

Consultation on Indicators for the Right to Health

Château de Penthes, Geneva

15 May 2003

Draft Meeting Report

Health and Human Rights

www.who.int/hhr

**Department of Ethics, Trade, Human Rights and Health Law
Sustainable Development and Healthy Environments
World Health Organization
Geneva**

January 2004



Disclaimer: The views expressed in this document are those of the participants in WHO consultations and do not necessarily represent the stated views or policies of the World Health Organization.

Table of Contents

1	BACKGROUND AND RATIONALE	3
2	KEY ISSUES AND CHALLENGES IN IDENTIFYING RIGHT TO HEALTH INDICATORS	3
2-1	DEFINING A RIGHT TO HEALTH INDICATOR.....	4
2-2	A MINIMUM SET OF INDICATORS	4
2-3	VARIABLE ELEMENTS IN MONITORING	4
2-4	LIMITATIONS OF QUANTITATIVE INDICATORS	5
2-5	ACCOUNTABILITY	5
2-6	DISAGGREGATION OF HEALTH DATA.....	5
2-7	STATE CAPACITY FOR DATA MANAGEMENT	5
2-8	HOW TO USE RIGHT TO HEALTH INDICATORS.....	6
3	EXISTING FRAMEWORKS IN WHO: HEALTH SYSTEMS PERFORMANCE.6	
3-1	HEALTH SYSTEMS COVERAGE	7
3-2	PRO-POOR INDICATORS	7
4	LINKAGES BETWEEN RIGHT TO HEALTH INDICATORS AND MILLENNIUM DEVELOPMENT GOALS (MDGS).....	7
5	FIRST STEP: REVIEWING INDICATORS IN WHO	8
5-1	RIGHT TO HEALTH INDICATORS: ESSENTIAL MEDICINES	9
5-2	RIGHT TO HEALTH INDICATORS: REPRODUCTIVE HEALTH.....	9
5-3	RIGHT TO HEALTH INDICATORS: WATER	9
6	CONCLUSION AND WAYS FORWARD.....	10
	ANNEX 1: CORE OBLIGATIONS OF STATE PARTIES EXTRACTED FROM GENERAL COMMENT 14 JUXTAPOSED WITH MILLENNIUM DEVELOPMENT GOAL INDICATORS	11
	ANNEX 2: BACKGROUND NOTE FROM HELENA NYGREN-KRUG, WHO HEALTH AND HUMAN RIGHTS ADVISER.....	12
	ANNEX 3: BACKGROUND NOTE FROM PAUL HUNT, SPECIAL RAPPORTEUR ON THE RIGHT TO HEALTH.....	14
	ANNEX 4: AGENDA	18

1 Background and rationale

Governments that have ratified the International Covenant on Economic, Social and Cultural Rights (ICESCR) have agreed to be legally accountable in respecting, protecting and fulfilling the right to the highest attainable standard of physical and mental health [hereinafter referred to as the “right to health”] and for the UN Committee on Economic, Social and Cultural Rights (CESCR) to monitor their performance.¹ In 2000, CESCR issued General Comment 14 on the right to the highest attainable standard of health.² General Comment 14 states, in relevant part: “National health strategies should identify appropriate right to health indicators and benchmarks. The indicators should be designed to monitor, at the national and international levels, the State party’s obligations under article 12”. The Comment identifies WHO as one UN agency to guide States in this process.³

This meeting was convened to advance the identification of relevant indicators as described in General Comment 14. It emphasized the importance of bringing together multi-disciplinary actors in health and human rights and seeking common ground on how to monitor the right to health. Both public health experts and human rights practitioners within and outside of WHO participated. Special focus was placed on identifying simple but effective right to health indicators, drawing as far as possible upon existing health and development frameworks.

2 Key issues and challenges in identifying right to health indicators

Several major challenges in identifying and establishing right to health indicators⁴ were identified. Any monitoring framework must accommodate differences across and within countries and over time as well as the variable elements of progressive realization and resource availability. Though quantitative indicators do have limitations, they can be complemented through additional methodologies. Clarification of the accountability of State and non-State parties and increased engagement of national stakeholders in the right to health monitoring process are also important. Disaggregating collected data on the grounds of non-discrimination in accordance with General Comment 14 will require improved capacity in many countries’ data

¹ International Covenant on Economic, Social and Cultural Rights. Adopted and opened for signature, ratification and accession by General Assembly resolution 200A (XXI) of 16 December 1966; *entry into force* 3 January 1976, in accordance with article 27. ICESCR currently has 148 State Parties.

² General Comments (sometimes referred to as General Recommendations) are documents issued by the treaty bodies in order to serve to clarify the scope and content of individual rights and States Parties (those that have ratified the treaty) obligations. When talking about General Comments, it is important to recognise that each human rights treaty monitoring body has developed its own approach. The Committee on Economic, Social and Cultural Rights has outlined the purpose of General Comments as follows: “The Committee endeavours, through its general comments, to make the experience gained so far through the examination of these reports available for the benefit of all States parties in order to assist and promote their further implementation of the Covenant; to draw the attention of the States parties to insufficiencies disclosed by a large number of reports; to suggest improvements in the reporting procedures and to stimulate the activities of the States parties, the international organizations and the specialized agencies concerned in achieving progressively and effectively the full realization of the rights recognized in the Covenant. Whenever necessary, the Committee may, in the light of the experience of States parties and of the conclusions which it has drawn therefrom, revise and update its general comments.” (Report of the Committee to the Economic and Social Council, Annex III (E/1989/22)) It is important to note that the drafting of general comments is also informed by information and advice provided by UN specialized agencies, individual experts and NGOs.

³ “...States may obtain guidance on appropriate right to health indicators, which should address different aspects on the right to health, from the ongoing work of WHO and the United Nations Children’s Fund (UNICEF) in this field...” (General Comment 14, paragraph 57).

⁴ “Issues and challenges” are based on Paul Hunt: a Background Note (Annex 2) and meeting discussions.

processing and reporting systems. Finally, country concerns about the political use of right to health indicators may impede their implementation.

2-1 *Defining a right to health indicator*

It is essential that right to health monitoring efforts build upon existing monitoring and evaluation initiatives in health and development. A clear understanding of what is meant by a “right to health indicator” is necessary for this effort. One definition suggests that “...a human rights indicator derives from, reflects and is designed to monitor realization or otherwise of a specific human rights norm, usually with a view to holding a duty-bearer to account...Essentially, what tends to distinguish a human rights indicator from a standard disaggregated indicator of socio-economic progress is less its substance than (i) its explicit derivation from a human rights norm and (ii) the purpose to which it is put viz human rights monitoring with a view to holding duty-bearers to account.”⁵

2-2 *A minimum set of indicators*

In addition to defining a right to health indicator, it may also be necessary to identify a generic set of indicators applicable across countries. For example, the core goals of a good functioning health system as set out in World Health Report 2000 may provide a useful handful of generic indicators against which all countries should be monitored under the right to health (good health, responsiveness and fair financial contribution). Another possible set of minimum indicators would be those that relate to the core content of the right to health as set out in General Comment 14 (see Annex 1). Decisions can then be made with respect to setting appropriate national benchmarks against which to monitor progress in the achievement of those internationally applicable indicators.

2-3 *Variable elements in monitoring*

Global monitoring using indicators and benchmarks will require a standardized understanding of state obligations across countries and over time. Article 2(1) of the ICESCR explains that the realization of the right to health is subject to progressive realization.⁶ Progress in implementing right to health obligations will, therefore, vary from country to country. Additionally, national health priorities shift over time, which in turn affects the type of measures deemed most appropriate to implement the right to health within countries.

In measuring progressive realization of the right to health as articulated in the ICESCR, it is often difficult to distinguish between governments’ lack of capacity and lack of willingness. Four pillars were proposed at the meeting to assess how effectively governments are progressively realizing the right to health: (1) Government commitment; (2) Government Actions; (3) Government Policy/Strategies; and (4) Impact of the three previous pillars on actual health

⁵ *Draft Guidelines on Human Rights Approaches to Poverty Reduction Strategies* Commissioned by OHCHR. (See Background Note by Paul Hunt, Paragraph 37)

⁶ Article 2(1) States “Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.”

outcomes. Each of these pillars would require further clarification and consensus before concrete indicators could be identified under each to measure progressive realization of the right to health.

2-4 *Limitations of quantitative indicators*

The causes and symptoms of human rights neglect or violations should be further analysed through additional methodologies, including qualitative indicators, to complement the analysis provided through quantitative indicators. Qualitative and long-term analyses could complement monitoring based on short-term indicators. Monitoring efforts for the right to health should be coordinated with monitoring efforts in other rights domains, e.g. the “Education for All Fast Track Initiative”, to ensure consistency for governments in guiding them in the fulfilment of their human rights obligations.

2-5 *Accountability*

The extent to and various means by which State parties can be held accountable should be clarified in the context of the use of right to health indicators. CESCR monitoring efforts encourage State parties to improve implementing, monitoring and reporting capacity on a right to health in line with national development policies rather than “policing”. Indicators provide a “snapshot” of the picture and would, in general terms, require more holistic and detailed analysis of the situation before assuming that a government had failed in its obligations and actually violated the right to health.

2-6 *Disaggregation of health data*

General Comment 14 notes that right to health indicators require disaggregation on the prohibited grounds of discrimination. However, in practice this may be difficult and may not always reflect those population groups most vulnerable in a specific society. Further work needs to be undertaken in this regard to address how best to ensure that freedom from discrimination is incorporated as well as to ensure attention to the most vulnerable population groups. For example, in the context of HIV/AIDS, vulnerable groups may include sex workers and injecting drug users; this information may not however be captured by relying exclusively upon the grounds for non-discrimination enumerated in provisions of human rights instruments.

2-7 *State capacity for data management*

Many countries lack capacity in processing data and reporting on health (or in development in general), and surveys remain the main sources of disaggregated data in these countries. One paper on MDG monitoring and indicators⁷ reported that the majority of developing countries have been experiencing difficulties in producing and collecting disaggregated data, even by gender or lower administrative units. Data management systems at the country level, encompassing both collection and dissemination, must be strengthened to make right to health monitoring operational. Monitoring the right to health should be based as far as possible upon the analysis of currently available data. WHO uses five criteria - validity, reliability, comparability, an explicit data audit trail and country consultation (which together constitute the

⁷ “MDG NET and HDR Measurement Network Reference Paper: MDG Monitoring and Indicators Discussion” Prepared by Tom Griffin, Sarah Renner and Sharmila Kurukulasuriya, UNDP, 2 May 2003.

WHO accountability framework on country data) - in order to ensure the quality of country health statistics.

2-8 *How to use right to health indicators*

Countries both in the North and the South may have concerns about the ways in which right to health indicators are used. Developed countries may be concerned if right to health indicators incorporate international assistance and obligations towards poor countries linking to MDG 8 and the provision to engage in international assistance and cooperation to progressively realize the right to health in accordance with Article 2(1) of the ICESCR. Developing countries may fear that increased ODA and related financial decisions could be conditioned upon improved national indicators. Clarity and transparency about the use of the right to health indicators can alleviate these fears.

The monitoring bodies established by governments can identify appropriate indicators (at this meeting, the CESCR and the UN Special Rapporteur on the Right to Health represented these types of mechanisms). Governments are the primary duty-bearers and should be at the centre of right to health monitoring process; international organizations should provide necessary support and guidance. Engaging national stakeholders in the right to health monitoring process will make the process more useful in generating positive action and change at the country level. Civil society must be empowered to use the indicators to monitor efforts and report input to appropriate fora and mechanisms for purposes of accountability.

3 Existing frameworks in WHO: health systems performance

The meeting reviewed and discussed existing monitoring and evaluation frameworks in health and development, focusing specifically on existing efforts within WHO. WHO's health systems performance assessment framework could further integrate human rights aspects. Conversely, right to health monitoring could consider and build upon the indicators developed for health systems performance. Using the indicator of effective coverage to assess duty-bearers' efforts to fulfil the right to health and forging stronger links between the work on pro-poor health policies and the right to health could be useful ways forward in this respect.

One of WHO's most important roles involves assisting Member States, upon request, to develop and implement strategies and policies to improve the performance of their health systems. Health systems performance assessment⁸ is a process which empowers decision-makers by providing them with reliable information for health policy and system development, and provides the public with information relevant to its well-being.

Measuring and comparing performance over time assists countries in monitoring their own performance and modifying policies accordingly; similarly, comparing performance across settings enables countries to learn from others' experiences. The assessment framework is measurable and comparable over time and across countries to the extent possible, though

⁸ The term "health system performance assessment" describes a series of activities: measuring the health system's contribution to socially desirable goals; measuring the health system and non-health system resources used to achieve these outcomes; estimating the efficiency with which the resources are used to attain these outcomes; evaluating the way the functions of the system influence observed levels of attainment and efficiency; and designing and implementing policies to improve attainment and efficiency and monitoring the effect.

diversity among countries in terms of social, economic and health situations remains an issue. Indicators for the health systems performance are measurable, reliable and comparable.

The health systems performance assessment framework could further integrate human rights aspects into the goals of health systems performance and into the assessment itself. The World Health Report 2000 identifies three intrinsic goals of any health system: health, responsiveness and fair financing. For example, substantive efforts to integrate human rights norms have always been undertaken in relation to the goal of responsiveness (defined as meeting people's legitimate non-health expectations about how the system treats them); these efforts link to rights involving privacy, participation and non-discrimination. An analysis to explore additional entry points and further integration of human rights aspects into the other two goals (health and fair financing) could be undertaken. In turn, right to health monitoring could take into account and build upon the indicators developed for health systems performance.

3-1 Health Systems Coverage

The concept of effective coverage was considered as a starting point to explore what information could be collected and measured to assess duty-bearers' efforts to fulfil the right to health-care (one dimension of the right to health.) WHO has defined the concept of coverage as "the probability of receiving a necessary health intervention conditional on a health care need"; this is defined at the individual level, takes an ex ante perspective and is conditional upon health care needs. Coverage focuses upon elements such as the content of, access to, and utilization of health interventions. The following set of interventions are considered to measure health systems coverage: reproductive health and safe motherhood; integrated management of childhood illnesses; HIV/AIDS prevention and testing; malaria treatment and prevention; vision, hearing and oral health; communicable diseases; non-communicable diseases; injuries; water and sanitation; and cancer screening.

3-2 Pro-poor indicators

WHO supports pro-poor health policies through advocacy for the disaggregation of data, which captures pro-poor health interventions and their health impacts. This work derives from the analysis of Poverty Reduction Strategy Papers (PRSPs) and Heavily Indebted Poor Countries (HIPC) initiatives by the World Bank. Defining pro-poor policies is challenging as the analysis must capture multi-dimensional aspects of poverty, including health and other social aspects. Existing monitoring systems in many countries do not disaggregate the data properly, and WHO has been advocating for improvements as well as providing assistance.

Right to health monitoring and pro-poor health policy promotion share many issues and certain methods and methodologies. It would be useful to establish stronger linkages between the work on pro-poor health policies and the right to health, and to draw upon lessons learned by pro-poor health policy initiatives.

4 Linkages between right to health indicators and Millenium Development Goals (MDGs)

Many countries have committed themselves to both MDGs and international human rights instruments. MDG's are policy instruments with a set target of 2015. International human rights

standards, by contrast, are legally binding and governments are committed permanently to submit themselves to periodic monitoring of performance in fulfilling obligations. While MDGs are considered central to current development efforts, human rights remain marginal. 18 of the 48 MDG indicators address health issues,⁹ and the discussion focused on the linkages between MDGs/their indicators and right to health obligations/indicators.

Annex 1 contrasts the core obligations of State Parties under General Comment 14 to health-related MDGs and their indicators. Though General Comment 14 focuses on the issue of access to health services while MDGs address results to be achieved through health-related interventions, the two frameworks overlap in focus. Linking the two and ensuring their consistency to the extent possible will be advantageous since most State parties are committed to and must report on both.

MDGs and their indicators do have limitations from the perspective of the right to health. They do not address crucial health issues that are essential features of the right to health (e.g. reproductive health and a range of non-communicable diseases and broader social health determinants are missing). Moreover, MDG indicators refer only to the level of achievements and are not disaggregated so that the conditions of specifically disadvantaged groups – poor women, minorities, indigenous peoples – are captured. Certain MDG indicators are particularly unsuitable for trends analysis (e.g. Maternal Mortality Ratio). From a human rights perspective, vulnerable groups would need to be identified and discrimination addressed.

It was noted that other international indicators and benchmarks established through various international conferences and UN interagency initiatives in specific health-related areas (e.g. reproductive health) could be considered. These could complement the MDG's in providing a holistic set of right to health indicators.

5 First step: reviewing health-topic specific indicators in WHO

Three areas of work in WHO (essential medicines, reproductive health and water) and their respective indicators were reviewed to assess their appropriateness as right to health indicators. It is foreseen that a set of indicators, spanning a range of health topics, could be identified; benchmarks to measure progress with respect to these indicators could then be set either by countries, by the CESCR, or by both in consultation. These “health-topic specific” indicators could be part of a monitoring “toolkit” in addition to some generic indicators applicable to all countries. For example, depending on the key challenges in a specific country context, a country reporting to CESCR would be asked to focus on specific health topic indicators and set relevant national benchmarks. Since benchmarking is done by the state party itself, some control mechanism is necessary to ensure that these goals are not set too low or too high; this scoping process involves the joint consideration by the State party and the Committee of the indicators and national benchmarks which will then provide the targets to be achieved during the next reporting period.

⁹ Prevalence of underweight children < 5yrs; % population < min level of dietary energy consumption; > 5 mortality rate; Infant Mortality Rate; % 1 year-old immunized against measles; Maternal Mortality Ratio; % births attended by skilled health personnel; HIV prevalence among 15-24 yr-old pregnant women; Condom use rate; Proportion of children orphaned by HIV/AIDS; Prevalence and death rates associated with malaria; % population using effective malaria prevention measures in malaria risk areas; Prevalence and death rates associated with TB; % of TB cases detected and cured under directly observed treatment short course (DOTS); % population using solid fuels; % population with sustainable access to an improved water source, urban and rural; % urban population with access to improved sanitation; and % population with access to affordable essential drugs on a sustainable basis.

5-1 *Right to Health Indicators: Essential Medicines*

WHO has developed a questionnaire to assess government commitment and action to promoting access to essential medicines.¹⁰ Criteria for the selection of questions/indicators ask whether indicators offer a cost-effective and standardized rapid-assessment method on government commitments and action to improve access to essential medicines, and whether indicators present a checklist of essential government actions to ensure access to essential medicines. The questions address the areas of: (1) national medicines (drug) policy; (2) legislation/regulation; (3) quality control of pharmaceuticals; (4) essential medicines list; (5) medicines supply system; (6) medicines financing; (7) rational use of medicines, and (8) intellectual property rights protection and marketing authorization. These are linked to access, rational use, pricing and regulation in essential medicines. The advantages of using these questions are that they have already been field-tested; that they have been standardized globally, with many governments already reporting on the questions; that data can be entered into the existing WHO database and compared to existing data; and that more detailed questions and survey protocols are available to build on these questions.

5-2 *Right to Health Indicators: Reproductive Health*

Three health indicators, taken from the global reproductive health indicators already agreed among relevant UN agencies, were proposed as potential right to health indicators in the area of reproductive health: (1) Maternal Mortality Ratio (MMR); (2) Birth attended by skilled health personnel; and (3) Percentage of obstetric and gynaecological admissions owing to abortion. Data must be disaggregated by relevant social categories, including socio-economic status, ethnicity, urban/rural etc. These indicators were selected because they derive explicitly from international human rights instruments and are linked directly or indirectly to MDGs. They also reflect reproductive health indicators based on the commitments made at International Conference on Population and Development (ICPD), ICPD+5 and the UN General Assembly on HIV/AIDS. They are based on an inter-agency reproductive health indicators framework, currently being pilot-tested. Feasibility of selected indicators has been an issue, since sufficient data could not be collected despite existing guidelines.

5-3 *Right to Health Indicators: Water*

WHO is compiling relevant indicators and plans to develop country-based tools on the right to water to enable State parties to report on efforts and progress. Water-related interventions require long-term efforts to bring about impact, with political commitment and physical infrastructure necessary to improve access. At least three to four indicators are needed to address the right to water. The influence of non-state duty-bearers is significant, and must be considered.

There are limited sources of data on water, and currently available data has been taken from major surveys which are not necessarily government sources. WHO receives a substantial number of requests to facilitate the data collection and management on water and right to water, and has an up-to-date database on water with data from over 70 countries. Outcome indicators on water supply and sanitation have been developed and data is available in WHO. Additional data

¹⁰ Questions/indicators were selected from WHO's standard questionnaire on "Structures and process of country pharmaceutical situation (Level 1)," which WHO has used since 1999.

could be collected on water related to children and young people in school. MDGs also include water as an issue, however this is of limited use as the benchmarks are quite low.

Right to water indicators, as right to health indicators, could play the following roles: ensuring consistent monitoring and coherent identification of pressing issues; assisting in the establishment of improved national policies, laws and standards on water; and facilitating international co-ordination and collaboration for joint management of water across borders.

6 Conclusion and ways forward

This meeting aimed to advance the identification of relevant right to health indicators. It was agreed that monitoring the right to health requires a conceptual framework, which must be practical for State parties, have the requisite “ownership” from State parties and carry political legitimacy. Selection criteria for indicators could include links to the normative frameworks of the right to health in international human rights law (e.g. General Comment 14) and major international policy commitments, such as MDGs, feasibility based on pilot-testing and cost-effectiveness. Finally, key human rights principles such as non-discrimination must be addressed and incorporated as far as possible.

The Special Rapporteur on the Right to Health will propose the use of indicators for right to health monitoring in his report to the UN General Assembly. Existing rights-monitoring tools, as well as monitoring and evaluation tools for health policies and programmes, should be further analysed; and some of the “good practices” on right to health monitoring and reporting could be recorded and shared. A monitoring framework and strategy for a right to health, including the selection criteria of right to health indicators, should be drafted for further consultations and finalization.

WHO is firmly committed to taking this process forward incrementally. This process will consult relevant stakeholders: CESCR, the Special Rapporteur on the right to health, governments, international organizations, civil society, academic institutions and NGOs. A second WHO meeting, planned for spring 2004, will further consider right to health monitoring and indicators including further linkages between the right to health framework and existing indicators (MDGs, WHO’s health systems performance assessment, pro-poor indicators etc.).

ANNEX 1: Core Obligations of State Parties extracted from General Comment 14 juxtaposed with Millennium Development Goal Indicators¹¹

Core Obligations:

1. to ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalised groups;
2. to ensure for everyone access to the minimum essential food which is sufficient, nutritionally adequate and safe, to ensure their freedom from hunger;
 - (4) prevalence of underweight children
 - (5) proportion of population below minimum level of dietary energy consumption
3. to ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water;
 - (29) proportion of population with sustainable access to an improved water source
 - (30) proportion of people with access to improved sanitation
4. to provide essential drugs, as from time to time defined by WHO's Action Programme on Essential Drugs;
 - (46) proportion of population with access to affordable essential drugs on a sustainable basis
5. to ensure equitable distribution of all health facilities, goods, and services;
6. to adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population... the process by which the strategy and plan of action is devised, as well as their content, shall give particular attention to all vulnerable or marginalised groups.

Obligations of Comparable Priority:

1. to ensure reproductive, maternal (pre-natal and post-natal) and child health care;
 - (16) maternal mortality ratio
 - (17) proportion of births attended by skilled health personnel
 - (19) contraceptive prevalence rate
 - (13) under-five mortality rate
 - (14) infant mortality rate
2. to provide immunization against the community's major infectious diseases;
 - (15) proportion of 1 year old children immunized against measles
3. to take measures to prevent, treat and control epidemic and endemic diseases;
 - (18) HIV prevalence among 15-24 year old pregnant women
 - (19) contraceptive prevalence rate
 - (20) number of children orphaned by HIV/AIDS
 - (21) prevalence and death rates associated with malaria
 - (22) proportion of population in malaria risk areas using effective malaria prevention and treatment measures
 - (23) prevalence and death rates associated with tuberculosis
 - (24) proportion of TB cases detected and cured under TOTS (directly observed treatment short course)
4. to provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them.

¹¹ By Ms. Audrey Chapman, Director, Science and Human Rights Program, American Association for the Advancement of Science.

ANNEX 2: Background Note from Helena Nygren-Krug, WHO Health and Human Rights Adviser

Background note to the Workshop on Indicators for the Right to Health, May 15

Introduction

This meeting constitutes an initial step in the process of identifying appropriate indicators to monitor the realization of the right to health.

3 core principles to guide us could be to:

- ✓ Build upon existing normative frameworks of the right to health that are emerging, to the greatest extent possible.
- ✓ Use existing health indicators as far as possible.
- ✓ Start very simple with indicators which are "user-friendly" for countries and understandable to the monitoring mechanisms.

Where do we want to go?

The idea of a "tool-kit" to finally emerge from this process has been put forward. There would be some core indicators which all countries should report on and then a "menu" along health topics which would be more or less relevant depending upon the main health problems, including their human rights implications, in a particular country.

What is the right to health?

The most authoritative interpretation of the right to health in international law is articulated in Article 12 of the International Covenant on Economic, Social and Cultural Rights (about 150 countries have ratified this treaty and must report regularly on progress achieved.)

Article 12 reads as follows:

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
 - (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
 - (b) The improvement of all aspects of environmental and industrial hygiene;
 - (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
 - (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

Recognizing that this interpretation of the right to health was somewhat outdated and that further guidance was needed in terms of what individuals are entitled to and what governments need to do to comply with their obligations, the Committee on Economic, Social and Cultural Rights adopted General Comment no.14 in May 2000. [Click here for General Comment 14:](#)

Importantly, General Comment 14. made clear that the right to health is not only about health-care but also underlying determinants (safe water, health information, etc.) Some elements of General Comment 14., for example, the framework of AAAQ (Availability, Accessibility, Acceptability & Quality), converge with indicators EIP is developing such as in this case the one on coverage.

What can we achieve on May 15?

There are more questions than answers when it comes to monitoring the right to health. The meeting is structured so that in the morning we can explore some of the "sticky" questions, whether they can be resolved and if so, how. Here are just a couple of examples of questions that I have asked myself in the past:

"Human rights are about government obligations and accountability...Should we, therefore, distinguish between indicators measuring the extent to which rights are enjoyed in given situations and indicators which measure what government is doing to fulfil its obligations? Needless to say they are intertwined yet it seems that for "accountability purposes" we would be more interested to know what government is doing (rather than how people out there are doing health-wise), in terms of instituting appropriate policies, governments structures, resource allocation, etc., although most traditional health indicators are concerned with peoples' health out there..."

"If we want to look at government performance then how can we distinguish between governmental "unwillingness" and government "incapacity"? Would we need to consider government INTENT...by considering overall budgetary spending and whether "reasonable steps" have been taken to advance human rights (health being one among many human rights.) In this context, how does one capture progressive realization? Perhaps not necessary as monitoring occurs periodically and progress is captured through time?"

Indeed there are more question than answers and I have been urged, by my wiser colleagues, to keep it simple otherwise we will not move forward. Also many human rights professionals find that health indicators provide one "snapshot" of the situation which needs to be assessed in terms of a broader framework which includes government policies and legislation. If so, it makes it easier to gather health indicators, accepting that they provide part of the picture, which needs to be complemented by the monitoring bodies with questions about government performance in their interactive dialogue with the country concerned...I have been advised to focus on some sensible indicators which are already out there and which "mesh" as far as possible with existing frameworks, including the MDGs, and start the process of monitoring with a view to readjustments and additions in the future....So.....in the afternoon, we will be very practical and consider 3 health topics- access to essential drugs, reproductive health and water/sanitation in terms of relevant indicators for monitoring the right to health.

Who are we?

This meeting constitutes a small group of WHO staff with interest and expertise in this topic together with a handful of human rights professionals with health expertise. Please feel free to share thoughts and ideas with others and let me know if we are missing anyone! I have tried to keep the group small so that we can "roll-up-our-sleeves", work in a brainstorming mode, and make some humble progress. Thanks to you all for coming.

Helena Nygren-Krug
2 May 2003

ANNEX 3: Background Note from Paul Hunt, Special Rapporteur on the Right to Health

WHO WORKSHOP ON INDICATORS FOR THE RIGHT TO HEALTH

15 MAY 2003

A BACKGROUND NOTE

by Paul Hunt, UN Special Rapporteur on the right to health

Introduction

1. The implementation of economic, social and cultural rights - such as the right to health - presents a number of challenges to the human rights community. For its part, the UN Committee on Economic, Social and Cultural (CESCR) - which monitors implementation of the International Covenant on Economic, Social and Cultural Rights (ICESCR) - has responded to these challenges in a number of ways. For example, in recent years, it has adopted various normative, conceptual and practical approaches which are designed to facilitate the implementation of these rights. Thus, with a view to making the normative content of these rights more understandable, it has used the notions of 'availability', 'accessibility', 'adequacy' and 'quality' - or similar formulations. It has also tried to develop the idea of 'core obligations' and an 'international minimum threshold'. And it has also adopted the notion of 'indicators' and 'benchmarks'. The Committee has adopted other approaches, too, but for today's purposes the most relevant concerns 'indicators' and 'benchmarks'. Here, I will make some brief remarks about 'indicators' and 'benchmarks' in the context of the international right to health.

Progressive realization and resource availability

2. Like other economic, social and cultural rights, the international right to health is subject to *progressive realization* and *resource availability* (article 2(1) of ICESCR). These phrases have two crucial implications. *First*, some right to health obligations will vary from one state to another (because states have different resources available to them). *Second*, in relation to the same state, some right to health obligations will vary over time (because of the notion of progressive realization). In short, inescapably, there is a *variable element* in relation to states' obligations arising from the international right to health. It is difficult to see how this variable element can be effectively monitored without right to health indicators and benchmarks.

The approach of CESCR

3. CESCR has recognized the importance of indicators and benchmarks. Thus, in a crucial passage in General Comment 14, the Committee sets out its approach:

“Right to health indicators and benchmarks

57. National health strategies should identify appropriate right to health indicators and benchmarks. The indicators should be designed to monitor, at the national and international levels, the State party's obligations under article 12. States may obtain guidance on appropriate right to health indicators, which should address different aspects of the right to health, from the ongoing work of WHO and the United Nations Children's Fund (UNICEF) in this field. Right to health indicators require disaggregation on the prohibited grounds of discrimination.

58. Having identified appropriate right to health indicators, States parties are invited to set appropriate national benchmarks in relation to each indicator. During the periodic reporting procedure the Committee will engage in a process of scoping with the State party. Scoping involves the joint consideration by the State party and the Committee of the indicators and national benchmarks which will then provide the targets to be achieved during the next reporting period. In the following five years, the State party will use these national benchmarks to help monitor its implementation of article 12. Thereafter, in the subsequent reporting process, the State party and the Committee will consider whether or not the benchmarks have been achieved, and the reasons for any difficulties that may have been encountered.”

4. Here, I highlight four points arising from this passage:

First, CESCR envisages the identification of right to health indicators i.e. carefully chosen yardsticks for measuring elements of the right to health. Alone, however, these indicators are neutral: they tell us next to nothing.

Second, CESCR envisages the setting of benchmarks - or targets - for each indicator in relation to each state, taking into account resource availability and progressive realization. It is when indicators and benchmarks are combined in this way that a powerful right to health monitoring and accountability tool is created.

Third, so far as practical, each indicator (and therefore each benchmark) should be disaggregated “on the prohibited grounds of discrimination”.

Fourth, CESCR has not yet firmly identified specific right to health indicators - that is the next challenge and one we are looking at today.

5. What is vital, however, is that CESCR adopts in General Comment 14, for the first time, its conceptual and methodological approach to indicators and benchmarks. Moreover, this approach was confirmed by the Committee in General Comment 15 on the right to water which it adopted in November 2002.

What is the difference, if any, between a health indicator and a right to health indicator?

6. This is one of the many important questions to which there is not yet a widely agreed answer.

7. Last year, at the request of the OHCHR, Siddiq Osmani (a developmental economist from Bangladesh), Manfred Nowak (an expert on civil and political rights) and myself, completed some *Draft Guidelines on Human Rights Approaches to Poverty Reduction Strategies*. These Draft Guidelines were the product of a long process of consultation to which WHO contributed in a very substantive and constructive way. The Draft runs to some 60 pages and includes a number of human rights indicators. As we drafted, we were confronted with the question: what is the difference between human rights indicators and developmental indicators? Paragraph 37 of the Draft provides our answer to this question:

“37. Fourth, most of the indicators proposed in these Guidelines have a striking resemblance to the standard indicators of socio-economic progress. So this raises the question, in what sense can they be characterized as human rights indicators? *In brief, a human rights indicator derives from, reflects and is designed to monitor realization or*

otherwise of a specific human rights norm, usually with a view to holding a duty-bearer to account. Thus, because there is overlap between human rights targets and socio-economic progress, there is likely to be a resemblance between human rights indicators and the standard indicators of socio-economic progress - although it should be observed that some human rights indicators, especially those relating to civil and political rights, do not usually figure in measures of socio-economic progress. Essentially, what tends to distinguish a human rights indicator from a standard disaggregated indicator of socio-economic progress is less its substance than (i) its explicit derivation from a human rights norm and (ii) the purpose to which it is put viz. human rights monitoring with a view to holding duty-bearers to account.” (italics added)

8. I will be very interested to learn if others agree with the last sentence.

Outstanding issues

9. Many difficult issues remain. We might consider some of them today. Some are conceptual. For example, can indicators really measure legal obligations? An infant mortality indicator measures infant mortality -- -- can it be argued that it also measures whether or not a state is conforming to its legal obligations in relation to children’s right to health? Other outstanding issues are practical. For example, do developing states have the capacity to gather the data necessary to use right to health indicators and benchmarks that are disaggregated on the prohibited grounds of discrimination?

10. Also, some of the remaining outstanding issues are political - here I mention two. *First*, there is an apprehension among some developing countries that right to health indicators will lead to new forms of conditionality. For example, that increased ODA will be made conditional on a state showing progress in relation to certain key right to health indicators. *Second*, some developing states are fearful that right to health indicators will lead to league tables which, as is well-known, some find grossly simplistic, misleading and offensive.

11. In my preliminary report as Special Rapporteur, I signal my intention to explore the issue of right to health indicators and benchmarks (see paras 33 and 36). Notwithstanding the conceptual, practical and political difficulties, I think this issue is important. The international right to health is subject to progressive realization and resource availability and thus it is necessary to develop pragmatic methods of monitoring this variable dimension of the right to health - and one compelling method is the application of right to health indicators and benchmarks.

12. I would also like to suggest, however, that we do not expect too much from right to health indicators and benchmarks. Elsewhere I put the point like this:

“In my view, human rights benchmarks have a significant role in the promotion and protection of economic, social and cultural rights. Nonetheless, it is important to keep their role in perspective. Even if we were to perfect the use of human rights benchmarks, they would only provide us with part of the story. They might tell us *what* is happening, but they cannot tell us *why* it is happening. If a State’s human rights record were a feature film, benchmarks would be an inadequate snapshot of human rights at a specific moment. Successive frames, frozen at regular intervals, can tell us something about the film, but not the whole story. So it is with human rights benchmarks: they can tell us part of the story but not all of it.” (*Human Rights Law and Practice* (NZ), September 1998, page 109, at 115.)

Conclusion

13. I strongly endorse the point made by other colleagues: keep it simple. In the context of human rights, General Comment 14's paragraphs on indicators and benchmarks represent a considerable advance. Now, in my view, we need to build on this basic conceptual framework in a measured, pragmatic and incremental manner.

Paul Hunt
15 May 2003
paulhunt28@hotmail.com

ANNEX 4: Agenda

WORKSHOP ON INDICATORS FOR THE RIGHT TO HEALTH

**May 15 2003
Château de Penthes
Geneva**

- 09:00 - 09:15 WELCOME & INTRODUCTIONS
- 09:15 - 09:30 Paul Hunt, UN Special Rapporteur on the Right to Health &
Eibe Riedel, Member of the UN Committee on Economic,
Social and Cultural Rights, (mandates and the need for
indicators to monitor the realization of the right to health)

Session I: Addressing some of the key issues

- 09:30 - 10:45 Defining a minimum set of interventions
- The MDGs as our starting point for right to health indicators
- Assessing fulfilment of obligations of poor vs rich countries
- Progressive realization of the right to health
- 10:45 - 11:00 *Coffee*
- 11:00 - 13:00 Considering some of the core features of the right to health in
relation to WHO work on indicators
- AAAQ and Coverage; affordability & fair financing; prioritizing
vulnerable groups & identification of pro-poor indicators;
discrimination & inequality indicators
- 13:00 - 14:00 *Lunch*

Session II: Exploring some indicators in practice for monitoring the right to health

- 14:00 - 15:45 Indicators on essential drugs, reproductive health and
water/sanitation for monitoring the right to health
- 15:45 - 16:00 *Coffee*
- 16:00 - 17:00 Lessons learned from the day, proposed ways forward, and final
conclusions.

