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HRBA AND HEALTH

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A Human Rights Based Approach to Health

Purpose and framework

The purpose of this brief is to provide guidance to staff on how to apply a human rights based approach to health, on health related programmes and policies.

A HRBA to health aims to realise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (right to health) and other health-related human rights. A HRBA makes explicit reference to human rights from the onset of programmes, policies, and projects, as a way to prevent violations from happening in the first place. As such, the introduction of a HRBA to health is about approaches and processes as well as maximum public health gains.

Evidence indicate that applying a HRBA will contribute to improving maternal and child health, by improving access and the quality of services, as well as collaboration with other sectors. Where a HRBA to health has been applied, it has contributed to significant reduction in maternal and child morbidity and mortality (Women's and Children's health: Evidence of Impact of Human Rights, WHO 2013). There is also evidence that applying a HRBA will improve quality of mental health services.

Most donors have developed methods and guidelines for practical application of HRBA. In Sweden the interpretation of a HRBA has been elaborated in the Policy for Global Development (PGD) and the government's Aid Policy Framework (section 3.2.2.). In short, applying a human rights based approach entails:

- Assessing how the initiative will further the realisation of human rights as laid down in the UN Treaties and internationally agreed standards, identifying and addressing underlying causes to non-fulfilment.
- Planning and monitoring how the values and principles underpinning these UN Conventions (non-discrimination, participation, accountability and transparency) are applied in the programme design and processes.
- Empowering men, women, youth, girls and boys (with hope, assertiveness, knowledge, skills, tools, communication channels, legal mechanisms, etc.) to enable them to address their situation and claim their rights individually and collectively
- Developing capacities of those who have power and formal obligations to protect, respect and fulfil human rights obligations.

The right to health in all its forms and at all levels contains the following interrelated and essential elements, ***availability, accessibility, acceptability and quality*** (AAAQ) – as explained below – the precise application of which will depend on the conditions prevailing in a particular State party. When assessing health initiatives, both the four key elements and the four HRBA principles need to

be considered. As such, a HRBA to health encompass AAAQ and non-discrimination, participation, accountability and transparency.

Sweden has a global strategy on “Socially sustainable development” 2014-2017, which includes directions and result expectations within the areas of health and education. In the area of health, the strategy has three focus areas;

- survival and healthier lives (including child and maternity health, strengthened health systems and reduced health hazards),
- better access to sexual and reproductive health and rights, and
- better access to safe water and sanitation.

In terms of normative guidelines, the Swedish strategy refers to WHO tools. Some of the most relevant to this brief are: The WHO brief on HRBA to health, UN Special Rapporteur on the Right to Health, WHO, Health and Human Rights web portal and the monitoring body of ICESCR (International Covenant on Economic, Social and Cultural Rights).

The right to health

The right to health is an abbreviation of the ‘enjoyment of everyone to the highest attainable standard of physical and mental health’. The right to health is not a right to be healthy: it is a right to facilities, goods, services and conditions that are conductive to the realisation of the right to health, such as, gender, water, sanitation, education. At the heart of the right to health is a functioning health system, accessible to all without discrimination.

The right to health was first recognised in the Constitution of the World Health Organisation (1946). Since then it has been protected in a number of treaties that spell out the rights of women, children and persons with disabilities, although the International Covenant on Economic, Social and Cultural Rights (ICESCR), seen as the core treaty on the right to health. It is also found in regional human rights treaties, such as the African Charter on Human and Peoples´ Rights, European Social Charter and the American Convention on Human Rights.

The right to health is a progressive right, implying that a State has to step by step improve the health of its populations, especially for those who presently have the least access to services (principle of non-discrimination). It also implies that more is expected of a rich country, such as Sweden than of a resource poor country. Although the right to health is a progressive right, some rights are of immediate effect and, irrespective of resource level of the country, needs to be in place immediately (referred to as core obligations).

The UN Committee on Economic, Social and Cultural Rights (CESCR), is a body of independent experts, which monitors the implementation of the ICESCR. Year 2000 they adopted the General Comment 14 on the right to health. This document sets out the Committee’s interpretation of this human right. Further, since 2002, a UN Special Rapporteur on the Right to Health has been appointed to e.g. further clarify the contour and content of the right to health, monitor its realisation and take complaints.

In its General Comment No. 14 of 2000, the Committee has defined core obligations and priority areas of the state. These apply to all countries irrespective of income level and should be carried out first:

> a) To ensure the right of access to essential primary health care facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalised groups;
>
> b) To ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone;
>
> c) To ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water;
>
> d) To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs;
>
> *e)* To ensure equitable distribution of all health facilities, goods and services; States have a special obligation to provide those who do not have sufficient means with the necessary health insurance and health-care facilities.
>
> *f)* To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised on the basis of a participatory and transparent process; they shall include health indicators and benchmarks, by which progress can be closely monitored and give particular attention to all vulnerable or marginalised groups.
>
> *General Comment 14, Priority areas*

The Committee has also pointed on some obligations that have very high priority:

> a) To ensure reproductive, maternal (pre-natal as well as post-natal) and child health care;
>
> b) To provide immunisation against the major infectious diseases occurring in the community
>
> c) To take measures to prevent, treat and control epidemic and endemic diseases ;
>
> d) To provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them ;
>
> e) To provide appropriate training for health personnel, including education on health and human rights.

With this in mind, the right to health makes a number of demands on health system, a health plan and respect for primary health care and reproductive health services. General comment 14 outlines the following essential elements of the right to health:

Availability (A)

Functioning public health-care facilities, goods, services and programmes are available in sufficient quantity within the State party. The nature of the facilities services will vary depending on numerous factors, including the State party's developmental level. They will include, however, the underlying determinants of health, such as safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs, as defined by the WHO Action Programme on Essential Drugs.

Accessibility (A)

Accessibility of health facilities and services for all, without discrimination: physically accessible and in safe reach for all, including women and girls, and disadvantaged persons (for example persons with disabilities) and groups, affordability for all, particularly for disadvantaged persons and groups, the right to seek, receive and impart health information, whilst respecting the confidentiality of personal integrity and data.

Acceptability (A)

Respect for medical ethics and confidentiality, and cultural appropriateness, sensitive to gender and life-cycle requirements, as well as specific individual needs in service delivery. Well-designed services aiming to improve health status of those concerned.

Quality (Q)

Health facilities, goods and services must be scientifically and medically appropriate and of good quality. This requires skilled personnel, unexpired drugs, hospital equipment, safe and portable water and adequate sanitation.

In its dialogue Sweden can use the UN treaties, the “core obligations” and the “core elements” established in General Comment 14 to justify raising questions and expect answers from partner governments and other donors – and also refer to evidence showing the added value of using a HRBA.

When working in conflict areas, Sweden can also make use of the Geneva Convention which speaks about the right to health services in conflicts and the right of health staff to be protected. It has been ratified by most states. Guidance is also provided in General Comment 14, which is also valid in conflicts.

Applying a HRBA to health sector programs

The questions below may guide staff to further improve the preparation, assessment and monitoring of initiatives and ensure that human rights are enhanced, respected and protected both in programme design and processes. First there are questions related to human rights instruments (L) and to empowerment and capacity development (E), followed by specific questions related to the four human rights principles of non-discrimination (N), transparency (T), participation (P) and accountability (A). In relation to health programmes the key elements of ***availability, accessibility, acceptability and quality*** are often used as an additional interlinked analytical tool.

Midwives at Nyong Primary Health Care centre in Eastern Equatoria attend to a pregnant mother. The health Pooled Fund is working with partners to strengthen supervision and on the job training for health workers across South Sudan. Sweden invests nearly two billion SEK per year in health sector programmes such as capacity development of health systems and reproductive health and rights. Photo: Andreea Campeanu/Health Pooled Fund

Linking to Human Rights commitments and core obligations (L)

The right to health is not a right to be healthy: it is a right to facilities, goods, services and conditions that are conductive to the realisation of the right to health, such as water, sanitation, good environment etc. At the heart of the right to health is a functioning health system, accessible to all without discrimination. The right to health makes a number of demands on the health system, including respect for primary health care and reproductive health services. Key issues to monitor and analyse in assessing support for health initiatives are:

- Have the HR obligations and key elements of availability, accessibility, acceptability and quality been used as a point of departure for dialogue, programming and funding decisions?

- Is the right to health recognised in the constitution, bill of rights or national legislation? If so, how can Sweden use these commitments to strengthen dialogue and programming?
- Is the program based on an analysis of the causes of the non-fulfilment of the rights to health?
- Is there a national public health strategy/ national health plan based on these analyses and on internationally recognised standards for health systems, which can guide donor contributions? (E.g. that the program is working towards improving the health system (and no parallel activities,) that there is an inter-sectorial collaboration, that the services are preventive, curative and rehabilitative also encompassing palliative care, that there are mental health services, etc.)

Empowerment and capacity development (E)

While the UN treaties and General Comments provide guidance on WHAT has to be achieved, a human rights based approach relates to the process – HOW development programs are implemented. A human rights based approach specifically entails holding the duty bearers (the state) accountable to their commitments as agreed in international Human Right treaties and in their own legislation. It also means empowering the rights holders (individuals and care givers) to know their rights and enabling them to challenge the state and complain to a mandated body when rights are violated.

Key issues to monitor and analyse in assessing support for health interventions are:

- Does the intervention build capacity of the authorities and health staff to plan, deliver and monitor availability, accessibility, acceptability and quality health services?
- Does the intervention build capacity of the poorer households and marginalised women and men so that they know how, where and when they can demand/ complain concerning their rights to health?

Non-discrimination (N)

Health Services must be provided to all without discrimination regardless of gender, religion, ethnicity, age, language, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status.

Key issues to monitor and analyse in assessing support for health interventions in order to combat discrimination in the health system are:

- *Are services affordable to all?* Preventive, curative and rehabilitative services and essential medicine for life threatening or disabling conditions (according to WHO list) as well as reproductive health measures for women and youth must be accessible also to poor and marginalised groups. Privatisation of health services must be accompanied by mechanisms that ensure access and quality for all. Programmes must monitor the affordability of essential health services closely and challenge inequalities and discrimination in the system. Insurance systems and subsidies must guarantee a minimum level. A good example has been introduced in Rwanda. Strategic alliances could be made between donors and with WHO in this respect.

- *Are services accessible, relevant and of good quality*? Long distances, poor transport and lack of expertise are often obstacles for poor and marginalised women, men girls and boys to access quality health services. Health systems must continue to build capacity of district and community health programs combined with training for staff and volunteers to improve their performance in terms of impact on health indicators especially for vulnerable and marginalised groups. Other measures may include mobile phone supported expert support (mHealth), sign language interpretation services, physical accessibility of health care facilities etc.
- *Are negative attitudes, stigma and prejudice addressed?* Governments must take deliberate measures and allocate resources to challenge actions and structures within the health service that lead to stigma and discrimination of certain groups (e.g. women, elderly, persons with disabilities (physical and mental), persons living with HIV and/or TB and Lesbian, Gay Bisexual and Transgender persons (LGBT-persons). Collaboration with the civil society and media actors may be a way forward in addressing stigma and misconceptions for example on physical and mental disability, LGBT rights, maternal mortality and sexual and reproductive health and rights (SRHR)
- Are there indicators? If so, are they disaggregated by e.g. sex, age, rural/urban?

Following the strong commitment to gender equality of Sweden, there is a need to focus specifically on how the national health sector plan and supported civil society health initiatives benefit women and girls and how their sexual and reproductive health needs and rights are met.

Key issues to monitor and analyse in assessing support for health interventions are:

- Does the national health plan encompass a SRHR component which is budgeted for? Does it include a strategy on SRHR with targets and time frames?
- Are there key indicators for gender equality outcomes and impact (e.g. reduced maternity mortality, increased access to legal and safe abortion, increased knowledge about sexual and reproductive health and rights among young women and men, decreased rate of fistula, existence and implementation of laws against FGM)?
- Are there key indicators for increased access to sexual and reproductive health and rights of young women and men (increased access to essential medicines and preventive methods, lower rates of unwanted pregnancies, increased use of condoms, attitude and behaviour change in relation to expectations on male sexual performance and female sexual accessibility, delayed sexual debut, decreased rates of forced marriage, presence of sexual and life-skills education in primary and secondary schools)?
- Is there a monitoring mechanism to supervise performance of the health service at different levels in relation to these indicators, particularly in rural areas?
- Are there functional, independent accountability mechanisms, such as gender commissions and civil society organisations?

Transparency (T)

In order for individuals and organisations to hold states' accountable – information on health policies, plans and budgets must be made available to the public as well as information on available services and how to access these.

Key issues to monitor and analyse in assessing support for health interventions are:

- Is the government communicating their health polices, plans, programs and available services in an accessible manner (e.g. radio, community and district offices, extension workers)? This includes information on the national and district health budgets and allocation of resources and health staff to different health areas and groups.
- Are policies, plans, budgets and services in the area of SRHR, mental health and rehabilitation for persons with disabilities explicit and communicated?
- Are the plans and programs communicated possible to realise "on the ground", in the communities? If not, what are the obstacles?
- Are medical research and technical capacity building accompanied with health campaigns/primary health care education to increase the awareness and knowledge of health issues and services among the population?
- Are economic and social costs for home-based care visible? This may not be stipulated in the law, but it is particularly important as chronic illnesses increase (such as HIV/Aids and cancer) and the population is aging. Making the unpaid work carried out by women visible and recognised, will also make it easier to support and train this group and improve quality of care.

Participation (P)

International treaties state that women, men, girls and boys have a right to participate in decision-making that affects them. This includes the health staff at all levels as well as the users of the health services, who have a right to participate in decisions regarding their treatment.

The socially prescribed role and expectations on women and girls as care givers have impact on their possibilities of choices, economic independence, access to education and labour market, and personal health. Different forms of gender discrimination have a great impact on women's health.

Everybody has a right to participation, but it is of particular importance that women and vulnerable and marginalised groups in the society have the possibility to give their input on how to challenge discrimination related to e.g. age, gender, HIV and disability(physical and mental) and have influence over the development of the health sector. Sweden could consider supporting relevant civil society groups to organise and be heard.

Key issues to monitor and analyse in assessing support for health interventions are:

- Are civil society organisations that organise marginalised groups (for example people living with HIV, patient organisations and disability organisations) invited as resources in programs and policy development? Are they taking part in formal spaces of decision-making such as local health committees, consultative development councils and likewise?

- Are home-care providers recognised as stakeholders in health programs and enabled to participate in decisions-making and monitoring of domestic and international HIV and Aids programs?
- Is the design of health education programs considering the views and experiences of different user groups and local health workers, including traditional healers and religious leaders (who are often key stakeholders that need to be brought on board)?
- Do patients participate in designing their treatment plan and do they have access to a patient complaints mechanism?

Sweden is one of the countries contributing most to the fight against Ebola epidemic in West Africa. As of 3 November 2014, the Swedish support reaches 549 million SEK, targeting the most urgent needs in crisis hit Guinea, Liberia and Sierra Leone.
Photo: Johan Lundahl, MSB

Accountability (A)

Governments must take responsibility for providing quality health services for all, and mechanisms must be put in place to hold them accountable.

Qualified health workers and accessibility of essential medicine (as listed by WHO) are basic conditions for the fulfilment of the obligation of providing quality health care to the population. The international community can facilitate access to essential drugs, assist governments to develop national medical education and research and support actions against so called brain drain in the health sector. Key issues to monitor and analyse in assessing support for health interventions are:

- Is there national legislation that guarantees the right to health for everyone without discrimination?
- Is the health sector program focusing firstly on essential primary health care, and secondly on preventive, curative, rehabilitative and palliative care in referral systems?
- Is health staff training of sufficient quality? Does it have both theory and practice? Are books and internet connections available and up-to date?
- Are there monitoring mechanisms of to ensure that availability, accessibility, acceptability and quality are guiding services at all levels and that the access to services is improving for vulnerable and marginalised groups such as women, poor, elderly and persons with disabilities?
- Are there independent complaints mechanisms, where individuals can go (e.g. ombudsperson, legal aid clinics or independent media)? Are there complaints mechanisms where civil society organisations and/or human rights commissions give voice to rights-holders and support them to report, call upon incongruities and seek compensation and corrections?
- Is there a mechanism for social audit of national health systems and budgets?
- Is there a system to regulate the transparency and quality of public health service provided through the private sector or civil society actors?
- Are health staff salary levels sufficient, thus preventing practices of corruption?

Useful links and references

Bustreo, F. and Hunt, P (2013), "*Women and Children's Health Evidence of Impact of Human Rights"* Geneva, WHO: http://www.who.int/maternal_child_adolescent/documents/women_children_human_rights/en/

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UN Special Rapporteur on the Right to Health http://www2.ohchr.org/english/issues/health/right/

The monitoring body of ICESCR: http://www2.ohchr.org/english/bodies/cescr/

UN Committee on Economic, Social and Cultural Rights 2000, General Comment No. 14, The Right to the Highest Attainable Standard of Health (E/C.12/2000/4) http://www2.ohchr.org/english/bodies/cescr/comments.htm

the Geneva Convention about the right to health services in conflicts http://www.icrc.org/eng/war-and-law/treaties-customary-law/geneva-conventions/index.jsp

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Human Rights Impact Centre http://www.humanrightsimpact.org/introduction-to-hria/hria-tutorial/introduction/

Human rights library: University of Minnesota: http://www1.umn.edu/humanrts/

International Federation of the Right to Health Organisations: http://www.ifhhro.org/

International network for Economic, Social and Cultural Rights http://www.escr-net.org/

Report on reproductive and sexual health from IPAS (International Programme on Reproductive and Sexual Health Law of the Faculty of Law/University of Toronto). http://www.ipas.org/

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