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Human Rights, Health and Poverty Reduction Strategies

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Human Rights, Health and Poverty Reduction Strategies

"We will not enjoy development without security, we will not enjoy security without development, and we will not enjoy either without respect for human rights. Unless all these causes are advanced, none will succeed."

"Strategies based on the protection of human rights are vital for both our moral standing and the practical effectiveness of our actions."

In larger freedom: towards development, security and human rights for all.
Report of the Secretary-General of the United Nations (A/59/2005, 21 March 2005).

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Foreword

Human rights can make a significant contribution to the struggle against poverty. They can strengthen and deepen poverty reduction strategies. They can help to clarify *what needs to be done* and provide practical guidance on *how to do it*.

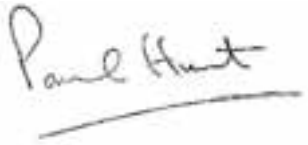
In recent years, I have worked with the Office of the High Commissioner for Human Rights and others to develop a set of Draft Guidelines on a human rights approach to poverty reduction strategies. These are based on the idea that poverty reduction strategies should rest upon national and international human rights, such as freedom from discrimination and the empowerment of vulnerable population groups; accountability of duty-bearers at the national and international levels; and the participation of all stakeholders, particularly the poorest.

Consultations on the Draft Guidelines highlighted the need to gather real, practical examples of how human rights can be successfully operationalized in the context of poverty reduction strategies. The consultations also signalled that the best way to operationalize the Draft Guidelines is by focusing on particular sectors, such as health.

This pioneering WHO booklet *Human Rights, Health and Poverty Reduction Strategies* responds to both of these needs, providing health policy-makers with a practical tool on how to design, implement and monitor a poverty reduction strategy through a human rights-based approach.

Of course, the booklet is not the final word on this large and complex issue. On the contrary, it should be regarded as work in progress. In 2005, consultations will take place on the basis of which the booklet will be revisited, revised and improved.

I applaud the World Health Organization for taking this important initiative and at such a timely moment. Breaking the vicious circle of ill-health and poverty constitutes a priority for all of us working in the fields of health, development and human rights. In this regard 2005 is a critical year. We are now just 10 years away from 2015, the target date for the Millennium Development Goals (MDGs). There are a number of important events planned throughout the year at which our global strategy for reaching the MDGs, and for reforming our systems of collective security, will be clearly laid out and agreed. Health and human rights must be at the centre of these efforts.



PROFESSOR PAUL HUNT
UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health

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Preface

This booklet, *Human Rights, Health and Poverty Reduction Strategies*, applies to the health sector a framework that has been articulated as the human rights approach to poverty reduction. It builds upon work done by the Office of the United Nations High Commissioner for Human Rights and others who conceptualized this human rights approach. We hope it will highlight the critical synergies among good practices in public health, human rights principles, and sound development policy.

Indeed, since this booklet is targeted primarily at health policy-makers in countries that are in the process of developing, reviewing or updating a poverty reduction strategy, it contains examples of "good practices" throughout. These are intended to demonstrate how human rights principles have been operationalized in the various stages of developing a poverty reduction strategy, from initial analysis to design of the content, and from implementation of the plan to monitoring and evaluation. The examples are also meant to inspire similar actions and initiatives in the future.

WHO is issuing this booklet in draft prior to undertaking widespread consultation on the content. Once the resources needed for these intensive discussions become available, they will be carried out through WHO country and regional offices and will shape the content of the final report. Meanwhile, we invite comments and input on this draft and ask that they be directed to those responsible for this project in our respective departments:
HDP: Rebecca Dodd (doddb@who.int) and
ETH: Helena Nygren-Krug (nygrenkrugh@who.int).

Finally, we wish to express gratitude to Paul Hunt, the UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, for the excellent collaboration, and to Penelope Andrea, who worked with WHO on this project.

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List of Acronyms

DAC	Development Assistance Committee
DOTS	Directly Observed Treatment Short-course
ICPD	International Conference on Population and Development
IMF	International Monetary Fund
MDGs	Millennium Development Goals
MOH	Ministry of Health
MTEF	Medium Term Expenditure Framework
NGO	Nongovernmental Organization
OECD	Organisation for Economic Co-operation and Development
OHCHR	Office of the United Nations High Commissioner for Human Rights
PAP	Participatory Action Plan
PRS	Poverty Reduction Strategy
PRSP	Poverty Reduction Strategy Paper
R&D	Research and Development
TRIPS	Trade-Related Aspects of Intellectual Property Rights
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
WHO	World Health Organization
WTO	World Trade Organization

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Introduction

Countries worldwide are making considerable efforts to achieve the Millennium Development Goals (MDGs), the eight over-arching targets derived from the Millennium Declaration that aim to dramatically reduce poverty, ill-health and inequality, as well as increase access to education and improve environmental stability. For most, these efforts are channelled into designing and implementing a national poverty reduction strategy (PRS).

Many poverty reduction strategies (PRSs), however, fail to pay adequate attention to human rights and the specific health threats facing the poor. In addition, countries are also facing many challenges in trying to operationalize their international commitments to human rights principles and standards.

This booklet seeks to provide a practical guide for policy-makers to help overcome both problems. It aims to bring together human rights principles and sound development and public health policies to the task of designing and implementing the health component of a PRS.

The structure of the booklet mirrors the process of developing a PRS, from initial analysis to design of its content to its implementation, and reflects the approach recommended by the World Bank in its *Poverty reduction strategy papers (PRSP) sourcebook.*[1] The guidance and suggestions would be equally relevant in designing any pro-poor health policy.

Although human rights instruments do not provide a simple blueprint that can easily be followed by development practitioners and policy-makers, a *human rights-based approach* defines and emphasizes clear principles that can help guide the process of developing and implementing a PRS. The additional value of bringing these principles to bear throughout is not so much that they change *what* needs to be done but that they suggest a new methodology on *how* to do it and, more importantly, *why*. Simply put, a human rights approach to poverty reduction can help to ensure a sustained focus on the poorest and most vulnerable groups.

Operationalizing and realizing human rights principles in practice is rarely straightforward, particularly in view of the financial and political constraints faced by all countries. Nevertheless, there is increasing evidence that human rights principles *can* and *have been* successfully used to underpin strategies and initiatives designed to help poor and marginalized communities, whether at the early planning stages or later in implementation, monitoring and evaluation. This document describes instances of such successes; some reflect national policies, others highlight initiatives by regional authorities or nongovernmental actors. Doubtless there are many more.

The booklet draws substantially on some wide-ranging conceptual work that has been under way in recent years within the health, human rights and development communities.

The right to the highest attainable

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

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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."

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.

Nonetheless, defining exactly what this right entails and on what its realization depends is relatively new and pioneering work. In 2000 the Committee on Economic, Social and Cultural Rights adopted General Comment No. 14 which outlined in detail the normative substance of the right to health, the obligations associated with it and the measures required for its implementation.[2] Two years later, the Commission on Human Rights appointed a Special Rapporteur to focus, for the first time, on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. The recent reports and ongoing work of the Special Rapporteur continue to explore, inform 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*[3] issued in 2002 provides a thorough and easily accessible introduction to what can at first appear to be a complex issue.

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 Millennium Development Goals (MDGs). However, it has only been relatively recently that headway has been made in exploring and elaborating the central role good health can play in macroeconomic development and growth. The publication *Poverty and health*[4], one of the Guidelines and Reference Series of the Development Assistance Committee (DAC) of the Organisation for Economic Co-operation and Development (OECD), published in collaboration with the World Health Organization (WHO) is a clear and detailed 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*[5] which presented a thorough assessment of the potential of health in global economic development.

Moreover, development practitioners, most notably those in the United Nations Development Programme (UNDP) and United Nations Children's Fund (UNICEF), as well as many nongovernmental organizations (NGOs), have been working with their colleagues in the human rights community to bring a new perspective to understanding poverty and poverty reduction – by looking at the problem through the prism of human rights.

In 2001, the United Nations Committee on Economic, Social and Cultural Rights expressed an interest in understanding how

[2] Committee on Economic, Social and Cultural Rights. General Comment 14. The right to the highest attainable standard of health (Article 12). In: *Twenty-second session, Geneva, 25 April–12 May 2000.* Brooklyn, NY, Center for Economic and Social Rights (E/C.12/2000/4, CESCR). http://www.hri.ca/fortherecord2000/documentation/tbodies/e-c12-2000-4.htm

[3] *25 questions & answers on health & human rights.* Health & Human Rights Publication Series Issue No. 1. Geneva, World Health Organization, 2002. http://whqlibdoc.who.int/hq/2002/9241545690.pdf

[4] *Poverty and health.* DAC Guidelines and Reference Series. Geneva, World Health Organization/Paris, Organisation for Economic Co-operation and Development, 2002. http://whqlibdoc.who.int/publications/2003/9241562366.pdf

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human rights principles could be brought to bear in designing development policies and, in particular, PRSs. The Office of the United Nations High Commissioner for Human Rights (OHCHR) responded by articulating this approach in two key documents, *Human rights and poverty reduction: a conceptual framework*[6] and *Draft guidelines: a human rights approach to poverty reduction strategies*[7] 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 the work in the *Draft guidelines* and explore what it means when applied specifically, in a practical way, to the health sector. The booklet aims to provide policy-makers with guidance, suggestions and real life examples to help demonstrate how human rights can and have been applied to pro-poor health policies and initiatives, and how they can enhance the effectiveness of a PRS.

Section 1 provides an *introduction* to human rights principles, the elements of a human rights-based approach and how health is protected by human rights standards. It introduces poverty from the perspective of a denial of human rights and explores 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 developing and formulating the health segment of a PRS based on human rights norms and standards. It suggests checklists to help analyse the nature and causes of poverty and its impact on the health of the poor. It also provides a suggested methodology to enable the poor to participate in this process.

Section 3 addresses the challenge of developing the *content* of a PRS. It outlines the areas of responsibility of the government from a human rights perspective and provides suggestions as to how to operationalize these. It also considers the challenges and tensions that are likely to be encountered and how human rights can help overcome them, and examines the responsibilities of international development partners.

Section 4 is concerned with the *implementation* stage of a PRS. It focuses on how human rights provide a sound basis for monitoring and evaluating the impact of the strategy. It suggests a list of indicators and targets that are based on human rights principles and deals with the difficult area of accountability and redress.

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

[5] Commission on Macroeconomics and Health. *Macroeconomics and health: investing in health for economic development.* Geneva, World Health Organization, 2001. http://www.cid.harvard.edu/cidcmh/CMHReport.pdf

[6] *Human rights and poverty reduction: a conceptual framework.* Geneva, Office of the United Nations High Commissioner for Human Rights, 2004. http://www.ohchr.org/english/issues/poverty/docs/povertyE.pdf

[7] *Draft guidelines: a human rights approach to poverty reduction strategies.* Geneva, Office of the United Nations High Commissioner for Human Rights, September 2002. http://www.unhchr.ch/development/povertyfinal.html

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SECTION 1
Principles of a human rights-based approach to poverty reduction strategies

This section provides an introduction to human rights principles, outlines the elements of a human rights-based approach and discusses approaches to PRSs and in particular the health component of a PRS. It points to the link between health and poverty and explains the rationale and value added of using a human rights-based approach to formulating a PRS. Reference is made to relevant source documents to which the reader may wish to refer for further information.

a. What are the characteristics of human rights?

Human rights lie at the heart of the Charter of the United Nations and have subsequently been the subject of numerous declarations, treaties and conventions.

International human rights *law* comprises a series of treaties that legally bind the governments that ratify them to respect, protect and fulfil the rights of all individuals and groups. In addition, the many declarations of commitments to human rights made by states reflect principles and standards that are now recognized and accepted by the international community. The Universal Declaration of Human Rights, the two International Covenants and the additional treaties concerned with specific groups, such as women or children, or particular categories of rights, together cover a wide range of civil, cultural, economic, political and social rights and apply to all human beings universally.

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.

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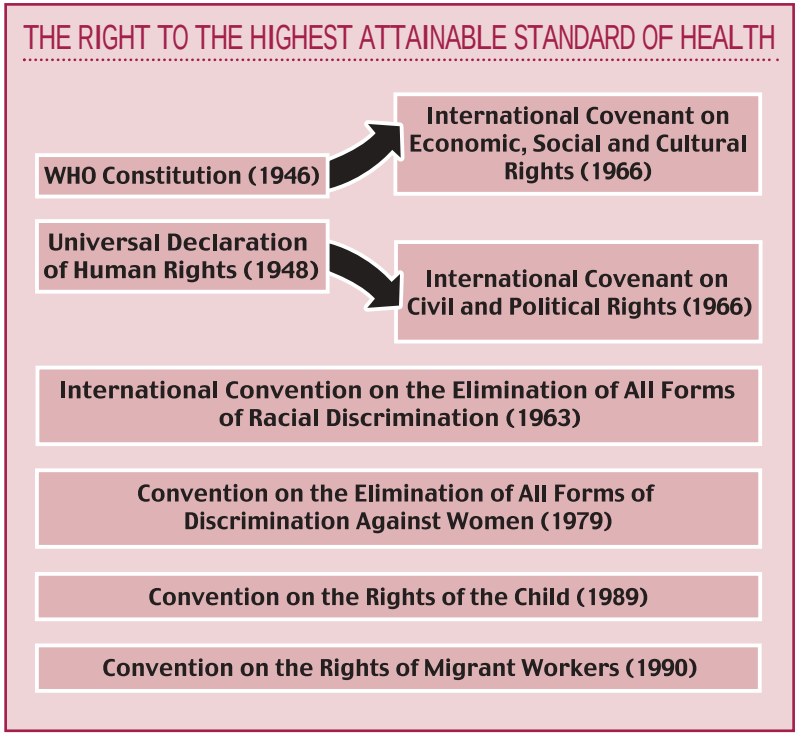

b. What are the elements of a human rights-based approach?

For many years, human rights remained largely the concern of specialist lawyers and of the international treaty bodies that were established specifically to monitor the compliance of each ratifying state with its obligations. The programme of United Nations reform introduced by Secretary-General Kofi Annan in 1997 broadened the range of activities relating to human rights. It encouraged both development and humanitarian practitioners within the United Nations system to incorporate human rights throughout their work. As a result, increased efforts are under way to further explore and articulate the links between the fulfilment of human rights and human development. From this shift in conceptual thinking emerged new ways to formulate development and poverty reduction programmes.

Although considerable conceptual work was already under way to consider what a human rights-based approach to development programming actually entailed, it was not until 2003 that the United Nations system came together to define and agree on the central elements of such an approach. Now generally referred to as the *"Common Understanding"*, it has three key guiding principles:

- Firstly, that 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.
- Secondly, that 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.
- Finally, that programmes of development cooperation should

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contribute to the development of the capacities of duty-bearers to meet their obligations and of rights-holders to claim their rights.[8]

A human rights-based approach to development programming differs from conventional approaches in that it emphasizes the *process* by which it is undertaken as much as the *outputs* or measurable results. Crucial to this process is the principle of the right of all stakeholders to *participate* in the design and implementation of any policies affecting them. In addition, it is stressed that human rights-based policies and programmes must address the *immediate, underlying* and *structural* causes behind the non-realization of human rights.

A human rights-based approach focuses on the *capacities* of both the claim-holders and the duty-bearers. Claim-holders may be individuals or groups whose human rights are to be respected, protected and fulfilled. Duty-bearers, on the other hand, are those who have the responsibility (and hold the power) to bring this about. The state is the principal duty-bearer and as such, human rights-based development policies are primarily concerned with the actions required of the government. However, the state is equally responsible for ensuring that the behaviour of others, including non-state actors, community leaders and even family members, who hold some power in determining the extent to which an individual's human rights can be fulfilled, live up to their responsibilities. In addition, states are also required to take all possible steps, either individually or in cooperation with others, to support one another in their endeavours to meet their human rights obligations. A comprehensive policy will therefore encompass the entire enabling environment necessary for human rights to be allowed to flourish.

c. How is health protected by the human rights legal framework?

Human rights recognize that the realization of the highest attainable standard of health depends upon a wide range of distinct, yet interrelated, human rights. The ways in which human rights can have an impact upon health fall into three main areas:

- The violation or neglect of human rights, such as torture, slavery, violence against women and children and exposure to other harmful practices, can lead to ill-health.
- The fulfilment of human rights can reduce a person's vulnerability to ill-health.
- Development policies can bring about the fulfilment of some human rights but may, in some circumstances, violate others.

The right to the highest attainable standard of health, often referred to as the right to health, is enshrined consistently within international law. It encompasses a range of rights from having access to care when ill,

[8] The human rights based approach to development cooperation: towards a common understanding among the UN agencies. In: *Interagency Workshop on a human rights-based approach in the context of UN reform, Stamford, CA, 3–5 May 2003.* New York, NY, United Nations. www.crin.org/docs/resources/publications/hrbap/HR_common_understanding.doc

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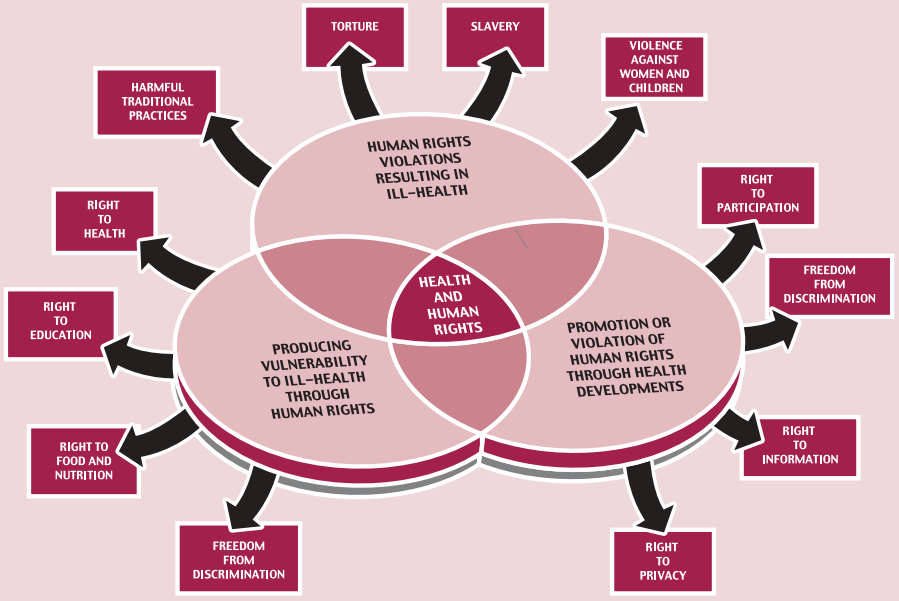
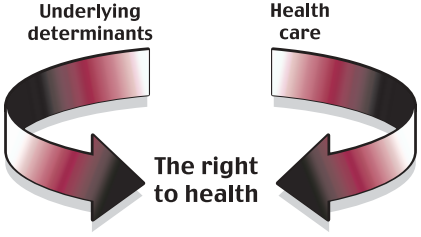
EXAMPLES OF THE LINKAGES BETWEEN HEALTH AND HUMAN RIGHTS



to protection against disease or the ill-effects of environmental living conditions.

Under the right to health, states are obliged to ensure that public health services, as well as medicines and health care staff, are made *available* to all, are *accessible* to all, regardless of geographical location or economic status, are *acceptable* to all cultures, genders and ages and respect the privacy of all individuals. Furthermore, the *quality* of the skills of the health personnel, the medicines available and the equipment used should be of a consistent standard for all communities and all individuals within those communities. In addition to the provision of health care, it is generally understood that the fulfilment of the right to health depends upon a number of



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related human rights that can have a direct impact upon health. These include the right to safe water and sanitation, the right to food and nutrition, the right to shelter, the right to occupational and environmental conditions that do not damage health, the right to health-related education and information, the right to non-discrimination, the right to participate, the right to enjoy the fruits of scientific progress and the right to social security or protection in times of severe hardship.

Under international law, some of the obligations of the duty-bearers are immediate and may not necessarily imply significant financial outlay.[9] A government must take *immediate* action to:

- Eliminate any and all forms of discrimination.
- Halt any actions or other measures that are having a detrimental effect on the health of any individuals or groups.
- Establish ways in which all stakeholders can participate in shaping the policies that will affect them.
- Take concrete steps, including financial and political commitments, that will eventually meet longer-term obligations.
- Refrain from embarking upon any course of action that may exacerbate the situation in the short or medium term.

Other obligations are harder to achieve immediately. Human rights law recognizes the severe resource constraints that poor countries face and requires instead that governments embark on a long-term plan that will lead to the *progressive realization* of human rights.

Developing a comprehensive pro-poor national public health strategy, or a PRS, is a concrete way in which a government can demonstrate that it is moving towards the realization of *all* human rights related to health. It should strive to allow affected populations, i.e. poor and vulnerable groups, to participate in the diagnosis of the situation and in the design, implementation and evaluation of the strategy. It should specify goals and indicators of progress and identify mechanisms, whether already in existence or newly created, that can play a role in monitoring progress towards realizing the different dimensions of the right to health.

A government must also work towards fulfilling other rights that can have an impact on health. Many of these associated rights traditionally fall outside the authority of the ministry of health (MOH). The challenge then for any government is to ensure these are given equal priority by all ministries and departments. Ensuring access to safe water and sanitation, protecting the living and working environments of communities, providing access to information and education related to health matters and ensuring no international agreements entered into by the government, such as trade laws or loans, are harmful to the health of the poor are as important as provision of

[9] Committee on Economic, Social and Cultural Rights. General Comment 14. The right to the highest attainable standard of health (Article 12). In: *Twenty-second session, Geneva, 25 April–12 May 2000.* Brooklyn, NY, Center for Economic and Social Rights (E/C.12/2000/4, CESCR), 11 August 2000, paras. 18-29. http://www.hri.ca/fortherecord2000/documentation/tbodies/e-c12-2000-4.htm

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primary health care. Developing a PRS provides an excellent opportunity for the government to address all these areas and to foster cohesion across all sectors and ministries.

d. How can a human rights approach help to define poverty?

Poverty has conventionally been defined in economic terms, focusing on an individual's or household's available financial capacity, either absolute or relative. In recent years, however, alternative views have emerged that now recognize that poverty is multidimensional. It can be defined not only as lack of material resources deemed necessary for an acceptable standard of living, but also a denial of other related capacities and opportunities, such as education and physical well-being, as well as less easily quantifiable factors such as lack of dignity, self-respect, freedom or access to power.

Although "poverty" is not specifically and explicitly referred to in any of the international human rights treaties, its existence as a phenomenon is recognized by the human rights community. Both the Universal Declaration of Human Rights and the International Covenant on Economic, Social and Cultural Rights refer to the right of everyone to an adequate standard of living, including adequate food, clothing, housing and medical care and necessary social services. In 2001, the UN Committee on Economic, Social and Cultural Rights reached agreement on the definition of 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."[10]

There is no single standard definition of poverty and the choice of definition remains a country's national prerogative. Any strategy that is to be sustainable and effective must, however, recognize and address the multidimensional nature of poverty and respond to not only its economic aspects but also other critical elements, be they structural, social or political, that contribute to its persistence in certain vulnerable groups.

e. What are poverty reduction strategies?

A PRS is a national cross-sectoral development framework, designed and implemented by national governments, specifically to tackle the causes and impact of poverty in a country. Even in high-income states, pockets of poverty 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). Today, PRSs are increasingly seen as the principal mechanism around which many bilateral and multilateral donors build their development cooperation programmes.

[10] Committee on Economic, Social and Cultural Rights. Poverty and the International Covenant on Economic, Social and Cultural Rights. In: *Twenty-fifth session, Geneva, 23 April–11 May 2001*. Geneva, Office of the United Nations High Commissioner for Human Rights, 2001 (E/C.12/2001/10). http://www.unhchr.ch/tbs/doc.nsf/0/518e88bfb89822c9c1256a4e004df048?Opendocument

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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 PRSs should be based:

- They should be driven by the needs and wishes of the country concerned.
- They should be founded upon a broad-based participatory approach - from initial diagnosis, to design, and on to monitoring and evaluation.
- They should be results-oriented and focused on outcomes of specific benefit to the poor.
- Analysis and diagnosis of the nature and causes of poverty should take account of its multidimensional nature, not merely income poverty.
- Data used to define the extent and location of poverty should be as disaggregated as possible to clarify the complex, structural and social, as well as economic, underlying causes.
- With limited resources, any policy that is to be sustainable will inevitably require an element of prioritization.
- Prioritization implies trade-offs, which in turn require short-, medium- and long-term targets, benchmarks and indicators for the evaluation of progress, and adjustment of priorities as circumstances change.
- Progress must be monitored and evaluated in partnership with those for whom the strategy is designed and should be based on a long-term view of poverty reduction.
- Mechanisms that foster and promote transparency and accountability of those charged with designing and implementing the strategy must be established and sufficiently resourced.

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

There are many *similarities* and *synergies* between a human rights approach to poverty reduction and a more conventional development approach. Although the language of rights and duties may at first appear daunting to the development practitioner, these synergies should provide reassurance that the two approaches are consistent and that using a human rights-based approach does not neccessarily imply a very different way of working or thinking.

Any national policy should be *consistent* with the government's international human rights obligations. From the outset, therefore, a "stock-taking" exercise of human rights provisions which bind the government concerned is required, including treaties ratified at the international and regional levels, and pertinent national instruments such as the Constitution. Integrating a human rights-based approach within a PRS is

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not only a matter of legal obligation, however, it can actually *enhance* the effectiveness of the PRS. Furthermore, there are a number of significant and *supplementary* advantages that add to the compelling argument of adopting a human rights-based approach to the development of a PRS:

- Rooting a national policy in an international legal framework strengthens the centrality of the state in design, implementation and oversight of PRSs.
- A PRS founded on human rights principles is an effective mechanism through which a state can gradually achieve its longer-term obligations.
- Any PRS, to be effective, legitimate and sustainable, depends upon the empowerment of the poor and human rights are effective tools of such empowerment.
- While other approaches focus on raising average indicator levels, a human rights approach can ensure that it is the most vulnerable, including the poorest of the poor, that are targeted.
- The resource constraints facing poor countries are recognized by both PRSs and human rights law under the principle of progressive realization and both frameworks recognize the importance of an enabling environment, including that dependent upon the wider international community and non-state actors.

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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 by the same health problems and each country's health strategy differs accordingly. A process that uses a human rights-based approach to identify a country's specific health situation will help to ensure that the strategy is built upon and reflects genuine needs rather than generalizations and assumptions that, crucially, may fail to recognize and address the reality of the most marginalized or vulnerable groups.

The first half of this section poses a series of questions on poverty from the perspective of human rights. When combined with an analysis of known health data such as burden of disease, mortality rates and health care uptake, finding answers to such questions can help to define the specific health needs of the poor as well as identifying the additional constraints that poverty brings. The questions can help to determine the nature of poverty and the factors that may be impacting upon the health of the poor, from the household and community life, up to the effects of national policies and international agreements.

The second half suggests a methodology based on the participation of the poor that can help arrive at some answers to these questions. Facilitating such a process of consultation and participation may at first appear to present a challenge. It is important, however, to try to find a mechanism by which the poor are able to participate in defining the nature of their poverty, how it is affecting their health and what changes are needed. This can be a significant first step not only in developing a PRS that truly addresses the specific nature of poverty, but also towards empowerment of the poor and the fulfilment of their human rights.

a. What is the nature of poverty in the country?

Although human rights instruments do not provide an easy checklist for analysing the nature of poverty in a country, the extent to which they are fulfilled and

***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

respected can certainly serve as indicators of poverty.

The following are just some of the key questions that should be asked when embarking on a process of identifying instances of poverty:

- Is everyone sufficiently well nourished?
- Is enough adequate shelter available for everyone?
- Can all children, girls and boys, receive a basic education?
- Can all heads of household, male or female, earn sufficient resources to provide for their families?
- Are some people dying prematurely from preventable causes?
- Are some people or communities without access to health care services?
- Do some individuals or groups of people suffer from discrimination or feel threatened with violence or injury from others?
- Does everyone have access to justice and the legal system?
- Do all people have a means of voicing their opinions and wishes?

Beyond these basic questions, it is important to ask the poor themselves what *they* consider constitutes poverty. The results may be surprising and revealing.

b. Who are the poor and where are they?

Once the nature of poverty within the country has been identified, the challenge then is to identify not only *how many* people are affected but more importantly *who* they are and *where* they are located. The key human rights principles of non-discrimination and equality of all people require that the poor are not merely represented as a percentage figure but are clearly identified as groups and individuals. These principles can guide a process of *disaggregation* which will be necessary to extract this information from the overall available data.

Like poverty in general, who the poor are will differ from country to country. Experience, however, has shown that in most countries there are some particular categories and groups within the population who tend to be more vulnerable to marginalization and are likely to suffer from poverty on a more consistent basis than others. The number of women living in poverty is increasing disproportionately to the number of men, particularly in the 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.

Looking closely at various vulnerable groups within a country and comparing the levels and extent of multidimensional poverty found within them against those found in the rest of the population is an important stage in the process of developing a sound PRS.

Some of the groups that have been identified as frequently being more vulnerable to poverty include:

- women and girls;
- some ethnic, religious or linguistic minorities;

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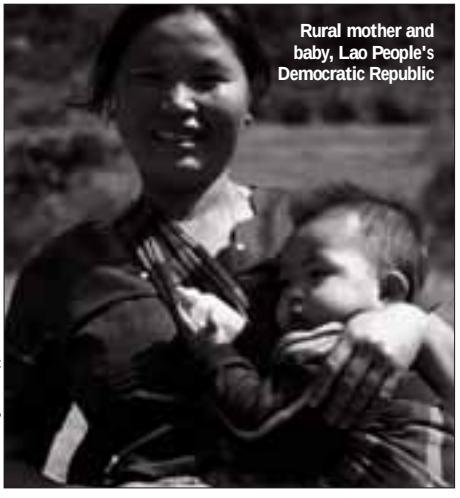
POVERTY IN AN INDIGENOUS CONTEXT

Rather than simply stating that indigenous peoples are poor, it seems more appropriate to talk about 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 sometime 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.



Rural mother and baby, Lao People's Democratic Republic

WHO/WPRO/Image Bank/Seppo Suomela

- indigenous and tribal peoples;
- children living in difficult circumstances, e.g. street children, orphans;
- the elderly;
- remote rural populations;
- communities living in particular locations or substandard housing, e.g. slum dwellers;
- workers in hazardous working conditions and migrant workers (particularly those undocumented);
- persons experiencing ill-health and those living with HIV/AIDS;
- people living with mental or physical disabilities;
- internally displaced persons;
- asylum seekers or refugees;
- the unemployed or homeless;
- prisoners.

c. In what ways does poverty affect the health of the poor?

Analysis of health data from poor and vulnerable population groups invariably reveals higher-than-average instances of disease, premature mortality, maternal mortality, or HIV/AIDS infection rates. The next stage therefore requires a closer look at *how* poverty is increasing the vulnerability of the poor to health-related problems, as well as exacerbating ill-health and whether poverty in itself is proving an impediment to the capacity of the poor to seek adequate health care when sick.

A close look at health care services available in the country may reveal that those living in poverty do not enjoy the same levels of care and treatment as other people. Some may not be able to access any health care at all. It may also reveal that poor people are less able to enjoy protection against ill-health that is available to others in the country. Some children within poor communities may not be systematically immunized against preventable diseases.

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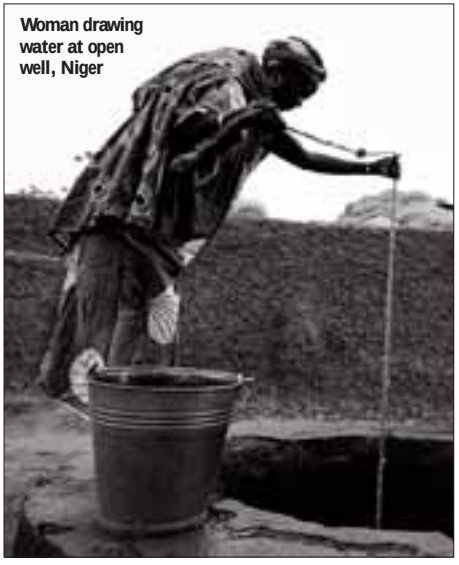
European Roma Rights Centre

"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."



Woman drawing water at open well, Niger

ILO/Marcel Crozet

Other means of prevention such as condoms to protect against HIV/AIDS or insecticide-treated bednets to prevent malaria may not be either available or affordable to poor communities.

A wider understanding of the effects of poverty on health should include:

- an analysis of the extent to which poor communities have access to information concerning their health or that of their families;
- the quality and availability of potable water, sanitation and nutritious food without which their health may suffer;
- the conditions of housing and shelter and whether these may be in any way endangering the health of the inhabitants;
- the extent to which poor communities are able to express their wishes and opinions concerning their health needs and the services available to them;
- the system by which health care is usually paid for, whether through direct fees or through forms of insurance or social security.

A human rights interpretation of what constitutes the right to health allows for a much broader understanding of the ways in which poverty can negatively impact upon the health of the poor. To be truly effective, any health component of a PRS should address these wider causes and include interventions that may traditionally lie outside the scope of the national health policy. To fulfil its obligations, the government leadership will need to support the MOH in convening and working closely with other ministries to ensure coherence across all areas of government.

CROSS-SECTORAL APPROACHES TO HEALTH IN PRSPs

A WHO study[11] suggests that most PRSPs focus on government delivery of health services to reach health goals. There are some important exceptions to this trend, however:

- Burkina Faso, where sanitation facilities will be built in schools;
- Ethiopia, which is developing rural electrification and telecommunications schemes to meet the needs of rural health services;
- Zambia, where the energy sector proposes to fit rural health centres with solar panels.

[11] *PRSPs; their significance for health; second synthesis report.* Geneva, World Health Organization, 2004 (WHO/HDP/PRSP/04.1). www.who.int/hdp/en/prspsig.pdf

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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.

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 risk reduction for livestock. Natural hazards compounded matters and conflict between communities over access to safe pasture emerged. 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.

THE LAYERS OF CAPACITY NEEDED FOR THE FULFILMENT OF HUMAN RIGHTS

d. What are the underlying causes?

The final stage in the process of developing the health component of a PRS is to consider *why* poverty is continuing to affect the health of the poor: What are the underlying causes? How can they be addressed? Once again, human rights can bring a novel approach to this challenge, both in helping to determine the *causes*, as well as in locating where the *responsibilities* and capacities might lie to change the situation.

Asking the poor themselves to participate in the process of identifying the underlying causes is the most effective means of bringing to light the real reasons and pin-pointing the most effective interventions. Although the primary obligation for ensuring the fulfilment of all human rights lies with the state, the actual capacity may lie within the family or household; it may rest at the community level due to local behaviour or norms or lie within the control of the local authorities or employers; it may rest with national government, within or outside the MOH; or indeed lie with international policy-makers in apparently unrelated areas such as trade or fiscal management. The challenge facing those preparing a national strategy is to identify not only where the responsibilities lie but equally, where capacities may be lacking or withheld and then formulate a policy that addresses this.

At the *household level*, there is a range of different factors that can have a direct effect on the health of those within the family, sometimes in an unequal or discriminatory fashion. The following are just some of the ways in which health can be protected or harmed at the family level:

- The nutritional quality of the food that is consumed or quality of the water and sanitation a family has access to, and the extent to which what is available is evenly distributed, will determine the health of family members.
- The effects of some practices, e.g. socially-ascribed gender roles, by some members of the family can have an impact on the health of other household members.

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.

- The amount of a family's income and whether it is spent on health care when needed, for adults and children, women and men alike.
- Whether all family members are permitted by other members to seek equal levels of health care or have access to the same quality and distribution of health information.

At the *community level*, additional factors may affect some members of the community. For example:

- Cultural norms or taboos may hinder some members of the community such as those affected by illness or disability from participating in community life or seeking care and treatment.
- Health services available at the community level may be inappropriate, insufficient or underutilized by some members of the community for economic or cultural reasons.
- Health centres may be located in inaccessible positions for some communities.
- Communities may have little say in defining their needs or the scope of the health services available to them.
- Environmental or infrastructural factors may be preventing the community from accessing available services promptly when needed at all times of the year.
- Corruption or prejudice of local health professionals may be a major factor in deterring poor communities from seeking treatment and care.

Hungary: Autonómia – Hungarian Foundation for Self-Reliance

Established in 1990, the foundation works directly with Roma communities to develop new models of development that reflected 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.

At the *national level*, some decisions and policies of the ministries of health, finance or planning may harm or disadvantage the health of poor or marginalized communities.

- Overall budget allocations may be based upon the prioritizing of issues (e.g. defence or tourism) other than human rights such as the right to health.
- Decisions around the setting of health budgets may result in insufficient funding of health services for some parts of the country or a concentration in urban areas.
- The mechanisms deployed for raising revenues for public health, such as user fees or insurance schemes, may penalize the poor.
- Decisions on prioritization may seriously reduce the cost-effectiveness of health care for the poor.
- Insufficient information may be available on health matters and on available services or may exist only in some formats that are of little relevance to the poor.
- The availability and quality of essential drugs may not be sufficient to meet the needs of the whole country due to inadequate procurement or licensing rules.
- Services delegated to the private sector may be unregulated with little government oversight.

Within the *health service*, wide discrepancies in the quality and availability of care between wealthier urban areas and poor rural communities is a frequently witnessed phenomenon:

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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."

- The physical availability of health facilities or outreach mechanisms for all parts of the country at all times of the year is often overlooked.
- Health centres may not be well equipped nor carry sufficient supplies of medicines and vaccines or have the appropriate storage facilities.
- The services provided may be inappropriate for the local needs or be delivered in ways that are offensive or unacceptable to some ethnic minorities or religious groups.
- There may be a failure to ensure that sufficient qualified and motivated staff are available at all health centres, are fulfilling their roles and are treating all their patients with the same dignity and courtesy, regardless of their gender, age, ethnicity, health status or level of poverty.
- Health centres may impose unaffordable financial burdens on those seeking medical treatment which will inevitably discriminate against the poor.

At the *international level*, a government is likely to be actively entering into 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 impact of international agreements or the behaviour of transnational corporations on the health of the poor in a country may not be evident at first glance, particularly those that do not appear to relate directly to health matters. A thorough analysis of the underlying causes of poverty in a country may, however, reveal that the conduct of governments at the international level is impacting negatively upon the health of poor people in other countries. Although the primary responsibility rests with the national government to promote and protect the human rights of its population, it is increasingly recognized that duties to promote and protect human rights extend beyond national borders. Governments should ensure that no policies or activities conducted in the international arena have a detrimental effect on the rights of people in other countries, particularly the poor and marginalized.

Special effort should be made to scrutinize and understand the impact on the health of the poor of each international agreement and every multinational company as part of the poverty assessment undertaken by the MOH, an onerous task but nevertheless, an essential element to ensure that the underlying causes of poverty and ill-health are identified and addressed.

As a starting point, the following are suggestions of areas of international activity which have already been identified and highlighted by experts as having a possible impact on individual human rights. Many agreements are entered into and conducted with the best of intentions and are based on sound economic or public health policies.

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However, they may have some detrimental side effects on the very poor, albeit only in the short term. Human rights principles do not permit the introduction of any measures that may have a retrogressive effect on the realization of human rights, even for a short period, unless the state can argue that they were inescapable and considered only after all possible alternatives were exhausted. Looking at these agreements and initiatives through the prism of human rights norms and standards can help protect against just such a possibility.

National Immunization Day, Freetown, Sierra Leone

WHO/Jean-Marc Giboux

- 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.
- Little international funding or research is devoted to "unprofitable" diseases, specifically those that only affect the poor. To date, international trade laws have been unable to provide alternative incentives to the major pharmaceutical companies to invest in these diseases.
- Recent developments in the 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 medicines, allow greater international mobility of patients in seeking specialized treatment, attract foreign direct investment

AFRICAN TRYPANOSOMIASIS – a neglected disease of the poor

African trypanosomiasis, or sleeping sickness, is a fatal disease if left untreated. Once close to eradication, it has thrived in recent years due to collapsing health systems. It affects only isolated areas of rural Africa but threatens over 60 million, mainly the very poor, in 36 countries. Most patients seek treatment only in the later stages of the disease and for many, the only medicine available is *Melarsoprol*. First released in 1949, it is the last arsenic-based drug in existence. It has devastating side effects, is excruciatingly painful and kills one in 10 of those treated. Although pressure is on the pharmaceutical industry to research new drugs, currently no long-term alternative is in the pipeline.

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India: Failing to protect – Bhopal

Arguably, the most infamous case of the activities of a multinational company having a devastating effect on the health of a poor community was the gas leak that occurred at a chemical plant in Bhopal, India, in 1984. Over 20 000 people in the area, many living in poor slum dwellings, lost their lives and over 100 000 continue to suffer ill-health effects from the disaster. Today many are unable to work, are living in desperate poverty and are unable to access appropriate medical treatment. To date, neither the company concerned nor the Indian authorities have been held responsible for failing to protect the health of local residents.

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 therefore imperative.

- In recent years, an increasing number of public/private partnerships have emerged. They fall into two main groups: those concerned with research and development (R&D) of new drugs to tackle diseases neglected by the commercial R&D sector; and those concerned with addressing specific health challenges, such as immunization and HIV/AIDS, at country level. The former clearly fill a gap: poor countries benefit least from the research and development of new drugs (it is estimated that less than 10% of global spending on health research is devoted to the diseases and conditions which account for 90% of the global disease burden) and are least able to finance public investments into R&D. The latter raise awareness, as well as much needed resources, for underfunded health threats and have had a powerful impact in tackling specific diseases. However, when looked at from a human rights perspective, it is important to ensure that investment in disease-specific initiatives is matched with investment in broader health systems, including human resources and health information systems.
- Some development policies advocated by international donors may have been founded upon tried and tested long-term economic principles but, in some circumstances, have called for cut-backs in social spending, particularly in the health sector, exacerbating the already limited access the poor have to health care and treatment.
- 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 should first and foremost be the responsibility of

SOME OF THE MANY PUBLIC/ PRIVATE PARTNERSHIPS FOR HEALTH:

- Global Alliance for Vaccines & Immunizations (GAVI)
- The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)
- Stop TB Partnership (STB)
- Roll Back Malaria (RMB)
- Global Alliance to Improve Nutrition (GAIN)
- Global Polio Eradication Initiative (GPEI)
- Global Alliance for the Elimination of Lymphatic Filariasis (GAELF)
- Global Alliance for Elimination of Leprosy (GAEL)
- African Programme for Onchocerciasis Control (APOC)
- Global Guinea Worm Eradication Programme (GWEP)

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Peru: Local Health Administration Associations (CLAS)

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.

the national government to oversee and regulate the activity of any international company when the human rights of its population are at stake.

e. Developing a participatory framework within which to formulate a health strategy

Throughout this booklet, the authors continue to stress the importance of the human right to active, free and meaningful participation. The right of every individual, no matter how poor or marginalized, to participate in public affairs and to have representation in the decisions affecting them is a fundamental principle of human rights, enshrined in international law.[12]

Without the participation of the poor, national policy planners run the risk of basing their strategies and policies on incorrect assumptions and misunderstandings while overlooking opportunities that may exist to make a real difference and bring about genuine change. However, participation is not just about output and results, it is also an important process in its own right. It is a powerful tool of empowerment for those who traditionally have had little say or input into the design of policies directly affecting them and is the foundation of a lasting, cohesive and democratic society.

Managing effective participation takes time and patience. Whether it takes place at the local project level or at national policy level, it is important to stress that 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 facilitate the participation of marginalized groups or individuals for whom existing structures are not sufficient to allow for their full participation.

There are three key elements of a participatory process:

- Identifying *who* should participate.
- Developing the *mechanism* within which information and opinions can be exchanged.
- Agreeing and clarifying at the outset how the *results* will influence decisions and policy design.

Many countries design what is commonly known as a Participatory Action Plan (PAP). The exact content of a PAP varies from country to country depending upon each country's context. However, in general, most PAPs comprise the following key steps.

Review of existing structures and systems

This will include considering what experience the government has had with previous attempts at participation and the extent to which poor communities or marginalized groups have been included. It

[12] *International Covenant on Civil and Political Rights. Adopted and opened for signature, ratification and accession by General Assembly resolution 2200A (XXI) of 16 December 1966; entry into force 23 March 1976, in accordance with Article 49.* Geneva, Office of the United Nations High Commissioner for Human Rights, Article 25. http://www.unhchr.ch/html/menu3/b/a_ccpr.htm

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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 of 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.

may also consider an analysis of the country's civil society organizations and whether they are considered credible by those they claim to represent.

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 people 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.

ii *Identify the stakeholders*

Stakeholders are any individuals or groups of people who may be affected by the PRS. Most significantly that will mean the poorest of the poor and those groups identified as otherwise vulnerable to poverty and ill-health within the national context. From a human rights perspective, it is essential that no groups of individuals that are normally discriminated against or marginalized in decision-making are left out of this process. The challenge then is to find ways in which representatives can be chosen to legitimately represent these groups.

iii *Defining the purpose and scope of the consultations*

The booklet has already stressed the importance of using participation to understand the nature and extent of poverty as well as its impact on poor people's health and the underlying causes behind it. However, participation will be essential beyond the process of drafting a PRS. If designed well, participatory mechanisms are powerful tools in the budget-making process, particularly when limited resources impose the need for prioritization and trade-offs, and in monitoring and evaluating progress. Participation is a highly effective means of ensuring transparency and accountability of the government and those tasked with implementing the policy to those it is designed to benefit.

iv *Build the institutional capacity and mechanisms to manage participation*

This is frequently the most challenging part of any PAP and there is no simple formula. Country experiences vary enormously. Some coordinate issue-specific working groups from a central point in the government, others delegate 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.

v *Plan the activities, information flows and outputs*

Again, what works best for one country may not suit another. Overall the PAP should

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include face-to-face discussions in a manner and space that makes attendance feasible, acceptable and unintimidating for poor and marginalized individuals and communities. It should be accompanied by an appropriate public information strategy on the issues at stake, delivered through a medium and form that directly reach the stakeholders. Finally, it should have a genuine impact and influence on decision-making and policy formulation. Failure to do so will undermine any future efforts at participation and foster disillusionment and cynicism on the part of those whose participation is most needed.

Building a truly effective participatory process is key to the future success of any PRS as well as being a fundamental principle of human rights. However, it is not without its inherent risks. It is logistically and politically challenging and no country, rich or poor, has yet found a simple formula to undertake such work. In some cases, it may raise expectations unrealistically, in others, it may expose conflicting interests and power struggles. Obstacles will always arise along the way but taking some first steps and recognizing the importance of participation will ultimately reap long-term rewards.

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 suffered from 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 and addresses a wide range of issues from discrimination and racism, to water and sanitation at traveller sites, from increasing traveller participation in priority setting to specific health risks facing traveller mothers.

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SECTION 3
Developing the content and implementation plan

Once the process of analysing and identifying the impact that poverty is having on the health of the poor has been completed, the next challenge is to identify what activities and interventions are needed to address and ameliorate the situation. These will comprise the actual *content* of the PRS.

Any policy-maker or planner working within the MOH will be familiar with the main elements of a health policy and may well have experience in tailoring the policy specifically to meet the needs of the poor. Bringing a human rights approach to the task, however, gives the policy or strategy an *additional* dimension that extends to tackling the underlying causes, some of which may not normally fall within the remit of a health policy or be under the mandate of the MOH. It also lays out a clear scope of obligations on the part of the government that can provide a helpful framework for policy-makers on the one hand, and demonstrate a solid public commitment to human rights principles on the other.

Human rights instruments state that a government has three clear overriding duties or obligations when endeavouring to realize the human rights of its population. Using the right to health as an example and as the entry point for our analysis, the government concerned has the obligation:

- *to respect:* by refraining from any activity or policy that directly or indirectly may jeopardize an individual's capacity to enjoy the right to health;

- *to protect:* by taking measures to ensure risks to health are minimized and that no other party is able to interfere with anyone's right to health;

- *to fulfil:* by providing, facilitating and promoting all the necessary resources and systems required to meet the health needs of all individuals.

The authors of this booklet have chosen to group a selection of suggested interventions along the lines of these three areas of responsibility in the context of the right to health. However, there are many other ways of structuring a PRS and the decision will rest with the policy-maker concerned as to which offers the most appropriate and useful approach.

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ILO/Marcel Crozet

Nurse taking notes in hospital ward, India

Of course, the exact detail of the health component of each PRS will vary depending upon each country's context and specific health threats. What follows are suggestions of interventions, either directly related to health care or those that address the underlying causes of ill-health, which are likely to feature in a PRS and would be in keeping with human rights principles and standards.

Formulating the strategy through the prism of the right to health means that it should improve the availability, accessibility, acceptability and quality of all services, treatment and care for the poor. This approach is as applicable to related rights and underlying determinants, such as water, sanitation, education and information as it is to health care services.

- Firstly, all the goods, services, facilities, technology and information required to meet the health needs of the people should be *available*. This not only requires producing or procuring sufficient quantities but also ensuring appropriate geographical distribution to reach all communities.
- Secondly, everyone should have access to the available services and information. Making services *accessible* relates not only to physical accessibility for rural and urban populations alike, no matter what the local infrastructure or weather conditions, but also ensuring equal accessibility by minority groups or women or those with disabilities or illnesses. Furthermore, economic accessibility will be of particular relevance to the poor – in other words, making sure the services that are available are also affordable to all, regardless of levels of income poverty.
- Thirdly, all services and information should be a*cceptable*. Acceptability relates to particular ethical, cultural or gender sensitivities, and taboos or needs that may otherwise deter some groups or minorities from seeking health treatment or care. It also calls for a level of dignity and confidentiality to be respected in the way people are welcomed, informed and treated.
- Finally, there should be a universal level of *quality* across the services provided and the information distributed, whether for rich or poor, women or men, urban or rural. This is particularly relevant to the quality of the skills of medical staff, the scientific methods being deployed, the drugs and treatments available and the equipment used.

Keeping those four objectives in mind, below is a selection of the type of interventions a good pro-poor health policy or PRS is likely to include and which will help to respect, protect and fulfil the right to health.

a. *Respect* the right to health

Actions that reinforce respect for all individuals' right to health are primarily concerned with what *not to do* and what actions to *avoid*. A government may unwittingly be implementing policies or projects that in some way interfere with poor people's state of health or with their ability to seek medical care when needed. For example, it may be entering into

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international trade agreements that could have health implications. Many of the interventions will therefore be concerned with what actions a government should refrain from taking or permitting. Some examples may be:

- refrain from introducing policies or practices that might impede the poor from seeking medical attention such as user fees;
- refrain from any form of discrimination against any minority group or vulnerable part of society;
- do not withhold or misrepresent any important health information;
- do not enter into international commitments without considering their impact on people's ability to realize their right to health;
- ensure that industrial and household waste is handled and disposed of in a way that does not harm the health of either workers or local communities;
- do not prohibit or impede the use of safe traditional care and medicines;
- do not market or distribute unsafe drugs;
- do not impose coercive medical treatment.

b. *Protect* the right to health

This subsection focuses on measures and actions a government should take to prevent any harm to the health of any member of the population being caused, either by the actions of others or by the effects of avoidable environmental factors.

There are frequently many non-state actors, such as private health care providers, or transnational corporations, whose policies and activities may be directly concerned with the health of the poor. Some may well be doing good work with positive outcomes, others may not have the health of the poor as their highest priority. It is the obligation of the government to ensure that no individual's rights are violated in any way by any discriminatory behaviour or undue damage they may be causing. The following are some ways in which a government can intervene to protect the rights of its population.

i *Ensure oversight and regulation of the conduct of non-state actors, including:*

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

ii *Introduce legislation, standards, regulations and guidelines to:*

- protect workers;
- protect consumers;
- protect the environment.

iii *Control and regulate:*

- the marketing or distribution of substances that harm health such as tobacco, alcohol or some food groups;
- some traditional practices or treatments known to be harmful to health.

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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 than to attend 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.

c. *Fulfil* the right to health

This subsection is concerned with what governments should *do* – the steps they can take to provide, implement and facilitate the use of appropriate health services, as well as other services essential for good health.

The details of this part of the strategy should be guided by an analysis of the nature of poverty-related health needs in the country, as described in the previous section, together with good practice in public health. This information should help to inform what actions the government will take and what additions or improvements will be needed. Some examples of appropriate interventions could be:

i *Health facilities, goods and services*

- Maternal, child and reproductive health services, including the provision of services and information regarding family planning, pre- and post-natal care, and emergency obstetric services.
- Accident and emergency services for injuries, epidemics and natural disasters.
- Immunization and vaccination programmes.
- Well equipped and staffed district hospitals and local clinics.
- Facilities, equipment and medicines to treat illnesses and injuries at the local level.
- Trained health workers and support personnel on call to reach outlying villages and communities.
- Sufficient stocks of essential medicines and appropriate storage facilities.
- Surveillance and screening systems to detect and respond to disease outbreaks and epidemics.

ii *Health-related education and information*

- Information and education on sexual and reproductive health and on the health risks attached to modes of transmission and methods of prevention of sexually-transmitted diseases such as HIV/AIDS.
- Information and education that address the social determinants of health and promote safety.
- Training, professional information and awareness-raising of human rights, such as the prohibition of discrimination, for health care staff and ancillary workers.
- Information for those in need of health care of the choices of services available and the possibilities for exemption or reduction of user fees and other out-of-pocket expenses.

iii *Related services*

- 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).

iv *Examples of broader social determinants*

- Equality between women and men to own and inherit property.

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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 healthcare 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.

- Equality between women and men in access to employment and working conditions.
- The right of every child to an identity (birth registration).
- The right of every child to free primary education.
- Freedom from neglect, exploitation and abuse, including in the labour market and in the domestic sphere.

d. Challenges and tensions

Human rights principles can be powerful tools in helping to shape the main elements of a PRS and in helping to foster cohesion between the policies of different ministries and across different sectors. However, they do not hold all the answers and inevitably, dilemmas and tensions will arise.

No matter how thorough the process of identifying the health needs of the poor and vulnerable has been or how effectively these are addressed in the content of a pro-poor strategy, every policy-maker or planner is conscious of the limited amount of resources available and the necessity of making stark choices between what is affordable and what is not. Human rights principles can give some guidance and help in this context.

Prioritizing the needs

Human rights instruments were drafted with the full knowledge and understanding of the reality of resource constraints facing all governments, especially those in the poorest countries. They realize and respect the fact that it would be virtually impossible for any government to comply with all its obligations under the right to health immediately or even in the short or medium term.

It was agreed therefore that human rights obligations should fall under one of two categories:

- those requiring *immediate obligation*;
- 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;

TUBERCULOSIS AMONG PRISONERS – Overcoming discrimination, exclusion and vulnerability

Evidence shows that 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 post-release 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.

● drafting and implementation of a plan or strategy that clearly maps out how to make progress towards the realization of all obligations (short, medium and long term).

It is very likely that a thorough and extensive participatory process will unearth a wide range of urgent and sometimes conflicting needs. At the same time, it is very unlikely that sufficient resources will be available for any government to address all these needs and it is therefore inevitable that some degree of prioritization, selection and trade-offs will be needed. The human rights principle of *progressive realization* recognizes that in the short and medium term, policy choices such as these will have to be made. It does not, however, allow for a government to postpone its obligations indefinitely. It calls instead for a clear, demonstrable plan that includes 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.

ii *Targeting and positive discrimination*

Another potential dilemma facing policy-makers concerns the human rights principles of equality and nondiscrimination and the need to target and focus efforts on particularly vulnerable groups whose health status falls considerably below national averages. Targeting the poorest and most vulnerable, as a priority, is consistent with international human rights standards and often constitutes the only practical way of redressing inequalities. In fact, a human rights-based approach advocates that any strategy should start by addressing the most serious, the most persistent and chronic and the most widespread violations and neglect of human rights.

In order to do this, in the short term, a degree of positive discrimination (or "affirmative action") that specifically targets particularly vulnerable groups may be needed. This may entail for example: 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 poor or vulnerable groups; or investing heavily in improving services such as water and sanitation in areas identified as being particularly lacking.

iii *Costing, budgets and financing*

Estimating the costs that will be incurred, preparing an appropriate budget or expenditure framework and then mobilizing the necessary resources is a highly complex technical and political process. Human

Cambodia: Phnom Penh's Urban Health Project

Many of Phnom Penh's poor live in illegal squatter areas with no access to basic services such as safe water or sanitation. They are unable to access official exemption schemes to enable them to access fee-paying health centres so many rely on illegal drugs suppliers or go heavily into debt whenever they need medical treatment. The Urban Health Project was launched. Two "health rooms" were established to provide free primary and preventive care and referrals to hospitals. The Project also manages an equity fund which covers 70% of hospital fees. The services are now accessed 10 times more than normal health centres and the services and use of funds are overseen by a "user group".

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Mexico: Analysing the budget

The Mexican NGO Fundar has undertaken some pioneering work in developing a methodology with which to analyse national budgets. The Mexican budget was examined to see how well it reflects the Government's human rights obligations and, in particular, the main components of the right to health. Results showed that not only was the MOH failing to spend its full allocation but that areas with a high proportion of marginalized people were in fact receiving fewer per capita resources for maternal care and immunizations, than average. Moreover, very little funding was being allocated to the infrastructure needed for remote communities to access health centres. In short, the budget revealed a failure to meet obligations of progressive realization within the maximum available resources, nondiscrimination and ensuring that health services are not only available, but also accessible.

rights instruments have no easy solutions to guide this process. What they can bring, though, are the key principles of nondiscrimination, equality, participation, transparency and accountability to bear at each stage, from the initial costing exercise through to budget allocation and mechanisms for raising required resources. They also provide powerful arguments to justify levels of expenditure and requested resources in favour of health, given that health is a human right, as opposed to some other government expenditures (e.g. defence).

(a) Costing the strategy

Undertaking a successful and accurate costing exercise requires skill, expertise and sound judgement. There are various different models and methodologies for costing and health planners should select the one that best suits their needs. They should consider not just the costs involved in the delivery of the intervention itself but also the systemic constraints that have led to inconsistent service provision in the past. It should be borne in mind that the costs of improving the availability and accessibility of quality health care to the poor may be significantly higher than to wealthier groups. The costs of *reaching* the poor in remote rural areas, with severe infrastructure constraints that have suffered decades of underinvestment in the local delivery systems, will inevitably be much higher than reaching well-serviced areas.

In addition, costing efforts will prove far more relevant and useful if they can be easily be mapped onto budgets which tend to be structured along spending levels by districts or regions.

Naturally, financial planners will strive for the greatest level of cost efficiency possible to utilize the limited available resources to the maximum possible effect. However, financing health services and related interventions for the very poor is rarely cost efficient in the short term. The moral and legal imperative of human rights may well be the only rationale a financial planner can draw on to justify the necessary expenditure.

(b) Drawing up the budget

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 MOH, 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 rests 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 not eliminate these conflicts entirely but will go a long way towards reconciling the key players and fostering understanding and ownership of the decisions made and the final budget approved.

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WHO/WPRO/Image Bank/Seppo Suomela

Nurse with mother and baby in mobile clinic, Samoa

Good development practice advocates strongly that the PRS budget should reflect national health and development priorities to avoid creating parallel processes to ensure coherence across the government. In addition, it is strongly recommended that annually-based budgets should relate to, if not be completely subsumed within a Medium Term Expenditure Framework (MTEF), that typically extends over three or more years. By looking at spending priorities over a multi-year period, MTEFs can facilitate the process of shifting resources from one area to another.

(c) Raising the resources

Resources to pay for the costs identified in providing health services, treatment and care can come from a variety of sources, including:

- Nationally-raised resources such as progressive 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.
- Private sector funding for services delivered by non-state actors such as private companies or NGOs.
- Public/private partnerships that focus on tackling single diseases or interventions.
- 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.

The country context will inevitably determine which sources are likely to be most viable and sustainable. What human rights principles do stress, however, is the responsibility of the government to ensure that resources are made available to the benefit of *all* on a *nondiscriminatory* basis and with priority to the most vulnerable and neglected segments of the population. Some form of oversight and regulation to *protect* the human rights of all individuals from interference by third-party financers is also required. In practical terms, thorough impact assessments to fully understand the

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China: Village Cooperative Medical Schemes (CMS)

Some rural villages in China now run minimal prepayment schemes to access village health services and to pay for immunizations and drugs prescriptions replacing traditional fee-for-service systems. The introduction of CMS has resulted in greater transparency and accountability of village health workers and better distribution of medicines. In addition, the schemes have resulted in useful record keeping of health data and information.

effect of proposed financing methods on the most vulnerable and poor will be required.

Many health systems in developing countries have tended to rely on some form of user fees to be paid by those seeking treatment from hospitals or health care centres. It should be noted, however, that evidence now suggests that user fees raise only very small levels of resources and are an unreliable form of financing in the long term. More importantly, from a human rights perspective, impact assessments of user fees have shown them to be a significant impediment to poor people being able to access health services. Exemption schemes or waivers, that would therefore be necessary, are often difficult to implement and manage effectively.

iv *Ensuring financial transparency and accountability*

Accountability and transparency in financial and expenditure management are not only key human rights principles, they are also basic principles of good governance and are essential in countering corruption and waste.

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 and efficiently.

Section 4 delves further into the challenges associated with monitoring and evaluation in general. It also considers how best to foster a climate of greater transparency and accountability of the government, as well as those tasked with implementing its policies, to the people.

e. International commitment and responsibilities

While human rights principles place the primary responsibility for the realization of a population's human rights with the national government, it is evident that a country does not and cannot conduct its affairs in isolation from the wider international environment. Many middle- and low-income countries may well be dependent upon the financial and technical support of donor partners to implement their PRSs.

i *A shared responsibility*

Human rights instruments recognize the importance of international assistance and cooperation alongside the steps that states should take individually. 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.

At the Millennium Summit in 2000, the Doha Ministerial Declaration issued at the 4th WTO 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

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

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."

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.

Donors including Denmark, Luxembourg, Norway, the Netherlands and Sweden are meeting their commitment to provide 0.7% of Gross National Income in aid. Others, including France, Ireland and the United Kingdom have pledged to meet the 0.7 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.

ii *The principles of good "donorship"*

Together with the attention directed at increasing aid flows, there is much discussion on maximizing aid *effectiveness* and improving the way government donors conduct and implement their aid programmes. Human rights norms and standards are rarely applied to international cooperation although they are as useful at the international level as they are to domestic poverty reduction initiatives and reinforce many of the principles now emerging as good "donorship".

- 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 from both a human rights perspective and for the long-term sustainability of the strategy itself. In some cases, donors have been tempted to repackage their existing development cooperation programmes rather than to respect the integrity of the national PRS.

Predictability of resource flows is a key issue; it allows governments to plan the use of aid over the long term. Some short-term interventions, such as funding for salaries or for time-limited health interventions, may even undermine long-term national capacity. 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 coherence in aid policy as governments change. Denmark is one country to have done this.

- The right to participation is recognized throughout the PRS process and is

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reaffirmed in many donor policies. In practice, however, it is essential 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 tax payers and to the recipient government but also to the very people for whom the aid programme is designed, the poor and the vulnerable.
- Donors should ensure that they too are incorporating human rights-based principles in their development cooperation programmes, particularly in the context 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 arise when different donors provide advice and support to a country. This often manifests itself in a substantial overload on the national government of reporting or evaluation requirements. This not only consumes scarce human and financial resources but can seriously undermine the principle of national ownership.

Donor overload?

In one developing country in 2003, donors fielded approximately 400 separate missions. Seven donors accounted for 75% of the total number of missions. Only 2% of all the missions were undertaken jointly and involved only three of the 15 donors who visited in that year. These statistics are not atypical and reflect practices common in most developing countries with active PRS processes.
Source: OECD/DAC

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 (CPRGS). 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% 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 CPRGS, 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.

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Canada: Act to export generic drugs

In May 2004, Canada passed new legislation to allow compulsory licences to be issued to Canadian manufacturers of generic-patented drugs for export to some particularly poor 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.

WHO/Eric Miller

Woman with HIV/AIDS receiving antiretrovirals, Gaborone, Botswana

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.

Beyond human rights responsibilities in the context of development cooperation, 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.

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SECTION 4

Implementation: transparency and accountability through monitoring and evaluation

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

Implementation inevitably requires adjustments. These may be at the level of budget allocations or in administrative policies and practices. It may also require institutional reform and reorganization at different levels from the central government down to the service providers and local authorities. Any changes in any country require political will and institutional effort and commitment; these can sometimes be hard to muster. It is necessary therefore that a "road map" for monitoring and evaluation is included in the PRS – not only to judge how well the strategy is performing and the impact it is having but also to hold to account those tasked with its implementation.

Monitoring and evaluation can have other additional benefits. It can help determine what areas need greater attention, or what further institutional or systemic changes may be needed; it is an effective way of publicizing good work and success, and it can provide justification for additional resources or budgets.

Most public health officials and policy-makers will be familiar with the challenges inherent in monitoring improvements in health outcomes such as collecting data on maternal mortality rates. Monitoring progress in poverty reduction presents additional logistic as well as conceptual challenges but has nevertheless become a standard feature of any PRS. Monitoring improvements in the health of the poor, from a *human rights* perspective, calls for a new approach in terms of *what* is monitored, *how* it is monitored and for *what* purpose. The conventional public health approach and the human rights approach are equally valid and one should not cancel out the need for the other. They should instead be seen as complementary and mutually reinforcing. Similarly, monitoring poverty reduction through the prism of human rights can bring an added rigour to the task at hand by taking it beyond the conventional practice of recording improvements in averages.

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Monitoring should take place throughout the entire application of the strategy. It requires careful planning at the outset in order to fulfil its purpose effectively.

Some key questions to ask when designing a monitoring mechanism should include:

- What poverty and health data will be used as indicators to measure progress and how will this information be collected?
- What targets or benchmarks can be signalled along the way, against which progress can be judged?
- Who will be engaged in the collection of data and the analysis of progress?
- How will the results be used?
- What mechanisms for remedy or redress are possible and are they sufficient?

Answering such questions helps to identify the essential elements of any monitoring system. However, from a human rights perspective, it is crucial that data, indicators and targets are *disaggregated* as far as possible to represent vulnerable population groups, that the poor *participate* in the monitoring process at all stages, and that they can *access* a means of redress if those responsible act negligently.

a. Promoting the strategy

One of the most crucial and yet often overlooked steps in any successful monitoring system is to announce at the outset what the government is proposing to do and what it is hoping to achieve. All too often, PRSs are known only to a small circle of government officials. Publicizing and disseminating the strategy in an *understandable* and *informative* format for the general public, and most importantly the poorest sections of society for whom it is designed, is a very simple yet effective way of demonstrating that the government is committed to addressing the needs of the poor and is a crucial first step in any monitoring process. It is also one way of fulfilling everyone's human rights to information and to participation.

b. What should be monitored?

There is no standard checklist of what should be monitored in either the health sector or in poverty reduction. It will be down to each national government to select what best suits the country and is relevant and feasible in the particular circumstances. The right to health refers explicitly to a number of steps to be taken to achieve the full realization of this right, including reducing infant mortality, preventing and treating diseases, improving environmental conditions, and ensuring the availability of health services. Freedom from discrimination, attention to vulnerable population groups, and rights to participation and information all constitute cross-cutting principles integral to a human rights-based approach.

In practice, therefore, monitoring should try to answer the following questions:

- Has discrimination on the prohibited grounds outlined in human rights law been eradicated at all levels of the health system?

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 Kiswahili. 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, as well as 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 on-line at www.hakikazi.org/eng

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- Are the poor and vulnerable able to participate in making decisions and choices about what health care they receive?
- Are health services becoming more available, accessible and acceptable to the poor and vulnerable?
- Is the quality of the service consistent throughout the country?
- Are levels of resources being spent on health care proportionate to the needs and commensurate with the overall budget available?
- Are related human rights, including rights to information, safe water, housing and sanitation, being addressed as part of the health policy?

SOUTH AFRICA: the Children's Budget Unit (CBU)

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 CBU in 1995 to monitor the extent to which the Government's human rights commitments were being reflected in its budgets. The CBU 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.

- Is the health of all people better protected from the damaging effects of either environmental factors or the behaviour of others?
- Is the health impact of government policies in other sectors now considered and taken into account on a regular basis?

c. Who should be monitored?

Any organizations or individuals responsible for, or capable of, determining how all or a part of the health component of the PRS is implemented, from the national and international level down to the household, should be monitored and evaluated and, ultimately, should be held accountable for the way in which they have delivered on their promises.

This may include:

- government departments or ministries;
- politicians;
- local authorities;
- health care providers;
- private sector actors providing services or medicines;
- community leaders;
- heads of households;
- international development cooperation partners.

d. Who should do the monitoring?

When considering what bodies or institutions could perform monitoring, one should take into account those already doing such work and that would be ready and willing to undertake such a task before seeking to

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 disadvantaged 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.

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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 improvements.

establish new ones. As monitoring will need to take place at several different levels, it will be necessary to find mechanisms at different levels. It matters less whether monitoring is undertaken by an official or by a non-official body, such as a civil society organization, than that it should be recognized by the government as competent in this task and that its findings will be treated as credible and legitimate. Equally it is essential, from a human rights perspective, that the views of the poor and vulnerable are not only taken into consideration but are treated as central to the process.

The kinds of entities often engaged in monitoring activities at various levels include:

- 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;
- private companies;
- community or village groups.

e. What indicators should be used?

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 set-backs. They can focus on process or outcome and may be quantitative or qualitative. In the health sector, they frequently include data such as mortality and morbidity rates, numbers of doctors available in the country and vaccination coverage rates.

There is considerable ongoing debate about which indicators could effectively monitor progress in the *progressive realization of human rights*, such as the right to health and associated rights. The authors of this booklet have decided not to repeat here the many suggestions currently being mooted and have chosen instead to list the general types of indicator that a human rights-based PRS should try to include. As stressed earlier, a commitment to human rights implies the greatest level of disaggregation.

The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health has proposed three distinct categories of indicator: structural, process and outcome. Together they can build a picture of the extent to which the government is respecting, protecting and fulfilling the right to health and other associated human rights. Below

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, 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 changes in policies or laws that are needed. Candidates are chosen for their professional expertise as well as their proven commitment to human rights principles such as equality and nondiscrimination.

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are some suggestions of the kind of indicators that would fall under these three headings:

i *Structural indicators*

- What legislation, regulation or codes of conduct have been introduced to address discrimination and other damaging practices?
- Have internal oversight mechanisms been put in place?
- Have any plans, policies or strategies been drafted and agreed?
- Can the poor and vulnerable participate effectively in decision-making and do they have a role in monitoring and evaluating?
- Has information about people's rights in the health system been disseminated?

ii *Process indicators*

- Have changes been made within the health service in the way staff are recruited and undertake their duties?
- Are poor people using the services more frequently?
- What additional prevention or immunization programmes are under way and are they effectively reaching the poor?
- What proportion of the population has access to affordable essential drugs when needed and on a sustained basis?
- To what extent have water and sanitation services improved?

iii *Outcome indicators*

The health indicators listed under the MDGs serve as a useful centre-piece around which to elaborate outcome indicators:

- What is the prevalence of underweight children under five years of age?
- What proportion of the population survives on a dietary energy consumption below the minimum level?
- What is the under-five mortality rate?
- What is the infant mortality rate?
- What proportion of one-year-old children is immunized against measles?
- What is the maternal mortality rate?
- What proportion of births is attended by skilled health personnel?
- What is the HIV-prevalence rate among pregnant women aged 15-24?
- How widely used are condoms as contraceptives?
- How many children have been orphaned by HIV/AIDS?
- What is the prevalence and death rate associated with malaria?
- What proportion of those living in

WHO/Philippe Blanc

Food distribution in Maslakh Camp, Herat, Afghanistan

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malaria-risk areas is using prevention and treatment measures?

- What is the prevalence and death rate of TB?
- What proportion of tuberculosis cases is being detected and cured under Directly Observed Treatment Short-course (DOTS)?
- Has there been a reduction in accidents or injuries from occupational or environmental factors?

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.

f. What targets should be set?

Targets, or benchmarks as they are sometimes called, are an important partner to indicators. They represent the progress the country would ideally like to have made in the medium and long term. Without benchmarks, momentum can easily be lost over time, and efforts and resources distracted by other concerns that may emerge.

Benchmarks should not be set unrealistically high, but neither should they be set too low to allow complacency to set in. They should present a challenge that with sufficient levels of commitment, diligence 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. These interim benchmarks are equally as important as it is only when indicators are measured against them that it is possible to ascertain whether the right levels of progress are being made in all areas or whether there are some areas that are slipping dangerously behind and are in urgent need of 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.

A government may well wish to set its own targets and benchmarks. It is worth recalling and including 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.

Goals and targets endorsed by governments

- MDGs: These eight goals are aimed at encapsulating the many and wide-ranging

WHO/James Mollison

Patient undergoing lung x-ray in Xingyi TB dispensary, China

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commitments made by governments at the United Nations conferences of the 1990s. Although not exhaustive, they are mobilizing efforts and activities by both national governments and the international community to an unprecedented level. Health outcomes and the underlying determinants of health for the poor feature prominently in the MDGs, but other targets of specific relevance to the national context will most likely be needed, such as health threats from injuries, noncommunicable diseases or environmental factors, or targets related to strengthening health systems in general.

- The United Nations International Conference on Population and Development (ICPD): the conference held in Cairo in 1994 and then five years later in 1999 set out many detailed targets of specific relevance to reproductive health and human rights, as well as health targets of a more general nature applicable to developing countries and the international community alike.
- Resolutions made at World Health Assemblies will also prove relevant for countries in defining what health targets to include in the PRS.

Referring to the 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.

Benchmarks 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. From a human rights perspective, however, it is essential to ensure that efforts towards reaching whole populations, and in particular poor and vulnerable groups that are traditionally most difficult to reach, do not become subordinate to the goal of meeting an interim target.

Some of the many "disease-specific health targets" are:

- "3 by 5", the global target to get three million people living with HIV/AIDS in developing and middle-income countries on antiretroviral treatment by the end of 2005;
- Detect 70% of new infections of tuberculosis and cure 85% of those detected by 2005;
- Halve the burden of malaria by 2010;
- Vaccinate all people in all countries against hepatitis B by 2007;
- By 2005, 80% of developing countries should have systematic immunization against measles and diphtheria-tetanus-pertussis in at least 80% of districts.

Brazil

With help from 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.

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g. Collecting the data

Gathering sufficient information and statistics is an important process throughout the implementation of the PRS. Reliable disaggregated data will firstly enable a thorough poverty and health analysis that will determine the strategy to be undertaken and secondly, provide relevant disaggregated indicators that, over time, can evaluate progress against the benchmarks and targets set.

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 insurmountable problems.

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;
- remain independent and trustworthy.

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:

- 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.

h. Holding to account

Accountability is an important part in any monitoring system and is a fundamental principle of human rights. It plays a key role in empowering poor people to challenge the status quo, without which poverty reduction is unlikely to succeed.

It provides an opportunity to explain why progress has not been as rapid as promised

Bolivia: Community health information system

Traditionally, health information has been gathered nationally from health facilities but has often missed very poor remote rural communities that do not use the facilities. The community system was designed to complement the national system and records information from the communities themselves such as births, deaths, pregnancies and illness. The data is presented in graph and map form for all community members and trends are discussed to determine needs. Results indicate much greater take-up rate of services such as birth attendants and child immunizations

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WHO/WPRO/Image Bank/Seppo Suomela

Father and children, Mongolia

and a chance for all parties to understand the constraints or changes of circumstances that may have impeded progress.

There are a variety of mechanisms that provide some form of accountability and some also include a system of redress or remedy. They include:

Judicial: National and regional courts have for many years been mechanisms through which human rights violations are addressed. National legislative measures can play a powerful role, not only in seeking accountability and redress for the case concerned, but in bringing about change in national legislature to protect the rights of others in the future. National measures should always be exhausted before turning to regional legislation. Alternatively, other non-judicial options also exist.

National human rights institutions: 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". Another less common but no less important variety are the "specialized" national institutions that function to protect the rights of a particular population group such as ethnic and linguistic minorities, indigenous populations, children, refugees or women. All national institutions are responsible for promoting awareness of human rights and many for receiving complaints from individuals about violations of their rights. "The Paris Principles", adopted by the General Assembly in its resolution A/RES/48/134 of 20 December 1993, give guidance on the role, composition, status and functions of national human rights institutions.

Administrative systems: Some health services have established systems, within or independent from the service, that can receive complaints and manage redress. These may be informal customer-service mechanisms or official government-sanctioned watchdogs.

Nongovernmental and unofficial: Many international and national NGOs are actively monitoring and publicizing their findings on the way health services and governments are

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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.

fulfilling their duties towards realizing the right to health of their populations. In addition, local and national media and civil society organizations can play an essential role in ensuring transparency and accountability.

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 crossparty committees that can be empowered to undertake impartial reviews of government activities and ensure they are implemented in line with their commitments.

International bodies: There are seven human rights treaty bodies that monitor 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, they consider the reports that states are periodically required to submit and that outline 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 on a state to change policies or practices to improve the human rights.

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SECTION 5

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

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.unhchr.ch/udhr/index.htm
- International Convention on the Elimination of All Forms of Racial Discrimination, 1965
  www.ohchr.org/english/law/cerd.htm
- International Covenant on Economic, Social and Cultural Rights, 1966
  www.ohchr.org/english/law/cescr.htm
- International Covenant on Civil and Political Rights, 1966
  www.ohchr.org/english/law/ccpr.htm
- Convention on the Elimination of All Forms of Discrimination against Women, 1979
  www.ohchr.org/english/law/cedaw.htm
- Declaration on the Right to Development, 1986
  www.ohchr.org/english/law/rtd.htm
- Convention on the Rights of the Child, 1989
  www.ohchr.org/english/law/crc.htm
- International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, 1990
  www.ohchr.org/english/law/cmw.htm
- Vienna Declaration and Programme of Action, 1993
  www.ohchr.org/english/law/vienna.htm

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

Relevant basic texts and resolutions of WHO

- Constitution of the World Health Organization, 1948
  http://policy.who.int/cgibin/om_isapi.dll?hitsperheading=on&infobase=basicdoc&jump=Constitution&softpage=Document42#JUMPDEST_Constitution
- Declaration of Alma-Ata, International Conference on Primary Health Care, 1978
  www.who.int/hpr/NPH/docs/declaration_almaata.pdf

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Examples of relevant United Nations conference documents

- Copenhagen Declaration on Social Development and Programme of Action of the World Summit for Social Development, 1995 and 2000
  www.un.org/esa/socdev/wssd/agreements/
- United Nations Millennium Declaration. General Assembly resolution 55/2 of 8 September 2000
  www.ohchr.org/english/law/millennium.htm
- Health in the Millennium Development Goals chart
  www.who.int/mdg/goals/en/
- Declaration of Commitment on HIV/AIDS. Special Session of the UN General Assembly on AIDS, 2001. Adopted by General Assembly resolution S-26/2 of 27 June 2001
  www.ohchr.org/english/law/hiv.htm
- Monterrey Consensus of the International Conference on Financing for Development, Monterrey, Mexico, 18-22 March 2002
  www.un.org/esa/ffd/aconf198-11.pdf
- Johannesburg Declaration on Sustainable Development and Plan of Implementation of the World Summit for Sustainable Development, 2002
  www.un.org/esa/sustdev/documents/WSSD_POI_PD/English/POI_PD.htm

Relevant documents of the World Trade Organization

- 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/english/thewto_e/minist_e/min01_e/mindecl_e.htm
- Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) signed in Marrakesh, Morocco, 15 April 1994
  www.wto.org/english/docs_e/legal_e/27-trips_01_e.htm

Regional human rights instruments

- American Convention on Human Rights, 1969
  www.hrcr.org/docs/American_Convention/oashr.html
- African Charter on Human Rights and Peoples' Rights, 1981
  www.hrcr.org/docs/Banjul/afrhr.html
- European Convention on Human Rights, 1950
  www.hrcr.org/docs/Eur_Convention/euroconv.html

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). In: *Twenty-second session, Geneva, 25 April–12 May 2000*. Brooklyn, NY, Center for Economic and Social Rights (E/C.12/2000/4, CESCR),

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11 August 2000, paras. 18-29
www.hri.ca/fortherecord2000/documentation/tbodies/e-c12-2000-4.htm

- Jonsson, Urban. *Human rights approach to development programming*. Eastern and Southern Africa Regional Office. United Nations Children's Fund, 2003.
- Commission on Macroeconomics and Health. *Macroeconomics and health: investing in health for economic development*. Geneva, World Health Organization, 2001 www.cid.harvard.edu/cidcmh/CMHReport.pdf
- *Poverty and health*. DAC Guidelines and Reference Series. Geneva, World Health Organization/Paris, Organisation for Economic Co-operation and Development, 2002 http://whqlibdoc.who.int/publications/2003/9241562366.pdf
- *What's behind the budget? Politics, rights and accountability in the budget process.* Overseas Development Institute, 2002 http://www.odi.org.uk/pppg/publications/books/budget.html
- *Poverty reduction and human rights: a practice note.* United Nations Development Programme, June 2003 http://www.undp.org/poverty/
- *Draft guidelines: a human rights approach to poverty reduction strategies.* Office of the United Nations High Commissioner for Human Rights, 2002 http://www.unhchr.ch/development/povertyfinal.html
- *Human rights and poverty reduction: a conceptual framework.* Office of the United Nations High Commissioner for Human Rights, 2004 http://www.unhchr.ch/html/menu6/2/povertyE.pdf
- 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) http://www.unhchr.ch/huridocda/huridoca.nsf/(Symbol)/E.CN.4.2001.56.EN?Opendocument
- *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, World Health 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

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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

- *The right to health.* Geneva, World Health Organization, 2002
http://www.who.int/hhr/activities/publications/en/
www.who.int/hhr/news/en/cartoon_health.pdf
- *HIV/AIDS: stand up for human right.* Geneva, World Health Organization, 2003
http://www.who.int/hhr/activities/publications/en/
www.who.int/hhr/news/en/cartoonenglish.pdf
- *Meeting report: consultation on indicators for the right to health, Château de Penthes, Geneva, 15 May 2003.* Geneva, World Health Organization, January 2004
www.who.int/hhr/activities/en/indicator%20reportFINALnopartlst.pdf
- *Meeting report: consultation on indicators for the right to health, Château de Penthes, Geneva, 1-2 April 2004.* Geneva, World Health Organization, December 2004
www.who.int/hhr/activities/en/Report%20indicatorsmtg04%20FINAL.pdf

Selection of organizations addressing human rights, health and poverty reduction

- CARE www.careinternational.org.uk
- Centre 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
- Office of the United Nations High Commissioner for Human Rights, Asia-Pacific Regional Office www.un.or.th/ohchr/issues/rba/rbaMain.html
- Oxfam 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
www.who.int/hdp/en/
www.who.int/hhr/en

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This booklet is intended as a tool for health policy-makers 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.

During this critical year – 2005 – only 10 years away from the target date for the Millennium Development Goals (MDGs), WHO plans to support countries in their efforts to operationalize a human rights-based approach in relation to poverty reduction strategies. This experience will serve to enrich the contents of the booklet further. We hope to issue it as a final publication in the WHO Health & Human Rights Publication Series early in 2006 and to disseminate it widely.

The booklet is a joint document of the Departments of MDGs, Health and Development Policy and Ethics, Trade, Human Rights and Health Law.

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