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Human Rights, Health and Poverty Reduction Strategies

United Nations Human Rights
OFFICE OF THE HIGH COMMISSIONER FOR HUMAN RIGHTS

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Human Rights, Health and Poverty Reduction Strategies

"We recognize that development, peace and security and human rights are interlinked and mutually reinforcing..."

"We resolve to integrate the promotion and protection of human rights into national policies and to support the further mainstreaming of human rights..."

2005 World Summit Outcome
(General Assembly resolution 60/1)

GENEVA, 2008

World Health Organization

United Nations Human Rights

OFFICE OF THE HIGH COMMISSIONER FOR HUMAN RIGHTS

Foreword by Navanethem Pillay

We are celebrating two important anniversaries this year: the adoption of the Universal Declaration of Human Rights (UDHR) and the establishment of the World Health Organization (WHO). The UDHR proclaimed 'freedom from fear' and 'freedom from want' as the highest aspiration of all peoples and affirmed the inherent dignity and equality of every human being. The WHO Constitution enshrined the enjoyment of the highest attainable standard of health as a fundamental human right. The key messages of the UDHR and the Constitution of the WHO – now both 60 years old – are more relevant than ever.

Globalization has brought an increased flow of money, goods, services, people and ideas. Yet, gaps are widening, both within and between countries – in life expectancy, in wealth, and in access to life-saving technology. Those left behind, and experiencing poverty and ill health, feel disempowered, marginalized and excluded.

The human rights principles of equality and freedom from discrimination are central to any efforts to improve health. We should strive to go beyond statistical averages and identify vulnerable and marginalized groups. And beyond identifying the most vulnerable, we must engage them as active participants and generators of change. This is not only to ensure that health policies and programmes are inclusive. It is also a question of empowering people.

We hope that this booklet *Human Rights, Health and Poverty Reduction Strategies* will inspire and guide health policymakers to design, implement and monitor poverty reduction strategies through a human rights-based approach.

NAVANETHEM PILLAY
UNITED NATIONS HIGH COMMISSIONER FOR HUMAN RIGHTS

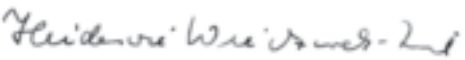
Foreword by Heidemarie Wieczorek-Zeul

The right to the enjoyment of the highest attainable standard of physical and mental health is at the centre of our development efforts for the achievement of the Millennium Development Goals (MDGs). Adopting a human rights-based approach to health in Poverty Reduction Strategy processes has not only an instrumental value for poverty reduction. More importantly, it also has an intrinsic value as most UN Member States have ratified the International Covenant on Economic, Social and Cultural Rights, which enshrines the right to health at the universal level. A human rights-based approach recognizes that every human being, by virtue of his or her inherent human dignity, is a holder of rights. And it is an obligation on the part of the Government to respect, protect and fulfil these rights.

Supporting Member States in progressively realizing the right to health for all is thus a legal and moral obligation incumbent on all members of the international community. The commitment to stronger focus on human rights in development cooperation has been underlined by the adoption of the first OECD DAC policy paper on "Human rights and development" in February 2007. This policy paper demonstrates that an increasing number of bi- and multilateral donors – Germany being one of them – are intensifying their efforts to promote and protect human rights and to integrate human rights principles more systematically into development cooperation at all levels of intervention as part of a broader governance agenda.

Poverty and ill health are strongly interlinked: lack of education, lack of nutritious food or safe water and unhealthy housing conditions often have a negative impact on the health of populations – with the effect that poor people suffer the highest burden of disease. Vice versa, ill health invariably increases vulnerability to poverty and increases the risk of poverty being transmitted to the next generation. A human rights-based approach to health can bring about a stronger poverty focus in PRS processes since it consistently focuses on issues of inclusion, availability, accessibility, acceptability and affordability for all. A better targeting of health services towards the poor can contribute decisively to poverty reduction and pro-poor economic growth and, ultimately, to achieving the MDGs.

I am pleased that the collaboration between WHO, OHCHR and my Ministry through its technical cooperation (GTZ) made this publication possible and hope it will provide constructive guidance for policymakers in both developed and developing countries so as to make the achievement of all MDGs a reality for all.



HEIDEMARIE WIECZOREK-ZEUL
German Federal Minister for Economic Cooperation and Development

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List of Acronyms and Terms

AAAQ	Availability, accessibility, acceptability and quality
Common Understanding	Central elements of the UN's understanding of a human rights-based approach to development
DAC	Development Assistance Committee
General Comment 14	General Comment on the Right to Health (2000)
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICPD	International Conference on Population and Development
ICPD+5	Five-Year Review of ICPD (1999)
IMF	International Monetary Fund
MDGs	Millennium Development Goals
NGOs	Non-governmental organizations
OECD	Organisation for Economic Co-operation and Development
OHCHR	Office of the United Nations High Commissioner for Human Rights
PAP	Participatory action plan
PPA	Participatory poverty assessments
PRS	Poverty reduction strategy
PRSP	Poverty reduction strategy paper
PSIA	Poverty and social impact assessment
TRIPS Agreement	Agreement on Trade-Related Aspects of Intellectual Property Rights
UDHR	Universal Declaration of Human Rights
UN	United Nations
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Introduction

Human rights are central to the achievement of the Millennium Development Goals (MDGs), the eight overarching targets derived from the Millennium Declaration that aim to reduce poverty, ill health and inequality as well as increase access to education and improve environmental sustainability. Human rights highlight the discrimination, inequality, powerlessness and accountability failures that lie at the root of poverty and deprivation.

Human rights have, in the past, been associated with conditionality and a focus on civil and political rights. This emphasis, together with a lack of understanding of economic, social and cultural rights, obscured the connections between human rights and poverty reduction and meant that human rights were seen as too controversial for use in development. Some Governments and organizations remain reluctant to address human rights explicitly in their policies and programmes.

A growing number of donors, Governments and non-governmental organizations are now exploring the practical ways in which human rights can be integrated into development. Human rights standards and principles have been used in villages and communities to strengthen the accountability of service providers and to monitor budget allocations and expenditure. They have formed the basis of national strategies to address HIV/AIDS as well as reproductive and sexual health. Human rights are increasingly seen as a useful framework for ensuring aid effectiveness and coherent donor action to support poverty reduction. The benefits of these approaches are beginning to be measured in terms of greater use of services by excluded groups and improved health outcomes.

The present booklet draws on this more recent body of experience and research. It seeks to strengthen efforts to achieve the MDGs by helping policymakers incorporate human rights into the design and implementation of the health component of national poverty reduction strategies (PRSs). It sets out how human rights standards and principles can provide a framework for:

- analysing and addressing inequalities and discrimination in access to health;
- supporting the demand side of poverty reduction through participation, accountability and redress;
- addressing the linkages between health and other areas, including macroeconomic policies and relevant sectors such as water and sanitation;
- identifying and delivering concrete entitlements to health service provision;
- formulating and monitoring budget allocations on health;
- clarifying Governments' and health ministries' regulatory role and enhancing health policy coherence;
- promoting mutual accountability and coherence in donor-Government relations.

Operationalizing and realizing human rights in practice is rarely straightforward, particularly in view of the financial and political constraints faced by all countries. This booklet provides examples of successful initiatives using human rights standards and principles to address poverty; some reflect national policies, others highlight initiatives by regional authorities or non-governmental actors. It aims to provide practical guidance on how to bring human rights, sound development practice and public health polices together in the health component of a PRS and addresses some of the challenges that this process may produce. The primary audience for the booklet is policymakers and planners working in ministries of health and other national ministries addressing health-related issues. It is hoped that it will also be a useful source reference for anyone working on health and PRSs, including those working in multilateral, donor and non-governmental organizations.

The structure of the booklet mirrors the process of developing a PRS, from initial analysis to design of its content to its implementation, and is consistent with the approach recommended by the World Bank in its *Poverty reduction strategy papers (PRSP) sourcebook.*[1] The guidance would be equally relevant in designing any pro-poor health policy. The booklet does not provide a blueprint, but instead offers broad guidance on how to apply a human rights-based approach to health in the context of poverty reduction. This guidance can be adapted to fit the particular circumstances of different countries. Each of the sections provides guidance on strengthening processes for participation, inclusion and accountability that empower excluded and marginalized people to claim their right to health.

Section 1 provides an *introduction* to human rights standards and principles, and explores how these apply to issues of poverty and health. It starts by examining the characteristics of human rights. It then reviews the principles underlying all human rights – including the indivisibility of rights, equality and non-discrimination, participation and accountability – and examines the importance of these principles for poverty reduction.

The section sets out how health is protected by human rights standards. It discusses the meaning of the right to health as set out in the International Covenant on Economic, Social and Cultural Rights (ICESCR). It further discusses how the UN Committee on Economic, Social and Cultural Rights, which monitors compliance with the ICESCR, has further clarified the scope and content of the right to health when adopting a General Comment on the Right to Health in 2000[2]. This General Comment (hereinafter referred to as "General Comment 14") on the right to health states that the right to health extends not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions and access to health-related education,

[1] Klugman J, ed. A sourcebook for poverty reduction strategies. Washington, DC, World Bank, 2002. http://www.worldbank.org

[2] General Comment 14 (2000), The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights). Geneva, United Nations, 2000 (E/C.12/2000/4). www.ohchr.org

including on sexual and reproductive health. Underlying determinants and facilities, goods and services must be available, accessible, acceptable and of good quality.

The section reviews human rights-based approaches to development. Common elements in these approaches include the use of human rights principles as the basis for participatory, inclusive and accountable analysis and interventions, and the achievement of human rights standards as objectives. The section concludes with a review of the value added of using a human rights-based approach in the task of formulating a PRS.

Section 2 provides suggestions for the process of *designing* the health segment of a PRS based on human rights standards and principles. It highlights both the intrinsic and instrumental value of participation and suggests a methodology to enable the meaningful participation of the poor or excluded in all stages of the PRS. It emphasizes the importance of provision of information and of transparency for meaningful participation.

The second half of the section explores how a rights-based approach can be used to analyse issues of health and poverty. It proposes three steps. The first step is to use the criteria of availability, accessibility, acceptability and quality to examine the barriers that prevent people who are marginalized and excluded from obtaining health services and the underlying determinants of health.

The second step is to use international and national standards as a basis for identifying who is a duty-bearer in the context of the provision of health care and the underlying determinants of health. The primary responsibility lies with the State in light of its human rights obligations under international human rights law. However, other duty-bearers, which may have responsibilities, include the private sector and international donors. In the context of a PRS, rights-holders are those people who are most excluded from access to health.

The third step is assessment of the institutional frameworks and capacity gaps shaping relations between rights-holders and duty-bearers. Institutional assessment includes analysis of mechanisms for ensuring participation and accountability, review of health-related legislation and policies, and assessment of financial constraints. Analysis of capacity gaps focuses on the knowledge, skills and information that rights-holders and duty-bearers require to realize the right to health.

Section 3 addresses the challenge of developing the *content* of a PRS in line with the rights-based analysis of health and poverty. Information from the rights-based analysis, PRS consultation process and clinical and geographical data are used to identify the essential health services and underlying determinants of health. A key element of a human rights-based approach is the identification of concrete entitlements, or minimum standards of service provision, that enable people to hold public policymakers

to account for service delivery. The analysis of availability, accessibility, acceptability and quality of health services helps to define these entitlements. The section then reviews the challenges of targeting excluded and marginalized populations, highlighting the importance of forming partnerships with a broad range of organizations, identified through the review of rights-holders and duty-bearers, to address the underlying determinants of health.

The creation of a task force is proposed, to address participation, accountability and the information needs of rights-holders identified in the institutional analysis. Such a task force should also ensure the effectiveness of linkages between local, national and international processes of participation and accountability. Skills, training and empowerment initiatives should be undertaken, to support the capacity of both service providers and people claiming those services. The amendment of existing discriminatory legislation and policies is recommended, as well as the initiation of new legislation to ensure that people are protected from actions by private sector and other organizations that may have a negative impact on their health.

Section 3 also addresses issues of funding for the health sector strategy, stressing the importance of human rights principles of transparency, accountability, non-discrimination and participation in decisions about macroeconomic policies. It reviews the key areas of macroeconomic policy that are likely to have an impact on the health sector, and looks at formulating the health sector budget on the basis of agreed policy objectives, minimum standards of service provision and human rights principles. Indicating the importance of taking into account the additional costs of reaching underserved populations, it discusses some of the challenges of allocating and redistributing resources against agreed priorities.

Finally, the section explores how human rights principles can provide the basis for building Government–donor relations to support the health sector strategy.

Section 4 is concerned with the *implementation* stage of a PRS. It reviews civil society PRS-monitoring initiatives, including community-based service monitoring and budget analysis. After discussing the challenges of establishing an effective national monitoring system and the production of disaggregated data, it suggests the type of indicators and targets that can be used to measure changes in health inputs and outcomes. The section concludes by exploring the role of political, judicial and quasi-judicial institutions in ensuring Government accountability for human rights.

Section 5 is a detailed *reference section* of relevant human rights instruments. It points to key documents and texts of specific relevance to health, human rights and poverty reduction that the reader may wish to refer to for further reading. Also included is a list of organizations active in this area.

SECTION 1

Principles of a human rights-based approach to poverty reduction strategies

This section provides an introduction to human rights principles, the links between human rights and poverty, and how health is protected by the human rights legal framework. It outlines the elements of a human rights-based approach, and explores the value of using this approach to formulate the health component of a PRS and to ensure that the overall PRS promotes and protects the right to health.

1.1 What are the characteristics of human rights?

Human rights are internationally agreed standards which apply to all human beings. They encompass the civil, cultural, economic, political and social rights set out in the Universal Declaration of Human Rights (UDHR 1948). The key international human rights treaties – the International Covenant on Economic, Social and Cultural Rights (ICESCR 1966) and the International Covenant on Civil and Political Rights (ICCPR 1966) – further elaborate the content of the rights set out in the UDHR and contain legally binding obligations for the Governments that become parties to them.

Building upon these core documents, other international human rights treaties have focused on groups and categories of populations, such as racial minorities,[4] women,[5] children,[6] migrants,[7] and persons with disabilities[8] or on specific issues such as enforced disappearance[9] or torture.[10]

All UN Member states have ratified at least one of the nine main human rights

HUMAN RIGHTS ARE:

- **universal, the birthright of every human being;**
- **aimed at safeguarding the inherent dignity and equal worth of everyone;**
- **inalienable (they cannot be waived or taken away);**
- **interdependent and interrelated (every human right is closely related to and often dependent upon the realization of other human rights);**
- **articulated as entitlements of individuals (and groups) generating obligations of action and omission, particularly on States;**
- **internationally guaranteed and legally protected.[3]**

[3] Office of the United Nations High Commissioner for Human Rights. *Frequently asked questions on a human rights-based approach to development cooperation.* New York and Geneva, United Nations, 2006 (HR/PUB/06/08) http://ohchr.org

[4] International Convention on the Elimination of All Forms of Racial Discrimination www.ohchr.org

[5] Convention on the Elimination of All Forms of Discrimination against Women www.ohchr.org

[6] Convention on the Rights of the Child www.ohchr.org

[7] International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families www.ohchr.org

[8] Convention on the Rights of Persons with Disabilities www.ohchr.org

[9] International Convention for the Protection of All Persons from Enforced Disappearance www.ohchr.org

[10] Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment www.ohchr.org

State obligations

All human rights impose three types of obligations on States:

Respect: *This simply means not to interfere with the enjoyment of human rights.*
Protect: *This means ensuring that third parties (non-State actors) do not infringe upon the enjoyment of human rights.*
Fulfil: *This means taking positive steps to realize human rights.*

11 United Nations Economic and Social Council, Committee on Economic, Social and Cultural Rights. *Substantive Issues arising in the implementation of the international covenant on economic, social and cultural rights. Poverty and the international covenant on economic, social and cultural rights.* Geneva, United Nations, 2001 (E/C.12/2001/10) www.ohchr.org

12 Adapted from: *Frequently asked questions on a human-rights based approach to development cooperation*, op. cit.

treaties, and 80 per cent have ratified four or more. When Governments ratify a treaty, they become legally bound to respect, protect and fulfil the rights they have acknowledged.

Human rights law recognizes the severe constraints that poor countries face and allows for the fact that it may not be possible to realize all economic, social and cultural rights for everyone immediately. However, Governments are obliged to provide a long-term plan that will lead to the *progressive realization* of human rights. They should also take immediate concrete steps, including financial measures and political commitments in accordance with available resources, targeted deliberately towards the full realization of all human rights. In situations where a significant number of people are deprived of human rights, the State has the duty to show that all its available resources – including through requests for international assistance, as needed – are being called upon to fulfil these rights.

1.2 What are the links between human rights and poverty?

Poverty has conventionally been defined in economic terms, focusing on individual and household, relative or absolute financial capacity. It is now generally recognized that poverty is multidimensional and not only defined by a lack of material goods and opportunities. The UN Committee on Economic, Social and Cultural Rights has defined poverty as:

> **"a human condition characterized by sustained or chronic deprivation of the resources, capabilities, choices, security and power necessary for the enjoyment of an adequate standard of living and other civil, cultural, economic, political and social rights."**[11]

Human rights *standards* set out the different objectives of development that have to be achieved in order to eliminate poverty, including health, education, freedom from violence, the ability to exert political influence and the ability to live a life with respect and dignity. Human rights *principles* underpin all civil, cultural, economic, political and social rights and provide the foundation for building interventions to achieve the realization of human rights and the elimination of poverty. Some human rights principles, including participation and non-discrimination, are also standards. This means that they should be incorporated into both the processes and objectives of development. Human rights principles include:[12]

Indivisibility: Indivisibility means that civil, cultural, economic, political and social rights are all necessary for the dignity of the human person and are interlinked. The principle of indivisibility implies that

responses to poverty should be cross-sectoral and include economic, social and political interventions.

Equality and non-discrimination: Human rights standards and principles define all individuals as equal and entitled to their human rights without discrimination of any kind, such as race, colour, sex, ethnicity, age, language, religion, political or other opinion, national or social origin, disability, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation or any other status as interpreted under international law. Inequality and discrimination can slow down economic growth, create inefficiencies in public institutions and reduce capacity to address poverty.[13]

Human rights law and jurisprudence recognize the importance of both formal and substantive equality. Formal equality prohibits the use of distinctions, or discrimination, in law and policy. Substantive equality considers laws and policies discriminatory if they have a disproportionate negative impact on any group of people. Substantive equality requires Governments to achieve equality of results.[14] This implies that the principle of equality and non-discrimination requires poverty reduction strategies to address discrimination in laws, policies and the distribution and delivery of resources and services.

Participation and inclusion: The human rights principle of participation and inclusion means that every person and all peoples are entitled to active, free and meaningful participation in, contribution to, and enjoyment of civil, economic, social, cultural and political development in which human rights and fundamental freedoms can be realized. It implies that people who are poor are entitled to participate in decisions about the design, implementation and monitoring of poverty interventions. This requires access to information, and clarity and transparency about decision-making processes. It also means that all people are entitled to share the benefits of the resultant policies and programmes.

Accountability, transparency and the rule of law: Processes of accountability determine what is working, so that it can be repeated, and what is not, so that it can be adjusted.[15]

Accountability plays a key role in empowering poor people to challenge the status quo, without which poverty reduction is unlikely to succeed. It is generally recognized that both the State and private sector are insufficiently accountable to support effective and equitable service provision.[16]

Accountability has two elements: *answerability* and *redress*. Answerability requires Governments and other decision makers to be transparent about processes and actions and to justify their choices. Redress requires institutions to address grievances when individuals or organizations fail to meet their obligations. There are many forms of accountability. Judicial processes are one form of accountability used to support the implementation of human

13 World Bank. *World development report 2006: equity and development*. Washington DC, World Bank, 2005 http://econ.worldbank.org/wdr

14 Elson D. *Budgeting for women's rights: monitoring government budgets for compliance with CEDAW*. New York, United Nations Development Fund for Women, 2006 www.unifem.org/resources/item_detail.php?ProductID=44, accessed 4 October 2007.

15 Hunt P. Report of the Special Rapporteur on the right of everyone to the highest standard of physical and mental health. New York, United Nations General Assembly. 17 January 2007 (A/HRC/4/28) www.ohchr.org

16 Gauri V. *Social rights and economics claims to health care and education in developing countries*. Washington, DC, World Bank, March 2003 (World Bank Policy Research Working Paper 3006) www.worldbank.org

rights. Human rights law means that States and other duty-bearers are answerable for the observance of human rights. Where they fail to comply with the legal norms and standards enshrined in human rights instruments, rights-holders are entitled to institute proceedings for appropriate redress before a competent court or other adjudicator in accordance with the rules and procedures provided by law.

Some processes of accountability are specific to human rights, for example inquiries by national human rights institutions and reporting to the UN human rights treaty-monitoring bodies. Others are general, including administrative systems for monitoring service provision, fair elections, a free press, parliamentary commissions and civil society monitoring.[17]

The principle of accountability requires that PRS processes of design, implementation and monitoring should be transparent and decision makers should answer for policy process and choices. In order to achieve this, the PRS should build on, and strengthen links to, those institutions and processes that enable people who are excluded to hold policymakers to account.

1.3 How is health protected by the human rights legal framework?

The most authoritative definition of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, often referred to as the right to health, is set out in article 12 of the ICESCR.[18]

THE RIGHT TO HEALTH

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

a. The provision for the reduction of… infant mortality and for the healthy development of the child;
b. The improvement of all aspects of environmental and industrial hygiene;
c. The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
d. The creation of conditions which would assure to all medical service and medical attention in the event of sickness.[19]

To clarify and operationalize the provisions of article 12, the UN Committee on Economic, Social, and Cultural Rights adopted General Comment 14. This acknowledges the importance of the underlying determinants of health by stating that the right to health is dependent on, and contributes to, the realization of many other human rights, such as the rights to food, to an adequate standard of living, privacy and access to information.

According to General Comment 14, moreover, the right to health contains both freedoms and entitlements. Freedoms include the right to be free from non-consensual medical treatment, torture and other cruel,

[17] Paul Hunt, 17 January 2007 op. cit.

[18 & 19] International Covenant on Economic, Social and Cultural Rights, 1966 (art.12). www.ohchr.org

[20] http://www.who.int/reproductive-health/gender/index.html

[21] World Health Organization/Office of the United Nations High Commissioner for Human Rights 2008. Fact Sheet Nº31 on the Right to Health. www.ohchr.org

inhuman or degrading treatment or punishment, and the right to control one's body, including sexual and reproductive freedom. Entitlements include the right to a system of health protection; the right to prevention, treatment and control of diseases; the right to healthy natural and workplace environments; and the right to health facilities, goods and services. Participation of the population in health-related decision-making at the national and community levels is another important entitlement. Non-discrimination and equality are critical components of the right to health. States have an obligation to prohibit discrimination and ensure equality to all in relation to access to health care and the underlying determinants of health. States must recognize and provide for the differences and specific needs of population groups, such as women, children, or persons with disabilities, which generally face particular health challenges, such as higher mortality rates or vulnerability to specific diseases.[21]

REPRODUCTIVE RIGHTS

Reproductive rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. They also include the right of all to make decisions concerning reproduction free of discrimination, coercion and violence.[20]

INTERNATIONAL HUMAN RIGHTS TREATIES RECOGNIZING THE RIGHT TO HEALTH *(see references below, section 5.2):*

- **International Convention on the Elimination of All Forms of Racial Discrimination (1965): article 5(e)iv;**
- **International Covenant on Economic, Social and Cultural Rights (1966): article 12;**
- **Convention on the Elimination of All Forms of Discrimination against Women (1979): articles 11(1) f, 12 and 14(2)b;**
- **International Convention on the Rights of the Child (1989): article 24;**
- **International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (1990): articles 28, 43(e) and 45;**
- **Convention on the Rights of Persons with Disabilities (2006): article 25.**

General Comment 14 sets out four criteria by which to evaluate the right to health:

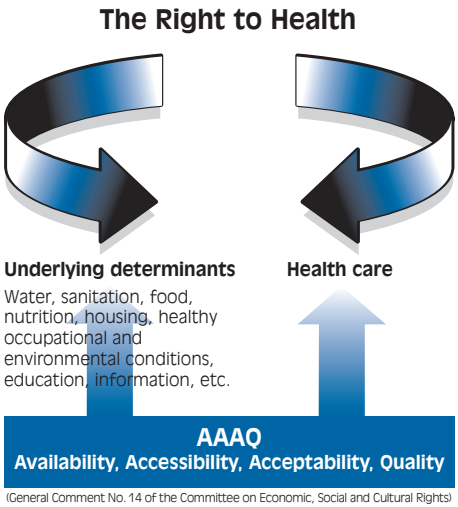
Availability. Functioning public health and health facilities, goods and services, as well as programmes, have to be available in sufficient quantity.

Accessibility. Health facilities, goods and services have to be accessible to everyone without discrimination, within the jurisdiction of the State party. Accessibility has four overlapping dimensions:

1. non-discrimination;
2. physical accessibility;
3. economic accessibility (affordability);
4. information accessibility.

Acceptability. All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.

Quality. Health facilities, goods and services must be scientifically and medically appropriate and of good quality.



1.4 What are poverty reduction strategies?

A PRS is a national cross-sectoral development framework, designed and implemented by the national Government, specifically to tackle the causes and impact of poverty in a country. Even in high-income States, groups or sectors of poor people remain and a national PRS is as necessary in these countries as in poorer ones. In low- and middle-income States, PRSs were initially introduced as a requirement for countries seeking concessional loans from the World Bank or the International Monetary Fund (IMF). In these countries, Governments produce a PRSP setting out their macroeconomic and social policies and plans. Today, PRSs are increasingly seen as the principal mechanism around which many bilateral and multilateral donors build their development cooperation programmes. They are also considered to be the national operational framework for achieving the MDGs. By March 2005, 44 countries had completed full PRSPs, and several are now revising their original strategies.

There is now broad agreement among all the leading development agencies, including the World Bank, on the key principles on which a PRSP should be based.

- It should be **result-oriented**, with targets for poverty reduction that are tangible and can be monitored.
- It should be **comprehensive**, integrating macroeconomic, structural, sectoral and social elements.

- It should be **'country-driven'**, representing the consensus on what steps should be taken.
- It should be **participatory**; all stakeholders should participate in its formulation and implementation.
- It should be based on **partnerships** between the Government and other actors.
- It should be **long-term**, focusing on reforming institutions and building capacity as well as long-term goals.[23]

1.5 Putting human rights into practice through development policies and programmes

While the value of human rights as a set of guiding norms is well established, development practitioners are now exploring how human rights can be used to strengthen poverty analysis and development operations.

For many civil society organizations, human rights provide a focus for empowerment initiatives which encompass human rights education, mobilization, advocacy and monitoring of Government policies by and on behalf of people who are poor and marginalized.

A number of donor and multilateral agencies have endorsed approaches that use human rights as a framework for development planning and implementation. The opportunities for the application of this work have been broadened by the World Bank's legal opinion,[24] issued in 2006, which indicates that it has a significant role to play in supporting Governments to fulfil their human rights obligations relating to development and poverty reduction. The Development Assistance Committee (DAC) of the Organisation for Economic Co-operation and Development (OECD) has also issued guidance on integrating human rights into development. It includes recommendations for the integration of human rights principles and analysis into the roll-out of the Paris Declaration on Aid Effectiveness.[25] The DAC guidelines highlight the potential of the human rights framework to strengthen principles of ownership, alignment, harmonization, managing for results and mutual accountability in the delivery of aid.

While there is no universal recipe for incorporating human rights into development processes, rights-based approaches generally have the fulfilment of human rights as their objective and apply underlying human rights principles to policies and programmes. In 2003 United

THE HUMAN RIGHTS-BASED APPROACH TO DEVELOPMENT COOPERATION: Towards a common understanding among UN agencies

- **GOAL: All programmes of development cooperation, policies and technical assistance should further the realization of human rights as laid down in the Universal Declaration of Human Rights and other human rights instruments.**
- **PROCESS: Human rights standards contained in, and principles derived from, the Universal Declaration of Human Rights and other international human rights instruments should guide all development cooperation and programming in all sectors and in all phases of the programming process.**
- **OUTCOME: Programmes of development cooperation should contribute to the development of the capacities of duty-bearers to meet their obligations and of rights-holders to claim their rights.[26]**

[23] *Paris declaration on aid effectiveness: ownership, harmonisation, alignment, results and mutual accountability.* Paris, High Level Forum, February 28 - March 2, 2005 www.oecd.org

[24] "Legal opinion on human rights and the work of the World Bank", dated January 27, 2006 http://www.ifiwatchnet.org

[25] Development Assistance Committee, *Action-oriented policy paper on human rights and development.* Paris, Organisation for Economic Co-operation and Development, 23 February 2006 [DCD/DAC(2007)15/FINAL] www.oecd.org

[26] The human rights-based approach to developement cooperation: towards a common understanding among UN agencies. In: *Interagency workshop on a human rights-based approach in the context of UN reform, Stamford, CT 3-5 May 2003.* New York, United Nations www.undp.org

Nations agencies agreed on a "Common Understanding" of the central elements of a human rights-based approach to development that would inform UN policies and practices.[27]

This booklet draws on the approach set out in the Common Understanding as the basis for exploring how human rights standards and principles can strengthen the design and implementation of the health component of a PRS. It uses the definition of the right to health set out in the ICESCR and General Comment 14 as a basis for building a cross-sectoral approach to health, with the criteria of availability, accessibility, acceptability and quality providing the underlying framework for analysis, design and implementation of the health strategy. It suggests processes and interventions which are based on the human rights principles of indivisibility, equality and non-discrimination, participation and inclusion, and accountability, transparency and the rule of law. Interventions address the institutional constraints and capacity gaps that prevent rights-holders from claiming their rights and duty-bearers from meeting their obligations.

1.6 In what ways do human rights and poverty reduction strategies complement each other?

There are many *similarities* between a human rights approach to poverty reduction and the key principles of a PRS. Strategies and approaches that are common to both include emphasis on participation, monitoring and accountability, long-term planning and incorporation of a multidimensional understanding of poverty. A human rights-based approach can help to strengthen these elements of a PRS.

Review of completed PRSPs suggests that, in many cases, they have been weak on issues of inequality in health provision. A WHO review of completed PRSPs found a lack of in-depth analysis of the linkages between poverty and health, insufficient emphasis on non-discrimination and an absence of indicators of health inequalities. In addition, the review identified a lack of participation by the relevant ministry of health in the PRS process.[28]

This booklet uses a human rights-based approach to address these gaps and strengthen the formulation of the health component of a PRS by identifying methods and interventions which support:

- a coherent, cross-sectoral approach to health and an enhanced regulatory role for the ministry of health;
- the participation of marginalized and excluded people in decisions that impact upon their health;
- the definition and communication of entitlements and minimum standards of service provision that enable people to hold public policymakers and providers to account for their actions;
- the non-discriminatory delivery of entitlements and identified minimum standards on a universal basis;

[27] Ibid.

[28] *PRSPs: their significance for health: second synthesis report*. Geneva, Workd Health Organization, 2004 (WHO/HDP/PRSP/0.4.1) www.who.int

- health sector budget allocations based on agreed service priorities and standards;
- accountability procedures which enable people to monitor provision and obtain redress when standards are not met;
- coherent and mutually accountable donor–Government relations.

The powerlessness, discrimination, inequality and accountability failures that lead to poverty are often politically driven, deeply rooted and not easily remedied. Nonetheless, these are the challenges that policymakers and planners have to face if health outcomes are to be improved. The following sections provide guidance and case studies that health planners can utilize to address these issues in their own countries. Summaries of experience and lessons learned inevitably gloss over the problems and setbacks that all individuals and organizations face when they try to support difficult changes. Policymakers and planners have to be determined, persuasive and innovative to overcome conflicts of interest within their own ministries as well as in the communities with which they are working. Champions of change at different levels of the ministry of health need to work together and build relations with a wide range of different organizations from the community, non-governmental and private sectors. Applying human rights principles of participation, inclusion, accountability and transparency to all these partnerships and working relations, within and outside the ministry of health, provides the most effective foundation for actions to support the realization of the right to health for all.

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SECTION 2

Formulating a pro-poor health strategy based on human rights principles

This section provides guidance on how human rights can support the process of developing and formulating the health segment of a PRS.

No two countries are faced with the same health problems and each country's health strategy differs accordingly. A human rights-based analysis of health and poverty provides context-specific cross-sectoral assessment of the causes of ill health. It addresses questions about *who* is denied the right to health, *why* they are deprived, and *what* can be done to improve their situation and prevent others from suffering. Participation, enabling people to have a voice in the decisions that affect their lives, is a central element of this process.

The first part of this section looks at participation as an essential principle of all phases of the PRS process, from gathering information about poverty, inequality, powerlessness and health to the participation process aimed at engaging a broad range of individuals and organizations in health-policy decisions. The second part of the section explores approaches for building a comprehensive information base on processes of discrimination and exclusion that lead to inequalities in health outcomes. Potential entry points for action are identified through assessment of rights-holders and duty-bearers and analysis of the institutional frameworks and capacities which shape their relations.

2.1 Participation

Participation is an essential principle of human rights and is intrinsic to inclusion and democracy at local, national and international levels. Information sharing is a critical component of participatory processes whether at the planning, implementation or monitoring stages of the PRS.

An effective participatory process is a key factor in the success of any PRS. It increases ownership and control over development processes and helps to ensure that interventions are responsive to the situations of the people they are intended to benefit. Building a health sector component of a PRS on sound information and broad-based participation places the ministry of health in a stronger position in resource

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negotiations with the ministry of finance and other organizations that have a strong stake in the PRS.

However, it is not without its inherent risks. Participation requires a willingness to share power and information on a non-discriminatory basis. Participation is, consequently, politically and logistically challenging. Participatory processes may raise expectations unrealistically or expose conflicting interests and power struggles. Initiating participatory processes requires time, patience, resources and planning.

Whether it takes place at the local project level or at national policy level, the principal mechanism for participation should, as far as possible, be existing democratic structures. In some circumstances, establishing alternative frameworks for participation can undermine fledgling democratic structures, create unwelcome parallel systems and, in the longer term, prove unsustainable. Nevertheless, in many cases, innovative arrangements may well be needed to ensure that participation is both inclusive and deep.

Many countries design what is commonly known as a Participatory Action Plan (PAP). This provides a roadmap for participation in all stages of the PRS cycle from design and implementation to monitoring. The exact content of a PAP varies from country to country. Key stages in designing a realistic PAP include:

i. identification of starting point
ii. stakeholder analysis
iii. determining the feasible level of participation for the PRS
iv. identifying the appropriate mechanisms for participation
v. developing institutional mechanisms for coordinating participation
vi. developing an action plan.[29]

These stages are discussed briefly below.

i *Identification of starting point*

Participation in the PRS will be different in each country, depending on a number of factors, including governance and political structures and the extent to which civil society and politicians regard the PRS as an important instrument for addressing poverty. In order to find a country's starting point, and a rough idea of the feasible level of participation, it is useful to assess the following factors:

- degree of ownership of previous national poverty reduction processes
- civil society organization and capacity
- previous experience with participation in policy processes
- Government capacity for organizing participatory processes.

ii *Stakeholder analysis*

One of the key steps in the participatory process is the identification of the stakeholders — all those individuals, groups and organizations that are affected by, or involved in the delivery of, the PRS. From a human rights perspective, it is

[29] Adapted from: Tikare S et al. *Organizing participatory processes in the PRSP.* Washington, DC, World Bank, April 2001 (draft for comments).

Selected from Voices of the Poor, **World Bank, 2000**

"If you don't have money today, your disease will take you to your grave!" Ghana

"Poverty is lack of freedom, enslaved by crushing daily burden, by depression and fear of what the future will bring." Georgia

"If you don't know anyone, you will be thrown to the corner of a hospital" India

"For a poor person everything is terrible - illness, humiliation, shame. We are cripples; we are afraid of everything; we depend on everyone. No one needs us. We are like garbage that everyone wants to get rid of." Moldova

"When one is poor, she has no say in public, she feels inferior. She has no food, so there is famine in her house; no clothing, and no progress in her family." Uganda[30]

[30] www1.worldbank.org/prem/poverty/voices/listen-findings.htm

important that the most marginalized groups and communities are identified and engaged in the PRS from the outset.

The nature of exclusion and the identity of the most marginalized vary from country to country. By definition, people who are marginalized live on the edges of society and may be invisible to policymakers and others in positions of authority. In most countries, however, there are particular social groups within the population that tend to be more excluded and more likely to suffer from poverty on a consistent basis than others. The number of women living in poverty, for example, is increasing disproportionately to the number of men, particularly in developing countries. The feminization of poverty is also a problem in countries with economies in transition as a short-term consequence of the process of political, economic and social transformation. Other groups which are consistently excluded include children, adolescents, the elderly, people living with HIV/AIDS, ethnic, religious and linguistic minorities, people with mental or physical disabilities, migrants (including migrant workers), internally displaced people, refugees, slum-dwellers, homeless persons and indigenous peoples. It is an important part of designing a PRS to determine which sections of the population are marginalized and excluded and to identify their location.

In addition to those people excluded, other key stakeholders are likely to include:

- Government policy planners, including civil servants in central ministries, line ministries and local government bodies;
- representatives from other State institutions, including elected bodies, national human rights institutions and the judiciary;
- civil society organizations, including non-governmental organizations (NGOs), community-based organizations, faith-based organizations, indigenous organizations and traditional leaders, trade unions, academic institutions, consumer groups, professional associations;
- private sector organizations, including health service providers, equipment suppliers and representatives of pharmaceutical companies;
- donors and multilateral organizations.

Level of participation

Participatory processes aim for, or result in, different levels of engagement.

- *Information sharing*. Authorities provide people and communities with information about policies and policy processes — a basic requirement for participation and increased transparency.
- *Information gathering*. Participatory methods are used to obtain information from different communities and social groups.
- *Consultation*. Policymakers ask for participants' views, but there is no obligation to listen or incorporate opinions expressed.

Mongolia: Vulnerability analysis

A participatory approach has helped to identify the complex, interlocking reasons for the increased vulnerability of Mongolia's poor pastoral communities. Economic vulnerability had been exacerbated by a crisis in the banking sector, which in turn led to indebtedness, selling of assets and a decline in livestock. Natural hazards compounded matters and conflict emerged between communities over access to safe pasture. This led to a breakdown in the traditional kinship and social support structures, which in turn led to increased alcoholism, domestic violence and crime. The analysis revealed how vulnerable poor communities can be to a series of unconnected yet cumulative shocks.

31 Adapted from: McGee R, Norton A. *Participation in poverty reduction strategies: a synthesis of experience with participatory approaches to policy design, implementation and monitoring.* Brighton, Institute of Development Studies, 2000 (IDS Working Paper 109) www.ids.ac.uk

32 *Declaration on the Right to Development. General Assembly resolution 41/128 of 4 December 1986.*

- *Joint decision-making*. Where those consulted have some rights with regard to decision-making.
- *Empowerment*. Initiation and control of decision-making by stakeholders.[31]

In a human rights-based approach, participation is both an underlying principle and a standard. While the principle stresses that all development processes should be participatory, the standard defines the empowerment of people who are marginalized and excluded as a development objective. In practice, this means that the process of formulating the PRS should be based on the highest possible standard of active, free and meaningful participation, as defined in the United Nations Declaration on the Right to Development.[32] Specific resources, mechanisms and strategies to enable the participation of people who are marginalized and excluded, as set out below, should be considered. The achievement of participation as a development objective requires that, in addition, the institutional constraints and capacity gaps that act as barriers to poor people's empowerment are addressed in the content of the PRS.

iv *Identifying the appropriate mechanisms for participation*

Different participatory mechanisms may result in varying depth and breadth of participation, with some approaches being more effective at reaching a wide range of communities and individuals who are impoverished and marginalized. Ensuring that participation in the formulation of the PRS is both deep and broad may require a combination of mechanisms and methods.

PARTICIPATORY RESEARCH METHODS

Participatory research methods strengthen the analysis of poverty, powerlessness, inequality and health by exploring the perspectives and priorities of the poor themselves. Planning a comprehensive participatory research process takes time. Depending on the point in the PRS cycle, it might be more appropriate to build participatory research into future cycles or to consider using participatory research methods to support implementation or monitoring and evaluation. Collaboration from the outset of the PRS process with other Government sectors is likely to be the most effective way of ensuring a cross-sectoral approach to health in policy implementation.

The primary experience in using participatory research methods in developing countries has been with Participatory Poverty Assessments (PPAs). These are structured research processes that include group discussions in villages and the use of peer group interviews, ranking and mapping techniques to explore people's views and priorities.

The information produced by PPAs is generally qualitative. PPAs often highlight issues that are common knowledge but may not be publicly admitted, such as

Mozambique: SolidarMed HIV and AIDS prevention project

SolidarMed facilitated a joint analysis of high-risk practices between health-care providers and community members, which identified possible sources of public health problems that may increase risk for HIV infection. These are the multiple use of material without sterilization by informal (illegal) care providers for injections and by traditional healers for circumcision and scarification. Local explanatory models were shared and exchanged (for example, blood contact is not perceived as bearing any risk of contamination). Common risk behaviours (for example, informal exchange of sexual services against material and financial benefits is not considered 'prostitution') and the social situations where they frequently take place (for example, meetings at taxi and bus stations or women selling beer in local markets) were jointly identified and analysed. This stage of analysis then leads to a dialogue with the aim of finding adapted, culturally acceptable and locally owned solutions.[33]

extortion of bribes for health treatment. Single-sex, age-specific or similarly focused groups are useful for exploring issues – such as reproductive and sexual health and domestic violence – that may be too sensitive or complex to uncover through conventional research techniques.

The World Bank and some bilateral agencies have supported PPAs in a range of countries. Many international NGOs and academic institutes have experience in using participatory research techniques. It is important to involve locally based organizations in the process to build domestic capacity as well as to extend the reach of the research. Participatory research also offers administrators, or indeed politicians, the opportunity to engage with local communities and reality-check their own perspectives and priorities.[34]

PARTICIPATORY PROCESS

The primary objective of the participatory process is in-depth civil society engagement in decisions about the different policy options for the health component of the PRS. Where possible, the participatory process should build on existing decision-making bodies and channels which may later be engaged in implementation and monitoring of the PRS.

It is important to aim for the greatest depth of participation possible in this process. In countries where there is not much experience of policy engagement with civil society, Government ministries have tended to consult NGOs and other stakeholders about their views on possible policies to be included in the PRS. Over subsequent PRS cycles, with the accumulation of experience and trust, some Governments have moved towards joint

USING PARTICIPATORY RESEARCH METHODS TO INVESTIGATE MATERNAL HEALTH-SEEKING BEHAVIOUR IN NEPAL

Key Informant Monitoring is a research methodology that is based on local women and men collecting information from peers or key informants on their perceptions of how the social environment enables women to access care. The conversations are structured around three themes: reduced barriers to obstetric care, improved quality of care, and improvements in women's social status and mobility. The findings from use of the Key Informant Monitoring tool in Nepal highlighted barriers to change and the reasons why families are delaying the use of emergency obstetric care. For example, key informant researchers have recorded instances of health workers discriminating against low-caste women, and the functional exclusion of extremely poor women from community emergency fund schemes. Local NGOs have facilitated meetings between key informant researchers and Village Development Committees on findings and recommendations of the research. The dialogue generated through this process has facilitated changes being made to improve the quality of service delivery.[35]

[33] Communication of Ruedin L, published in: Somma D, Bodiang C. *The cultural approach to HIV/AIDS prevention.* Geneva, Swiss Agency for Development and Cooperation and Swiss Centre for International Health, 2006 www.sdc-health.ch

[34] Norton A et al. *A rough guide to PPAs: participatory poverty assessment, an introduction to theory and practice.* London, Overseas Development Institute, 2001 www.hri.ca

[35] Hawkins K et al. *Developing a human rights-based approach to addressing maternal mortality: desk review.* London, DFID Health Resource Centre, January 2005 www.dfid.gov.uk

[36] O'Malley K. *Children and young people participating in PRSP processes.* London, Save the Children, 2004 www.inclusion-international.org

decision-making, particularly where civil society and Government working groups or other permanent institutions have been set up. In all cases, it is important that the purpose and scope of the consultation are discussed and agreed with stakeholders at the outset. It is better to be clear about the limitations of the process than to raise false expectations and foster disillusionment and cynicism.

It is essential that no groups of individuals that have been identified as being discriminated against or marginalized are left out of the consultation. The challenge then is to find organizations or individuals that legitimately represent these groups. This may involve assessment of groups' capacity, representativeness and their internal accountability mechanisms. It may be necessary to manage tensions among NGOs themselves about who should participate and identify those organizations with less experience of policy engagement, such as those representing children, to prevent them from being squeezed out of the process.

v *Build the institutions and mechanisms to ensure meaningful participation*

This is frequently the most challenging part of any participatory process. It is useful to start with an assessment of the institutions, quality of information and tools that would allow for an inclusive process for diverse stakeholders, particularly those sectors of the population that have been marginalized or excluded.

The institutions and processes most likely to achieve legitimacy and inclusion vary between countries. Some have coordinated issue-specific working groups from a central point in the Government; others have delegated the task to local government officials and community leaders. If the country context permits, working alongside a reputable civil society organization or NGO may generate additional trust in the process and a belief in its worth.

CHILDREN'S PARTICIPATION IN THE PRS

Civil society participation in PRSs can be highly contested. As relative newcomers, children, and the organizations that represent them, have to negotiate with other civil society actors for space to engage. They have to raise awareness of their right to participate and the value of their contributions among their fellow citizens, as well as officials. As with other people's engagement in the PRS process, it is hard to gauge systematic impact. Nonetheless, there are examples of children's participation leading to small, but significant, policy changes. In Viet Nam, Save the Children organized three large-scale consultations in Ho Chi Minh City involving over 400 children and young people. Children at these meetings highlighted the problems migrant families faced in accessing education, health care and social welfare services. This information helped change procedures to allow unregistered migrants access to services more quickly.[36]

Ireland: traveller health strategy

Ireland's recent economic success has exposed the increasing disadvantages facing its minority traveller community, which is now recognized as a distinct minority group with its own culture and customs. The community suffers from far lower-than-average levels of health and life expectancy, having experienced exclusion, prejudice and poverty for generations. Previous strategies to address traveller health needs have tended to focus on bringing the traveller population to services designed for settled communities, with little success. However, in 1998, a Traveller Health Advisory Committee with the participation of representatives of the traveller community was established to look specifically at the particular needs of travellers and to design a strategy to meet these needs. The national strategy was launched in 2002 to address a wide range of issues from discrimination and racism, to water and sanitation at traveller sites, and from increasing traveller participation in priority setting to specific health risks facing traveller mothers.[37]

[37] Department of Health and Children, Ireland. www.dohc.ie

vi *Develop an action plan*

The cost of the participatory process will depend on the starting point, coordination mechanisms, the extent of use of participatory research methods, the types of activities planned and the amount of local civic engagement envisaged. Ways to minimize costs include drawing on local capacity to organize participatory processes, working with existing networks and organizations, use of low-key but well planned focus groups, interviews and town-hall meetings rather than large workshops, and looking for donors to share costs.

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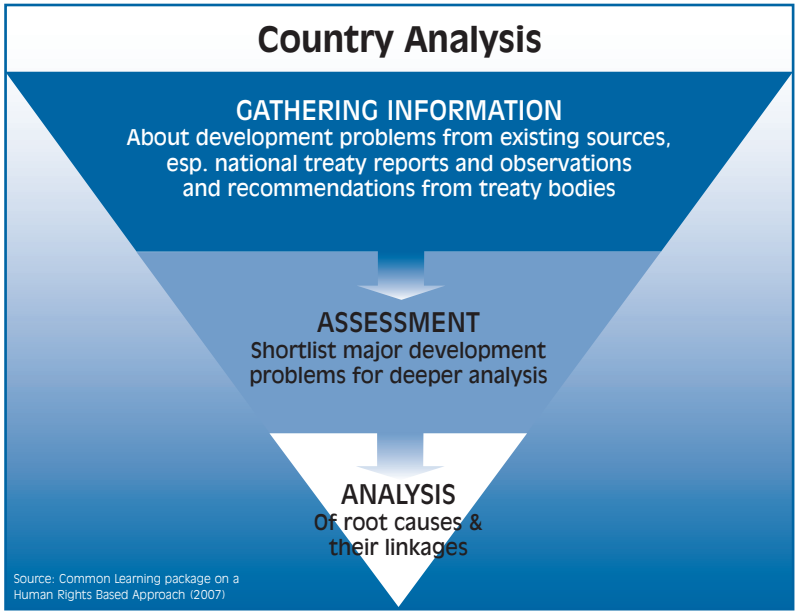
Carrying out an effective participatory process requires sufficient time. In many countries, the constraints of the PRS process have meant that there is usually a maximum of 12 to 18 months available for participation. It is important, however, to think beyond the production of the strategy and to plan participation in both implementation and monitoring.

2.2 Human rights-based analysis of health and poverty

Participatory research processes can be used to build an information base on inequality, poverty and health. This information base should also draw on existing research on poverty, gender, geographical and clinical data. The analysis should aim to assess who is denied the right to health, why they are deprived and what can be done to improve their position. The approach suggested here outlines three steps that can be used to answer these questions and can be adapted and tailored to different contexts:

i. country analysis of the level of the realization of the right to health;
ii. identification of rights-holders and duty-bearers in relation to the right to health and related rights;
iii. assessment of institutional constraints and capacity gaps that prevent individuals, groups and organizations from claiming or fulfilling the right to health.

The analysis will inevitably uncover a broad range of social, economic and political causes of discrimination and ill health, moving beyond the usual remit of the ministry of health. This broad perspective enables the development of a comprehensive health strategy. It also allows the identification of effective entry points for action and strategic partnerships with private and non-profit as well as



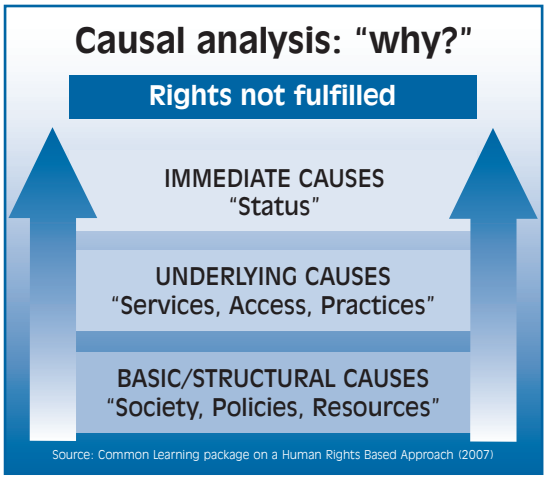
State institutions aimed at generating an enabling environment for the realization of the right to health of people living in poverty.

Country analysis of the level of the realization of the right to health

Important sources of information on the country concerned, and available at the international level, are reports from UN human rights treaty bodies, the Universal periodic review mechanism and UN special rapporteurs of the UN human rights council. Others are the WHO and other international organizations working on health and human rights in countries. At national level, clinical data from poor and excluded populations will invariably reveal higher-than-average instances of disease, premature mortality, maternal mortality, or HIV/AIDS infection rates. Participatory research may further reveal population groups more likely to suffer from a range of health problems including environment-related and occupational conditions and injuries. Examination of the health-care services in the country may confirm that those living in poverty do not enjoy the same levels of health care, treatment and protection as other people. Children within poor communities may not be systematically immunized against preventable diseases. Other means of prevention, such as condoms to protect against HIV/AIDS or insecticide-treated bednets to prevent malaria, may not be available or affordable to poor communities.

While the specific linkages between population groups and health will be different in each country, it is likely that those groups already identified as being poor and excluded will suffer disproportionately from morbidity and premature mortality. People who experience multiple forms of disadvantage, such as women refugees or children with disabilities, are likely to be particularly vulnerable to ill health. The identity of those most deprived of the right to health cannot be assumed, but needs to be investigated in each country.

These differences in access to health and health outcomes are often the product of different forms of discrimination and



inequalities in the distribution and delivery of health services and other resources that impact upon health. Exploration of these inequalities requires analysis of the underlying barriers to access to services and resources. The availability, accessibility, acceptability and quality (AAAQ) framework set out in General Comment 14 on the Right to Health (section 1.3) is useful for the systematic exploration of these barriers. Although the precise nature of the health facilities, goods and services as well as underlying determinants of health will vary depending on numerous factors, including the State party's developmental level, an analysis will include questions as to:

The Availability of:

- safe and potable drinking water and adequate sanitation facilities;
- trained medical and professional personnel receiving domestically competitive salaries;
- essential drugs, as defined by the WHO;
- nutritious food;
- adequate housing and shelter.

The Accessibility of the underlying determinants and of health care such as:

- whether access to health facilities, goods and services is ensured on a non-discriminatory basis in law and in fact;
- whether health facilities are in safe reach for all sections of the population including rural populations, persons with disabilities, children, adolescents and older persons;
- whether health services are affordable to all, including economically disadvantaged groups;
- whether information about different health services, medicines, or preventive measures are freely available to all groups, such as adolescents, within the community.

The Acceptability of the underlying determinants and of health care:

- such as the extent to which health facilities, goods and services are culturally appropriate, sensitive to gender and life-cycle requirements.

The Quality of the underlying determinants and of health care:

- such as whether available drugs are scientifically approved and unexpired;
- whether available water is safe and potable;

KENYA: OLDER PEOPLE'S ACCESS TO HEALTH SERVICES

Since 2003, HelpAge Kenya has been working with older people in Ngando, an urban slum area of Nairobi, and Misanyi, a rural area, to monitor their access to health services.
Older people voiced concerns such as:

- the distance they have to travel to the nearest hospital and the prohibitive cost of transport. Many older people live on less than a dollar a day but the average fare to the hospital is US$ 0.80;
- discriminatory treatment, abusive language and rough handling. 70 per cent of older people in Ngando said that health staff had a negative attitude towards them;
- long queues. 54 per cent of older people surveyed in Misanyo waited for between 2 and 5 hours before seeing a doctor;
- health practitioners' ignorance about diseases in later life;
- the prohibitive cost of health services. 12 per cent of older people in Ngando were unable to afford the medication they were prescribed;
- neglect if older people were admitted to hospital. 86 per cent of older people in Ngando reported having shared beds in hospital.

In order to address these issues, older people organized themselves into groups and elected community leaders. They identified a number of indicators to use for monitoring. Community leaders met with health services to highlight their concerns and to change the attitudes of health staff. As a result of these actions, older people have reported an improvement in the attitude of staff at the hospital near to Misanyi. The doctor in charge has agreed to set up a separate section in the ward for older people. The Ministry of Health has provided an annual supply of US$ 2,650 worth of drugs to Misanyi Health Centre. The Ministry of Health's second National Health Sector strategic plan includes specific reference to entitlements for older people as a special group with special medical needs.[38]

[38] HelpAge International. Report on older citizens' monitoring project, Kenya. www.helpage.org

- whether the health personnel is trained and skilled;
- whether the quality of the hospital equipment is adequate and safe;
- whether places of employment are safe and healthy.

UNDERLYING DETERMINANTS OF HEALTH

Inequalities in the realization of the right to health are also a consequence of the denial of other human rights. Migrant workers, for example, are frequently employed in mining, construction, heavy manufacturing and agricultural tasks that can expose them to a range of occupational health risks including unprotected exposure to toxic agents, unsafe equipment and long hours. Migrants often live in poor urban areas in overcrowded, substandard housing with inadequate sanitation. Conditions creating vulnerability to ill health are often compounded by limited entitlements to health care as well as barriers of language, culture, information and finance.

Human rights standards provide a basis for the systematic identification of the civil, political, economic, social and cultural factors that impact on the health of people who are marginalized and excluded.

Other standards defined in key human rights instruments can be used as a reference point for participatory research into underlying factors that directly or indirectly affect the health of marginalized and excluded people. Common issues are:

- violence against women
- violence and abuse at home and at work
- harmful traditional practices, including female genital mutilation
- lack of voice in household and community decision-making
- lack of access to education
- inadequate or non-existent social protection
- lack of birth registration or identity papers.

Women's health and social compromises in Mali

By the age of 17, 38 per cent of women in Mali have already had one child or are pregnant. 94 per cent of women in Mali of childbearing age have undergone female genital mutilation. High fertility and vulnerability to domestic violence are common features of the life of many rural women. Traditional attitudes and discrimination discourage women from working outside the home. Early marriage prevents many girls from continuing their secondary education, leaving women economically dependent on their husbands. Women are expected to keep working throughout pregnancy and to resume work shortly after childbirth. It is the social norm for women to eat last at meal-times, even during pregnancy. It is a woman's husband or mother-in-law who decides whether she seeks obstetric care and controls the household resources to pay for that care.[39]

[39] Hawkins K et al., op. cit.

A causal analysis reviews and reveals the immediate, underlying and basic/structural causes of the non-fulfillment of the right to health.

ii *Identification of rights-holders and duty-bearers*

The next step requires identification of the wide range of stakeholders. These comprise both those responsible for ensuring that the right to health is realized (duty-bearers) and those with a claim or entitlement to the right to health (rights-holders).

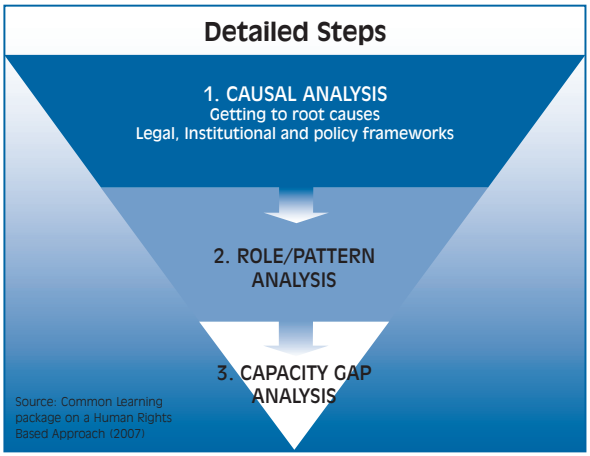
In the context of a PRS, the primary concern is with those rights-holders who are most deprived of their enjoyment of the right to health. Rights-holders, in this context, can be understood as those individuals and population groups that have been identified as facing discrimination and inequalities in their access to health care and the underlying determinants of health.

Duty-bearers are those individuals and organizations that have obligations and responsibilities in relation to the right to health and the underlying determinants. Reference to human rights standards provides a basis for the systematic identification of duty-bearers in relation to different rights, and the nature of their obligations and responsibilities. Human rights law defines the State as the primary duty-bearer with respect to the human rights of the people living within its jurisdiction. The State has obligations to respect, protect and fulfil all human rights (see section 1). However, individuals, families, communities, non-governmental organizations, private-sector organizations and the international community all have human rights responsibilities, even if less clearly defined in law. The Government, in turn, has obligations to regulate and support civil society and private sector organizations in fulfilling their responsibilities.

Reference to national laws and procedures can help to identify the specific obligations and rights assigned to different duty-bearers and rights-holders. For example, national health legislation can establish concrete standards that should be met by public and private health service providers and specific

POVERTY IN AN INDIGENOUS CONTEXT

Rather than simply stating that indigenous peoples are poor, it is important to look at impoverishment processes. Indigenous peoples do not necessarily consider themselves to be poor; many in fact dislike being labelled as such because of its negative and discriminatory connotations. On the contrary, they consider that they have resources, unique knowledge and know-how, and that their cultures have special values and strength. However, they often feel impoverished as a result of processes which are out of their control and sometimes irreversible. These processes have dispossessed them of their traditional lands, restricted or prohibited their access to natural resources, resulted in the breakdown of their communities and the degradation of their environment, thereby threatening their health and social well-being, as well as physical and cultural survival.



European Roma Rights Centre

"Poor Roma frequently become ill, because Roma live in slums, jammed together in unhygienic conditions; they have inadequate diets, and cannot get decent medical care. When they become sick, they stay sick longer than others. Because they are sick more often and longer than anyone else, they lose wages and work, and find it difficult to hold a steady job. Because of this, they cannot pay for good housing, for a nutritious diet, for doctors. At any given point in the circle – particularly when there is major illness – they are threatened with sinking to an even lower level, towards even more suffering."[40]

40 "Grassroots strategies to combat extreme poverty" ERRC talks with András Bíró. http://www.errc.org

mechanisms for users to complain if the service received does not meet these minimum standards.

In order to identify all relevant duty-bearers, it may be helpful to chart different health services, including mother and child, and reproductive and sexual health services, and the underlying determinants of health. In each of these areas, the organizations and groups that operate at different levels from the community, local and provincial authorities through to national Government and international organizations should be identified. At the local level, there is likely to be a wide range of health-care providers including traditional healers, skilled birth attendants and pharmacies in addition to government and non-governmental health facilities. At national and international levels, the duty-bearers are likely to include parastatal, domestic and international non-governmental and private sector organizations as well as Government ministries, donor organizations and multilateral development agencies. Identification of the range of organizations with responsibilities for realizing the right to health and the underlying determinants of health is an important step in the development of a comprehensive and coherent Government approach to its duties to respect, protect and fulfil the right to health.

Assessment of institutional constraints and capacity gaps

Analysis of rights-holders and duty-bearers will reveal a complex web of organizations that have an impact on the health of people who are poor and marginalized. It is the relations between rights-holders and these duty-bearers which underpin the barriers to access to health care and the underlying determinants of health. Where rights-holders can participate, directly or indirectly, in the decision-making of duty-bearers and hold them to account, services and resources are more likely to reach poor populations and be responsive to their needs.

Examining the institutional frameworks and capacity issues that shape the relations between duty-bearers and rights-holders can help to highlight entry points for Government interventions to improve poor people's access to health. The term "institutional frameworks" is used here to refer to the rules and procedures that

Mozambique - health and poverty

The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt, has systematically emphasized in his reports that health problems must be understood in the context of widespread poverty. In his Mozambique Mission report of 2005, the Special Rapporteur notes that some of the major ill-health conditions in this country are both cause and consequence of extreme poverty. The country's gross domestic product of US$ 230 per capita is well below even the average for least developed countries. Approximately 70 per cent of the population lives below the poverty line and an estimated 13–16 per cent of Mozambique's population is living with HIV/AIDS. Malaria accounts for 30–40 per cent of under-five deaths, and is a particular problem in some rural areas. Water- and sanitation-related diseases, such as diarrhoea, cholera, dysentery, malaria, scabies and schistosomiasis, are widespread. Around 30–40 per cent of children suffer from chronic malnutrition.[41]

[41] Hunt P. *Report of the Special Rapporteur, Paul Hunt, to the Commission on Human Rights. Mission to Mozambique.* New York, United Nations Economic and Social Council, 4 January 2005 (E/CN.4/2005/51/Add.2).

[42] www.ohchr.org

define entitlements and obligations, accountability, people's voice in decision-making processes and the availability of financial resources to fund provisions. "Capacity" refers to the knowledge, skills and information that people require to claim and deliver entitlements and engage in decision-making.

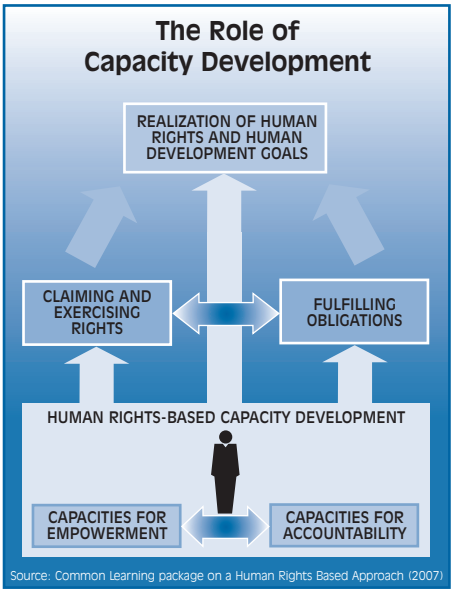
Analysis of institutional frameworks and capacity is likely to reveal how little power people who are poor have to affect changes in the organizations that impact on their health and lives. It may reveal the severe skills and financial constraints that face many Governments attempting to improve the health of excluded populations. But it can also show where actions can be taken to ensure that existing resources and services reach poor populations rather than being captured by elites.

The analysis reviews institutional frameworks and capacity issues that shape:

- participation
- accountability
- knowledge, information and skills
- legislation and policies
- financial resources.

PARTICIPATION

The continued participation of people who are poor in decisions that affect their health requires the existence of effective inclusive and democratic governance bodies. In some countries decision-making bodies only exist at the higher, national levels of the health service. Programmes



Source: Common Learning package on a Human Rights Based Approach (2007)

of decentralization, however, mean that there is often some form of local government, district or village level health committee. The extent to which these enable people who are excluded to have a voice in decisions that impact on their health depends on a number of factors. Questions to address include:

- are the powers of local-level decision-making bodies clearly defined by law?
- are there rules and processes for the inclusion of women and representatives of excluded groups in local- and higher-level decision-making bodies?
- do local communities have access to relevant information about policies and budgets?
- are local decision-making institutions effectively linked to higher-level bodies?

Vienna Declaration and Programme of Action 1993 article 1

"Human rights and fundamental freedoms are the birthright of all human beings; their protection and promotion is the first responsibility of Governments."[42]

Declaration on the Right to Development article 4

"Sustained action is required to promote rapid development of developing countries. As a complement to the efforts of developing countries, effective international cooperation is essential in providing these countries with appropriate means and facilities to foster their comprehensive development."[43]

[43] *Declaration on the Right to Development*, op. cit.

[44] Jonsson U. *Human rights approach to development programming.* Nairobi, Eastern and Southern Africa Regional Office. United Nations Children's Fund, 2003. Cited in: Office of the United Nations High Commissioner for Human Rights. *Frequently asked questions on a human rights-based approach to development cooperation.* Op.cit. www.unicef.org

[45] There are other Special Procedures that deal with health issues, in addition to the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Examples include the Special Rapporteurs dealing with adequate housing, food and toxic waste. See www.ohchr.org

THE UN'S APPROACH TO CAPACITY DEVELOPMENT

Capacity development has become a dominant strategy in the development work of the United Nations. It entails the sustainable creation, use and retention of that capacity in order to reduce poverty, increase self-reliance and improve people's lives. Under the UN's human rights-based approach to programming, various components are integral to capacity development.

- **Responsibility/motivation/commitment/ leadership. This refers to things that rights-holders and duty-bearers *should* do about a specified problem.**
- **Authority. This refers to the legitimacy of an action, when individuals or groups feel or know that they *may* take action.**
- **Access to and control over resources. Knowledge that something should and may be done is often not enough. Capacity must therefore also include the human, economic and organizational resources influencing whether a rights-holder *can* take action.**[44]

- is the voice of excluded groups and poor communities properly represented in national and international policy processes?
- do local communities have a voice in the decision-making processes of private sector providers?

ACCOUNTABILITY AND REDRESS

Participation in decision-making by itself is not sufficient to ensure that duty-bearers respond to the claims and concerns of rights-holders. Institutions and processes for accountability need to be in place to ensure the answerability of duty-bearers and redress for rights-holders when they have a grievance:

- *Administrative* – local, district or provincial and national health management committees, complaints and mediation processes and mechanisms for monitoring and regulation of public and private provision of health services.
- *Judicial* – including the ministry of justice, local and national courts, traditional and indigenous justice systems and a vibrant civil society with litigation capacity.
- *Political* – formal political procedures, such as parliamentary commissions, local and national elections or informal advocacy and voicing concerns to political representatives.
- *Social* – community-based monitoring and action, participation in policy processes, NGO monitoring and media reporting.
- *Quasi-judicial* – national human rights institutions, ombudspersons, national commissions and international institutions including UN human rights treaty-monitoring bodies and Special Rapporteurs.[45]

Transparency of information on service performance, policy implementation and budget processes is critical for the effective functioning of all these forms of accountability.

The analysis should aim to identify the most effective entry points for

Peru: local health administration associations

Local health administration associations, called CLAS, were established as a result of reform of the national health-care system in Peru in the mid-1990s aimed at ensuring basic health care for all. They are legally created non-profit organizations working at the community level to oversee health-care services. Each CLAS comprises six elected community members and one health-care worker who work together on a voluntary basis for three-year terms to help set priority needs for the communities, approve the budget and oversee expenditure, determine exoneration from fees, and monitor the quality of health services and attitude of health-care providers to patients. The CLAS have proved to be a powerful means of community participation in control over delivery of health services.[46]

[46] Altobelli LC, Pancorvo J. *Peru: shared administration program and local health administration associations (CLAS) in Peru.* Barcelona and Washington, DC, IESE Business School, University of Navarra and World Bank, 2000

strengthening the direct and indirect accountability of health and other related services to people who are excluded. In many countries, administrative and social accountability mechanisms are more likely to be directly accessible at local level than legal, political and human rights institutions. However, administrative accountability institutions and procedures for health and related services, such as local health committees, are often seen as ineffective and unfair. While Government and some non-governmental providers may be subject to some form of accountability, it is less likely that local informal health providers, private sector or NGOs and donor organizations are answerable to rights-holders. Among the issues to assess are:

- is service provision monitored and, if so, by whom?
- is information about service performance freely available to local communities?
- what mechanisms exist to ensure that local concerns lead to effective local level action?
- what procedures exist for people to voice concerns about service provision? Do these procedures protect whistle-blowers?
- are vertical and horizontal lines of administrative accountability clearly defined and effectively enforced?
- do local legal aid centres or paralegals exist and address health and related issues?
- what quasi-judicial institutions exist and does their mandate include health?
- is information about public health policies and performance made freely available to the press, parliamentarians and other accountability systems?
- what procedures exist to ensure accountability of domestic and international private sector, non-governmental and donor organizations?

KNOWLEDGE, INFORMATION AND SKILLS

Even where institutions exist that enable people to participate and hold duty-bearers to account, claiming and fulfilling rights requires knowledge, information and skills that lead to changes in attitudes and behaviour. Capacity gaps in the information and skills of rights-holders and duty-bearers are likely to exist at all levels from local through to international. Issues to consider include:

- in addition to information about policy and budget processes, people require information about health issues and their rights. Information should be provided in formats and through media that are accessible to marginalized and excluded people;
- individuals who have been discriminated against may not believe that they have entitlements to health, may be unable to access information about their rights to services or may lack the self-confidence to act on information that is provided;

Ukraine: The People's Voice Project: scaling up public participation

The People's Voice Project began in 1999 as a means to enable the public to engage effectively and influence local government. It was implemented at the municipal level and focused on service delivery issues of immediate day-to-day concern to local people, and in particular worries over corruption. Coalitions of civil society organizations that utilized a number of citizen engagement mechanisms, such as public hearings and report cards, were formed. By 2003, results showed significant improvements in accessibility to local officials, local capacity to monitor delivery and conduct surveys and the introduction of municipal initiatives to tackle directly the deficiencies exposed.[47]

[47] http://www.worldbank.org

- communities, or groups within the community, may lack the organizational, advocacy, policy and budget analysis, political networking and legal skills to participate in decision-making, act collectively, voice their health concerns or seek redress for violations of their rights;
- members of local health committees and people in positions of authority, such as councillors, chiefs or local magistrates, may lack understanding, information, training and skills on non-discrimination and human rights, policy and budget analysis;
- health staff may lack knowledge about their human rights responsibilities, and training and information which requires them to treat all people with dignity and respect;
- health staff may lack the management skills and support to ensure consistent provision of services;
- ministry of health personnel may lack the requisite information and skills to develop a comprehensive, cross-sectoral health policy and budget;
- staff in donor organizations may not understand or support human rights.

REVIEWING LAWS, POLICIES, REGULATIONS AND OTHER MEASURES

Under human rights law, it is the State's responsibility to provide a coherent, inclusive legislative and policy environment, which ensures that all people's rights to health are respected, protected and fulfilled. In many countries, legislation and policies fail to provide all people with a clear and equal set of health entitlements and, where these do exist, they are not always translated into protocols and administrative rules for front-line staff. In the absence of consistent, clear, and concrete legal and policy frameworks, service providers' actions tend to be shaped by local norms and customs.

The Government's obligation to ***respect*** the right to heath requires it to refrain from interfering directly or indirectly with its enjoyment. In reviewing national legislation, policies and practices, it would be important to consider whether these conflict with the obligation to respect the right to health. For example, it would be important to ensure that legislation and policies refrain from:

- limiting access to contraceptives and other means of maintaining sexual and reproductive health, and from censoring, withholding or intentionally misrepresenting health-related information, including sexual education and information;
- imposing discriminatory practices relating to women's health status and needs;
- denying or limiting access for all persons, including prisoners or detainees, minorities, asylum-seekers and undocumented migrants, to preventive, curative and palliative health services;

Norway: Sámi Parliament

Although already a well-functioning and inclusive democracy, in 1989 Norway decided to establish an independent institution elected by and for the Sámi, the indigenous peoples of Norway. It has not replaced the existing national democratic structure but is a complement to it, to address and advise specifically on matters directly affecting Sámi people and culture and to represent the Sámi to the national Government. It also has the responsibility to administer funds and to regulate expenditure provided by the Government.[48]

Ethiopia: women's access to information

In Ethiopia, women are more likely to be infected with HIV/AIDS and less likely to have ever heard of the disease or know about and use prevention mechanisms. One of the primary reasons for this is their lack of access to outside information through media outlets. Less than 14 per cent of women in Ethiopia have access to the media, and women are much less likely than men to have heard of HIV/AIDS through media resources.[49]

- unlawfully polluting air, water and soil, e.g. through industrial waste from State-owned facilities;
- prohibiting or impeding traditional preventive care, healing practices and medicines;
- marketing unsafe drugs.

Review of legislation and policies is also likely to reveal health-related regulations, or the absence of regulation, which expose people to harmful practices and prevent them from accessing the underlying determinants of health.

The Government's obligation to ***protect*** the right to health requires it to take measures that prevent third parties from interfering with the enjoyment of the right to health. When reviewing national policies and legislation, in this context, consider:

- the extent to which legislation protects health and safety standards at work;
- measures taken to ensure equal access to health care provided by third parties;
- efforts made to ensure that privatization of the health sector does

At the international level, Governments are engaged in a variety of multilateral and bilateral agreements, treaties and commitments relating to a wide range of issues from trade to environmental concerns, and from development assistance to tourism. The following areas of international activity have already been identified as having a possible negative impact on the enjoyment of the right to health:

- **The Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement), which protects the use of patents on pharmaceuticals as well as medical suppliers' trademarks and research data, has done much to assure minimum standards in medical research and the development of new drugs. However, it may adversely affect the ability of indigenous peoples to benefit from traditional medicines, including commercially, and can push prices for essential drugs beyond the reach of poor countries with no domestic pharmaceutical manufacturing capacity.**
- **To date, international trade laws have been unable to provide incentives to the major pharmaceutical companies to invest in research devoted to diseases which specifically affect the poor.**
- **There have been numerous examples over many years of multinational companies failing to ensure safe working conditions for employees or harming the environment to the detriment of the health of local communities. While efforts are increasing at the international level to impose some form of control over these entities, it is the responsibility of the national Government to oversee and regulate the activity of any international company in order to protect the human rights of its population.**

Armando Waak (WHO-352038)

not constitute a threat to the availability, accessibility, acceptability and quality of health care;

- the extent to which legislation effectively prohibits and addresses early marriage, female genital mutilation and violence against women, including rape within marriage.

Finally, the Government's obligation to *fulfil* the right to heath requires states to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health. Reviewing Government laws, policies and practice in this context will reveal:

- whether health has been recognized as a human right in the national constitution and national legislation and whether there is a national health policy or plan which details its realization;
- whether there is a health insurance system (public, private or mixed) affordable to all, including the economically disadvantaged;
- whether the State disseminates and fosters the dissemination of appropriate information relating to healthy lifestyles and nutrition, harmful traditional practices and availability of services;
- whether the State promotes medical research, ensures appropriate training of doctors and other medical personnel and the provision of a sufficient number of hospitals, clinics and other health-related facilities;
- whether the State has formulated and implemented national policies aimed at reducing and eliminating pollution of air, water and soil.

FINANCIAL RESOURCES

Constraints in the level, distribution and supply of financial resources are often at the heart of discrimination and inequalities in access to health and health outcomes. The rights-based analysis can be used to provide a broad assessment of the factors leading to financial resource constraints. Bottlenecks may occur at different levels, from local to international, due to various causes:

[48] Gáldu Resource Centre for the Rights of Indigenous Peoples. www.galdu.org

[49] Alsop R, Bertelsen M, Holland J. *Empowerment in practice: from analysis to implementation.* Washington, DC, World Bank, 2006 http://www.worldbank.org

- insufficient level of resources leading, for example, to overall shortage of trained health personnel or shortages in particular geographical areas and clinical skills, such as midwifery;
- national distribution of resources, or corruption and diversion of resources, may prevent some health centres from being well equipped, carrying sufficient supplies of medicines and vaccines or having appropriate storage facilities;
- failure to disburse funds to district and village health committees may prevent them from carrying out their mandate;
- irregular or unreliable funding from international donors may impact on level and quality of health service provision.

INTERNATIONAL COOPERATION – A HUMAN RIGHTS RESPONSIBILITY

The notion of shared responsibility for poverty reduction and the need for a partnership between developed and developing countries have been cited repeatedly in many United Nations conferences and declarations, including the 1986 Declaration on the Right to Development. At the Millennium Summit in 2000, the Doha Ministerial Declaration issued at the 4th World Trade Organization Ministerial Conference in 2001, the International Conference on Financing for Development in 2002 and the Johannesburg World Summit on Sustainable Development in 2002, Governments pledged to commit resources and assistance to enable developing countries tackle poverty. Goal 8 of the MDGs states clearly the need for a global partnership to address the current inequities in the global trading system, to address the problem of debt and to ensure that advancements in technology and science can benefit all countries. Some donors – including Denmark, Luxembourg, the Netherlands, Norway and Sweden – are meeting their commitment to provide 0.7 per cent of their gross national income in aid. Others, including France, Ireland and the United Kingdom, have pledged to meet the 0.7 per cent target over coming years. Even so, there is growing concern that there are insufficient resources being made available to meet the targets set out in the MDGs. The Monterrey Consensus agreed by Governments in March 2002 noted that not only were additional domestic resources required, but also increases in international financial flows and international trade as well as financial and technical cooperation, sustainable debt financing and debt relief.[50]

[50] A/CONF.198/11. www.un.org

SECTION 3
Developing the content and implementation plan

Once the human rights-based analysis has been completed, the next challenge is to identify appropriate interventions. These will form the *content* of the PRS.

Designing a pro-poor health sector plan in the context of limited resources is not a simple task. The human rights-based analysis is likely to reveal a wide range of sometimes conflicting issues to address. Even where policy priorities can be clearly identified and agreed upon, the process of securing additional funding and moving resources between different areas within the health sector is complex and may provoke resistance. Human rights principles can provide guidance for agreeing on policy priorities and helping to identify and resolve conflicts and trade-offs.

This section examines how human rights principles can be used by the ministry of health and other ministries whose work impacts on the enjoyment of the right to health, to design interventions which address the issues identified through the human rights-based analysis.

Actions outlined in the subsections below are as follows:

3.1 Addressing inequality and discrimination in health and the underlying determinants of health by:

- **i.** setting universal minimum standards of service provision;
- **ii.** targeting excluded and marginalized populations;
- **iii.** engaging with other ministries to address the underlying determinants of health.

3.2 Addressing institutional constraints and capacity gaps by:

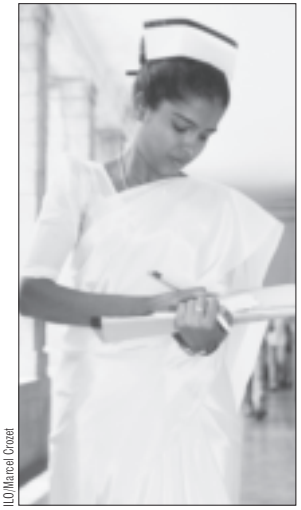
- **i.** strengthening participation and accountability in health services;
- **ii.** providing information and skills for rights-holders and duty-bearers;
- **iii.** enacting legislation and policies to respect and protect the right to health.

3.3 Financing the health strategy through:

- **i.** macro-economic policies;
- **ii.** the health sector budget.

3.4 Drafting a long-term strategy aimed at realizing the right to health by ensuring that health services and underlying determinants of health are made available, accessible, acceptable and of the highest quality.

3.5 Working with donors to promote human rights through the PRS.



ILO/Marcel Crozet

3.1 Addressing inequality in the realization of the right to health

Setting universal minimum standards of health service provision

The first step in formulating the content of the health sector component of the PRS is often the definition of the package of essential services that the Government will ensure to everyone. Many developing countries have identified an essential health package on the basis of methodologies which prioritize cost-effectiveness rather than equality. Consequently, existing definitions of essential health services often fail to address the priorities of people who are marginalized or excluded.[51]

Public debate about the content of the essential service package, through the consultation process, provides a potentially powerful basis for engaging people in the PRS and making it locally owned rather than globally driven. Debate should be informed by the human rights-based analysis carried out by the ministry of health together with other relevant stakeholders through a participatory approach, and include information on the priorities of people who are marginalized, and disaggregated statistical data as well as clinical and geographical data. (See section 4.3 for discussion of disaggregated data.)

General Comment 14 sets out what it calls core obligations of the right to health.

Minimum essentials are:

- minimum essential food which is nutritionally adequate and safe;
- basic shelter, housing and sanitation and an adequate supply of safe and potable water;
- essential drugs as defined under the WHO Action Programme on Essential Drugs;
- reproductive, maternal (prenatal as well as post-natal) and child health care;
- immunization against the major infectious diseases;
- education and access to information concerning the main health problems in the country, including how to prevent and control them.

In order to ensure equality of access, it is important not only to decide what services are to be provided but also to define minimum standards of service provision that the Government will guarantee are delivered to all people. The identification and widespread communication of rights and standards enables people to hold public policy makers and providers to account for service delivery and is a central part of a human rights-based approach to development.[52] The AAAQ criteria outlined in section 1 and used as a suggested basis for the human rights-based analysis in section 2.2 can also provide a sound basis for developing minimum service standards or entitlements. Information from the consultation, participatory research, disaggregated statistics, clinical and

[51] Pearson M. *Allocating public resources for health: developing pro-poor approaches.* London, DFID health systems resource centre, 2002 www.healthsystemsrc.org

[52] World Bank. *Rights, entitlements and social policy: concept note.* Washington, DC, November 2006 www.worldbank.org

geographical data can be used to identify service provision standards that are clear, concrete and meaningful to people who are excluded and address the key issues identified under each of the criteria. For example:

- reproductive and sexual health services for all within a given distance;
- no user fees for primary health care, including maternal and reproductive and sexual health services;
- primary health-care facilities physically accessible to people with disabilities;
- access to comprehensive health services for migrant workers;
- health information in local languages;
- separate and private rooms for consultations;
- skilled birth attendants at all primary health-care facilities.

Publicizing minimum standards of service provision in the form of a charter of patients' rights can be an effective method of communicating entitlements to people. Charters of patients' rights in Bangladesh and Ghana include guarantees for informed consent, medical confidentiality, a second opinion and access to one's medical records.[53] In 2000 the Ugandan Ministry of Health set out patients' rights in its quality of care strategy for Government and NGO primary health-care facilities, including the right to confidential treatment, the right to polite treatment according to a first-come, first-served basis; the right to receive information on ailment and drugs; free health care; the right to be attended within one hour.[54]

Whatever the content of the rights defined and the vehicle for communicating them, it is important that the Government should be committed to meeting the standards identified. Ensuring that standards are relevant, obtainable and are more than empty promises requires attention to the following issues:

- standards should be established through a democratic, participatory process – such as the PRS consultation process and participatory research;
- standards should be enshrined in national law, and be consistent with international law
- standards should be widely communicated;
- local-level accountability mechanisms should be accessible and effective (section 3.2i);
- attention to training, professional information and raising awareness of human rights, such as the prohibition of discrimination, for health-care staff and ancillary workers is essential (section 3.2ii);
- standards should be set at a level that can be financially met on a sustainable basis (section 3.3ii);
- standards should be regarded as a minimum and not a ceiling.[55]

Setting standards that meet these criteria

[53] Murthy RK, Klugman B, Weller S. Service accountability and community participation. In Ravindran TKS, de Pinho H (eds). *The Right reforms? Health sector reform and sexual and reproductive health.* Johannesburg, Women's Health Project, School of Public Health, University of Witwatersrand, 2005 (study manual).

[54] Björkman M, Svensson J."Power to the people: evidence from a randomized experiment of a community based monitoring project in Uganda", London, Centre for Economic Policy Research, June 2007 (CEPR Discussion Paper No. 6344) www.cepr.org

[55] Norton A, Elson D. *What's behind the budget? Politics, rights and accountability in the budget process.* London, Overseas Development Institute, 2002 www.odi.org.uk

Chile: explicit health guarantees

Chile's law setting out its Regime on Health Guarantees came into effect on 1 July 2006. The law, and associated joint decree of the Ministry of Health and the Treasury, specifies 40 medical conditions and the services guaranteed in relation to them. The law and decree define standards of health-care access, quality, opportunity (waiting time) and financial protection. The law entitles the lowest-income groups in the country to 100 per cent payment for services by the Fondo Nacional de Salud, the national health insurance fund to which most of the population is affiliated. The law also sets out rights of redress via procedures for making claims to the Superintendency on Health. The Ministry of Health and the Treasury are responsible for reviewing and updating the legally defined standards every 3 years.[56]

is not a simple task. The process is likely to be iterative, as the availability of financial resources will shape the ministry of health's capacity to deliver. Furthermore, demand is not static and, in some cases, guaranteeing entitlements to particular services or standards of provision may lead to unforeseen bottlenecks in quality and quantity of supply. The key issue here is to ensure that the institutions and procedures exist that allow changes in demand to be translated into political voice and response in the form of adjustments to resource allocations. Periodic review and revision of standards will also be necessary. The PRS cycle provides a useful vehicle for the revision process.

Targeting

Human rights law allows positive discrimination (or affirmative action) that specifically targets people who are excluded. Targeting by type of service, community or clear social categories, such as older persons and children, can be an effective means of redressing disadvantage and is likely to be necessary to ensure universal provision of minimum standards of health care. Examples include: allocating higher-than-average expenditure to improve health services for communities with high rates of poverty; targeting immunization programmes that prevent diseases known to disproportionately affect excluded groups; or investing heavily in improving services such as water and sanitation in areas identified as being particularly lacking.

Targeting services, or fee-exemptions, on the basis of individual poverty is less effective as it is difficult to devise easily administered and fair criteria that are immune to corruption. Targeting has hidden costs such as:

- cost of mis-targeting: it is difficult to identify the poor, especially poor women;
- cost of administration: narrower targeting requires more checks on beneficiaries;
- cost to beneficiaries of documenting eligibility and claiming benefits;
- cost of non-sustainability: if people who are not poor are beneficiaries of services, political commitment to maintain their scope and quality fails.[57]

In some contexts, the costs of targeting outweigh the potential savings from concentrating scarce resources on a narrowly defined group of people. This is likely to be the case in conflict-affected areas or crisis situations, where any form of targeting may be inappropriate or administratively impractical. In these situations, it may be more effective to provide a basic range of universal services rather than aiming to deliver a higher level of targeted provision which, in practice, ends up being rationed and utilized by the more priviliged.

Addressing the underlying determinants of health

As the rights-based analysis of health and poverty highlights, inequalities in health

[56] World Bank. Prepared in collaboration with FUNASUPO and with inputs from the IDB, ECLAC and OAS. "Realizing rights through social policy". Draft working paper for "Workshop on explicit guarantees in the implementation of the economic, social and cultural rights in Latin America and the Caribbean" April 2-4, 2007, Santiago, Chile www.eclac.cl

[57] Elson D, op. cit.

Brazil: Bolsa Familia

Brazil's Government has focused considerable effort and resources on improving social safety nets for very poor families. The programme transfers money directly to the family on condition that all family members are able to benefit from social assistance when needed.[59]

outcomes are the product of access to a broad range of services and resources. While the ministry of health may not have direct responsibility for addressing these underlying determinants, it does have a duty to work with others to promote coherence across the PRS and ensure that policies in other sectors do not reinforce vulnerability to ill health. The assessment of rights-holders and duty-bearers can be used to identify those organizations which have direct responsibilities for, or impact upon, the underlying determinants of health. Building partnerships with a range of private and non-governmental as well as public organizations is a key strategy for addressing these issues.

In many cases, the primary duty-bearer will be another Government ministry. Intersectoral policy initiatives are often logistically and managerially difficult. To fulfil its obligations, the Government leadership will need to support the ministry of health in convening and working closely with other ministries. Addressing complex issues such as maternal mortality and HIV/AIDS generally requires a clear institutional focal point to lead and coordinate activities. This does not necessarily have to be located in the ministry of health. It is important that horizontal linkages between sectors and organizations do not obscure the need for vertical linkages of participation and accountability to rights-holders in poor communities.

Other health-related issues that require intersectoral coordination include the provision of:

- safe and potable water for households and basic sanitation services;
- adequate and safe housing or shelter;
- safe and hygienic working conditions;
- sufficient quantities of nutritious food supplies and food security early warning systems and responses;
- social security (or insurance schemes);
- health education in schools.

Standard setting and targeting issues outlined above are equally relevant to addressing discrimination and inequalities in access to the underlying determinants of health.

3.2 Addressing institutional constraints and capacity gaps

Strengthening participation and accountability in health service delivery

The content of the health section of the PRS should address the institutions and processes for enabling excluded groups to

[58] Merlin. Fact sheet: "TB treatment in Tomsk, Russia" www.merlin.org.uk

[59] Lindert K. "Brazil: Bolsa Familia Program - scaling up cash transfers for the poor" In: *MfDR principles in action: sourcebook on emerging good practices.* www.mfdr.org

RUSSIAN FEDERATION: TB TREATMENT PROGRAMME IN PRISONS

In countries with high TB prevalence, prisoners, many of whom are young men from very poor backgrounds, are up to 100 times more likely to contract TB than the general population. Frequently, however, prisoners' health is a low priority and they are left vulnerable to the hazardous environment in which they are kept. In Tomsk, the Russian Government has been working with a consortium of NGOs to extend a DOTS-Plus programme to treat prisoners and in Dzerzhinsk, the British NGO, MERLIN, is providing essential care to former prisoners, ensuring they are able to finish their course of treatment and reducing the risk of drug resistance in the community at large.[58]

participate in, and ensure accountability of, health and other related services.

In many countries, the human rights-based analysis is likely to show that existing administrative accountability processes and local governance institutions serve the interests of local elites and that monitoring of services is not effective. In these contexts, social mechanisms can strengthen accountability between people who are excluded and marginalized and providers. These mechanisms include report cards and community-based monitoring. Where national legislation has enshrined a minimum set of entitlements under the right to health or a charter of patients' rights has been adopted, these can provide a useful basis for local engagement in identifying indicators, monitoring and reporting on implementation. Making information easily available, so that people can see how their health facility is performing in relation to others, is a key factor in the success of community-based monitoring.

Greater local engagement in management of local health services can have a positive impact on the effectiveness of bodies charged with responsibility for ensuring administrative accountability, such as local and district health committees. Systematic improvements in local-level accountability may, in turn, lead to improvements in quality of provision, use of services and health outcomes.[62]

One means of strengthening these institutions through the PRS is the establishment of a task force within the ministry of health to facilitate community participation and health service accountability.[63] The remit of the task force could encompass issuing

Mexico: Progresa

Introduced by the Government of Mexico in 1997, Progresa is the largest national poverty alleviation programme, reaching 2.6 million poor households. It provides cash transfers and food supplements to poor families on condition they enrol their children in school and attend preventive medicine and basic health-care services. Designed to address many related determinants of health, eligible households receive benefits in return for agreeing and continuing to participate in the services provided.[61]

SRI LANKA: ACCESSIBILITY IN WATER AND SANITATION

In Sri Lanka, after the tsunami in December 2004, thousands of people were left homeless and accommodated in temporary camps. Handicap International carried out camp assessments within the districts of Batticaloa and Ampara to collect data on accessibility of water and sanitation facilities. For each camp, a plan was drawn up of how to improve access to water and sanitation facilities. The plan was implemented through lobbying of implementing organizations, and construction funded by Handicap International and implemented by a local partner or private construction companies. Issues highlighted by Handicap International included water and sanitation facilities that were difficult to reach because they were located at the back of buildings, outside or in the basement, and the problems of ensuring that local constructors understood the importance of accessibility features such as standardized steps and smooth finishing of wooden rails. Rectifying these problems was more difficult and costly than it would have been if accessibility features had been addressed in planning and the original construction. After the post-emergency phase, the focus shifted to permanent construction. As a result of this work, the Deputy Provincial Director of Health Services in Ampara has decided to introduce basic guidelines on accessibility for all new toilets built as part of the reconstruction programme.[60]

[60] Spitschan S, Mesman A. *Accessibility in water and sanitation: The Handicap International experience*. Leicestershire, Water Engineering and Development Centre, Loughborough University, 2006 http://wedc.lboro.ac.uk

[61] Wodon Q et al. "Mexico's PROGRESA: Innovative targeting, gender focus and impact on social welfare". In: The World Bank Group, "*en breve*" no. 17, January 2003. www.worldbank.org

[62] Björkman M et al., op. cit.

[63] Murthy RK et al., op. cit.

Philippines: community planning and decision-making

In January 2003, the Government of the Philippines launched a community-based poverty alleviation initiative – the KALAHI-CIDSS Project. The initiative is based on local decision-making through village assemblies that include the whole community. Communities identify their own priorities, select projects, monitor the flow of funds and oversee implementation. The project has now been extended across 42 of the poorest provinces in the country.[64]

[64] www.worldbank.org

reccommendations on:

- the interface between national, district and local level lines of management, participation and accountability;
- the use of report cards and other community-based monitoring mechanisms as a means of increasing direct accountability between people and service providers;
- the effectiveness of administrative forms of monitoring and redress, including watchdog organizations, to ensure that policies are implemented and local concerns are translated into action;
- measures to ensure transparency of budget and monitoring processes;
- quota measures for the participation of women, people with disabilities and other people who are excluded and marginalized on local, district and national committees;
- the scope and limits of parcipitation – for instance, managing logistics of drugs supply is not necessarily amenable to participation;
- measures to increase the capacity of people who are excluded and marginalized, and the organizations that represent them, to participate in decision-making processes;
- provision of information to enable people to claim their rights (see section 3.2ii).

The issue of donor accountability to people who are poor is addressed in the final part of this section. The use of community-based mechanisms for monitoring and evaluation of the PRS is explored in more detail in section 3.3, as is the role of judicial, quasi-judicial and political accountability processes in protecting the rights of people who are poor.

Information and skills for rights-holders and duty-bearers

Capacity-building programmes for knowledge, skills and practices that support human rights are a key element of a comprehensive health sector strategy. Institutional reform is unlikely to succeed where people do not have the capacity to engage with revised systems and procedures. In contexts such as post-conflict States, where State institutions are non-existent or completely discredited, capacity-building of rights-holders and duty-bearers may be the most effective entry point for strengthening the provision of health care and related resources.

Review of, and recommendations on, information needs of rights-holders and duty-bearers can form part of the remit of the task force on participation and accountability (section 3.2i). Health information strategies conventionally focus on informing people about public health issues, such as HIV and AIDS and reproductive and sexual health. A human rights-based approach emphasizes the

UGANDA: EVIDENCE OF EFFECTIVENESS OF COMMUNITY-BASED MONITORING

In response to perceived weak health-care delivery at the primary level, a pilot citizen report card project was initiated by the World Bank and Stockholm University in cooperation with the Ugandan Ministry of Health in 50 health facilities in rural areas of Uganda. The main objective of the project was to strengthen providers' accountability to users by enhancing communities' ability to monitor providers on an ongoing basis. In each participating district, half the facilities were randomly assigned to the treatment group, i.e. report cards were introduced, and half to the control group. The patients' rights identified in the Government's quality-of-care strategy provided a basis for monitoring. One year into the programme, average utilization was 16 per cent higher in the treatment communities; provider practices – including immunization of children, waiting time and examination procedures – had improved significantly; the weights of infants were higher and the number of deaths among children under-five markedly lower. Treatment communities became more extensively involved in monitoring providers following the intervention, but there was no evidence of increased Government funding. These results suggest that the improvements in the quality and quantity of health service delivery resulted from increased effort by health unit staff to serve the community as a result of improved accountability.[65]

[65] Björkman M et al., op. cit.

[66] Standing H. *Understanding the 'demand side' in service delivery: definitions, frameworks and tools from the health sector*. London, DFID Health Systems Resource Centre, March 2004 www.dfidhealthrc.org

[67] Khoza S, ed. *Socio-economic rights in South Africa*, 2nd ed. Bellville, Community Law Centre, University of the Western Cape, 2007.

[68] www.autonomia.hu

importance of ensuring that information on health issues is evidence-based, freely available and accessible to all people, including adolescents.

People need to be aware of their rights and entitlements in order to claim them. Information about these issues can be publicized using a variety of innovative methods including mass media and culturally relevant forms of communication such as theatre, role play and storytelling.

Providing the information that rights-holders need to claim their entitlements to health is more complex in highly pluralistic environments with a wide range of public and private health-care providers. Even where legislation exists to regulate the activities of private sector and non-governmental organizations that provide health services or impact upon health, the number and diversity of these organizations make it difficult to ensure their accountability. In order to negotiate this environment, people need basic information on, for example, how to determine if over-the-counter drugs are genuine and within their sell-by date, and simple protocols on common disease treatments.[66]

Individuals and groups within communities require a range of skills in order to claim their rights. Individuals who have suffered discrimination or abuse require support to build their self-confidence so that they can be assertive when they have to deal with service providers and officials. Individuals and groups within the community need the organizational, advocacy and political skills as well as legal awareness and training to participate in decision-making and to claim their rights. Community-based and non-governmental organizations are often best placed to build these skills. Such organizations may be funded by international NGOs and donors. Ministry of health policymakers, planners and providers can recognize the legitimacy of this work by cooperating with local organizations and, where possible, engaging with their capacity-building programmes.

Government officials and health-care staff themselves also need information and training to enable them to promote the

South Africa: complaints procedures

The South African National Health Act of 2003 says that there must be guidelines on procedures to be followed by users making complaints, claims or suggestions on the provision of health-care services. Every health-care establishment must display the procedure for laying a complaint at its entrance so that it is visible to everyone. Every complaint received must be acknowledged. Complaints can also be made to the councils that license doctors, nurses and other health professionals about the way a particular health professional has behaved.[67]

Hungary: Autonómia Alapítvány – Hungarian Foundation for Self-Reliance

Established in 1990, the foundation works directly with Roma communities to develop new models of development that reflect the unique cultural and economic circumstances of the Roma. Based on horizontal dialogue between the funder and the beneficiary, the Roma plan their own projects and define loan repayment schedules.[68]

rights of people who are poor. Human rights training needs to go beyond providing formal information about rights, and to focus on building the skills, attitudes and practices which enable service providers to treat all people with respect and in ways that are culturally acceptable. Other skills that are likely to require strengthening within the ministry of health include budget formulation and analysis skills, cross-sectoral expertise and research skills, and increased capacity to engage in participatory processes. Capacity and skills-building programmes for ministry of health personnel should be included in the health-sector strategy and costed in the budget.

Training in gender awareness, analysis and planning is a critical element of capacity-building programmes to support human rights. Some international NGOs, donors and development agencies, as well as national academic research institutes and NGOs, have expertise on these issues. Many donor organizations have clear commitments to promoting gender equality and may be a useful source of funding for gender training.

Legislation and policies to respect, protect and fulfil the right to health

RESPECTING THE RIGHT TO HEALTH

The State's obligation to respect human rights requires action to rectify discriminatory legislation, such as restrictions on adolescents' and women's access to reproductive and sexual health services, identified in the human rights-based analysis. In some countries, Governments have enacted new anti-discrimination legislation to protect, for example, the rights of people who have HIV and AIDS. Legislative review and reform can be a lengthy process but, in the long term, may be necessary to ensure a coherent legal framework to underpin the standards set for the health system and ensure consistency with international human rights standards.

Legislation, policies and practices that lead to discrimination in access to the underlying determinants of health should also be addressed. Gender discrimination in legislation that determines access to resources and services is common. In many countries, gender discrimination is not just the result of gender bias in statutory law; it is also the consequence of discriminatory customary laws, traditions, social norms and attitudes. Addressing this issue may require training programmes for personnel in informal and formal legal systems (see section 4.6) as well as legislative reform. Aspects to be considered include:

- equality between women and men to own and inherit property;
- equality between women and men in access to employment and working conditions;
- equal right of girls and boys to free primary education;
- equal access to justice and administrative mechanisms of redress.

The PRS should include legislative and

Peru: culturally acceptable safe motherhood

Maternal mortality among Andean communities is triple the national average in some areas. Many factors contribute to this – one of which is the proportion of mothers who prefer to give birth at home rather than at maternity clinics. Consultations with Andean women revealed that the services available were based upon modern medical practices and were not sensitive to traditional Andean practices, presenting a significant barrier to their acceptability to Andean mothers. UNICEF has been working with local health providers to adapt the care provided to Andean women, to include preferences such as herbal teas, traditional birth attendants, birthing positions, privacy from male health professionals and more acceptable wall and fabric colours.[69]

[69] Mayhew S. "Acting for reproductive health in reform contexts: challenges and research priorities" (background paper prepared for Technical consultation on health sector reform and reproductive health: developing the evidence base), Geneva, WHO 2004 www.who.int/

policy measures to control and regulate other activities that the human rights-based analysis identifies as being harmful to people's health. Regulatory mechanisms should:

- forbid the marketing or distribution of unsafe drugs;
- prevent coercive medical treatment;
- ensure that important health information is not withheld or misrepresented;
- ensure that the confidential health information of each person is safeguarded;
- prohibit traditional practices or treatments known to be harmful to health;
- ensure that the use of safe traditional care and medicines is not impeded;
- redress international commitments which have a negative impact on people's ability to realize their right to health.

PROTECTING THE RIGHT TO HEALTH

The identification of rights-holders and duty-bearers provides an overview of non-State actors which impact upon people's health.

Non-State organizations concerned are groups such as:

- multinational corporations, including pharmaceutical companies
- national private sector companies
- health insurance providers
- providers of private health care
- medical research institutes
- international and national NGOs.

While many of these organizations may be supporting positive health outcomes, it is the Government's obligation to ensure oversight and regulation, for example, by:

- regulating the marketing or distribution of substances that harm health such as tobacco, alcohol or some food groups;
- regulating and monitoring to ensure that industrial and household waste, including agrochemicals, are handled and disposed of in a way that does not harm the health of either workers or local communities.

Governments should also ensure that neither their own policies and activities nor the overseas operations of any non-State actors, such as companies headquartered in their country, in any way violate the right to health of individuals living in other countries. This applies, for example, to decisions to impose sanctions or embargoes on another country, to the negotiation of trade agreements or customs treaties, and to regulating the global activities of national pharmaceutical manufacturers.

FULFILLING THE RIGHT TO HEALTH

The obligation to fulfil the right to heath requires States to take positive measures that enable and assist individuals and communities to enjoy the right to health. It means that the State must engage proactively in activities that would strengthen people's ability to meet their own needs. It also goes one step further,

involving direct provision of services if access to health-care services cannot be realized otherwise, for example to compensate for market failure or to help groups that are unable to provide for themselves.

In this context, the definition of the package of essential services that the Government ensures will be delivered (see section 3.1) will provide an important reference for the minimum entitlements under the right to health at the national level. This package of essential services should be integral to and with consistent with any national health insurance system in place.

WHO/WPRO/Image Bank/Seppo Suomela

More broadly, the obligation to fulfil the right to health requires the State to: disseminate and foster the dissemination of appropriate information relating to healthy lifestyles and nutrition, harmful traditional practices and availability of services; promote medical research; ensure appropriate training of doctors and other medical personnel and the provision of a sufficient number of hospitals, clinics and other health-related facilities; and formulate and implement national policies aimed at reducing and eliminating pollution of air, water and soil.

3.3 Financing the health strategy

Macroeconomic policies

Some of the interventions outlined above can be achieved with minimal additional resources. Overall, however, meeting obligations to respect, protect and fulfil the right to health is likely to require both increases in funding and redistribution of existing resources. Macroeconomic policies determine the overall size of the Government's resource envelope and the share of resources that is allocated to the health sector. While there is no simple formula for identifying the macroeconomic policies that are most likely to advance the right to health, principles of non-discrimination, equality, participation and accountability can help to identify conflicts and evaluate trade-offs between health spending needs, inflation, debt and growth.

Economic orthodoxy supports low rates of inflation, low budget deficits and limiting public debt to sustainable levels as the best policies for achieving growth and reducing poverty. Policies based on these principles have not always been effective at addressing poverty. It has been argued that greater flexibility on macroeconomic targets would provide more resources for health and support stronger growth.

In some countries a poverty and social impact assessment (PSIA) of projected

Philippines: HIV/AIDS anti-discrimination legislation

The 1998 National AIDS Prevention and Control Act of the Philippines was a result of an extensive campaign by a coalition of Philippine NGOs and human rights lawyers over several years that held the State accountable for recognizing the rights of vulnerable groups. Among other things, the Act requires written informed consent for HIV testing and prohibits compulsory HIV testing. It also guarantees the right to confidentiality, prohibits discrimination on the basis of actual, perceived or suspected HIV status in employment, schools, travel, public service, credit and insurance, health care and burial services.[70]

[70] *HIV/AIDS and human rights in a nutshell: a quick and useful guide for actions, as well as a framework to carry HIV/AIDS and human rights actions forward.* Program on International Health and Human Rights, Francois-Xavier Bagnoud Center for Health and Human Rights, Harvard School of Public Health and the International Council of AIDS Service Organizations, 2004

Karnataka, India: the impacts of lack of regulation on maternal health care

Research on maternal health care in Karnataka, India, found that one of the key factors in maternal deaths and morbidity was the irrational or inappropriate care provided to women with obstetric emergencies. Government doctors and junior health assistants as well as untrained rural medical practitioners provided, for example, injections or intravenous drips to women in labour whether necessary or not. In the absence of effective regulation by the Government or professional associations, health providers are guided by competitive pressures to sell pharmaceutical commodities and use diagnostic technology rather than provide preventive advice or even effective curative services.[71]

[71] George A, Iyer A, Sen G. *Gendered health systems biased against maternal survival: preliminary findings from Koppal, Karnataka, India.* Brighton, Institute of Development Studies, September 2005 (IDS Working Paper 253) www.ids.ac.uk

economic policy measures has been undertaken and can, if carried out by independent organizations, help identify potential negative impacts of different policy options. Work has recently been undertaken to suggest how a human rights impact assessment could be integrated into other forms of policy assessment, including the PSIA.[72] A PSIA can be a useful tool for generating public debate about difficult policy choices. However, the costs of undertaking a PSIA need to be carefully considered. A PSIA entails financial costs both to lending institutions and borrowing countries. It also requires that lenders and borrowers are prepared to accept what may be unwelcome recommendations.

Human rights standards and principles require macro-policy decision-making processes that are participatory, inclusive, accountable and transparent. This means parliamentary oversight and the engagement of key stakeholders, including the ministry of health and civil society. In practice, macroeconomic policy is often formulated on the basis of bilateral discussions between the IMF and the ministry of finance without the involvement of the ministry of health or other stakeholders.[73] Formulating the health sector component of the PRS on the basis of broad-based civil society consultation may help to provide the ministry of health with leverage in macroeconomic policy discussions with the ministry of finance. Building the capacity of ministry of health staff and civil society actors to engage in these issues is also important.

In aid-dependent countries there may be additional challenges in managing the engagement of donors in macro-policy decision-making. The Paris Declaration on Aid Effectiveness, outlined in section 1 and discussed at the end of this section, provides a basis for building donor–Government relations that are coherent as well as participatory, inclusive and accountable.

The health sector budget

The health sector budget is the primary vehicle for ensuring that resource allocations support agreed policy objectives, priorities and service standards. Estimating the costs involved, preparing an appropriate expenditure framework and then mobilizing the necessary resources are highly complex technical and political processes. Human rights principles of non-discrimination, equality, participation and accountability are applicable at each stage of the budget process.

COSTING THE STRATEGY

Conventional budget allocation practices often lead to resources being distributed as they have been in the past, with each facility receiving a particular allocation which is increased or decreased in line with overall changes in the health budget. This incremental approach may exaggerate existing inequalities in inputs and access and can exacerbate inequalities in health

KEY ISSUES FOR CONSIDERATION IN DISCUSSION OF THE IMPACTS OF MACROECONOMIC POLICY ON THE RIGHT TO HEALTH INCLUDE: [74]

Liberalization of trade in services may have a direct impact upon the quality and availability of health services for the poor. Although it may increase opportunities for Internet-based medicine, allow greater international mobility of patients in seeking specialized treatment, attract foreign direct investment in health services and allow health services to recruit internationally, there is concern that all these may prove to be of benefit only for the wealthy and may have a directly detrimental effect on poor countries and poor communities. At present, national Governments can control to a certain extent the rate at which they will commit to liberalizing their services, including in the health sector. A careful examination of how any such moves may affect the right to health of all people, particularly the poor, is imperative.

Monetary policy. The IMF has recently revised its guidance on targets for inflation to accommodate inflation rates of 5–10 per cent, instead of advocating rates in low single figures. High levels of inflation can harm the poor by reducing growth and the value of cash held by the poor. But where targets are set too low, measures may restrict spending on social sectors, including health, and other pro-poor Government expenditures.

Aid flows. There are mixed views on the macroeconomic impacts of increasing aid flows. On the one hand, it has been argued that large aid flows may lead to 'Dutch Disease', or macroeconomic instability in the form of inflation and exchange-rate appreciation. A rise in the exchange rate could reduce international competitiveness and ability to export and, consequently, slow economic growth. On the other hand, it is argued that these problems can be mitigated if aid is properly 'spent' and 'absorbed'. This means that increased Government spending should be focused on public investment and increased imports should be focused on capital goods. In many developing countries, underutilized productive capacities can readily respond to rising Government demand for domestic goods and services without leading to inflation and 'crowding out' of private investment.[75]

Wage ceilings. Even if a country's economic policy does not impose health sector wage ceilings, it may encourage overall constraints on wages so that resources can be freed up to invest in and maintain priority areas and to maintain future budget flexibility. This may have an indirect impact on health sector wage bills and human resources. In the health sector the volume of workers per population is a vital factor in delivering effective health services. In many developing countries, staffing levels are below what is considered to be the necessary minimum. Cutting back on administrative staff to fund front-line workers may, in the end, reduce Governments' capacity to disburse funds quickly and effectively.

outcomes. Instead, the budget should support the distribution of resources between populations, geographical areas and services in accordance with policy objectives, priorities and minimum standards identified through the consultation process.

[72] Hunt P, MacNaughton G. *Impact assessments, poverty and human rights: a case study using the right to the highest attainable standard of health*. Paris, United Nations Educational, Scientific and Cultural Organization, 2006 (Health and Human Rights Working Paper Series No 6) www.who.ist/hhr

[73] Wood A. *IMF Macroeconomic Policies and Health Sector Budgets*. Amsterdam, Wemos Foundation, September 2006 www.wemos.nl

[74] *Influencing poverty reduction strategies*, op. cit.; Wood A, op. cit.

[75] McKinley T. *Why is 'the Dutch disease' always a disease? The macroeconomic consequences of scaling up ODA*. Brasilia, International Poverty Centre, United Nations Development Programme, November 2005 (UNDP working paper number 10) www.undp.org

Work on gender budgeting has demonstrated the difficulties of identifying simple, quantitative expenditure ratios that provide an indicator of the resources that should be allocated to redressing particular inequalities. Gender budget analysis shows that not all expenditures targeted to women promote gender equality, while many programmes that are not specifically targeted to women have an equality-enhancing impact. Some Governments require a minimum proportion of the expenditure of all public agencies to be devoted to the promotion of gender equality. The Government of the Philippines, for example, requires 5 per cent of public finance to be allocated in this way. However, public agencies do not automatically spend this money in ways that promote gender equality. A more useful formula has been defined as:

> *Equal weight to women's and men's priorities, with an emphasis on priorities that are, in fact, equality-enhancing.*[76]

Where priorities and minimum standards of health-care provision have been established on a participatory basis as outlined in section 3.1, similar formulas can be extended to other excluded groups.

Costing agreed services and standards requires skill, expertise and sound judgement. There are various models and methodologies for costing. Whichever model is chosen, health planners should consider not just the costs involved in the delivery

WHO/Eric Miller

of the intervention itself but the systemic constraints that have led to inconsistent service provision in the past. The costs of improving the availability and accessibility of quality health care to people who are excluded may be significantly higher than to wealthier groups. Reaching the poor in remote rural areas that have suffered decades of underinvestment will inevitably cost more in terms of transport, staff costs and health infrastructure than reaching well-serviced areas. Calculation of costs should also take into account the greater burden that ill health places on people who are excluded and the greater proportional cost to poor people of seeking health treatment. While the costs of redressing inequalities may be high, the potential longer-term costs of failure to do so include less effective public services, slower economic growth and social unrest.

[76] Elson D. op. cit.

As it is unlikely that increased resources alone will be sufficient to offset existing inequalities, gradual redistribution of existing allocations will often be necessary. Redistribution between geographical areas or levels of care in any setting is a political action and can only be effected successfully if it has broad support. The PRS consultation process provides an opportunity to engage stakeholders and build coalitions in favour of resource distribution. Experience from South Africa suggests that the following issues also need to be taken into consideration:

- ***transparency*** is critical so that all stakeholders can understand the basis on which resource allocations have been made;
- a ***strong central role*** is essential. Although not requiring centralized determination of health budgets, it is critical that the centre always monitors progress towards policy objectives and revises policy guidelines as appropriate;
- the pace of ***budget reallocation must be realistic*** in order to ensure health sector sustainability and to reduce opposition to the process of redistribution.[77]

IMF guidelines recommend that annual budgets should relate to, if not be completely subsumed within, a Medium Term Expenditure Framework that typically extends over three or more years. By looking at spending priorities over a multi-year period, Medium Term Expenditure Frameworks can facilitate the process of shifting resources from one area to another.

The process of completing the budget for the health component of a PRS will involve several different actors, each with competing interests and priorities. It is likely that once the budget has been drafted by the ministry of health, it will need the endorsement of the other related ministries and sectoral departments, particularly those whose mandates are concerned with related issues such as education, housing or water. In some countries, final decisions on budget allocation rest with the ministry of finance or planning. In others, further approval may be required from parliament. Keeping a human rights focus when defining the rationale behind the budget, particularly if choices have been made through consultation with the beneficiaries themselves, may help to foster understanding and ownership of the decisions made and the final budget approved.

RAISING THE RESOURCES

Resources to pay for the costs identified usually come from a variety of sources:

- nationally raised resources such as direct and indirect taxation, distributed by the treasury through the central budget;
- bilateral or multilateral official development assistance, contributed directly to the central treasury;
- bilateral or multilateral funding, in the form of loans or grants earmarked for specific health sector interventions or particular district-level hospitals or clinics;

Porto Alegre - participatory budgeting

Participatory budgeting has its origins in Porto Alegre, Brazil, in 1990 and has since been implemented in at least 200 other municipalities throughout the country. Participatory budgeting gives citizens a direct voice in the process of municipal budget formulation. The process begins with neighbourhood assemblies in which citizens deliberate and set budgeting priorities. It concludes when delegates directly elected by the neighbourhood assemblies formulate a citywide budget that incorporates the citizens' demands. The aim of the process is to ensure that budget priorities correspond to local priorities and popular needs.[78]

[77] Pearson M, op. cit.
[78] Alsop R et al., op. cit.

Mexico: analysing the budget

The Mexican NGO Fundar's analysis of the Government's budget showed that systems designed to address inequality were, in fact, exacerbating the problem. In Mexico, the Government has initiated FASSAR, a mechanism which is supposed to decentralize health funds to offer services for the population with no social security. The population covered by FASSAR is heavily concentrated in the poorer States of south and southeast Mexico. But the amount of money available per capita in those States is lower, despite being the areas where need is highest. Fundar's analysis suggests that this is because the formula for allocation between States gives higher consideration to existing infrastructure and personnel rather than to unfulfilled needs.[79]

- private sector funding for services delivered by non-State actors such as private companies or NGOs;
- public/private partnerships that target certain vulnerable groups or focus on a specific disease or issue;
- national- or community-level insurance schemes, either of a formal or informal nature;
- out-of-pocket expenditure such as user fees, costs of purchasing drugs or vaccines or other associated costs incurred in accessing health care.

Sources of domestic revenue need to be expanded if public spending is to be increased. It is important to ensure, however, that taxation and user fees are consistent with human rights principles and do not impose additional burdens on people who are poor. The most excluded are likely to be outside the direct scope of personal income tax since there is generally a minimum income below which there is no liability to pay. Indirect taxes, such as value-added tax, are generally regressive as poor people contribute a higher share of their income to payment of such taxes than do rich people. Indirect taxes can also discriminate against women when taxes are imposed on basic consumer items that women are more likely to buy and use than men. Indirect taxes can be made less regressive through exemptions of items purchased primarily by poor people, particularly women.

Many health systems in developing countries rely on some form of user fees to be paid by those seeking treatment from hospitals or health-care centres. Human rights treaties do not state that user fees for health services are a violation of human rights. However, they do oblige Governments to ensure that health services are accessible and this includes economic accessibility (i.e. affordability). Impact assessments of user fees have shown them to be a significant impediment to poor people being able to access health services. In Africa, fees have been shown to discourage poor women more than poor men in seeking health care, because women have less income and less voice in household decision-making. Exemption schemes or waivers are often difficult to implement and manage effectively.[80] Moreover, evidence now suggests that user fees raise only very small levels of resources and are an unreliable form of financing in the long term. In practice, then, user fees for health services rarely support non-discrimination, equality and the rights of people who are poor.

ENSURING FINANCIAL TRANSPARENCY AND ACCOUNTABILITY

There is little point in using budget processes to increase the resources available to meet the priorities of people who are poor if that money cannot be tracked to ensure that funds are released and that they reach their agreed destination. Accountability and transparency in financial and expenditure management are not only key human rights

[79] Keith-Brown K. *Investing for life: making the link between public spending and reduction of maternal mortality.* Tizapán, Fundar, Centro de Análisis e Investigación, 2005 www.fundar.org.mx

[80] Elson D, op. cit.

BURUNDI: THE IMPACT OF USER FEES

The international NGO Human Rights Watch reports that, over the past few years, public hospitals in Burundi have detained hundreds of patients who were unable to pay their bills. The detention of patients results from and draws attention to broader problems of health care in Burundi. Although one of the poorest countries in the world, Burundi implemented a cost-recovery system as part of its delivery for health-care services in 2002. Patients must pay all medical costs, including consultations, tests, medicines and supplies, as well as the costs of their stay in hospital. There is a health insurance and a waiver system, meant to assist the poorest in meeting medical expenses, but neither functions effectively. Public hospitals do not receive enough income from patient fees, direct donations and funding from the Government to allow proper functioning, with well-trained staff, equipment and medicine. Inconsistent funding as well as corruption among typically underpaid staff add to the problem of funding shortfall. Patients detained are generally very poor, often belong to vulnerable groups, such as widows, orphans, single mothers or those displaced by Burundi's civil war, and lack family or larger networks of social support. In order to address this problem, President Pierre Nkurunziza announced on 1 May 2006 that maternal health care and health care for children under the age of five would be free of charge.[81]

principles; they are also basic principles of good governance and are essential in countering corruption and waste. The availability of accurate information about the budget process is a critical factor in ensuring accountability at national as well as local levels. All individuals have the right to seek, receive and impart information, including on:

- where public money is being spent
- whether the funds are being disbursed appropriately and promptly
- whether funds are being used effectively.

An increasing number of civil society budget initiatives analyse Government budget allocations and track whether funding reaches those sources. These and other approaches to monitoring and evaluation of the PRS are explored in section 4.

3.4 Drafting or implementing a long-term strategy

Human rights instruments acknowledge the fact that it would be virtually impossible for any Government to raise enough resources to meet all the health needs identified through participatory processes or to comply immediately with all its obligations under the right to health. It was therefore agreed that human rights obligations should fall under one of two categories:

- those requiring *immediate attention;*
- those that can be worked towards progressively over a period of time, known as the principle of *progressive realization.*

Core obligations requiring *immediate attention* include:

- non-discrimination and equality of all persons;
- participation of all stakeholders;
- cessation of any detrimental activity or policy;
- prohibition of any steps that may be retrogressive in the short term;
- drafting and implementation of a plan or strategy that maps out how to make progress towards the realization of *all* obligations.

81 *A high price to pay: Detention of poor patients in Burundian hospitals*, Bujumbura, Human Rights Watch, 2006 www.hrw.org

Universal Declaration of Human Rights
Article 28
"Everyone is entitled to a social and international order in which the rights and freedoms set forth in this Declaration can be fully realized."

Denmark: international development cooperation
Danish development policy is based on the Act on International Development Cooperation of 1971, most recently amended by Consolidated Act No. 541 of 10 July 1998. The Act lays down the goals for governmental cooperation with developing countries: "The goal of Denmark's governmental assistance to developing countries shall be to support – through cooperation with the Governments and official bodies of these countries – their endeavours to attain economic growth, thereby strengthening their social progress and political independence in accordance with the United Nations Charter, its objectives and bearing principles, and also through cultural cooperation to promote mutual understanding and solidarity."[82]

[82] www.um.dk

[83] CESCR, General Comment 3, para 9. www.ohchr.org

The human rights principle of *progressive realization* recognizes that in the short term, as set out above, policy choices, prioritizations and trade-offs have to be made. It does not, however, allow for a Government to postpone its obligations indefinitely. Progressive realization imposes a continuing duty to move as expeditiously and effectively as possible towards the full realization of rights for men and women.[83] This calls for a clear, demonstrable plan that includes time-bound targets, benchmarks and indicators to measure achievement and maps out a long-term strategy, using the maximum available resources, to reach the full realization of the right to health.

A PRS, with its associated budgets and costing frameworks, as well as a clear programme for monitoring and evaluation, constitutes a practical and concrete instrument to articulate the rationale behind the policy choices that prioritize some needs over others while meeting the obligations inherent within the principle of progressive realization.

3.5 Working with donors to promote human rights through the PRS

Analysis of rights-holders and duty-bearers is likely to reveal the extent to which donors' actions impact on poor people's right to health. Many middle- and low-income countries may well be dependent upon the financial and technical support of donor partners to implement their PRSs. Rights-holders, however, rarely have any means of participating, directly or indirectly, in donors' decision-making processes or in holding them to account. Principles of participation, inclusion, transparency and accountability are central to maximizing aid effectiveness and improving the way Government and donors conduct and implement their aid programmes. Guidance issued by the Development Assistance Committee of the Organisation for Economic Co-operation and Development includes recommendations for integrating human rights into the roll-out of the Paris Declaration on Aid Effectiveness.

- Development partnerships need to be grounded in ***national leadership*** and ***ownership*** which are, in turn, underpinned by democratic and participatory processes. Donor Governments inevitably work closely alongside national Governments in designing and implementing PRSs but it is important that the notion of national ownership is respected and upheld both from a human rights perspective and for the long-term sustainability of the strategy itself.

- *Predictability of resource flows* is a key issue; it allows Governments to plan the use of aid over the long term. Building long-term development partnerships based on human rights principles ensures that development cooperation programmes are less vulnerable to short-term political changes within the donor Government. Incorporating development cooperation policies within domestic legislation of donor countries

provides a way to protect the long-term predictability of aid flows, and provides coherence in aid policy as Governments change.

- *The right to participation* is recognized throughout the PRS process and is reaffirmed in many donor policies. It is essential, however, that donor Governments recognize that effective participation requires funding and support. Moreover, it takes time and patience, and cannot be rushed to meet external deadlines. Incorporating indicators for donor recipients and donors themselves to report on participation in all phases – the design, implementation and monitoring – of PRSs may be a way of ensuring that participation actually happens in practice.

- Donors should *respect the priorities* set by the national Government and be prepared to finance much needed but less "attractive" interventions, such as building management capacity.

- While much focus has traditionally been placed upon the need for accountability of the recipient Government to the donor, little emphasis has been placed on ***reciprocal or mutual accountability.*** This extends not just to the accountability of the donor Government to its own taxpayers and to the recipient Government but also to the very people for whom the aid programme is designed, people who are poor and vulnerable. Innovative means of addressing this issue include building mechanisms for mutual review and accountability into the memorandum of understanding between donor and Government and using participatory methods to enable local communities to review donor programmes and policies.

- Donors should ensure that they, too, are incorporating ***human rights-based principles in their development cooperation*** programmes, particularly in the context

OECD-DAC PRINCIPLES FOR INTEGRATING HUMAN RIGHTS INTO DEVELOPMENT COOPERATION

1. Build a shared understanding of the links between human rights obligations and development priorities through dialogue.
2. Identify areas of support to partner Governments on human rights.
3. Safeguard human rights in processes of State-building.
4. Support the demand side of human rights.
5. Promote non-discrimination as a basis for more inclusive and stable societies.
6. Consider human rights in decisions on alignment and aid instruments.
7. Consider mutual reinforcement between human rights and aid effectiveness principles.
8. Do no harm.
9. Take a harmonized and graduated approach to deteriorating human rights situations.
10. Ensure that the scaling-up of aid is conducive to human rights.[84]

Canada: act to export generic drugs

In May 2004, Canada passed new legislation to allow compulsory licences to be issued to Canadian manufacturers of patented *drugs for export to some low-income countries. The products listed in the Act are drawn from the WHO's list of essential medicines and include antiretrovirals, used to treat HIV/AIDS.*[85]

[84] Action-oriented policy paper on human rights and development, op.cit.

[85] www.parl.gc.ca

ActionAid: Accountability, Learning and Planning System

In 2000, ActionAid, an international non-governmental organization, launched its Accountability, Learning and Planning System. One of its aims was to allow people who are poor a greater voice in the organization's monitoring and decision-making processes. Innovations included the introduction of annual participatory review and reflection programmes at local, country and global levels to involve stakeholders – particularly the poor, but also partners, donors and peers – in the analysis of programme expenditure, plans and initiatives. Other changes included the development of new organizational incentives to support the Accountability, Learning and Planning System and development of ways of sharing key financial data with partners who had little financial experience and were, in many cases, illiterate. Tensions continue to exist between the pulls for upward accountability to donors and managers and downward accountability to people who are poor and excluded. Nonetheless, country teams remain strongly committed to the Accountability, Learning and Planning System and the participatory review and reflection programmes have acted as a catalyst for coherent change processes across the organization.[86]

of conditionality and selectivity in development practice. Just as human rights can form a sound basis to enable difficult choices at the domestic level surrounding prioritization and trade-offs, so too can the imperative of human rights principles help guide the inevitable process of selecting which countries to support.

● Considerable overlap and contradictions may arise when different donors provide advice and support to a country. This may place substantial reporting or evaluation requirements on Government, consuming scarce human and financial resources and seriously undermining the principle of national ownership. Donors are aware of the problems in coordination and cohesion between different development programmes and some are trying to improve matters by ***harmonizing their policies and activities*** and aligning behind country strategies.

VIET NAM: PROGRESS IN ENSURING NATIONAL OWNERSHIP OF THE PRS

The Government of Viet Nam is working hard to try to harmonize the many different stakeholders involved in the national PRS, the 10-year Comprehensive Poverty Reduction and Growth Strategy. The harmonization initiative includes not only relevant Government ministries but extends to bilateral and multilateral donors providing support to the strategy. According to the principle that the Government must take the lead in harmonization, the Ministry of Planning and Investment has endeavoured to reach a common understanding with development partners on a framework within which the Government and the donors can cooperate and coordinate activities, finances, monitoring and evaluation. European donors now coordinate much of their dialogue with the Government through the "Like-Minded Donor Group" and plan their support through Government-led sector workshops. However, more work on aligning donor policies and monitoring requirements is needed particularly to reduce the burden of reporting. In addition, with over 50 donors active in the country, many of whom have yet to join the like-minded group and of which over 90 per cent are providing support to the health sector, greater efforts at harmonization and coordination are needed. The Government is increasingly able to hold donors to account for unfulfilled pledges or for deviating away from the Comprehensive Poverty Reduction and Growth Strategy, but more commitment on the part of the donors is needed to ensure transparency and to share information with the Government and with one another on indications of aid flows.[87]

[86] David R, Mancini A. *Going against the flow: the struggle to make organisational systems part of the solution rather than part of the problem.* Brighton, Institute of Development Studies, 2004 (Lessons for change in policy and organizations, No. 8) www.livelihoods.org

[87] www.oecd.org

SECTION 4

Implementation: transparency and accountability through monitoring and evaluation

The final stage in completing any sectoral component of a PRS is to lay out clearly how the strategy will be implemented and how progress will be monitored and evaluated.

Monitoring and evaluation are key elements of accountability. The collection and dissemination of data about policy implementation increases the answerability of Governments and enables evaluation of whether obligations to respect, protect and fulfil human rights are being met. Monitoring improves the effectiveness of Government spending and policymaking, particularly in the delivery of public services. It enables adjustments to be made where necessary in budget allocations or in administrative policies and practices. It can help to build political will for change by demonstrating the Government's commitment to implementing pro-poor policies, publicizing where reform has worked and highlighting the consequences of inequities in existing policy frameworks. Monitoring should take place throughout the entire application of the strategy. It requires careful planning at the outset of the PRS process in order to fulfil its purpose effectively.

The first part of this section looks at community-based and civil society-led monitoring initiatives. The second part reviews budget initiatives. The requirements for the production of national statistical information on the right to health are then examined. Subsequent parts review indicators, goals and targets against which progress can be measured. Finally, different mechanisms of redress are discussed, including the judicial system and international human rights reporting.

4.1 Community-based and civil society monitoring

Community-based monitoring exercises are usually initiated by civil society organizations and often aim to empower people who are excluded and marginalized as well as provide data on policy implementation. They use participatory methods (see section 2.1) to enable local communities to assess service performance against policy commitments. Civil society

engagement in monitoring strengthens social accountability, increases the depth and range of reporting and helps to build responsiveness to ineffective or inefficient delivery of goods and services.

Community-based and civil society monitoring can provide an invaluable complement to national monitoring systems, particularly given the difficulties in many developing countries of building effective comprehensive mechanisms for gathering statistical data. In some countries, including South Africa and Uganda, civil society monitoring processes are integrated with Government-initiated monitoring. As suggested in section 3, this can be a constructive approach where there is mutual trust and sufficient separation of the political and financial interests of Government and civil society organizations. While some degree of cooperation is generally mutually beneficial, in some contexts civil society organizations may wish to set up parallel monitoring systems in order to maintain their independence.

Whether or not Government and civil society monitoring initiatives are integrated, Governments have an obligation to promote an environment in which civil society can operate. This requires promotion of rights to information as well as participation and association. In Bolivia, for example, the Government passed the National Dialogue 2000 Law that resulted in the setting-up of Bolivia's National Social Oversight Mechanism. This law legitimizes civil society participation in policy processes. One of the main objectives of the National Social Oversight Mechanism is to monitor the impact of the Bolivian Poverty Reduction Strategy and the use of financial resources, including those resulting from the cancellation of part of Bolivia's external debt under the Highly Indebted Poor Countries Initiative.

One simple way of facilitating community and civil society engagement in the monitoring process is to ensure adequate communication of the content of the PRS. Publicizing what the Government is proposing to do and hoping to achieve is a step that is often overlooked. Information about the PRS needs to be disseminated in an *understandable* and *informative* format for the general public, and most importantly the poorest sections of society for whom it is designed.

Where a charter of patient's rights has been developed or national legislation adopted (see section 3), this should be broadly communicated. In Uganda, for example, patients' rights are publicized through posters in local health facilities.[88] The definition and communication of standards also facilitates monitoring by providing an agreed baseline against which service delivery can be assessed. Participatory methods can help to identify locally relevant indicators which can then be used to measure progress in relation to nationally agreed standards.

4.2 Budget initiatives

An increasing number of civil society initiatives to monitor the implementation of the PRS focus on the budget. Analysis of resource flows and expenditures provides concrete evidence of the extent

United Republic of Tanzania: A Plain Language Guide to the PRS

The Tanzanian civil society organization, Hakikazi Catalyst, has produced a people's version of the national PRSP in both English and Swahili. Using accessible language and illustrative cartoons, the guide answers key questions such as how poverty has been defined across the country and what the elements of the overall plan are. It outlines the targets, activities and indicators, and explains how it will all be paid for. It also describes how the process of developing the strategy evolved and what might change the next time. ***The guide is available online at www.hakikazi.org/eng***

[88] Björkman M et al., op. cit.

[89] Baez C, Barron P. *Community voice and role in district health systems in east and southern Africa: a literature review.* Regional Network for Equity in Health in east and southern Africa (EQUINET). June 2006 (EQUINET Discussion Paper 39). http://equ inetafrica.org/

[90] Norton A et al., op. cit.

to which the Government acts upon its policy commitments. Moreover, budget analysis generally includes a review of policies and their implementation, making the approach a useful one for structuring a comprehensive evaluation of the PRS. Budget initiatives vary along a number of axes including:

- level of the exercise - central, sector or local government;
- scope of coverage - macroeconomic issues, expenditure or revenue;
- role that Government plays in the initiative;
- involvement of different kinds of organizations - membership organizations, social movements, NGOs or research organizations.[90]

Budget initiatives have been particularly successful as a method for assessing the extent to which Governments' use of resources is promoting equality. In South Africa, the Women's Budget Initiative is the result of collaboration between civil society and Government that aims to use budget and policy analysis to review resource allocation from a gender perspective, and the impact of policies on gender equality and women's rights. Some budget initiatives, such as Fundar's analysis of health expenditure in Mexico, have explicitly used the human rights framework as a basis for assessing budget allocations. The methodology involved evaluating health budget allocations and changes in expenditure over time against international, regional and domestic commitments to realize the right to health.[91] Similar methods have been developed to analyse public expenditure, revenue, macroeconomic policies and budget decision-making processes in terms of Governments' obligations to ensure gender equality under the Convention on the Elimination of All Forms of Discrimination against Women.[92]

Transparency of information is central to budget initiatives. Some Governments are reluctant to open up their budget processes to public scrutiny. Greater transparency, however, can confer legitimacy on the budget process by allowing access to the

MALAWI: COMMUNITY SCORE CARDS

In Malawi, Community Score Cards were introduced in some areas of the country on a trial basis. Services are scored by users and the results are compiled and presented to health centre staff by a village health committee. The committee is elected at consultative village meetings and is the bridge between health staff and the community. All aspects of health care are analysed from how staff listen to patients to how they care for undernourished children. Staff also score their own performance. All feedback is used to improve the way things work, ensuring that local needs are met. Reports suggest that where score cards have been introduced, services have improved and community confidence has risen.[89]

India: Bangalore citizen report cards

In 1994, a group of Bangalore citizens launched an initiative to produce citizen report cards to assess the quality of public services in the city from the perspective of the users. Surveys were undertaken among users of different services including health-care facilities and their views were analysed on the quality, adequacy and efficiency of the services provided, as well as the attitude of the staff. The media followed the results carefully and public discussions and calls for change followed. Later surveys and report cards have shown dramatic improvements in the city's services and an overall reduction in problems and corruption as providers have responded to the wave of publicity and calls for improvement. [93]

[91] *Dignity counts: a guide to using budget analysis to advance human rights.* Fundar, International Human Rights Internship Program and International Budget Project, 2004 www.iie.org/

[92] Elson D, op. cit.

[93] http://paf.mahiti.info

Kenya: Mtaa dispensary health information system

The key figure in developing the health management information system at Mtaa was a volunteer and a member of the Dispensary Health Committee. Zabibu Chizi Mwero started collecting data for the Mtaa Dispensary and writing it up on a blackboard and on charts. Information is taken from registers completed by the nurse-in-charge. Zabibu notes how many patients have been treated for malaria, respiratory problems and bilharzia, as well as figures for growth monitoring and immunization. For all the main activities, the Mtaa Dispensary Health Committee sets targets and the board shows whether the dispensary achieves each target every month. Information is used by the Dispensary Health Committee and people using the clinic can see what the Dispensary Health Committee is doing about health problems.[94]

information on which decisions were based and clarifying the rationale for resource allocations. It can help to reduce the scope for corruption through the misallocation of expenditure or the diversion of resources for private ends. The IMF produces cross-country comparisons of budgetary transparency and these can also provide a basis for building support for increasing access to information about budget flows and expenditures.[95]

A number of countries, including Uganda and India, have passed legislation setting out citizens' rights to access Government information. Even where such legislation exists, however, it is important to ensure that local officials are given training and practical guidance on transparency and information dissemination. It is often at the local level that civil society access to information is blocked.[96] Suggestions for incorporating a review of information needs for rights-holders and duty-bearers are outlined in section 3.2.

A key factor in the success of budget initiatives is an often lengthy process of capacity-building of those involved. This may include officials and elected representatives as well as researchers and poor and excluded people themselves. Many people working in Government ministries are unfamiliar with the technical aspects of the budget and these initiatives provide a good opportunity for them to build their own capacity to engage on budget issues.

INDIA: JAN SUNVAIS, PUBLIC HEARINGS

Originally initiated by a local organization of poor workers and farmers in Rajasthan, jan sunvais, or public hearings, have now become an established means for citizens to scrutinize public records and hold Government officials to account for any misappropriation of public funds or negligence in programme management. The hearings are now supported by the national Government and have spread to urban areas, including the capital, New Delhi. Some focus specifically on the right to health care. Evidence gathered is used in court cases against corrupt officials, and laws have been changed to allow all citizens access to documentation concerning any Government-run anti-poverty programme.[97]

4.3 National monitoring and statistics collection

Governments developing a PRS generally set up a national mechanism to monitor implementation, such as Uganda's National Integrated Monitoring and Evaluation System. In some cases, as indicated above, the national monitoring system is integrated with civil society monitoring initiatives. Numerous organizations may produce data, narrative or survey-based reports relevant to PRS monitoring:

- local and district health committees;
- parliamentary committees;
- quasi-independent government departments;
- ombudspersons, national human rights commissions or special rapporteurs;
- civil society organizations;
- international NGOs;
- international organizations;
- United Nations human rights treaty bodies, regional human rights bodies and United Nations special rapporteurs.

One of the primary sources of data for national monitoring is official quantitative

SOUTH AFRICA: the Children's Budget Unit

After the end of apartheid, the new South African Government committed itself to addressing the desperate needs of the nation's children, over 10 million of whom were living in poverty. It began by ratifying the Convention on the Rights of the Child and entrenched human rights in the new Constitution. IDASA, a national NGO, established the Children's Budget Unit in 1995 to monitor the extent to which the Government's human rights commitments were being reflected in its budgets. The Children's Budget Unit focuses on the principle of progressive realization of rights and whether this is being done for the poorest of the poor using the maximum available resources. It disseminates its analysis widely to the public and to Parliament and has done much to advocate the special needs of children orphaned through AIDS, who lack parental, legal or financial support. [98]

socio-economic statistics. Quantitative data are important as they enable Governments to report systematically on their actions to address poverty and realize human rights. It is also useful for civil society initiatives, which aim to hold Governments to account for their commitments.

Official statistics are compiled by national institutes and international organizations mandated by the State. Organizations compiling official statistics are expected to be impartial, neutral and objective. In many developing countries, their capacity is severely limited. Establishing and managing a national statistical system takes time and resources and presents a significant challenge to any country. In large, sparsely populated countries that are predominantly rural and have little nationwide infrastructure or internal communication, it can pose huge problems. Where such technical problems exist, donors and Governments need to recognize the importance of a functioning statistical system and invest in building national statistical skills and capacity.

The main functions of a statistical system are to:

- collect data from a variety of sources
- process and analyse the information to highlight differences and trends
- coordinate data from different sectors and cross-reference it
- disseminate the results to users in suitable formats
- produce measurable results of reliable quality over time.

The kind of information required for health and poverty analysis will range from broad nationwide statistics down to focused quality detail from the household or community level. Statistical information and data can be obtained from a variety of sources which may already exist, and others that may need to be generated. The choice of source to use will be determined largely by the type of information and the level of specificity required.

Philippines: community auditing

The Philippine Commission of Audit introduced a scheme to involve civil society in the auditing process. The "Value for Money" audit system focuses not only upon transparency and accountability of public funds and expenditure but also provides a judgement by the community as to whether it has been money well spent, particularly for the benefit of excluded groups in the community, including women. Links with the media are being established to keep the public informed of the results of the scheme, which is being scaled up to include many more communities and regions. [99]

94 Baez C et al., op. cit.

95 Robinson M. *Budget analysis and policy advocacy: the role of non-governmental public action.* Brighton, Institute of Development Studies, September 2006 (IDS Working Paper 279). www.ntd.co.uk

96 Wood A. *Beyond data. A panorama of CSO experiences with PRSP and HIPC monitoring.* The Hague, Cordaid, October 2005 www.cordaid.nl

97 www.sasanet.org

98 www.idasa.org.za

99 (case study) The Philippines: enhancing public transparency and accountability through civil society participation in monitoring government services, in Responsiveness and accountability for poverty reduction, Bergen Seminar Series 2002/2003 www.undp.org/oslocentre/

Kelly T (WHO 200387)

[100] Diaz D, Hofbauer H. *The public budget and maternal mortality in Mexico: an overview of the experience*. Washington, DC, International Budget Project, Center on International Budget and Policy Priorities, November 2004 www.internationalbudget.org

- The **national census** is the most complete statistical profile of a country, but it is expensive and time-consuming and therefore usually only undertaken every decade.
- **Sample surveys** can be conducted at much more frequent intervals and can provide an approximate picture of the national situation.
- **Focused surveys** that look at a particular vulnerable group, such as indigenous communities or internally displaced persons, can help determine the particular problems faced by that group, especially when compared with national averages.
- **Regular administrative systems** such as health centre or school records or local authority information can provide a plethora of detailed data but, crucially, will not include those who do not use these services, such as the very poor or some specific groups.

From a human rights perspective, it is critical that data are disaggregated as far as possible. Data should, ideally, be disaggregated by prohibited grounds of discrimination, such as sex, age, disability, ethnicity, religion, language, social, economic, regional or political status of people. It is not always feasible, however, to disaggregate data to the desired level. Disaggregation by sex, age, regions or administrative units, for instance, may be less difficult than by ethnicity. Identification on the basis of ethnicity may require both subjective criteria, such as self-identification, as well as objective criteria, including language. Attempts to produce disaggregated data sometimes invoke social and political sensitivities where, for example, minority groups fear victimization as a result of identification. Data gathering should respect these sensitivities as well as issues of privacy and confidentiality.

In some countries legal restrictions prevent the collection of data along ethnic lines in order to promote social cohesion. While such restrictions may be grounded in genuine concerns, arguments about potential tensions have also been used as an excuse by Governments to prevent the publication of data that could be politically embarrassing. In these cases, civil society organizations, donors and other interested stakeholders may need to develop strategies to demonstrate the value of statistical information, influence Government behaviour and remove restrictions.

4.4 Indicators

Data gathered through the national

statistical system are used to produce indicators of different socio-economic trends. Indicators are tools with which to measure a wide range of factors at any given moment. They provide a picture at the start of implementation of a strategy and, when compared with later results, can show trends and changes, and highlight emerging differences or setbacks. In the health sector, they frequently include mortality and morbidity rates, numbers of doctors available in the country and vaccination coverage rates. The availability of reliable data is a key issue in selecting indicators.

OHCHR defines human rights indicators as specific information on the state of an event, activity or an outcome that can be related to human rights norms, standards and principles. In many cases, MDG indicators or other existing national indicators can be related to human rights norms and standards. Maternal and infant mortality rates, for example, can be understood as outcomes that are central to the realization of the right to health. Indicators chosen to measure implementation of the health strategy should cover the different dimensions of the right to health identified in General Comment 14, including reproductive health; child mortality and health care; sanitation and potable water; natural and occupational environment; prevention, treatment and control of diseases; and accessibility to health facilities and essential medicines.

The specific indicators chosen in any country should reflect, and be adapted to, policy objectives and commitments. Where a charter of patients' rights has been developed, or national legislation adopted, indicators should relate to the implementation of agreed standards of service provision, thus reflecting legal and policy commitments and the implementation of policy as well as health outcomes.

Suggested indicators include:

- the period of application and coverage of domestic laws relevant to the implementation of the right to health;
- the net official development assistance for health sector received/provided as a proportion of public expenditure or gross national income;
- the proportion of the population covered under awareness-raising programmes on the transmission of diseases, e.g. HIV/AIDS;
- the incidence of deaths/diseases caused by unsafe natural and occupational environments.

Indicators to measure adherence to human rights standards and principles, including non-discrimination, participation, accountability and transparency, should also be identified. For example:

Non-discrimination:

- the existence of laws prohibiting violence against women and harmful traditional practices;
- the existence of laws allowing migrants access to comprehensive health services;

Mexico: the public budget and maternal mortality

During 2002, Fundar, a research organization working on budget issues in Mexico, evaluated the extent to which public resources were being allocated to the reduction of maternal mortality. Initial analysis found that the basic health services were insufficient to meet the challenge of reducing maternal mortality among the poor. The services provided to marginalized communities relied on mobile attention and could not offer the coverage and quality needed to guarantee continual medical care, effective and timely transfer of women to the second level of medical attention, real access to emergency services and availability of blood transfusions. These structural shortcomings were the product of decreasing funds. Under the Coverage Extension Programme, one of the explicit goals was to provide 'universal coverage' of basic health services. Priority was consequently given to the number of people reached instead of putting emphasis on real access to health services. This meant that every year, the per capita allocation was reduced, decreasing from US$ 4.6 to US$ 3.8 per person between 1998 and 2001. The States with the highest number of poor people had the lowest per capita allocations.[100]

STRUCTURAL, PROCESS AND OUTCOME INDICATORS: OHCHR's approach to indicators for promoting and monitoring the implementation of human rights

OHCHR has developed a conceptual and methodological framework for using qualitative and quantitative indicators to promote and monitor the implementation of human rights. The framework outlines an approach to systematically translate universal human rights standards into operational and contextually relevant indicators at country level.

More specifically, the framework, which adopts a common approach for civil and political rights and economic, social and cultural rights, transforms the narrative on the normative content of a human right, as articulated in core international human rights instruments, into a few characteristic attributes and a configuration of structural, process and outcome indicators. For a human right, the identified indicators bring to the fore an assessment of steps taken by a State in addressing its obligations – from acceptance of international human rights standards (structural indicators) to efforts being undertaken by the primary duty-bearer, the State, to meet the obligations that flow from the standards (process indicators), on to the outcomes of those efforts from the perspective of rights-holders (outcome indicators). An assessment of a State's commitments, efforts and the results of those efforts in meeting its human rights obligations is the cornerstone of this approach.

The framework focuses on two categories of indicators and data-generating mechanisms: (a) indicators that are or can be compiled by official statistical systems using statistical surveys and administrative records, which in most instances are available; and (b) indicators or standardized information more generally compiled by non-governmental sources and human rights organizations focusing on alleged violations reported by victims, witnesses or NGOs. Based on the framework and in consultation with experts, illustrative lists of indicators have been drawn for a number of rights that are being validated through expert consultations and workshops at country level. For the 'right of everyone to the enjoyment of the highest attainable standard of physical and mental health', the framework identifies five attributes namely 'reproductive health'; 'child mortality and health care'; 'natural and occupational environment'; 'prevention, treatment and control of diseases'; 'accessibility to health facilities and essential medicines' and the corresponding configuration of structural, process, outcome indicators.

The framework developed by OHCHR was outlined in the Report on Indicators for Monitoring Compliance with International Human Rights Instruments (HRI/MC/2006/7) available at http://www.ohchr.org

Bangladesh: older citizens' monitoring project

HelpAge International and the Resource Integration Centre in Bangladesh have set up a monitoring project that aims to increase older people's access to the Government's old-age allowance and other services. The project covers 3,325 older people in 54 villages in Pubail and 2,401 older people in 26 villages in Sriramkathi. At an early stage of the project, the older people conducted their own census and found significantly higher percentages of older people than the last Government census had recorded. In Sriramkathi, for example, 9 per cent of the total population was over 60, compared to 6 per cent recorded by the official census. As a result of this project, more people who are eligible for the old-age allowance are now receiving it. At national level, in 2005 there was an increase in the allowance from US$2.5 to 2.6 per month and the number of people receiving it was extended from 1 million to 1.32 million.[101]

101 HelpAge International Asia/Pacific. *Older citizens' monitoring: the experience of Bangladesh.* Chaing Mai, Thailand, 2007 www.helpage.org

- the proportion of the health budget allocated to maternal health care;
- the proportion of births attended by skilled health personnel;
- the proportion of children covered under nutrition supplement programmes;
- the adolescent fertility rates.

Participation, information and accountability:

- coverage of domestic laws on rights to information, decentralization, civil society participation and association;
- number of registered civil society organizations involved in the promotion and protection of the right to health;
- representation of women and people from other excluded and marginalized groups on national, district and village level health committees;
- proportion of sector budget earmarked to support participation;
- information available on budget flows and expenditures at national and district level;
- information available on entitlements and minimum standards of service provisions;
- the existence of a human rights institution or ombudsperson working on health issues;
- number of health-related reports submitted on time to UN human rights treaty-monitoring bodies.

4.5 Targets

Targets are an important partner to indicators. They represent the progress the country would ideally like to make in the medium and long term. Without targets, momentum can easily be lost over time, and efforts and resources distracted by other concerns that may emerge. Targets should not be set unrealistically high, but neither should they be set too low, allowing complacency to set in. They should present a challenge that with sufficient levels of commitment and resources could be achievable. They should be set for the end of the duration of the PRS, as well as at regular intervals along the way. Interim targets are equally important, as it is only when indicators are measured against them that it is possible to ascertain whether progress is being made in all areas or whether there are some areas that are slipping, and require urgent attention. This is vital, not only for the successful outcome of a PRS, but also as a way of demonstrating that the Government is meeting its obligation of the progressive realization of human rights.

The many international targets that have been set in the health sector, as well as the more technical goals that relate to certain health interventions or particular health challenges, provide a broad framework for national target setting. These targets, including the MDGs, represent indicators of international progress and cooperation. These targets should be adapted to reflect national circumstances and priorities. Governments should aim to make the greatest and fastest progress given country-specific constraints and level of external support, rather than aiming to keep on track with international targets.[102]

[102] Vandemoortele J, Roy R. *Making sense of MDG costing.* New York, Poverty Group, United Nations Development Programme, August 2004 www.undp.org

Brazil

With help from the United Nations Children's Fund (UNICEF), Brazil developed an equity ratio to apply to the MDGs to cover all regions, States and municipalities, disaggregated by gender, income, race/ethnicity, disability, level of education and location.[103]

National targets provide a framework within which subnational and local targets can be identified. Target setting that is based on civil society input and participatory processes increases local ownership and relevance. It is also important that strategies geared towards achieving targets for whole populations do not subsume efforts to improve equality and address the rights-holders who are extremely poor, excluded and difficult to reach.

GOALS AND TARGETS ENDORSED BY GOVERNMENTS

Referring to internationally recognized targets such as the MDGs and others resulting from international conferences not only brings legitimacy to the targets and ensures consistency, but can also prove powerful advocacy tools to mobilize the support of development partners and Government ministries concerned:

- MDGs: These eight goals aim to encapsulate the many and wide-ranging commitments made by Governments at a series of United Nations conferences held in the 1990s. Health outcomes and the underlying determinants of health for the poor feature prominently in the MDGs. At national level, MDG targets should be complemented with locally relevant targets such as those related to health threats from injuries, non-communicable diseases or environmental factors, or targets related to strengthening health systems in general. Disaggregation according to ethnicity, region, gender and so forth is essential, so that the aggregate picture does not obscure critical disparities in social and economic progress.
- The ICPD held in Cairo in 1994 and the 1999 Five-Year Review (ICPD+5) by the UN General Assembly[104] set out many detailed targets of specific relevance to reproductive rights.
- Resolutions made at World Health Assemblies may also include targets and goals related to specific aspects of health, and may also be useful in defining health targets to include in the PRS.

TARGETS AND OBJECTIVES OF HEALTH INITIATIVES

In addition to the general international health targets, there are many specific goals that may relate to eradication of a specific disease or achievement of a certain level of vaccine coverage. These targets relate to the goal of a specific technical programme or initiative, and may prove useful and relevant in particular national contexts and may attract the support of various parties. Some of the many "disease-specific health targets" are:

- universal access to comprehensive prevention programmes, treatment, care and support for people living with HIV/AIDS by 2010;
- halve the burden of malaria by 2010.

4.6 Political, judicial and quasi-judicial accountability

Throughout this booklet the importance of

103 http://hdr.undp.org

104 www.unfpa.org

accountability has been emphasized. A range of institutions and processes have been outlined that can support different forms of accountability at various levels from local through to international. Section 2 looked at analysis of the different systems of accountability that are accessible to people who are poor and excluded. Section 3 explored the development of minimum standards that people could use to hold policymakers and providers to account, and examined ways of building health service institutions to ensure administrative accountability and redress. It also highlighted the importance of accountable and transparent budget processes. The first part of this section discussed methods for promoting social accountability, including community-based monitoring and budget initiatives. The role of national statistical systems, targets and indicators was then reviewed. The final part of this section looks at judicial, quasi-judicial and political institutions that support accountability for human rights standards and principles. Enabling the work of these institutions through, for example, full and timely provision of information on health policies and issues, is an important strategy for ensuring the implementation of the health sector strategy of the PRS.

MILLENNIUM DEVELOPMENT GOALS

The health targets:

- Halve, between 1990 and 2015, the proportion of people who suffer from hunger.
- Reduce by two thirds, between 1990 and 2015, the under-five mortality rate.
- Reduce by three quarters, between 1990 and 2015, the maternal mortality rate.
- Have halted by 2015 and begun to reverse the spread of HIV/AIDS.
- Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases.
- Halve by 2015 the proportion of people without sustainable access to safe drinking water.
- By 2020 to have achieved a significant improvement in the lives of at least 100 million slum-dwellers.
- In cooperation with pharmaceutical companies, provide access to affordable, essential drugs in developing countries.

PARLIAMENTARY OR OTHER POLITICAL PROCESS

Depending upon the complexity or nature of the domestic parliamentary system, opportunities for oversight and accountability may exist within the national governance system. In a multiparty democratic system, many parliaments will have mechanisms such as cross-party committees that can be empowered to undertake impartial reviews of Government activities and ensure they are implemented in line with their commitments. Where excluded groups are given a voice in the hearings of parliamentary committees and other oversight mechanisms, they can play a significant role in ensuring the delivery of constitutionally guaranteed socio-economic rights.[105]

Virot Pierre (WHO-212117)

105 *Programming for justice: access for all. A practitioner's guide to a human rights-based approach to access to justice.* Bangkok, Asia-Pacific Rights and Justice Initiative, United Nations Development Programme, 2005 www.undp.org

Pierre Virot (WHO-2180861)

There are other means by which parliamentary oversight of the implementation of health and related policies can be strengthened, such as:

- engaging research institutes and universities to carry out research and audits;
- ensuring that NGOs can have access to all relevant public policy documents;
- stimulating the existence and functioning of NGOs by lowering the bureaucratic barriers for legal recognition of NGOs or giving financial support;
- allowing the media to cover issues of Government performance and encouraging media awareness on issues relevant to the health sector;
- requesting that independent institutions conduct research on the executive's budget and activities.[106]

JUDICIAL

Full accountability requires the availability of redress for human rights violations. National courts have for many years been mechanisms through which human rights violations are addressed. It is only recently that litigation has been used specifically for economic and social rights. The collective nature of these rights as well as the budgetary implications associated with economic and social policy has made litigating these violations more difficult than action to defend civil and political rights. In general, litigation is difficult, costly and not a route that is easy for individuals living in poverty. Paralegals and legal advice centres can facilitate access to court systems. But courts are often inefficient, corrupt, out of touch with the realities of people living in poverty, and biased against marginalized groups, including women.

However, where civil society organizations can pursue cases on behalf of people who are excluded, litigation can provide a springboard for broader social and political action. As the landmark South African *Grootboom*[107] and *Treatment Action Campaign* cases (below) have demonstrated, social and economic rights are justiciable and judges can make policy-literate rulings. In the latter case and many others, litigation has helped to ensure that Governments fulfil their constitutional and international treaty obligations, and has vindicated the entitlements of people who are excluded.

In many countries, including those that have just emerged from conflict, local-level disputes are settled through traditional or

South Africa: legal action to secure Nevirapine

In December 2001, the Pretoria High Court passed judgement in the case of the South African Ministry of Health versus the Treatment Action Campaign, a civil society organization that campaigns for the rights of people with HIV and AIDS. The case involved the enforcement of the right of access to health care and the obligation of the State to make Nevirapine available to pregnant women living with HIV so as to prevent mother-to-child transmission of HIV. At the time, Government-provided Nevirapine was limited to 18 pilot-study sites. The Court's judgement required the State to make Nevirapine immediately available to pregnant women with HIV who give birth in facilities in the public sector, and to their babies, where medically indicated. The Court also ordered the Government to devise and implement in a reasonable manner an effective national programme to reduce mother-to-child transmission, including Nevirapine or other appropriate medicine, the provision of voluntary counselling and testing, and formula milk. The judgement was upheld by the Constitutional Court in 2002. As a result of the judgement, the South African Government adopted a comprehensive mother-to-child transmission programme.[109]

informal courts using customary law. While these bodies are generally more accessible to people who are poor than the formal judicial system, it cannot be assumed that such processes support the entitlements of all and are non-discriminatory. Women and children may be at a particular disadvantage in traditional or customary law systems in relation to issues including inheritance, property, early marriage and violence against women.[108] Access-to-justice programmes work with these processes to increase awareness of, and adherence to, human rights standards and principles.

National human rights institutions

National human rights institutions are quasi-judicial or statutory bodies whose general mandate includes investigation of complaints in cases of human rights violations, promotion of human rights education and review of potential legislation. Most of the nearly 100 national human rights institutions now established in all parts of the world can be grouped together in two broad categories, "human rights commissions" and "ombudspersons". Some "specialized" national institutions function to protect the rights of a particular population group such as ethnic and linguistic minorities, indigenous populations, children, refugees or women.

"The Paris Principles", adopted by the General Assembly in its resolution 48/134 of 20 December 1993,[110] give guidance on the role, composition, status and functions of national human rights institutions (see also section 3). The effectiveness of national human rights institutions depends on their mandate, resources and links to civil society and Government. For example, the South African Human Rights Commission helps to monitor the implementation of socio-economic rights nationally through an 'Economic and Social

ARGENTINE HAEMORRHAGIC FEVER VACCINE

Argentine haemorrhagic fever has become endemic in the pampa zone of Argentina. The best way to combat this disease is through a highly effective vaccine. The production of this vaccine, however, had proven unprofitable for private laboratories and, as a result, the vaccine had become difficult to obtain. The Centre on Social and Legal Studies mounted a court challenge based on the right to health, and eventually won. The court, citing Argentina's constitutional and international human rights law obligations, stated that when, for economic or commercial reasons, private institutions do not provide health care for a population, the State must find the necessary resources to do it. The court further established a schedule according to which the State had to proceed and followed up to monitor compliance with the schedule. The Centre on Social and Legal Studies is continuing to pressure the Government for progress.[111]

India: Legal action against discrimination

The Lawyers Collective, HIV/AIDS Unit, responds specifically to the legal needs of people living with HIV/AIDS. For example, it filed a writ petition with the Bombay High Court on behalf of a person who was removed from employment from a public sector corporation because of his HIV status. The High Court agreed with the petitioner and directed that individual be reinstated and be paid compensation for the period of his non-employment with the corporation.[112]

106 Ibid.

107 Government of the Republic of South Africa and Others v Grootboom and Others 2000 (11) BCLR 1169 (CC) www.communitylawcentre.org.za/

108 Ncube W, ed. *Law, culture, tradition and children's rights in Eastern and Southern Africa*. Brookfield, VT, Aldershot, 1998.

109 *Minister of Health v Treatment Action Campaign*. Bellville, South Africa, Community Law Centre, University of Western Cape, 2002 www.communitylawcentre.org.za.

110 UN General Assembly Res.48/134, 1993. www.un.org/

111 Viceconte, Mariela c. Estado Nacional (Ministerio de Salud y Ministerio de Economía de la Nación) s/ Acción de Amparo, Federal Administrative Court of Appeals, June 2, 1998 www. http://www.escr-net.org

112 *HIV/AIDS and human rights in a nutshell*, op. cit.

Brazil: national rapporteur on the right to health

In October 2002, Brazil appointed six national rapporteurs to monitor economic, social and cultural rights, including one for the right to health. Chosen by a council comprising NGOs and United Nations agencies as well as Government officials, the rapporteurs have the mandate to receive complaints, investigate violations and make annual reports. They can also recommend needed changes in policies or laws. Candidates are chosen for their professional expertise as well as their proven commitment to human rights principles such as equality and non-discrimination.[113]

[113] http://www.gajop.org.br

Rights Protocol' system, involving periodic surveys issued to Government authorities assessing compliance with constitutional and international human rights obligations.

International human rights reporting

There are seven human rights treaty bodies monitoring the implementation of core international human rights treaties that contain provisions relating to the right to health and other health-related human rights. Comprising independent experts, these monitoring bodies consider the reports that States are periodically required to submit outlining progress. They can also receive reports from other sources, such as NGOs or United Nations agencies, and some are able to receive complaints from individuals who have reason to believe their rights have been violated. The reports of the treaty bodies can serve to raise awareness of the state of human rights in a country and can bring pressure to bear to change policies or practices where needed.

SECTION 5

Human rights instruments, international resolutions and declarations, useful documents, and organizations

The first part of this section provides an outline of the evolution of work on the right to health and poverty in development. The second part lists key resources on the right to health and documents for further reading on health, poverty and human rights. All the documents mentioned in the overview are referenced in the resource lists.

5.1 The evolution of the right to health and poverty in development

The right to the highest attainable standard of health has been recognized as a fundamental human right for many years. It was enshrined in the Preamble to the WHO Constitution in 1948 and reaffirmed in the Alma-Ata Declaration on primary health care in 1978. The most authoritative definition of the right to health was set out in article 12 of the ICESCR.

Constitution of the World Health Organization

Preamble:

"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."

Civil society campaigns, including on issues of reproductive and sexual health and HIV/AIDS, helped open up debates about the interpretation and application of the right to health. This, along with growing interest in developed and developing countries in using a rights framework, and research and advocacy from academia and UN institutions, placed human rights firmly on international development agendas. This is reflected in the emphasis on reproductive rights and women's human rights in the reports of the 1994 Cairo ICPD,[114] the 1995 Beijing Fourth World Conference on Women[115] and in the publication of the International Guidelines on HIV/AIDS and Human Rights.[116]

In 2000 the Committee on Economic, Social and Cultural Rights adopted General Comment 14 which outlined in detail the

114 *Programme of action of the international conference on population and development, Cairo, Egypt*, op. cit.

115 *Beijing declaration and platform for action*. Fourth World Conference on Women, A/CONF.177/20 and Add.1

116 *International guidelines on HIV/AIDS and human rights*. 2006 consolidated version. Geneva, Office of the United Nations High Commissioner for Human Rights/the Joint United Nations Programme on HIV/AIDS, 2006 www.ohchr.org

normative substance of the right to health, the obligations associated with it and the measures required for its implementation.[117] Two years later, the Commission on Human Rights appointed a Special Rapporteur to focus on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. The ongoing work of the Special Rapporteur continues to explore and raise awareness of this fundamental human right. In parallel, health professionals have been cooperating with their human rights counterparts to consider the operational significance of the relationship between health and human rights, and have acknowledged the powerful contribution that human rights can make in improving health outcomes. The WHO publication 25 questions & answers on health & human rights of 2002 provides an accessible introduction to this issue.[118]

The link between poverty and ill health has been recognized for some time and is reflected clearly in the prominence given to health within the MDGs. However, it has only been relatively recently that headway has been made in exploring the central role good health can play in macroeconomic development and growth. The publication Poverty and health, published jointly by OECD and WHO,[119] is a clear reference document on this matter and includes a useful set of policy recommendations. In 2001, the Commission on Macroeconomics and Health published its report Investing in health for economic development,[120] which presented a thorough assessment of the potential of health in global economic development.

Development practitioners, most notably those in UNDP and UNICEF, as well as many civil society organizations, have been working with their colleagues in the human rights community to explore the links between poverty and human rights. A growing number of civil society organizations, such as the People's Health Movement Right to Health campaign,[121] now articulate their concerns about health and poverty in terms of human rights. Their work demonstrates how human rights can be used to empower marginalized people and communities and contribute to pro-poor policy change.

In 2001, the United Nations Committee on Economic, Social and Cultural Rights expressed an interest in understanding how human rights principles could be brought to bear in designing development policies and, in particular, PRSs. OHCHR responded by articulating this approach in three key documents, Human rights and poverty reduction: a conceptual framework,[122] Principles and guidelines: a human rights approach to poverty reduction strategies,[123] and Claiming the MDGs: a human rights approach,[124] which together provide practitioners with concrete guidance on the overall approach to utilizing human rights norms and standards in PRSs. WHO has now attempted to take forward this work and explore what it means when applied, in a practical way, to health.

117 General Comment 14

118 *25 questions & answers on health & human rights*, op.cit.

119 *Poverty and health*. Geneva, World Health Organization/Paris, Organisation for Economic Co-operation and Development, 2003 (DAC Guidelines and Reference Series). www.who.int

120 Commission on Macroeconomics and Health. *Macroeconomics and health: investing in health for economic development*. Geneva, World Health Organization, 2001 www.who.int

121 www.phmovement.org

122 *Human rights and poverty reduction: a conceptual framework*. Geneva, Office of the United Nations High Commissioner for Human Rights, 2004 www.ohchr.org

123 *Principles and Guidelines: a human rights approach to poverty reduction strategies*. Geneva, Office of the United Nations High Commissioner for Human Rights, 2006 www.ohchr.org

124 *Claiming the MDGs: a human rights approach*. Geneva, Office of the United Nations High Commissioner for Human Rights, 2008

5.2 Key references and organizations on the right to health and poverty

Relevant international human rights instruments

Below is a selection of key international human rights instruments that relate to the right to health and/or other health-related human rights:

- Universal Declaration of Human Rights, 1948
  www.ohchr.org
- International Convention on the Elimination of All Forms of Racial Discrimination, 1965
  www.ohchr.org
- International Covenant on Economic, Social and Cultural Rights, 1966
  www.ohchr.org
- International Covenant on Civil and Political Rights, 1966
  www.ohchr.org
- Convention on the Elimination of All Forms of Discrimination against Women, 1979
  www.ohchr.org
- Declaration on the Right to Development, 1986
  www.ohchr.org
- Convention on the Rights of Persons with Disabilities, 2006
  www.ohchr.org
- Convention on the Rights of the Child, 1989
  www.ohchr.org
- International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, 1990
  www.ohchr.org

★ *For a more comprehensive list of international human rights instruments, please refer to* www.ohchr.org/ *or* www.who.int/hhr/readings/en

Relevant basic texts and resolutions of WHO

- Constitution of the World Health Organization, 1948
  www.who.int/governance/eb/who_constitution_en.pdf
- Declaration of Alma-Ata, International Conference on Primary Health Care, 1978
  www.who.int/hpr/NPH/docs/declaration_almaata.pdf

Examples of relevant United Nations conference documents

- Vienna Declaration and Programme of Action, 1993
  www.ohchr.org

- Copenhagen Declaration on Social Development and Programme of Action ofthe World Summit for Social Development,1995 and 2000
  www.un.org

- Declaration of Commitment on HIV/AIDS. Special Session of the UN General Assembly on AIDS, 2001. Resolution S-26/2 of 27 June 2001
  www.un.org

- Monterrey Consensus of the International Conference on Financing for Development, Monterrey, Mexico, 18-22 March 2002 (A/CONF.198/11)
  www.un.org

- United Nations Millennium Declaration. General Assembly resolution 55/2 of 8 September 2000
  www.un.org

- Health in the Millennium Development Goals chart
  www.who.int/mdg/goals/en/

- Johannesburg Declaration on Sustainable Development and Plan of Implementation of the World Summit for Sustainable Development, 2002
  www.un.org

Relevant WTO documents

- Ministerial Declaration adopted at the Fourth Session of the Ministerial Conference, Doha, 9-14 November 2001. (WT/MIN(01)/DEC/1), 20 November 2001
  www.wto.org

- Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) signed in Marrakesh, Morocco, 15 April 1994
  www.wto.org

Regional human rights instruments

- American Convention on Human Rights, 1969
  www.corteidh.or.cr

- African Charter on Human and Peoples' Rights, 1981
  www.achpr.org

- European Convention on Human Rights, 1950
  www.coe.int

Useful source documents and suggestions for further reading

- Asher, Judith. *The right to health: a resource manual for NGOs*, 2004
  http://shr.aaas.org/Right_to_Health_Manual/index.shtml

- Committee on Economic, Social and Cultural Rights. General Comment 14. The right to the highest attainable standard of health (article 12). (E/C.12/2000/4), 11 August 2000
  www.ohchr.org

- Jonsson, Urban. *Human rights approach to development programming*. Eastern and Southern Africa Regional Office. United Nations Children's Fund, 2003 www.unicef.org/rightsresults/files/HRBDP_Urban_Jonsson_April_2003.pdf

- *International Guidelines on HIV/AIDS and Human Rights, 2006*. Consolidated version. Geneva, Office of the United Nations High Commissioner for Human Rights and Joint United Nations Programme on HIV/AIDS www.ohchr.org

- Commission on Macroeconomics and Health. *Macroeconomics and health: investing in health for economic development*. Geneva, World Health Organization, 2001 www.who.int

- *Poverty and health*. DAC Guidelines and Reference Series. Geneva, World Health Organization/Paris, Organisation for Economic Co-operation and Development, 2003 http://whqlibdoc.who.int/publications/2003/9241562366.pdf

- *Human rights and poverty reduction: a conceptual framework*. Office of the United Nations High Commissioner for Human Rights, 2004 (HR/PUB/04/1) http://www.ohchr.org

- Elson, Diane and Norton, Andy. *What's behind the budget? Politics, rights and accountability in the budget process*. Overseas Development Institute, 2002 www.odi.org.uk/pppg/publications/books/budget.html

- *Poverty reduction and human rights: a practice note*. United Nations Development Programme, June 2003 www.undp.org/governance/docs/HRPN_(poverty)En.pdf

- *Principles and Guidelines: a human rights approach to poverty reduction strategies.* Office of the United Nations High Commissioner for Human Rights, 2006 www.ohchr.org

- *Claiming the MDGs: a human rights approach*. Office of the United Nations High Commissioner for Human Rights, 2008 www.ohchr.org

- United Nations Commission on Human Rights. *The highly indebted poor countries (HIPC) initiative: a human rights assessment of the poverty reduction strategy papers (PRSP)*. United Nations Economic and Social Council. 18 January 2001 (E/CN.4/2001/56) www.ohchr.org

- *Human development report 2000. Human rights and human development*. New York, United Nations Development Programme, 2000 http://hdr.undp.org/reports/global/2000/en/

- Klugman J, ed. *A sourcebook for poverty reduction strategies*. Washington, DC, World Bank, 2002 www.worldbank.org

- *PRSPs: their significance for health: second synthesis report*. Geneva, WorldHealth Organization, 2004 (WHO/HDP/PRSP/04.1) www.who.int/hdp/en/prspsig.pdf

- Health & Human Rights Publication Series. Geneva, World Health Organization http://www.who.int/hhr/activities/publications/en/
  Issue No. 1 *25 questions & answers on health & human rights, July 2002* www.who.int/hhr/en/NEW37871OMSOK.pdf
  Issue No. 2 *Health and freedom from discrimination, August 2001* www.who.int/hhr/activities/q_and_a/en/Health_and_Freedom_from_Discrimination_English_699KB.pdf
  Issue No. 3 *The right to water, 2003* www.who.int/docstore/water_sanitation_health/Documents/righttowater/righttowater.pdf
  Issue No. 4 *International Migration, Health & Human Rights, December 2003* www.who.int/hhr/activities/en/FINAL-Migr-HHR-01%203-Qd-Uk_90.pdf

- *Health & Human Rights Fact Sheet Series*, Geneva, World Health Organization, 2007 http://www.who.int/hhr/activities/factsheets/en/index.html

Selection of organizations addressing human rights, health and poverty reduction

- CARE www.careinternational.org

- Center for Economic and Social Rights www.cesr.org

- Commonwealth Medical Trust www.commat.org

- Fundar www.fundar.org.mx

- International Council on Human Rights Policy www.ichrp.org

- International Network for Economic, Social & Cultural Rights www.escr-net.org

- Office of the United Nations High Commissioner for Human Rights www.ohchr.org

- Oxfam International www.oxfam.org

- Save the Children www.savethechildren.org.uk

- UNDP
  www.undp.org

- UNICEF
  www.unicef.org

- Wemos Foundation
  www.wemos.nl

- World Bank
  www.worldbank.org

- World Health Organization
  www.who.int

Poverty and ill health are deeply intertwined with disempowerment, marginalization and exclusion. Today's major challenge to effectively address poverty is to weaken the web of powerlessness and to enhance the capabilities of women and men so that they can take more control of their lives. In this context, poverty is increasingly being addressed as the lack of power to enjoy a wide range of human rights – civil, cultural, economic, political and social. Health constitutes a fundamental human right, particularly relevant to poverty reduction. A healthy body enables adults to work and children to learn, key ingredients for individuals and communities to lift themselves out of poverty.

The task of addressing poverty, health and human rights cannot be handled by any single global institution and requires rigorous interdisciplinary and coordinated action. This is why the WHO and the OHCHR have worked together with a range of stakeholders to develop this guide. It is intended as a tool for health policymakers to design, implement and monitor a poverty reduction strategy through a human rights-based approach. It contains practical guidance and suggestions as well as good practice examples from around the world.

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