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Practice Note

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Women's Health and Human Rights: Converging Avenues for Action in East Africa

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Abstract

Describing a long-term community-based action research project on improving health conditions for displaced persons in Rwanda and South Sudan, this practice note discusses human rights as a framework for improving people's health. In the course of researching women's health concerns, researchers learned that human rights violations were a major root cause of poor health among many displaced persons, and especially for women. Partnering with an international non-governmental organization (NGO), the American Refugee Committee, Congolese refugees in Rwanda, and returnees in South Sudan, researchers first explored local perceptions of human rights. Findings were presented to community members and incorporated into a culturally-nuanced health and human rights training programme. We offer lessons learned when working with community members and international partners to develop this community-based educational project on human rights. Primarily, we argue that human rights are intricately related to women's health. We also suggest that human rights messages are best conceptualized with local concepts and best spoken by trusted community members such as community health workers. Human rights are conceptualized across cultural differences as an ongoing struggle for respect and fair treatment. Women's experiences of human rights violations most often occur in the context of everyday life and lead to poor outcomes in women's health. A rights-based framework could assist practitioners and organizations that aim to promote women's health, development, and well-being.

Keywords: advocacy; community-based action research; women's health; women's rights

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In recent years, a human rights framework has become increasingly important as the foundation for achieving more equitable development opportunities and health outcomes for women. This practice note reflects work done by a community–academic partnership that first explored local perceptions of human rights among internally displaced populations in South Sudan and Congolese refugees in Rwanda. Study findings were subsequently woven into a learning programme to address the community priorities that surfaced. In this article, we describe the project that unfolded as community members along with local staff from the American Refugee Committee, an international non-governmental organization (NGO), and researchers collaborated to assess and address community concerns. We then present lessons learned when transferring research results into an actionable community-based health and human rights campaign. By detailing the lessons learned from this community–academic partnership, we envision that others in conflict-affected regions may adopt a similar approach when creating locally-meaningful programmes to address long-standing social norms such as the status of women. We view our staged process as an example of community-driven 'principled social change' (Uvin 2004: 4) which, in post-conflict settings, is viewed by human rights activists and conflict transformation practitioners as 'a common calling' to build 'structures and communities that do justice to the needs and potential of every human being' (Dudouet and Schmelzle 2010: 6). Furthermore, human rights dialogue in post-conflict settings creates an opportunity for justice and health workers to collaborate in the 'Peace through Health' movement which seeks to strengthen community-based initiatives that proactively address widespread violence and the impact it has on people's health (Arya and Santa Barbara 2008).

Localizing human rights

Academic debate on whether human rights are a product of Western civilization (Donnelly 1982; Panikkar 1982) or whether these values were present in other cultures before codification in the 1948 Universal Declaration of Human Rights (de Varennes 2006) is often intense. This controversy is especially important when considering how human rights operate in local contexts. For example, expanding beyond individual rights, African human rights documents outline 'duties' to promote family cohesion and collective obligations to 'preserve and strengthen positive African cultural values' (African Charter on Human and Peoples' Rights, Article 29). Some argue that locally-based human rights notions are more valuable to communities and states than universal ideals (Cobbah 1987; Ake 1987; Woods 2003), an idea critiqued by other scholars (Oyowe 2014).

In determining the universality of human rights, conflicting theories exist, with some (Henkin 1989) arguing that each human being is entitled to human rights and others (Sandel 1984; Etzioni 2015) presenting the community as the ultimate litmus test. The notion of cultural relativism further challenges the understanding that all human beings have the same rights, by arguing, often in the context of women's human rights (Sen 1997; UN Commission on Human Rights 2003a, 2003b; Nussbaum 2005), that some deviation from accepted standards is acceptable to account for cultural differences among nations (Donnelly 2007).

Ultimately, the true test of human rights as a socio-political movement capable of creating change lies in the understanding of ordinary people of what human rights are and how they could benefit their daily lives (Odinkalu 2000; Farmer 2008). The present project explores these understandings and ways to create messages that promote

women's rights given a community context that is often sceptical of human rights doctrine.

Overview of the American Refugee Committee in South Sudan and Rwanda

As an NGO that addresses the needs of people affected by conflict and natural disasters, the American Refugee Committee was developed in 1979 and currently works in Africa, the Middle East, and South Asia. It hires primarily local staff and it values working collaboratively with affected populations to improve the health, safety, livelihoods, and dignity of displaced persons and host communities. In Rwanda it provides the following services: shelter, infrastructure development, water and sanitation, environmental protection, microenterprise, primary and reproductive health care, nutrition education, HIV/AIDS prevention and treatment, and community education on available services in six refugee camps that serve families fleeing violence in eastern Democratic Republic of Congo and, most recently, Burundi.[1] The American Refugee Committee also works in five counties across three states in South Sudan to assist the country in transitioning from a state of crisis to early recovery. Primary initiatives include: a) strengthening primary, secondary, and tertiary health care systems; b) offering gender-based violence prevention and response services; c) developing microenterprise activities; and d) providing water, sanitation, and hygiene at the community and health facility levels.

Methods and findings leading to the human rights research project

Phases 1 and 2: focusing on women's health

This emergent research project started in 2003 when Pavlish, working with community health workers (CHWs) in a camp for Congolese refugees, conducted a community health assessment that identified women's primary health concerns (Table 1). The purpose was to incorporate women's voices in planning health initiatives for camp residents (Pavlish 2005a). This initial assessment occurred over four months and involved working with 12 representatives from a local women's group to conduct focus groups in each camp section. Key informant interviews supplemented focus group data. The representatives and Pavlish co-analysed data and then developed a pragmatic action plan which included mental health initiatives and income generation opportunities for the American Refugee Committee to implement.

As follow up, a narrative study of refugees' daily lives was conducted in 2004–5 and included two to three in-depth interviews with 15 men and 14 women (Pavlish 2005b, 2007). Findings from this study revealed the importance of addressing gender-based violence and discrimination. During our presentation of findings in local forums, women often attributed this gender-based violence and discrimination to a paucity of respect for their human value. Some women incorporated human rights language into their explanations.

Phase 3: focusing on local meanings of human rights

Because violations of women's rights were viewed as root causes for many health concerns, in 2009 we launched an ethnographic study to explore men's and women's views of human

1 Refugees of other nationalities as well are represented in these camps, from as far away as Angola.

Table 1. Phases in the research project

Research phases	Summary of findings	Examples of programme planning
Phase 1: community-based assessment of women's health concerns	Health implications of poverty, struggle to survive, women's daily work burden, ambivalence about family size, and 'smothered voices' (not being heard)	• Support for women's groups • Mental health initiatives in the clinic • Community outreach with community health worker model
Phase 2: narrative study of men's and women's everyday lives	Health implications of poverty, violence and discrimination, chronic sorrow, fear of the future when opportunities are limited. Every woman's story had elements of violence, exploitation, and discrimination. Men described frustration with the inability to provide for their families	• Gender-based violence prevention and treatment programmes • Income-generation programmes • Girls' education initiatives • Community outreach
Phase 3: focused ethnography on local understandings of human rights	See findings in Table 2	Rights-based programme planningProtection / security initiatives
Phase 4: localizing human rights messages	Five lessons emerged when working with local NGO staff and CHWs to incorporate Phase 3 study findings into principled and pragmatic human rights messages	• Community outreach • Docu-dramas on the impact of violence and discrimination • Human rights messaging in other programmes such as Respectful Maternity Care

rights. We conducted key informant interviews and held focus groups with displaced populations in two settings: the initial Congolese refugee camp in Rwanda and a district resettling returnees in South Sudan. We asked participants to describe what people should be afforded simply for being human and the factors that influence achieving those entitlements. Findings, as reported in Table 2, aligned with formal human rights documents and concentrated primarily on securing socio-economic rights, and secondarily, civil and political rights (Ho and Pavlish 2011; Pavlish and Ho 2009a, 2009b, 2009c; Pavlish, Ho, and Rounkle 2012). Quite notably, participants frequently described human rights in terms of specific violations. For example, some women described being bribed by leaders to provide sexual favours in order to obtain shelter repairs. In general, men tended to emphasize gender similarities in human rights violations ('everyone suffers from poverty'), whereas women often described gender differences ('women have no say'). Women also described daily struggles to achieve their rights. This was not as evident for men.

Phase 4: localizing human rights messages

The American Refugee Committee representatives along with Pavlish and Ho met with community members to discuss findings and plan next steps. Besides expanding health and development opportunities, community members called for spreading awareness about human rights and responsibilities throughout the community. This call is echoed by An-Na'im

Table 2. Human rights research results

Category	Rwanda human rights research findings	South Sudan human rights research findings
Community members' human rights definitions	• ***Right to equal value*** – entitled to respect, equal acknowledgement, access to essential goods and health care services, access to opportunities for human development • ***Right to self-determination*** • ***Right to responsive governance*** • ***Right to protection*** – rights protection, harm protection	• ***Right to good governance*** • ***Right to self-determination*** • ***Right to participation in society's development*** • ***Right to security*** • ***Right to equality***
Human rights violations	• ***Right to equal value violations*** – discrimination (vulnerable groups – women, widows, poorest of the poor, orphans and children head of household, marginalized children, people with mental problems or disabilities, people with HIV, refugee status); inadequate access to essential goods (food, firewood, shelter) and services (health care for unusual conditions and advanced education) • ***Right to self-determination violations*** – forced relocation, restricted safe travel, forced labour, forced early marriage) • ***Right to responsive governance violations*** – gender disparities, economic disparity • ***Right to security and protection violations*** – sexual exploitation, rape, physical violence, partner violence, culture of silence, enforcement deficiencies	• ***Right to equality violations*** – discrimination (vulnerable groups: older women, widows, pregnant women, adolescent girls, youth and children, orphans, people living with HIV, people with physical / mental disabilities) • ***Right to security violations*** – harm and gender-based security concerns • ***Right to development opportunities violations*** – inadequate access to necessary materials (food, water), inadequate access to affordable services (health care, education), inadequate access to employment / income generation opportunities, forced early marriage, abandonment, and unresponsive governance
Human rights facilitators	• ***Sensitization campaigns*** • ***Collaboration*** between community members and agencies and agency collaboration with each other • ***Human rights safeguards*** – economic opportunity and education	• ***Enlightenment*** of the population about human rights • ***Cohesion*** between community members as displaced persons return • ***Community development*** with stronger governance • ***Advocacy*** as role of community-based organizations • ***Protection*** of citizens from militias
Human rights barriers	• ***Cultural attachment*** • ***Social and power distance*** between decision-makers and camp residents • ***Inadequate human rights knowledge*** • ***Poverty***– resources and opportunities	• ***Mistrust and doubt*** about human rights • ***Weak infrastructure*** – new and evolving government • ***Poverty*** – resources and opportunities • ***Inadequate human rights information***

(continued)

Table 2. (Continued)

Category	Rwanda human rights research findings	South Sudan human rights research findings
Human rights – gendered perspective	Men emphasized gender similarities in the human rights experience whereas women emphasized gender differences. Two very strong coding associations occurred: a) when women described human rights abuses, they also discussed poverty; and b) when participants described human rights barriers, they also discussed living the life of a refugee	Women tended to be more silent about their human rights experiences in the presence of men. Women tended to emphasize their daily responsibilities and struggles whereas men were more apt to detail entitlements, and some men emphasized gender similarities in the human rights experiences whereas some women focused on gender differences

(2002b), an African-born human rights scholar, who advocated for 'campaigns to raise public awareness about the importance and benefits of legal protection of human rights' (ibid: 11). The challenge was how to create community-sensitive human rights messages, especially for women, in a cultural context where some view human rights advocacy as a form of western colonization. We chronicle five lessons that we learned when collaborating with community-based NGO staff in creating locally-sensitive human rights messages along with community-based learning activities that engage community members in applying human rights concepts to local challenges.

Spreading human rights awareness: lessons learned

Originally, we planned to develop and test human rights campaign messages with local NGO representatives and community members on site. Because of political instability in the area, we instead met with local NGO representatives from both sites in a neutral setting and developed guidelines for a rights-based approach to programme planning. Then, drawing on both principled and pragmatic human rights ideas, Pavlish and three assistants developed an electronic interactive human rights course based on five interrelated lessons that emerged from blending research results, community discussions, and the writings of African-born scholars.

Lesson 1: human rights messages are best provided by trusted community members

Community health workers (CHWs) are well positioned to contextualize the meaning of human rights within local priorities, struggles, and strengths. In a systematic review of ten studies from Africa, Central America, and Asia, Ehiri and colleagues found that lay persons trained as CHWs positively affected health among displaced persons (Ehiri et al. 2014). Another systematic review of 53 studies revealed that trust between local CHWs and community members strengthened health messages (Glenton et al. 2013). Sabo et al. (2013) studied CHW activities and described a process framework on how CHWs create 'opportunities for community voice and action [on] social and structural conditions that are known

to have wide-ranging health effects on communities' (ibid: e67). These processes included activities such as engaging community members to identify health priorities and organizing a local coalition to address the community-identified concerns.

Drawing on noted strengths of the CHW model, we adopted a train-the-trainer approach to the human rights modules. Training pathways in the train-the-trainer model reveal that as more health-care workers are counselled on how to train others in the local contexts, information is rapidly dispersed into communities (Hiner et al. 2009). This approach has demonstrated effectiveness in many settings. For example, using experiential, interactive, and locally-based trainings for CHWs in China and Vietnam, researchers evidenced sustainable knowledge transfer and improved attitudes about caring for HIV-infected persons with their train-the-trainer HIV programmes (Williams et al. 2006; Williams et al. 2014). In Nigeria, researchers evaluated train-the-trainer effects for HIV prevention. Results indicated increased HIV knowledge among newly trained health-care workers and more condom use by those who were trained by health-care workers (Ajuwon et al. 2008). Similarly, Nyamathi and colleagues (2008) studied train-the-trainer effects of HIV workshops for nurses in India and found that as more trainings occurred, HIV knowledge increased and stigmatization of HIV-positive patients decreased. However, as noted by Baron (2006), limitations to the technique include inconsistent or inadequate training in the skills being taught and inadequate support for the trainers as they implement training. With that in mind, we included leadership and advocacy training for the CHWs, a post-learning assessment, and an online discussion forum, although the forum was rarely used. Instead, local NGO staff provided support to CHWs, although NGO staff turnover remains an ongoing challenge.

We also learned that narrative is often the preferred method for sharing knowledge in these communities. Therefore in the human rights training we provided CHWs with story-based discussion and problem-solving activities that could be adapted and used with community members to analyse intersections between health and human rights. We included social advocacy training tips and ways to collaborate with community members to analyse local threats to human rights and contextualize human rights campaign messages—especially as they pertain to recognizing and advancing women's rights and health. Specifically, we introduced the five steps in the Social Advocacy Model (Ipas 2006). Then, using the story of Wangari Maathai and the Greenbelt Movement, we provided an example of how an advocacy campaign through media messaging is capable of starting locally and spreading outward to create a social movement. We then developed activities within each step of the Social Advocacy Model so CHWs could partner with community members in crafting contextualized human rights media messages for their own communities.

Lesson 2: health and human rights are intricately linked

Because study participants often described human rights in terms of violations and subsequent harms to people's health and well-being, we decided to emphasize human rights as a mechanism for improving people's health. Therefore, the course was re-conceptualized within an analytic framework on the intersections between health and human rights. The UN Committee on Economic, Social and Cultural Rights (CESCR) (2000) issued General Comment 14 that firmly asserts the human right to the 'highest attainable standard of health'. The World Health Organization (WHO) (2002) links health and human rights in three ways: a) harms to health that occur as a consequence of human rights violations such

as gender-based violence; b) harms that develop when certain groups are inadvertently excluded or discriminated against in health policies and programmes; and c) health promotion that accompanies opportunities afforded by human rights protection such as equal access to education, work, and health care. Furthermore, the WHO Commission on Social Determinants of Health (WHO 2008) provides further evidence that socio-economic factors influence individual and population health.

Similarly, London (2008) claimed that civil, political, and socio-economic rights are indivisible and, by ensuring more equitable opportunities and reversing conditions of poverty, which is strongly linked to poor health, these rights create a powerful initiative for improving health. This is especially true for women's health (Chi et al. 2015; Dauer and Gomez 2006; Ho and Pavlish 2011; Merali 2000; Nussbaum 2005). The findings in our studies noted numerous examples of how discrimination such as unequal educational opportunities for girls restricted future choices and limited women's voices in demanding social change. Women also described less power in the family when lacking economic opportunities which decreased their protection against the health-harming effects of gender-based violence (Ho and Pavlish 2011).

Using human rights as normative standards increases not only state but also institutional and personal accountability for people's well-being. Gruskin and colleagues (2012) urged global health advocates to adopt a human rights framework as a catalyst for expanding community participation in health system development, broadening opportunities to achieve health equity, and strengthening accountability for human well-being. These principles clearly align with a communitarian view of health care which draws on community engagement in health planning and locates responsibility for health care within the community (Chuwa 2014).

In the training course, we selected theories that align with non-Western perspectives on health and well-being (Chilisa 2009; Chuwa 2014; Kanyoro 2002). For example, Chuwa (2014) noted that in contrast to Western-based, Cartesian perspectives that emphasize mind–body dualism, many non-Western societies view disease as physical manifestations of psychogenic, spiritual, and sociological disharmony. These holistic and contextual views of health were evident when we conducted focus group discussions on women's health. For example, Fig. 1 illustrates a situational map that was drawn by Congolese women during one of our projects on factors that influence women's health in a refugee camp (Pavlish 2005a). This type of mapping uncovers underlying and contributing factors that require action. For example, by identifying lack of educational opportunities as a factor that impacts women's health, new opportunities and partners to address women's health are discovered. Discussion with local administrators about ways to keep girls in school took place during the women's health study. Situational mapping also reveals how complex women's lives and health can be. Mapping also provides a visual diagram for discussing action priorities. Since holistic and contextual health perspectives were evident in our findings, situational mapping served as a foundation for discussing individual and collective health and well-being throughout the course.

We also incorporated activities such as root cause analysis and process mapping that required learners (that is, CHWs) to apply concepts from the WHO's Social Determinants of Health (London 2008). Introducing the idea of social determinants as vectors of health broadened the framework for analysing factors that affect well-being. Contextual mapping on health determinants also provided potential sites and avenues for action to improve women's health and human rights. Subsequent community-based planning identified ideal

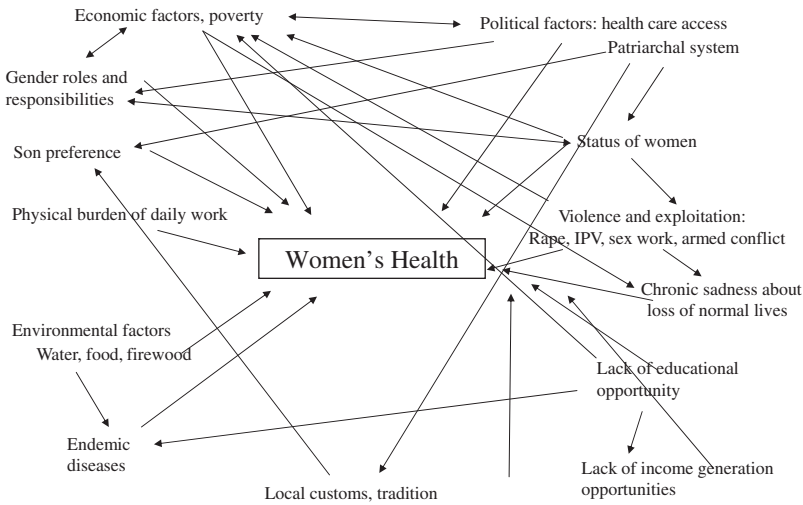

Figure 1. Contextual map of women's health concerns

actions, social conditions, and specific activities to achieve the action-ideals with pragmatic outcome measures. The action plan also tracks accountability by clarifying responsible agents and a realistic timeline.

Lesson 3: priorities for health and human rights messages need to be established locally

Some study participants questioned whether human rights, a notion espoused by many Western thinkers, is locally relevant. These doubts are frequently attributed to Western colonization and the political instability that followed (Kanyoro 2002). However, some historians provide evidence that values such as justice and individual dignity, which are cornerstones of human rights, prevailed in pre-colonial African societies (An-Na'im and Hammond 2002; Chuwa 2014; Matua 2002). Colonization disrupted these traditional values. Given the historical context, conceptualizing human rights as a 'common struggle for social justice and resistance to oppression' could become an important starting point for human rights dialogue (An-Na'im and Hammond 2002: 19). Transforming human rights messages into activism for 'shared rights objectives' is important to advancing public health initiatives (London 2008: 8).

During discussions with community members about research results and whether human rights documents pertain to their daily lives, determining where to start was difficult. So we simply asked those attending to select which human rights seemed most important for women in their communities. After much discussion, four priorities emerged: right to non-discrimination, right to equality and justice under the law, freedom of expression, and freedom from torture and degrading treatment. Participants provided local examples of how these rights were often violated, especially for women and vulnerable groups such as people living with HIV/AIDS. These examples often illustrated domestic and regional disputes. While human rights commissions and advocacy groups are often established to redress human rights violations between state actors and community members, these efforts exclude many infractions such as domestic violence (Ray and Purkayastha 2012).

Furthermore, similar to our own findings, these researchers found that women often turn to informal mechanisms such as family or advocacy groups to address human rights abuses. Alternative avenues for dispute resolution, such as judicial hearings, were viewed by women as expensive, time-consuming, and sometimes biased. Additionally, there are historical, political, and cultural barriers, and these mediate how human rights violations are addressed in communities (Uvin 2004).

Women in our projects emphasized the importance of preventing rights violations in their daily lives. Community members suggested that a community campaign 'to awaken the people' on these four human rights could avert or mitigate violations to their equality, voice, and security rights. Finding local ways to prevent human rights violations was considered an important avenue for action to improve women's lives. Therefore, in the course, we emphasized the importance of spreading awareness about human rights. We introduced pertinent international and regional human rights documents such as the Universal Declaration of Human Rights and the African Charter on Human and Peoples' Rights, and national documents such as the South Sudan Bill of Rights. However, to emphasize local relevance, the focal point of human rights analysis and advocacy was on the four priorities as identified by community members. We adopted a story-based approach and provided participatory learning activities for analysing health consequences and community impacts when these four rights were violated (see Kumar 2002 for examples of participatory methods). Additionally, exercises that CHWs could use with community members to create their own campaign messages and posters regarding these rights were included.

The participatory learning approach was evaluated in a meta-analysis of seven randomized controlled trials in countries such as Bangladesh, Malawi, and Nepal. Researchers in that study concluded that the use of women's groups practising participatory learning was a cost-effective method to improve maternal and neonatal survival (Prost et al. 2013). Opening avenues for community discussion about local ways to prevent human rights violations is also considered an important method for working upstream to induce policy changes. However, describing collaborative human rights work with indigenous women in Guatemala, Destrooper (2015) found that communication barriers exist when local community-based organizations try to work upstream with international organizations and donors. She concluded that new mechanisms that transmit local voices into broader policy arenas are needed.

Lesson 4: human rights are linked to responsibilities

Some study participants viewed human rights as empty promises and suggested no claims can exist without accompanying responsibilities. However, the African Charter on Human and Peoples' Rights (Banjul Charter) clearly specifies responsibilities. For example, in the Preamble, the Charter states, '. . .the enjoyment of rights and freedoms also implies the performance of duties on the part of everyone'. In our work, research participants emphasized personal and interpersonal obligations such that relationships between neighbours and within families are based on the notions of respect and reciprocity. Similarly, An-Na'im and Hammond (2002) suggested that advancing human rights in Africa must include promoting relationships based on respect, restraint, responsibility, and reciprocity.

In the health and human rights course, we developed the notion of rights in tandem with responsibilities by emphasizing and connecting with local values. For example, Desmond Tutu (1999) describes the South African ideal of ubuntu:

> A person with ubuntu is open and available to others, affirming of others, does not feel threatened that others are able and good, for he or she has a proper self-assurance that comes from knowing that he or she belongs in a greater whole and is diminished when others are humiliated or diminished, and when others are tortured or oppressed.

Ubuntu's ideal of respectful reciprocity recognizes individuality as an entity within a web of relationships (Chilisa 2009; Chuwa 2014). Therefore, individual claims to rights instantly acknowledge concomitant obligations to observe similar treatment toward others in the context of all living things.

Other local values that surfaced during community discussions of research findings included uhaki (harmony), ukweli (truth), utulivu (justice), ujamaa (community), and kujitoa (commitment). These ideals were consistent with research results and African scholars' descriptions of traditional values such as generosity, solidarity with fellow human beings, tolerance for individual and political differences, and avoidance of gross inequalities (Chuwa 2014; Matua 2002). These concepts are presented in a specific lesson and threaded throughout activities in the health and human rights modules. For example, case studies encourage learners to consider local issues through African-centred human rights documents. Appendices include documents such as the Banjul Charter, the Protocol on the Rights of Women in Africa (Maputo Protocol), and laws prohibiting discrimination and violence against women and other vulnerable groups. Each module includes discussion questions that encourage learners to embrace and celebrate local ideas as a foundation for creating respectful relationships and reciprocal responsibilities. We focused not only on interpersonal but also international relationships. For example, in the discussion about human rights violations, we exemplify violations in various settings such as civil rights violations in the United States and property rights violations experienced by indigenous populations across the globe. We also provide examples of solidarity in local and global efforts to respond to and redress rights violations. Throughout the course, we embed videos such as Nelson Mandela's 1994 Presidential address and Martin Luther King's 1963 'I Have a Dream' speech that illustrate expansive and inspiring human rights ideals.

Lesson 5: human rights violations often occur in the context of everyday lives

Community members provided evidence that both men and women experienced human rights violations in their daily lives. Because women's experiences of discrimination and violence were more frequently described, we decided to focus on women's experience of human rights violations. Being subject to exploitation and violence, struggling to gain access to education and income, and not being listened to in the community or at home were described by women as the most significant sources of disrespect and unfair treatment. Occurring within family and community contexts, rights violations experienced by women were notably embedded in the socio-political structures that surrounded them. Women clearly identified 'cultural attachment' as a barrier to advancing women's social status and rights. Similarly, Muriithi asserted, 'In Africa, women's rights have often been viewed as controversial, creating a blurry line between the need to protect human rights in general and the preservation of African identity, culture and morality' (Muriithi 2013: 43). Kanyoro, an African feminist, claimed culture is often used to justify oppression, violence, and other injustices against African women. She developed cultural hermeneutics as a framework for community members to 'question, examine, and scrutinize culture' in an effort to understand how social norms and traditions shape people's realities (Kanyoro 2002:

55). Kanyoro claimed that deconstructing oppressive social systems can only emerge from dialogue based in the processes of mutuality and participation.

The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol) clearly outlines rights and protections for African women. In the health and human rights course, we applied the Maputo Protocol when describing issues such as discrimination, exploitation, and violence. We also developed exercises to examine cultural norms and traditional practices. For example, learners select a tradition that is practised in their community, such as child marriage, and then hold structured conversations about the tradition's benefits and harms including whose health benefits and whose health is harmed by the tradition. Dialogue about differential harms and benefits leads to new insights about ways to adhere to tradition's benefits while eliminating the harms. Emphasizing the value of all voices in these discussions is essential.

The key to applying human rights principles to women's situations, which often includes deconstructing harmful or potentially harmful social practices, is accepting two premises. First, cultures are 'constantly changing through a wide variety of interactions between actors and factors both inside and outside a cultural group' (An-Na'im and Hammond 2002: 13). The idea that 'breaks with tradition are constantly happening in all cultures' emphasizes the notion that multiple, complex, community-based processes evolve and spark social change—a perspective that is often overlooked in critiques of human rights as a form of external hegemony. Second, the mechanism for cultural transformation resides within community processes that are inclusive, participatory, and grounded in advancing the holistic health and well-being of all members in the community. Reconciling competing notions requires open reflective dialogue within and between all sectors of the social order, critical analysis, inclusive and synergistic planning, good governance, and commitment to human rights as standards that value all aspects of human health and well-being.

Conclusion

This community-based project on health and human rights stemmed from an exploratory action-based research project on women's health experiences and the factors that impact their well-being. Lack of respect for women's value to society and corresponding human rights violations were frequent contributors to poor mental and physical health. The women also identified 'cultural attachment' as an underlying thread and encouraged further exploration into cultural perspectives on women's socio-political value. Additionally, women in community forums asserted that their own situations will only improve if we also worked to improve everyone's situations. An ethnographic study followed and revealed deeper insights on human rights experiences and structures, including ways to engage community members in the process of creating contextually sensitive human rights messages, especially for women. Based on our lessons learned, we note four implications for health and development practitioners.

First, a human rights framework provides a solid basis for forming coalitions to correct resource and power inequities that frequently lead to poor health outcomes (Rasanathan et al. 2010). Learning about local human rights deficits and the mechanisms by which these deficits harm human health is essential to planning comprehensive health-related programmes. With this in mind, health-care workers become a valuable resource in human rights initiatives, and human rights advocates contribute in important ways to community health work. Furthermore, community perspectives on health and well-being also become more significant. Community-identified priorities, objectives, and measures of success (that

is, specific indicators of improved health and well-being as achieved through human rights) should be the primary drivers of our shared work. When we form new partnerships and we view justice and health initiatives as inseparable domains of practice, new and innovative possibilities for improving human health and well-being blossom.

Second, the philosophical perspective of 'ubuntu' with its notions of reciprocity, interrelatedness, and synergism demands a collective view of health. Expanding beyond the ideas of individualism and individual rights that are frequently associated with human health, ubuntu suggests we have collective responsibilities for creating conditions associated with good health. In demanding our individual rights toward the 'highest achievable standard of health' (UN CESCR 2000), we must acknowledge all humans have the same rights, and therefore, we all share interests in and responsibilities for creating healthy conditions for all persons. When human rights is framed within ubuntu, old adversaries in fighting one another for individual rights become new partners in creating shared objectives for better and more equitable systems of care (London 2008). Furthermore, 'mechanisms that both foster public participation and enable meaningful agency on the part of those most affected by policies that limit or violate rights' must exist at local levels where 'antecedents for health violations, manifested in disparate power, may be traced' (ibid: 74).

Third, a rights-based approach expands our notions of accountability. In contrast to the customary needs-based approach which could evoke a charity or rescue mentality, a rights-based approach regards recipients of health and development initiatives as persons with legitimate claims and inherent power. Community members, therefore, should have a voice in shaping the health and development work that affects their daily lives. As health and development workers, our obligation is to partner with communities in creating rights-enabling structures that improve people's health and daily lives—the key aspects being inclusion, dialogue, mutual respect and accountability, and shared pragmatic work toward achieving human rights and better health in everyday lives (Pavlish and Pharris 2012).

Finally, human rights has evolved from a document that sought 'to place explicit limits on the way states could treat their own citizens' (Uvin 2004: 9) to include core principles that mandate the way health and development work as well as interprofessional and interpersonal relationships operate in everyday lives. As Eleanor Roosevelt stated in 1958 on the tenth anniversary of the Universal Declaration of Human Rights:

> Where, after all, do universal human rights begin? In small places, close to home—so close and so small that they cannot be seen on any maps of the world. Yet they are the world of the individual person; the neighbourhood he lives in; the school or college he attends; the factory, farm or office where he works. Such are the places where every man, woman and child seeks equal justice, equal opportunity, equal dignity without discrimination. Unless these rights have meaning there, they have little meaning anywhere. Without concerned citizen action to uphold them close to home, we shall look in vain for progress in the larger world. (Eleanor Roosevelt, 'In Our Hands', cited on United Nations (UN) 2016. Global Issues website)

Women in our studies suggested that human rights work should occur in the context of daily lives and should benefit all persons. Unfortunately, local understandings of how human rights concepts and mechanisms play out in daily lives are not often the starting point or even the focal point of international human rights organizations. A rights-based approach requires this attention and accountability at local and all levels and mandates participatory, collaborative mechanisms for creating rights-enabling structures that operate in people's daily lives.

In this practice note, we introduced a collaborative approach that firmly locates problem identification and analysis, as well as social change planning, messaging, and evaluating, within the community. Achieving broad participation in constructing the meaning of human rights within universal and daily experiences such as human health offers an opportunity for dialogue on shared human experiences and ideals. The process also provides an avenue for developing policies and social practices that protect human dignity, promote equity, and advance well-being within a variety of cultures.

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