



**Linking Human Rights and Aid Effectiveness  
for Better Development Results:**

**Practical Experience from the Health Sector**

Report for the Human Rights Task Team of the OECD-DAC Network on  
Governance (GOVNET)

Clare Ferguson, May 14th 2008.

## **Acknowledgements**

The support of the Human Rights Task Team of the OECD-DAC GOVNET and, in particular, Sebastian Bartsch, Mac Darrow, Siobhán McInerney and Juliane Osterhaus, is gratefully acknowledged. I would also like to thank Rajat Khosla, Ruth Charo, Annelie Rostedt and Juana Sotomayor for their helpful comments on earlier drafts and case studies. Thank you to all those people who agreed to be interviewed and to Bharat Devkota, Ariel Frisancho, Robinah Kaitiritimba and Itai Rusike for their time, inputs and for travelling to London to present their work.

## **Table of Contents**

<b>Abbreviations</b>	<b>4</b>
<b>Executive Summary</b>	<b>5</b>
<b>Introduction</b>	<b>11</b>
<b>Section one: Human rights and health - analytical linkages</b>	
1.1 Introduction	14
1.2 The international human rights framework	14
1.3 Human rights principles	16
<b>Section two: Case studies, approach and methodology</b>	
2.1 Approach and methodology	20
2.2 Overview of case studies	20
<b>Section three: Ownership</b>	
3.1 Introduction	24
3.2 Partner country ownership	24
3.3 Donor support for ownership	32
<b>Section four: Mutual accountability</b>	
4.1 Introduction	35
4.2 Partner country accountability	35
4.3 Donor accountability	42
<b>Section five: Managing for results</b>	
5.1 Managing for results	45
<b>Section six: Harmonization and alignment</b>	
6.1 Introduction	48
6.2 Harmonization	48
6.3 Alignment	49
<b>Section six: Recommendations</b>	<b>51</b>
<b>Bibliography</b>	<b>54</b>
<b>Annex one: Country case studies</b>	
A Kenya health sector	57
B Kenya water sector	66
C Nepal	72
D Peru	81
E South Africa	87
F Uganda	93
G Zimbabwe	104
<b>Annex two: Country study analysis framework</b>	<b>107</b>

## **Abbreviations**

AOPP	Action Oriented Policy Paper on Human Rights and Development
ARV	Antiretroviral
BMZ	German Federal Ministry for Economic Cooperation and Development
CBO	Community Based Organization
CCSI	Cross Cutting Social Issues
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CRC	Convention on the Rights of the Child
CSO	Civil Society Organization
CWGH	Community Working Group on Health (Zimbabwe)
DAC	Development Assistance Committee
DFID	Department for International Development
EAP	Equity and Access Programme (Nepal)
ESC	Economic, Social and Cultural
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit (GmbH)
HSSP	Health Sector Strategic Plan (Uganda)
ICESCR	International Covenant on Economic, Social and Cultural Rights
INGO	International Non-Governmental Organization
KJAS	Kenya Joint Assistance Strategy
JAS	Joint Assistance Strategy
MDG	Millennium Development Goal
MoH	Ministry of Health
MoHP	Ministry of Health and Population (Nepal)
MTCT	Mother-to-Child Transmission
MWI	Ministry of Water and Irrigation (Kenya)
NGO	Non-Governmental Organization
NHSSP	National Health Sector Strategic Plan (Kenya)
OECD	Organization for Economic Cooperation and Development
OHCHR	Office of the High Commissioner for Human Rights
PD	Paris Declaration
PEAP	Poverty Eradication Action Plan (Uganda)
PPP	Public Private Partnership
PRSP	Poverty Reduction Strategy Paper
Sida	Swedish International Development Cooperation Agency
SWAp	Sector Wide Approach
TAC	Treatment Action Campaign (South Africa)
TMB	Treaty Monitoring Body
UDHR	Universal Declaration of Human Rights
UHRC	Uganda Human Rights Commission
UN	United Nations
UNDP	United Nations Development Programme
UNHCO	Uganda National Health Consumers Organization
WHO	World Health Organization

# **Linking human rights and aid effectiveness for better development results: Practical experience from the health sector**

## **EXECUTIVE SUMMARY**

This report looks at the linkages between aid effectiveness, human rights and improved results in the health sector. It is premised on the argument, set out in the OECD-DAC 2007 Action Oriented Policy Paper on Human Rights and Development, that human rights and aid effectiveness frameworks should inform each other, rather than progressing on separate, disconnected tracks. The report assumes that human rights are critical development goals in their own right and, consequently, critical objectives of aid effectiveness. It assesses the functional contribution of human rights as a means of strengthening the implementation of the Paris Declaration and ensuring the achievement of human rights and the MDGs.

The report identifies and analyses examples of the application of human rights standards and principles to the health sector. It reviews how these approaches contribute to strengthened health systems through supporting the Paris Declaration principles of ownership, mutual accountability, managing for results, harmonization and alignment. While the focus of the report is on the health sector, the analysis and recommendations have cross-sectoral relevance and applicability.

## **1. Human rights links and synergies with PD Principles**

### **Ownership**

The application of human rights in the health sector has supported democratic ownership at local, regional and national levels, leading to more sustainable development results, through the following practical processes:

- Integration of human rights standards in constitutions, legislation and policies, and patients' charters, providing a framework for Ministry of Health led health sector provision, coordination and regulation.
- Inclusive participatory processes providing a foundation for broad-based ownership of health agendas. For example, the work of CARE and ForoSalud in Peru supports the participation of women and excluded groups in local, regional and national decision-making bodies and has helped to establish demand-side issues in national health policy, including gaining Ministry of Health authorization for support of cultural practices in health service provision.
- Vertical linkage of local, regional and national processes which ensures that health policies are responsive to local concerns. For example, the voice capturing exercise of Nepal's Equity and Access Programme uses reports of women's views on maternal health services to support improvements in service delivery at local and district level as well as

contributing to national level policy changes, such as the abolition of health service user fees.

- Focusing events, such as the country missions of the UN Special Rapporteur on the Right to Health to Peru and Uganda, which legitimize civil society participation in decision-making and help to build broad political support for inclusive and equitable health policies.
- Identification of clear policy solutions to complex development challenges, providing the basis for results-oriented operational programmes. In Kenya, for example the Kenyan Ministry of Water and Irrigation has used international human rights standards to strengthen regulation of private sector water providers and ensure a pro-poor focus in the sector reform programme.

### **Mutual Accountability**

The human rights framework emphasizes the importance of mutual accountability between government and citizens as well as between donor and country partner governments. Human rights have strengthened partner country accountability of governments to citizens through use of, and effective linkages between, a range of accountability processes. This has enabled broad participation in assessment of partner country progress against human rights commitments, helping to ensure that commitments are implemented and that improved development results are achieved and sustained. These processes include:

- Engagement with parliamentary committees to review health sector policies and budgets in relation to the right to health.
- Use of human rights tools, such as the WHO/Sida human rights gender equality tool, in joint donor, partner country and civil society health sector review processes.
- Administrative complaints procedures, such as South Africa's health clinic complaints boxes, allowing individuals to take action when service standards are not met.
- Social accountability processes, including local civil society led monitoring of patients' charters in, for example, Uganda and Zimbabwe and civil society monitoring of the health budget in Kenya.
- Use of judicial systems to obtain court rulings on the basis of legal rights in constitutions and national legislation, such as the Treatment Action Campaign case in South Africa which led to the adoption of a national HIV/AIDS treatment plan.
- Quasi-judicial review mechanisms, including human rights commissions and ombudspersons. For example, the Uganda and Kenya Human Rights Commissions have recently initiated programmes to review action on the right to health.
- International quasi-judicial processes, including the reporting mechanisms of the UN Treaty Monitoring Bodies and Special Rapporteur on the Right to Health.

The human rights framework supports donor accountability to governments and citizens in partner countries through:

- UN Treaty Monitoring Bodies and missions of the Special Rapporteurs, which provide an objective, independent mechanism for monitoring donors' adherence to international development commitments and human rights obligations.
- Support for the use of partner country accountability processes, such as parliamentary committees, national human rights institutions and civil society watchdog mechanisms, to monitor donor programmes and action.

### **Managing for Results**

The human rights framework helps to define critical development goals and strengthens strategies for achieving those goals through:

- Use of human rights indicators and benchmarks, including on issues of participation and accountability, to track progress towards the realization of human rights. The Ugandan Joint Assistance Strategy, for example, includes indicators on human rights violations and citizens' awareness of their rights, ensuring that attention is paid to the underlying power structures that perpetuate poverty.
- Use of disaggregated data to monitor differential impacts of health policies and programmes on social groups. In Nepal, for example, the Ministry of Health and Population is piloting the collection of data from health facilities on the basis of age, sex, caste, as well as ethnic and regional identities, ensuring that resources are benefiting the most marginalized.
- Enabling broad participation in monitoring systems and mobilizing communities around the achievement of development results. In Peru, for example, community surveillance of maternal health services by local women's groups helps to ensure that health care standards are maintained and that health services are accessible to all without discrimination.

### **Harmonization and Alignment**

The human rights framework can support processes of harmonization and alignment by:

- Providing a common platform of shared standards and norms. In Kenya, for example, the Ministry of Water and Irrigation has explicitly used human rights standards as a basis for sector reform, leading to strengthened donor harmonization and increased aid to the water sector.
- Promoting the rights to information, accountability and transparency that are necessary to ensure effective auditing and public monitoring of budget processes, strengthening assurances that aid will be used for nationally agreed purposes.

## **2. Addressing unintended consequences from the application of Paris Declaration Principles**

Application of the human rights framework can be used to identify, and resolve, unintended negative impacts that may arise through application of the PD principles:

- Focus on the technical aspects of aid effectiveness can lead to neglect of impacts and the development results that are the overall objective of the PD. Building development processes on human rights standards and principles can help to ensure that the overarching objectives of the PD are kept in sight and that the means to achieve those goals are put in place.
- The principle of ownership is difficult to maintain in contexts of severe human rights violations. Explicit discussion of the human rights framework with partner countries provides a means of clarifying mutual values and expectations in relation to human rights standards, and supports a harmonized and graduated approach to deteriorating human rights situations.
- Processes of donor co-ordination may lead to neglect of difficult but critical agendas, such as sexual and reproductive health rights. Basing harmonization on a common and clear understanding of the equal value of all human rights can ensure that donor co-ordination does not lead to joint action around the lowest common denominator.
- Donor focus on processes of harmonization and alignment can lead to fewer opportunities for civil society participation in policy processes, as well as a decrease in funding for civil society organizations, undermining democratic ownership. Using human rights as a basis for development action can ensure that the importance of civil society engagement is recognized and supported.

## **3. Recommendations**

### **Partner countries**

Partner country governments can utilize the human rights framework to strengthen aid effectiveness and improve development results in the health sector by:

- Building health sector legislation, regulations and policies on international human rights standards, regional human rights charters and rights identified in the constitution.
- Using the rights identified in constitutions, legislation and policies as a basis for identifying and communicating citizens' entitlements to health

care through, for example, a charter of patients' rights drawn up on the basis of civil society consultation.

- Using the human rights framework, including international human rights reporting mechanisms, to open up and take the lead on national debate about critical issues such as equal access to basic health services or maternal mortality.
- Establishing quasi-judicial human rights mechanisms, such as national human rights commissions, with a mandate to report regularly on economic, social and cultural as well as civil and political rights.
- Institutionalizing mechanisms to enhance the engagement of civil society in national policy processes, including sector working groups.
- Supporting adequate allocation of resources in health sector budgets to enable meaningful civil society participation in decision-making processes.
- Establishing the right to information in legislation and in practice to enable public monitoring of budget and development processes.
- Taking action to reallocate health sector budgets on the basis of the core elements of the right to health; availability, accessibility, acceptability and quality.
- Respecting and supporting the use of international human rights mechanisms, including the Treaty Monitoring Bodies and Special Rapporteurs, to report on donor and partner country commitments and action.
- Enabling Parliamentary Committees, and other national accountability mechanisms, to review donor programmes as well as government action.

## **Donors**

Donors can utilize the human rights framework to strengthen aid effectiveness and improve development results in the health sector by:

- Developing clear and consistent positions between donors, as well as within bilateral agencies, on human rights issues
- Recognizing the importance of partner countries' and own international human rights commitments and constitutional commitments in engagement with partner countries on development policy.
- Using human rights diagnostic tools in joint planning and review missions to ensure that donor-supported programmes, at the very least, do no harm to the human rights of people in partner countries<sup>1</sup>.
- Supporting the capacities of national institutions to collect and analyze disaggregated data.
- Building the capacities of the Ministry of Health at national, regional and local levels to support the promotion of human rights issues, including gender equality and other forms of non-discrimination.

---

<sup>1</sup> Examples of harmful impacts of donor practices may include discontinuation of targeted services for particular groups, such as adolescents or refugees, as a result of basket funding or donor harmonization.

- Ensuring that new aid modalities and channels of donor co-ordination do not result in less attention to, and funding for, difficult agendas, such as reproductive and sexual health rights.
- Ensuring that channeling aid through budget support and SWAPs does not lead to a decrease in support to civil society organizations (CSOs) or to a reduction in the range of CSOs that are supported.
- Supporting the capacity of national human rights institutions to monitor and report on economic, social and cultural rights.
- Recognizing the importance of human rights issues, including rights to meaningful participation, non-discrimination, information, accountability and transparency, in the process of alignment.
- Respecting and supporting the use of international human rights mechanisms, including the Treaty Monitoring Bodies and Special Rapporteurs, to report on donor and partner country commitments and action.
- Strengthening donor accountability to partner country governments and people through provision of public information on programmes and enabling partner country Parliamentary Committees, National Human Rights Institutions and civil society watchdogs to review donor programmes.
- Recognizing international donor obligations defined in human rights treaties, including the ICESCR and CRC, to provide aid and technical assistance.

### **Local, national and international human rights organizations**

Focus on PD principles can help to inform understanding of some of the most effective ways of building strategies to promote human rights. Key issues identified include the importance of:

- Linking different accountability processes to enable, for example, broad-based participation in the monitoring processes of national human rights institutions.
- Demonstrating how the human rights framework can help identify the concerns and priorities of health workers planners and policy-makers as well as those of citizens.
- Focusing on the translation of human rights principles of equality and non-discrimination in budgets through, for example, analysis of the equity impacts of universal versus targeted budget allocations.
- Building links with parliamentary processes including parliamentary committees.
- Identifying a manageable number of human rights indicators that can be included in results frameworks, for which data are cost-effectively available, particular on issues of participation and accountability.

## **Linking human rights and aid effectiveness for better development results: Practical experience from the health sector**

### **Introduction**

The Director of the OECD Development Co-operation Directorate, Richard Carey, observed at the 2007 Dublin Workshop on Development Effectiveness that, "whilst achieving gender equality, human rights and environmental sustainability are worthy goals of development in their own right, each is at the same time functionally essential to achieving the overall goal of the Paris Declaration." (DCD/DAC (2007) 40). This report assumes the intrinsic value of human rights as essential goals of development. It examines their functional contribution, in the health sector, to the achievement of the Paris Declaration objectives of aid effectiveness and improved development results.

The report looks at the linkages between aid effectiveness, human rights and improved health results. It identifies and analyses examples of the application of human rights standards and principles to the health sector. It reviews how these approaches contribute to strengthened health systems through supporting the Paris Declaration (PD) principles. It makes recommendations from the evidence on the ways that partner countries, donors and civil society can further strengthen aid effectiveness and development results through the application of human rights standards and principles in aid processes.

The Paris Declaration on Aid Effectiveness was agreed in March 2005 between a wide range of governments and donors. It is based on five key principles that are seen as providing a roadmap for improving the quality of aid and its impact on development. These principles are ownership, mutual accountability, alignment, harmonization and managing for development results.

Human rights standards and principles are established in international human rights treaties which are legally binding on countries that sign and ratify them. Today, all UN member states have ratified at least one of the core human rights treaties and 80% have ratified four or more. Standards relate to civil, political, economic, social and cultural rights. Underlying principles are based on these standards and include non-discrimination, meaningful participation and information, indivisibility, accountability, transparency and the rule of law. Human rights standards and principles define the goals of development, as well as providing a basis for development processes of policy design, programming and implementation. UN human rights accountability mechanisms, including Special Rapporteurs and the Human Rights Treaty Monitoring Bodies, provide an independent means of assessing donor and partner country governments' actions against their human rights obligations.

At the conceptual level, the potential links between the human rights framework and the PD principles have already been identified. The Action-Oriented Policy Paper on Human Rights and Development (AOPP) states that the human rights and aid effectiveness frameworks should inform each other, rather than progressing on separate, disconnected tracks (OECD 2007). The areas of strongest synergy have been identified as relating to the principles of ownership and mutual accountability (ODI 2006). In order to move beyond the theoretical, however, it is necessary to look at how these approaches have been translated into practice and the linkages on the ground.

The application to development practice of both the PD and the human rights framework, is still at an early and evolving stage. This is particularly the case in economic and social sectors, where development issues have not generally been framed in terms of human rights. The health sector, however, provides a useful body of experience with both frameworks. Health SWAps and co-ordination around the 'three ones' in national plans of action on HIV/AIDS provide well-established examples of work on aid effectiveness. International and national action on sexual and reproductive health rights, as well as the links between HIV/AIDS and human rights and, increasingly, the right to health as a whole, are areas where the practical application of human rights standards and principles is relatively strong. The human rights framework is now being used, for example, to increase service provider accountability to communities, to monitor the allocation of health budgets, and as a basis for sector strategies and regulation.

The health sector also presents major challenges. Progress on the Millennium Development Goals for child mortality (Goal 4) and maternal health (Goal 5) is both slow and uneven. National trends in health outcomes often mask deep disparities within countries. While wealth is one form of inequality that has slowed progress on child mortality and maternal health, ethnic, linguistic and other divisions are often equally or more significant. One of the main supply-side factors underlying this lack of progress is fragmented health systems that are unable to ensure availability, access and utilization of key primary health interventions in sufficient volume and quality to meet the goals. Fragmented health services are themselves often the product of a lack of political will as well as shortage of resources and capacity to deliver at the local level. Demand-side factors are equally critical to addressing poor services and unequal access to health care. Key issues include the lack of voice and meaningful participation of marginalized groups in relevant decision making processes, as well as underlying economic and social disparities which perpetuate inequalities in access to services (UN Millennium Project 2005).

The report looks at the contribution of the human rights framework to addressing these health challenges through review of case study material. The case studies were chosen because they illustrate best practice, not because they are representative. In general, human rights issues are not comprehensively addressed in health sector aid co-ordination processes. This report aims to

encourage more systematic application of the human rights framework through illustration of the concrete ways in which human rights have strengthened aid effectiveness and improved development results in the health sector.

**Section one** reviews the analytical contribution of human rights to the health sector. It briefly identifies the conceptual synergies between human rights principles and the PD.

**Section two** introduces the case studies. It outlines the approach and methodology used for selecting and analyzing the material and provides a summary overview of the case studies, highlighting the application of human rights standards and principles.

**Section three** analyzes the case studies to illustrate the links between the PD principle of ownership and human rights.

**Section four** demonstrates the linkages between the PD principle of mutual accountability and human rights.

**Section five** assesses how human rights can strengthen the PD principle of managing for results.

**Section six** reviews the linkages between human rights and the PD principles of harmonization and alignment.

**Section seven** draws out recommendations for partner country governments, donors and civil society organizations.

## **Section one: Human Rights and health - analytical linkages**

### **1.1 Introduction**

This section reviews the analytical contribution of human rights to the health sector and the achievement of the health Millennium Development Goals (MDGs). It outlines the key elements of the human rights framework and identifies the conceptual synergies between the human rights framework and the PD principles.

### **1.2 The international human rights framework**

The human rights framework is a set of internationally agreed rules that define what all governments should do in relation to citizens, understood here as all human rights-holders, in their own and other countries. The human rights framework of civil, cultural, economic, political and social rights is set out in the Universal Declaration of Human Rights (UDHR 1948) and elaborated in subsequent treaties. When governments ratify a treaty, they become legally bound to respect, protect and fulfill the human rights they have signed up to. Human rights, consequently, provide a legal and normative baseline on which donors and country partner governments can build a common platform of shared policies and approaches.

#### **International Human Rights Treaties and number of States Parties**

International Covenant on Economic, Social and Cultural Rights (ICESCR 1966).....	157
International Covenant on Civil and Political Rights (ICCPR 1966).....	161
International Convention on the Elimination of All Forms of Racial Discrimination (ICERD 1966).....	173
Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW 1979).....	185
Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT 1984).....	145
Convention on the Rights of the Child (1989 CRC).....	193

As outlined in section three, these standards and principles are regularly incorporated into national law and policies. In addition to defining the obligations of governments to their citizens, international treaties also reinforce donor governments' duty to provide international co-operation and assistance to partner countries. The ICESCR defines the obligation of governments to support the fulfillment of the right to health, as well as other economic, social and cultural rights, through international assistance and co-operation as well as through domestic measures (ICESCR 1966:2.1). The respective roles, rights and responsibilities between citizens, partner governments and donors, defined by human rights treaties, correspond to the underlying logic of the PD, with donors supporting partner country governments in relation to development for all citizens.

The UDHR states that everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including...medical care and necessary social services (Article 25 (1) UDHR). This right is elaborated in the ICESCR, which states that the realization of the highest obtainable standard of physical and mental health (the right to health) should include steps that reduce infant mortality and ensure the healthy development of the child; improve environmental and industrial hygiene; prevent, treat and control epidemic, endemic, occupational and other disease and create conditions to ensure access to health care for all (ICESCR 1966: Article 12). General Comment 14 from the UN Committee on Economic, Social and Cultural Rights has further clarified that the right to health includes sexual and reproductive health rights and access to maternal health care.

The General Comment indicates that this right extends to the underlying determinants of health including an adequate supply of safe food, nutrition and housing, access to safe drinking water and adequate sanitation, healthy occupational and environmental conditions and access to health-related education and information, including on sexual and reproductive health. The right to health contains four principal elements: availability; accessibility, acceptability, quality. These criteria apply to the delivery of the underlying determinants of health as well as health services (General Comment 14, Committee on ESC rights).

#### **Principal elements of the right to health**

**Availability.** Functioning public health and health care facilities, goods and services, as well as programmes in sufficient quantities.

**Accessibility.** Health facilities, goods and services accessible to everyone, within the jurisdiction of the State party. Accessibility has four overlapping dimensions:

- non-discrimination
- physical accessibility
- economic accessibility (affordability)
- information accessibility.

**Acceptability.** All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, as well as sensitive to gender and life-cycle requirements.

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

(WHO and OHCHR 2007, two page briefing note on the right to health)

The creation of an integrated, coherent health sector is central to the definition of the right to health. The UN Special Rapporteur on the Right to Health describes the right to health as "the right to an effective and integrated health system

encompassing health care and the underlying determinants of health, which is responsive to national and local priorities and acceptable to all" (UN E/CN.4/2006/48). The definition of the right to health emphasizes the stewardship of the Ministry of Health and supports the PD principle of ownership and leadership by partner countries.

### **1.3 Human rights principles**

Human rights principles provide guidance on the processes that should underpin legislation, policy and implementation processes at local, national and international levels and between all actors. These principles ensure that development procedures, as well as outcomes, meet human rights standards. There is considerable synergy between these principles and the content of the PD. Key human rights principles are reviewed below.

***Participation and information.*** In the human rights framework, participation is the term used to describe people's right to meaningful, informed engagement in the decision-making processes that affect their lives. It is an essential principle of human rights and is intrinsic to democracy at local, national and international levels. The human rights framework emphasizes the importance of inclusive participation that enables excluded groups to be heard. The right to information is a critical element of participation, as well as being integral to transparency and accountability. Without information, people cannot participate meaningfully in decision-making or assess whether governments are meeting their commitments.

The PD also recognizes the importance of broad civil society participation in policy decision-making and links this to both ownership and mutual accountability (OECD- DAC 2005: 14, 48). In practice, however, development interventions often fall short of the standards of, and commitments to, participation set out in the PD as well as human rights treaties. Poverty Reduction Strategy processes have opened up some opportunities for civil society engagement in national policy decision-making. To date, however, this has tended to be on the basis of donor and recipient government led consultation, rather than recognition that it is all citizens' right to participate.

The concept of participation in the health sector often refers to clients' engagement in health education activities or contribution of time and finances to health service provision. Commitment to local level participation in decision-making has become more common in the health sector with the establishment, in many countries, of decentralization. One of the stated aims of decentralization programmes is often to bring decision-making closer to local communities. Translating commitment into action, however, requires the resources and local level capacities to ensure that decision-making bodies are able to function effectively and that excluded groups are able to voice their views and be heard. It also requires attention to the provision of information that enables people to make decisions about health service provision as well as their own health.

**Equality and non-discrimination.** The human rights framework prioritizes action to support the most excluded groups. It addresses discrimination and inequality on the basis of any social identity including race, religion, age, disability and status as a refugee, internally displaced person or migrant as well as poverty. The PD also recognizes the importance of ensuring that aid contributes to the reduction of inequality in its overarching statement of objectives (OECD 2005: para 2).

The human rights framework recognizes the importance of both formal and substantive equality. Formal equality prohibits the use of distinctions, or discrimination, in law and policy. Substantive equality considers laws and policies discriminatory if they have a disproportionate negative impact on any group of people (Elson 2006).

In the health sector, equality and non-discrimination are often equated with the provision of services for women and children. However, this approach does not address discrimination and inequality in service supply, such as disrespectful or poor quality treatment of, for example specific ethnic groups, and inequalities in demand caused by, for example, lack of finances to pay for services and transport. Different forms of inequality and discrimination, and inadequate attention to these issues, have slowed progress on the achievement of the MDGs on child mortality and maternal health (UN Millennium Project 2005).

**Indivisibility.** The human rights principle of indivisibility, and the related principles of interdependence and interrelatedness, means that the international community must treat human rights globally in a fair and equal manner, on the same footing, and with the same emphasis (UN 1993. A/CONF.157/23). This principle is particularly relevant to the health sector, where policies and programmes are often limited to a narrow range of technical interventions. The principle of indivisibility requires a holistic approach to health which incorporates human rights to participation, information and non-discrimination as well as to the immediate and underlying determinants of health outlined in the definition of the right to health.

The principle of indivisibility has synergies with the PD principle of ownership and country partner leadership on national and sector level strategies. Indivisibility supports the stewardship role of the Ministry of Health in ensuring cross-sectoral co-ordination on health related issues and in working with other ministries to ensure the realization of all human rights. It provides a basis for building approaches that address the reality, in many countries, of fragmented health systems and lack of co-ordination between the different sectors that impact on the right to health.

**Progressive realization.** Human rights law recognizes the severe constraints that poor countries face, or that any government can face, in relation to limited resources, and allows for the fact that it may not be possible to realize all human

rights for everyone immediately. Governments are consequently obliged to provide a long-term plan that will lead to the progressive realization of human rights. They should also take immediate concrete steps, including financial measures and political commitments in accordance with available resources, targeted deliberately towards the full realization of all human rights. This approach to targeted planning resonates with the PD emphasis on prioritized, results-oriented operational programmes linked to medium-term expenditure frameworks and annual budgets, which is identified as a critical element of partner country ownership (OECD 2005: 14).

***Accountability and transparency.*** Accountability in the health sector is often understood only as managerial and financial accountability. Both the PD and the human rights framework support a broader concept of public accountability. Accountability is the lynchpin of the human rights framework. It enables citizens to claim their rights and ensures different actors, particularly governments, implement their defined responsibilities. Transparency is an essential part of accountability, as without transparency individuals and organizations cannot access the information needed to hold governments and others to account.

As with the PD principle of mutual accountability, the human rights framework emphasizes the proper role of parliament in ensuring accountability to citizens. Human rights institutions further support the PD principle of mutual accountability by reinforcing participatory approaches and involving a broad range of development partners in the formulation and implementation of development strategies.

From a human rights perspective, accountability can be understood as an ongoing process of reviewing the performance of the government and other duty-bearers against their human rights obligations. The key elements of accountability in the human rights framework are:

- Clear identification of the standards and norms for which different actors are responsible.
- Monitoring, to collect information on performance.
- Mechanisms to allow those with responsibilities to explain and justify their performance in relation to their obligations.
- Processes of redress.

The human rights framework incorporates specific national, regional and international judicial and other accountability mechanisms for reviewing governments' implementation of their human rights obligations. From a human rights perspective, accountability often requires linkages between these different institutions and processes to ensure that authorities answer to people who are most marginalized and vulnerable. Accountability mechanisms include:

- International UN Treaty Monitoring Bodies and Special Rapporteurs.
- Regional human rights courts and commissions.
- Judiciary and national courts.

- National human rights commissions and ombudspersons.
- Administrative monitoring and review.
- Political processes, including elections and parliamentary committees.
- Social accountability mechanisms.

These different methods are discussed in more detail in section four. Redress refers to the achievement of some form of action in response to a finding that obligations have not been fulfilled. This may include rehabilitation, compensation, and guarantee of non-repetition or changes in policies, practices and budget allocations (Potts 2008). In practice, successful achievement of redress often requires the interaction of different processes of accountability. As case studies utilized in this report illustrate, social and political mobilization is often critical for ensuring that court judgments are enforced. Equally, social accountability mechanisms can gain more traction when they are linked with a quasi-judicial or judicial process.

The human rights emphasis on the importance of monitoring for accountability resonates with the PD principle of Managing for Results and the partner country commitment to establish results-oriented reporting and assessment frameworks that monitor progress against key dimensions of the national and sector development strategies (OECD 2005: para 44). Human rights approaches to monitoring are discussed in section five.

## **Section two: Case studies, approach and methodology**

### **2.1 Approach and methodology**

The remainder of this report reviews how the practical application of human rights standards and principles, outlined in section one, has strengthened aid effectiveness and improved outcomes in the health sector. The review draws, primarily, on seven case studies. The full case studies can be found in annex one. A brief summary of the case studies is provided below. Case studies were chosen on the basis of written evidence indicating that development partners or governments were explicitly using some or all elements of the human rights framework. The aim of the case studies was to provide examples of good or informative practice, from which lessons about human rights and aid effectiveness could be drawn.

Telephone and e-mail interviews were conducted, wherever possible, to build a more realistic picture of practice and implementation. Interviews were limited in number and often revealed the complexity of processes on the ground and the competing ideas and interests both within and between organizations. The case studies, then, are based on my interpretation and analysis of this information and do not necessarily represent the opinion of the people or organizations consulted.

Interviews and research took place between December 2007 and February 2008. All of the case studies, apart from the South African case study, focus on events at the time of the research and relevant preceding processes. It has not been feasible to take into account the impact of political changes that were taking place during, or just after, the research period - notably elections in Kenya in December 2007, Zimbabwe in March 2008 and Nepal in April 2008. The South African case study is based entirely on secondary sources and focuses primarily on the 2002 court case between the Treatment Action Campaign and the South African government.

In order to analyze the different kinds and levels of information from each of the case studies, a common framework was used to identify key elements of the human rights agenda and to review how these elements contributed to the PD principles of mutual accountability, ownership, management for results, harmonization and alignment. This framework is attached at annex two. The categorization in the analysis framework draws from background literature and the categories are explained in the relevant sections of the report.

### **2.2 Overview of case studies**

***Kenya health sector.*** The case study reviews the extent to which the National Health Sector Strategic Plan's (NHSSP II) explicit commitment to a human rights-based approach to health has been operationalized and implemented through the health sector SWAp and Joint Programme of Work and Finance.

The human rights-based approach outlined in the NHSSP II is defined in terms of community participation in decision making and more equitable reallocation of resources. It emphasizes the importance of Private-Public-Partnerships (PPPs) as a means of supporting service delivery to hard-to-reach populations and their participation in local decision-making. Policy commitments, however, have not been translated into subsequent operational plans or funding. Reallocation of resources between higher and local level services, as well as between geographical areas has been limited. Civil society organizations have co-ordinated to support the implementation of the SWAp, signing up to a code of conduct that commits them to ensuring all their programmes support the NHSSP II. However, SWAp funding mechanisms to support PPPs with CSOs have not been established.

**Kenya water sector.** The Kenyan Ministry of Water and Irrigation, with the support of a group of donors and development agencies including GTZ, has used human rights standards as a basis for the national sector reform programme and SWAp. International human rights standards on the right to water and adequate sanitation have informed the development of guidelines across the sector and provided the basis for standards to be included in contracts between Water Services Boards and Water Service Providers. The objectives of the reform have been to increase accountability between the MWI, water service providers and citizens and to promote higher standards of accessibility, affordability, acceptability and quality in the water sector. The reforms have provided a platform for greater donor alignment and harmonization.

**Nepal.** The case study reviews the ways in which human rights and inclusion are addressed in Nepal's Safe Motherhood Programme. Nepal's 2007 Interim Constitution and Strategy explicitly outline the government's commitment to the right of all citizens to free basic health care and the right of non-discrimination in access to services. The Safe Motherhood Programme incorporates an Equity and Access Programme, managed by Action Aid. This uses a rights-based approach to increase demand by women from excluded groups by informing them about their entitlements to services and supporting service providers to address their concerns. The programme's voice capturing exercise records the views of excluded women. Reports from this process are used to support improvements in local and district level management of service delivery. The voice capturing exercise has also contributed to national policy debates on the abolition of user fees, as well as informing the framework of the International Health Partnership.

The Ministry of Health and Population's Safe Motherhood Programme is supported by DFID through the partial health SWAp. It is part of a broader focus of DFID, the World Bank and other donors on social exclusion in Nepal. At the conceptual level, the social exclusion framework draws on, and overlaps with, the human rights framework. DFID defines social exclusion as discrimination and

explicitly references international human rights treaties, including CEDAW, in its documentation of the social exclusion work in Nepal (DFID 2005).

**Peru.** This case study reviews the role of civil society and human rights institutions in strengthening government leadership on the right to health in the context of high-turnover of officials and poor government reach in rural areas. While there is no health SWAp in Peru, partnership between CARE and the civil society network Forosalud has helped to ensure that inequities in access to health are addressed in national policy and the programmes of development partners, including USAID and UNFPA. Their work has contributed to the introduction of Ministry of Health (MINSA) regulations addressing discriminatory health service practices as well as Congress consideration of a new law outlining rights to health.

CARE and ForoSalud facilitate the participation of women and people from excluded ethnic groups, including the Quechua and Aymara people, in local-level health management committees. They have supported the development of regional plans to address the right to health as well as capacity building within MINSA on issues of human rights and gender equality. The mission of the Special Rapporteur on the Right to Health in 2005 helped to cement existing partnerships and further facilitate government ownership of work on the right to health. CARE, Forosalud and Physicians for Human Rights are now working to establish a maternal health services monitoring system, linking local women's groups with the Regional Office of the Human Rights Ombudsperson.

**South Africa.** The case study outlines how the Treatment Action Campaign (TAC) has utilized judicial and social accountability mechanisms to defend the rights of people living with HIV&AIDS to antiretroviral treatment. The ruling from the 2002 Court Case between TAC and the Government of South Africa led to the government adoption and implementation of an HIV&AIDS treatment plan. Co-operation between civil society organizations and the government has subsequently led to the development of a National Strategy on HIV& AIDS and STIs, which prioritizes human rights issues.

**Uganda.** The case study reviews how partnerships between local, national and international organizations have supported partner country ownership and leadership on the right to health. The civil society organization, the Uganda National Health Consumers Organization (UNHCO) provides an example of the role of CSOs in ensuring broad-based ownership of the right to health. The UNHCO has worked at local level to inform people about their entitlements to health. It has also worked with the Ministry of Health to develop a charter of patients' rights and has been involved in the formulation of national health strategies. The World Health Organization (WHO) and Office of the High Commissioner for Human Rights (OHCHR) have facilitated and legitimized CSO engagement with the Ministry of Health. The support of WHO and OHCHR, as well as the Swedish International development Cooperation Agency (Sida), for

missions to Uganda by the Special Rapporteur on the Right to Health has provided opportunities for legitimizing the engagement of civil society in health sector policy processes. The Special Rapporteur has reviewed the actions of both the government and the Sida in relation to their commitments to implement the right to health in Uganda.

**Zimbabwe.** This case study reviews how a human rights-based approach can support the local-level governance structures necessary for the delivery and maintenance of basic services in the context of a fragile state. The Community Working Group on Health (CWGH) focuses on community participation in village and district health committees. It has used the Charter of Health Rights drawn up by the Ministry of Health as a basis for informing people about their entitlements and enabling them to hold local level facilities to account for the supply of drugs and services. It brings together civil society, traditional leaders, local councilors and parliamentarians in its work to support adolescent knowledge about sexual and reproductive health rights. At national level, the CWGH works with the Parliamentary Portfolio Committee on Health to review health budget proposals. It has a Memorandum of Understanding with the Committee which covers joint working on the regional Right to Health Campaign.

## **Section three: Ownership**

### **3.1 Introduction**

The Paris Declaration defines ownership as effective leadership by partner countries over their development policies and strategies and co-ordination of development actions. At the conceptual level, human rights provide a framework for strengthening the quality and depth of ownership, thereby building more sustainable policy and programme responses. As outlined in section one, the key elements of the human rights framework that support the PD principle of ownership include:

- Emphasis on the Ministry of Health's role of leadership and stewardship of the health sector.
- Normative emphasis on meaningful participation and inclusion, providing a basis for building broad-based democratic ownership.
- Normative emphasis on the responsibilities of donor governments to support partner countries fulfill their obligations and leadership role in health.

The first part of this section draws on the case studies to review how national level application of human rights standards and principles in the health sector has, in practice, strengthened partner country democratic ownership. The second part of the section reviews how donor action on human rights standards and principles has supported country partner ownership.

### **3.2 Partner country ownership**

The PD commits partner countries to exercise leadership in developing and implementing their national development strategies through broad consultative processes. It outlines partner countries' commitment to co-ordinating aid at all levels and encouraging the participation of civil society and the private sector. Analysis of effective processes of policy change in the health sector indicates that these factors are critical for strengthening the depth and quality of ownership and ensuring that policies are implemented. Practical actions which enable partner countries to exercise democratic ownership and effective national leadership at all levels include:

- Integration of norms into legislation and policies.
- Consultation between providers, citizens and policy-makers.
- Policy community cohesion.
- Focusing events that strengthen government commitment.
- Identification of clear policy solutions that can inform prioritized operational programmes.

(drawn from ODI 2007, CGD 2007).

These factors are used below as a basis for analysis of the specific processes through which the human rights have strengthened partner country ownership and leadership.

**Integration of norms.** International human rights standards are woven into regional and national legislation, policy agreements and strategies of partner countries, as well as those of donors. Human rights are consequently an integral part of all countries' legislative and policy framework, providing an existing platform on which to build strategies and programmes. The African Charter on Human and Peoples' Rights and other international Human Rights Treaties, for example, provide the underlying principles of the Africa Health Strategy 2007-2015, agreed by the African Union.

**African Union: Africa Health Strategy 2007 - 2015**

"Health is a human right that is increasingly being recognized as enforceable. Governments have a responsibility for guaranteeing health care for all their citizens in an equitable manner..... while using resources accountably. Governance includes providing stewardship, including vision and direction and providing transparent leadership" (African Union 2007)

Case study material illustrates how human rights standards have been incorporated in national frameworks of legislation and policies, defining the roles of key actors, including parliament and the Ministry of Health, in the health sector. These actors can broadly be grouped into three categories - citizens, the state and service providers - linked by a triangular set of rights and obligations (Gauri and Brinks 2008). These relations are discussed below:

Citizens-state. In most countries, the constitution provides the basic and most important framework for defining the legal "contract" between the different branches of the government and citizens in terms of human rights and responsibilities. The definition of constitutional rights often draws directly on the human rights defined in the UDHR and subsequent human rights treaties. In addition to civil and political rights and clauses on discrimination, the constitution in a number of countries also defines economic, social and cultural rights, including the right to health. In some cases, such as Uganda, India or Nepal, these rights are incorporated as directive principles or have some form of limitation. In other countries, including South Africa and most Latin American countries, the right to health is defined as a right with equal status to civil and political rights. The practical importance of this distinction depends, in part, on the strength and independence of the court system in the country concerned, as demonstrated by experience in claiming socio-economic rights in India.

**South African Bill of Rights, Article 27**

- (1) Everyone has the right to have access to-
    - (a) health care services, including reproductive health care;
    - (b) sufficient food and water; and,
    - (c) social security, including, if they are unable to support themselves and their dependants, appropriate social assistance.
  - (2) The state must take reasonable legislative and other measure, within its available resources, to achieve the progressive realization of each of these rights.
  - (3) No one may be refused emergency medical treatment.
- (Constitution of the Republic of South Africa, Act 108 Of 1996)

State - providers. Case studies illustrate how human rights in the constitution, or international human rights standards, have provided a basis for the inclusion of these standards and principles in legislation and policies governing public health provision. South Africa's National Health Act 61 (2003) explicitly builds on the rights outlined in the Bill of Rights. The aims of the National Health Act include ensuring protection, respect and fulfillment of the rights of people of South Africa to progressively realize the constitutional right to health; establishing a national health system that will provide people with the best possible health services that available resources can afford; ensuring that state and state-funded health centres provide free health care to particular categories of people including pregnant women and children under the age of six who are not on medical aid schemes (Khoza, 2007). Following the Constitutional Court's ruling on the 2002 TAC case, the government has worked with civil society organizations to produce a new National HIV&AIDS and STI Strategic Plan for South Africa (2007-2011) that outlines the human rights of people living with HIV&AIDS, including their rights to ARV treatment.

The Directive Principles of the 1995 Ugandan Constitution include the government's commitment to ensure that all Ugandans enjoy rights, opportunities and access to health. Uganda's PEAP includes an objective, under the social development pillar, of moving towards mainstreaming gender and the rights of the poor and vulnerable in the health sector (PEAP 2004:179). The Health Sector Strategic Plan II makes explicit reference to sexual and reproductive health rights and emphasizes principles of equality, participation and accountability. The work of UNHCO and other CSOs has resulted in commitments, in the Health Sector Strategic Plan II, to address consumers' health rights and to strengthen accountability between service users and providers.

In Nepal, the 2007 Interim Constitution defines the right of all citizens to get basic health services free of cost from the State, as provided for in the law. This right is taken up as a key point in the 2007 Interim Strategy, which replaces the recent PRSP and reiterates the government's commitment to providing free basic health care to all citizens, without discrimination (Nepal MoHP 2007). Kenya's National Health Sector Strategic Plan II explicitly refers to human rights-based approaches, with an emphasis on reducing inequalities and supporting local participation. In Peru, the advocacy of Care and ForoSalud has contributed to the current consideration by Congress of a national law on health service users' rights and responsibilities.

Human rights standards have also been used to regulate private sector health providers. Work by BMZ/GTZ in partnership with the Kenyan Ministry of Water and Irrigation illustrates how the human rights framework can be used directly for the purposes of regulation of all providers. The Ministry of Water and Irrigation has used international standards relating to the right to water and adequate sanitation as part of an evolving process of defining guidance for, and contractual relations with, Water Service Providers, usually registered private companies

owned by the municipalities. It is intended that contracts will include clauses which reflect human rights guidance on water availability, accessibility, quality and affordability. For example, General Comment 15 of the UN Committee on Economic, Social and Cultural Rights indicates that water supply and sanitation should be affordable and should not reduce people's capacity to secure other essential goods and services. Governments should ensure affordability through measures including use of a range of appropriate low-cost techniques and technologies and appropriate pricing policies (UN 2002 E/C. 12/2002/11). In compliance with these standards, the Ministry of Water and Irrigation has set a target date of 2008/2009 for implementation of a pro-poor tariff system. The implementation plan also includes promotion of water kiosks and on-site sanitation as a major part of the sector strategy (MWI 2007).

Chile's recent law on Health Guarantees provides a further example of health sector regulation that is informed by human rights standards and principles.

***Chile: Explicit Health Guarantees.***

Chile's law setting out its Regime on Health Guarantees came into effect on July 1st 2006. The law, and associated joint decree of the Ministry of Health and the Treasury, specifies 40 medical conditions and the services guaranteed in relation to them. The law and decree define standards of health care access, quality, opportunity (waiting time) and financial protection. The law entitles the lowest-income groups in the country to 100% payment for services by the Fondo Nacional de Salud (FONASA), the national health insurance fund to which most of the population is affiliated. The law also sets out rights of redress via procedures for making claims to the Superintendency on Health. The Ministry of Health and the Treasury are responsible for reviewing and updating the legally defined standards every 3 years. (World Bank 2008)

*Citizens-providers.* Charters of patients' rights and responsibilities are the main vehicle by which human rights standards and principles have been incorporated into institutional frameworks defining citizen-provider relations. While these charters are not always legal documents, they may provide a practical basis for community monitoring and enable citizens' use of other avenues of accountability and redress, such as administrative complaints procedures. Charters also help to provide a common standard of service provider behaviour and help to inform clients about the services they should be receiving.

In Kenya and South Africa, the Ministry of Health has produced patients' charters of rights. In Uganda, UNHCO and other CSOs have worked with the Ministry of Health to define a charter of patients' rights and responsibilities. The Ugandan charter of rights includes clauses on the right to medical care, the prohibition of discrimination and the right to informed consent and privacy. In Zimbabwe, the CWGH was one of a number of civil society groups that, in 1998, reviewed the

charter of patients' rights drafted by the Ministry of Health which, until recently, was displayed in all health clinics.

***Consultation between citizens, providers and policy-makers.*** Research on effective policy change in the health sector indicates that consultation between providers and citizens, as well as policy-makers, enhances the quality and breadth of partner country ownership and, consequently, programme sustainability (ODI 2007). Meaningful participation that includes people who are marginalized and vulnerable helps to ensure that policies are responsive to the concerns of all groups in society. Consulting service providers helps to develop policies that are more likely to be implemented

In Peru, in the context of high turnover of official positions, the engagement of people themselves in decision-making is critical for continuity and sustainability of health policies and programmes. CARE and ForoSalud have worked at local, regional and national level to support the participation of women and people from excluded ethnic groups in decisions about health policy. At local and regional levels, they have supported participation in local health management committees (CLAS) and regional health planning meetings. At national level, Forosalud has participated in the National Health Council, ensuring that the views of people who are excluded are heard in debates about national health policies.

The work of CARE and Forosalud has helped to establish the post Fujimori emphasis on demand-side issues, participation in health service management and equitable access to health services. It has contributed, for example, to the introduction in 2005 of Ministry of Health (MINSA) regulations authorizing health-service support for cultural preferences, such as giving birth in a vertical position. In the absence of a health SWAp, partnerships with key development actors have helped to ensure that aid addresses inequalities through specific programmes, such as their alliance with USAID and UNFPA, among others, to promote Safe and Healthy Motherhood.

Vertical linkages and consultation between local, national and international levels deepen partner country ownership and coordination at all levels and can help to ensure that national policies respond to local realities. In Nepal, reports from ActionAid's local-level participatory voice capturing exercise, highlighting women's concerns about the financial barriers to maternal health services, contributed to the national level policy debate and the decision to abolish fees at lower level health services. The process and results of the voice capturing exercise are also contributing to debates about the substance of the International Health Partnership Agreement, ensuring that the issue of service responsiveness to excluded groups is on the agenda.

Effective participatory processes often reveal conflicts of interest between different stakeholders, but can also help to resolve differences and build solidarity. In Uganda, the UNHCO has worked at local level with patients and

service providers to discuss and resolve problems with health provision. This approach has helped service providers themselves to identify their resource and other constraints and provides a basis for articulating these issues with their managers.

In Zimbabwe, the work of the CWGH to support community participation in Village Health Committees has strengthened local ownership and maintenance of public health clinics. This has been critical in the current context where government support for basic service provision is minimal and local governance structures are disintegrating. The CWGH has encouraged the participation of women's group leaders in decision-making, along with traditional leaders and health service providers. Dialogue between the different stakeholders is seen as the key to building bottom-up ownership and solidarity. Instances where there have been complaints about quality of services, for example, have been amicably resolved at local level rather than being referred up to the district committee. In the villages and districts where the CWGH is operating, there has been a notable improvement in service and drug supply, as well as service uptake.

Case studies demonstrate that effective participation requires time and resources to build the capacities of people, providers and policy-makers to engage with each other. Nepal's Equity and Access Programme works with service providers and local health committees to strengthen their capacity to listen and respond to the concerns of women from low caste and excluded ethnic groups about maternal health services. In Peru, CARE and ForoSalud have developed methodologies that support the capacities of excluded groups to participate in local health management committees. In the absence of these capacities, as the Kenya health sector demonstrates, commitments to provide the local-level services necessary to address child and maternal mortality are unlikely to be successfully implemented.

***Policy community cohesion.*** A primary strength of the human rights framework is that the language of rights is often a more effective means than other development concepts of encouraging civil society mobilization and, consequently, policy community cohesion. "A human rights framework is one that is shared among a large number of groups. Thus use of that framework will facilitate and encourage the development of collaborative relationships with other organizations and the possibility that...analysis will have a greater impact through being used in advocacy by others" (Fundar 2004:4).

In Peru, post Fujimori administrations have taken up the language and concepts of the right to health. This has helped to open up dialogue with civil society about problems in health service provision. In Kenya, the use of international human rights standards by the Ministry of Water and Irrigation has provided a framework for debate with CSOs about addressing water supply sustainability through pro-poor pricing tariffs.

Quasi-judicial human rights institutions can provide an important bridge for strengthening collaboration between CSOs and government ministries on human rights issues and pro-poor agendas. In Uganda, for example, the engagement of the Uganda Human Rights Commission in stakeholder meetings with the Ministry of Health has helped to build the legitimacy of the voice of CSOs working on the right to health and encouraged the Ministry of Health to act on this agenda.

In some contexts, such as Zimbabwe, the phrase 'human rights' is associated with political opposition and can create tensions rather than cohesion. In Zimbabwe, the concept of the right to health is utilized instead and has been the basis for social mobilization, joint action between civil society and parliamentarians and linkages between Zimbabwean civil society and the regional Right to Health campaign. As the South African TAC case demonstrates, sharing the language and concepts of human rights with the government does not necessarily mean agreement on all issues. It does, however, provide a common framework and set of institutions for resolving differences.

***Focusing events and links with key government actors.*** Multi-stakeholder focusing events provide a means of cementing ownership of an agenda and building government leadership. They can also attract individuals with strong connections who can generate high-level political commitments. Case studies from Peru and Uganda illustrate how the missions of the UN Special Rapporteur on the Right to Health have built on existing partnerships and have, in turn, created a focus for national events around the right to health, a point of leverage for building the support of government leaders, and provided a catalyst for further action.

The Special Rapporteur has made two official visits to Uganda at the invitation of the Ugandan Government. The first of these visits in March 2005, supported and funded by WHO, was to report on neglected diseases. The report on the mission included a recommendation that the Uganda Human Rights Commission establish a right-to-health unit responsible for looking at neglected diseases. The report also urged WHO to assume a more proactive role in Uganda (UN 2006: 22 E/CN.4/2006/48/Add.2). Following the Special Rapporteur's report, OHCHR and WHO helped the Ministry of Health to organize a two day right to health capacity building workshop in May 2006. The report of the workshop echoed the Special Rapporteur's recommendation that the Uganda Human Rights Commission should establish a health unit with a remit to cover the whole of the health sector. In response to these recommendations, the Uganda Human Rights Commission has now established a unit, funded by UNDP, whose key function is to monitor policies, programmes and projects relating to the right to health, with a focus on neglected diseases. This partnership with UNDP is also supporting the establishment of district level human rights desks, in line with commitments made in the PEAP, which can help to monitor inequalities in access to services.

The second mission of the Special Rapporteur was in February 2007, supported by the OHCHR and WHO. One of the aims of this mission was to contribute to the mid-term review of the Health Sector Strategic Plan II. In order to facilitate this process, Sida, WHO and OHCHR worked with the Ministry of Health to organize a stakeholder meeting during the Special Rapporteur's visit. The workshop had high level attendance and helped to legitimize the participation of CSOs in the sector review process. The meeting initiated a human rights evaluation of the Health Sector Strategic Plan II, using a human rights and gender equality tool developed by Sida and WHO. It is intended that one of the outcomes of this evaluation will be the re-establishment of the Ministry of Health committee on gender and human rights, originally formed as part of the planning process for the first visit of the Special Rapporteur.

In June 2004, the Special Rapporteur on the Right to Health was invited by the Government to visit Peru and report on implementation of the right to health. During this period, ForoSalud organized a National Health Conference attended by nearly 2000 delegates, presided over by the Minister of Health, where rights-based health policy proposals were presented and discussed. As a result of the conference and the impetus provided by the Special Rapporteur's visit, The Minister of Health launched a National Mobilization for Health Rights, supported by the Ministry of Health, which aimed to ascertain people's views on their health rights and services. This led, in turn, to a series of macro-regional meetings to analyze health rights and responsibilities at regional and local levels and develop appropriate health plans. The result of these processes was the 2006 Political Parties Health Agreement, signed by sixteen national political parties. The Agreement committed the parties to support the achievement of the Millennium Development Goals through universal access to good quality health services, decentralization and social participation.

***Clear policy solutions.*** The PD defines the formulation of prioritized, results-oriented operational programmes as critical to effective country partner leadership. As outlined in section one, this requirement resonates with the human rights principle of progressive realization and governments' obligation to take concrete, planned steps towards the realization of all human rights.

The Kenyan water sector case study demonstrates how the human rights framework can be used to develop an effective results-oriented operational programme. The primary implementation problem faced by the Ministry of Water and irrigation was the regulation of the private sector providers in order to ensure a pro-poor orientation. In the context of its policy advisory role, GTZ suggested using international human rights standards as a basic framework for setting guidelines for, and regulation of, Water Service Providers. Key individuals within the Ministry of Water and Irrigation realized the value of the human rights emphasis on the central stewardship and regulatory role of the ministry, and saw that it provided a stronger normative basis than a straightforward poverty focus for pro-poor regulation of the water sector. GTZ and other development partners

are now working with the MWI to translate international standards on water and sanitation availability, accessibility, affordability and quality into indicators that can be incorporated into sector guidelines and contracts between water service providers and water boards. The MWI's use of the human rights framework has, additionally, opened up opportunities for civil society to engage with the MWI and strengthen its focus on accountability, transparency and local community participation in decision-making.

The human rights framework has also provided the basis for the identification of problems in the first instance and for establishing these issues in international and national agendas. In Uganda, for example, emphasis on women's right to maternal health care is helping citizens, health care workers and policy makers to recognize that women's death in childbirth requires action and is not simply a common and inevitable occurrence. In South Africa, the actions of TAC ensured that the issue of antiretroviral treatment for HIV & AIDS was on the national agenda and that government responded to the need for a comprehensive treatment plan.

### **3.3 Donor support for ownership**

The Paris Declaration commits donors to respect partner country leadership and help strengthen their capacity to exercise it. Analysis of policy processes suggests that on the ground, the national processes already outlined are more important than international factors in building partner country leadership (ODI 2007). International factors that do have an impact, however, and can either support or undermine national ownership and leadership include:

- Norm promotion.
- Resources.

***Norm Promotion.*** International UN human rights institutions, including the Treaty Monitoring Bodies and the Special Rapporteurs, maintain an explicit and consistent dialogue with partner country governments on human rights standards and principles. It could be argued that this consistency and independence strengthens their authority and influence with partner country governments. It is often assumed that donors derive power and influence from the financial incentives they are able to offer. However, evidence suggests that the use of financial incentives, or conditionalities, has not proved effective as a means of building recipient government ownership and leadership (ODI 2006).

The PD aims to move beyond donor imposed conditionalities on aid. The DAC Action-oriented Policy Paper (AOPP) on Human Rights and Development states that donors should " Take a harmonized and graduated approach to deteriorating human rights situations.....Establishing human rights as part of the development partnership will help enhance predictability, and provide a basis for open and transparent dialogue where needed." (OECD 2007: para 9).

Nonetheless, donors are likely to want to include a basic human rights 'floor' in any agreed framework for programme monitoring (ODI 2006:20). In this context, donor dialogue over shared values, including human rights, has assumed an increasing importance. Policy dialogue is viewed, by some, as the new tool for resolving the dilemmas of ownership versus promotion of basic standards (Sida 2002). Current debate about the value of "the policy dialogue" as a means of influencing recipient governments indicates that there is also a large body of donor skepticism about what can be achieved through this channel (Ministry of Foreign Affairs, the Netherlands 2008). Whatever its potential, donor dialogue is unlikely to be useful without a consistent approach among donors on core issues such as human rights, as outlined in the DAC AOPP. This has not yet been achieved. In Uganda, for example, the Joint Assistance Strategy identifies human rights as a potential trigger for low funding (Gaynor and Jennings 2008). However, it is not clear that donors have established an explicit, co-ordinated position on the nature and level of human rights violations that might lead to the lower funding scenario or conveyed this in dialogue with the Government of Uganda.

The Zimbabwe case study highlights some of the challenges of promoting ownership in the context of a fragile state and the need for flexibility in the delivery of aid in such situations. As a result of the on-going political crisis in Zimbabwe, donors do not provide funding directly to the Government. Instead, multi-donor programmes of support, such as the UNICEF managed programme of support for implementation of the National Plan of Action on Orphans and Vulnerable Children, provide humanitarian aid to CSOs to deliver basic services. There is a danger, however, that this approach will lead to the creation of parallel CSO structures that undermine the governance structures necessary to ensure basic service provision in a transition period. Some CSOs that have adopted a human rights-based approach, such as the CWGH, work with local governance institutions, including village health committees, district councils and parliamentary committees, to ensure a degree of local democratic process and to maintain governance structures and capacities. There are undoubtedly political risks attached to funding the work of such organizations. Greater flexibility in donor funding, however, and support for CSOs that are taking a human rights-based approach may help to build the foundations for future democratic ownership and mutual accountability of development processes.

**Resources.** The PD principle of ownership includes donors' commitment to strengthen partner countries' capacities to lead on development policy and implementation. A positive example of the implementation of this commitment is DFID Nepal's Support to the Safe Motherhood Programme. Capacity building to address issues of social exclusion and discrimination is integral to this programme.

Resource allocations through aid modalities such as budget support and SWAps, however, do not always support the capacity development in both government

and civil society necessary to ensure that partner countries' human rights commitments are implemented. Case studies indicate that lack of government capacity to address the relevant social and political issues is a key constraint on governments trying to move from commitment to action. In Kenya, for example, the National Health Sector Strategy Paper II includes explicit commitments to implementing a human rights-based approach with an emphasis on equity through reallocation of resources and greater local participation in decision-making. This commitment has not been translated into a clear implementation plan, taken up in the Joint Programme of Work and Financing or addressed in the Joint Assistance Strategy. Mid-term review of the sector strategy suggested that a key constraint, although certainly not the only one, was lack of capacity within the Ministry of Health to analyze and address gender and human rights issues. The review recommended setting up a unit within the Ministry of Health to fill this gap (WHO 2007).

A further constraint, in some cases, is lack of clear funding mechanisms for civil society. In Kenya, the implementation of a human rights-based approach is dependent on co-ordination with civil society organizations, both as providers of services for hard-to-reach communities and as a means of strengthening local-level capacity to engage in decision-making. The importance of public-private-partnerships is acknowledged in policy documents. Civil society organizations have committed to supporting implementation of the government's health sector strategy through signing of the SWAp code of conduct. To date, however, the emerging health sector SWAp, does not contain any clear mechanism for funding civil society organizations to implement the policy.

The recent report on Uganda of the Special Rapporteur on the Right to Health highlights the fact that CSOs working on the right to health are concerned that the establishment of a basket civil society fund will lead to reductions in their financial support. Donors, then, need to ensure that where CSO funding mechanisms do exist, they do not favour the most mainstream and well-established organizations working on the least controversial issues (UN 2008 A/HRC/7/11/Add.2).

## **Section four: Mutual accountability**

### **4.1 Introduction**

The Paris Declaration defines mutual accountability as "donors and partners being accountable for development results". Review of the implementation of the PD suggests that this is the least understood and implemented of all the PD principles (OECD-DAC 2006). The PD sets out the need for governments to be accountable to citizens and donors and partner countries to be accountable to each other. On the ground, the strongest accountability relationship in aid processes remains that of recipient governments to donors (ODI 2006). In contexts of unequal power relations between donors and partner countries, mutuality tends to be interpreted as meaning that donors' accountability is contingent on partner countries proving, to the satisfaction of donors, that they have fulfilled their commitments. Where this is the case, aid relations may undermine the credibility and leadership of partner governments and their accountability to citizens.

The human rights framework can strengthen mutual accountability by anchoring all governments' accountability in national democratic institutions and processes of citizen-government review as well as independent international monitoring processes. The first part of this section looks at national and international mechanisms to strengthen partner country accountability. The second part of the section reviews national and international processes for holding donors to account for their commitments.

### **4.2 Partner country accountability**

The PD states that partner countries' accountability should be achieved through governments committing to:

- Strengthen the parliamentary role in national development strategies and budgets.
- Reinforcing participatory approaches by systematically involving a broad range of development partners when formulating and assessing progress in implementing national development strategies.

The human rights framework places these key elements of the PD in a broader context of citizen and government rights and obligations and democratic institutions. As outlined in section one, human rights can strengthen the PD's commitment to partner government accountability through:

1. Clear legal obligations and norms against which partner countries can be held accountable.
2. International, national and local accountability processes which enable broad participation in assessment of partner country progress against human rights obligations in legislation and policies.

The incorporation of human rights standards into national legislation and policies has been reviewed in section three. In this section, processes to hold

governments to account for those standards are reviewed. National accountability processes include parliamentary and administrative procedures, joint reviews, social, quasi-judicial and judicial mechanisms. International level processes include the quasi-judicial reporting mechanisms of the Treaty Monitoring Bodies and Special Rapporteurs. As the case studies demonstrate, successful attempts to hold governments, or others, to account, are often the product of interaction and linkages between these different processes. Strengthening mutual accountability for aid effectiveness, consequently, requires support for a range of accountability mechanisms and the inclusive engagement of stakeholders in review processes.

**Political accountability.** The PD outlines the importance of the role of parliament in scrutinizing budget and policy proposals. Human rights standards on civil and political rights underpin the democratic nature of parliament and the role of parliamentarians as elected representatives of the people. In addition to fair electoral processes, regular contact between constituents and their representatives is an important part of building the credibility of parliament as a mechanism of accountability.

Parliamentary committees provide a further avenue for civil-society engagement with parliamentarians in their role of reviewing budgets, legislation and policies. Parliamentary committees exist in most countries in a variety of forms. They conduct inquiries into specific legislative or policy issues. They may take submissions and hear witnesses (Potts 2008). In the United Kingdom, the International development Committee is the primary body for reviewing the UK government's international aid programme.

In Zimbabwe, the Community Working Group on Health (CWGH) has a close working relationship with the Parliamentary Portfolio Committee on Health. Their relationship is set out in a Memorandum of Understanding. This covers a number of joint areas of work, including the engagement of committee members in CWGH work and campaigns on the right to health. The CWGH has also been involved with the Committee in reviewing budgetary allocations to the health sector, helping to strengthen transparency and accountability in budget processes.

**Administrative accountability.** Administrative accountability requires the existence of clear standards and protocols of practice as well as internal review processes to monitor compliance. From the service users' perspective, clear complaints procedures provide an avenue for individuals to hold the Ministry of Health and service providers to account for their actions when standards have not been met. In South Africa, the National Health Act states that every person has the right to make a complaint about the way they have been treated at any health establishment by any of the staff. Any hospital, clinic or other State or private health facility has a duty to display the procedure for making a complaint at the entrance to the facility where it is easily visible (Khoza 2007).

While health strategies often contain commitments to set up complaints procedures, these processes are not always effectively implemented. In Kenya, the health strategy includes a commitment to setting up patients' complaints procedures. A recent report by the Federation of Women Lawyers in Kenya, however, argued that the lack of clear, formalized complaints procedures and mechanisms for redress was one of the primary causes of continuing abuses of women's rights, including discrimination and abuse, in health centres (FIDA 2007). Similarly, research by the UNHCO found that local-level feed-back mechanisms in Uganda were weak. The majority of people surveyed were not aware of the existence of suggestion boxes in health facilities or of the role of Health Unit Management Committee in addressing people's concerns about health services. The work of the UNHCO has led to a commitment in the Health Sector Strategic Plan (HSSP II) to strengthen health facility complaints' mechanisms (UNHCO 2003).

**Joint reviews.** The PD highlights the importance of joint reviews between donors, country partner governments and civil society organizations as a mechanism for increasing mutual accountability. A number of tools, such as human rights impact assessments, have been developed and can be applied to the health sector to assess adherence to human rights standards. The application of these tools helps to ensure that the underlying causes of poor health outcomes are addressed. In Bangladesh, for example, a human rights impact assessment has been carried out in relation to the government's policies on maternal health and helped to identify critical inequities in access to maternal health services.

**Bangladesh: The Human Rights of Women Assessment Instrument (HeRWAI) and maternal health services.**

Naripokkho, a membership activist women's organization working for the advancement of women's rights and entitlements, used the HeRWAI tool to assess maternal health services in Bangladesh. The assessment reviewed the Bangladesh National Strategy for Maternal Health against the government's national and international human rights commitments. The analysis revealed that the measures set out in the Strategy were mainly benefiting middle and upper-middle class women. Rural and poor women had too little information about where they can get treatment and often fail to reach services in time. The assessment included recommendations to the government for measure that would fulfill their human rights obligations to ensure equal access to maternal health services.  
(Naripokkho 2006)

Bilateral donors, including DFID, have developed their own governance and human rights assessment tools which form part of the planning and review cycle of their country strategies. There are also examples of these tools being used, in accordance with the PD, as part of joint review processes with a partner country. In Uganda, Sida, WHO and the Ministry of Health are collaborating with civil society partners to develop and use a tool for assessing human rights and

gender equality as part of the mid-term review of the Health Sector Strategic Plan (HSSP II). The main goals of the review are to appraise the status of health and human rights within the context of HSSP II planning and reporting at the national and local government levels and to assess mechanisms for strengthening health and human rights structures within the health sector. The analysis will reveal gaps and needed actions in relation to the promotion and protection of human rights as well as gender mainstreaming and will help to ensure that the health sector strategy is supporting equitable health outcomes.

The focus of the tool is on the planning, reporting and processes/mechanisms for implementation. The health system's building blocks, as identified in the WHO framework for health systems "Everybody's Business", serve to focus the analysis, which incorporates key elements of the right to health, other health related human rights standards and human rights principles. The human rights and gender equality tool developed by WHO and Sida will also be piloted in Zambia.

**Social accountability.** Social accountability processes can be defined as the use of monitoring and reporting by civil society to strengthen direct accountability to citizens, rather than via an intermediary, such as parliament or the judicial system. Social accountability mechanisms are particularly important where the "long route" of accountability via democratic parliamentary or judicial processes is not well established (World Bank 2003). Research by the World Bank suggests that social accountability mechanisms can increase the effectiveness of service provision, even in the absence of additional financing.

**Uganda: Research on the impact of social accountability mechanisms.**

Research initiated by the World Bank and University of Stockholm, in cooperation with the Ugandan Ministry of Health and 18 community-based organizations, has demonstrated how social accountability mechanisms can lead to improvements in both service provision and health outcomes even in the absence of increased funding. The research project identified 50 health facilities in rural areas of Uganda. In community catchment areas for 25 of these facilities, a pilot citizen report card project was established. Patients' rights, identified in the government's quality of care strategy, provided a basis for community monitoring of services in these areas. The other 25 facilities and catchment areas were used as a control. One year into the programme, average utilization was 16 per cent higher in participating communities than in non-participating control communities. Provider practices, including immunization of children, waiting time and examination procedures had improved significantly; the weights of infants were higher and deaths among children under-five were markedly lower. (Bjorkmann and Svensson 2006)

Social accountability processes include specific methods, such as citizens' report cards, for holding service providers to account, and broader campaigns of civil society mobilization and activism. Budget monitoring is a growing area of social accountability. Standards on the right to health and discrimination provide a clear framework for civil society monitoring of inequalities in health budget allocations.

Human rights standards and principles of transparency and the right to information provide an essential underpinning to all budget monitoring activities. The contribution of human rights standards and principles to budget processes is discussed in more detail in section five on alignment. The work of the Uganda Debt Network, below, illustrates the impact of community budget monitoring on health service delivery.

**Uganda: Community Based Monitoring and Evaluation System.** In 2002, the Uganda Debt Network (UDN) initiated a Community Based Monitoring and Evaluation System (CBMES) to engage people who are poor and marginalized in monitoring and evaluating programmes for poverty reduction in their own communities. The programme provides people with information about poverty strategies and teaches them to do local budget analysis. It supports the participation of women and people from excluded groups in its work. As part of the CBMES, volunteer monitors work directly with health service providers to evaluate service delivery and discuss the results. The findings are also presented to local government officials by the community monitors, who use their knowledge to request further information and negotiate solutions. The programme has documented significant obstacles to health service delivery including deficiencies in management, procurement and control systems of local health units as well as raising issues of bribery and corruption. It has also mobilized community support for the establishment of local health facilities and monitored construction of agreed facilities. The programme was originally piloted in four districts and is now being established in a further seven. An evaluation of the original pilot phase showed an improvement in health and education services and a reduction in substandard work in the districts where the CBMES was established.  
(Uganda Debt Network [www.udn.or.ug](http://www.udn.or.ug); Keith-Brown 2005)

In Nepal, social accountability mechanisms are an integral element of the Ministry of Health and Population's Support to Safer Motherhood Programme. The "voice capturing" component of the Equity and Access Programme involves community based organizations using a range of participatory methods to ascertain the views of women, particularly those from disadvantaged groups, on maternal health issues and service. The reports generated by this process are then used in village and district health committee meetings as a basis for reviewing service provision. Examples of direct action as a result of the voice capturing reports include allocation of staff to health centres following reports of absenteeism, and the introduction of local level emergency funds to support costs for women who have been referred to higher level services.

The work of the CWGH in Zimbabwe demonstrates that patients' charters can be a powerful tool for holding service providers and the government to account. In Zimbabwe the Ministry of Health introduced a Patients' Charter of Rights in 1996. In 1998 civil society organizations, including the CWGH, trades unions and church organizations were involved in review of the charter. The Charter was distributed to all health clinics and centres. It was well received by both clinic staff and service users. Relatively high levels of literacy in Zimbabwe meant that there was strong community awareness of the charter and its contents. Where

the CWGH was working at village level, they mobilized communities around the Charter and it became a basis for people to raise questions with service providers and local and district health committees about drug supply, the use of resources and provisions of services. The deteriorating economic and political situation in Zimbabwe, however, led the government to withdraw the Charter from display in local clinics and services. The CWGH still uses it as a basis for village-level mobilization and education (interview with Itai Rusike, CWGH).

**Judicial accountability.** Where the right to health has been incorporated into the constitution or other national legislation, it provides the opportunity for citizens to challenge government legislation and policy through judicial systems. Litigation on the right to health is often undertaken on the basis of individual grievances. The South African case of the Treatment Action Campaign (TAC) versus the Minister of Health provides an example of the use of public interest litigation to challenge the government's policy on provision of antiretrovirals (ARVs) to pregnant women.

In 2002, TAC challenged the government's policy on antiretroviral (ARV) provision through the Constitutional Court. The case centered on the provision of nevirapine, for the prevention of mother-to-child transmission (MTCT), which the government had limited to eighteen pilot sites. TAC challenged this policy on two grounds. It argued that the government unreasonably prohibited administering nevirapine at public hospitals and clinics and that the government had not produced and implemented a comprehensive national programme for the prevention of MTCT of HIV.

The High Court and the Constitutional Court decided that the programme was unreasonable as it restricted access to a potentially life saving drug to only a few sites, and thus a few people. Both the High Court and the Constitutional Court found that the state's programme did not comply with its obligations in terms of section 27(1) and (2) of the Constitution. It ordered the government to remove the restriction from the programme and roll it out nationwide. TAC threatened further litigation when the government failed to implement the Court orders. However, this was averted when the Department of Health moved to purchase ARVs in 2004 (Khoza 2008).

The success of the campaign, however, rested not only on the use of litigation but on the civil society mobilization around the right to treatment for HIV/AIDS. Civil society advocacy and action ensured that the government followed up on the Court's ruling (Gauri and Brinks 2008). The government and civil society organizations have subsequently worked together to produce the current National HIV & AIDS & STI Strategic Plan. The new national plan identifies human rights as one of four key priorities for government and civil society action.

**Quasi-judicial accountability.** Quasi - judicial mechanisms include independent bodies established by the government for the specific purpose of

advancing and defending human rights, such as National Human Rights Institutions and Ombudspersons. These bodies are established by the government and have varying degrees of power (Potts 2008). In South Africa, the Constitution established the South African Human Rights Commission to monitor the observance and respect for human rights and to review progress in the realization of socio-economic rights. It carries out its monitoring task through scrutinizing information from government departments and holding public hearings on particular rights. It also has the power to receive and investigate individual complaints (Khoza 2008)

National Human Rights Commissions have also been established in Kenya, Uganda and Nepal. The value of their role has been increasingly recognized by development partners. In Uganda, for example, reports from the Human Rights Commission provide an indicator of governance in the Joint Assistance Strategy results framework (JAS 2006:44). National Human Rights Commissions have conventionally focused on civil and political rights. Both the Kenyan and Ugandan Commissions are now broadening their remit to address social and economic rights, including the right to health.

In Peru, in the absence of effective and accessible administrative or judicial mechanisms of redress, civil society organizations have linked up with the Ombudsperson to monitor women's right to health in relation to maternal health care. CARE, in partnership with ForoSalud, Physicians for Human Rights and the Ombudsperson Regional Offices has initiated a programme of citizen surveillance of maternal health services in Piura and Puno regions. The purpose of the project is to build the capacity of community networks of women from excluded Quechua and Aymara ethnic groups to observe the operation of health services and report back their findings to the regional Ombudsperson offices.

The programme started with training workshops for women's groups and liaison meetings with local authorities and health facilities. The pilot of the monitoring networks was initiated in October 2007. Women have been working in three hospitals, three health centres and six health posts where they visit on a weekly basis to speak with health service users and watch health care procedures. Women report to the Regional Ombudsperson office in a monthly meeting. The Ombudsperson officers then discuss the findings with the health facility managers and health team. The surveillance scheme has helped to identify and the practice of imposing fines on families that have had a home-birth, when they come to register their new-born. Forosalud experience has contributed to current Ministry of Health debates about establishing similar schemes in national hospitals.

***International accountability processes.*** International quasi-judicial processes for reviewing governments' implementation of the right to health include the Committee on Economic, Social and Cultural Rights and the Special Rapporteur on the Right to Health. The ESC Committee is the UN body of independent

experts that monitors implementation of the International Covenant on Economic, Social and Cultural Rights by states that have ratified the convention. Governments must report within two years of accepting the Covenant and every five years thereafter (Potts 2007). Civil society organizations are encouraged to engage with the Committee through verbal or written submissions as well as the preparation and presentation of shadow reports on a government's implementation of its obligations (Khoza 2007). In Peru, for example, civil society organizations collaborated to produce a shadow report in 2006, following up on recommendations made by the Special Rapporteur on the Right to health in 2004.

The Human Rights Commission appointed a Special Rapporteur on the Right to Health in 2000. The role of the Special Rapporteur is to undertake country visits to investigate implementation of the right to health at national level (Potts 2008). These missions have included missions and follow-up reports to Peru and Uganda. In both cases, as discussed in section three, the mission has provided a catalyst to further country level action on the right to health. The power of the Committee and the Special Rapporteur lie in their capacity to generate national and international publicity through their reports. Governments are increasingly aware of their global and domestic image. It is in this context that international human rights accountability processes are becoming an important entry point for moving partner governments from rhetoric to action (FEMNET 2007).

#### **4.3 Donor accountability**

The PD outlines a clear commitment to mutual accountability between donors and partner governments. It sets out donors' commitment to providing more comprehensive and transparent information on aid flows. It also states that both partner countries and donors should jointly assess through existing and increasingly objective country level mechanisms mutual progress in implementing agreed commitments (OECD 2005). Despite these commitments, however, it is a commonly held view that aid accountability is one-way. Moreover, current accountability patterns, in which donors hold aid recipients accountable, undermine partner countries' accountability to their citizens (Afrodad 2007). The human rights framework includes standards and processes that strengthen the basis for strengthening the implementation of PD commitments to donor accountability and ensuring that donors are accountable to partner country governments and people.

Human rights treaties reinforce donors' obligations to support governments deliver their human rights obligations. The Special Rapporteur on the Right to Health notes that "a rich State's human rights responsibility to provide international assistance and cooperation is underpinned by a legal obligation. ... The human rights responsibility of international assistance and cooperation should not be understood as only encompassing financial assistance from North to South. It also includes, for example, a procedural responsibility on rich States

not to withdraw critical aid without first giving the recipient a reasonable opportunity to make alternative arrangements" (UN2007 A/HRC/4/28/Add.2).

The UN does not have special mechanisms for reviewing the implementation of these obligations. In the absence of dedicated processes, however, existing review procedures are used to evaluate donors' actions. When a donor country appears before the Committee on Economic, Social and Cultural Rights, for example, committee members can present questions about fulfillment of their obligations to provide aid, as well as reviewing governments' action in relation to their own citizens. The Special Rapporteur on the Right to Health has also used his mandate as a basis for review of donors' programmes of international assistance. These mechanisms provide one of the few existing independent, rather than political or peer, processes of reviewing donor action. As such, they provide an important existing means of fulfilling the PD commitment to increasingly objective review of donor and partner country action.

In 2007, the Special Rapporteur reviewed Sida's development programme on health in Uganda, as part of a follow-up on an earlier visit to Sweden to review the government's overall implementation of the right to health. The Special Rapporteur's notes that, "as a State party to ICESCR and CRC, Sweden not only has a duty to give effect to the right to health domestically but also through "international assistance and cooperation"(UN 2008:7 A/HRC/7/11/Add.2). This duty includes both financial and non-financial dimensions. The report notes that the Swedish Government has also made domestic commitments to addressing human rights in international assistance. In its policy document, Human Rights in Swedish Foreign Policy, the Swedish Government pledges to integrate human rights into all areas of foreign policy and to mainstream human rights into the work of global and regional organizations (UN 2007 A/HRC/4/28/Add.2).

The final report of the Special Rapporteur commends the Sida programme and notes that it does support the Government of Uganda's fulfillment of its constitutional and international obligations towards the right to health. Nonetheless, the report notes that human rights are not mainstreamed consistently throughout Sweden's development cooperation in Uganda, including in Sida's support to the health sector (UN 2008 A/HRC/7/11/Add.2). As outlined in previous sections, one of the outcomes of the Special Rapporteur's reports and missions has been contribution to the initiation of a human rights and gender equality review of the health sector strategy with the Ministry of Health, supported by Sida and Who.

Information from the UN monitoring processes is publicly available and often widely reported, and so contributes to the public accountability of donors. The report of the Special Rapporteur suggests a number of other ways in which Sida could improve their accountability, including through provision of accessible information about their programme in Uganda, presentations to the Ugandan Parliamentary Committee on Social Services and a strengthened role for the

Uganda Human Rights Commission in monitoring donor policies as well as those of the government (UN 2008 A/HRC/7/11/Add.2).

Engaging a wide range of partner country institutions and processes to report on donors' actions enhances the credibility of partner country democratic processes as well as increasing donor accountability to partner countries. Civil society engagement in these processes is critical to ensuring that donors are accountable to intended beneficiaries of aid as well as to governments. Recent work by UNDP in Sri Lanka provides an example of a civil society watchdog mechanism that could be replicated elsewhere to enhance mutual accountability of donors to partner countries.

**Sri Lanka: Civil society monitoring of post-tsunami development work.** AID WATCH is an initiative of UNDP in Sri Lanka that aims to empower civil society to 'ask the right questions' on recovery and development activities in participant communities. The objective is to change attitudes of donors and participants, moving beyond the idea of charity and ensuring that recovery and development takes place in an environment of increased accountability, transparency, participation and empowerment. The project facilitates a dialogue between civil society and relevant stakeholders, providing technical know-how and mobilization skills. In a UNDP housing project, for example, participants are encouraged to discuss the project with field staff, ask questions, share grievances and make recommendations. They are also engaged in dialogue with local government representatives and the National Human Rights Commission. They are provided with training on the technical aspects of the project and on rights awareness, mobilization and empowerment. (UNDP 2007).

## **Section five: Managing for results**

### **5.1 Managing for results**

The PD states that "managing for results means managing and implementing aid in a way that focuses on the desired results and uses information to improve decision making". Evaluations find that relatively little attention is being given to the implementation of this commitment. One reason given for this is unclear definitions and lack of clarity of the concept (OECD 2008: 32). The human rights framework can help to address these shortcomings by providing a basis for clarifying both the results that need to be achieved, the strategies for achieving them and the most effective means of monitoring implementation.

As noted in section one, the PD principle of managing for results resonates with the human rights emphasis on monitoring as a critical element of government accountability for the implementation of human rights obligations (ODI 2006). From a human rights perspective, monitoring provides information to duty-bearers to determine what is working and where changes need to be made. It also provides rights-holders with the information they need to claim their rights (Potts 2008).

Key elements that a human rights monitoring processes add to managing for results include:

1. The use of human rights indicators and benchmarks to monitor progress towards the realization of particular rights.
2. Disaggregated data to monitor differential impact of interventions on excluded social groups and their level of engagement in development processes.
3. Civil society participation in monitoring processes.

**Indicators.** The PD's focus is on a manageable number of indicators for which data are cost-effectively available. Indicators included in health sector results frameworks generally include indicators on maternal and infant mortality rates. These can be understood as indicators of the realization of the right to health as well as being MDG indicators. Review of case study documentation, however, suggests that few results frameworks at sector or national level include human rights indicators on participation and accountability. In the absence of these indicators, there is little incentive to ensure that attention is paid in development programmes to those democratic processes that support the PD principles of ownership and mutual accountability and are critical to achieving the MDGs.

The results framework of the Kenyan Joint Assistance Strategy, for example, includes MDG indicators on maternal and child mortality under the health pillar. The narrative identifies 'governance' as an obstacle to the achievement of results. However, the results framework does not include indicators on processes of participation and accountability. Similarly, the Kenyan National Health Sector Strategic Plan II and Joint Programme of Work and Financing do not include indicators on participation and accountability. Failure to address these issues

contributes to the lack of implementation of commitments to support those local level services that are critical for reducing maternal and child mortality.

***Disaggregated data.*** Disaggregated data is essential to monitor equality and non-discrimination. Some indicators included in results frameworks in national and sector documents are disaggregated by gender and age. In general, however, review of case study policy and strategy documents suggests that disaggregation of data by other social identity remains the exception. While collecting disaggregated data is often both technically and politically difficult, this is an area where consistent and co-ordinated donor support could have a major impact on poverty monitoring and, consequently, outcomes.

The World Bank/DFID work on social exclusion in Nepal provides an example of donor-government collaboration on strengthening the collection of disaggregated data. It highlights the research and commitment required to establish such systems as well as the support for capacity building required at different points to enable health workers and others to collect the data. World Bank/DFID funded research on social exclusion provided the basis for identification of six categories which could be used for monitoring purposes. These categories are as follows: Brahman/Chhetri; Tarai/Madhesi other castes; Dalits; Newar; Janajati; Muslims. Gender is monitored as a cross-cutting category. The National Planning Commission is currently considering whether or not to increase the number of categories for monitoring from six to nine. These categories are seen as capturing the key axes of differentiation in Nepal, without taking disaggregation to a level which would not be practical to implement. The categories were used first as a basis for monitoring DFID livelihood programmes in Nepal. DFID is now working with different line ministries to implement this framework as a basis for monitoring across different sectors. In the health sector, the Ministry of Health and Population is in the process of piloting the collection of disaggregated data in three districts. Key challenges include difficulties of defining individuals against the categories identified and the lack of capacity at lower level health centres to collect and record the required data.

Where the generation of national disaggregated data is not currently feasible, human rights-based approaches have generated qualitative data, such as the information on women's perspectives generated by Action Aid's Equity and Access Programme in Nepal, the Uganda National Health Consumers' Organization's reports on local health feed-back mechanisms and the Kenyan Federation of Women Lawyers' report on women's reproductive health in Kenya (FIDA 2007).

Qualitative methods and data often complement statistical information, providing greater depth of understanding of the causes of health problems and systemic failures in health systems. In Peru, for example, research by Physicians for Human Rights on maternal mortality involved the use of multiple sources of evidence to reconstruct individual case histories and to analyze the causes of

high maternal mortality rates. Methods included in-depth interviews with family and community members of women who died due to pregnancy-related complications, as well as with women who survived obstetric complications. The report found that maternal deaths in Peru are overwhelmingly related to the three delays relating to EmOC; the delay in the decision to seek care, the delay in arriving at care, and the delay in receiving appropriate care. These delays, in turn, are linked to systemic inequities in Peruvian society and the health care system. It found that delays in seeking care, for example, were affected by the inequitable distribution of healthcare facilities, economic barriers of access and the lack of cultural acceptability of care at health facilities (PHR 2007).

***Civil society participation.*** Conventional monitoring processes, particularly in the health sector, focus on top-down, technical and financial information. The human rights standards and principles of participation and the right to information emphasize the engagement of civil society in monitoring processes and the importance of disclosing information from monitoring processes. Using rights as objectives, benchmarks and indicators against which progress is monitored can have a greater mobilizing effect on civil society than more technical approaches. Civil society mobilization can, in turn, ensure greater focus on and engagement in the achievement of development objectives (ODI 2006). Case study material reviewed in sections three and four illustrates how this approach has strengthened mutual accountability and partner government ownership.

## **Section six: Harmonization and alignment**

### **6.1 Introduction**

The PD defines the principle of harmonization as donors' actions being harmonized, transparent and collectively effective. Alignment is defined as donors basing their overall support on partner countries' national development strategies, institutions and procedures. As human rights standards and principles are generally an integral part of partner countries' and donors' domestic legislation and policies, as well as their international commitments, they should provide a common platform on which processes of alignment and harmonization can be built. In practice, however, few donors systematically ensure that support is aligned with human rights enshrined in national legislation and policies and harmonization between donors has not generally built on the human rights framework.

### **6.2 Harmonization**

As noted in section three, explicitly addressing human rights in donor dialogue with partner countries can help to ensure a graduated response to deteriorating human rights situations. Achieving this approach requires a consistent, harmonized position on human rights among donors themselves. In practice, however, this has not been achieved. Moreover, the Special Rapporteur on the Right to Health comments, on the basis of his mission to Uganda, that there is a danger the search for common positions among donors will lead to agreement around the lowest common denominator and neglect of difficult issues, such as sexual and reproductive health rights (UN 2008. A/HRC/7/11/Add.2). Donor consistency and co-ordination on human rights, then, requires a position that respects the human rights principle of indivisibility, treating all human rights on the same footing rather than, for example, focusing on a narrow range of civil and political rights.

As the case of the adoption of a human rights framework by the Kenyan Ministry of Water and Irrigation illustrates, where human rights do inform the process of donor alignment and harmonization, they can provide a strong platform for increasing aid allocations and effectiveness. In the Kenyan water sector, support for human rights based approaches is included as one of the general principles of the Partnership Principles. The MWI states that, "as human rights are universal principles, the MWI expects donors to align to these by harmonizing their actions and programmes to the sector policies and strategies. In this context, commitment towards the right to water supports the implementation of the Paris Declaration on Aid Effectiveness" (MWI 2007: 5). The use of the human rights framework has helped to increase donor confidence in the MWI's commitment to a pro-poor agenda and to increasing participation, accountability and transparency. This confidence has contributed to increases in the donor budget allocation from Kshs 3.4 Billion in 2006/2007 to Kshs 6.8 Billion in 2007/2008. (MWI 2007a).

### 6.3 Alignment

The human rights framework further supports processes of alignment by promoting rights to information and transparency necessary for public scrutiny of budgets. National and sectoral budgets are at the core of alignment to systems of public financial management. In large-scale programmes which involve multiple stakeholders, tracking budget disbursement and expenditure is a complicated task. Public scrutiny of these processes can help to ensure that resources are used for nationally agreed priorities and translated into development results on the ground.

Government commitment to transparency and the provision of information enables public monitoring of budgets. In Kenya, for example, the Kenya Health Rights Advocacy Network, hosted by the Kenyan Human Rights Commission, has recently started to review and monitor Kenya's health sector budget. Their work has been facilitated by the increasing openness of the ministries of Health and Finance to information sharing and provision of calendars setting out details of the budget cycle. Legislation protecting the right to information has also been critical in India to the success of civil society social audits of large-scale poverty-alleviation programmes.

**Social audits in Rajasthan.** In the Indian state of Rajasthan, a network of civil society organizations called the Rozgar Evum Suchna Ka Adhikar Abhiyan has been conducting social audits of projects under the National Rural Employment Guarantee Act (NREGA). The Act, passed in 2005, guarantees 100 days of employment each year to any rural household whose adult members are willing to do unskilled manual work. Failure to provide work within 15 days gives the applicant a right to claim unemployment allowance. The Right to Information Act, also passed in 2005, has made public scrutiny of the NREGA possible. Civil society-led social audits access relevant information about allocation and expenditure of resources, consolidate it in an accessible form and then verify that information through public meetings with stakeholders. Regular social audits since 2005 have resulted in strong transparency measures, such as boards at worksites detailing the funds allocated for, and spent on, labour and material. In addition to the identification of corrupt practices and the deviation of funds, social audits have also helped to identify where regulations and details of the NREGA could be improved to ensure that associated programmes successfully address the rights of the rural poor. (IBP 2008).

An increasing number of civil society initiatives use the human rights framework as a basis for assessing whether budget allocations and expenditures match national policy commitments. The Central American Institute of Fiscal Studies (ICEFI), an independent research centre founded in 2005, has recently analyzed the budgets of every Central American country to determine if they protect citizens' economic, social, cultural, political and legal rights. The ICEFI examines the budget in the light of the country's constitutional and other national legal

obligations, as well as its international commitments and its political commitments reflected in the Millennium Development Goals. This analysis has helped to highlight key trends in health expenditure in the region (IBP 2008). The work of the Mexican NGO Fundar further demonstrates how human rights analysis of the budget can provide a strong basis for advocacy for pro-poor spending in the health sector.

**Mexico: Human rights budgeting.**

In Mexico, the NGO Fundar used the right to health and the human rights framework as a basis for identifying inequalities in the government's health budget. It found that the costing formula used by the Ministry of Health resulted in lower per capita amounts of health spending in the poorer states of south and south-east Mexico. Fundar has also used this framework for analysis of expenditure on maternal health care. The results of this analysis were used successfully to advocate for the inclusion of basic obstetric care in the government's poverty-focused popular insurance. (FUNDAR 2004)

The Nepal case study highlights the importance of disaggregated monitoring data in health budget processes. Nepal's 2007 Interim Constitution and Plan set out commitments to addressing discrimination in access to health and targeting excluded groups. Nonetheless, some senior officials in the Ministry of Health and Population maintain the view that, in the context of limited resources and large numbers of people living in poverty without access to services, the priority should be increasing coverage of services rather than more costly targeted interventions. Their current strategy is to introduce targeted interventions once near-universal coverage has been achieved (Foster et al 2007). The development of a disaggregated monitoring system, outlined in section five, will provide information that shows who is benefiting from the current strategy and will help health planners to reallocate resources to under-served groups and communities.

## **Section seven: Recommendations**

### **Partner countries**

Partner country governments can utilize the human rights framework to strengthen aid effectiveness and improve development results in the health sector by:

- Building health sector legislation, regulations and policies on international human rights standards, regional human rights charters and rights identified in the constitution.
- Using the rights identified in constitutions, legislation and policies as a basis for identifying and communicating citizens' entitlements to health care through, for example, a charter of patients' rights drawn up on the basis of civil society consultation.
- Using the human rights framework, including international human rights reporting mechanisms, to open up and take the lead on national debate about critical issues such as equal access to basic health services or maternal mortality.
- Establishing quasi-judicial human rights mechanisms, such as National Human Rights Commissions, with a mandate to report regularly on economic, social and cultural as well as civil and political rights.
- Institutionalizing mechanisms to enhance the engagement of civil society in national policy processes, including sector working groups.
- Supporting adequate allocation of resources in health sector budgets to enable meaningful civil society participation in decision-making processes.
- Establishing the right to information in legislation and in practice to enable public monitoring of budget and development processes.
- Taking action to reallocate health sector budgets on the basis of the core elements of the right to health: availability, accessibility, acceptability and quality.
- Respecting and supporting the use of international human rights mechanisms, including the Treaty Monitoring Bodies and Special Rapporteurs, to report on donor and partner country commitments and action.
- Enabling Parliamentary Committees, and other national accountability mechanisms, to review donor programmes as well as government action.

### **Donors**

Donors can utilize the human rights framework to strengthen aid effectiveness and improve development results in the health sector by:

- Developing clear and consistent positions between donors, as well as within bilateral agencies, on human rights issues

- Recognizing the importance of partner countries' and own international human rights commitments and constitutional commitments in engagement with partner countries on development policy.
- Using human rights diagnostic tools in joint planning and review missions to ensure that donor-supported programmes, at the very least, do no harm to the human rights of people in partner countries.
- Supporting the capacities of national institutions to collect and analyze disaggregated data.
- Building the capacities of the Ministry of Health at national, regional and local levels to support the promotion of human rights issues, including gender equality and other forms of non-discrimination.
- Ensuring that new aid modalities and channels of donor co-ordination do not result in less attention to, and funding for, difficult agendas, such as reproductive and sexual health rights.
- Ensuring that channeling aid through budget support and SWAPs does not lead to a decrease in support to civil society organizations (CSOs) or to a reduction in the range of CSOs that are supported.
- Supporting the capacity of national human rights institutions to monitor and report on economic, social and cultural rights.
- Recognizing the importance of human rights issues, including rights to meaningful participation, non-discrimination, information, accountability and transparency, in the process of alignment.
- Respecting and supporting the use of international human rights mechanisms, including the Treaty Monitoring Bodies and Special Rapporteurs, to report on donor and partner country commitments and action.
- Strengthening donor accountability to partner country governments and people through provision of public information on programmes and enabling partner country Parliamentary Committees, National Human Rights Institutions and civil society watchdogs to review donor programmes.
- Recognizing international donor obligations defined in human rights treaties, including the ICESCR and CRC, to provide aid and technical assistance.

### **Local, national and international human rights organizations**

Focus on PD principles can help to inform understanding of some of the most effective ways of building strategies to promote human rights. Key issues identified include the importance of:

- Linking different accountability processes to enable, for example, broad-based participation in the monitoring processes of National Human Rights Institutions.

- Demonstrating how the human rights framework can help identify the concerns and priorities of health workers planners and policy-makers as well as those of citizens.
- Focusing on the translation of human rights principles of equality and non-discrimination in budgets through, for example, analysis of the equity impacts of universal versus targeted budget allocations.
- Building links with parliamentary processes including parliamentary committees.
- Identifying a manageable number of human rights indicators that can be included in results frameworks, for which data are cost-effectively available, particular in the areas of participation and accountability in health sector processes.

## **Bibliography**

Afrodad 2007. A critical assessment of aid management and donor harmonization. The case of Kenya.

Bjorkmann and Svensson 2006. Power to the people. Evidence from a randomized experiment of a community based monitoring project in Uganda.

Centre for Global Development (CGD) 2007. Generating political priority for public health causes in developing countries: Implications from a study on maternal mortality.

DFID 2005. Reducing Poverty by Tackling Social Exclusion. A DFID Policy Paper.

Elson 2006. Budgeting for Women's Rights. Monitoring Government Budgets for Compliance with CEDAW. UNIFEM.

FEMNET 2007. Reproductive and Sexual Health Rights in Kenya, Tanzania and Uganda.

FIDA 2007. Federation of Women Lawyers (FIDA) Kenya and Centre for Reproductive Rights 2007. Failure to Deliver. Violations of Women's Human Rights in Kenyan Health Facilities.

Foster, Quinley, Regmi and Shrestha 2007. Review of Nepal Health Sector Programme: A Background Document for the Mid-Term Review.

Fundar with the International Budget Project and the International Human Rights Internship Program (2004). Dignity Counts. A Guide to using budget analysis to advance human rights.

Gauri, V. and Brinks, D.M. 2008. Courting Social Justice: Judicial enforcement of social and economic rights in the developing world. Cambridge University Press.

Gaynor and Jennings. 2008. Cross-cutting issues in Joint Assistance strategies/harmonization mechanisms. Gender equality, environmental sustainability, human rights and HIV/AIDS.

International Budget Project (IBP), 2008. International Budget Project Newsletter No. 43.

Keith-Brown, Kimberley, 2005. Investing for Life: Making the link between public spending and the reduction of maternal mortality. FUNDAR, Mexico.

Khoza, S 2007. Socio- Economic Rights in South Africa. Second Edition. Community Law Centre, University of the Western Cape.  
Khoza,S 2008. South African Case Study in World Bank 2008.

Ministry of Foreign Affairs, the Netherlands 2008. Is the 'policy dialogue' an effective tool for poverty reduction? A synthesis of an email-debate.

MWI 2007. Ministry of Water and Irrigation, Government of Kenya: Water sector reform in Kenya and the human right to water.

Naripokkho 2006. Government Policy on Maternal Health in Bangladesh and the Impact on the Right to Health.

ODI 2006. Foresti, M, Booth, D and O'Neil T. Aid effectiveness and human rights: strengthening the implementation of the Paris Declaration.  
ODI 2007. Briefing Paper. How can the analysis of power and process in policy-making improve health outcomes?

OECD 2005. Paris Declaration on Aid Effectiveness  
OECD 2006. Survey on Monitoring the Paris Declaration  
OECD 2007. DAC Action Oriented Policy Paper on Human Rights and Development.  
OECD 2008. Draft synthesis report: The implementation of the Paris Declaration.

Physicians for Human Rights (PHR) 2007. Deadly Delays. Maternal mortality in Peru. A Rights-Based Approach to Safe Motherhood

Potts, H. 2008. Draft: Accountability and the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health. University of Essex.

Sida. 2002. Supporting ownership. Swedish development cooperation with Kenya, Tanzania, Uganda.

UN 12th July 1993. A/CONF.157/23. Vienna Declaration and Programme of Action.

UN 19th January 2006. E/CN.4/2006/48/Add.2 Report of Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt. Mission to Uganda.

UN 28th February 2007. A/HRC/4/28/Add.2 Report of Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt. Mission to Sweden.

UN 5th March 2008. A/HRC/7/11/Add.2 Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt. Addendum. Missions to the World Bank and the

International Monetary Fund in Washington, D.C. (20 October 2006) and Uganda (4-7 February 2007).

UNDP 2007. Civil Society and UNDP in Sri Lanka: Partnerships in Crisis Situations.

UN Millennium Project 2005. Task Force on Child Health and Maternal Health. Who's Got the Power? Transforming health systems for women and children.

WHO 2007. Draft external mid-term review report of the National Health Sector Strategic Plan 2005 - June 2010. Thematic Area: Social Development (Gender, Equity and Human Rights). Kenya.

WHO/OHCHR 2007. Fact Sheet. The Right to Health.

World Bank 2003. World Development Report 2004. Making Services Work for Poor People.

World Bank 2008. Realizing Rights Through Social Guarantees: An Analysis of New Approaches to Social policy in Latin America and South Africa. Social Development Department. Report No 40047 - GLB.

## **ANNEX ONE: Case studies**

### **A. Kenya - health sector**

#### **1. Summary**

CSOs interviewed suggest that there is evidence that the Ministry of Health is committed to addressing human rights but that it lacks the capacity to translate commitment into action. The Ministry of Health's National Health Sector Strategic Plan 2005 - 2010 (NHSSP II) makes equitable access to health services one of its central objectives. It explicitly identifies human rights-based approaches as the means of achieving this through community participation in decision-making and equitable allocation of resources. However, NHSSP II and subsequent planning documents do not contain a clear implementation plan for this approach.

It is not clear that donors have provided consistent and coordinated support to the MoH to implement the demand-side objectives and approaches set out in NHSSP II. The Joint Programme of Work and Financing (JPWF) and subsequent Annual Operation Plans(AOPS), the basis of the evolving SWAp, focus almost exclusively on the supply-side. Nonetheless, agreement on the terms of a Code of Conduct for the SWAp has enabled a broader range of CSOs to engage in Ministry of Health planning processes at national level. These CSOs are strategizing on how to collaborate with the MoH and, at the same time, advocate for implementation of NHSSP II to address the human rights issues set out in this strategy.

#### **2. Aid and donor co-ordination**

The 2006 Kenya integrated household budget survey indicates that the proportion of Kenyans living below the poverty line declined from 52.6% in 1997 to 46.6% in 2005/6. However, Kenya remains a highly unequal society. The fall in poverty was greater in urban than in rural areas and urban households are more likely to have access to health care, schools and piped water than those in rural areas. About 74% of people living in North Eastern province are poor in comparison to 30% of those in Central province. These disparities are reflected in social indicators. Only 19% of eligible girls were enrolled in primary school in 2005/6 in comparison to 87% in Central Province (KJAS 2007).

As the crisis following the elections in January 2007 demonstrates, poverty and politics are bound-up with issues of ethnicity. The African Peer Review Mechanism 2006 Country Review Report of Kenya observed that most political parties have a distinct ethnic base and political debate often focuses on the relative status of ethnic or regional groups. Moreover, most power is held by the executive, while the parliament, judiciary and local governments are marginalized in decision-making, thereby strengthening the dominance of the group that controls the executive (KJAS 2007).

Net official development assistance (ODA) to Kenya increased from USD 394 million in 2002 to USD 635 million in 2004 (OECD 2006). Along with the increases in aid, there has been an increase in the number of processes aimed at harmonization. The Kenya Economic Recovery Strategy 2004-7 (ERS), is currently being reviewed and will be replaced in 2008.

The more recent Kenya Joint Assistance Strategy (KJAS) sets out three pillars for harmonized action: Encouraging economic growth; investing in people and reducing poverty and vulnerability; strengthening institutions and improving governance (KJAS 2007). The KJAS states that the strategy was drawn up on the basis of civil society consultation. AFRODAD, however, reports that civil society participation in the production of these national documents has been limited: "Most stakeholders interviewed about the (KJAS) process viewed it as not open. They were only invited to meetings to be briefed on status and trends" (Afrodad 2007: 9). The report points out that sector working groups have been more inclusive, a finding discussed below and in the case study on the Kenyan water sector.

The KJAS includes selective civil and political rights under the third pillar of improving governance, including access to justice, transparency and accountability and broad-based participation. These issues are reflected in the results framework through the inclusion of indicators on access to justice as well as the proportion of survey respondents reporting that they are "well informed" and the proportion of survey respondents reporting that they are able to influence community decisions (Gaynor and Jennings 2008, KJAS 2007). However, these indicators are not clearly defined and are not related to sector specific processes.

Issues of transparency, accountability and participation are not explicitly mentioned in the KJAS narrative outline of plans to promote better health or in relation to water services. The results framework states that governance is a key "issue and obstacle" in both cases but does not include any governance indicators in either case. While the KJAS narrative refers to the equity focus of the National Health Sector Strategic Plan (NHSSP II), and the results framework includes indicators for maternal and child health, these are not disaggregated by location or sex. The indicators for the water sector are disaggregated into rural and urban areas but do not reflect issues of regional and gender inequalities in access.

### **3. Health sector policy framework and SWAp**

The need to address issues of human rights, discrimination, citizen participation, transparency, and accountability in the health sector has been highlighted by the recent report by the Federation of Women Lawyers in Kenya on women's health rights. The report found cases of discrimination, abuse and violence against women in health facilities, particularly those in the public sector. It argued that

women accept this treatment without complaint because they perceive treatment to be a favour rather than a right. The lack of clear, formalized complaints procedures and mechanisms for redress prevents formal action from being taken (FIDA 2007).

The National Health Strategic Plan 11 2005-2010 (NHSSP II) provides a relatively strong basis for addressing these issues.

NHSSP II sets out five objectives:

1. Increasing equitable access to health services.
2. Improving the quality and responsiveness of services in the sector.
3. Improving efficiency and effectiveness of service delivery.
4. Enhancing the regulatory capacity of the MoH.
5. Fostering partnerships in improving health and delivering services.

NHSSP II identifies strengthened primary health care services as the main vehicle for delivering low-cost and accessible services in rural areas. These services are bundled together in the Kenya Essential Package for Health (KEPH). The strategy sets out six service delivery levels through which the package should be delivered, with a focus on community level provision, or level 1 services.

The importance of human rights in achieving these goals is explicitly recognized. It is stated that the strategy places "the human rights approach squarely at the core of its interventions." The human rights-approach outlined in the document contains two key elements:

1. ensuring more equitable supply of services (2005: xii).
2. strengthening demand for services by enabling communities to "understand their rights, to claim them, and to make meaningful contributions to realizing these rights" (MoH 2005:xii)

The primary means identified for ensuring more equitable supply of services is the reallocation of resources. The NHSSP II states that measures will be taken to shift resource allocations from higher levels of service delivery (hospitals) to lower levels (health centres and dispensaries).

NHSSP II identifies a number of actions to strengthen demand including:

- Establishing and protecting client rights through the development and promulgation of a Citizens Health Charter.
- Ensuring that essential information - including fees and exemption schemes are visible
- Ensuring that complaint procedures are in place (MoH 2005:13)

The strategy for engaging communities is further elaborated in the MoH document; "Taking the Kenya Essential Package for Health to the Community" (MoH 2006). It defines a series of committees and structures from the village to

provincial level to enable the community "to participate effectively in decision making processes related to matters of health at the community level". These include the village health committees (VHC), Health Facility Committees and District Health Stakeholders Forum (DHSF) (MoH 2006). NHSSP II defines the DHSF as the platform where coordination and methodology development for the human rights approach will take place. It also makes a commitment to ensuring adequate resources for these interventions (MoH 2005 ).

However, as CSOs have pointed out, the term human-rights based approach outlined in these documents is defined in very broad terms, which are not always clear and consistent. Neither NHSSP II nor the community health strategy contains any a clear implementation plan or indicators, setting out who will be doing what with which resources and how success will be measured.

The MoH, implementing partners and donors, are now moving towards a Sector Wide Approach (SWAp) to implement NHSSP II. Key agreements and operational plans in this process include:

The Joint Programme of Work and Financing (JPWF)

The Code of Conduct (CoC)

The Annual Operational Planning Process (AOP)

Joint Monitoring and Review (JMR)

The JPWF identifies priority interventions as well as their resource and financing implications for the GoK and health sector partners. There was limited civil society participation in its production. The JPWF picks up the NHSSP II theme of resource allocation and sets out indicators for measuring the extent to which resources have moved from tertiary to primary level. However, the JPWF drops any explicit mention of human rights or human rights-based approaches. It does outline what is described as a community-based approach, but largely interprets community participation in terms of engaging communities and individuals in health education initiatives. The implementation framework does not include indicators on the initiation and functioning of governance structures at any level. Engagement of CSOs in the delivery of services is not clearly addressed (MoH 2006). While the JPWF retains a focus on equity, it does not address the demand-driven changes envisioned in the NHSSP II and focuses primarily on supply-side interventions. A GTZ mission report on the Kenyan SWAp processes notes that the fact that the SWAp basically targets the supply side of health provision, and focuses on governmental rather than non-governmental services, "is likely to limit its efficacy concerning health-related poverty alleviation" (GTZ 2006).

#### **4. Public-private partnerships**

NHSSP II, the JPWF and the Community Health Strategy stress the importance of partnerships with the private health sector, comprising NGOs, CBOs, Faith Based Organisations (FBOS) and Private for Profits (PFPs). In Kenya the private

sector is responsible for a large proportion of health infrastructure. In particular, it is the FBOs, NGOs and CBOs who have most engagement with hard-to-reach communities and vulnerable populations (HENNET 2007 a). Kenyan NGOs and CBOs have worked at local level developing community based health care since the 80s. They have developed approaches for supporting participation in health prevention and promotion, community empowerment and demand creation, addressing interfaces between community level and facility based interventions, and capacity building through training (HENNET 2007 b). Promoting the demand side activities outlined in the NHSSP II, then, is dependent on partnerships between the MoH and CSOs.

The Code of Conduct for all partners involved in the emerging health SWAp is the primary mechanism for fostering public-private-partnerships and ensuring co-ordination between government, donors and CSOs. The Code of Conduct identifies respect for human rights, equity, democratic principles and good governance as underlying principles of the partnership between all actors. Key commitments on the part of the GoK and donors include ensuring that all plans are consistent with the NHSSP II. Implementing partners agree to organize themselves into umbrella organizations for the purpose of engaging with the SWAp. The GoK makes a commitment to hold an annual Joint Review Mission to evaluate implementation of the NHSSP II.

HENNET, the umbrella organization for NGOs, believes that the Code of Conduct has had a concrete impact on the way that NGOs do business, with HENNET members now working to ensure that their programmes are aligned with MoH plans. CSOs view the MoH as increasingly open to their engagement in health policy processes, although the detail of this engagement and its formalization are still evolving.

At national level, HENNET, sits on the Health Sector Coordinating Committee of the MoH. Members of HENNET are also members of other MoH task forces such as the child health, malaria, HIV/AIDs, and Health Financing Task Force. A broader range of organizations are now engaged in health sector policy debates. The human rights organization the Centre for Rights Education and Awareness (CREAW), for example, is a member of the health financing task force, whose remit includes the development of a national social insurance scheme. The Health Rights Advocacy Forum (HERAF), a programme hosted by the Kenya Human Rights Commission, is also increasingly involved in monitoring budget allocations and expenditure in the health sector. While full budget data is not always available, both the MoH and the Ministry of Finance have publicized their budget calendars, enabling greater CSO participation in budget processes. HERAF has organized capacity building workshops for CSOs and health professionals to enable their greater involvement in the health budget monitoring ( HERAF 2007).

Engagement at district level and below, however, is hampered by the lack of the clearly defined, functioning stakeholder fora. While there is a degree of integration of health NGOs within the District Health Sector Forum, this institution has not yet been given a clear mandate and so cannot perform the coordination function envisaged in the NHSSP II (HENNET 2007b). Implementation of the Code of Conduct, and accountability of all partners, has been further hampered by the lack of a monitoring and evaluation framework. Plans are now underway to draft the necessary monitoring framework.

### **5. The 2007 mid term review**

The recent mid-term review of the health sector confirms CSOs' views on the lack of clearly defined roles for lower-level institutions. The review found that the operation of coordinating committees from district level downwards was patchy and varied considerably between districts (MoH 2007). As part of the 2007 mid term review of the NHSSP II, an evaluation of gender, equity and human rights was carried out at the instigation of WHO. The review found that "views and input from clients are hardly incorporated into the delivery of services. In fact, it was observed that the various committee meetings hardly garnered views on specific health issues and what could be done about them, but rather focused more on how the community could support ongoing efforts by government." The review noted the lack of capacity within the MoH to deal with issues of equity, gender and human rights and recommended setting up a post within the MoH to take forward the agenda (WHO 2007: 11).

Other elements of the human rights-based approach outlined in NHSSP II have also been incomplete in their implementation. The service charter, promised in NHSSP II, was finalized in December 2006. Civil society consultation on the content of the charter was inadequate. Nonetheless, it includes a broad range of commitments and obligations on the part of the MoH including ensuring transparent and equitable resource allocation; equitable distribution of health services; treating all clients equally without discrimination and desisting from corrupt practices such as preferential treatment of clients. Customer rights include the right to accurate information; the right to dignified treatment; the right to personal/own opinion and to be heard; and the rights to participate in the planning and management of health care services (MoH 2006).

The mid-term review noted that, "the MOH has developed and circulated the ministerial service charter for health service delivery. The document, launched in January 2007, could service as a human rights instrument if properly used, and should be monitored during the implementation of the NHSSP II. While it could be argued that service standards should be developed in consultation with users, it is intended that this will form the basis for developing health facility level charters. These need to provide specific information on the services available and the specific standards of care" (MoH 2007:37). However, it is not clear that the MoH has a plan for implementing the charter. Moreover, in the absence of functioning local level committees, it is not obvious what mechanisms are

available for adapting it to local needs and ensuring its implementation is monitored.

Underlying many of the challenges in the health sector is the issue of equitable resource allocation. The NHSSP II mid term review report indicates that "the shift to the KEPH has still not taken root in the sector. Services are still largely curative". Finances for MOH provided services have not been reallocated from the higher levels of provision to Level 1 community services. Analysis of the health sector budget indicates that it is skewed in favour of tertiary and secondary facilities while rural health facilities receive relatively limited funding. Resource allocation between districts has not occurred as allocation criteria currently in use are based on existing infrastructure and other population parameters and need to be improved if resource allocations are to favour underserved communities. Leakage of funds that are allocated is common and the systems for efficiently allocating and monitoring resources below district level are not in place (MOH 2007).

A second related resource issue is the lack of a clear mechanism for providing funding through the SWAp for NGOs and CSOs who are supposed to participate in delivering the services and fostering the programme of participation and empowerment at community level outlined in NHSSP II (HENNET 2007b). In the absence of this mechanism, resources put into the SWAp are channeled primarily to the governmental sector, rather than to supporting the public-private partnerships that are more likely to deliver to hard-to-reach communities. Consequently, while the commitment to delivering health services to the most vulnerable, and enabling them to claim their rights to those services, has been outlined in NHSSP II, the operational plans and institutional arrangements which form the basis of the evolving SWAp do not support the necessary demand-side activities.

## **6. Strengthening capacities**

A number of factors appear to have contributed to the lack of a clear implementation plan for the human rights-based approach in the NHSSP II and follow-through in the JPWF. Lack of capacity within the MoH to address human rights has hampered attempts to develop and implement an operational plan. Moreover, while a number of CSOs are committed to supporting the human rights-based approach outlined in the NHSSP II, many of these organizations also lack the technical capacity to provide practical support to the MoH on this agenda. While there is a long history of NGO advocacy on civil, political and some economic, social and cultural rights, much of this work has been around publicizing violations of those rights. Campaigns to address HIV/AIDS have also strengthened awareness of the human rights framework and its application to health. Consequently, human rights and human rights-based approaches are becoming a clearer CSO focus for advocacy and co-ordination. Nonetheless, the

use of human rights as a practical tool for development planning is relatively recent and CSO technical capacity in this area is limited.

Among the donors, BMZ/GTZ is, at present, the primary champion of a human rights-based approach in the health sector. It is not clear, however, that there is consistent support among other donors for implementation of a human rights-based approach, or demand side activities in general. Furthermore there has not been any systematic assessment of government and CSO capacities to deliver the demand-side activities outlined in NHSSPII or support for addressing the capacity gaps among both MoH and CSO staff.

Despite the lack of substantive progress on these issues, many CSOs remain positive about collaboration with the MoH and believe that there is commitment to addressing human rights. It is hoped that broadening the range of organizations involved in health policy processes to include human rights NGOs and institutions will lead to strengthened implementation of the human rights-based approach outlined in the NHSSP II.

### **People interviewed**

Ruth Charo. Hennenet.

Klaus Hornetz. Senior Coordinator, GTZ Health Sector Programme, Kenya

Miano Munene, (KNHRC) HERAF.

### **Documents reviewed**

*Afrodad* 2007. A critical assessment of aid management and donor harmonization. The case of Kenya.

*Federation of Women Lawyers (FIDA) Kenya and Centre for Reproductive Rights* 2007. Failure to Deliver. Violations of Women's Human Rights in Kenyan Health Facilities.

*Gaynor, C and Jennings, M.* January 8th 2008. Cross cutting issues in Joint Assistance Strategies/ Harmonisation Mechanisms: Gender Equality, Environmental Sustainability, Human Rights and HIV/AIDS.

*GDC* 2007. Reproductive Health and Health Financing. Draft.

*GTZ* 2006. Dr Andreas Kalak. Mission Report: External contribution to the Kenyan SWAp process.

*Government of Kenya:*

Kenya Joint Assistance Strategy 2007-2012.

*MoH* documents:

August 2005. Reversing the Trends. The Second National Health Sector Strategic Plan of Kenya. NHSSP II 2005 -2010.

June 2006. Taking the Kenya Essential Package for Health to the community. A strategy for the delivery of Level One services.

June 2006. Joint Programme of Work and Funding for the Kenyan Health Sector 2006/07-2009/10

December 2006. Service Charter for Health Service Delivery.

Code of Conduct 5th June 2007. Final Draft, Kenya Health Sector Wide Approach

August 2007. Draft NHSSP II midterm review report. August 2007 version.

*HENNET* 2007a. Kenya Sector Wide Approach: Role of civil society organisations in the context of public private partnerships.

*HENNET* 2007b. The role of non-governmental and the faith-based organizations in the rolling out of the Joint Programme of Work and Financing (JPWF).

*HERAF* 2007: Quarterly Newsletter November 2007; Report on Capacity Building workshop for health professionals and CSOs to monitor and track health and HOV/AIDS budgets for effective involvement in the budget making process in Kenya.

*WHO* 2007. Draft external mid-term review report of the National Health Sector Strategic Plan 2005-June 2010. Thematic Area: Social Development (Gender, equity and human rights).

## **B. Kenya Water Sector**

### **1. Summary**

GTZ and other development partners/ donors have worked with the Ministry of Water and Irrigation (MWI) to incorporate international standards on the right to water and sanitation in the framework of water sector policy, strategies, guidelines and contractual agreements with commercial water providers. The human rights approach applied in the Kenyan water sector uses human rights standards as a basis for the strengthening the stewardship role of the MWI and regulation of supply and resource management. This contrasts with other case studies, where a human rights-based approach has been understood as a means of strengthening demand. The MWI has found that using a human rights framework, rather than a straightforward poverty approach, has given them a stronger basis for addressing regulation of the water sector. It has also, according to the MWI, provided a stronger basis for donor alignment, harmonization and increased aid flows to the sector.

### **2. Water sector reform and SWAp**

A process of water sector reform was commenced by the GoK in the late 1990s. The Water Act of 2002 was one of the results of this process, setting up a new institutional framework for the water sector. The Act set up institutions to manage the water sector, separating out water resources management and development from water and sanitation service delivery with the aim of increasing accountability:

The **Ministry of Water and Irrigation** (MWI) has overall political responsibility for the Water Sector and its reform.

The **Water Services Trust Fund** finances provision of water and sanitation to disadvantaged groups.

The **Water Resources Management Authority** (WRMA) has the responsibility for regulating water resources and supporting management by the Water Resource Users Associations.

The **Water Services Regulatory Board** (WASREB) regulates and monitors service provision, sets standards and guidelines for provision of water services and carries out tariff negotiation.

The regional **Water Services Boards** (WSBs) contract Water Service Providers and manage investment planning as asset holders.

**Water Service Providers**, usually registered private companies owned by the municipalities or users (associations), provide water and sanitation services.

The **Water Appeals Board**, arbitrates disputes and conflicts between sector institutions and individuals (MWI 2007, Water sector reform in Kenya).

Key policies in the sector reform process are included in:

The National Water Resource Management Strategy 2006 -2008

The National Water Services Strategy (NWSS) 2007

Pro-Poor Implementation Plan for Water Supply and Sanitation (PPIP-WSS) 2007.

Sector reform has provided the platform for an evolving SWAp, which was commenced in 2005. The Partnership Principles were signed by the Ministry of Finance, the MWI and Development Partners (DPs) working in the sector. The SWAp includes the development of Sector Investment Planning (SIP) and a Sector Information System (SIS). Overall coordination in the water sector between the GoK and DPs takes place in the Water Sector Working Group (WSWG). This includes representatives from other ministries with links to the water sector, including the Ministry of Health (MoH).

### **3. MWI ownership of the human rights-based approach**

While the Water Act did not define people's rights to water and sanitation, it helped to set the pro-poor direction of sector management by defining one of its objectives as serving areas without basic water supply and sewerage (GTZ 2007). One of the primary implementation problems faced by the MWI continues to be regulation of the private sector providers in order to ensure a pro-poor orientation. As the MWI observes, "Another lesson learned in the water sector is that private sector involvement in WSS ... does not automatically reduce the number of non - or under-served. " (PPIP-NWSS). Project interventions by donors and NGOs aiming to assist poor people's access to water have sometimes exacerbated the underlying problems by supporting informal provision and inconsistent standards. Key challenges facing the MWI, then, are to increase its stewardship and coordination of the sector and regulate Water Service Providers (WSPs) to ensure both sustainability of supply and access by the poorest, according to the minimum requirements of the human right to water and sanitation.

BMZ/GTZ, which has selected Kenya as one of two pilot countries for implementing human rights-based approaches, suggested international human rights standards as a basic framework for setting these guidelines. Some key individuals within the MWI realized the value of the human rights emphasis on the central stewardship and regulatory role of the ministry. They saw that it provided a stronger basis than a straightforward poverty focus for addressing their concerns about regulating the water sector and ensuring minimum standards of provision. However, others were reluctant to enter into a public dialogue on human rights because they were concerned it might make them more vulnerable to criticism from human rights NGOs. GTZ in the context of its policy advisory role, were able to demonstrate that the sector reforms the MWI had introduced were already contributing towards the progressive realization of the human right to water through sector reform focus on increasing accountability, transparency, participation and introducing a pro-poor agenda. This enabled officials to feel more confident about engaging with NGOs using human rights language and standards. GTZ then drew on human rights treaties

and jurisprudence to work through international standards on the right to water with the ministry to decide how they could be usefully applied to the water sector. This approach has become increasingly important since 2006 and is still in the process of being adopted and implemented in MWI operations.

#### **4. Incorporation of international standards**

The on-going process of adopting and implementing a human rights-based approach is reflected in principles, targets and indicators included in the National Water Resource Management Strategy (NWRMS), the National Water Services Strategy (NWSS) and the Pro-Poor Implementation Plan. The guiding principles of the NWSS defined sustainable access to safe water and basic sanitation as a human right. It sets out a commitment include to measurable indicators for human rights and water as part of the set of sector indicators (MWI 2007: NWSS 32).

Specific targets and regulations relating to international standards include: *Water availability*. General comment 15 indicates that the water supply for each person must be sufficient and continuous for personal and domestic uses (UN 2002). The prioritization of water for personal and domestic use is reflected in licensing requirements set out in the NWRMS: "Water required to meet basic human needs and to maintain environmental sustainability will be guaranteed as a right, whilst water use for all other purposes will be subject to a system of administrative authorizations". (AAS,COHRE 2007).

*Water access*. General comment number 15 indicates that sufficient, safe acceptable water and sanitation must be accessible within, or in the immediate vicinity of each household. It should normally take no more than 30 minutes both ways, including waiting times, to collect water and the distance to be covered, going and returning, to a water source should be no more than one kilometer (UN 2002). The PPIP-NWSS indicates that its objective for the urban and rural setting is to ensure that WSPs conform to minimum standards of offering access to water for any consumers within a reach of 30 minutes in urban and within a range of 2,000m in rural areas (MWI 2007:PIPP-NWSS:14).

*Water Quality*. General comment number 15 provides that water must be safe and free from hazardous substances that could endanger health (UN 2002). The water quality standards in Kenya follow the WHO guidelines on drinking water referred to in the General Comment. The WSBs in collaboration with the WSPs are responsible for water quality at water points and piped systems (GTZ 2007).

*Water affordability*. International standards indicate that the costs of securing water and sanitation should not reduce any person's capacity to purchase other essential goods and services. Governments must adopt measures to ensure affordability that are appropriate for their financial options such as use of low-cost technologies; appropriate pricing policies and income supplements. The PPIP-WSS sets a target date of 2008/2009 for implementation of a pro-poor tariff

system which also ensures that water sales (subsidized tariffs for the poor) at the kiosks are not used by informal providers to make profit. It also includes promotion of low cost technologies including water kiosks and on site sanitation as a major part of the sector strategy (MWI 2007: PPIP-WSS:21).

The PPIP-NWSS sets out the intention to translate these standards into practice through making operators of water and sanitation facilities comply with minimum standards through signing Service Provision Agreements (SPAs) with the relevant WSB and WSRB ( MWI 2007; PPIP - NWSS: 11). It is proposed to establish and distribute a list of indicators and actions derived from the NWSS and PPIP to all relevant institutions, and to collect feed-back from these institutions on how these have been inserted into annual work plans and performance contracts. Monitoring the compliance and performance of WSPs, WSBs and WASREB is a key challenge. The Sector Information System (SIS), initiated as part of the SWAp aims to address this through supporting the development of management information systems for sector institutions and supplementing this through sample surveys and special studies (MWI 2007: Annual water sector performance report). It is intended that results from the SIS will be included in the annual sector report and annual sector conference.

## **5. Implementation**

According to the MWI, the introduction of a human rights-based approach has provided a basis for increasing aid effectiveness in the water sector. Support for human rights based approaches is included as one of the general principles of the Partnership Principles (MWI 2006). The MWI states that, "as human rights are universal principles, the MWI expects donors to align to these by harmonizing their actions and programmes to the sector policies and strategies. In this context, commitment towards the right to water supports the implementation of the Paris Declaration on Aid Effectiveness." (MWI 2007. Water sector reform in Kenya and the human right to water: 5). The impact of the reforms on aid effectiveness can be illustrated by the increase in contributions to the sector as the result of greater confidence in the MWI and its programme. The donor budget allocation to the MWI doubled within one year from Kshs 3.4 Billion in 2006/2007 to Kshs 6.8 Billion in 2007/2008. (MWI 2007, PPIP - NWSS: 12).

Nonetheless, there are some areas of the water sector planning and coordination process where human rights standards and principles do not appear to have been comprehensively applied. The 16 "Golden Indicators" agreed as the key indicators for the sector do not include any indicators clearly relating to human rights. GTZ review of the water sector, for example, suggested that key sector indicators to be used in the SWAp framework should include one marking whether spending for water and sanitation services exceeded 5% of household income, the internationally agreed standard on this issue (GTZ 2007). The available list of 16 key sector indicators does not include one on pricing (MWI 2007: Annual water sector performance report:12).

It is generally acknowledged that the water sector reforms have led to improvements in delivery (JAS 2007). A primary concern, however is the lack of progress in securing water supply for the most vulnerable, particularly those living in informal settlements. Challenges in this area include lack of infrastructure in informal settlements, the lack of experience of WSPs in dealing with informal as opposed to regularized communities and the greater financial incentives to provide services for regularized customers because of tariff structures (GTZ 2007) The MWI acknowledges that despite progress, the proportion of non-served people remains more or less stagnant. This can partly be attributed to increases in population and particularly the fast growing settlements of the urban poor. However, extension into urban informal settlements and rural semi-arid areas has been limited. The MWI indicates that it intends to address this issue through: increased mobilization of funds for the Water Services Trust Fund; greater use of those funds in settlements of the urban poor and rural poor in arid and semi-arid areas; promotion of low cost technologies including water kiosks and basic on site sanitation; including pro-poor investment plans as part of the SIP (MWI: PPIP-WSS)

### **Civil society participation**

Use of the human rights framework has, to a certain extent, provided a common framework for dialogue with civil society and opened up a basis for debate about pricing of services and sustainability of supply. Donors and NGOs have been consulted during policy and strategy drafting processes and public hearings have encouraged broader engagement. However, although the MWI has made increased efforts to consult CSOs on policy, civil society representatives themselves do not think that they have participated adequately in the formulation of recent MWI strategies. Whatever the value of policy content in terms of acknowledging human rights standards and principles, CSOs do not feel ownership of the policy because they do not think they have made sufficient contribution to its design, implementation and monitoring.

At community level, it is not clear that there have been sufficient efforts to ensure CBOs participation in decision making and monitoring or to inform people of their rights and set up functioning accountability mechanisms, including complaints procedures. It is difficult to find, for example, a clear outline of national service delivery standards, such as those provided by the South African Ministry of Water Affairs and Forestry, which could be understood and used by all water consumers.

Governance problems are acknowledged in recent review of the reform process (GTZ 2007). The PPIP - WSS indicates that closer monitoring of the WASREBs, WSBs and WSPs is required. It suggests the possibility of including representatives of the poor in different control and decision-making bodies, better access of consumers to complaint procedures and enhanced information dissemination ( MWI 2007; PPIP - NWSS: 11). Examples of successful attempts to tackle these issues in Zambia are now being used as a basis for increasing

community participation in monitoring and thereby strengthening accountability. In Zambia, WSPs are monitored by community-based Water Watch Groups which function as a sub-structure of the regulator. A Kenyan delegation to Zambia was recently organized and discussions are now underway to gradually install a similar structure in Kenya.

### **People interviewed**

Roland Werchota. GTZ Water Programme  
Dona Mokeira. Economic and Social Rights Centre.

### **Documents**

GTZ 2007. Kenyan-German development cooperation in the water sector. Assessment from a human rights perspective. By Munguti Katui KAtua, Ashfaq Khalfan, Malcolm Langford, Monika Luke.  
*Government of Kenya, Ministry of Water and Irrigation:*  
2006. National Water Resources Management Strategy.  
2006. Partnership principles. Water sector in Kenya. Sector Wide Approach to Planning.  
2007. The National Water Services Strategy (NWSS) (2007-2015)  
2007. Pro-Poor Implementation Plan for Water Supply and Sanitation (PPIP-WSS)  
2007. Draft Annual water sector performance report.  
2007. Water Sector Reform in Kenya and the Human Right to Water.  
*UN Committee in Economic, Social and Cultural Rights, General Comment*  
Number 15. 2002. E/C. 12/2002/11

## **C. Nepal**

### **1. Summary**

In Nepal, work on social exclusion led by DFID and the World Bank has contributed to the National Planning Commission (NPC) taking on issues of exclusion and a social exclusion pillar in the PRSP. Other donors are also beginning to align around this agenda. The more recent three year Interim Plan from the NPC is explicit in its references to discrimination, human rights including the right to health and rights based approaches. There are questions, however, about the extent to which commitments are being translated into action. The Ministry of Health and Population (MoHP), has been seen as slower to take on the social exclusion agenda, focusing on achieving universal coverage of services before allocating resources on programmes targeted at hard-to-reach populations. A system of disaggregated data collection, drawing on the social categories defined by the DFID/World Bank research on social exclusion, in consultation with the NPC, is now being piloted. It is hoped that this will help to demonstrate where resources and health services are being captured by particular groups and will influence the MoHP.

Ownership of the social exclusion agenda is also being built from the bottom-up through Action Aid's rights-based Equity and Access Programme (EAP), as part of the Support to the Safe Motherhood Programme. The EAP focuses on demand-side issues, including building awareness of rights among excluded groups and supporting local organizations to address equity and access. The "Voice Capturing" exercise uses participatory methodologies to identify women's views on both social and maternal health issues, including concerns about services. The reports are used to influence programs and policies at local and national levels. Responsiveness to citizens is one of the principles of the International Health Partnership (IHP). It is hoped that IHP will strengthen the MoH's receptiveness to the Voice Capturing exercise and provide a channel for addressing demand side issues throughout the sector.

### **2. Aid and donor co-ordination**

Nepal is the poorest country in Asia, with 3 out of 10 people living on less than \$1 per day (DFID October 2007). Social, political and economic power has largely been dominated by high-caste Hindu groups, particularly Brahmans and Chhetris, whilst women, Dalits (previous 'untouchable' castes), Janajatis (ethnic indigenous groups), Madhesis (plain dwellers of the Terai), Muslims, children, older people and the disabled have been excluded (Watkins 2007). Since 1996, the Maoist movement has harnessed the demands of excluded groups, including women, Janajatis and people from lower castes in a "People's War" aiming to replace the monarchy with a socialist republic. A deal was struck between the Government and the Maoists in November 2006. However, the Interim Government postponed elections to a Constituent Assembly slated for November 2007. The elections are now due to take place in April 2008. Madhesi groups from the Terai, whose concerns about political representation and citizenship

rights were not championed by the Maoists, began to use violence to pursue their claims (DFID 2007). However, leading Madheshi groups have now settled their grievances with the interim government in exchange for proportional representation.

Poverty has been the overriding focus of successive Government of Nepal National Plans from 1980 onwards. Attempts to identify excluded groups and allocate funds in these earlier plans were largely welfare driven, rather than systematic attempts to address discrimination. The Ninth Plan (1997- 2002) outlined a strategy for gender mainstreaming including de jure and de facto gender inequalities (EC/UNIFEM 2008). However, the intensifying conflict meant that the government was increasingly keen to find a means of addressing the concerns of different social groups (Lynn Bennett 2007). Donors were also co-ordinating around conflict and its causes (Alan Whaites 2007). A programme of research on social exclusion set up in 2002, jointly funded by the World Bank and DFID, was highly influential in providing a framework for addressing these issues. Informal and formal discussions between Nepal's National Planning Commission and the social exclusion research programme, as well as an extensive programme of consultations and civil society advocacy, led to social inclusion becoming one of the key pillars of the 10th Plan/PRSP (Lynn Bennett, Jasmine Rajbhandary 2007/08). One of the key outputs of the research has been the identification of a set of social categories which is currently being introduced across different sectors as a basis for disaggregated monitoring (DFID 2006).

Following the adoption of the social inclusion pillar in the PRSP, a number of donors began to use the concept and base their programmes around it. The World Bank, ADB, DFID, Danida and Swiss Cooperation all address social inclusion in their Country Assistance Strategies (OPM/DFID case study 2008). However, there are a number of challenges to this process of harmonization. First, it is generally acknowledged that the donor focus on the primary conflict has meant that concerns of the Madhesi population have only been belatedly recognized (Alan Whaites, Jasmine Rajbhandary 2007/08). While the DFID/WB research identified discriminated-against groups living in the Terai, the political agenda of the Madhesis was not picked up. Second, not all donors have internalized issues of discrimination (UN/OHCHR 2007). Third, there is an on-going debate about the extent to which poverty, rather than discrimination on the basis of caste, ethnicity, regional identity and gender, is the driver of differential access to services and resources and the extent to which social identity can be taken as a proxy for poverty (Susan Clapham 2008).

There are strong parallels between the concept of social exclusion and discrimination as defined within a human rights framework. DFID defines social exclusion as a process of disadvantage on the basis of discrimination (DFID 2005). The social exclusion conceptual framework generated by the research programme defines three inter-related domains that perpetuate social exclusion: rules of the game (legislation, policies and institutions); assets and services; and

voice, influence and agency. The DFID report on its work in Nepal refers consistently to citizens' rights, rights-based approaches and the international human rights framework (DFID 2006). One notable difference between the concept of exclusion and the human rights definition of discrimination, however, is that the DFID definition of social exclusion does not include poverty as a basis for discrimination.

There were differences of opinion among interviewees about the relationship between these two frameworks. Some interviewees said that they were not compatible and others said that the rights terminology added nothing to the social inclusion framework. Action Aid saw the two approaches as complementary and overlapping, with a rights-based approach focusing more on issues of empowerment than the social inclusion agenda. Action Aid uses a "rights and social inclusion approach" in its Equity and Access Programme as part of the DFID funded Support to Safe Motherhood Programme in conjunction with the MoHP. National CSOs have mobilized around explicit group rights and claims as well as around a social exclusion banner. CSOs have increasingly taken up the language of social inclusion as donors have introduced funding requirements to explain the contribution of programmes to addressing exclusion issues.

All interviewees agreed that government officials generally used the language of social exclusion rather than that of human or citizens' rights. Nonetheless, the recent 2007 Interim Constitution explicitly addresses issues of discrimination and outlines the rights of different groups to equality. It also defines a number of social and economic rights, although these do not have the same status in the constitution as civil and political rights. The Interim Constitution includes the right of "every citizen to get basic health service free of cost from the State as provided for in the law." (Interim Constitution 2007). The Interim Plan of 2007 builds on the Interim Constitution. It uses the language of rights and social exclusion inter-changeably and indicates that "education, health and employment will be promoted as rights based programmes." Questions remain, however, about the extent to which these commitments are being translated into action.

### **3. Health Sector**

Nepal has made rapid progress on a number of health indicators and has achieved lower under five and infant mortality than India, despite less favourable economic conditions (Foster et al 2007). The infant mortality rate has dropped from 79 per 1,000 births in 1995 to 48 per 1,000 births. Maternal mortality has been halved over the same period from 539 maternal deaths per 100,000 child births to 281 deaths per 100,000 child births (NDHS figures cited in MoHP 2007). DFID/World Bank research on social exclusion, however, underlines the disparities in health outcomes between different caste, regional and ethnic groups. Disaggregated data from the 2001 Nepal Demographic Health Survey showed that the under-five mortality ratio for Brahmans is 65 per 100,000 and for Newars it is 75. The rate for Dalits is 171, Muslims 158 and Tamangs 141 (DFID 2006: 26).

The development of the health sector legislative and policy response to these issues reflects the evolving approaches outlined above to address poverty and social exclusion. The Health Sector Strategy (2004) outlines the Government of Nepal's decentralized approach to healthcare. Funds and responsibilities for managing health facilities are supposed to be decentralized to Local Health Management Committees. Decentralization is intended to bring more bottom-up accountability to communities and enable them to tackle local problems, respond to local priorities and hold service providers accountable to those they serve (Foster et al 2007). In reality, however, Health Management Committees are often under-resourced and lacking in authority.

The Nepal Health Sector Programme 2003-07, based on the Health Sector Strategy, sets out its goal as establishing equitable access to quality healthcare for all by expanding access to and increasing the use of essential health care services. Key primary health care services are to be provided by Mother and Child Care Workers and community based, voluntary Female Community Health Volunteers. DFID observes that this plan is better on vision than proposals for concrete implementation (DFID 2006). The Vulnerable Community Development Plan 2004/5-2008/9 explicitly acknowledges the impact of social exclusion and discrimination on health service delivery and, consequently, health outcomes. It further elaborates on strategies to address exclusion including capacity building within the MoHP and setting up a Health Management Information System to collect data disaggregated by gender, disability, caste and ethnicity (MoHP 2004).

As indicated above, the 2007 Interim Constitution and Plan make explicit references to the right to health and to discrimination. The 2007 Interim Plan states that " policies will be adopted in the spirit and provision of the Interim Constitution 2007 to guarantee the citizens' fundamental right to quality health services without discrimination based on caste, creed, sex, religion, ethnicity and political beliefs". It further specifies that, "Rights to free basic health services to each citizen will gradually be established. Special priorities will be given to promote the health status of the poor, women, marginalized, Dalit, indigenous groups and people with disabilities" (Interim Plan 2007).

The health sector strategies outlined above form the basis for the on-going health sector SWAp. Currently eight donors are funding the sector. All donors are supposed to work within the legislative and policy framework outlined. Only the World Bank and DFID participate in pooled funding managed by the MoHP (EC/UNIFEM 2008).

#### **4. Ownership by the Ministry of Health and Population**

Interviewees agreed that, while there had been a gradual take-up of the social exclusion/discrimination agenda within the MoHP, ownership of the approach was generally low and there has been a reluctance to fund targeted programmes.

Lack of disaggregated monitoring data has been one of the barriers to action on the social exclusion agenda within the MoHP. Disaggregated project monitoring data from the Equity and Access Programme (EAP), discussed below, has helped to demonstrate differential access to services. It shows, for example, that Dalit women tend to use peripheral institutions for deliveries, such as Primary Health Care Centres and Health Posts while Brahman/Chhetri and Newar women are more likely to opt for hospital deliveries. Nonetheless, in the absence of systematic, sector-wide monitoring data, it is harder to demonstrate the extent to which resources are being captured by particular groups and, consequently, to make the case for targeted programmes.

The collection of Health Monitoring Information System (HMIS) data disaggregated on the basis of the six social categories identified through the DFID/WB social inclusion research is now being piloted in three districts. These categories are as follows: Brahman/Chhetri; Tarai/Madhesi other castes; Dalits; Newar; Janajati; Muslims. Gender is monitored as a cross-cutting category. The NPC is currently considering whether or not to increase the number of categories for monitoring from six to nine. The capacity of health facilities to collect the data needs to be assessed before the programme can be expanded. In addition, a Gender and Social Inclusion Unit is being set up in the MoHP and it is hoped that this will help to build capacity and willingness to support the targeted programs.

Many senior MoHP officials, however, maintain the view that, in the context of limited resources and large numbers of people living in poverty without access to services, the priority should be increasing coverage of services rather than targeted interventions, which cost more to deliver. The MoHP's stated strategy is to introduce targeted interventions once near-universal coverage has been achieved (Foster et al 2007). Interviewees differed on the extent to which they thought this was a rational response to resource shortage or the result of deeply engrained norms and practices in the MoHP.

In practice, the MoHP's approach to health service provision has been to move towards free access to a limited set of cost-effective public health interventions. This approach has been accelerated since the publication of the Interim Constitution and Interim Plan. The MoHP has moved quickly, although not necessarily smoothly, to abolish user fees and to establish free essential health care. By October 2007, extensions to the policy had resulted in the abolition of fees at health post and sub post level in all districts and in hospitals in low HDI districts (Foster et al 2007). However, it is not clear how effectively this policy is being implemented on the ground.

A background study for the mid-term review of the health sector attributes the recent declines in under five and maternal mortality to the MoHP's approach of increasing coverage. The report cautions against over-drawing the impact of social exclusion on access to services at the expense of factors, such as lack of funds for treatment, that simply reflect poverty. The 2006 NDHS indicates that

cost factors and issues of service quality, such as lack of staff and drugs at facilities, may be the most significant constraints on demand. The report recognizes that social differences and discrimination may be more significant in particular sub-sectors including maternal care. The report recommends that, once the 2006 NDHS data has been disaggregated and analyzed, guidance on addressing issues of exclusion in work plans and budgets should be issued (Foster et al 2007:42).

Preliminary reports on the basis of disaggregation of the 2006 DHS data confirm the findings of the EAP outlined above. Analysis suggests that Brahmins and Newars tend to seek maternal care from doctors and nurse/midwives while lower social groups, including Dalits, Terai/Madhese Other Castes, Janajatis and Muslims all use the services of lower level health workers. The report confirms that lack of money is a major constraint faced by women, and particularly by women from excluded groups, to accessing health care. It identifies Dalits, especially those from the Terai, Muslims and Terai/Madhese Other Castes as groups that have consistently low indicators across most dimensions covered by the DHS survey. Janajati groups also perform poorly on many, but not all of the indicators. The report also found significant variations within some groups. For example, Hill Chhetris are well below Hill Brahmins in social indicators as well as on indicators of wealth. The report highlights the importance of targeting on the basis of caste, ethnicity and regional identity but also highlights the importance of ensuring that this is combined with monitoring on the basis of wealth to ensure that the needs of all those who are poor are addressed (Bennett and Dahal 2008).

## **5. Support to the Safe Motherhood Programme**

As part of its package of support for the health sector in Nepal, DFID has provided funding for the maternal mortality programme. DFID is increasingly viewing maternal mortality as a tracker for the effectiveness of the health system, as a comprehensive health system has to be in place in order to ensure progress (Hansard December 2007). Between 1997 and 2005, DFID support was provided through the Nepal Safer Motherhood Project (NSMP). This was one of the first large-scale projects to focus on access to emergency obstetric care, covering 15% of Nepal. This has subsequently been scaled up as part of the health sector reform package and SWAp. Funding is now provided to the MoHP through Support to the Safe Motherhood Programme (SSMP). Both the NSMP and the SSMP have been managed for DFID by Options Consultancy Services. Inputs for SSMP are designed with the MoHP. Financial aid is paid directly to the government with technical assistance provided through a core team of centrally-based advisers and five implementing partners responsible for activities in selected districts, reports from which feed into central planning and advocacy.

As the background report for the NHSP mid-term review acknowledges, maternal care is an area where social difference is particularly critical (Foster et al 2007). Factors found to discourage lower caste use of maternal services include the fact

that the majority of mother and child health care workers were from higher caste groups themselves, limiting uptake from lower caste groups (Dembo Rath et al 2007). Other factors identified include limited knowledge of maternal and neonatal health issues and services and lack of prior preparation to access the available services, particularly among Dalits and Janajatis (ActionAid 2006).

The MoHP National Safe Motherhood and Newborn Health Long Term Plan (2006-17) recognizes the need to address demand issues to empower communities to demand for and utilize the available services. The Equity and Access Programme (EAP), supported by DFID, is designed to address this need as an integral part of the MoHP Safe Motherhood programme. The programme is being implemented primarily by ActionAid Nepal. ActionAid Nepal (and Options) define the EAP as being rights-based: "It aims to create an environment in which poor and excluded women and communities can exercise their right to access Safe Motherhood and Newborn Health(SMNH) services. This approach enables community member to advocate for changing power structures and decision making processes which affect maternal and neonatal health, in favour of pro-poor and inclusive approaches. EAP will work with the right holders to help ensure their rights of access to, and control over, resources for SMNH services" (ActionAid 2006).

The main components of the programme are activities:

- to increase knowledge of SMNH in the community; to add
- to address social, cultural, economic and physical barriers to SMNH services
- to enhance the capacity of local governments, rural health committees and community groups to promote equity and access
- to capture and use the 'voice' of rights holders (citizens) and service providers to influence policy and program development (ActionAid 2006).

The latest EAP report suggests that the approach is having an impact on service utilization among some disadvantaged groups. Monitoring information indicates that in the 8 Districts covered by the EAP, between 2004/5 and 2006/7, there has been a 45.9% increase in hospital deliveries by Brhaman and Chhetri women compared to increases of 107.8% among relatively advantaged Janjatis, 93.8% among relatively disadvantaged Janjatis and 23.7% among Dalits (ActionAid 2007). Participation in EAP activities has also increased women's understanding of their rights. For example, in one district women from the Village Development Committee came to the District Public Health Officer to demand staff for the local sub-health post, because the appointed person was never on duty. The DPHO responded by posting a new member of staff and the community (ActionAid 2007). The programme has also increased the understanding of equity and inclusion issues among front-line health workers, whom the EAP engages on a regular basis (Bharat Devkota).

The voice capturing exercise is particularly important in the current context, as accountability to the community is weak in the absence of elected local bodies pending a political settlement. Methods used include key informant monitoring with community women, in-depth interviews with a range of service providers, client exit interviews and case studies. The first round of this exercise has been completed. Results have been analyzed, disseminated and discussed at both Village and District Level Committees. These exercises have led to changes in programmes at District level with, for example, the creation of an emergency fund to provide financial assistance for those who need referral to a higher level facility (Bharat Devkota 2008).

## **6. International Health Partnership**

It is intended that information from the voice capturing exercise will be used for advocacy at higher levels of the MoHP to try and bring about changes in policies that will support more equitable delivery of SMNH (Bharat Devkota 2008). DFID's Support to Safe Motherhood Programme has recently begun Rights and Social Inclusion awareness training in the MoHP. While this is still work in progress, it is thought that central MoHP staff are increasingly aware of the importance of listening to, and responding to, citizens' voices and views. Engaging more with citizens and civil society is one of the central planks of the International Health Partnership (IHP). It is hoped that the IHP will provide both a lever for increasing the MoHP's receptivity to the voice capturing work of the EAP and a mechanism through which demand-side activities can be taken up and used throughout the health sector (Greg Whiteside, Susan Clapham).

### **People interviewed**

Lynn Bennett. Social Scientist, Nepal.

Bharat Devkota, ActionAid Equity and Access Programme, Nepal

Susan Clapham. DFID Nepal Senior Health Adviser.

Jasmine Rajbhandary, Social Development Adviser, Nepal

Alan Whaites. DFID Senior Governance Adviser.

Greg Whiteside. Options.

### **Documents reviewed**

*Action Aid Nepal* 2006. Equity and Access Programme leaflet

*Action Aid Nepal* 2007. EAP Biannual Report - 4. July to December 2007.

*Bennett, Lynne and Dahal, Dilli Ram* 2008. Preliminary Exploration of Caste/Ethnic and Regional Identity Dimensions of the Nepal 2006 Demographic and Health Survey.

*Brown and Stewart* 2006. The implication of horizontal inequality for aid. CRISE Working Paper No.36.

*Dembo Rath, Indira Basnett, Melissa Cole, Hom NAth Subedi, Deborah Thomas, Susan Murray* 2007. Improving emergency obstetric care in a context of very

high maternal mortality: the Nepal Safer Motherhood Project 1997-2004. *Reproductive Health matters* 15(30).

*DFID* 2007. Nepal Fact sheet.

*DFID* 2006. Unequal citizens. Gender, caste, ethnicity and exclusion in Nepal.

*EC/UNIFEM* 2008. Draft report on aid effectiveness in Nepal: Review in a gender perspective.

*Foster, Quinley, Regmi and Shrestha* 2007. Review of Nepal Health Sector Programme: A Background Document for the Mid-Term Review.

*Hansard*. United Kingdom Parliament. Tuesday 18th December 2007. Transcript of Oral Evidence taken before the International Development Committee on maternal health.

*Government of Nepal*: Three Year Interim Plan 2007.

*MOHP* 2004. Vulnerable Community Development Plan for Nepal Health Sector Programme Implementation Plan (2004/5-2008/9).

*MOHP* 2007. Administrative Data System of Ministry of Health and Population in Nepal.

*UN/OHCHR* 2007. Nepal Field Assessment Mission Report

*USAIDS* 2005. Nepal Family Health Program Mid-Term Survey. By Valley Research Group, Kathmandu, Nepal.

## **D. Peru**

### **1. Summary**

Post Fujimori administrations in Peru have explicitly used the language of human rights and passed legislation on human rights issues, including the establishment of participatory budget processes at local level. However, frequent changes of government and ministers, as well as changes in the middle income funding policies of major donors, have led to lack of a consistent health strategy in Peru, poor government reach into rural areas and slow implementation of legislation. The development of a strong network of civil society organizations working on the right to health, however, has ensured continuing engagement of successive ministries on issues of inequality in health service provision. Government ownership of, and leadership on, this agenda has been strengthened through linkages with international human rights processes, as the mission of the UN Special Rapporteur on the Right to Health encouraged the Ministry of Health into practical action on the Right to Health.

Civil society action on the right to health has strengthened the accountability of the government to its citizens. In the absence of systematic monitoring and clear mechanisms for accountability on the issue of health in general and maternal mortality in particular, civil society organizations are now piloting a project with local women to review and report on the provision of maternal health care. These networks are linked with offices of the Ombudsperson and provide a basis for the Ombudsperson to make reports to local health committees, as well as through parliament, on efforts to address maternal mortality. This experience is currently feeding into Ministry of Health discussions about establishing citizen surveillance schemes for national hospitals.

### **2. Aid and donor coordination**

Peru has a population of approximately 28 million people, of which 70% live in the capital, Lima, and other cities on the coastal strip ( DFID 2005). Because it has a gross national income per capita of USD 2360 (2004), it is designated as a middle income country by the international aid community. The distribution of income, however, is extremely unequal. Around 18% of the population have an average income of less than a dollar-a-day and as much as 38% of the population fall below the two-dollars-a day poverty line. Many of the poor live in remote highland areas (OECD 2006). Indigenous groups, that make up roughly 47% of Peru's population, are disproportionately represented in rural areas and among the rural poor (PHR 2007).

The Peruvian Government has endorsed the Paris Declaration and is concerned that its middle income status should not lead the international community to underestimate its need for poverty-focused assistance. The OECD Evaluation noted that while development planning is technically quite well developed in Peru, there was a lack of an overall policy framework for poverty reduction. Moreover, in the poorest regions of the country, where much of the donor-

supported activity is located, the presence of the government and the influence of government policy guidelines are severely limited. The government of Peru is now starting to co-ordinate external assistance through the Peruvian Agency for International Cooperation (APCI) (OECD 2006). In this context, CSOs play an important role in delivering services and monitoring the impact of government policies on poverty and inequality.

Active donors and agencies include UNDP, UNICEF, the US and the European Commission. Peru's most significant financial support now comes in the form of unsubsidized loans from the International Financial Institutions, particularly the World Bank and the Inter-American Bank (DFID 2005). There is no health SWAp or clear mechanisms for linking national health policies to budgets. In 1999 the World Bank and the IADB agreed a joint loan of USD 87,000,000 for a Programme to Support Health Sector Reform (PARSalud 1). Following review of the Programme in 2004, it was narrowed to focus primarily on maternal and child health and the reduction of maternal mortality as a means of improving the overall health sector. PARSalud 1 has three components: increasing demand for services; improving service supply and modernizing the Ministry of Health (MINSA) (PHR 2007).

### **3. DFID, CARE and ForoSalud**

The Government of Peru has ratified a range of international and regional human rights treaties recognizing the right to health and other health-related rights, including the International Covenant on Economic, Social and Cultural Rights (ICESCR). These rights are protected, to a certain extent, in the Constitution of Peru (1993), which recognizes the right of everyone to the protection of their health and emphasizes the responsibilities of the State in relation to health policy planning and implementation. Peru's General Health Law outlines the State's duty to regulate, safeguard and promote health. However, significant obstacles to the enjoyment of the right to health remain, largely related to poverty and discrimination.

In 2000, the fall of Fujimori provided the setting for a shake-up of existing approaches to development. The transitional government initiated the Roundtable for Poverty Reduction, bringing together government, civil society, the private sector and donors to reach agreement on improving efficiency in service delivery, financial planning for state-funded social policies, and institutionalizing citizen participation in decision-making. In 2001, the newly elected President Toledo employed the language of human rights in legislation and policies to distinguish the government from the Fujimori era. One of the main pillars of this approach was the Peruvian Social Charter, setting out objectives of building a state at the service of its people, creating employment for all and guaranteeing access to health, education and culture.

It was in this context that the Peru office of the Department for International Development (DFID) had its own policy shake-up. DFID had been involved in

Peru's health sector reform programme from the mid 1990s. However, the fall of Fujimori provided the opportunity to review the effectiveness of the predominantly supply-side reforms, led by the World Bank. At DFID headquarters in London, work on citizenship and rights-based approaches gave the DFID Peru office the official hook to develop a programme of support that addressed the demand-side agenda and relations between the state and civil society.

DFID's new direction coincided with the growing strength of Peruvian civil society organizations working on health issues. These included the Social and Economic Research Consortium (CIES), which highlighted the capture of health resources by the urban middle classes, and ForoSalud (Health Forum), an umbrella organization for health associations, NGOs, CBOs and members of Local Centres of Health Administration (CLAS) to meet and discuss collective concerns.

DFID's aim was to bring together a range of organizations across the state civil-society divide in a dialogue to help reformulate the health sector programme with a focus on delivering citizens' right to health. DFID's proposal was for an integrated programme to improve Public Services run by the MINSA, and to defend citizens' health rights through supporting civil society organizations and the Ombudsperson's Office. However, DFID's ambitions were thwarted by a protracted period of negotiation with the MINSA, which was unable to trust the outspoken ForoSalud. Then in 2003, DFID HQ took a decision to close down the bilateral programme in Peru, in order to fund reconstruction in Iraq and as part of a general move away from funding for middle-income countries. DFID was only able to provide funding for a 15 month period, from December 2003 to February 2005, to the Ombudsperson's Office and to the International Non Governmental Organization (INGO) CARE to implement the civil society project in partnership with ForoSalud (DFID 2005). DFID's funding for the project was extended through a partnership programme with CARE from 2005 to 2008.

#### **4. Engagement with MINSA at local and national levels**

The project has worked at local, regional and national levels to build support for and action on the right to health. At local level, the opportunities for civil society engagement in decision making were opened up with the 2004 legislation requiring that local governments formulate budgets in a participatory manner. Along with on-going processes of decentralization, this new policy has led to an upsurge in local level participation. However, these processes face significant challenges including lack of resources, lack of municipal capacity, misalignment of community-development projects with long-term development goals as well as opposition from traditional leaders. CARE and ForoSalud have worked to address some of these problems through developing methodologies to support more effective participation in CLAS.

In 2004 a new Minister of Health was appointed, who was committed to the right to health and keen to re-establish cordial relations with CSOs. In June 2004,

Paul Hunt, the Special Rapporteur on the Right to Health, was invited by the Government to visit Peru and report on implementation of the right to health. One of the observations in the Special Rapporteur's mission report was that the co-operation between the MINSA, international organizations, donors and civil society "created an unprecedented opportunity for the promotion and protection of the right to health in Peru" (UN 2005 E/CN.4/2005/51/Add.3.). During this period, ForoSalud organized a National Health Conference attended by nearly 2000 delegates, presided over by the Minister, where rights-based health policy proposals were presented and discussed (DFID 2005). As a result of the conference and the impetus provided by the Special Rapporteur's visit,

The Minister of Health launched a National Mobilization for Health Rights, supported from MINSA. This led to a series of macro-regional meetings to analyze health rights and responsibilities at regional and local levels. One of the results of the mobilization was the introduction of a MINSA regulation in 2005 supporting cultural practices in service provision, including giving birth in a vertical position. In January 2005, MINSA created a functional unit of Health Rights, Gender equity and cross-cultural issues (CARE 2005-8). The Care project has subsequently supported training of MINSA staff on the right to health. The National Mobilization also led to the 2006 Political Parties Health Agreement, signed by sixteen national political parties. The Agreement committed the parties to support the achievement of the Millennium Development Goals through universal access to good quality health services, decentralization and social participation.

Continuing advocacy work by ForoSalud has led to the introduction of Their work has also contributed to the presentation of a national law proposal "Law on Health Service Users Rights and Responsibilities" which is currently pending in the Peruvian Congress. In the absence of a health SWAp, Forosalud and CARE have worked with key health sector development partners to ensure that their programmes support equality of access to health and health rights. They have, for example, worked with USAID and UNFPA on a programme to support safe motherhood. They have also worked with NGOs and the World Bank to ensure that MINSA prioritizes programmes to address malnutrition.

##### **5. Partnership with the Ombudsperson to monitor maternal mortality**

CARE and Forosalud have strengthened their partnership with the Ombudsperson's Office in order to promote women's rights to maternal health care. In 2007, the CARE office facilitated research for a report by Physicians for Human Rights (PHR) on maternal mortality in Peru. Social inequalities in Peru are reflected in patterns of maternal mortality. Estimates from WHO, UNICEF and UNFPA indicate that the maternal mortality rate (MMR) was 410 per 100,000 live births in 2005. While the MMR for Lima was 52 per 100,000 live births in 2000, the MMR for the rural areas of Huancavelica and Puno were 302 and 361 per 100,000 live births respectively. Nationwide, in rural areas 74% of women

give birth in their homes, while 90% of women in indigenous communities do so (PHR 2007)

The PHR report found that maternal deaths in Peru are overwhelmingly related to the three delays relating to EmOC: the delay in the decision to seek care; the delay in arriving at care; and the delay in receiving appropriate care. These delays, in turn, are linked to systemic inequities in Peruvian society and the health care system. It found that delays in seeking care, for example, were affected by the inequitable distribution of healthcare facilities, economic barriers of access and the lack of cultural acceptability of care at health facilities.

The main strategy, adopted in the World Bank funded PARSalud 1, for addressing these access barriers has been to focus on the government's social insurance scheme, Seguro Integral de Salud (SIS). While SIS has expanded health care coverage, it has failed to ensure that benefits are directed to the most needy (PHR 2007). Lack of a clear strategy for disseminating information about SIS is thought to be one of the primary causes of this failure (World Bank 2007). Informal and formal fees still create significant barriers to care, including Emergency Obstetric Care (EmOC). The SIS was replaced in April 2007 by a new public insurance scheme that is supposed to transform the SIS from a reimbursement scheme into a true insurance scheme with co-payments and premiums. However, it is not yet clear whether this will be more effective than its predecessor (PHR 2007).

The report also found that accountability in the context of maternal mortality was deficient because existing mechanisms for redress are largely focused on individual errors, rather than institutional and systemic factors. It noted that judicial avenues of redress are difficult to pursue and administrative mechanisms are ineffective. However, the Defensoria del Pueblo (Human Rights Ombudsperson Office) has been critically important in investigating and bringing to light violations of human rights in relation to the right to health, including the widespread practice of fining families who give birth at home when they seek certificates for their newborns. In light of this investigation, the Ombudsperson was able to influence the creation of a new MINSA regulation outlawing the fines (PHR 2007).

Following on from this report, Care, in partnership with ForoSalud, PHR and the Ombudsperson Regional Offices has initiated a programme of citizen surveillance of maternal health services in Piura and Puno regions. The purpose of the project is to build the capacity of community networks of quechua and aymara women to observe the operation of health services and report back their findings to the regional Ombudsperson offices. The programme started with training workshops for women's groups and liaison meetings with local authorities and health facilities. The pilot of the monitoring networks was initiated in October 2007. Women have been working in 3 hospitals, 3 health centres and 6 health posts where they visit on a weekly basis to speak with health service users and

watch health care procedures. Women report to the Regional Ombudsperson office in a monthly meeting. The Ombudsperson officers then discuss the findings with the health facility managers and health team. It is hoped that the programme will be expanded into other areas this year. (CARE 2005-08). This experience has fed into current MINSA debates about establishing citizen surveillance of national hospitals and authorizing civil society initiatives to monitor health facilities at local level.

### **Interviews**

Paul Hunt, Special Rapporteur on the right to health.

Ariel Frisancho, Manager Right to Health Programme, Care Peru.

### **Documents reviewed**

*CARE* 2005 -08. Project documentation for "Improving the Health of the Poor: A human rights approach

*DFID* 2005. Alliances against poverty. DFID's experience in Peru 2000-2005.

*OECD* 2006. OECD 2006 Survey on Monitoring the Paris Declaration: Peru.

*Physicians for Human Rights (PHR)*2007. Deadly Delays. Maternal mortality in Peru. A Rights-Based Approach to Safe Motherhood.

*UN* 2005 E/CN.4/2005/51/Add.3.. Report submitted by the Special Rapporteur on the right of everyone to the highest available standard of physical and mental health, Paul Hunt. Mission to Peru. 4 February 2005.

## **E. South Africa**

### **1. Summary**

This case study demonstrates how human rights standards and institutions provide a basis for accountability of the government for the right to health to citizens. It further demonstrates that ESC rights are justiciable and that the judicial system can produce policy-literate judgments that result in changes in the allocation of public resources. It outlines how the South African Constitution and related institutions protecting economic, social and cultural as well as civil and political rights have enabled CSOs to hold the government to account through the judicial system and civil society activism. Civil society and the Government of South Africa have had a long-running conflict over the public response to HIV/AIDS and, in particular, the government's refusal to adopt a comprehensive treatment plan. The legal case bought by the Treatment Action Campaign (TAC) against the government precipitated a change in HIV/AIDS policy.

Since the TAC case, the South African National Aids Council (SANAC), which has members from both civil society and government, has produced the National HIV & AIDS and STI Strategic Plan for South Africa 2007 -2011. The new National Plan, identifies human rights as one of four key priorities. It is anticipated that the National Plan will provide a clearer entry point for donor support to address HIV/AIDS. Given the lack of attention to human rights in other national plans, acknowledged by UNAIDS, its development, content and implementation should provide important lessons for other countries and the international effort to address HIV/AIDS<sup>2</sup>.

### **2. Constitution and legal institutions**

The current institutional and socio-economic condition of South Africa can only be understood in the context of the four decades of apartheid legislation. The apartheid state institutionalized racial discrimination through the attitudes of Government officials, the absence of information concerning rights, roles and responsibilities and the lack of accountability by all levels of government. The system of government was both centralized and fragmented along racial lines with three separate administrations covering whites, Indians and coloureds. It resulted in the systematic and routine violation of human rights as people were stripped of their assets, especially land, denied health and other services and subjected to overcrowding, environmental degradation, violence and destabilization (Hunter et al 2003).

A key feature of the post 1994 Government of National Unity's response to apartheid was the Bill of Rights of the Constitution of the Republic of South Africa

---

<sup>2</sup> This case study is based on a paper prepared by Sibonile Khoza, 2007: "Rights, entitlements and social policy in South Africa" as part of World Bank commissioned programme of research on social guarantees.

of 1996. This includes a comprehensive list of civil, political, economic, social and cultural rights drawn from international human rights treaties. The right of access to health care services, including reproductive health care, is recognized in section 27(1) (a) of the Constitution. Section 27(2) of the Constitution imposes an obligation on the state to take reasonable legislative and other measures, within available resources, for progressive realization. It also recognizes other health related rights including the right to bodily and psychological integrity; the right to an environment that is not harmful to health or well-being and the right to emergency medical treatment. Section 7(2) I imposes duty on the State to respect, protect, promote and fulfill these rights. The Constitution recognizes the interdependence, indivisibility and interrelatedness of rights. It protects a range of civil, political, social, economic and cultural rights related to health including the rights to human dignity, equality, education, sufficient food and water, privacy and life. The Constitution further provides for public engagement in social and economic policies by promoting the values of openness, transparency and accountability and imposing an obligation on Parliament to facilitate public involvement in the law making process.

The Constitution also defined and established the institutions to oversee and implement the Bill of Rights. The Constitutional Court was established as the highest court in all decisions relating to constitutional matters. The first judges appointed to the Constitutional Court were drawn from the human rights activists and legal practitioners who had played a critical role in the liberation and human rights struggle. Below the Constitutional Court, the Supreme Court has final say on all matters except those that involve the constitution. The High Courts have jurisdiction over defined geographical areas in which they are situated and their decisions are binding on Magistrates' Courts within those areas. The Community Courts and Courts for Chiefs and Headmen address customary law disputes. A person with a civil claim has the right to choose whether to take it to the Chief's Court or Magistrate's Court.

A critical factor in the engagement of courts in shaping South Africa's laws and policies is the broad nature of the provision of locus standing in the Constitution through which people access courts and justice. Section 38 of the Constitution states that as well as people acting in their own interests and on behalf of another individual, anyone acting as a member of, or in the interest of, a group of class of persons, or anyone acting in the public interest can approach the court. In South Africa, as well as in other countries, public interest litigation enables legal challenges to government policies based on their impact on social groups rather than individuals.

The Constitution also established the South African Human Rights Commission to monitor the observance and respect for human rights and to monitor progress in the realization of socio-economic rights. It carries out its monitoring task through scrutinizing information from government departments and holding public

hearings on particular rights. It also has the power to receive and investigate individual complaints.

### **3. Social and health policy framework**

The Constitution provides the basic framework for the formulation of social policies. In practice, however, the extent to which policy formulation processes and substance explicitly relate to the Constitution is variable. The 1994 Reconstruction and Development Programme was designed after wide consultations with civil society organizations. Its objectives were to eradicate poverty and undo the underdevelopment left by apartheid. It explicitly acknowledges health as a human right. It committed the government to delivering social services in a manner consistent with human rights principles of inclusiveness, participation and transparency. It prioritizes the needs of vulnerable groups including women and children.

The macro-economic framework, designed to generate the resources to deliver social policies, was formulated with less consultation and was more controversial. The 1996 Growth Employment and Reconstruction (GEAR) programme, which remains the most important macro-economic framework in South Africa, was largely produced by a government technical team. GEAR focused on achieving financial stability and advocated reduced and more efficient state expenditure. Its contribution to South Africa's current levels of poverty and inequalities is an issue of debate (Hunter et al 2003).

The 1997 White Paper on the Transformation of the Health System of South Africa of 1997 aimed to unify the fragmented health system, give priority to primary health care and make it available and accessible to all. It gave special attention to the health needs of vulnerable groups and promoted the participation of community structures in the delivery of health care. The 14 apartheid departments of health were unified into one department and decentralized into nine provincial departments. The White Paper also marked a shift to primary health care, to be introduced through a decentralized District Health System (DHS). A 10 year plan for the introduction of Primary Health Care was adopted and health services are now being organized around the DHS.

The National Health Act 61 of 2003 put the new administrative structure on a statutory footing, establishing a national health system. It provides overall direction on health rights in South Africa, aiming to make health services available to the population equitably and efficiently and to progressively realize the constitutional right to health. The Act allows certain groups, including pregnant women and children under six, to have free health care in public health services. It also determines that there must be guidelines on procedures to be followed by users making complaints, claims or suggestions on the provision of health care services. Every health care establishment must display the procedure

for laying a complaint at its entrance and every complaint received must be acknowledged (Khoza 2007a).

In 1999, the government adopted the National Patients' Rights Charter which defines the core health rights and contains a consumer rights charter. However, it is not a legally binding document and does not offer any recourse. Its objective is to define quality standards for service provision and increase awareness about rights and responsibilities of patients.

#### **4. Treatment Action Campaign (TAC)**

The Treatment Action Campaign (TAC) is the most successful example of a civil society organization that has used the rights and institutions established in the Constitution to challenge the government's health policies and provision. The Treatment Action Campaign (TAC) was launched on International Human Rights Day, 10 December 1998. It is a grass roots organization that campaigns for the rights of people with HIV to treatment, justice and non-discrimination.

South Africa has one of the highest HIV/AIDS prevalence rates in the world, with the estimated number of people infected with HIV at 5.6 million, of which 3.1 million are women. Initial programming on HIV/AIDS in South Africa was oriented towards prevention. Care and support strategies were limited to the treatment of opportunistic infections, home-based care of the dying and community-based strategies for orphans and vulnerable children. Moreover, public debate was clouded by the President's well-publicized questioning of the link between HIV and AIDS. The launch of TAC opened up the debate about access to essential treatments for HIV/AIDS. Its strategies focus on active engagement with civil society, the media and the government to strengthen awareness about, and build advocacy for, HIV treatment.

In 2002, TAC challenged the government's policy on antiretroviral (ARV) provision through the Constitutional Court. The case centered around the provision of nevirapine, for the prevention of mother-to-child transmission (MTCT), which the government had limited provision to 18 pilot sites. TAC challenged this policy on two grounds. It argued that the government unreasonably prohibited administering nevirapine at public hospitals and clinics and that the government had not produced and implemented a comprehensive national programme for the prevention of MTCT of HIV.

The High Court and the Constitutional Court decided that the programme was unreasonable as it restricted access to a potentially life saving drug to only a few sites and thus a few people. Both the High Court and the Constitutional Court found that the state's programme did not comply with its obligations in terms of section 27(1) and (2) of the Constitution. It ordered the government to remove the restriction from the programme and roll it out nationwide. TAC threatened further litigation when the government failed to implement the Court orders.

However, this was averted when the Department of Health moved to purchase ARVs in 2004.

It can be argued that the TAC case kick-started the government into action on producing an HIV/AIDS treatment programme. The success of the case, however, was dependent upon the broader campaign of civil society activism both in the run up to and in the aftermath of the Constitutional Court judgment. The case helped to strengthen the organizational profile of TAC and laid the foundation for further advocacy, campaign work, mobilization and litigation, which has been necessary to ensure that the government develops and implements its treatment programme (Berger 2008).

### **5. National plan of action on HIV& AIDS**

Ongoing disagreement between civil society organizations, particularly TAC, and the government over its treatment policy came to a head at the 2006 High Level Meeting on AIDS in New York. The government responded by taking steps to improve coordination, enhance communication and build partnerships with civil society. The Inter-Ministerial Committee on AIDS, under the leadership of the Deputy President has since been revived. The Deputy President is also the chair of the restructured South African National Aids Council (SANAC). For the first time a civil society representative, Mark Heywood, Director of the AIDS Law Project and national treasurer of TAC, has been selected as the deputy chair of SANAC. SANAC has been involved in the finalization of the National HIV & AIDS and STI Strategic Plan for South Africa 2007- 2011. It is intended that the plan will provide the basis for future funding arrangements with donors on HIV/AIDS.

The plan identifies human and legal rights as one of four key priority areas. It aims to:

- increase knowledge of and adherence to the existing legal and policy framework,
- mobilize society and build leadership of HIV positive people to protect and promote human rights;
- identify and remove legal, policy and cultural barriers to effective treatment and support
- focus on the human rights of women and girls, including those with disabilities and mobilize society to stop gender-based violence and advanced equality in sexual relations.

At the United Nations High Level Meeting on HIV/AIDS in 2006, world leaders reaffirmed that "the full realization of all human rights and fundamental freedoms for all is an essential element in the global response to the HIV/AIDS pandemic." Yet, as UNAIDS acknowledges, the human rights community and UNAIDS have not yet developed a systematic or concerted strategy with which to engage donors on human rights issues in a way that would help to ensure the political and financial support for programmatic responses that are necessary to protect human rights at the national level. Much of the recent support of UNAIDS to

countries has focused on assisting them to strengthen national ownership, institutional capacity and national funding for their HIV responses. In many national responses to HIV there has been insufficient political, funding and programmatic commitment to human rights and gender equality (UNAIDS 2007). The substance, funding arrangements and implementation of the South African plan should, consequently, provide useful lessons for other countries.

### **Documents reviewed**

*Berger, J* (to be published 2008). Litigating for social justice in Post-Apartheid South Africa. A focus on health and education. Draft chapter from Gauri Government of South Africa 2007. HIV and AIDS and STI Strategic Plan for South Africa 2007-2011. Draft 9

*Hunter, N, May, J, Padayachee, V* 2003. Lessons for PRSP from Poverty Reduction Strategies in South Africa.

*Khoza, S.* 2007. Rights, entitlements and social policy in South Africa. Paper commissioned for Social Development Department, World Bank. Published in World Bank 2008. Realizing Rights Through Social Guarantees: An Analysis of New Approaches to Social Policy in Latin America and South Africa". Report No. 40047-GLB.

*Khoza, S.* 2007. Socio-Economic Rights in South Africa. A resource book. Community Law Centre.

*Charles Ngwenya and Ebenezer Durojaye* (to be published 2008) Draft version of the Right to Health South Africa - as part of collection edited by Stephen Marks on the Right to Health.

*UNAIDS* 2007. Issue paper for the session: Engaging donors in the protection and promotion of HIV-related human rights. UNAIDS reference group on HIV and Human Rights. Seventh session.

## **F. Uganda**

### **1. Summary**

Strengthened ownership of the right to health by the Ugandan Ministry of Health (MoH) has been the result of multi-stakeholder partnerships and action. The sustained and focused work of CSOs, including the Ugandan National Health Consumers Organization, has been critical in providing bottom-up pressure, evidence and the opening up of spaces in policy processes involving the MoH for discussion of the right to health. The engagement of the World Health Organisation (WHO) and Office of the High Commissioner for Human Rights (OHCHR) has helped to facilitate and legitimize engagement between CSOs and the MoH. Official visits by the UN Special Rapporteur on the Right to Health have built on and cemented these partnerships and helped to set in train the establishment of a series of institutions working on the right to health. As a result of these processes, the MoH has agreed a Charter of Patient Rights, taken steps to set up a standing committee on health and human rights, and agreed to a human rights and gender equality analysis as part of its mid-term review of the Health Sector Strategic Plan (HSSP II). This will use a tool developed jointly by Sida and WHO, currently also being piloted in Zambia.

The work of the Special Rapporteur in Uganda demonstrates how UN human rights mechanisms can strengthen mutual accountability by providing a means of *independent* review of both donors and partner governments' actions. The Special Rapporteur has reported on the Ugandan government's fulfillment of particular aspects of the right to health and has contributed to the mid term review of the HSSP II. The Special Rapporteur has also reported on the role of Sida's international assistance and cooperation in supporting the Uganda government's international and constitutional obligations to fulfill the right to health.

### **2. Aid and donor co-ordination**

Uganda is an aid dependent country. In 2004, net official development assistance was UDS 1 159 million, up from USD 712 million in 2002. ODA as a percentage of gross national income (GNI) has also increased substantially, jumping from 12.4% in 2002 to 17.3% in 2004 (OECD 2006). The 2006 OECD notes that "Uganda is a good example of a country where aid volumes have increased, in part as a response to successful efforts to demonstrate that aid can be used effectively (OECD 2006. 31- 1). The review also notes that the World Bank's Aid Effectiveness Review for 2006 commends the "sustainable structure for continuous government-stakeholder dialogue. Civil-society and private-sector interests have been involved in formulating and revising the PEAP." (OECD 2006 31-2).

An earlier Sida review of ownership in Uganda, however, noted that "Donor views on transparency, effective implementation, and stakeholder ownership are excessively positive, perhaps due to their wish to support a 'success case'." (Sida

2002:1). In 2005, a number of factors, including slow transition to multiparty politics, the arrest of the leader of the Opposition Party, the Forum for Democratic Change, and concern about continuing violence in northern districts exposed underlying governance problems in Uganda and led to aid cuts. The donors who either cut aid or withheld it included the World Bank, Denmark, Britain, Norway and Sweden.

In 2006, President Museveni was re-elected in the first multi-party elections in Uganda for 25 years which were seen to be well-administered, transparent and competitive (DFID 2008). The election encouraged donors to increase aid flows, but governance problems remain. Reports suggest that the constitutional amendments, allowing both formal party political competition and the abolition of Presidential term limits, created uncertainty and confusion in Uganda. Issues of concern include low credibility of key institutions, increasing concentration of power, deterioration in practices around the budget report and a lack of opportunities for citizen participation in resource allocation at the local level (Robinson 2006). Some donors continue to place restrictions on aid. Sida, for example, allows sectoral but not budget support.

Key policies papers around which donors have coordinated include:

- Poverty Eradication Action Plan 2004/5 - 2007/8 (PEAP)
- Joint Assistance Strategy for the Republic of Uganda (2005-2009) (JAS).

During the drafting of the PEAP, the Uganda Human Rights Commission (UHRC) advocated for the PEAP to explicitly include human rights as a cross-cutting issue. However, explicit mention of human rights is primarily confined to the good governance pillar, where civil and political rights are defined as a key priority. Nonetheless, the social development pillar includes a commitment to move towards mainstreaming gender and the rights of the poor and vulnerable in the national development process. Proposed interventions include undertaking capacity strengthening activities for enhancing gender and Rights Based Approach skills of decision makers and planning/implementing officers to mainstream gender and rights in at least 5 priority sectors, including health, in all sub-counties in half of the districts (PEAP 2004: 179). The drafting process for the National Development Plan, which will replace the PEAP, is now underway and the Uganda Human Rights Commission is again advocating for human rights to be included as a cross-cutting issue.

The JAS reiterates the emphasis on human rights, noting that bilateral development partners will provide assistance to the government and civil society for programmes on political governance, democratization and strengthened protection for human rights. They will also work with parliament and the Ugandan Human Rights Commission. As with the PEAP, however, mention of human rights in the JAS is largely limited to a selection of civil and political rights (including some human rights relating to gender equality). An indicator on human rights is included in the results framework: "Decrease in the number of human

rights abuses reported by the Uganda Human Rights Commission from 669" (JAS 2006: 44).

While human rights are identified in the JAS as a potential trigger for low funding, donors have not apparently set out a clear view on the nature and level of human rights violations that might lead to the lower funding scenario (Maarit Kohonen, OHCHR, Uganda). The Partners for Democracy and Governance Group coordinates dialogue among heads of mission on governance and human rights for bilateral partners ie it is a diplomatic, rather than development group and does not include the World Bank. There is also a basket fund to support the Uganda Human Rights Commission (Gaynor and Jennings 2008).

There is a view among CSOs that donors are supporting the budget, but not consistently supporting the accountability of the government for the budget. CSOs argue that donors should be more consistent in sticking to standards. They should also be more consistent in supporting civil society to hold the government to account. There is, apparently, a lack of consistency among donors on their views on civil society engagement. This may often boil down to individuals' views and, particularly in the health sector, preference for working directly with government ministries.

In 2003, civil society organizations managed an extensive consultation process for the revision of the PEAP and are also involved in implementation and monitoring (JAS 2006). Individual organizations and networks have managed to make an impact both on international and national policy debates. The Ugandan Debt Network, for example, is known for its outspoken attitude and use of the media to disseminate findings on the budget process and issues of corruption at national and district levels (Renzio and Krafchik 2007). The Ugandan Government is seen by some CSOs to be particularly concerned with its global image, possibly because of its own experience of the impact of donor perceptions on aid flows. Consequently, it is seen as likely to respond to publicity-driven campaigns and the 'power of shame'. In this context, human rights and UN accountability mechanisms are seen by CSOs as an increasingly important means of moving the government from rhetoric to action (FEMNET 2007). There are now a number of CSOs working on the right to health, including the Ugandan National Health Consumers Organization (UNHCO), discussed below, HEPs-Uganda, the Action Group for Health, Human Rights and HIV/AIDS, and Basic Needs Basic Rights, which focuses on mental health.

### **3. Health sector - legal and policy framework**

Although the Ugandan government has signed or ratified the ICCPR, ICESCR, ICERD the CRC, CEDAW and the CPD, the 1995 Constitution does not expressly protect the right to health or sexual and reproductive health rights. Health issues are addressed in the National Objectives and Directive Principles of State Policy and have no binding force upon the government. Other relevant legislation includes the Local Governments Act of 1997. This provides for the

devolution of powers, functions and resources from central government to districts and local authorities. Districts/local authorities are charged with service provision and implementation of national policies and standards (FEMNET 2007).

While sexual and reproductive health rights are explicitly mentioned in the MoH's policy documents, the right to health and other human rights are not explicitly referred to. Nonetheless, the PEAP and health sector strategies do address issues of equality, discrimination and participation. Participatory Poverty Assessments have highlighted the connection between health and poverty in Uganda. Successive poverty and health policies have stated the government's commitment to addressing this linkage. The first Health Sector Strategic Plan led to the abolition of user fees in 2001 in all government facilities. This resulted in a rapid rise in utilization of public sector health services. However, inequalities in access remain with coverage rates for primary care services ranging from 7.1% in Kotido to 100% in Kampala (HSSP II). Following decline of HIV/AIDS prevalence rates in the late 90s, HIV/AIDS prevalence among 15-49 year olds is now 6.4% (Uganda HIV/AIDS Sero-behavioural survey 2004/5). Under 5 mortality and maternal mortality remain high at 137 per 1000 and 435 per 100,000 respectively (UDHS 2006 cited in DFID 2008).

The current PEAP outlines the government's commitment to achieving the MDGs and, consequently, health is a key part of the Human Development pillar. The health strategy outlined in the PEAP does not make an explicit link to human rights although, as already noted, the social development pillar includes a commitment to mainstreaming gender and human rights in health in all sub-counties in half of the districts. Health priorities outlined in the PEAP include improving quality of and access to child and maternal health care, continued improvement on past reductions in reducing HIV prevalence and increasing parents' ability to plan the size of their families (PEAP 2004).

The Health Sector Strategic Plan (HSSP II) has the same priorities. The primary strategy to address these issues is the roll-out of an integrated Minimum Health Care Package which covers control of communicable diseases including HIV/AIDS and TB; integrated management of childhood illness at all health facilities and a package of measures to address Sexual and Reproductive Health and Rights (SRHR). The SRHR package addresses essential antenatal and obstetric care; family planning; adolescent health; violence against women including female genital mutilation and other forms of VAW.

HSSP II also addresses issues of inequality and participation. It proposes to strengthen access of vulnerable groups to health services through targeted measures, including resource reallocations. The implementation plan highlights the need to link health care providers and consumers of health care through reactivating local Health Unit Management Committees, strengthening Village Health Teams and working with civil society organizations, especially those

working on health consumer rights, to build individuals and communities awareness of their rights and obligations.

The JAS reiterates the themes set out in the PEAP and HSSP II. It notes that while all other MDGs are likely to be achieved, "progress towards MDG 4(reduce child mortality) and MDG 5 (improve maternal mortality) is uncertain even with improvements in policies, institutions and funding" (JAS 2006:6). This concern is reflected in the results matrix with indicators on maternal and child mortality, increased percentage of children of deliveries in health care centres and increased access to family planning services (JAS 2006).

#### **4. Health and Human Rights Initiatives**

A number of stakeholders have contributed to a growing commitment among MoH staff to addressing the right to health. These actors include the Uganda National Health Consumers Organisation (UNHCO) and other health rights CSOs, the Special Rapporteur on the Right to Health, Sida, WHO and the Uganda Human Rights Commission.

##### **4.1 UNHCO**

The work of UNHCO provides an illustration of the role that CSOs have played in opening up debate with the Ministry of Health on the right to health. At the time of its foundation in 1999, the practical links between health and human rights had not been clearly articulated and there was no strong recognition of the importance of accountability in the health sector. Since then, UNHCO's National Coordinator, Robinah Kaitiritimba, has used her understanding of policy processes in Uganda to advocate and ensure that issues of accountability, transparency and participation are embedded in health sector policies and practices.

UNHCO is currently funded by DFID. It aims to raise awareness among health consumers, providers of health services and other stakeholders on the rights and obligations of health care consumers; develop stronger institutional mechanisms for the articulation of the voices of all consumers of health services in Uganda and advocate for the recognition, protection and provision of accessible health care for all as a fundamental human right. At local level, UNHCO works with partners to strengthen participation in planning, monitoring and evaluation and feed-back mechanisms between services users and services. Their aim is to inform people about their health rights and also to enable them to understand policies, resource allocation process and administrative systems so that they know where to go and what to do when there are problems with health services.

At national level, they aim to bring civil society organizations working on health together and provide strategic direction for engagement in policy processes such as the PEAP and the NHSSP II. UNHCO's 2002 baseline report on the right to health informed the HSSP II. It outlined the low level of awareness of health rights among Uganda citizens and pointed to a lower level of awareness among

women. It surveyed violations of people's rights to health, including the right to be treated with respect and the right to information about services and treatment. It argued that if people were more aware of these rights, they were less likely to be violated (UNHCO 2002). HSSP II references this survey in its plans to address consumers' health rights, and the focus on local level participation and accountability between services users and providers (HSSP II).

In order to supplement the baseline survey, UNHCO carried out a further study of health service user feed-back mechanisms. The study found that the majority of people surveyed were not aware of the existence of suggestion boxes in health facilities or of the role of the Health Unit Management Committee in addressing people's concerns about health services (UNHCO 2003). Current accountability mechanisms at local level are weak.

Since the publication of these reports, UNHCO has worked with the MoH Department of Quality Assurance to provide community input into the development of a Patients' Charter, published in May 2007. The charter includes clauses on the right to medical care, the prohibition of discrimination, the right to informed consent and the right to privacy. It outlines the responsibilities of the patient to supply health workers with complete information, to comply with treatment instructions and treat other patients and health workers with respect. It notes that health care workers contravening these rights may face disciplinary action from Health Unit Management Committees, Health Professional Councils, Medical Boards and Courts of Law (MoH May 2007). The charter is awaiting final Ministry of Health approval. UNHCO is now involved in the mid-term review of HSSP II and has been engaged in work to evaluate human rights in the health sector, including carrying out studies of client satisfaction.

Robinah Kaitiritimba suggests that one of the reasons for the increasing success of their work in Uganda has been their holistic approach, working on the problems and rights of health workers as well as citizens. Health workers, at first, did not see the benefit of a rights-based approach for their own work. UNHCO then worked at district level with health workers and planners to demonstrate how a human rights perspective could help to expose their own lack of resources and clear management and accountability structures, and the MoH's responsibilities to address these. A second factor has been the MoH's concern about reaching the MDGs, its failure to turn around maternal and child mortality indicators and consequent impact on its international reputation. The MoH is beginning to realize that the demand focused human rights-based approach outlined by UNHCO can help to increase the responsiveness of services which is, in turn, a critical component of efforts to address maternal and child mortality.

#### **4.2 The Mission of the Special Rapporteur on the Right to Health**

The missions of Paul Hunt, the Special Rapporteur on the Right to Health, to Uganda were made possible by existing partnerships around the right to health. In turn, the missions were seen by interviewees to have helped to build a broader constituency around this agenda, cemented and legitimized existing partnerships and strengthened the commitment of the MoH to work on the right to health. The Special Rapporteur has made two official visits to Uganda at the invitation of the Ugandan Government. The first of these visits, supported and funded by WHO, was in March 2005 in order to consider the issue of neglected diseases. The collaboration between WHO and the Special Rapporteur was helped by the existence of a health and human rights officer in the Ugandan WHO office, a post funded by Sida. The Head of the Office of the OHCHR in Uganda observed that the initial entry point for the mission was relatively uncontroversial, a fact which helped to ensure that Paul Hunt was well received by the MoH. The consequent report on the mission made a number of specific recommendations to the MoH on neglected diseases, including increased support to Village Health Teams. The Report further recommended that the Uganda Human Rights Commission (UHRC) establish a right-to-health unit responsible for monitoring policies, programmes and projects related to neglected diseases. The report also urged WHO to assume a more proactive role in Uganda (UN 2006: 22 E/CN.4/2006/48/Add.2).

Following the Special Rapporteur's report, OHCHR and WHO helped the MoH to organize a two day right to health capacity building workshop in May 2006. In order to facilitate the MoH's leadership of the workshop, a steering committee was formed. The committee was chaired by the Assistant Commissioner for the Planning Department and included representatives from WHO, the OHCHR, the Uganda Human Rights Commission, UNAIDS, UNFPA and civil society. The MoH committee continued to meet after the completion of the workshop. Meetings have not been held recently, but the MoH is now keen to restart it.

The report of the workshop echoed the Special Rapporteur's recommendation that the UHRC should establish a health unit with a remit to cover the whole of the health sector. In response to these recommendations, the UHRC has now established a unit whose key function is to monitor policies, programmes and projects relating to the right to health, with a focus on neglected diseases. The unit is currently funded by UNDP and has one member of staff.

The second mission of the Special Rapporteur was in February 2007, supported by the OHCHR and WHO. This mission had two aims. The first was to follow-up on recommendations made in his first report and to contribute to the mid-term review of the HSSP II. As part of this process, Sida, WHO and OHCHR supported the MoH in organizing a stakeholder meeting during the Special Rapporteur's visit. This meeting built on the May 2006 capacity building workshop, had high level attendance and further cemented partnerships between

different organizations working on the right to health. It also initiated a human rights analysis of the HSSP II.

The second objective of the mission was to complete a review of the extent to which Sweden's international and domestic commitments to fulfil the right to health are implemented on the ground through Sida's programme of support to Uganda. The Special Rapporteur's report notes that, "as a State party to ICESCR and CRC, Sweden not only has a duty to give effect to the right to health domestically but also through "international assistance and cooperation""(UN 2008:7 A/HRC/7/11/Add.2). This duty includes both financial and non-financial dimensions. It further includes procedural fairness, which requires donors not to withdraw critical right-to health aid without first giving the recipient reasonable opportunities to make alternative arrangements. The report notes that the Swedish Government has also made domestic commitments to addressing human rights in international assistance. In its policy document, Human Rights in Swedish Foreign Policy, the Swedish Government pledges to integrate human rights into all areas of foreign policy and to mainstream human rights into the work of global and regional organizations (UN 2007 A/HRC/4/28/Add.2).

The final report of the Special Rapporteur commends the Sida programme and notes that it does support the Government of Uganda to fulfil its constitutional and international obligations towards the right to health. Nonetheless, the report notes that human rights are not mainstreamed consistently throughout Sweden's development cooperation in Uganda, including in Sida's support to the health sector (UN 2008 A/HRC/7/11/Add.2).

The report also includes a number of observations on the Paris Declaration and the right to health in Uganda. The report notes that alignment and harmonization in the health sector have reportedly led to greater coordination between donors. It observes, however, that the right to health has not consistently informed this process and cautions against the neglect of difficult issues, such as sexual and reproductive health rights, in the search for common ground among donors. The report also highlights proposals to establish a basket-fund for CSOs. It notes concerns among health NGOs that this might jeopardize their funding and urges donors to ensure that basket-funds do not result in less support to those organizations working on sensitive issues (UN 2008 A/HRC/7/11/Add.2).

The report of the Special Rapporteur observes that the Paris Declaration has helped to draw attention to the issue of donor accountability to recipient countries. It suggests a number of ways in which Sida could improve their accountability, including through provision of accessible information about their programme in Uganda, presentations to the Ugandan Parliamentary Committee on Social Services and a strengthened role for the UHRC in monitoring donor policies as well as those of the government (UN 2008 A/HRC/7/11/Add.2).

The Special Rapporteur's missions and reports on the work of Sida demonstrate the importance of UN accountability processes as a means of strengthening the accountability of donors, as well as partner governments. The key feature of UN processes is that they provide a means of *independent* rather than peer or political review, of donor programmes. In the UK for example, the select committee monitors international development and cooperation. As this is a political body, it is more likely to measure the UK programme against domestic commitments to aid than against international standards. Agreed international standards, including duties to provide financial and non-financial assistance to developing countries and to respect principles of procedural fairness in the provision of aid, are likely to provide a more objective basis for review of donor actions. In the absence of dedicated UN procedures for ensuring donor accountability, existing mechanisms, such as the Special Rapporteurs and Treaty Monitoring Bodies, have been used to review donor action against internationally agreed standards. The power of these mechanisms lies in the use of publicity to encourage or shame governments into action. While lacking in formal authority to ensure redress, these mechanisms are, in reality, the primary existing, independent means of addressing the accountability of donors in relation to MDG 8.

#### **5. WHO/Sida human rights and gender equality tool**

According to interviewees, one of the perceived outcomes of the missions and reports of the Special Rapporteur has been the increased engagement of Sida with the MoH on the right to health. One consequence of this engagement has been the agreement by the MoH to a human rights and gender equality evaluation of the health sector as part of the mid-term review of NHSSP II. This work will be carried out by two local consultants with technical support from WHO and Sida. The main goals of the review will be to appraise the status of health and human rights within the context of HSSP II planning and reporting at the national and local government levels and to appraise mechanisms for strengthening health and human rights structures within the health sector. The review will consist of field visits and interviews as well as document appraisal.

The review will provide an opportunity for testing the human rights and gender equality tool being developed by the Health & Human Rights Team (HHR) in the Department of Ethics, Equity, Trade and Human Rights (ETH), the Department of Gender, Women and Health (GWH) and Sida. The aim of this work is to analyze the extent to which health sector plans and policies are consistent with, and promote, human rights standards and principles, including gender equality. The focus of the tool is on the planning, reporting and processes/mechanisms for implementation. The health system's building blocks, as identified in the WHO framework for health systems "Everybody's Business", serve to focus the analysis, which incorporates key elements of the right to health, other health related human rights standards and human rights principles. This analysis will potentially reveal gaps and needed actions in relation to the promotion and protection of human rights as well as gender mainstreaming. The tool is targeted for use by

health policy makers, development partners, CSOs and other relevant stakeholders.

It is hoped that the review will identify and open up existing institutional spaces for work on human rights and health. Possible entry points include the re-establishment of the MoH steering committee on human rights and health and links with local government human rights desks, which are currently being established in each district with the support of UNDP.

### **People interviewed**

Ulrika Hertel. Sida Uganda.

Paul Hunt. UN Special Rapporteur on the Right to Health.

Robinah Kaitiritimba. National Co-ordinator Uganda National Health Consumers Organisation.

Maarit Kohonen. Head of Office. OHCHR Uganda.

Margaret Sekaggya. Chairperson Uganda Human Rights Commission.

### **Written comments**

Annelie Rostedt, WHO.

### **Documents reviewed**

*Bjorkmann and Svensson* 2006. Power to the People. Evidence from a randomized experiment of a community based monitoring project in Uganda.

*DFID* January 2008. Uganda Factsheet.

*FEMNET* (African Women's Development and Communication Network) 2007. Reproductive and Sexual health Rights in Kenya, Tanzania and Uganda.

*Gaynor and Jennings* 2008. Cross-cutting issues in Joint Assistance strategies/harmonization mechanisms: Gender equality, environmental sustainability, human rights and HIV/AIDS.

*De Renzio and Krafchik* 2007. Lessons from the Field. The impact of Civil society budget analysis and advocacy in six countries.

*OECD*. 2006. Survey on Monitoring the Paris Declaration: Uganda.

*Sida* 2002. Supporting Ownership. Swedish development cooperation with Kenya, Tanzania and Uganda.

*Government of Uganda:*

*Ministry of Finance, Planning and Economic Development*. Poverty Eradication Action Plan (2004/5-2007/8)

Joint Assistance Strategy for the Republic of Uganda (2005-2009).

*Ministry of Health*. Health Sector Strategic Plan II 2005/06 - 2009/10

*Ministry of Health*. Patient's Charter May 2007.

*UN* 19th January 2006. E/CN.4/2006/48/Add.2 Report of Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt. Mission to Uganda.

*UN* 28th February 2007. A/HRC/4/28/Add.2 Report of Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt. Mission to Sweden.

*UN* 21st March 2007a. A/HRC/4/28/Add.3 Report of Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt. Preliminary Note. Missions to Uganda and to the offices of the Executive Directors at the Nordic-Baltic Countries at the World Bank and the International monetary Fund.

*UN* 5th March 2008. A/HRC/7/11/Add.2 Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt. Addendum. Missions to the World Bank and the International Monetary Fund in Washington, D.C. (20 October 2006) and Uganda (4-7 February 2007).

*UNHCO* 2002 Report on baseline survey on the Right to health.

*UNHCO* 2003. Patient feedback mechanisms at health facilities in Uganda.

## **G. Zimbabwe**

### **1. Summary**

The Community Working Group on Health (CWGH) provides an example of a human rights-based approach that builds bottom-up ownership of, and accountability for, the provision of basic health services in a fragile context. The CWGH focuses on strengthening capacities to enable broad-based civil-society participation in village and district level health structures. It brings together service providers, representatives from women's groups, traditional leaders, local councilors and parliamentarians to discuss operational programmes for the delivery of health care.

The CWGH supports the parliamentary role in health through its work with the Parliamentary Portfolio Committee on Health to review the health budget and provision of basic health services. It has used the Charter of Patients' Rights, published by the Ministry of Health and Child Welfare (MHCW), as a basis for participatory approaches to assessing village-level basic health care provision.

**2. Context.** As a result of the worsening political and socio-economic crisis in Zimbabwe, donors no longer give direct support to the Government of Zimbabwe (GoZ). Humanitarian aid is instead channeled through UN agencies and civil society organizations. In a difficult political environment, CCSIs including HIV/AIDS, gender and disability provide a relatively neutral entry point for donor engagement. For example, UNICEF manages a multi-donor programme of support for implementation of the National Plan of Action on OVCs. Funding is allocated to civil society organizations with no money going through the government. Selection of eligible NGOs is carried out by a committee consisting of representatives from government ministries as well as donor representatives. Zimbabwe's national action plan is based on the CRC, as well as the Government's National Orphan Care Policy. It has provided a politically neutral framework for action. While human rights are a contentious issue, donors, civil society and the government of Zimbabwe can agree on the language of child rights.

One of the primary challenges of implementing the national action plan, and of work in Zimbabwe in general, is to engage at local, district and provincial level in the context of decreasing government capacity. There is a risk that funding NGOs, rather than the government, to provide local level services will create a parallel system and undermine any government capacity to operate in the future. NGOs using a human rights-based approach address this issue through a focus on the identification of duty bearers, including local, district and provincial councils, and assessment of the difficulties they face in meeting their obligations to rights holders. The human rights-based approach thus identifies issues relating to governance institutions that support service delivery and people's economic and social rights.

### **3. Community Working Group on Health (CWGH)**

The Community Working Group on Health (CWGH) provides an example of how human rights-based programming supports aid effectiveness in fragile contexts. The CWGH is a civil society network that incorporates 35 membership-based organizations. It was formed in 1998 in response to increasing challenges in the health sector including high rates of HIV & AIDS, and retrenchment as the result of the structural adjustment programme. It now works in 24 out of 63 districts in Zimbabwe. It does not receive core funding from any one donor, but has received funding from a range of development partners for specific programmes, including funding from UNICEF's ECHO programme for its work on sexual and reproductive health among OVCs.

The CWGH operates at all levels in Zimbabwe. At local level, the CWGH supports community participation in village and district health committees. Village health committees supported by the CWGH include women's group leaders and traditional leaders as well as the nurse in charge of the health clinic and local councilors. The CWGH supports capacity building in the areas of health planning and budget management, enabling the committees to produce operational plans and effectively manage the limited resources available.

Dialogue between the different stakeholders is seen as the key to building bottom-up ownership and solidarity. Instances where there have been complaints about health staff rudeness, for example, have been amicably resolved at local level rather than being referred up to the district level. In the villages and districts where the CWGH is operating, there has been a notable improvement in service and drug supply, as well as service take-up. The CWGH has used this consultative approach as a means of engaging local parliamentary representatives as well as other stakeholders in consensus building around youth rights to reproductive and sexual health.

The CWGH has also used the Patients' Charter of Rights, introduced by the Ministry of Health in 1996, as a tool for local level education and accountability. In 1998 civil society organizations, including the Community Working Group on Health, trades unions and church organizations were involved in review of the charter. The Charter was distributed to all health clinics and centres. It was well received by both clinic staff and service users. High levels of literacy in Zimbabwe meant that there was good awareness of the charter and its contents. The CWGH mobilized communities around the Charter and it became a basis for people to raise questions with service providers and local and district health committees about drug supply, the use of resources and provisions of services. However, the success of local-level mobilization and calls for accountability around the Charter, as well as the deteriorating economic situation in Zimbabwe, led the government to withdraw it recently from display in local clinics and services. The CWGH still uses the Charter as a basis for village-level mobilization and education.

At national level, the CWGH works with the Parliamentary Portfolio Committee on Health to review the health budget and discuss health policy issues. The current economic crisis in Zimbabwe means that there is a limited amount that can be achieved - there is currently no funding for the Ministry of Health from April through to December of this year. Nonetheless, the CWGH is able to raise questions on a number of issues with parliamentarians, including the practice of detaining women who have given birth in government facilities but are unable to pay the fees.

In Zimbabwe, the term 'human rights' is associated with political opposition and creates tensions rather than cohesion. The Government has introduced legislation restricting the operation of civil society in Zimbabwe, including the Public Order and Security Act and the Access to Information and Protection of Privacy Act, which restrict freedom of association and expression. Nonetheless, the CWGH is able to utilize its contacts to build up advocacy campaigns and also explicitly utilizes the concept of the right to health. The CWGH has signed a MOU with the Parliamentary Committee which includes joint action between civil society and parliamentarians on the regional Right to Health campaign. This regional action campaigns for cheap drugs for treatment of HIV & AIDS. It also campaigns for increased spending in the health sector in line with the target of 15% of total budget allocated to health, as outlined in the Abuja Declaration (interview with Itai Rusike, CWGH).

#### **People interviewed**

Jose Bergua, UNICEF Zimbabwe  
Rene Lowensen, EQUINET  
Itai Rusike, CWGH

#### **Documents reviewed**

Itai Rusike. March 2007. Civil society promotion of equity and the social determinants of health through involvement in the governance of health systems: the case of the community working group on health in Zimbabwe. A case study commissioned by the Health Systems Knowledge Network.

*Community Working Group on Health*. July 2007. Report on 14th National Conference.

*Government of Zimbabwe*. June 2004. National Plan of Action for Orphans and Vulnerable Children.

## **Annex two: Country study analysis framework**

	<b>Country case study evidence</b>
<b>Human rights and health</b>	
Explicit use of human rights standards	
Participation in decision-making	
Non-discrimination and equality	
Budget allocation (progressive realization)	
Cross-sectoral linkages (indivisibility)	
Disaggregated monitoring	
Processes of accountability	
<b>Ownership</b>	
<i>Partner govt.</i> Norm integration	
Consultation providers, clients, policy-makers	
Policy community cohesion - national and local	
Focusing events	
Clear policy solutions	
<i>Donors:</i> Norm promotion	
Resource allocation	
<b>Mutual Accountability</b>	
<i>Donor accountability:</i> UN HR processes	
<i>Partner government accountability :</i>	
International accountability- UN HR processes	
Government - citizen accountability:	
- judicial	
- independent	
- political	
- social	
- administrative	
<b>Managing for Results:</b>	
Disaggregated data	
Indicators	
<b>Harmonization</b>	
<b>Alignment</b>	