and co-responsibility of men in sexual and reproductive health;
- (e) adopt a human resources policy that addresses the issues of recruitment, training, and retention to respond to the needs of women and newborns;
- (f) improve the capacity to generate information and research on sexual and reproductive health, maternal mortality, and severe maternal morbidity for the development of evidence-based strategies that permit monitoring and evaluation of their results, in keeping with the recommendations of the Commission on Information and Accountability for Women's and Children's Health;
- (g) undertake internal review and analysis of the Plan of Action, for implementation in the national context;
- (h) advocate for dedicated public budgets, where applicable, based on strategic results aimed at improving the coverage and quality of care for women and children;
- (i) promote the development of social protection programs for women and children.

3. To request the Director to:

- (a) support the Member States in implementing the Plan of Action, in keeping with their needs and their particular demographic and epidemiological characteristics;
- (b) promote implementation and coordination of the Plan of Action, ensuring its integration into programs;
- (c) promote and strengthen information systems and maternal health surveillance, including a regional repository available to all stakeholders, and encourage operations research to design relevant strategies and carry out interventions based on the Region's specific needs and contexts;
- (d) support the Member States in developing and creating capacities for training and appropriate distribution of maternal and neonatal health personnel;
- (e) consolidate and strengthen technical cooperation with the committees, organs, and rapporteurships of the United Nations and inter-American bodies, in addition to promoting partnerships with other international and regional organizations,

scientific and technical institutions, organized civil society, the private sector and others, within the framework of the Regional Working Group for the Reduction of Maternal Mortality;

- (f) report periodically to the PAHO Governing Bodies on progress and constraints in implementing the Plan of Action, as well as on changes made to the Plan to adapt it, as necessary, to new circumstances and needs.

(Eighth meeting, 29 September 2011)



PAN AMERICAN HEALTH ORGANIZATION
WORLD HEALTH ORGANIZATION



50th DIRECTING COUNCIL
62nd SESSION OF THE REGIONAL COMMITTEE

Washington, D.C., USA, 27 September–1 October 2010

CD50.R8 (Eng.)
ORIGINAL: SPANISH

RESOLUTION

CD50.R8

HEALTH AND HUMAN RIGHTS

THE 50th DIRECTING COUNCIL,

Having considered the concept paper, *Health and Human Rights* (Document CD50/12);

Bearing in mind that the Constitution of the World Health Organization establishes a basic international principle whereby, “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition;”

Recognizing that in the Health Agenda for the Americas (2008–2017) the ministers and secretaries of health: (a) declared their renewed commitment to the above-mentioned principle established in the WHO Constitution; (b) recognized that human rights are part of the principles and values inherent to the Health Agenda; and (c) declared that, to make the right to the enjoyment of the highest attainable standard of health a reality, the countries should work toward universality, accessibility, quality, comprehensiveness, and inclusion in the health systems that are available for individuals, families, and communities;

Aware that the PAHO Strategic Plan 2008–2012 Amended states that “Human rights law, as enshrined in international and regional human rights conventions and standards, offers a unifying conceptual and legal framework for these strategies, as well

as measures by which to evaluate success and clarify the accountability and responsibilities of the different stakeholders involved;”

Recognizing that the human rights instruments of the United Nations and Inter-American systems are useful for the progress of the Member States towards the achievement of the Millennium Development Goals (MDGs), especially those related to eradicating extreme poverty and hunger (MDG 1), reducing child mortality (MDG 4), improving maternal health (MDG 5), and combating HIV/AIDS, malaria and other diseases (MDG 6);

Observing that the Pan American Sanitary Conference and the Directing Council have recommended that the Member States formulate and adopt policies, plans, and legislation in health consistent with the applicable international human rights instruments in the context of mental health (Document CD49/11), active and healthy aging (Document CD49/8), adolescent and youth health (Document CD49/12), gender equality (Document CD49/13), reduction of maternal mortality and morbidity (Document CSP26/14), access to care for people living with HIV (Document CD46/20), health of indigenous peoples (Document CD47/13), and the prevention and rehabilitation of disability (Document CD47/15), among others;

Recognizing that in some PAHO Member States matters related to health may fall under different jurisdictional levels,

RESOLVES:

1. To urge Member States, taking into account their national context, financial and budgetary resources, and legislation currently in force, to:
 - (a) strengthen the technical capacity of their health authority to work with the corresponding governmental human rights entities, such as ombudspersons’ offices and human rights secretariats, to evaluate and oversee the implementation of the applicable international human rights instruments related to health;
 - (b) strengthen the technical capacity of the health authority to provide support for the formulation of health policies and plans consistent with the applicable international human rights instruments related to health;
 - (c) support PAHO’s technical cooperation in the formulation, review and, if necessary, reform of national health plans and legislation, incorporating the applicable international human rights instruments, especially those related to the protection of groups in vulnerable situations;

- (d) promote and strengthen training programs for health workers on the applicable international human rights instruments;
 - (e) formulate and, if possible, adopt legislative, administrative, educational, and other measures to disseminate the applicable international human rights instruments on protecting the right to the enjoyment of the highest attainable standard of health and other related human rights among the appropriate personnel in the legislative and judicial branches and other governmental authorities;
 - (f) promote, as appropriate, the dissemination of information among civil society organizations and other social actors on the applicable international human rights instruments related to health, to address stigmatization, discrimination, and exclusion of groups in vulnerable situations.
2. To request the Director, within the financial possibilities of the Organization:
- (a) to facilitate PAHO technical cooperation with the human rights committees, organs, and rapporteurships of the United Nations and Inter-American systems;
 - (b) to train Organization staff so that the technical areas, especially those most closely involved in protecting the health of groups in vulnerable situations, gradually incorporate the international human rights instruments related to health into their programs;
 - (c) to promote and stimulate collaboration and research with academic institutions, the private sector, civil society organizations, and other social actors, when appropriate, to promote and protect human rights, in keeping with the international human rights instruments related to health;
 - (d) to promote the sharing of good practices and successful experiences among the Member States of PAHO so as to prevent the stigmatization, discrimination and exclusion of groups in vulnerable situations.

(Sixth plenary, 29 September 2010)

Annex III

Reproductive Health Observatory (OSAR)

In March 2008 the Reproductive Health Observatory (OSAR) was created and publicly launched in partnership with the Congress of the Republic. OSAR is a mechanism made up of universities, organizations of health professionals, including the Medical Association of Guatemala, the Guatemalan Association of Women Physicians (AGMM), the Association of Gynecologists and Obstetricians (AGOG), and nongovernmental organizations (NGOs) involved in reproductive health issues.

This partnership is characterized by the freedom of the participating organizations to state their own opinions and the oversight role of members of Congress. OSAR also partners with other government agencies: the ministries of Finance and Health, the Ombudsman for Indigenous Women, and the Presidential Secretariat of Women, among others. A network of 17 departmental observatories has been created, in addition to the central observatory in Guatemala City.

OSAR's members oversee compliance with the legal framework for reproductive health. Because they currently monitor compliance with the Healthy Motherhood Act, they participate in: i) the multisectoral committee on healthy motherhood; ii) the analysis of maternal deaths carried out by health service providers at the national and departmental levels; iii) ensuring that the information on the number of maternal deaths that the central observatory receives from MSPAS coincides with the actual findings in the departments; iv) the requirement of transparent management of the funds allocated to the healthy motherhood program; and v) requests for accountability regarding actions taken and funds allocated for the prevention of maternal and neonatal deaths.

The creation of departmental reproductive health observatories has enabled local civil society leaders on the departmental development councils (CODEDEs) to freely lodge complaints—if necessary—when there is a lack of programmatic funding to comply with the legal framework protecting sexual and reproductive rights, and about limited public access to information and services on reproductive health, especially among the poorest inhabitants at the local level. The departmental OSARs raise awareness among local authorities by providing evidence-based information on unaddressed reproductive health needs.

The OSARs also show the social impact of high maternal mortality rates: i) a large number of orphans who do not receive government assistance; ii) high rates of adolescent pregnancies and deliveries; and iii) a lack of family planning information and services; a cost-effective strategy to meet the reproductive expectations of women and their families, and to help reduce maternal mortality. The network also seeks to ensure that sex education is provided in schools, so that the information and education received by students in public institutions helps reduce unwanted pregnancies and prevent sexually transmitted diseases in adolescents—factors that contribute to maternal morbidity and mortality.



Annex 4

National partnership of indigenous women for health, nutrition, and education (ALIANMISAR).

In June 2008, ALIANMISAR, a national partnership of indigenous women for health, nutrition, and education was created with the participation of six civil society groups, mainly from the department of Chimaltenango. This is a national network whose members belong to networks of indigenous women's organizations. It is currently made up of 100 groups organized by women from the different ethnic groups of the central, south-west, north-west, and northern regions of Guatemala.

This network works to close the wide gaps in health, nutrition, and education observed between urban/rural and indigenous/nonindigenous populations. It seeks to help change policies to guarantee the delivery of timely services with an intercultural approach that respect the dignity of indigenous women, so that they are able to exercise their civil rights in society.

