Original Article

'Rights-based approaches' to health policies and programs: Articulations, ambiguities, and assessment

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Abstract *Rights-based approaches* (*RBAs*) to health encompass an exciting range of ways that the United Nations, governments, and non-governmental organizations incorporate human rights into public health efforts. By reviewing the academic literature and discrepant articulations of human rights and RBAs by key institutions, the authors identify common rights principles relevant to health and discuss a framework to improve implementation and guide assessment of the contributions of RBAs to health. *Journal of Public Health Policy* (2010) **31**, 129–145. doi:10.1057/jphp.2010.7

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A Rights-Based Approach To Health

Over the last 20 years the public health community has come to a largely shared perspective that a human rights lens on health helps shape understandings of who is disadvantaged and who is not; who is included and who is ignored; and whether a given disparity is merely a difference or an actual injustice.[1,2] Even so, academics, the United Nations (UN), government agencies, and non-governmental organizations (NGOs) still struggle with how to operationalize a *rights-based approach* (RBA) to health.[3]

Below we identify principles underlying RBAs and key definitional challenges. We review how scholars describe RBAs and analyze statements of key institutions as the basis for discussing the implications of diverse understandings of RBAs for policy, programs,

and outcomes. We suggest a framework to guide the implementation and assessment of the contribution of RBAs to health. Our immediate aim is to promote more systematic learning about what works; the longer-term aim is to ascertain the impact of RBAs on health outcomes.

Methods

We reviewed the English-language scholarly literature and relevant organizational statements through early 2009, relying heavily on the development literature to identify common elements of RBAs.[7] Our sources for institutional statements are primary websites of UN agencies (not country office websites), major government bilateral organizations, and international NGOs active in health.

RBAs: Underlying Concepts

Human rights concepts and methods encompass delivery of health services and the determinants of health (see Table 1). In 2000, the UN Committee on Economic, Social, and Cultural Rights called for ensuring availability, accessibility, acceptability, and quality of health services, and highlighted underlying determinants of health, 'such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, and healthy occupational and environmental conditions'.[8] Relevant rights include non-discrimination, education, information and privacy, which can help focus programmatic attention and promote health-related interventions in sectors such as education and housing. An RBA requires adoption of an approach explicitly shaped by human rights principles.[9,10] Countries bear responsibility for national health plans consistent with their international human rights obligations, ensuring non-discrimination and the participation of affected communities. National plans frame sub-national responsibilities. Incorporating human rights into health and development work means that policies and programs will contribute to the fulfillment of human rights – and, it is assumed, improve outcomes.[10–14]

Definitional Challenges of RBAs

A diversity of public health initiatives claims relevance of human rights to their efforts.[15–17] A common definition has yet to take root, making comparison and identification of promising practices difficult.[18] Some organizations use the term *RBA to health* and specify their meanings; others use *human rights focus* and *RBA* interchangeably. Some simply refer to *human rights*, implying they may use RBAs. Commentators call on ambiguities to argue against RBAs, or to assert that 'rights-based' talk requires caution: it may be only a new label for the 'same old development' approaches.[9,19–20] Some call RBAs examples of 'northern hegemony' (when required by funding agencies regardless of the perceived appropriateness in a particular context).[7] Some note the lack of documented value of integrating human rights into public health programming.[21] Awareness of human rights remains low among development actors, as does political will for implementation. Priority attention to outcomes often means secondary concern for the processes at the core of an RBA.[7,20]

RBAs: Academic Articulations

The academic literature contains a common set of elements of an *RBA to development*; commonalities among *RBAs to health* appear to be less clear. Scholars frequently highlight the interdependence of rights as support for multi-sectoral approaches. For example, fulfilling the right to health may require attention to education, transport, or information. *Process* in an RBA – how it is that outcomes are achieved – is central.[22–28]

The former UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health emphasized the promotion of human rights and the incorporation of human rights principles within the *processes* of health policy and program development as fundamental to RBAs to health.[29,30] His definition of a 'rights-based health system' advocates a 'people-centered approach' to health care, the collection of disaggregated data, and the use of human rights-based indicators.[29–31] Some authors note the importance of examining the political, legal, and policy environments in which programs take place. Two examples: Laws restricting drug prescription to highly trained health

Table 1: Core terms applied in rights-based approaches (RBAs) to health

Human rights	Are legal guarantees, equally applicable to everyone everywhere in the world, enshrined in international human rights documents. Human rights protect against actions that interfere with fundamental freedoms and human dignity and support the agency of individuals and populations.[4–6]
Duty-bearer	All governments have the duty to respect, protect, and fulfill human rights. Duty-bearers include actors at various levels of government. Non-state actors can also be duty-bearers, such as parents in relation to their children.[37]
Rights-holder	Every individual is a rights-holder. This means that each one is entitled to the same rights without distinction regardless of race, color, sex, age, language, religion, political or other opinion, national or social origin, disability, property, birth or other status, such as sexual orientation.[37]
Discrimination	Discrimination refers to the legal, institutional, and procedural ways people are denied access to their rights. Discrimination can negatively affect people's health outcomes or access to services. Discrimination can occur on the basis of real or perceived health status, membership within a stigmatized or vulnerable group, or engagement in a stigmatized behavior such as sex work or injecting drug use.[37]
Participation	Every person is entitled to active, free, and meaningful participation in, contribution to, and enjoyment of civil, economic, social, cultural, and political development. Ensuring the inclusion and full participation of key stakeholders and affected communities at every stage of health programming is an essential component of an RBA to health.[37]
Accountability	Governments are accountable to their populations and to the international community for their actions which impact on health and development. Accountability mechanisms exist at local, national, regional, and international levels to monitor compliance and support governments in fulfilling their human rights obligations.[8]

The right to health in relation to goods and services (the 3AQ):	The right to health has been defined by the Committee on Economic, Social and Cultural Rights to include the availability, accessibility, acceptability, and quality of health-related goods and services: *Availability*: Requires making available in sufficient quantity functioning health-care facilities, goods, services. Although varying by context, these should address the underlying determinants of health, including safe and potable drinking water and adequate sanitation facilities, hospitals, clinics, trained medical personnel and essential drugs. *Accessibility*: Encompasses four distinct components, all of which require special attention to the most vulnerable and affected populations: (i) Non-discrimination: Health facilities, goods and services must be accessible to all; (ii) Physical accessibility: Health facilities, goods and services must be physically accessible to all; (iii) Affordability: Health facilities, goods and services must be affordable for all, yielding accessibility of needed services, whether privately or publicly provided; and (iv) Access to information: Includes the right to seek, receive, and impart information and ideas concerning health issues, but does not impair the right to have personal health data treated with confidentiality. *Acceptability*: Requires that all health facilities, goods and services be respectful of medical ethics and culturally appropriate, sensitive to sex and life-cycle requirements, as well as designed to respect confidentiality and improve the health status of those concerned. *Quality*: Requires goods and services to be scientifically and medically appropriate and of good quality: specifically, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water and adequate sanitation.[8]

professionals might limit drug access in areas with few such qualified health workers;[32] and, criminalization of sex between men might impede access to services for people who engage in such behaviors for fear of discrimination or reports to authorities.[33] Many also stress elements of the right to health such as the availability, accessibility, acceptability and quality of services.[2,22,28,34–36]

RBAs: Institutional Articulations

Organizations explicit about their use of RBAs emphasize benefits including greater local ownership of development processes, stronger partnerships, and more equitable service delivery.[38]

The UN System

Global attention to RBAs came to the fore in 1997 when Kofi Annan, then UN Secretary General, called for the UN to integrate human rights into all of its work.[39] Only in 2003 did the UN develop a unified definition of an RBA, the 'Common Understanding on a Human Rights-Based Approach to Development Cooperation'. This 'Common Understanding' calls for human rights principles to guide 'all phases of the programming *process*' of all UN agencies.[37]

The Common Understanding appears to be a lowest common denominator approach, privileging consensus over specificity. Its general nature has made it difficult to operationalize, and agencies have taken on different aspects of the Common Understanding, reflecting their respective mandates.[40–43]

UNICEF highlights the principles of universality, indivisibility, and accountability, while focusing on child and youth participation, inclusion of marginalized children, and the four foundational principles of the Convention on the Rights of the Child: non-discrimination; the right to life, survival and development; the best interests of the child; and respect for the views of the child.[44,45] The United Nations Population Fund frames its RBA around the International Conference on Population and Development Programme of Action, the primary document that guides its work, stressing the importance of ensuring a culturally and gender-sensitive RBA.[46,47]

The World Health Organization (WHO) uses the Common Understanding definition framed around the right to health,

highlighting availability, accessibility, acceptability, and quality of goods and services.[48] The Pan American Health Organization, a regional office of WHO, defines its 'health and human rights approach' as firmly based on international human rights treaties, explicitly recognizing health as a human right, empowering vulnerable and marginalized groups, and enhancing government accountability, among other factors.[49]

The UN continues to try to harmonize its implementation of the Common Understanding. Despite an October 2008 inter-agency meeting to review conceptualization and implementation of RBAs, and to improve coordination, progress appears slow.[3]

Selected National Governments and their Foreign Aid Agencies (Bilateral Donors)

We analyzed statements of governments that made the largest contributions to population assistance programs in 2006 (the most recent year for which such data are available), the United States and the United Kingdom, and two that have been particularly proactive with regard to RBAs, Sweden and Spain.[50]

The US government refers to human rights and RBAs repeatedly in its international health and development agenda. President Obama's foreign assistance is intended to 'advance human rights and freedoms'.[51] The Operating Principles of the Office of the Director of US Foreign Assistance commit to accountability, transparency, and bringing stakeholders together to develop coordinated approaches to programs.[51] These Principles apply to the US Agency for International Development (USAID) including their 'rights-based' projects and trainings on RBAs.[52] The President's Emergency Plan for AIDS Relief (PEPFAR) also lists 'rights-based' projects[53] but neither USAID nor PEPFAR defines an RBA.[53–54]

The United Kingdom's Department for International Development (DFID) emphasizes 'human rights-based' programming informed by participation, inclusion, and fulfilling obligations.[55] Participation – as a right and as a requirement – embodies DFID's understanding of an RBA.[56] DFID's RBA, unlike the UN Common Understanding, 'does not insist that all its development cooperation activities should directly strive towards the realisation of at least one human right'.[56] Instead, DFID 'views the realisation of human rights

as an incidental result of development'.[56] References to RBAs appear in DFID materials on poverty reduction, maternal health, and child health, but little outside these areas.[55]

Sweden has not embraced the term RBA although it lists human rights as a priority in development cooperation. The core of Sweden's Policy for Global Development is a 'rights perspective' based on the international human rights framework defined by the Ministry of Foreign Affairs as 'basing development on human rights and democracy' while stressing respect for all human rights, equality, and non-discrimination.[57,58] The Ministry characterizes this as a broader application of international conventions, noting that participation and a focus on those who live in poverty are essential.[59] The Policy for Global Development offers questions to guide integration of 'the rights perspective' and discusses implementation challenges. Sweden is one of the few bilaterals reviewed here to explicitly discuss implementation.[59]

The Spanish Agency for Development Cooperation (AECID) promotes human rights as a cross-cutting issue based on international, regional, and national human rights frameworks.[60–62] This commitment requires empowerment of individuals to fulfill their roles as the 'main agents, protagonists and beneficiaries' of development policy and strengthening the capacities of states, donors, managers, and partners to promote and protect these rights.[61,62] AECID explains *how* to integrate its 'human rights focus' into international cooperation including: within the political and legal context of a country, the strategic planning of projects and country action plans, and the monitoring and evaluation at all phases of program implementation.[61,62] AECID-written materials offer the greatest detail on implementation of an RBA.

Non-governmental Organizations

International NGOs working in health claiming to operationalize human rights have incorporated rights concepts in equally varied ways. In its strategic framework, the International Planned Parenthood Federation (IPPF) notes that RBAs are integral to promoting universal access to sexual and reproductive health information, education, and services.[63] Although not called an RBA, their rights-emphasis appears to ensure that marginalized groups can access

services, promote availability and acceptability of services, strengthen partnerships, and ensure high quality services.[63] By using extracts from international human rights treaties, IPPF's Charter on Sexual and Reproductive Rights strengthens the legitimacy of sexual and reproductive rights as key human rights issues.[64]

The International Save the Children Alliance describes its RBA as an approach grounded in moral and legal obligations of the state. Its core 'child rights programming' recognizes children as rights-holders, ensures their participation in development processes, tackles unequal power structures, and encourages legal reform.[65]

Oxfam International defines its RBA as respect for human rights that will 'help lift people out of poverty and injustice, allow them to assert their dignity, and guarantee sustainable development'.[66] The stated focus of its work encompasses promoting the rights to security and a sustainable livelihood.[67] Similarly, CARE International's RBA 'deliberately and explicitly focuses on people achieving the minimum conditions for living with dignity', and is grounded in participation, non-discrimination, and accountability.[68]

In 2008, Oxfam America and CARE USA together clarified the definition and value-added of RBAs to their efforts. Their RBAs 'are grounded in the normative framework of human rights and in direct interventions aimed at building rights-holders' capacity to claim their rights and duty-bearers' ability to meet their obligations'.[69] They agreed on a list of 'essential elements' of RBAs, including participation, inclusion, and non-discrimination, and an emphasis on processes, not only outcomes, through engaging communities in project development, and building alliances.[69]

Discussion of Variation in Articulations of RBAs

A first step towards systematic assessment of the practical value of RBAs to health across projects, institutions, and countries, requires attention to commonalities and differences in their articulations. Consensus as to common elements of an RBA to health is greatest in the academic literature. These include: contributing to the fulfillment of human rights, attention to the interdependence of rights necessitating a multi-sectoral response, participation and inclusion of those affected, and consideration of both non-discrimination and accountability. The academic literature acknowledges the lack of

conceptual and operational clarity of RBAs and skeptics point to a lack of empirical evidence of their added value.[26,70]

Although all institutions reviewed explicitly commit to human rights, some do so only in general terms. Others unambiguously state they adopt an RBA but fail to specify operational aspects. A small minority details how an RBA shapes programming; even fewer mention implementation processes. Absent from institutional articulations of RBAs, with the exception of WHO, is attention to availability, accessibility, acceptability, and quality of goods and services. Institutions' choice of terminology varies: Sweden chose 'rights perspective'; Spain uses 'human rights focus'. Variations among organizations outside the UN system may indicate a desire to avoid the constraints of the UN Common Understanding definition of an RBA. Differences in interpretation of RBAs have clear implications for assessment of their operation and ultimately of their value-added for health.

RBAs: Moving Towards Assessment of RBAs to Health

Below we propose a framework, based on four questions, for assessing institutional articulations of RBAs to highlight areas for consideration in their implementation:

1. *To what extent is the RBA grounded in international human rights law?*
   With the aim of ensuring that uses of human rights terms align with globally agreed-upon norms and standards, this question requires looking beyond institutional or national articulations of RBAs to discern exactly *how* policies and programs are designed, and to identify the specific legal frameworks relied upon.
2. *To what extent is attention paid to specific human rights and rights principles?*
   An RBA to health requires more than mentioning human rights in a broad sense. The naming and integration of specific norms and standards will facilitate operation of RBAs. A minimal checklist includes:

   Participation. Are efforts made to ensure affected communities are able to participate? Is participation representative of the populations the program seeks to reach? Are participants' views adequately

taken into account in design and implementation? Adequacy is difficult to determine; minimal requirements include ensuring that target populations have been active in planning processes and found all proposed activities to be necessary and acceptable.

Non-discrimination. Has the organization, in its own operations, policies and programs, taken steps to ensure discrimination does not occur (for example, with regard to human resources)? With respect to programs, are there appropriately disaggregated data available for analyzing whether discrimination is being avoided? Does the agency use these responsibly? Assessment may require special efforts such as interviewing difficult-to-reach populations who already face discrimination in accessing relevant goods and services.

Availability, Accessibility, Acceptability, and Quality of Services. Is there systematic attention to ensuring the availability, accessibility, acceptability, and quality of relevant goods and services? Assessment of these elements may identify efforts towards an RBA even if this has not been explicit in documentation. Focus group discussions with local communities might explore these issues and help to identify barriers to project implementation.

Transparency and Accountability. Are clear and transparent accountability mechanisms in place for decision-making, review, and redress? Do all stakeholders have clear understandings of where responsibility lies and to whom they can bring comments or complaints?

3. *To what extent is there explicit concern not only with the health outcomes to be derived from programming, but the specifics of how these outcomes are to be reached?*

   Programmatic ends alone do not justify the means; the processes of implementation must also be human rights-based. An increase in the number of people undergoing HIV testing might be achieved through coercive testing or through a concerted voluntary campaign including appropriate counseling and ensuring informed consent. The outcome might be the same, but in an RBA the process is critical. How are human rights integrated into every component of a project and every step of the process: policy, program design, implementation, monitoring, and evaluation – including work plans and budgets?

4. *To what extent is there an integrated multi-sectoral response to the health issue of concern?*
   The interdependence and indivisibility of human rights require engaging a wide range of stakeholders to promote collaboration among sectors and levels of government, external partners, and community members. Assessment includes determining the extent to which government and civil society participants find themselves in a true partnership, sharing understanding of the aims of collaboration and processes through which the aims are to be achieved.

Conclusion

Systematic and context-specific attention to these issues is crucial to promote consistency in assessing the value-added of an RBA to health. Assessment is needed to determine how even well-articulated and well-designed RBAs are implemented to ensure rights principles are not ignored or distorted. Organizations committed on paper to RBAs may not have invested sufficiently in institutional transformation, including staff capacity or adaptation of internal processes and checklists, to ensure systematic implementation.[71]

The questions above provide a starting point. Determining assessment criteria for how differently articulated RBAs operate in policies and programs is next on the path to understanding what difference RBAs make to policies, programs and, ultimately, to population health.[29,31,72]

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