

HUMAN RIGHTS AND GENDER EQUALITY IN HEALTH SECTOR STRATEGIES

HOW TO ASSESS POLICY COHERENCE



WHO Library Cataloguing-in-Publication Data

Human rights and gender equality in health sector strategies: how to assess policy coherence.

1.Women's rights. 2.Gender identity. 3.Women's health. 4.Human rights. 5.National health programs. 6.Health policy.
I.World Health Organization.

ISBN 978 92 4 156408 3

(NLM classification: HQ 1236)

© World Health Organization 2011

All rights reserved. Publications of the World Health Organization can be obtained from WHO Press, World Health Organization, 20 Avenue Appia, 1211 Geneva 27, Switzerland (tel.: +41 22 791 3264; fax: +41 22 791 4857; e-mail: bookorders@who.int). Requests for permission to reproduce or translate WHO publications – whether for sale or for noncommercial distribution – should be addressed to WHO Press, at the above address (fax: +41 22 791 4806; e-mail: permissions@who.int).

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by the World Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use.

Cover photo credits (from left to right):

Upper row: (1) WHO/Henrietta Allen, (2) WHO/Marko Kokic

Lower row: (1) WHO/Christopher Black, (2) WHO/Henrietta Allen, (3) WHO/Harold Ruiz

Design & layout:  services-concept.ch

HUMAN RIGHTS AND GENDER EQUALITY IN HEALTH SECTOR STRATEGIES

HOW TO ASSESS POLICY
COHERENCE



Acknowledgements

This tool was developed by the departments of Ethics, Equity, Trade and Human Rights and Gender, Women and Health of the World Health Organization (WHO), the Office of the High Commissioner for Human Rights (OHCHR) and the Swedish International Development Cooperation Agency (Sida). The technical team responsible for tool development includes Shelly N. Abdool, Helena Nygren-Krug, Adepeju Olukoya and Annelie Rostedt (WHO), Alfonso Barragués (OHCHR) and Birgitta Sund and Eva Wallstam (Sida).

The team is grateful for technical and administrative inputs from (alphabetically, by agency):

WHO: Carla Abou Zahr, Shambhu Acharya, Avni Amin, Britta Baer, Anjana Bhushan, Cristina Bianchessi, Funke Bogunjoko, Mario Roberto Dal Poz, Nathalie Drew, Tessa Edejer, Arfiya Eri, Mirona Eriksen, David Evans, Samantha Figueroa Garcia, Bob Fryatt, Michelle Funk, Monika Gehner, Sabrina Hassanali, Hans Hogerzeil, Sowmya Kadandale, Rania Kawar, Eszter Kismodi, Jennifer Knoester, Alexandra Lacko, Richard Laing, Yunguo Liu, John McKnight, Mitra Motlagh, Milly Nsekaliye, Ashi Ofili-Okonkwo, Vanessa Perlman, Annette Peters, Sohail Raj Sud, Riikka Rantala, Chen Reis, Ana Rodriguez Garcia, Melissa Sandgren, Shadrokh Sirous, Marcus Stahlhofer, Erna Surjadi, Phyllida Travis, Willem Van Lerberghe, Javier Vasquez, Gemma Vestal, Joanna Vogel, Yehenew Walilegne, Jens Wilkens, Isabel Yordi Aguirre, Yolande Zaahl and participants of the 2009 lunchtime seminar on finalizing the tool.

OHCHR: Melinda Ching Simon, Mac Darrow, Rosa Da Costa, Lisa Oldring, Thomas Pollan, Juana Sotomayor and Viet Tu Tran.

Sida: Anette Dahlström, Lena Ekroth, Eva Nauckhoff, Göran Paulsson, Helena Reuterswärd, and all participants of the November 2008 consultation.

Others: Sarah Thomsen, Saskia Bakker.

Countries involved in the development, piloting and finalization included the following country teams:

Uganda – George Bagambisa, Ulrika Hertel, Grace Murengezi, Nelson Musoba, Juliet Nabyonga, Kellen Namusisi and Olive Sentumbwe.

Yemen – Mona Al Mudwahi, Eman Al Kobaty, Fatima Elawah and Jameela Al Raiby.

Zambia – Nicholas Chikwenya, David Chimfembwe and Vincent Musowe.

The technical team is grateful to all country participants for their time and inputs.

Table of contents

<i>About the Tool</i>	7
<i>Acronyms</i>	8
A. GETTING TO KNOW THE TOOL	
1. Introduction	9
1.1 Background and rationale.....	9
1.2 Objectives and target-audience.....	12
1.3 Scope, assessment levels and outline of the tool.....	12
2. Approach	15
2.1 Human rights-based approach and gender mainstreaming.....	15
2.2 Human rights and gender equality concepts used in the tool.....	16
2.3 How the tool operationalizes the two approaches.....	20
B. PROCESS – PRACTICAL GUIDANCE FOR USING THE TOOL	
1. Opportunities to use the tool	23
1.1 Use of the tool as part of a broader review or planning exercise.....	23
1.2 Use of the tool for a stand-alone human rights and gender equality study.....	24
2. Preparatory arrangements and sources of information	25
2.1 Document review.....	25
2.2 Interviews.....	27
3. Information gathering and analysis	28
3.1 Preparing for document review.....	28
3.2 Process of data collection.....	28
3.3 Analysis.....	29
4. Sharing the findings	30
4.1 Presenting the conclusions and recommendations.....	30
4.2 Dissemination.....	33
4.3 Catalyse action.....	33
C. ANALYSIS TABLES	
ASSESSMENT LEVEL 1: State obligations and commitments to human rights and gender equality	35
1.1 International human rights treaties.....	35
1.2 Consensus documents.....	45
1.3 Universal periodic review.....	49
1.4 Special procedures.....	52

ASSESSMENT LEVEL 2: Legal, policy and institutional framework for human rights and gender equality	56
2.1 The constitution.....	56
2.2 Legislation.....	61
2.3 National development plans (and/or poverty reduction strategies).....	67
2.4 Institutional framework for human rights and gender equality.....	74
ASSESSMENT LEVEL 3: Health sector strategy	81
3.1 The process of assessment, analysis and strategic planning.....	83
3.2 Leadership and governance (stewardship).....	93
3.3 Health systems building block: service delivery.....	103
3.4 Health systems building block: health workforce.....	114
3.5 Health systems building block: medical products, vaccines and technologies.....	123
3.6 Health systems building block: information.....	129
3.7 Health systems building block: financing.....	138
ANNEXES	
Annex 1 – Resources.....	145
Annex 2 – Feedback questionnaire.....	148

About the Tool

Human Rights and Gender Equality in Health Sector Strategies: how to assess policy coherence is designed to support countries as they design and implement national health sector strategies in compliance with obligations and commitments. The tool focuses on practical options and poses critical questions for policy-makers to identify gaps and opportunities in the review or reform of health sector strategies as well as other sectoral initiatives. It is expected that using this tool will generate a national multi-stakeholder process and a cross-disciplinary dialogue to address human rights and gender equality in health sector activities.

The tool is intended for use by various actors involved in health planning and policy making, implementation or monitoring of health sector strategies. These include (but are not limited to) ministries of health and other sectors, national human rights institutions, development partners and civil society organizations. The tool provides support, as opposed to a set of detailed guidelines, to assess health sector strategies. It is not a manual on human rights or gender equality, but it does provide users with references to other publications and materials of a more conceptual and normative nature. The tool aims to operationalize a human rights-based approach and gender mainstreaming through their practical application in policy assessments.

The tool, adaptable to different country contexts, is composed of three parts:

- A. Conceptual approaches of the tool
- B. Practical guidance on how to use the tool
- C. Analysis tables

The analysis tables in Part C constitute the backbone of the tool and are designed to guide the user through three separate assessment levels: 1) State obligations and commitments, 2) national legal, policy and institutional frameworks, and 3) health sector strategies, using the various components/building blocks of a health system.

Acronyms

AAAQ	Availability Accessibility Acceptability Quality
ACHPR	African Commission on Human and Peoples' Rights
CAT	Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CERD	Convention on the Elimination of All Forms of Racial Discrimination
CESCR	Committee on Economic, Social and Cultural Rights
CRC	Convention on the Rights of the Child
CRPD	Convention on the Rights of Persons with Disabilities
CSO	Civil society organization
ECOSOC	United Nations Economic and Social Council
ECSR	European Committee of Social Rights
FWCW	Fourth World Conference on Women
GA	General Assembly
GBV	Gender-based violence
GLIN	Global Legal Information Network
HRBA	Human Rights-Based Approach
HRC	Human Rights Council
IACHR	Inter-American Commission on Human Rights
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICPD	International Conference for Population and Development
ICRMW	International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families
IDHL	International Digest of Health Legislation
ILO	International Labour Organization
MDG	Millennium Development Goal
MoH	Ministry of Health
NGO	Nongovernmental organization
NHRI	National Human Rights Institution
NTD	Neglected tropical disease
OAS	Organization of American States
OHCHR	Office of the High Commissioner on Human Rights
PHC	Primary health care
PRS	Poverty reduction strategy
Sida	Swedish International Development Cooperation Agency
SR	Special Rapporteur
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UDHR	Universal Declaration of Human Rights
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UPR	Universal periodic review
WHA	World Health Assembly
WHO	World Health Organization



GETTING TO KNOW THE TOOL

A. GETTING TO KNOW THE TOOL

1. Introduction

1.1 Background and rationale

The basic premise of this tool is that aligning national health sector strategies¹ with obligations and commitments on human rights and gender equality is not only the *right* thing to do, ethically and legally, it also leads to better, more sustainable and equitable results in the health sector.

Every UN Member State has undertaken international legal obligations for human rights. More than 80 per cent of Member States have ratified 4 or more of the 9 core international human rights treaties². There is near-universal ratification for the Convention on the Rights of the Child (CRC) and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), both of which recognize health as a human right, the importance of gender equality and several other rights relating to underlying determinants of health^{3,4}. Further, international consensus documents such as the Cairo Programme of Action⁵ and the Beijing Platform for Action⁶, the Millennium Declaration and the Millennium Development Goals (MDGs)⁷ provide guidance on some of the policy implications of placing health at the centre of development agendas, meeting governments' human rights obligations and reinforcing commitments to promoting gender equality and women's empowerment. Moreover, the World Health Assembly (WHA) – the governing body of the World Health Organization (WHO) – adopts resolutions to guide and direct the WHO Secretariat and the Member States of WHO in the field of health, including gender equality and health-related human rights. Greater efforts are needed to help Member States fulfil goals and obligations such as those outlined in Box 1. This includes ensuring that national health sector strategies are consistent with, and further reinforce, human rights standards and principles and gender equality.

Historically, international human rights law did not effectively address women's human rights, and women were even excluded from participating in its early development. Initially, the right to health was also narrowly interpreted to exclude women's needs and experiences and failed to address obstacles faced by women in making decisions pertaining to health and obtaining health-related services. The adoption of CEDAW in 1979 marked a turning point. CEDAW's preamble explains that, despite the existence of other instruments in which principles of equality and non-discrimination exist, women still do not have equal rights with men⁸. Today, particular focus is still needed towards realizing women's human rights. While CEDAW is almost universally ratified, it is also the treaty with the highest number of reservations, presenting significant obstacles to its effective implementation⁹.

In relation to health, CEDAW sets out specific provisions with respect to women's sexual and reproductive health rights⁴. Years later, the International Conference for Population and Development Programme of Action and Beijing Platform for Action called for increased attention and action around women's sexual and reproductive health rights. The Beijing Platform for Action, among other mechanisms, broadened approaches to women's health to include a range of other risk factors and conditions that contribute to women's ill health and mortality; Strategic Objective C (women's health) and D (violence against women) are of particular note⁶. This is in line with holistic approaches to women's health that address the determinants of their health including and beyond reproductive health matters. Indeed, the WHO report on Women and Health¹⁰ highlights that sexual and reproductive health is central to women's health. However, high rates of morbidity and mortality

among women from all countries are attributable to non-communicable diseases, violence and injuries and mental health. These areas require urgent attention in a gender and human rights-based approach to women's health.

The Declaration of Alma-Ata, adopted at the Alma-Ata Conference of 1978 on Primary Health Care (PHC), affirmed health as a fundamental human right¹¹. This was consistent with the International Covenant on Economic, Social and Cultural Rights (ICESCR), Article 12, which enshrined the right to the enjoyment of the highest attainable standard of physical and mental health in 1966¹².

The 2008 World Health Report and the WHA resolution 62.12 take forward the values pursued in the Declaration of Alma-Ata: social justice, the right to health for all, participation, equity and solidarity. The PHC policy directions aim at achieving universal access and social protection; reorganizing service delivery around people's needs and expectations; securing healthier communities through better public policies across sectors; and remodelling leadership for health around more effective government and active participation of key stakeholders^{13,14}.

Box 1

Selected Action Oriented Policy Commitments to Human Rights and Gender Equality

1993 – The Vienna Declaration and Programme of Action affirmed that the human rights of women and girls are inalienable, integral and indivisible parts of universal human rights and that the equal status and human rights of women should be integrated into the mainstream of UN system-wide activity.

1995 – The Beijing Declaration and Platform for Action stated that, *"in addressing violence against women, Governments and other actors should promote an active and visible policy of mainstreaming a gender perspective in all policies and programmes so that before decisions are taken an analysis may be made of their effects on women and men, respectively."*

2000 – In the UN Millennium Declaration, Member States resolved *"to combat all forms of violence against women and to implement the Convention on the Elimination of All Forms of Discrimination against Women"* while calling for *"the promotion of gender equality and the empowerment of women..."*

2005 – At the 2005 World Summit, UN Member States recognized the *"importance of gender mainstreaming as a tool for achieving gender equality"* undertaking to *"actively promote the mainstreaming of a gender perspective in the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and social spheres"*. Member States also unanimously resolved *"to integrate the promotion and protection of human rights into national policies"*.

2008 – The Accra Agenda for Action, which aimed to accelerate the implementation of the Paris Declaration on Aid Effectiveness, commits developing countries and donors to *"ensure that their respective development policies and programmes are designed and implemented in ways consistent with their agreed international commitments on gender equality, human rights, disability and environmental sustainability"*.

2010 – At the 2010 Follow-up to the Outcome of the Millennium Summit, UN Member States *"recognise(d) that the respect for and promotion and protection of human rights is an integral part of effective work towards achieving the MDGs."* In the same year, the UN General Assembly unanimously established the Entity on Gender Equality and the Empowerment of Women, known as UN Women. The new composite entity began official operations on 1 January 2011 and will report to the General Assembly through ECOSOC.

The right to "the highest attainable standard of physical and mental health" is not confined to the right to health care. The right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment. The underlying determinants of health, when neglected, can lead to health inequities, which are understood as unfair and avoidable differences in health status within and between countries. In 2005, the WHO established the Commission on Social Determinants of Health to provide advice on how to reduce persistent and widening inequities. The report of the Commission and the WHA resolution 62.14 provide specific recommendations on reducing health inequities through action on the underlying determinants of health^{15,16}.

Given the many inter-linkages between PHC, underlying determinants of health, a HRBA and gender mainstreaming, the present tool contributes to the implementation of the various declarations, resolutions and policy commitments (see Box 1) mentioned here.

A human rights-based approach and gender mainstreaming add value to health sector strategies and actions by:

- contributing to the reduction of gender-based (and other) health inequities;
- supporting the overall health system and ensuring that health systems functions such as health information, health financing, and leadership and governance (including policy-making) create sustainable, enabling environments for health services to be organized and delivered in equitable ways;
- supporting transparent and accountable strategies to empower women and men – especially the most marginalized – to participate in policy formulation, implementation, monitoring and evaluation;
- supporting and facilitating linkages with other sectors that impact upon health (see Box 2 for one such example);
- ensuring that they give priority attention to issues that concern the health of vulnerable and marginalized groups;
- ensuring that they address gender inequalities and redress discriminatory practices and unjust distributions of power that impede progress towards the MDGs and other health development goals.

Box 2

"HRBA helps us to understand that maternal mortality is not simply an issue of public health but the consequence of multiple unfulfilled rights. A woman suffering from chronic malnutrition, who lives in a slum without access to safe water and sanitation and who does not have an education, is at a much higher risk of dying during pregnancy or childbirth. The same woman is at an even higher risk of dying if she is aged between 15 to 19, has suffered female genital mutilation, an early or forced marriage, gender-based violence or sexual exploitation. She would be more exposed if she has HIV/AIDS or if she is discriminated in her private and public life because she belongs to an indigenous group or because of her race, or for being an irregular migrant worker. In order to ensure that vulnerable women and girls in remote rural parts of a country have access to family planning, skilled attendants at birth and access to emergency obstetric care without delays, public policies must address broader human rights issues, rather than simply deliver a set of technical interventions. A failure to do so, might continue to condemn millions to be neglected in the fulfilment of the MDGs."¹⁷

Navanethem Pillay,
United Nations High Commissioner for Human Rights

1.2 Objectives and target-audience

The overall aim of the tool is to enhance coherence between: international obligations and commitments; national legal, policy and institutional frameworks; and health sector strategies with respect to human rights and gender equality.

The specific objectives of the tool are to:

1. Assess the extent to which health sector strategies are consistent with, and promote, human rights standards and principles, including gender equality.
2. Identify gender equality and human rights-related gaps and opportunities with respect to national commitments and health sector strategies, in order to facilitate effective relevant and strategic health sector interventions.
3. Generate a multi-stakeholder process and a cross-disciplinary dialogue to address human rights and gender equality in relation to health.

The tool addresses various actors in health planning, policy-making, implementation and/or monitoring of health sector strategies. This includes health policy-makers and planners, national human rights institutions, development partners and CSOs. Its use will vary depending on the specific context and focus of the assessment exercise. However, ideally the tool supports:

- a review of – or preparation for a new – health sector strategy;
- other studies to evaluate or assess a health sector strategy.

The tool is not exhaustive and does not provide a set of detailed guidelines. The tool can be adapted to different country contexts.

1.3 Scope, assessment levels and outline of the tool

Effective implementation of State obligations and commitments on human rights and gender equality, as expressed in international consensus documents and through the ratification of human rights treaties, requires that such obligations and commitments are also reflected in national legislation, policies, institutional frameworks and sectoral strategies. The **scope** of the current tool is focused on health sector strategies. Health strategies are plans which set out how a government intends to move forward in meeting its obligation to realize health as a human right and to ensure progressive measures towards gender equality within a specific time frame. As such, the tool is not issue/disease-specific but considers, more broadly, the health system as a whole. It seeks to review the legal, policy and institutional environment of the health strategy, as well as its contents in light of the various components of a well-functioning health system, and human rights and gender equality obligations and commitments.

This tool is based on three **assessment levels** as reflected in Figure 1. Presumably, there should be coherence between international obligations and commitments on human rights and gender equality, the national legal, policy and institutional frameworks, and health sector strategies. However, such coherence is not always "top down", nor is it static or linear. Legislation, policies and strategies change over time and amendments are made regularly.

Assessment level 1: State obligations and commitments made on human rights and gender equality

The first assessment level aims to clarify specific State obligations and commitments on human rights and gender equality. For example, has the State ratified core human rights treaties and followed up on recommendations from UN treaty bodies; agreed to implement key consensus documents such as the Beijing Platform for Action (and subsequent reviews and follow-ups); or engaged with the HRC and special procedures?

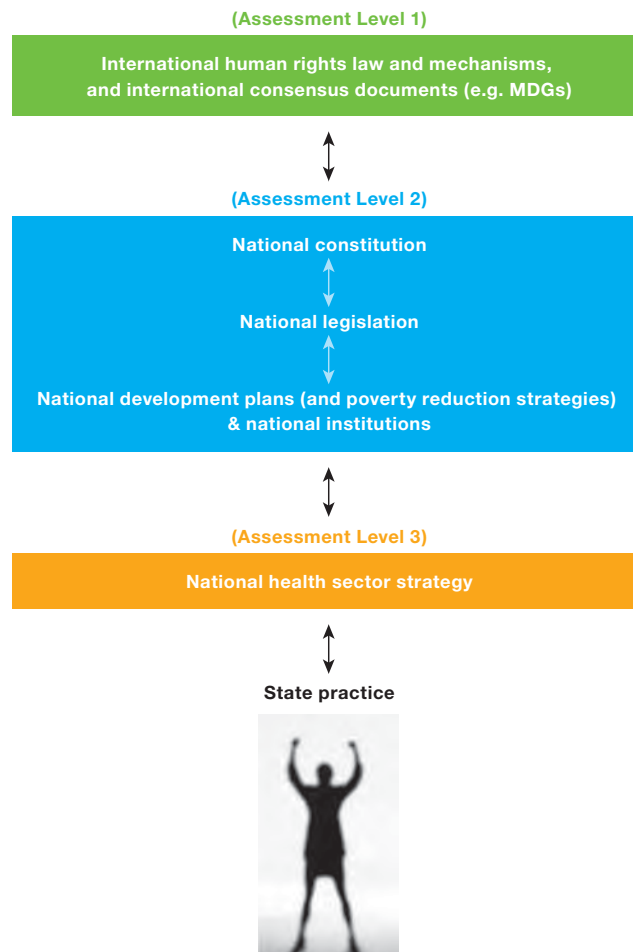
Assessment level 2: Translating human rights and gender equality obligations and commitments in the national legal, policy and institutional framework

The second assessment level reviews if and how governments have applied human rights standards and principles, and promoted gender equality in national legislation, development plans, and the institutional framework.

Assessment level 3: Identifying human rights and gender equality obligations and commitments in national health sector strategies

The third assessment level analyses the incorporation of human rights standards and principles and gender equality elements into the health sector strategy document according to six health systems components (see Box 3), based on the WHO framework for action on strengthening health systems.¹⁸ Each system component/building block is further elaborated and explained in Part C, Section 3 – Assessment Level 3: Health Sector Strategy.

Figure 1 – Scope of the tool: three levels of assessment



Box 3

WHO framework for action on health systems

1. Leadership and governance (stewardship)
2. Service delivery
3. Health workforce
4. Information
5. Medical products, vaccines and technologies
6. Financing

Ideally, all three assessment levels should be part of a review. However, it is also possible to use only selected parts of the tool, depending on the purpose of the review.

Outline of the tool

The tool consists of three parts. Part A includes an introduction and an overview of the approach. Part B includes practical guidance on how to implement the tool. Part C includes the analysis tables with background information and additional guidance to support the review of health sector strategies.

A. GETTING TO KNOW THE TOOL

A.1. Introduction: background and rationale, aim and objectives, scope, assessment levels and outline of the tool.

A.2. Approach: overview of the conceptual approaches guiding the tool. The conceptual approaches used are HRBA and gender mainstreaming which are both grounded in international human rights law.

B. PROCESS

B.1. Practical guidance for using the tool: Tips on planning and process, sources of information, data collection and analysis, dissemination of results and catalysing action.

C. ANALYSIS TABLES

C.1. Assessment level 1: State obligations and commitments to human rights and gender equality. The review of these commitments provides the basis for the subsequent analysis of central health sector documents.

C.2. Assessment level 2: Legal, policy and institutional framework for promoting human rights and gender equality. The review supports the understanding of the context in which health sector strategies are developed.

C.3. Assessment level 3: Health sector strategies. The analysis of national health strategies is structured in part according to the overall priorities and objectives and in part around different building blocks of the health system's framework. It incorporates key human rights and gender equality elements.

Annexes:

1. Key readings and resource materials
2. Feedback questionnaire

2. Approach

2.1 Human rights-based approach and gender mainstreaming

This tool is anchored in a *HRBA* and *gender mainstreaming*.

A HRBA applies a conceptual framework to understand the causes of (non-)fulfilment of human rights. It is based on international human rights standards and principles and it develops the capacities of rights-holders to claim their rights and duty-bearers to fulfil their commitments. A HRBA has a normative value as a set of universally agreed values, standards and principles. A HRBA also aims to support better and more sustainable health outcomes by analysing and addressing the inequalities, discriminatory practices (intentional and non-intentional) and unequal power relations that are often at the heart of development challenges¹⁹. The use of a HRBA is guided by the Stamford Statement of a Common Understanding on a Human Rights Based Approach to Development Cooperation²⁰, outlined in Box 4.

Box 4

The Common Understanding on a Human Rights Based Approach to Development Cooperation

Goal: All programmes of development cooperation, policies and technical assistance should further the realization of human rights as laid down in the Universal Declaration of Human Rights (UDHR) and other international human rights instruments.

Process: Human rights standards and principles guide all development cooperation and programming in all sectors and phases of the programming process.

Outcome: Development cooperation contributes to the development of the capacities of "duty-bearers" to meet their obligations and/or of "rights-holders" to claim their rights.

Promoting gender equality and reducing gender-based discrimination are at the heart of a HRBA. If health-care systems are to respond adequately to problems caused by gender inequality, it is not enough to simply "add in" a gender component late in the implementation phase. The system must be designed to address gender norms, roles and relations from the outset. This is the basis of gender mainstreaming.

Gender mainstreaming is a long-term process and strategy that aims to reflect women's and men's concerns and experiences as an integral part of the design, implementation, monitoring and evaluation of all sectoral policies and programmes, including health. The ultimate goal is to achieve gender equality.²¹

2.2 Human rights and gender equality concepts used in the tool

The tool requires a systematic review of the health strategy and other relevant documents and processes through the framework of human rights and gender equality.

Advancing gender equality is a requirement of a HRBA²²; therefore, gender mainstreaming methods must be effectively applied. Combining the two approaches upholds commitments in the Millennium Declaration⁷, the 2007 HRC resolution 6/30 (*Integrating the human rights of women throughout the United Nations system*)²³ and the UN System-Wide Policy on gender equality and the empowerment of women²⁴.

Methods such as gender analysis and increased involvement of women in decision-making are fundamental to realizing human rights – and in particular, women's human rights. Specifically, gender analysis in health examines how biological and sociocultural factors interact to influence health behavior, outcomes and services. It also uncovers how gender inequality affects health and well-being. Critical questions on where, how and why women or men are affected by a particular condition help to uncover root causes of illness and disease and to shed light on risk-factor exposure and vulnerability that women and men experience²⁵. Gender analysis further enables identification of women's health needs beyond sexual and reproductive health²⁶.

Human Rights Concepts

Human rights standards are legal guarantees protecting universal values of human dignity and freedom. They encompass civil, cultural, economic, political and social rights. All human rights are interdependent and interrelated. The standards define the rights and entitlements of all women and men, boys and girls, and the corresponding obligations of the State as the primary duty-bearer. Human rights standards have been negotiated by States and agreed upon in human rights treaties, such as conventions and covenants, which are legally binding on State parties.

Box 5

"Even if he can vote to choose his rulers, a young man with AIDS who cannot read or write and lives on the brink of starvation is not truly free. Equally, even if she earns enough to live, a woman who lives in the shadow of daily violence and has no say in how her country is run is not truly free.

Larger freedom implies that men and women everywhere have the right to be governed by their own consent, under law, in a society where all individuals can, without discrimination or retribution, speak, worship and associate freely.

They must also be **free from want** – so that the death sentences of extreme poverty and infectious disease are lifted from their lives – and **free from fear** – so that their lives and livelihoods are not ripped apart by violence and war."

In Larger Freedom: towards security, development and human rights for all. Report of the United Nations Secretary-General Kofi Annan, 2005.

A key human rights standard for the purposes of this tool is **the right to the enjoyment of the highest attainable standard of physical and mental health, often referred to as "the right to health"**. It is recognized in the ICESCR¹² and some of its key elements are also found in five other international treaties²⁷. The UN Committee on Economic, Social and Cultural Rights (CESCR), which monitors compliance with the ICESCR, adopted General Comment 14 on the right to health to clarify the contents of this right and support its implementation.

General Comment 14, as diagrammed on page 18, clarifies that the right to health is an inclusive right, extending beyond health care to underlying determinants of health, such as access to safe and potable water; adequate sanitation; adequate supply of safe food; nutrition; housing; healthy occupational and environmental conditions; access to health-related education and information, including on sexual and reproductive health; and freedom from discrimination. States have an obligation to take immediate steps to progressively ensure that health services, goods and facilities are Available, Accessible, Acceptable and of good Quality (AAAQ)²⁸.

State parties to the ICESCR have three types of obligations with regard to the Right to Health:

- **Respect:** not to interfere directly or indirectly with the enjoyment of the right to health, e.g. refrain from denying or limiting access to health-care services, or marketing unsafe drugs.
- **Protect:** prevent third parties from interfering with the right to health, e.g. ensure that privatization does not constitute a threat to the accessibility, affordability and quality of services.
- **Fulfil:** adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures to fully realize the right to health, e.g. adopt a national health policy/plan covering the public and private sectors.

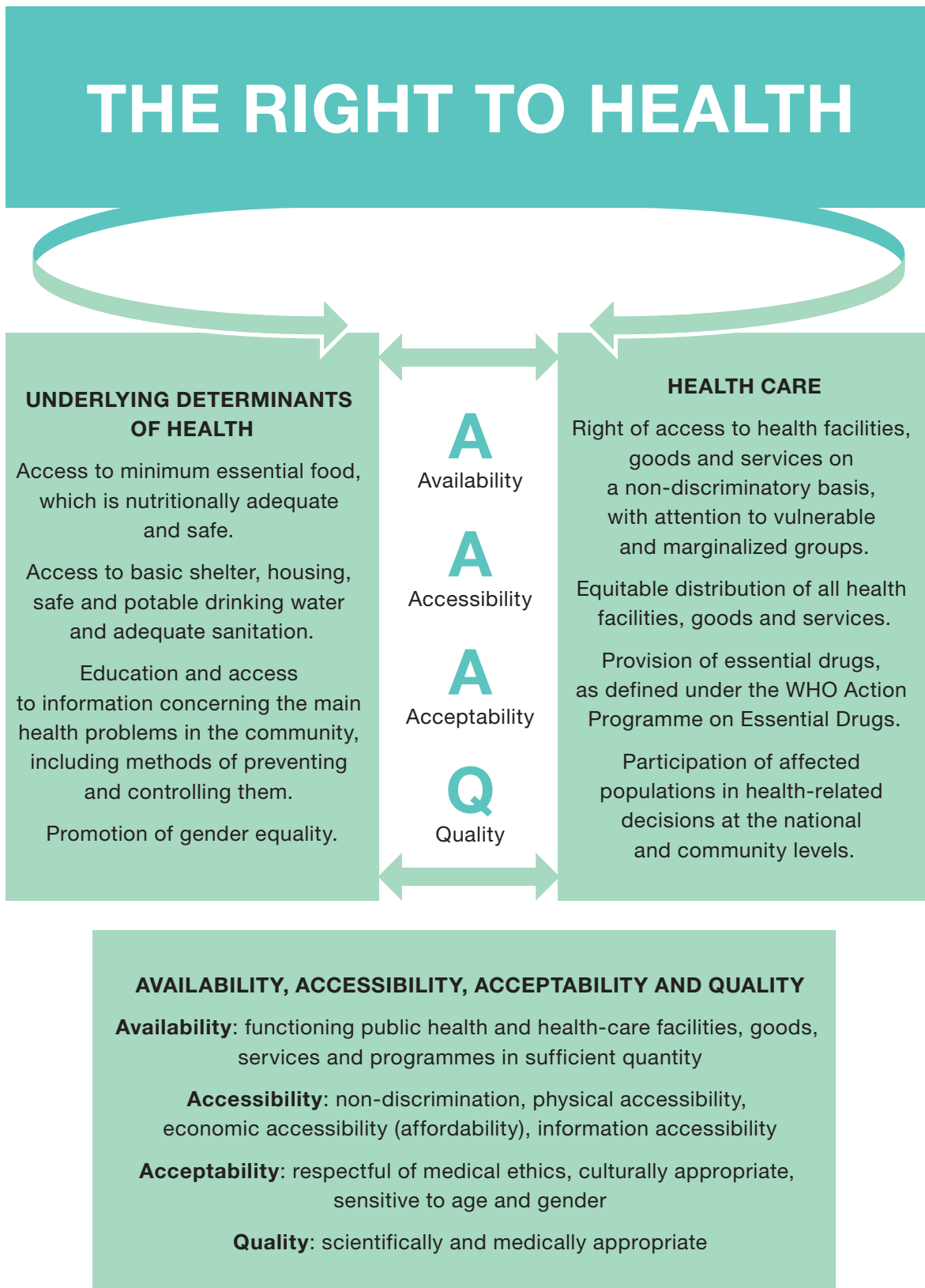
CESCR General Comment 14 also recommends that States integrate a **gender perspective** in their health-related policies, planning, programmes and research in order to promote better health for both women and men.

Human rights principles derive from the human rights treaties. They provide important guidance to interventions and processes. Key human rights principles in relation to health are the following:

- The **principle of equality and non-discrimination**. All individuals are equal as human beings and by virtue of the inherent dignity of each human person. All human beings are entitled to their human rights without discrimination of any kind, as to race, colour, sex, ethnicity, age, language, religion, political or other opinion, national or social origin, disability, property, birth or other status, as enshrined in all human rights treaties. This principle requires States to address discrimination (intentional and non-intentional) in laws, policies and practices, including in the distribution and delivery of resources and health services.

The principle of equality and non-discrimination is particularly relevant for addressing gender, because the situation faced by marginalized groups of women and girls is due not only to their sex and gender roles, but also if they are a member of other vulnerable groups – such as those living with a disability or part of an ethnic minority group. This compounds the types of discrimination such groups face.

Figure 2 – The Right to Health



- The **principle of participation and inclusion** means that people are entitled to participate in decisions that directly affect them, such as the design, implementation and monitoring of health interventions. Participation should be active, free and meaningful.
- The **principle of accountability** requires governments and other decision-makers to be transparent about processes and actions, and to justify their choices (answerability). Also, there should be mechanisms in place to address grievances when individuals and organizations fail to meet their obligations (redress). Judicial, administrative, political and policy mechanisms can be used to ensure accountability at different levels.

Box 6

"Human rights principles are complementary and must be pursued together. Applying just one principle will not do the job.

Development is more likely to be successful if everyone affected is included in the process. The involvement of individuals and communities enables them to have a say and allows the government to better understand their real needs. As a result, policies will be more responsive to the people and thus governments will be more accountable. In order to ensure that everyone benefits from development, governments must combat discrimination that marginalizes some groups and ensure their active and meaningful participation."²⁹

Gender Concepts

Gender mainstreaming is a strategy to make women's and men's concerns and experiences an integral part of the design, implementation, monitoring and evaluation of all sectoral policies and programmes, including health. The ultimate goal is to achieve gender equality.

Gender is used to describe those characteristics of groups of women and men which are socially constructed, while **sex** refers to those which are biologically determined.

Gender equality or equality between different groups of women and men refers to the equal enjoyment by groups of females and males – of all ages and regardless of sexual orientation or gender identity – of rights, socially valued goods, opportunities, resources and rewards. Equality does not mean that women and men are the same but that their enjoyment of rights, opportunities and life chances are not governed or limited by whether they were born female or male.

Gender analysis identifies and addresses inequalities and/or differences experienced by different groups of women and men. With respect to health, it explores the ways that norms, roles and relations may impact differently upon the health of women and men. Critical questions on where, how and why women or men are affected by a particular condition help to uncover root causes of illness and disease and to shed light on risk-factor exposure and vulnerability that women and men experience²⁶.

2.3 How the tool operationalizes the two approaches

A HRBA and gender mainstreaming share norms and standards of international human rights treaties and instruments, and other international agreements, such as the Millennium Declaration and the Beijing Platform for Action³⁰. In order to determine to what extent gender norms, roles and relations are addressed, several tools and classification frameworks exist – see Box 7.

Box 7

Gender terms used to classify policies, programmes or activities

Gender unequal: Policies, programmes or activities that perpetuate gender inequalities by reinforcing unbalanced norms, roles and relations for women and men. They do this by either privileging men over women, or vice versa, and tend to ensure that one sex will have more rights and opportunities than the other.

Gender blind: Policies, programmes or activities that ignore gender norms, roles and relations, and tend to reinforce gender-based discrimination. Also referred to as *gender neutral policies*, these tend to ignore differences in opportunities and allocation of resources for women and men.

Gender sensitive: Indicates gender awareness, although no remedial action is developed.

Gender specific: Policies, programmes or activities that take account of women's and men's different roles, norms and responsibilities as well as their specific needs within a programme or policy. Such programmes make it easier for women and men to fulfil duties that are ascribed to them on the basis of their gender roles – without necessarily trying to change gender roles.

Gender transformative: Addresses the causes of gender-based health inequities by including ways to transform harmful gender norms, roles and relations. The objective of such programmes is often to promote gender equality and foster progressive changes in power relationships between women and men.

Note: These terms are based on the WHO Gender Responsive Scale.²⁶

This tool enables an assessment of health strategies based on the right to health (both health care and underlying determinants through the lens of AAAQ) as well as the principles of equality and non-discrimination, participation and accountability. It uses gender analysis to uncover how gender inequality may influence differential ways that the health of groups of women and men have been addressed in the strategy (in terms of both process, such as participation and information sources, and outcome, or what is actually reflected in the strategy). In crafting the review questions, obligations to respect, protect and fulfil human rights have been incorporated as well as core elements of the Beijing Platform for Action (health-related critical areas of concern and strategic objectives) and other international consensus documents.

Endnotes

- 1 The term “health sector strategy” refers to a national medium-term strategy identifying priority areas and actions to improve health outcomes. The terminology may vary between countries and other common terms are “health sector strategic plan” and “health sector plan”. The health sector strategy may be guided by a long-term “health policy”.
- 2 Office of the High Commissioner on Human Rights (OHCHR). “Human Rights Bodies.” Available at <http://www.ohchr.org/EN/HRBodies/Pages/HumanRightsBodies.aspx>, accessed 25 August 2010.
- 3 United Nations General Assembly, *Convention on the Rights of the Child, Resolution 44/25, November 20, 1989*. Retrieved from <http://www2.ohchr.org/english/law/pdf/crc.pdf>, accessed 25 August 2010.
- 4 United Nations General Assembly, *Convention on the Elimination of All Forms of Discrimination against Women, December 18, 1979*. Retrieved from <http://www2.ohchr.org/english/law/cedaw.htm>, accessed 25 August 2010.
- 5 *Report of the International Conference on Population and Development: Programme of Action of the International Conference on Population and Development*. International Conference on Population and Development, Cairo, 5-13 September 1994 (A/Conf.171/13). Retrieved from <http://www.un.org/popin/icpd/conference/offeng/poa.html>, accessed 25 August 2010.
- 6 *Report of the Fourth World Conference on Women: Beijing Declaration and Platform for Action*. Fourth World Conference on Women, Beijing, 4–15 October 1995 (A/CONF.177/20). New York, United Nations, 1995. Retrieved from <http://www.un.org/esa/gopher-data/conf/fwcw/off/a--20.en>, accessed 15 January 2010.
- 7 United Nations General Assembly. *United Nations Millennium Declaration, A/res/55/2, 2000*. Retrieved from <http://www.un.org/millennium/declaration/ares552e.htm>, accessed 24 May 2010.
- 8 OHCHR. *Discrimination against women: The Convention and the Committee*. Geneva, OHCHR, 1995. Retrieved from <http://www.ohchr.org/Documents/Publications/FactSheet22en.pdf>, accessed 24 May 2010.
- 9 *Women's health and human rights: monitoring the implementation of CEDAW*. Geneva, World Health Organization, 2007. Retrieved from http://www.who.int/reproductivehealth/publications/gender_rights/9789241595100/en, accessed 15 January 2010.
- 10 *Women and health: today's evidence, tomorrow's agenda*. Geneva, WHO, 2009. Retrieved from http://www.who.int/gender/women_health_report/en/index.html, accessed 15 January 2010.
- 11 WHO and UNICEF (1978). *Declaration of Alma-Ata*, adopted by the International Conference on Primary Health Care, Alma-Ata, 6 – 12 September 1978. Alma-Ata, USSR: WHO/UNICEF, 1978.
- 12 United Nations General Assembly, *International Covenant on Economic, Social and Cultural Rights, Resolution 2200, 16 December 1966*. Retrieved from <http://www2.ohchr.org/english/law/pdf/cescr.pdf>, accessed 25 August 2010.
- 13 *The World Health Report 2008 – Primary health care: now more than ever*. Geneva, WHO, 2008.
- 14 Resolution WHA62.14. Reducing health inequities through action on the social determinants of health. In: *Sixty-second World Health Assembly, Geneva, 18–22 May 2009, Volume 1: Resolutions and decisions, Annexes*. Geneva, WHO, 2009 (WHA62/2009/REC/1) 21–25.
- 15 Commission on Social Determinants of Health. *Report by the secretariat to the Sixty-second World Health Assembly*. Geneva, WHO, 2009 (A62/9). Retrieved from http://apps.who.int/gb/ebwha/pdf_files/A62/A62_9-en.pdf, accessed 31 March 2010.
- 16 Resolution WHA62.12. Reducing health inequities through action on the social determinants of health. In: *Sixty-second World Health Assembly, Geneva, 18–22 May 2009, Volume 1: Resolutions and decisions, Annexes*. Geneva, WHO, 2009 (WHA62/2009/REC/1) 16–19.
- 17 Statement by Navanethem Pillay, UN High Commissioner for Human Rights. *Seminar on the MDGs and Human Rights, organized by the Government of the Netherlands, Geneva, 28 May 2010*. Retrieved from <http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=10071&LangID=e>.
- 18 *The World Health Report 2000 – Health Systems: Improving Performance*. Geneva: WHO, 2000.
- 19 United Nations. *Guidelines for UN country teams on preparing a CCA and UNDAF, pages 17-18*. February 2009. Retrieved from <http://www.undg.org/docs/9879/CCA-and-UNDAF-Guidelines-FINAL-February-2009.doc>, accessed 25 March 2010.
- 20 United Nations Development Group (UNDG). *UN Statement of Common Understanding on Human Rights-Based Approach to Development Cooperation and Programming*. May 2003. Retrieved from http://www.undg.org/archive_docs/6959-The_Human_Rights_Based_Approach_to_Development_Cooperation_Towards_a_Common_Understanding_among_UN.pdf, accessed 25 August 2010.
- 21 UN Economic and Social Council (ECOSOC). *Gender Mainstreaming. Extract from the Report of the Economic and Social Council for 1997*. Vienna, 18 September 1997 (A/52/3). Vienna, UN Department of Economic and Social Affairs, 1997.
- 22 UNDG. *UN Common Learning Package on HRBA of the Action 2 Programme; Human Rights Based Approach: Step-by-step, Session 4*. Geneva, UNDG, 2007. Retrieved from <http://www.undg.org/index.cfm?P=221>, accessed 24 August 2010.
- 23 Human Rights Council. *Integrating the human rights of women throughout the United Nations system, Resolution 6/30, 2007*. Retrieved from http://ap.ohchr.org/documents/E/HRC/resolutions/A_HRC_RES_6_30.pdf, accessed 24 May 2010.
- 24 Chief Executives Board for Coordination. *United Nations system-wide policy on gender equality and the empowerment of women: focusing on results and impact, CEB/2006/2, 2006*. Retrieved from http://www.un.org/womenwatch/ianwge/gm/UN_system_wide_P_S_CEB_Statement_2006.pdf, accessed 15 January 2010.

- 25 Boys and girls are implicitly included within the category of men and women when referred to in this publication.
- 26 *Gender mainstreaming for managers: a practical approach*. Geneva, WHO, 2011.
- 27 International Convention on the Elimination of all Forms of Discrimination (ICERD, 1965); Convention on the Elimination of all Forms of Discrimination against Women (CEDAW, 1979); Convention on the Rights of the Child (CRC, 1989); International Convention on the Protection of the Rights of Migrant Workers and Members of their Families (ICMW, 1990); Convention on the Rights of Persons with Disabilities (CRPD, 2006). See: <http://www2.ohchr.org/english/law/index.htm>.
- 28 Committee on Economic Social and Cultural Rights (CESCR). *The Right to the Highest Attainable Standard of Health*, General Comment 14. E/C.12/2000/4, 25 April-12 May 2000. Retrieved from [http://www.unhcr.ch/tbs/doc.nsf/\(symbol\)/E.C.12.2000.4.En](http://www.unhcr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En), accessed 25 August 2010.
- 29 OHCHR. *Information Note: Human Rights – Foundation for engagement to achieve the MDGs*. Geneva, OHCHR, 2010. Retrieved from <http://www.ohchr.org/Documents/Issues/MDGs/MDGsInfonoteFinal.pdf>, accessed 25 August 2010.
- 30 United Nations. *Guidance note: application of the programming principles to the UNDAF*. 12 February 2010. See <http://www.undg.org>.

B

PROCESS – PRACTICAL GUIDANCE FOR USING THE TOOL

B. PROCESS – PRACTICAL GUIDANCE FOR USING THE TOOL

1. Opportunities to use the tool

The tool can be useful for different purposes and by different actors. The way it is used will vary, depending on the specific context and focus of the assessment exercise. There are two intended primary uses for the tool:

1. For use by a health sector review team during an annual/mid-term review or planning exercise. A health sector review process often involves many stakeholders who review various aspects of health sector planning and implementation. In this context, elements of the tool can be incorporated into other tools and review exercises. The annual/mid-term health sector review or planning process is usually implemented under the coordination and leadership of the Ministry of Health (MoH).
2. For use by a review team for a specific study aimed at evaluating or assessing a health sector strategy from a human rights and gender equality perspective. The study may be one separate component of an overall health sector review process, or may be independently commissioned by the MoH, an international or national CSO or a development partner.

Using the tool for an assessment exercise facilitates discussions between various partners. To make the most of these discussions, it is important to prepare ahead of time for the review.

Ideally, all three assessment levels should be part of the review. However, it is also possible to use only selected parts of the tool, depending on the purpose of its use.

1.1 Use of the tool as part of a broader review or planning exercise

If the tool is used within a broader health sector review or planning process, it is important to:

1. Include human rights and gender equality as part of the overall terms of reference.
2. Integrate specific questions on human rights and gender equality into existing tools that the cross-disciplinary team will address.
3. Discuss gender equality and human rights in the appropriate context between MoH professionals and team member experts; they should not be seen or handled as an “add on” or parallel exercise.
4. Have the team review the questions and discuss how they relate to the specific country context and adapt as needed.
5. Ensure that each team member identifies, understands and is accountable for human rights and gender equality questions related to the particular level or analysis table that the team member handles.
6. Assign or appoint someone with expertise in human rights and gender equality to collect the information required under assessment levels 1 and 2 to guide the analysis of elements relating to assessment level 3 (which is likely to be the focus of the review or planning exercise).

7. Integrate the results from the use of this tool into larger team reports (such as a Mid-term review). The larger report should address human rights and gender issues both under each subheading and in a summary chapter; ensure that the results of this assessment are part of all formal reviews of health sector strategies and not seen as parallel efforts.
8. Include on the review team at least one lead person with technical and political competency regarding human rights and gender equality who can:
 - > ensure that human rights and gender equality issues are properly addressed;
 - > strengthen the capacity of other team members as needed and appropriate.

Such individuals can often be found within national human rights institutions and/or ministries of gender/social affairs as well as CSOs, think-tanks and universities.

1.2 Use of the tool for a stand-alone human rights and gender equality study

If the tool is used for a focused and separate human rights and gender equality study, the following points are important to note:

1. A national team should provide guidance and inputs to the study. Team members should have competence and experience related to:
 - > the workings of a national health system, health policy-making and planning, including the areas of service delivery, health workforce, health information, medicines and health financing;
 - > human rights concepts and a HRBA to programming and gender mainstreaming, ideally in the area of health. Annex 1 contains key readings and resource materials in the area of health sector strategies, human rights and gender equality. For those team members responsible for ensuring human rights expertise, an e-learning kit referred to in Annex 1 can be useful. It contains two modules (45 minutes each).
2. The national team should also purposely include both women and men to ensure attention to potential gender-related barriers for both groups.¹ The team should ideally include male and female representatives of government institutions (MoH, Ministry of Gender, NHRIs, etc.) and CSOs with expertise in the areas of human rights, gender equality and health.
3. A national coordinator should be designated – or endorsed – by the national government, for example, the MoH. The responsibilities of the coordinator include:
 - > ensure effective planning and coordination of the study, including capacity-building of team members (as required) and information sharing with national and international health development partners, CSOs, health professional associations and other sectors/ministries;
 - > facilitate regular meetings between national team members and researchers, to discuss results, analysis and recommendations;
 - > support effective sharing and dissemination of findings with a range of health actions at national and sub-national levels.

4. One or two people should be identified to work full-time on the data gathering, initial analysis and report writing. They should have expertise in the areas of human rights and gender equality relating to public health policies. Their responsibilities include:
 - > review relevant documents and conduct interviews to collect the information required in the analysis tables;
 - > share findings, initial analysis and recommendations with national team members for inputs, interpretation and recommendation drafting;
 - > prepare and/or present the findings, conclusions and recommendations for multiple audiences.
5. All involved – national team members, coordinator, and the people described in Point 4 – will need explicit Terms of Reference that clearly reflect a HRBA and gender mainstreaming knowledge, skills and application.

2. Preparatory arrangements and sources of information

When planning the review, it is important to determine who should be involved and how. The MoH is envisaged to lead the review, but other stakeholders such as the Ministry of Gender or Social Affairs, NHRIs, health development partners and CSOs also offer important contributions to the review, dissemination of findings or catalysing of actions.

Capacity building of team members in the areas of human rights and gender equality may be needed before and during the review. Capacity building is an important strategy in both a HRBA and gender mainstreaming to make sure such skills are wide-spread and implemented.

The team should prepare a timeline for the review, ensure access to relevant documents, and identify people to interview. Ample time should be allotted for data collection, analysis, and report-writing. Additional time will be required for report/presentation preparation and sharing. It may be helpful to have a designated focal person in the MoH and other ministries – apart from those involved in the analysis – to facilitate procurement of relevant documents, as well as to facilitate appropriate permissions and appointments for interviews.

Sources of information will include documents, information available on the internet and interviews with key informants. The tables include space to note issues for follow-up during the document review or interviews.

2.1 Document review

The main method of data collection employed in this tool is document review. Key documents to review in addition to the Health Sector Strategy Plan include:

- human rights and gender equality instruments
- the national constitution and public health law
- the national development plan (or PRS)

- country reports of Special Procedures, UPR recommendations, Treaty Bodies' recommendations, and reports of regional human rights mechanisms, if applicable
- national MDG reports and State reports to UN Treaty Bodies and the UPR

Other documents which may also be relevant:

Overall

- National health policy and health-care law
- Gender or women's equality/development policy or strategy (note that some countries may have a women's health or gender and health strategy)
- Human rights policy, strategy or action plan
- National hospital policy, laws or regulations
- Special reports relating to equitable access to health care, quality of care and clients' perception of quality
- Demographic health survey (or other population-based survey findings)
- Periodic basic health statistic reports
- Reports related to human rights mechanisms and consensus documents
- Reports or analysis by key NGOs on health sector performance and women's health

Service delivery

- Policies for key interventions or areas, for example child health, HIV/AIDS, sexual and reproductive health, mental health, and laws and regulations related to health services procurement and delivery

Health workforce

- Human resource policy or strategy (addressing either recruitment, training, mobility or retention) and health professional legislation and regulation (e.g. licencing)
- Code of conduct
- Occupational health and safety laws and regulations

Health information

- Guidelines for information systems, for example health management information system
- Guidelines on health indicators
- Policy or laws and regulations on data access and sharing

Medical products, vaccines and technologies

- Medicines policy or strategy (including essential medicines/health technology lists or guidelines), and laws and regulations on governing drugs (pharmaceutical regulations) and R&D
- Policy on access to medical products and technology, including stipulations on age of consent

Health financing

- Health financing policy or strategy and laws and regulations related to health insurance
- Policy on user fees or out-of-pocket expenditures

Leadership and governance

- Strategy or guidelines on community participation in health decision making or policies (e.g., consultations on survey development, service design and plans, etc.)
- Policy on public-private partnerships and development partnerships (i.e. foreign aid)
- Health sector performance report(s)
- All health-related laws/policies in above categories
- National studies that address health inequities, including studies by CSOs²

It is advisable to have access to an electronic version of this tool to facilitate an easy compilation of findings; the accompanying CD-Rom is for this purpose. It is also desirable to get the documents that need to be reviewed in electronic format, preferably one that allows for cutting and pasting of sentences/phrases for inclusion of direct quotes in analysis tables. However, in many countries, laws and regulations may not be available in electronic format, which should be taken into account. Separate tables could be printed/copied for key informant interviews. When searching for information in the documents for review or identifying relevant background documents on the internet, the search words included in Box 8 may be helpful. Where electronic copies of documents are not available on the internet, government ministries or national bodies such as NHRIs may be contacted for access.

2.2 Interviews

Beyond content and development, process and implementation are key for review. Analysis tables 8 and 9 focus on the institutional framework and the process of assessment, analysis and strategic planning in relation to the national health sector strategy. Interviews may be required to provide additional information that the document review cannot. In addition, the team may have further questions after reviewing the required documents. It may also be helpful to discuss the findings with national experts in the different areas for a more thorough understanding of the findings.

Box 8

Suggested search words

- accountability
- boys
- convention
- covenant
- empowerment
- equality
- equity
- gender/gender equality/
gender equity/gender
sensitive/gender
mainstreaming
- gender awareness
- girls
- health differences
- human rights
- marginalized/marginalization
- men
- non-discrimination
- participation
- poverty/pro-poor
- rights/rights-based
- transparency
- treaties
- vulnerable
- women/women's health/
women's rights

In order to properly plan for these interviews, a tentative list should be made at an early stage of:

- Key persons to meet and interview as well as agencies and institutions to visit for further information and clarification of issues unearthed by the review;
- Key meetings and consultations to be held with different groups of stakeholders, for example to discuss crucial issues or to debrief before finalizing findings and report preparations.

3. Information gathering and analysis

3.1 Preparing for document review

Part C of the tool is divided into 3 assessment levels, with a total of 15 analysis tables. The introduction to each analysis table provides brief background information, indicated by the following icon:



BACKGROUND INFORMATION

Possible sources of information are proposed after each analysis table indicated by the following icon:



WHERE TO FIND THE INFORMATION

When information is available on the internet, specific web sites are listed.

3.2 Process of data collection

Each analysis table is composed of analysis questions, a rationale for the area/questions and selected references to relevant instruments/documents.

Rationale provides a brief clarification as to why the question is important from a human-rights and gender-equality perspective. Rationales are included in Assessment levels 2 and 3.

A column with *selected relevant instruments/documents* is included in Assessment levels 2 and 3. This column provides a listing of documents that serve as the foundation for analysis questions. The listing of documents is not exhaustive, and only includes selected human rights and gender equality instruments addressed under Assessment level 1. There are other relevant documents and instruments (such as, for example, ILO conventions, WHA resolutions and technical guidelines, which have not been included). Moreover, regional human rights treaties developed in Africa, the Americas, Europe and the Arab region may be relevant sources for context-specific analysis questions.

Regional human rights treaties reflect particular human rights concerns of the regions and provide specific mechanisms for protection. If a State has ratified both international and regional human rights treaties, the State is legally bound by both. States are usually expected to report on their progress in implementing the treaties to regional institutions (commissions/committees/courts) responsible for monitoring compliance with these treaties. The reporting requirements vary between regions according to the treaty ratified (see pages 40-43 for information resources on regional human rights mechanisms).

3.3 Analysis

When conducting the analysis, users should remember that the progressive realization of the right to health and the achievement of gender equality is not a uni-directional linear process. In some contexts we may find that sectoral strategies promote elements of human rights and gender equality even when not incorporated in legislation nor expressed through ratification of human rights treaties. The promotion of human rights and gender equality requires joint efforts at different levels and areas of the State administration – with potential for synergies between different processes.

In other words, the absence of “top down” coherence from assessment level 1 to 2 to 3, does not necessarily constitute a lack of willingness to operationalize obligations and commitments on human rights and gender equality. Rather, exploring coherence in this analysis is a way of identifying entry points for strengthened actions (see Figure 1).

The analysis should note both weaknesses and strengths and focus on identifying entry points for action. It should be noted that findings are likely to be shown in ranges or degrees of achievement. The progressive realization of the right to health and the achievement of gender equality require that targeted steps are taken in the right direction. In other words, answers do not need to be “yes” for a State to realize its obligations and commitments. In most cases, a “yes” or “no” answer will not be easily given; rather, ranges or degrees of a “yes” or “no” are most likely to be found.



ANALYSIS TIPS

Analysis tips, indicated by the symbol above, are provided and include suggestions to:

- summarize analysis questions by theme;
- link analysis tables and assessment levels to explore policy coherence;
- compare findings with other sources of local information on gender equality, human rights and/or health;
- explore ways that the findings could be used to spark broader dialogue and activities on gender equality and human rights in the health sector (where applicable).

Based on the analysis, users can draw general conclusions – bearing in mind that the purpose of the assessment is not to “pass” or “fail” a health sector strategy. Use the 'general conclusions' to highlight key findings.

General conclusions are represented as follows:



GENERAL CONCLUSIONS

4. Sharing the findings

The findings of the review should be effectively shared with stakeholders in order to catalyse action.

4.1 Presenting the conclusions and recommendations

The findings may be shared in different ways, depending on the context in, and the purpose for which the tool is used. The findings may be shared in stakeholders' meetings, through a report, community meetings or activities, media, etc.

If the tool is used in the context of a health-sector review, reporting will follow the format agreed upon with the MoH and development partners (as relevant). If the tool is used as a stand-alone study, there may be more flexibility on the reporting format. It may be useful to agree on a format for the reporting *before* the start of the assessment. For example, the findings could be grouped for presentation/dissemination as follows:

- Results of relevance to the MoH and health sector partners and actions.
- Results of relevance for intersectoral partners and actions on human rights, gender equality and health.

The findings, as incorporated in the analysis tables and reflected in the general conclusions, can help to identify recommendations on practical steps for the integration of a HRBA and gender mainstreaming in health sector actions and planning.

The analysis team may find it relevant to develop an action plan to implement the recommendations. Recommendations should ideally reflect the “what” and the “how” of a HRBA, gender mainstreaming and health, including “who” the responsible stakeholders are.

A practical way to present recommendations is to divide them into short-term, medium-term and long-term actions, matched to specific activities and responsibilities of different partners. The table below provides an example of how such information could be structured. It is important to make time for discussions on the findings, and also to gain insight concerning the gaps identified as well as the feasibility of taking forward proposed recommendations. Findings and recommendations relating to intersectoral action should be discussed with relevant sectors and partners before disseminating.

Figure 3 – Sample table for presenting review recommendations

SHORT-TERM RECOMMENDATIONS: 0 – 2 Years				
	Findings	Recommendations	Actions	Responsible partners
1				
2				
3				

MEDIUM-TERM RECOMMENDATIONS: 3 – 5 Years

	Findings	Recommendations	Actions	Responsible partners
1				
2				
3				

LONG-TERM RECOMMENDATIONS: 6 – 10 Years

	Findings	Recommendations	Actions	Responsible partners
1				
2				
3				

4.2 Dissemination

The findings should be disseminated strategically and be made available to all stakeholders involved in the development and implementation of the health strategy. Time should, therefore, be allocated for this exercise. The format for the dissemination of findings will depend on the country context and specific target audiences (e.g. policy makers, health managers, CSOs, development partners, general public etc.). The following dissemination opportunities or target audiences may be considered:

- I. Strategic health sector meetings, national health assemblies and joint review missions.
 - Inform key health stakeholders such as CSOs, health professional associations, development agencies and bilateral organizations about the findings, in order to facilitate follow-up actions.
- II. Policy fora in relevant sectors.
 - Meetings with ministries of health, gender or women's affairs, national human rights commission (or the equivalent), and other relevant sectors, preferably together, with the objective of stimulating dialogue and effective action.
 - Community meetings, village health council/committee meetings, etc.
- III. General media for informing the general public.
 - Newsletters, posters, flyers, press releases or policy briefs may reach a broader audience and facilitate access by the public.
 - Lecture series/seminar presentation to health systems researchers, policy makers, students, etc.
- IV. Strategic development cooperation meetings, mechanisms and procedures such as UNDAF and UNCT meetings/activities on gender, human rights or health.
 - Inform UN special procedures, UPR of the HRC, and UN treaty bodies, if applicable and as appropriate.

4.3 Catalyse action

The findings are expected to catalyse action and provide inputs into policy and reporting processes to:

- Contribute to the development of subsequent gender-responsive health sector strategies grounded in a HRBA and provide input into health planning, involving all stakeholders.
- Enhance the ability of marginalized groups to participate actively and meaningfully in the policy process.
- Strengthen mechanisms for dialogue among multisectoral partners on how to enhance attention to human rights and gender equality in health sector planning.
- Develop or revise monitoring (such as indicators) of health sector strategies that will adequately capture human rights and gender equality outcomes.
- Strengthen capacity of decision-makers and staff in the health sector on human rights and gender equality.
- Promote collaboration between the health sector and other sectors – such as justice,

women's development or gender education, employment and transportation – to discuss ways to enhance the design and implementation of the political and legal framework with respect to human rights, gender equality and health.

- Develop joint activities between various actors. For example, curricula revision for health professionals (pre- and in-service training), and filling information gaps on gender equality, human rights and health through enhanced research initiatives (academic and NGO-based).
- Develop advocacy strategies in promoting legal and policy reforms to support the progressive realization of the right to health.
- Provide input to human rights reporting and mechanisms, including State and “shadow reporting” to UN treaty bodies, special procedures mandate-holders of the Human Rights Council³ and reports to the Council's UPR⁴.
- Provide inputs to national MDG reports, particularly how the health sector strategy (or other reviewed documents) support national achievements of MDG targets and goals.
- Provide inputs to ICPD and Beijing annual reports.
- Provide input to national human rights action plans and national monitoring efforts.

Endnotes

- 1 Examples of gender-related barriers include lower professional status (and hence opportunities to take part in assessment activities), restricted travel outside of the city of residence, childcare responsibilities (and therefore less time for dedication to extra-professional activities), allowances from employers for the use of staff time, burden of additional, uncompensated working hours, etc.
- 2 Such studies may be available from the national NGO coordination council. If such a study/evaluation is not available, it is recommended that a pre-study be carried out to identify the key organizations that could have essential information/team members to contribute to the study.
- 3 OHCHR. “Special Procedures of the Human Rights Council.” Available at <http://www2.ohchr.org/english/bodies/chr/special/index.htm>, accessed 25 August 2010.
- 4 OHCHR. “Universal Periodic Review.” Available at <http://www.ohchr.org/EN/HRBodies/UPR/Pages/UPRmain.aspx>, accessed 25 August 2010.

C

ANALYSIS TABLES

C. ANALYSIS TABLES

Assessment level 1: State obligations and commitments to human rights and gender equality

Assessment level 1 focuses on national obligations and commitments to human rights and gender equality as expressed in international treaties and agreements and includes analysis tables linked to international human rights treaties, key consensus documents, the UPR and UN special procedures. Information is provided on regional human rights treaties that users may want to adapt/modify in analysis table 1. Note that the information provided on regional treaty bodies is not exhaustive.

1.1 International human rights treaties

Analysis table 1 reviews whether the State has ratified key international human rights treaties and whether steps have been taken at the national level to report and implement recommendations in relation to the right to health and gender equality.



BACKGROUND INFORMATION

Analysis table 1 includes six human rights treaties which recognize the right to health¹. The analysis table also incorporates the International Covenant on Civil and Political Rights (ICCPR) and the Convention Against Torture (CAT) as violations of many of the rights contained in them would have direct implications on the enjoyment of the right to health.

The equal right of men and women to the enjoyment of all human rights is enshrined in all of these human rights treaties.

EXAMPLES OF TREATIES RECOGNIZING THE RIGHT TO HEALTH

International Covenant on Economic, Social and Cultural Rights (ICESCR)

Art. 3: The States Parties to the present Covenant undertake to ensure the equal right of men and women to the enjoyment of all economic, social and cultural rights set forth in the present Covenant.

Art. 12: 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.

Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)

Art. 12: 1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health-care services, including those related to family planning.

Convention on the Rights of the Child (CRC)

Art: 24: 1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health-care services.

Some of the core international human rights treaties are supplemented by optional protocols addressing specific concerns. This tool does not provide guidance on analysing commitments expressed through ratification of these optional protocols.

When a State ratifies or accedes to a human rights treaty, it undertakes a legal obligation to implement the provisions in the treaty. If a State makes a reservation against a particular article in a human rights treaty, the State is not legally bound by the provisions in that article.

Human rights *treaty bodies* are committees of independent experts that monitor the implementation of the core international human rights treaties. Once a State ratifies a human rights treaty, it is required to submit periodic reports (usually every 4–5 years depending on the treaty) to the relevant treaty body on its implementation of the treaty.

The treaty body reviews the report in dialogue with government representatives and identifies concluding recommendations/observations. The recommendations from treaty bodies can be used to support development planning in different sectors, including health.

EXAMPLE OF TREATY BODY RECOMMENDATION

General recommendations by the Committee on Elimination of Racial Discrimination (CERD) to the United States in 2008

The Committee regrets that despite the efforts of the State party, wide racial disparities continue to exist in the field of sexual and reproductive health, particularly with regard to the high maternal and infant mortality rates among women and children belonging to racial, ethnic and national minorities, especially African Americans, the high incidence of unintended pregnancies and greater abortion rates affecting African American women, and the growing disparities in HIV infection rates for minority women (art. 5 (e) (iv)).

The Committee recommends that the State party continue its efforts to address persistent racial disparities in sexual and reproductive health, in particular by:

- (i) Improving access to maternal health care, family planning, pre- and post- natal care and emergency obstetric services, inter alia, through the reduction of eligibility barriers for Medicaid coverage;
- (ii) Facilitating access to adequate contraceptive and family planning methods;
- (iii) Providing adequate sexual education aimed at the prevention of unintended pregnancies and sexually transmitted infections.

(United States, Distr. General CERD/C/USA/CO/6, 8 May 2008, para. 33)

<http://daccessdds.un.org/doc/UNDOC/GEN/G08/419/82/PDF/G0841982.pdf?OpenElement>

Analysis table 1: International human rights treaties

International human rights treaties	Has the State ratified (acceded to) the treaty? When?	Has the State made any reservations to the treaty related to the right to health and/or gender equality?	Did the MoH and/or other relevant health stakeholders provide input on the preparation of the last report to the treaty body?	Did the treaty body provide any recommendations relating to the right to health and/or gender equality?	Are health-related recommendations from the treaty body disseminated to the MoH and/or other health stakeholders?	Is the State taking action to follow up on treaty body recommendations? How?
International Convention on the Elimination of All Forms of Racial Discrimination (CERD)						
International Covenant on Economic, Social and Cultural Rights (ICESCR)						
Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)						
Convention on the Rights of the Child (CRC)						

International human rights treaties	Has the State ratified (acceded to) the treaty? When?	Has the State made any reservations to the treaty related to the right to health and/or gender equality?	Did the MoH and/or other relevant health stakeholders provide input on the preparation of the last report to the treaty body?	Did the treaty body provide any recommendations relating to the right to health and/or gender equality?	Are health-related recommendations from the treaty body disseminated to the MoH and/or other health stakeholders?	Is the State taking action to follow up on treaty body recommendations? How?
International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (ICRMW)						
Convention on the Rights of Persons with Disabilities (CRPD)						
International Covenant on Civil and Political Rights (ICCPR)						
Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT)						



WHERE TO FIND THE INFORMATION

OFFICE OF THE HIGH COMMISSIONER FOR HUMAN RIGHTS Human Rights by Country

At this website, you can click on the country concerned and access information on ratifications, reservations and recommendations as well as country visits by special procedures
<http://www.ohchr.org/EN/Countries/Pages/HumanRightsintheWorld.aspx>



- Information on the process and mechanisms linked to the *preparation* of periodic reports and the implementation of recommendations from treaty bodies may be found by contacting relevant authorities. Usually the ministry of foreign affairs takes a lead role. Others worth contacting are the national human rights commission (or ombudsperson), ministry of justice, MoH, ministry of gender, women's affairs (or equivalent), the UNCT or human rights NGOs.

The Americas

The American States, in exercise of their sovereignty and within the framework of the Organization of American States (OAS), adopted a series of international instruments that have become the grounds for a regional system for the promotion and protection of human rights, known as the Inter-American Human Rights System (Inter-American System or IAHR). This system acknowledges and defines these rights and establishes obligations tending to their promotion and protection and creates bodies destined to supervise their observance. The Inter-American System was formally initiated with the approval of the American Declaration of the Rights and Duties of Man in 1948, within the framework of the Charter of the Organization of American States. Additionally, the system has other instruments such as the American Convention on Human Rights; Protocols and Conventions on specialized matters, such as the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (Protocol of San Salvador), the Convention to Prevent and Punish Torture, the Convention on Forced Disappearance of Persons, and the Convention on the Prevention, Punishment, and Eradication of Violence against Women, and the Inter-American Convention on the Elimination of All Forms of Discrimination Against Persons with Disabilities among others; as well as the Rules of Procedure and Statutes of its bodies.

The IAHR is made up of two bodies: the Inter-American Commission on Human Rights, whose headquarters are located in Washington, D.C, United States of America, and the Inter-American Court of Human Rights, whose headquarters are in San José, Costa Rica.

- Information on the rules of procedure of IACHR are available on: <http://www.cidh.oas.org>.
- For information as to whether the State has ratified the human rights treaty or made any reservations, refer to the OAS web site: http://www.oas.org/DIL/treaties_and_agreements.htm.
- Annual reports of the IACHR to the General Assembly can be found at: <http://www.cidh.oas.org/annual.eng.htm>.
- Special reports regarding the situation in a specific State, and country reports (following on-site visits) of the IACHR are available on <http://www.cidh.oas.org/pais.eng.htm>.
 - > Recommendations are found towards the end of the special reports and country reports.

Africa

The African Charter on Human and Peoples' Rights, the Protocol to the African Charter on the Rights of Women in Africa and the African Charter on the Rights and Welfare of the Child include provisions relevant to the right to health and gender equality.

States that have ratified the African Charter on Human and Peoples' Rights are obliged to report every two years to the African Commission on Human and Peoples' Rights (ACHPR) on the legislative and other measures taken to implement the charter.

If the State has also ratified the Protocol to the African Charter on the Rights of Women in Africa, then that State should also include information on measures taken to implement the Protocol in its report to the ACHPR.

States that have ratified the African Charter on the Rights and Welfare of the Child are required to report every three years to the Committee of Experts on the Rights and Welfare of the Child on the measures taken to implement the charter.

- For information as to whether the State has ratified the human rights treaty or made any reservations, refer to the web site of the African Union: <http://www.africa-union.org/root/au/Documents/Treaties/treaties.htm>.
- For information on submission of reports to the ACHPR, refer to their web site: http://www.achpr.org/english/_info/status_submission_en.html.

The Arab region

The revised Arab Charter on Human Rights was adopted in 2004, but only entered into force in 2008 when the Standing Committee on Human Rights at the Arab League became functional. State Parties are expected to report every three years to the Arab Committee of Experts on Human Rights. The Committee considers the reports in the presence and with the participation of representatives of the State concerned. The Committee shall submit an annual report, complete with its observations and recommendations, to the Standing Committee on Human Rights at the Arab League.

- For information as to whether the State has ratified the human rights treaty or made any reservations, refer to the web site of the Human Rights Index in the Arab Countries: <http://www.arabhumanrights.org/en/countries/country.aspx?cid=1>
- For information on States' reports and corresponding recommendations: <http://www.arabhumanrights.org/en/bodies/reports.aspx?ct=1&rt=25>

Europe

The European Convention for the Protection of Human Rights and Fundamental Freedoms does not incorporate the right to health explicitly. However, violations of many of the civil and political rights contained in the treaty affect the enjoyment of the right to health. The European Social Charter guarantees social and economic human rights. It was adopted in 1961 and revised in 1996. The European Committee of Social Rights (ECSR) ensures that States Parties are in conformity in law and in practice with the provisions of the European Social Charter. Under the new reporting system (2007), the provisions of the Charter have been divided into four thematic groups. States are expected to present a report on part of the provisions annually and each provision of the Charter, including Art. 11 on the right to protection of health, will be reported on once every four years. The ECSR examines the reports. It decides whether or not the situations in the countries concerned are in conformity with the European Social Charter. The decisions are known as "conclusions". In the conclusions, the ECSR notes positive developments and existing challenges.

- For information as to whether the State has ratified the human rights instruments listed below or made any reservations, refer to the following web sites of the Council of Europe:
The European Convention for the Protection of Human Rights and Fundamental Freedoms:
<http://www.echr.coe.int/nr/rdonlyres/d5cc24a7-dc13-4318-b457-5c9014916d7a/0/englishanglais.pdf>
European Social Charter:
http://www.coe.int/t/dghl/monitoring/socialcharter/Presentation/ESCCollectedTexts_en.pdf
European Social Charter (revised):
<http://www.coe.int/t/dghl/monitoring/socialcharter/Presentation/ESCRBooklet/English.pdf>
- Reports submitted to the European Committee of Social Rights are available on the Council of Europe web site:
http://www.coe.int/t/dghl/monitoring/socialcharter/Reporting/StateReports/Reports_en.asp
- Conclusions by the European Committee of Social Rights are available on the Council of Europe web site:
http://www.coe.int/t/dghl/monitoring/socialcharter/Conclusions/ConclusionsIndex_en.asp



ANALYSIS TIPS AND NOTES FOR DRAWING GENERAL CONCLUSIONS: INTERNATIONAL HUMAN RIGHTS TREATIES

- ☞ Analysis table 1 is primarily a **descriptive account of State obligations**. Relevant information for understanding findings from this table includes:
 - ☞ Prior to ratification or accession, a State normally reviews the treaty to determine whether national laws are consistent with its provisions and to consider the most appropriate ways of promoting compliance with the treaty.
 - ☞ If the State has made a reservation against an article related to the right to health and/or gender equality, review the text of the reservation for an understanding of the specific concern. The State can decide to withdraw a reservation at any time.
 - ☞ It is common that one ministry/entity (usually ministry of foreign affairs) is responsible for preparing the treaty body report in coordination with other stakeholders. Different ministries/entities may be responsible for different reports. The coordinating ministry/entity may invite other Government entities and civil society partners to be part of a drafting committee or provide input on the report through stakeholder meetings or written submissions. Note if and how health sector actors have been consulted and/or involved in these processes.

- ☞ Recommendations from treaty bodies (called "concluding recommendations" or "concluding observations") often address issues related to the right to health and/or gender equality. In its recommendations, the Committee usually notes/welcomes positive developments, expresses concerns about specific challenges and puts forward recommendations for further implementation. These are important to note if they are health-related.
 - ☞ Recommendations from the treaty body are shared formally with the Government and are also made available on the OHCHR web site. The Government may ensure dissemination of the recommendations to relevant stakeholders. Note if and how recommendations have been disseminated among health stakeholders.
 - ☞ The State can take action in different ways to follow up on treaty body recommendations. Effective dissemination of recommendations is one important element. The Government may also identify specific strategies to implement the recommendations in coordination with different parts of the State administration and other stakeholders. The implementation of previous recommendations from treaty bodies may be reviewed when preparing a new State party report.
- ☞ **Analysis table 1 can be used as a quasi-benchmark for exploring coherence across assessment levels.** Users are recommended to keep a copy of this table and its findings handy when putting together the final report.



GENERAL CONCLUSIONS: INTERNATIONAL HUMAN RIGHTS TREATIES

- The State has ratified the following international human rights treaties which either recognize the right to health or are important for the equal enjoyment of the right to health:
- The MoH and/or other health stakeholders have provided input on the reports to treaty bodies on the implementation of the following treaties:
- The following examples of State actions to follow up on the health-related recommendations were identified, including dissemination to the MoH and/or other health stakeholders:
- The following gaps and entry points were noted:

1.2 Consensus documents

Analysis table 2 reviews key consensus documents for which it is reasonable to expect national action and monitoring.



BACKGROUND INFORMATION

Examples of consensus documents which play an important role in catalyzing state action for health are the ICPD Programme of Action, the Beijing Platform for Action of the FWCW and the MDGs. Other relevant commitments may be in relation to specific health challenges such as the UNGASS on HIV/AIDS.

Consensus documents, such as declarations, are not legally binding but demonstrate a commitment to fulfil their objectives. Often, plans or programmes of action with strategic activities are elaborated to accompany consensus documents. States are expected to monitor national implementation of these commitments. Actions may include the establishment of certain mechanisms, development of national plans of actions or national progress reports.

EXCERPTS OF BOTSWANA COUNTRY STATEMENT TO THE FOURTH WORLD CONFERENCE ON WOMEN

"At our last preparatory national conference for Beijing held in August 1995, Botswana adopted a general framework for the National Action Plan. The National Action Plan constitutes both the national programme of action for further advancement of women, and the national follow-up activities to this Conference. Our national package contains six critical areas in which poverty, education and violence against women have been accorded the highest priority. The other areas of highest concern to Botswana are health, political empowerment and the girl child".

Statement delivered by the Minister of Labour and Home Affairs, the Honourable B.K. Temane 1995.

<http://www.un.org/womenwatch/daw/beijing/govstatements.html>

Analysis table 2: International consensus documents

Key international consensus documents	Has the State signed (or agreed to implement) the principles and objectives of the consensus document?	Is there a national plan of action based on the consensus document? Is it regularly updated?	Has the State participated in monitoring efforts (e.g. reporting) for this document? Who is responsible?	Have the MoH and/or other health stakeholders provided inputs to monitoring/reporting efforts?	Is the document mentioned in strategic planning and legislative processes?
Programme of Action of the International Conference on Population and Development, Cairo (ICPD)					
Platform for Action, FWCW, Beijing					
The Millennium Declaration and the Millennium Development Goals: 3. Promote gender equality and empower women 4. Reduce child mortality 5. Improve maternal health 6. Combat HIV/AIDS, malaria and other diseases					
Other health-related consensus documents of relevance (Specify document:_____)					



WHERE TO FIND THE INFORMATION

- Information on these instruments is available on the following web sites:
 - ICPD: <http://www.iisd.ca/Cairo.html>
 - UN Women: <http://www.unwomen.org>
 - FWCW: <http://www.un.org/womenwatch/daw/beijing>
 - MDGs: <http://www.undp.org/mdg/basics.shtml>
 - UN General Assembly Special Session (UNGASS) on HIV/AIDS: <http://www.un.org/ga/aids/coverage/>
- National reports that measure progress towards the MDGs are available on the UNDP web site: <http://www.undp.org/mdg/reports.shtml>
- Information on actions taken at national level in response to the consensus documents may be found through contacting the ministry of gender and women affairs (or equivalent), the MoH, UN agencies or relevant CSOs.
- If access to internet is limited, documents such as ICPD and the Beijing Platform for Action can usually be found through ministries for women's affairs, gender equality or its equivalent. UN offices (in particular the WHO, UNFPA and/or UN Women should also have hard copies of these documents and the subsequent national plans and/or reports. For national MDG reports, users should consult the UNCT or national UNDP office. Bilateral partners are also a good source of documentation on international consensus documents.



ANALYSIS TIPS: INTERNATIONAL CONSENSUS DOCUMENTS

- ☞ In line with the expectation that States are to implement the declarations and commitments expressed in international consensus documents that they sign, users should use this table to **summarize the actions taken and mechanisms established**.
- ☞ This table is about presenting a quick snapshot of State activities; therefore, the analysis should focus on summarizing State commitments and follow-up (i.e. implementation of national plans of action). It is also important to note those exceptions or additions to international consensus documents that States may have made.
- ☞ In terms of **policy coherence**, findings on these consensus documents can be **compared with analysis table 1 findings**. Users can **map ratification of treaties such as ICESCR, CRC, CEDAW, ICCPR, etc.** to responses here. Note that "top down" coherence may not be apparent. For example, a country may have a national plan of action to implement the Beijing Platform for Action without ratification of CEDAW or ICCPR, despite the Platform's attention to violence against women, gender-based discrimination, women's political rights and participation. Such a finding could, for example, enable a dialogue towards ratification of CEDAW given the country's commitment to similar principles.



GENERAL CONCLUSIONS: INTERNATIONAL CONSENSUS DOCUMENTS

- The State has expressed its commitments to the principles and objectives of the following consensus documents (note exceptions and additions):
 - > This is concordant/discordant with international human rights commitments and obligations revealed in analysis table 1 (provide details as necessary):

- The following examples of State monitoring efforts were identified (note any inputs by the MoH and/or other health stakeholders):

- The following gaps and entry points are noted:

1.3 Universal periodic review

Analysis table 3 analyses commitments on the right to health and gender equality in the UPR mechanism of the HRC.



BACKGROUND INFORMATION

The UPR is a review of the human rights records of all 192 Member States once every four years. The UPR is a state-driven process, under the auspices of the HRC, which provides the opportunity for each State to declare what actions they have taken to improve the human rights situations in their countries and to fulfil their human rights obligations. As one of the main features of the Council, the UPR is designed to ensure equal treatment for every country when their human rights situation is assessed.

The HRC, based in Geneva, consists of 47 Member States of the UN. The UN GA has mandated the HRC to undertake a "universal periodic review" of the fulfilment by each State of its human rights obligations and commitments. This review started in 2008 and, in a period of 5 years, all States will be reviewed.

The UPR is intended to assess the extent to which States respect their human rights commitments as set out in various human rights instruments. However, the State may decide to give more or less space to the right to health and gender equality in the report, which they are expected to prepare for the HRC. Also OHCHR prepares a compilation of UN information as well as a summary of stakeholders information, including information from CSOs, that has been submitted to OHCHR. The review is conducted in one working group, chaired by the President of the Council and composed of the 47 member States of the Council. An outcome report with recommendations is adopted by the Council.

States themselves are responsible for the implementation of UPR recommendations, and upon their second review, are expected to explain progress made and remaining gaps. In the event of a non-complying country, the Council will decide whether or not further measures need to be taken.

OBSERVATIONS AND RECOMMENDATIONS TO PANAMA FROM THE UPR, HRC IN 2010

As an outcome of the UPR, some positive developments were noted, such as the provision of free antiretroviral treatment covering over 70 per cent of people affected by HIV/AIDS, and the elimination of HIV exams as a requirement for entry or residency in the country.

However, the uneven distribution of wealth was highlighted as a pressing problem - large numbers of people, particularly indigenous communities, still live in poverty, with poor education and health facilities as well as limited access to drinking water and sanitation, particularly in remote areas.

The recommendations included concrete actions to address the situation of vulnerable populations, in particular children, indigenous peoples, people of African descent, prisoners and people living in rural areas. These included reform of the health systems, in particular with regard to primary health to ensure access to basic services related to health and food. Finally, it was recommended that Panama sign and ratify the Optional Protocol to the ICESCR.

(A/HRC/16/6)

<http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G11/100/34/PDF/G1110034.pdf?OpenElement>

Analysis table 3: Universal Periodic Review

When has the State gone through the UPR?	Did the MoH provide inputs to the drafting of the UPR national report? What health information is reflected in the compilation report of UN information and the stakeholder report?	Did the HRC provide any recommendations relating to the right to health and /or gender equality?	Is the State taking action to follow up on the conclusions and/or recommendations of the HRC? How?




WHERE TO FIND THE INFORMATION

- The schedule for the UPR is available on the OHCHR web site: www.ohchr.org/EN/HRBodies/UPR/Pages/UPRMain.aspx
- The UPR reports are available on the OHCHR web site: www.ohchr.org/EN/HRBODIES/UPR/Pages/Documentation.aspx. The reports include information on which ministry/ entity has been responsible for preparing the report.
- Recommendations of the HRC are available on the OHCHR web site: www.ohchr.org/EN/HRBodies/UPR/Pages/Documentation.aspx
- Information on the process linked to the preparation of reports and follow-up to the recommendations may be found by contacting relevant authorities, including the ministry of foreign affairs, ministry of justice, NHRIs or the UNCT. While it may be the case that a ministry/government entity is responsible for coordinating the report, other government or CSO stakeholders may be invited to provide inputs, through, for example, participation in committees, stakeholder meetings or written submissions.



ANALYSIS TIPS AND NOTES FOR DRAWING GENERAL CONCLUSIONS: UNIVERSAL PERIODIC REVIEW

 **Coherence** can be explored by comparing whether actions to address conclusions and/or recommendations of the HRC reflect follow-up action on treaty body recommendations (analysis table 1).



GENERAL CONCLUSIONS: UNIVERSAL PERIODIC REVIEW

- The following issues relating to health and gender equality were raised in the national UPR report:
- The HRC provided the following recommendations related to health and gender equality:
- The following examples of State actions follow up on the recommendations of the HRC:
- The following gaps and entry points were identified:
- Coherence between the UPR process and reporting and follow-up on recommendations on international (and regional) human rights treaties are noted in the following ways:

1.4 Special procedures

Analysis table 4 analyses special procedures relevant to the right to health and/or gender equality during country missions.



BACKGROUND INFORMATION

UN special procedures are mechanisms established by the HRC (or its predecessor, Commission on Human Rights) to address either specific country situations or thematic issues. Special procedures are either an individual (called Special Rapporteur, Special Representative of the Secretary-General or Independent Expert) or a working group usually composed of five members (one from each region). Currently, there are 29 thematic and 9 country mandates supported by OHCHR.

Special procedures carry out country visits as part of their mandate, and following the country mission they submit a report, which includes recommendations. Several special procedures may raise issues relevant to the right to health and/or gender equality. The SR on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health ("right to health") and the SR on violence against women and its causes and consequences are particularly relevant. Others may include the SR on toxic waste, extreme poverty, indigenous peoples and migrants.

Regional special procedures may also play an important role in advancing the right to health and gender equality. For those regions where special procedures are in place, users are encouraged to include these when relevant.

RECOMMENDATIONS BY THE SPECIAL RAPporteur ON THE RIGHT TO HEALTH FOLLOWING COUNTRY MISSIONS:

Mission to Romania, para 80, E/CN.4/2005/51/Add.4

The Special Rapporteur recommends that the Government extend the participation of Roma, including Roma women and children, in the development, implementation and monitoring of health policies and programmes affecting them. He encourages the Government to extend the Roma community health mediator scheme, and to develop schemes to encourage Roma to train and qualify as health professionals.

http://ap.ohchr.org/documents/alldocs.aspx?doc_id=10720

Mission to Peru, E/CN.4/2005/51/Add.3

The decrease in budgetary allocations to the health sector, in particular in light of Peru's continuing poor health indicators, is inconsistent with the State's international right to health obligations. The Special Rapporteur strongly recommends that this decline in expenditure be reversed and that greater financial resources allocated to the health sector, in line with the commitment made in the *Acuerdo Nacional*, as well as Peru's international human rights obligations, and that these resources be utilized on the basis of the pro-poor equity-based health policy signalled in the preceding paragraphs.

<http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G05/106/45/PDF/G0510645.pdf?OpenElement>

Analysis table 4: Country visits of special procedures

Title/Mandate of Special Procedure	Did the special procedure make any health and/or gender equality related recommendations in his/her mission report?	Have the health-related recommendations of the report been disseminated to the MoH and/or other health stakeholders?	Is the State taking action to follow up on the recommendations by the special procedure? How?
SR on the right to health			
SR on violence against women			
Other relevant special procedure			



WHERE TO FIND THE INFORMATION

- For a list of all special procedures and reports on thematic issues, please refer to the web site of OHCHR: <http://www2.ohchr.org/english/bodies/chr/special/>.
- For information on whether any special procedures have provided health-related recommendations to the Government, please refer to the OHCHR database (<http://www.universalhumanrightsindex.org>). On this site, you will find the following search annotations:
 - > "*Countries*": select the name of your country.
 - > "*Rights*": select the "right to health" and "elimination of discrimination against women", or any other relevant search annotations, such as for example, "non-discrimination", "right to social security" or "indigenous people".
 - > "*Bodies*": select the relevant special procedure, for example "SR health" or "SR violence against women".
- Information on the process linked to dissemination of the mission report and follow-up to the recommendations may be found by contacting relevant authorities, including the ministry of foreign affairs, ministry of justice, NHRIs or the UNCT.



ANALYSIS TIPS AND NOTES FOR DRAWING GENERAL CONCLUSIONS: COUNTRY VISITS OF SPECIAL PROCEDURES

- ☞ Since country missions usually focus on a specific topic, the recommendations by the special procedure are likely to be targeted and not as broad in scope as treaty body recommendations. In other words, there may be a different focus from treaty body recommendations.
- ☞ **Coherence** can be explored by comparing whether actions to address conclusions and/or recommendations of the special procedures reflect follow-up action on treaty body recommendations (analysis table 1).



GENERAL CONCLUSIONS: COUNTRY VISITS OF SPECIAL PROCEDURES

- The following country-specific recommendations related to health and/or gender equality have been made by special procedures:
- The following examples were identified of how health-related recommendations have been disseminated to the MoH and/or other health stakeholders:
- The following actions have been taken on these recommendations:

C

ANALYSIS TABLES

Assessment level 2: Legal, policy and institutional framework for human rights and gender equality

Assessment level 2 focuses on human rights and gender equality in national legal, policy and institutional framework. Assessment level 2 includes analysis tables addressing elements of the constitution and other legislation; national development plans (poverty reduction strategies), including the budget framework; and relevant institutions.

2.1 The constitution

Analysis table 5 includes guiding questions in relation to the national constitution.



BACKGROUND INFORMATION

Most States have a written national constitution which sets out the rules for how society shall be governed. This also sets up the framework from which all sectoral policies are developed. Civil, cultural, economic, social and political rights are often enshrined in constitutions. Most constitutions provide specific entitlements in relation to the right to health and the right to equality.

EXAMPLE FROM A CONSTITUTION: SOUTH AFRICA

Elements of the right to health in the Constitution of South Africa (1996):

Chapter II, Section 27: Health care, food, water and social security:

- "(1) Everyone has the right to have access to
 - a. health-care services, including reproductive health care;
 - b. sufficient food and water; [...]
- (2) The State must take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of each of these rights.
- (3) No one may be refused emergency medical treatment."

Analysis table 5: The constitution

Analysis questions	Findings	Rationale	Selected relevant documents
1. Is the right to health included and if so, is it included as a fundamental right and/or as a State obligation?		The inclusion of the right to health as a fundamental right generates concrete legal obligations. Lesser provisions, such as directive principles, only express a general intention. Provisions that are included in the preamble express a general intention. The operational articles, however, carry more legal weight.	ICESCR, Art. 12; Report of the Special Rapporteur on 'the right to health' (A/63/263), para. 47; Beijing Platform for Action, para. 232(b); ICPD Chap. 8, 13; ICPD principle 8
2. How detailed are the explicit entitlements to the right to health? Are the following elements included?			
a. Child health		These are important elements of the right to health. Constitutional provisions ensuring their existence illustrate broad State commitment to the health of its inhabitants. They also provide clear legislative intent regarding the scope of constitutional rights which facilitates implementation and enforcement.	ICESCR, Art. 12a; CRC, Art. 24; CESCR General Comment 14, para. 14; Beijing Platform for Action, para. 106(e); MDG 5; ICPD Chap. 7
b. Sexual and reproductive health, including maternal health			CEDAW, Art. 12; CESCR General Comment 14
c. Healthy workplace environments			ICESCR, Art. 12b; CESCR General Comment 14, para. 15; Beijing Platform for Action, para. 106(p); ICPD Chap. 8
d. Underlying determinants of health, such as the right to education, housing, water, etc.			CESCR General Comment 14
e. Prevention, treatment and control of diseases			ICESCR, Art. 12c; CESCR General Comment 14, para. 16; Beijing Platform for Action, paras. 106, 107; ICPD Chap. 8
f. Health facilities, goods and services, including provision of essential medicines			ICESCR, Art 12d; CESCR General Comment 14, para. 17; Beijing Platform for Action, paras. 106, 107; ICPD Chap. 8

Analysis questions	Findings	Rationale	Selected relevant documents
3. Are provisions for the right to equality and freedom from discrimination included? On which grounds is discrimination prohibited (including for example grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health)?		Non-discrimination is both a right and a principle. As a right, States have an obligation of non-discrimination, both "de jure" and "de facto". The principle of non-discrimination is fundamental to promoting human rights, gender equality and health equity.	CESCR General Comments 16, 20; CESCR General Comment 14, paras. 18, 19; HRC General Comments 18, 28; Beijing Platform for Action, paras. 92–105; MDG 3; ICPD Chap. 4
4. Are provisions for the right to participation included?		Participation is both a right and a principle. As a right, every individual has the right to participate in public affairs. Participation should be free, active and meaningful. Participation is also a critical principle for empowering women and men from different groups to be included in the social, political and economic organization of communities and States. Equal and meaningful participation of women and men is a means of ensuring that State policies and processes reflect the actual needs and realities of women and men. Participation also serves as an accountability mechanism.	CESCR General Comment 14, para. 17, 54; CESCR General Comment 16; CEDAW General Recommendation 23; HRC General Comment 25; ICPD Chap. 4; ICPD 12.19; Declaration on the Right to Development Art.2
5. Are provisions on freedom of association included?		Freedom of association includes the right to form and join trade unions. Trade unions and interest groups provide people with leverage when negotiating with larger and more powerful institutions.	ICCPR, Art. 22; HRC General Comment 25, para. 8; Beijing Platform for Action, para. 166(I); ICPD Chap. 4

Issues for follow up via either interview, additional document review or otherwise



WHERE TO FIND THE INFORMATION

- University of Richmond database of constitutions and other related documents: <http://confinder.richmond.edu>.
- The WHO Health and Human Rights Law Database (draft) on national constitutions (upcoming): <http://who.int/hhr>
- For those with limited internet access, consult colleagues working in the ministry of justice for access to hard copies of the constitution.



ANALYSIS TIPS AND NOTES FOR DRAWING GENERAL CONCLUSIONS: THE CONSTITUTION

- ☞ **Summarize Questions 1–2** to outline references to the right to health in the constitution.
- ☞ **Summarize Questions 3–5** to describe how selected human rights principles and standards are reflected in the constitution.
- ☞ Remember that if the constitution does not make reference to the right to health or gender equality, it does **not** mean that other national legal and policy documents also fail to make reference to them.
- ☞ Some constitutions may pre-date international human rights instruments and therefore users may find limited **coherence** with analysis table 1 if exact phrases are sought. **The constitution should, however, ideally reflect in some way international obligations and commitments to gender equality and human rights.** Note that even if States have not ratified all relevant human rights treaties or signed international consensus documents (analysis table 2), the constitution may still incorporate human rights and gender equality provisions.

2.2 Legislation

Analysis table 6 supports an analysis of a national public health law and/or other specific legislation relating to gender equality and health.



BACKGROUND INFORMATION

National public health laws generally set out the powers needed for governments to deliver essential public health functions. These functions include (among others) surveillance, screening, notification; and laws relating to sanitation, safe water, food safety and the safety of consumer products. Specific legislation may exist to address specific public health issues such as tobacco use or to regulate the private sector to overcome inconsistency with public health goals or to ensure that human rights are protected.

Gender-based discrimination may be upheld in legislation and can serve to restrict women's ability (and marginalized groups of men) to claim rights to education, inheritance and voting – all of which are also underlying determinants of health. In order to determine to what extent legislation may or may not do so, it is necessary to examine how such restrictions differentially affect the health of women and men.

Analysis table 6: Legislation

Analysis questions	Findings	Rationale	Selected relevant document
1. Is there a public health law or other relevant legislation that incorporates/addresses the following elements:		A public health law or other legislation can set out concrete governmental obligations to ensure universal access to health-related services and resources. Such legislation may also include the creation of a department charged with disseminating resources and services, as well as establishing a budget.	CESCR General Comment 14, paras. 12, 34–37; Beijing Platform for Action, paras. 89–111; ICPD Chap. 8
a. The right to health articulated as AAAQ of both health care and the underlying determinants of health			CESCR General Comment 14

Analysis questions	Findings	Rationale	Selected relevant document
b. Identification or reference to judicial and administrative mechanisms of redress to deal with violations of the right to health?		Judicial and administrative mechanisms, such as courts, impact assessments and audits, respectively, ensure that violations are properly redressed. They also help to ensure that violations are not repeated, and that the health-care system operates effectively.	CESCR General Comment 9; Beijing Platform for Action, paras. 89–111
c. The right to participation?		Public participation within the health sector generates transparency and accountability as well as ensures that the health sector is responsive to public needs. According to the Declaration on the Right to Development, all individuals have the right to active, free and meaningful participation in development.	ICCPR Art. 25; Declaration on the Right to Development Art.2; HRC General Comment 25, para. 8; HRC General Comment 28; CESCR General Comment 16; CEDAW General Recommendations 23, 24; Beijing Platform for Action, paras. 181–195; ICPD 4.4; ICPD 12.19
d. The right to equality and freedom from discrimination?		The law should either include an explicit reference to equality and non-discrimination, or be based on self-standing and over-arching national legislation which sets this out.	ICESCR Art. 2; CEDAW Art. 1–5; ICCPR Art. 26; HRC General Comments 18, 28; CESCR General Comment 16 and 20; CEDAW General Recommendations 23, 24; Beijing Platform for Action, paras. 92–105; MDG 3

Analysis questions	Findings	Rationale	Selected relevant document
2. Is there legislation which specifies the following:			
a. Minimum age for marriage?		Legislation should specify a minimum age for marriage and make the registration of marriages in an official registry compulsory. Marriage should only be entered into with the free and full consent of both parties. The minimum age for marriage should be equal for men and women and protect against child marriage, especially among young girls. The lack of legislation stipulating a minimum age of marriage is widely recognized as linked to the health of young girls, e.g. early and multiple pregnancies, premature sexual debut and an increased exposure to sexually transmitted infections for young girls.	CEDAW Art. 16; ICCPR Art. 23; CRC Art. 24(3); CEDAW General Recommendation 21; CESCR General Comment 16, para. 27; Beijing Platform for Action, para. 268; ICPD 4.21
b. Minimum age of consent for sexual intercourse?		While there are no international laws or guidelines on the age of consent, children and adolescents have the right to be protected from all forms of sexual abuse and exploitation.	CRC Art. 24(3), 36
c. Prevention of GBV (including marital rape)?		GBV includes acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty. Gender-based (including interpersonal, domestic and sexual) violence is associated with a range of physical and psychological health consequences, such as injuries, sexually transmitted infections including HIV/AIDS, unwanted pregnancy, depression and a range of other mental health disorders. Laws against sexual and GBV should give full protection to all women, and respect their integrity and dignity. Appropriate protective and support services should be provided for victims.	CEDAW General Recommendation 19; Beijing Platform for Action, Violence against Women chapter; ICPD Chap. 4

Analysis questions	Findings	Rationale	Selected relevant document
d. Equal rights for men and women to own and inherit property?		The right to own and inherit land has long been an essential means of investing in the economic welfare of the family. Gender-based discrimination regarding land ownership often works against women, keeping them at a constant economic disadvantage. Poverty is widely recognized as a predictor of ill health, and when compounded by gender inequality the effects can be worse.	CEDAW General Recommendation 21, para. 25-35; HRC General Comments 18, 28; Beijing Platform for Action, para. 165(e); MDG 3; ICPD 4.6
e. Equality between women and men in access to employment and working conditions?		Both women and men have a right to work, to safe, just and favourable conditions of work and to protection against unemployment. Legislation must uphold equality in relation to employment.	ICESCR Art. 6 and 7; CEDAW, Art. 11, CEDAW General Recommendation 19, paras. 17, 18; CESCR General Comment 16, paras. 21, 25; CESCR General Comment 14, para. 15; HRC General Comments 18, 28; UDHR, Art. 23; Beijing Platform for Action, paras. 158, 165(b), 178(b); MDG 3; ICPD Chap. 4
f. Equal right of girls and boys to free, primary education?		Primary education should be compulsory and available free to all. Many girls, however, are denied their right to education, which has been demonstrated to have significant impact on fertility rates, birth spacing, health literacy and health seeking behaviours.	ICESCR Art. 13; CRC Art. 28; CEDAW Art. 10, 14(2)d; HRC General Comments 18, 28; CESCR General Comment 13, paras. 5, 24, 55; CEDAW General Recommendation 19, para. 15; Beijing Platform for Action, paras. 27, 69–88; MDG 2; MDG 3 Target 3.1
Issues for follow up via either interview, additional document review or otherwise			



WHERE TO FIND THE INFORMATION

- NATLEX is an ILO database of national labour, social security and related human rights legislation. Refer to the web site for information on relevant legislation. Click on the country of interest and then click on "Basic laws" (http://www.ilo.org/dyn/natlex/country_profiles.byCountry?p_lang=en).
- The IDHL includes national health legislation, searchable by country and health topic: <http://apps.who.int/idhl-rils/index.cfm>
- The GLIN is a public database of official texts of laws, regulations, judicial decisions, and other complementary legal sources contributed by governmental agencies and international organizations (<http://www.glin.gov/search.action>).
- The ministry of justice or the ministry of women's affairs (or equivalent) may be consulted for information on relevant legislation.



ANALYSIS TIPS AND NOTES FOR DRAWING GENERAL CONCLUSIONS: LEGISLATION

- ☞ **Summarize Question 1** for ways that the public health law or other legislation addresses the right to health and gender equality.
- ☞ **Summarize Question 2** for an idea of how legislation deals with important markers of gender equality that, if unaddressed, can lead to negative impacts on the health of women and girls.
- ☞ National legal documents often include provisions on the right to health and gender equality that are absent from the State constitution. Compare findings here with analysis table 5 to explore issues of coherence.
- ☞ Provisions in public health laws should be in accordance with international human rights law. This means that provisions should oblige governments and other duty-bearers to respect, protect and fulfil the right to health. Users should confirm **such instances of coherence with respect to the reviewed legislation in analysis table 6**.
- ☞ Note that in many countries, gender-based discrimination is not just the result of gender bias in statutory law; it is also the consequence of discriminatory customary laws, traditions, social norms and attitudes. This means that **legislation may reinforce existing inequalities, harmful beliefs or practices about women and men**. For example, some countries have legislation that stipulates rape as a crime within the context of marital relations, while other rape laws are not explicit that forced sexual relations are criminal regardless of the relationship between the parties involved. Such legislation may be based on social norms and attitudes around heterosexual marriage where, in some contexts, male authority in all matters is accepted without question. Users can compare ways that women and men are treated and/or represented in national documents such as the constitution (analysis table 5) and legislation (analysis table 6) to engage in broader dialogue on ways that gender norms or inequalities are upheld in national legislation and policies – so as to reduce the harm that may result.

👉 **Identify potential areas for collaboration with other sectors** related to determinants of health (law and justice in particular). While legislative reform may not be the objective of the exercise, identifying entry points to raise health issues with other sectors is important. Note potential areas for comparison with assessment level 3 on ways that issues, such as non-discrimination, are addressed within health sector documents. Users may choose to contextualize some of these findings with other local data or experiences as a means of contributing to multi-sectoral dialogue and broader awareness-raising on gender equality and the right to health. For example, if there is no minimum age of marriage established in national legislation, users may identify local information on early (or child) marriage and its health consequences as a means to advocate for such legislative change, protective health policies in line with CRC obligations, or stronger evidence on the health risks that early marriage poses for girls and boys.



GENERAL CONCLUSIONS: LEGISLATION

- The public health law or other legislation (which) supports the realization of the right to health in the following ways:

- The legislation promotes gender equality in the following ways:

- The following gaps were identified:

2.3 National development plans (and/or poverty reduction strategies)

Analysis table 7 supports an analysis of the national development plan (and/or PRS), including the national budget and expenditure framework.



BACKGROUND INFORMATION

A "national development plan" or "poverty reduction strategy" provides a cross-sectoral development framework². The government develops and implements a national development plan in collaboration with development partners and civil society. In some countries, PRS papers have provided the basis for development assistance and are increasingly seen as the national operational framework for development activities. A national development plan or PRS influences and guides sector-specific strategies, while various sectors including health, contribute to the development of the PRS.

The transition of health systems to reach universal access to quality health care requires a sustainable financial resource base. National ownership of health development policies and processes and effective use of maximum available resources are essential. Implementation of fair and sustainable health financing reforms, strategies and action plans should be based on the principles of accountability, transparency, non-discrimination and stakeholder participation.

NATIONAL STRATEGIC DEVELOPMENT PLAN, CAMBODIA 2006–2010

3.03 The leaders of the world meeting at the United Nations in 2000 agreed upon a Millennium Declaration. The Declaration is a commitment to human rights, democracy, peace and security and good governance, to create and sustain an enabling environment to achieve poverty reduction. Cambodia fully endorsed the Declaration and signed it because it is fully consistent with the long-term commitment of the Government to improve living standards and reduce poverty, as also with the spirit of SEDP [Socio-Economic Development Plan] I & II (para 3.03, p.27).

4.98 Very critical to poverty reduction are speedy removal of latent and overt barriers inherent in gender disparities such as unequal access to education, paid employment, land ownership, their [women's] reproductive health care, vulnerability to HIV/AIDS and trafficking, and the generally disadvantaged position in both family and society while at the same time bearing a heavy share in raising a family (para 4.98, p. 64).

[http://siteresources.worldbank.org/INTPRS1/Resources/Cambodia_PRSP\(Dec22-2005\).pdf](http://siteresources.worldbank.org/INTPRS1/Resources/Cambodia_PRSP(Dec22-2005).pdf)

Analysis table 7: National development plans (and/or poverty reduction strategies)

Analysis questions	Findings	Rationale	Selected relevant documents
1. Is participation in the design and implementation of the plan, particularly of the poorest and most marginalized population groups, recognized as a right? If so, is a mechanism or structure mentioned that will ensure this?		The right to active, free and meaningful participation requires mechanisms and access to information, as well as clarity and transparency about decision-making processes.	ICCPR Art.25; Declaration on the Right to Development Art.2; CEDAW General Recommendation 23; HRC General Comment 25, para. 8; CESCR General Comment 20; CESCR General Comment 14, paras. 11, 12, 54; Report of Special Rapporteur on the Right to Health (A/60/348), para. 74; Beijing Platform for Action, paras. 181–195; ICPD 12.19
2. Is the right to health explicitly recognized as a national priority/goal?		Recognition of the right to health is an important step towards ensuring that implementation of the national development plan and related sectoral strategies effectively contribute to its realization.	Report of Special Rapporteur on the Right to Health (A/62/214); Beijing Platform for Action, paras. 10, 210; ICPD Chap. 8, 13; Outcome document of the HLPD on the MDGs paras. 73 and 75 (a).
3. Is gender equality (including women's empowerment) explicitly recognized as a national priority/goal?		Recognition of gender equality as a national priority is important to ensure that policies and sector-specific strategies effectively address gender inequalities. Critical issues in this regard include sexual and GBV.	CEDAW General Recommendation 24, esp. para. 12; HRC General Comments 18, 28; CESCR General Comment 16; Beijing Platform for Action, paras. 10, 210; MDG 3; ICPD Chap. 4, 13
4. Does the plan support the building of capacity of rights-holders (including those living in poverty) to claim health as a human right?		It is important to build capacity towards the engagement of rights-holders in health development. Such capacity-building should ensure that rights-holders are aware of their ability to demand transparency and accountability, and that they have access to the means by which to do so.	Declaration on the Right to Development Art.2; CEDAW General Recommendation 24, para. 14; HRC General Comment 25, para. 8; Implementation of GA Resolution 60/251 (A/HRC/5/3), para. 35; Beijing Platform for Action, paras. 5, 36; p.75
5. Are underlying determinants of health addressed and cross-sectoral mechanisms mentioned?		The right to health cannot be realized without proper recognition of underlying determinants of health. Addressing them will necessarily involve working together with other relevant branches of local and national government.	CESCR General Comment No. 14, paras. 11, 12(b), 36; CESCR General Comments 8, 12, 15, 17, 18; Beijing Platform for Action, paras. 89–111; ICPD Chap. 8

Analysis questions	Findings	Rationale	Selected relevant documents
6. Is there a health section/pillar of the plan which incorporates the following:			
a. Child health?		<p>The elements listed are important elements of the right to health, and should be addressed in a national development plan.</p> <p>All children should enjoy their rights to health-care services and preventive care. Areas of attention include diminishing infant and child mortality; provision of necessary medical assistance and health care to all children with emphasis on the development of PHC; ensuring appropriate pre-natal and post-natal health care for mothers, provision of adequate nutritious foods and clean drinking-water, abolishing harmful traditional practices and ensuring access to health information.</p>	<p>ICESCR Art. 12; CRC Art. 24; CESCR General Comment No. 14, paras. 12, 14, 22-24; CRC General Comment 4; CEDAW General Recommendation 24; MDG 4; ICPD Chap. 7, 8, 15; Report of the Special Rapporteur on the right to health (A/59/422); Beijing Platform for Action, (L); Outcome document of the HLPM on the MGDs, paras. 73, 74 and 75</p>
b. Sexual and reproductive health, including maternal health?		<p>Sexual and reproductive health are important components of overall health, and in particular for women's health, throughout the life cycle. Policies and programmes should enable all women and men to make free and informed choices in regard to their sexual and reproductive health, ensure freedom from sexual violence and coercion, and the right to privacy. Areas of attention include improved access to, and the quality of, family planning, sexuality education and other sexual and reproductive health services; increase skilled attendance at birth and strengthened referral systems; reducing unsafe abortions and improving the quality of existing abortion services, and ensuring that all adolescents have access to information on how to protect their sexual and reproductive health.</p>	<p>ICESCR Art. 12; CEDAW Art. 11; CESCR General Comment No. 14, paras. 12, 14-18, 21; CRC General Comment 4; CEDAW General Recommendation 24; MDG 5; ICPD Chap. 7, 8, 15; Report of the Special Rapporteur on the right to health (A/59/422); Beijing Platform for Action, paras. 89-111; Outcome document of the HLPM on the MGDs, paras. 73, 74 and 75</p>

Analysis questions	Findings	Rationale	Selected relevant documents
c. Healthy workplace environments?		Workers represent half the world's population and contribute to economic and social development. The workplace should not be detrimental to health and wellbeing. Primary prevention of occupational health hazards should be given priority.	ICESCR Art 7 (b), 12; CEDAW Art. 11; CESCR General Comment No. 14, paras. 12, 14, 15, 16; ICPD Chap. 4, 7, 8, 15; Report of the Special Rapporteur on the right to health (A/59/422)
d. Health facilities, goods and services, including provision of essential medicines?		Health is central to poverty reduction and socioeconomic development. It is therefore important that the national development plan strengthens the health system, including facilities, goods and services.	ICESCR Art. 12; CESCR General Comment No. 14, paras. 12, 14-18; ICPD Chap. 7, 8, 15; Report of the Special Rapporteur on the right to health (A/59/422)
National budget and expenditure framework			
7. What is the total public expenditure on health as a percentage of GDP?		According to the principle of the progressive realization of the right to health in light of maximum available resources, the percentage of resources allocated to the health sector provides an indication of the commitment to realize the right to health. However, activities in related sectors also have an impact on the health of the population.	ICESCR Art. 2(1); CESCR General Comment 14, paras. 33, 36; CESCR General Comment 3, para. 7; Report of Special Rapporteur on the Right to Health (A/HRC/7/11), para. 96; Beijing Platform for Action, paras. 58(d), 346; ICPD Chap. 13
8. Utilizing the percentage or share of executed budget, what is:			
a. The trend of budget allocation to the health sector in the last 5 years?		Given the differences in available State resources, sometimes a trend is more helpful in the assessment of a country's commitment to the right to health. An upward trend in budgetary allocations towards health sector growth in real terms, which means that nominal increases in allocation have to be adjusted for inflation, shows a concrete commitment to ensuring the right to health.	ICESCR Art. 2(1); CESCR General Comment 14, paras. 33, 36; CESCR General Comment 3, para. 7; Report of Special Rapporteur on the Right to Health (A/HRC/7/11), para. 96; Beijing Platform for Action, paras. 58(d), 346; ICPD Chap. 13
b. The trend of budget allocation to sectors addressing underlying determinants of health (education, water/sanitation, etc.) in real rather than nominal terms?			

Analysis questions	Findings	Rationale	Selected relevant documents
9. Utilizing the percentage or share of executed budget, what is:			
a. The target for budget allocation to the health sector (general government expenditure on health as a percentage of total government expenditure)?		The executed budget to health and sectors addressing underlying determinants of health provides an indication of a State's commitment to use the maximum available resources for the right to health. Absolute figures per capita help determine whether there is adequate funding for health. Accountability mechanisms are equally important to ensure effective use of resources.	ICESCR Art. 2(1); CESCR General Comment 14, paras. 33, 36; CESCR General Comment 3, para. 7; Report of Special Rapporteur on the Right to Health (A/HRC/7/11), para. 96; Beijing Platform for Action, paras. 58(d), 346; ICPD Chap. 13
b. The per capita government expenditure on health (in international dollars)?			
c. The target for budget allocation to sectors addressing underlying determinants of health (education, water/sanitation, etc.)?			
d. The per capita government expenditure on sectors addressing underlying determinants of health (education, water/sanitation, etc.)?			
10. Is there a target for reducing the number of households with catastrophic expenditure?		Avoiding catastrophic expenditure is a measure of social protection. Services need to be affordable for all including disadvantaged groups. Out-of-pocket payments can cause households to incur catastrophic expenditures, which in turn can push them into poverty.	CESCR General Comment 19
Issues for follow up via either interview, additional document review or otherwise			



WHERE TO FIND THE INFORMATION

- Individual country pages provide updated expenditure information on health for 1995-2008 for 193 Member States of the WHO (2008 data are provisional estimates). This information can be found on the following web site: <http://www.who.int/nha/country/en/index.html>
- National development plans and poverty reduction strategies are normally available on the web site of the Government department charged with the task of monitoring internal affairs.
- PRS papers are available on the web site of the World Bank under "Topics" at: <http://www.worldbank.org/html/extdr/thematic.htm>
- Information on the national budget and expenditure framework may be found through contacting the focal point for health financing in the ministry of finance or in the MoH.
- WHO Database on Poverty Reduction Strategy Papers (PRSP): <http://apps.who.int/hdp/database/index.aspx>



ANALYSIS TIPS AND NOTES FOR DRAWING GENERAL CONCLUSIONS: THE NATIONAL DEVELOPMENT PLAN

- ☞ **Summarize Questions 1 and 4** for a recap of ways that human rights and gender equality are reflected in the national development plan. Make sure to pay attention to how disparities between different groups and geographical areas are measured, addressed or reported.
 - ☞ These findings can be compared to findings from **analysis tables 1–4 for exploring coherence** on State obligations and commitments to the right to health and gender equality at the international (assessment level 1) and national level (assessment level 2).
- ☞ **Summarize Questions 2–3 to establish explicit recognition of the right to health and gender equality** (or recalled commitments). This can be compared to findings from **analysis tables 1–4 and 5–6 to explore coherence** with State obligations and commitments to the right to health and gender equality at the international level (assessment level 1), constitution and national legislation (assessment level 2). Note where coherence can be detected, or where there appears to be a disconnect between or within assessment levels.
 - ☞ Pay attention to how the differential needs and life changes of women and men are reflected within the text of the plan.
 - ☞ Indicate if any specific population groups are mentioned (for example children, adolescents, older persons, persons with disabilities, persons living with HIV; ethnic minorities and indigenous peoples) in relation to health.
- ☞ **Summarize findings from Question 5–6** for a description of technical elements on health included in the plan. **Note whether the plan places health as central to national development**, and whether it aims to address the health needs of marginalized groups and devotes attention to gender differences.
- ☞ **Summarize Questions 7–9** to determine the positioning of health in the broader national development agenda. Compare with findings on MDG in **analysis table 2**; as the MDG framework clearly posits health as a central element of sustainable development, **degrees of policy coherence may be found between MDG activities and commitments** and the allocation of resources to the health sector in the national development plan.
 - ☞ Difficulties in finding information on the national budget and expenditure framework may highlight transparency issues.



GENERAL CONCLUSIONS: THE NATIONAL DEVELOPMENT PLAN

- The national development plan positions health as central to development by:
- The Government's commitment to identifying and addressing the effects of underlying determinants of health is demonstrated in the following ways:
- The Government's commitment to realize the right to health progressively is demonstrated by its budgetary allocation for health in the following ways:
- Identified gaps:

2.4 Institutional framework for human rights and gender equality

Analysis table 8 assesses existing and relevant institutions and actors to understand how countries implement obligations and commitments in practice.



BACKGROUND INFORMATION

To ensure effective and sustainable human rights protection at the national level, it is crucial to have strong institutions that operate independently and adhere to international human rights standards. Important elements of a national protection system include independent human rights institutions or ombudspersons and a strong civil society, including a free and independent media. The Paris Principles (UN GA resolution 48/134) set out principles to govern NHRIs in relation to issues such as competence and responsibilities; composition and guarantees of independence and pluralism; and methods of operation; thus constituting the main relevant reference for this section. Beyond this, however, the section below does not include a dedicated column with selected relevant documents.

Analysis table 8: Institutional framework

Analysis questions	Findings	Rationale
1. Are national mechanisms in place to support the systematic integration in sector policies and plans of:		National mechanisms are required for coordination and monitoring of progressive measures towards fulfilling obligations and commitments to human rights and gender equality. The absence of such mechanisms, while not making progress impossible, may be an indicator of lower capacity for sustainable actions.
a. Human rights?		
b. Gender mainstreaming?		
2. Does the State have an institution/body addressing human rights issues (e.g. a national human rights commission or ombudsperson)? If so, does the institution:		NHRIs are indispensable elements of national protection systems. NHRIs are generally vested with a broad mandate and global competence to protect all categories of human rights in accordance with the Paris Principles GA resolution 48/134. NHRIs are also strategic actors at the national level given their authority as public institutions and the powers they enjoy in protecting victims of human rights violations. Several NHRIs have the power to investigate; gather information and report on human rights violations; and periodically publish reports on their findings.
a. Have a mandate to address economic, social and cultural rights?		
b. Support activities aimed at integrating a HRBA in national development planning?		
c. Have a mandate to promote, monitor and raise awareness of the right to health?		

Analysis questions	Findings	Rationale
d. Have a budget on right to health activities?		
e. Produce any monitoring reports on the right to health?		
f. Produce any monitoring reports on gender equality?		
g. Have linkages with the health sector? If so, in what areas and for what activities?		
3. Does the state have an institution/body addressing gender equality and women's issues/rights? If so, does the institution:		Such an institution can facilitate gender mainstreaming across sectors. Addressing women's health requires the involvement of several government ministries and other partners.
a. Have a mandate to monitor national progress towards gender equality and women's empowerment?		A mandate acts as a constant target towards which an institution progresses. It is important that this mandate touch upon issues of gender equality and women's empowerment, so that the institution's focus is on target. This ensures that the work of the institution moves more efficiently towards gender equality goals without costly detours.
b. Have a budget on gender mainstreaming across line ministries? If so, what proportion goes to health?		Without a budget, an institution is not likely to be able to deliver. A budget is necessary to hire workers with a particular set of skills and knowledge, and to implement strategies and projects, and as such, a budget is necessary to the effective implementation of the right to health.
c. Have relations or linkages with the health sector? If so, in what areas or for what activities?		Ensuring the right to health is equally enjoyed by women and men requires that the institution works in coordination with the health sector to support gender analysis and gender mainstreaming.
4. Is there a mechanism or process in place for national oversight of implementation of international treaties, including State Party reporting?		State Parties have a central obligation to give effect to the rights incorporated in international treaties and report on their progress in doing so.
5. Does the MoH have a focal point or coordination mechanisms on:		Such mechanisms within the MoH will help ensure that human rights and gender equality are systematically integrated into the Ministry's daily processes. They will also help facilitate coordination and collaboration with human rights and gender equality institutions and other partners working on related issues.
a. Human rights?		
b. Gender?		

Analysis questions	Findings	Rationale
6. Is there a parliamentary committee on: a. Health? b. Human rights? c. Gender equality?		Parliamentary committees play an important role in discussing and taking forward specific issues, to be addressed in legislation. A parliamentary committee would ensure that health/human rights/gender equality interests are being represented throughout the national legislation process.
7. Are there any fora or mechanisms aimed at promoting intersectoral action in the areas of health, human rights or gender equality?		The right to health encompasses underlying determinants of health that often fall outside of the health sector. Intersectoral action is key to improving people's health.
8. Is the media considered an institutional partner in national efforts on human rights and gender equality?		Media can play an important informative and mobilizing role and increase knowledge among the general population on the importance of human rights and gender equality. Press conferences, media campaigns, and standing invitations for the media at events are examples of mechanisms for engagement.
9. Are there any CSOs addressing: a. Human rights in the area of health? b. Gender equality in the area of health?		CSOs are often active stakeholders and partners in health advocacy and implementation of health programmes. They can also play an important watchdog role, which is important from an accountability perspective. CSOs focusing on health may not always have an understanding of human rights and/or gender equality. Equally, CSOs focusing on human rights and/or gender equality may not necessarily give attention to the right to health. It is important CSOs strengthen their understanding and capacity on the linkages between health, human rights and gender equality.
10. Are any CSOs addressing human rights and/or gender equality represented in health sector working groups and other fora?		
Issues for follow up via either interview, additional document review or otherwise		



WHERE TO FIND THE INFORMATION

- Interviews with informants will be necessary to find the information for this analysis table. Informants may be found in the MoH (planning and health promotion units), NHRI, ministry of gender and national coordination body for CSOs.
- The National Human Rights Institutions Forum is an international forum for researchers and practitioners in the field of NHRIs. It provides key global and regional documents, documentation on the work of global and regional fora, information on and from NHRIs, bibliography and research materials, and capacity building and training resources. <http://www.nhri.net/>. Additional information on NHRIs can be found on the OHCHR webpage: <http://www.ohchr.org/EN/Countries/NHRI/Pages/NHRIMain.aspx>
- The WHO database on Health and Human Rights Actors contains information gathered from a survey of organizations related to their structures and programs. It is searchable by country (where the organization is located) or by specific health issue: <http://www.who.int/hhr/databases/en/>
- The NGO Branch, Office for ECOSOC Support and Coordination, has developed a web portal devoted to non governmental organizations, and to members of UN agencies, funds and programmes, in order to share and promote best practices in the field of economic and social development, as well for the purpose of establishing collaborative development solutions and partnerships among these groups: <http://esango.un.org/irene/index.html>



ANALYSIS TIPS AND NOTES ON DRAWING GENERAL CONCLUSIONS: INSTITUTIONAL FRAMEWORK

- **Summarize Questions 1 to 7** to describe national bodies or mechanisms in place to support progressive achievements in human rights and gender equality.
- **Summarize Questions 8 to 10** for an indication of the measures that exist for civil society involvement in national actions towards human rights and gender equality.
- Note that the existence of institutional mechanisms can be compared with findings from **analysis tables 1–4** (assessment level 1) **and 5–8** (assessment level 2) to determine the degree of **coherence with State obligations, commitments, policies and laws on human rights and gender equality**. Analysis table 9 (assessment level 3) can be seen as one way of operationalizing such obligations and commitments. The absence of functioning mechanisms may not, therefore, demonstrate a lack of coherence – but may indicate a challenge to fulfilling obligations and commitments.
- The establishment of mechanisms and institutions/bodies is likely to be an important step in advancing human rights and gender equality. However, note that just because mechanisms/institutions/bodies are in place, it does not mean that they are necessarily independent or effective in practice. Based on the findings, note any areas or entry points for improvements.
- The analysis questions do not enable a comprehensive analysis of institutional mechanisms. Follow-up questions may be added for the purpose of the review.



GENERAL CONCLUSIONS: INSTITUTIONAL FRAMEWORK

- The following mechanisms are established to promote health as a human right and gender equality:
- There is commitment to human rights and/or gender equality between the MoH, national institutions and CSOs in the following ways:
- The following examples of media engagement on human rights and gender equality issues in relation to health were identified:
- Findings from this table are coherent/not coherent with State obligations and commitments because:
- The following gaps and entry points were identified:

C

ANALYSIS TABLES

Assessment level 3: Health sector strategy

A **health sector strategy**³ under government ownership and in collaboration with various stakeholders is an important means to strengthen a health system. The health sector strategy provides an overarching guiding framework and identifies medium-term priority actions to improve health outcomes. The health sector strategy is sometimes guided by a longer-term **health policy**.

Assessment level 3 analyses the extent to which a HRBA and gender mainstreaming methods have guided the health sector strategy development, and are reflected in the document itself.

Assessment level 3 is based on the health systems components used in the framework for action developed by WHO: *Everybody's business – strengthening health systems to improve health outcomes: WHO's framework for action*⁴. This framework defines six building blocks that make up a health system, based on the functions defined in the World Health Report 2000⁴. The building blocks are:

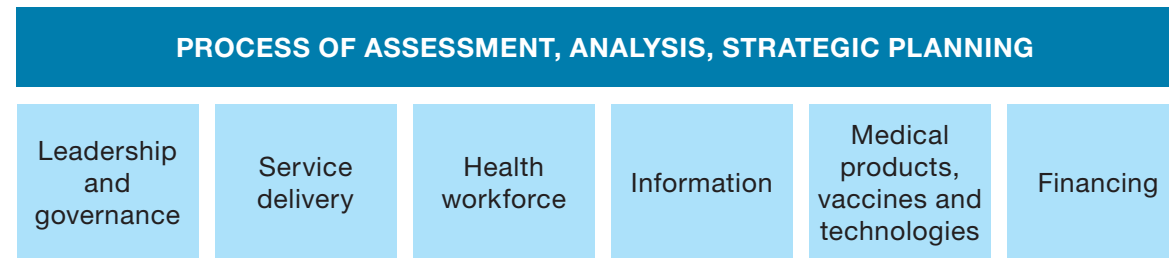
1. Leadership and governance (stewardship)
2. Service delivery
3. Health workforce
4. Information
5. Medical products, vaccines and technologies
6. Financing

The framework for action recognizes the importance of the values, principles and goals enshrined in the Alma-Ata Declaration and obligations and commitments on gender equality and human rights. Assessment level 3 provides guidance on how these obligations and commitments can be systematically assessed or addressed in relation to the building blocks.

A HRBA and gender mainstreaming require that human rights and gender equality are systematically incorporated in *all* stages of the development of the health sector strategy. This means that attention is required not only to the specific elements reflected and incorporated in the strategy itself but also to the different stages of developing, implementing and monitoring the strategy.

Analysis tables addressing the process of assessment, analysis and strategic planning, and key elements of the six building blocks are included to do this. The identification of questions has been guided by:

- States' obligations to respect, protect and fulfil human rights
- Human rights treaties and reports by special procedures
- Elements of the right to health (AAAQ), as outlined in the CESCR General Comment 14 on the right to the highest attainable standard of health
- Key human rights principles (equality and non-discrimination; participation and inclusion; and accountability and transparency)
- Core gender equality consensus documents (e.g. Beijing Platform for Action)
- Health systems expertise



Issue-specific health policies also play an important role in guiding the response to various health challenges. However, Assessment level 3 will not reach the level of detail necessary for a comprehensive review of issue-specific policies, such as policies on mental health, or sexual and reproductive health. Nevertheless, **analysis table 9** captures elements which are relevant to all policy documents and plans. **Analysis tables 10–15** may also support a partial review of certain issue-specific policies. Issue-specific policies may also provide useful background information for the review of the health sector strategy. See the adjacent text box for additional examples of issue-specific health policies.

EXAMPLES OF ISSUE-SPECIFIC HEALTH POLICIES

- Essential medicines
- Human resources
- Disabilities
- Mental health
- Sexual and reproductive health
- Child and adolescent health
- Gender-based violence
- HIV/AIDS
- Women's health
- Maternal health

3.1 The process of assessment, analysis and strategic planning

Analysis table 9 reviews whether the strategy reflects key elements of a HRBA and gender mainstreaming in relation to the *process* of assessment, analysis and strategic planning. The issues captured in analysis table 9 are relevant to the strategy as a whole, but could also be used to analyse sub-sections of the plan in relation to the building blocks.



BACKGROUND INFORMATION

The realization of human rights, including gender equality, requires attention to both process and results. A human rights-based analysis aims to identify main development and human rights issues, and helps to understand the underlying and root causes of problems, identify specific actions and bring attention to issues at a legal, policy, budget or practice level. With respect to human rights and gender equality, the following elements of the assessment, analysis and strategic planning stages should be given emphasis:

- ✓ The **assessment (including information gathering)** aims to identify the main human rights and health challenges and the most affected groups. In order to detect inequalities, the assessment needs disaggregated data. This enables the identification of groups who have least access to health care and the underlying determinants of health. It will also benefit from including reports from national and international human rights mechanisms among the sources of information. The assessment responds to the question: *What is happening, where, and who is most affected?*
- ✓ The **analysis** seeks to identify the underlying and root causes of exclusion, discrimination and inequality. Underlying causes are often the consequence of policies, laws and availability of resources. Root/structural causes reveal conditions that require long-term interventions in order to change societal attitudes and behaviour at different levels, including those at the household, community and higher decision-making levels. The analysis also seeks to identify individual and institutional duty-bearers and their corresponding obligations and clarify the skills, abilities, resources, responsibilities, authority and motivation needed by those affected to claim their rights and those obliged to fulfil rights. It also identifies risks and power dimensions. In short, the analysis responds to the questions: *Why are these problems occurring? Who has the obligation to do something about it? What capacities are needed by those affected, and those with a duty, to take action?*
- ✓ Building on the assessment and analysis, **strategic planning** should outline how to build the capacity of duty-bearers and ensure that there is a focus on empowering rights-holders. Priority needs to be given to the most excluded and marginalized groups. Strategic planning responds to the question of where and how capacity development can produce the greatest results.

Analysis table 9: Process of assessment, analysis and strategic planning

Analysis questions	Findings	Rationale	Selected relevant documents
<p>1. Were the most vulnerable and marginalized groups and communities identified and systematically involved in preparing the strategy (e.g. women and men of indigenous communities; people living with HIV; ethnic, linguistic and religious minorities; low-income groups; rural populations)?</p>		<p>Participation and the empowerment of people who are marginalized and excluded is a development objective. The process of formulating the strategy should be based on the highest possible standard of active, free and meaningful participation.</p> <p>The identification of the most vulnerable and marginalized groups is facilitated by availability of adequate and disaggregated data on health status, etc. However, when data is not available efforts should be made to identify these groups (e.g. through focus group discussions and consultations with civil society).</p>	<p>CESCR general Comment 14, para. 54; Declaration on the Right to Development Art.2; Human rights and extreme poverty, Commission on Human Rights, (E/CN.4/1999/48), para. 109; Specific Groups and Individuals: Minorities: Report of the independent expert on minority issues (E/CN.4/2006/74), para. 65; Report of the Special Rapporteur on Violence against Women, its causes and consequences: Indicators on violence against women and State response (A/HRC/7/6), para. 45; Outcome document of the HLPD on the MGDs, paras. 36 and 68</p>
<p>2. Were a range of State and non-State actors identified and engaged in developing the strategy?</p>		<p>Participation by a broad range of actors helps ensure cross-sectoral and coordinated interventions which encompass both health care and underlying determinants of health. Participation of stakeholders with human rights and gender equality expertise will facilitate attention to these issues in the strategy development. Relevant actors may include government officials at all levels of administration, representatives of other state institutions and sectors, including parliamentarians, the judiciary, NHRIs, public and private service providers, development agencies and CSOs.</p>	<p>CESCR General Comment 14; ICPD 15.6</p>

Analysis questions	Findings	Rationale	Selected relevant documents
3. Were women and men equally engaged with equal decision-making responsibilities in developing the strategy (refers to both marginalized groups and communities, and State and non-State actors)?		Women and men have an equal right to participation in decisions relating to the right to health taken at both the community and national levels. Women often lack influence in decision-making, which has adverse impacts on their health. In addition, women face particular health issues which require attention in strategy development.	CESCR General Comment 14, para. 17; CESCR General Comment 16, para 20; Beijing Platform for Action; MDG 3; ICPD Chap. 4
4. Was information made available to all stakeholders involved in the process (including on differences in access, underlying and root causes of health challenges)?		Participatory processes must be transparent, and require attention to providing information in forms that diverse groups can access.	Report of Special Rapporteur on the Right to Health (A/HRC/7/11), para. 81; (A/HRC/4/8) 7 Feb. 2007, para. 32
Assessment			
5. In preparing for the development of the strategy were the following sources of information used to inform the assessment and analysis:			
a. Observations and recommendations of international human rights mechanisms (treaty bodies, special procedures and the UPR) and information provided by other international, regional and national human rights actors (NHRIs or ombudspersons)?		Observations, recommendations and other information provided by international, regional and national human rights actors can provide guidance on steps to be taken to progressively realize the right to health and gender equality. Recommendations/observations of international and regional human rights mechanisms advise on specific legislative, judicial, administrative and other measures needed to implement the provisions of human rights treaties.	CEDAW, Art. 18; CEDAW General Recommendation 22; CESCR General Comment 3, para. 10
b. Information provided by persons from usually excluded, marginalized and discriminated groups according to sex, age, ethnicity, disability, geographical, social, political or any other conditions?		Information from excluded, marginalized and discriminated groups helps ensure that interventions are responsive to the situations of the people they are intended to benefit, and maximize ownership and sustainability.	CESCR General Comment 20; CESCR General Comment 14, para. 54

Analysis questions	Findings	Rationale	Selected relevant documents
c. Quantitative and qualitative sources of information that allow for the identification of vulnerable groups?		<p>The assessment aims at identifying the most disadvantaged groups. There may be great differences between national averages and the situation in certain communities or among certain groups. States are obliged to ensure equitable distribution of health facilities, goods and services.</p> <p>A combination of quantitative and qualitative sources of information help provide a comprehensive understanding of health challenges and who is affected. Data should be disaggregated to identify differences between men and women of different ages, groups and regions. Qualitative data may provide information on how men and women of different groups experience their situation in relation to key health problems.</p>	CESCR General Comment 14, para. 63; Report of the independent expert on human rights and international solidarity (A/HRC/4/8) 7 Feb. 2007, para. 32; The due diligence standard as a tool for the elimination of violence against women (E/CN.4/2006/61), para. 37; Report of Special Rapporteur on the Right to Health (A/HRC/7/11), para. 94
d. Civil society and/or community based organizations?		Information obtained from civil society often complements and/or serves as an alternative to State-based data sources. Community-based organizations that gather data on excluded, marginalized and discriminated groups help to ensure that all pertinent populations are included and addressed.	CESCR General Comment 14, para. 12(b); Report of Special Rapporteur on the Right to Health (A/60/348), paras. 8-17, 80
6. Did the assessment identify the major health challenges and the most affected population groups?		The assessment should proportionately reflect the significance of various health challenges and the extent to which different groups are affected. Any resulting strategy based on the assessment must then prioritize according to the major challenges identified such that resources are used appropriately to bring about change in an optimal and efficient manner.	CESCR General Comment 14, para. 12(b); Report of Special Rapporteur on the Right to Health (A/60/348)

Analysis questions	Findings	Rationale	Selected relevant documents
Analysis			
7. Did the analysis identify:			
<p>a. Differences in physical and geographical access, affordability and quality of health services,</p> <p>Differences in access to the underlying determinants of health (water, sanitation, education, etc.), and</p> <p>Differences in opportunities and life chances for women and men of different groups?</p>		<p>Laws and policies may maintain the inherent disadvantage that particular groups experience. For example, laws and policies may perpetuate inequalities between men and women because they do not take account of existing gender norms, roles and relations, particularly those experienced by women and that lead to gender inequality. Respecting human rights obliges States to repeal laws and rescind policies, administrative measures and programmes that have a negative impact on the health and well being of women and men of different groups.</p>	<p>CESCR General Comment 16, para.18; CESCR General Comment 14, paras. 9, 20; CEDAW General Recommendation 19, para. 11; Report of Special Rapporteur on the Right to Health (A/60/348); ICPD Chap. 8</p>
<p>b. Societal attitudes and behaviour patterns (at the household, community and national/sub-national decision-making levels), including gender, cultural or linguistic barriers?</p>		<p>The obligation to protect human rights requires States to take steps to eliminate prejudice, customary and other practices that perpetuate inequalities and stereotyped roles for men and women. The State also has a responsibility to address barriers that may limit access for certain groups.</p>	<p>CESCR General Comment 20, paras. 1, 8(b); CESCR General Comment 16, para. 19; CEDAW General Recommendation 19, para. 11; Report of Special Rapporteur on the Right to Health (A/60/348); ICPD Chap. 4</p>
<p>8. Did the analysis identify State and non-State duty-bearers responsible for addressing key health challenges and their broader determinants at different national and sub-national levels?</p>		<p>It is essential to clarify obligations at different levels of the state administration in order to facilitate action and monitor results. Important categories of duty-bearers include policy-makers, managers/ coordinators, service deliverers and monitors/ inspectors.</p>	<p>CESCR General comment 14, para. 30-45 for State Duty-Bearers and from 63-65 for non State Duty-Bearers</p>

Analysis questions	Findings	Rationale	Selected relevant documents
9. Did the analysis identify capacity gaps of:			
a. Duty-bearers to fulfil their roles and responsibilities?		<p>Capacity is an essential prerequisite for duty-bearers to fulfil their obligations and for rights-holders to claim their rights.</p> <p>A human rights-based analysis aims to identify the skills, abilities, resources, responsibilities, authority and motivation needed by those who are obliged to address key health challenges. The analysis is also aimed at identifying the capacity of claiming rights, including the ability to access information, organize and participate, advocate for policy change and obtain redress.</p>	CESCR General comment 14, para. 30-45 for State Duty-Bearers and from 63-65 for non State Duty-Bearers
b. Rights holders to claim their rights (in particular, of excluded and discriminated groups)?			CESCR general Comment 14, para. 12
Strategic planning			
10. Does the strategy promote institutional and behavioural changes needed to deliver basic quality health services without discrimination?		In order to ensure the strategy is successfully implemented and supports the progressive realization of the right to health, the response should aim to increase the level of respect, protection and fulfilment of the right to health by duty-bearers.	CESCR General Comment 14

Analysis questions	Findings	Rationale	Selected relevant documents
11. Does the strategy seek to empower the most affected rights-holders (women and men) to claim and exercise their rights?		Human rights are fundamentally concerned with empowerment and the ability to participate, influence and hold institutions accountable. Strategies which give attention to entitlements and awareness of rights, ability to access information, organize and participate, and to advocate for policy change and obtain redress, support ownership and sustainable change.	CESRC General Comment 14; CEDAW General Recommendation 24, para. 14; Implementation of GA Resolution 60/251 (A/HRC/5/3), para. 35; ICPD Chap. 4, 13; Beijing Platform for Action
12. Is priority given in the plan to the most excluded and discriminated groups?		A HRBA requires that the strategic response does not only target those that are easy to reach. All human beings are entitled to enjoy their human rights equally without discrimination. While it may not be possible to reach everybody at once, priority must be given to the most marginalized.	CESRC General Comment 20
13. Was an impact assessment carried out <i>ex ante</i> to examine the potential impact of the strategy in realizing the right to health and/or gender equality?		<i>Ex ante</i> impact assessments aim to evaluate the potential impact of policies on human rights. It is important that they are carried out at the earliest possible stage in order to prevent interventions with a negative impact on the enjoyment of the right to health. It is also essential to carry out impact assessments to determine the impact on health and human rights of policies and strategies outside the health sector, such as economic policies and trade agreements.	CESCR General Comment 16, para. 18; Special Rapporteur on the Right of everyone to the enjoyment of the highest attainable standard of physical and mental health (A/62/214); ICPD Chap. 4, 8, 13; Beijing Platform for Action, para. 110(d)
Issues for follow up via either interview, additional document review or otherwise			



WHERE TO FIND THE INFORMATION

- For information on the process, information gathering, assessment and analysis, interviews with key informants are necessary. Key informants may be staff members of the planning and monitoring units in the MoH, the health systems focal point in the WHO country office and civil society representatives participating in health policy fora.
- The health sector strategy document is likely to provide some information on the process of developing the strategy, including information gathering, assessment and analysis. The analysis of the health situation should be outlined in the health sector strategy as the basis for prioritization. If this is not the case, clarifications can be sought from staff members in the planning unit in the MoH.
- For information on the strategic response refer to the health sector strategy document.



ANALYSIS TIPS AND NOTES ON DRAWING GENERAL CONCLUSIONS: PROCESS OF ASSESSMENT, ANALYSIS AND STRATEGIC PLANNING

- ☞ A good process to develop a strategy should include an analysis which looks at the immediate, underlying and root causes of exclusion, discrimination and inequality, role/pattern analysis and capacity-gap analysis.
- ☞ There will be a range of different findings for each of these questions. Analysis of such responses should not focus on a mere "yes" or "no" answer; rather **users should focus on strengths and weaknesses, gaps and entry points**. Note any suggested actions for improvement or issues for follow-up.
- ☞ Remember that the questions apply to the health sector strategy as a whole, but could also support the analysis of sub-sections relating to the building blocks.
- ☞ **Summarize questions 1–4** to describe ways that the strategy development was inclusive, participatory and transparent.
 - ☞ Note if specific groups were included or excluded, in what ways, and whether or not information was made available in limited or "full disclosure" manner, and to which groups in society. If, for example, information was only made available to planning units in the MoH, this may identify gaps in the process of engaging various health sector stakeholders (e.g. health professionals or researchers, those responsible for health information, etc.) – as well as those beyond the health sector. Such a gap could be used as a basis for increased sharing and collaboration in future health sector strategy planning.
- ☞ **Summarize questions 5–6** to capture sources of information and methods applied in the assessment stage, with a particular emphasis on purposeful methods to highlight potential vulnerabilities of certain population groups.

- ☞ Note how women and men are differentially, or similarly, represented when analysing the plans for attention to vulnerable groups. If there is no sex differentiation when discussing vulnerable groups, users may want to draw upon other sources of information on the ways that gender inequality can increase women's (or men's) health vulnerabilities in order to clearly identify gaps in information and methods used. If such information does not exist, users should note this absence. It should then be included as an area for further development among health stakeholders involved in generating evidence for policy use.
- ☞ **Summarize questions 7–9** to identify the types of methods used for developing the plan in the analysis stage. These questions can help to determine to what extent the plan is rooted in a holistic approach to health, attempting to identify underlying and root causes of health conditions and behaviours. Note whether gender inequality is listed as an underlying cause of ill health and in what ways. Users may want to use this as an entry point for discussing or building upon national actions to address gender inequality as a determinant of health with multiple stakeholders.
- ☞ Summarize health sector capacities to fulfil the right to health and gender equality obligations and commitments with these questions, noting areas of focus and if specific stakeholders (either rights-holders or duty-bearers) are mentioned.
- > If, for example, only rights-holders are mentioned, users may want to raise this issue in multi-sectoral discussions on ways to strengthen State (and other duty-bearer) capacities to deliver on obligations and commitments listed in analysis tables 1–4 (international commitments).
 - > Note if male and female rights-holders are mentioned in terms of capacity development. If no distinction is made, users may need to turn to other sources of information in order to determine the different types of capacities needed by different groups of men and women to enjoy the right to health and gender equality in the given context.
- ☞ **Summarize questions 10–13** to identify core elements of the strategic response from a HRBA perspective. Note where and how the response addresses issues raised in the assessment and analysis stages.
- ☞ **Coherence can be mapped by comparing findings from Assessment level 1** (analysis tables 1–4), in particular looking for obligations and commitments to ICESCR, CEDAW, Beijing and the MDG (see references for specific questions).
- ☞ **Coherence with Assessment level 2** can be explored by examining concordances/discordances with **analysis table 7**, in particular the questions on the health chapter of the national development plan. Users could further track how commitments to the right to health and gender equality (explicit or implied) in the constitution (analysis table 5) and legislation (analysis table 6) appear to be upheld in the development process of the health sector strategy.



GENERAL CONCLUSIONS: PROCESS OF ASSESSMENT, ANALYSIS AND STRATEGIC PLANNING

- Equal and informed participation of women and men of vulnerable and/or marginalized population groups, and State and non-State actors, was ensured in the following ways:
- The assessment identified marginalized groups of women and/or men through the following sources of information:
- The analysis identified the following underlying causes of health challenges and capacity gaps:
- The strategic response addresses capacity gaps, empowerment and priority to marginalized groups in the following ways:

3.2 Leadership and governance (stewardship)



BACKGROUND INFORMATION

The health systems building block on leadership and governance is about governmental roles in health as well as its relations with other sectors that impact upon health (also known as multi-sectoral relations). Leadership and governance, including stewardship functions, include several tasks, such as^{4,6}:

- design of the health system
- development, implementation and monitoring of strategic policy frameworks
- proper functioning of mechanisms such as oversight, coalition building, regulation and accountability
- definition of vision and direction of the overall health system
- adherence to governance principles such as the rule of law, effectiveness, efficiency and health equity

Reviewing whether leadership and governance is consistent with a HRBA and gender mainstreaming methods requires attention to both the strategy itself and the process surrounding the strategy in terms of how it is designed, implemented and monitored. This will include attention to:

- ✓ mechanisms for meaningful participation of male and female stakeholders in all of the above tasks, including CSOs such as patient advocacy groups, health professional associations and representative groups of marginalized populations;
- ✓ clearly defined and transparent roles and responsibilities for all actors in the health system;
- ✓ strategic legislative and policy frameworks – as well as other institutional mechanisms – based on human rights and gender equality principles to explicitly protect vulnerable groups in society;
- ✓ references to national obligations and commitments on human rights and gender equality when determining an overall vision for the health system in addition to developing laws and policies;
- ✓ health systems mechanisms (programmes, services, policies and laws) which reflect current socio-demographic trends (including changing gender norms, roles and relations); and
- ✓ oversight functions to ensure that discrimination against men or women from any social group are neither reinforced nor upheld but rather addressed through leadership and governance functions and tasks.

Analysis table 10: Leadership and governance (stewardship)

Analysis questions	Findings	Rationale	Selected relevant documents
1. Is the right to health and/or human rights explicitly reflected as a national priority and/or goal in the strategy?		Human rights are a first priority of States and health strategies should advance the realization of the right to health. Effective implementation of human rights – including the right to health – requires consistent attention to human rights in legislation, policies, strategies and plans.	Vienna Declaration and Programme of Action (A/CONF.157/23), para 1; Report of Special Rapporteur on the Right to Health (A/62/214); Outcome document of the HLP on the MDGs, paras. 73-76; ICPD Chap. 13
2. Is achieving gender equality (including women's empowerment) a national priority and/or goal in the strategy?		Men and women should enjoy the right to health on an equal basis. However, women are often disadvantaged.	CESCR General Comments 16; CEDAW General Recommendation 24, esp. para. 12; ICPD Chap. 4; MDG 3; Beijing Platform for Action; Outcome document of the HLP on the MDGs, para. 72
3. Are legislative measures identified to achieve the right to health and gender equality?		Legal protections for women and men of different social groups are necessary to ensure the right to health and to promote gender equality.	CEDAW General Recommendation 24, para. 15; ICPD Chap. 4, 8; MDG 3; Beijing Platform for Action, paras. 89–111, 196–209, 286–344
4. Is there mention of any inter-sectoral mechanism in place?		The right to health encompasses underlying determinants of health. As many of the determinants of health are under the responsibility of other sectors (such as education, justice, employment, transport, water, sanitation, etc.), the MoH must engage with these sectors to promote health as a central element of social and economic development, as well as to ensure that each sector contributes to overall health goals. Similarly, other sectors should be aware that the right to health means that health is an obligation of the government as a whole.	Report of Special Rapporteur on the Right to Health (A/62/214), para. 22; ICPD Chap. 13, 15; Beijing Platform for Action, paras. 89–111, 196–209, 286–344
a. Is coordination, and effective use, of health-related data across sectors recognized?			

Analysis questions	Findings	Rationale	Selected relevant documents
5. Is the oversight role of the government recognized in relation to:			
a. Licensing of health professionals in public and private sectors?		Good policy making requires transparency in the decision-making process. By holding several branches of the health sector accountable for their actions and decisions, government oversight of the health sector results in greater efficiency and effectiveness as well as enhanced human rights protections.	CESCR General Comment 14, paras. 36, 44; Report of Special Rapporteur on the Right to Health (A/60/348), paras. 14, 53, 68, 80; Report of the independent expert on the effects of economic reform policies and foreign debt on the full enjoyment of all human rights particularly economic, social and cultural rights (A/HRC/7/9), para. 11; ICPD Chap. 13, 15; Beijing Platform for Action, paras. 89–111, 196–209, 286–344
b. Licensing/accreditation of service provision?			
c. Ensuring protection of human rights in the provision of health services (informed consent, privacy, etc.)?			CESCR General Comment 14, paras. 44; Report of Special Rapporteur on the Right to Health (A/64/272); Report of the independent expert on the effects of economic reform policies and foreign debt on the full enjoyment of all human rights particularly economic, social and cultural rights (A/HRC/7/9); ICPD Chap. 7, 13, 15; Beijing Platform for Action, paras. 89–111, 196–209, 286–344
d. Regulating the supply and distribution of essential medicines?			CESCR General Comment 14, paras. 43, 52; Report of Special Rapporteur on the Right to Health (A/65/255); Report of the independent expert on the effects of economic reform policies and foreign debt on the full enjoyment of all human rights particularly economic, social and cultural rights (A/HRC/7/9); ICPD Chap. 7, 8, 13, 15; Beijing Platform for Action, paras. 89–111, 196–209, 286–344, UN Declaration on the Right to Development

Analysis questions	Findings	Rationale	Selected relevant documents
6. Is the responsibility of Government in regulating the private sector recognized?		States have an obligation to protect the right to health. This requires States to take measures that prevent third parties from interfering with the right to health. For example, States must ensure that privatization does not constitute a threat to the AAAQ of services.	CESCR General Comment 14, para. 33; ICPD Chap. 13, 15; Beijing Platform for Action, paras. 89–111, 196–209, 286–344
7. Is there an explicit commitment to universal access to health services at: <ul style="list-style-type: none"> • Primary level? • Secondary level? • Tertiary level? 		An explicit commitment to universal access to health services supports rights holders in holding governments accountable for ensuring access to health services for women and men of different groups.	Declaration of Alma-Ata, paras. V–VIII; CESCR General Comment 14, para. 43; ICPD Chap. 8; Beijing Platform for Action, paras. 89–111, 196–209, 286–344
8. Is decentralization addressed (or mentioned)? If so, are there mechanisms for communication, coordination, transparency and monitoring among different decision-making levels?		A decentralized system disperses governmental decision-making closer to people. This, in theory, allows greater participation and representation of local and community needs. Participation, in addition to being a human rights principle, is a critical strategy to ensure that a health system is responsive in the way that it is designed and implemented.	CESCR General Comment 14, para. 55
9. Is equal representation in senior management at different administrative levels promoted (of women and men of different ethnic/cultural, geographical or linguistic backgrounds)?		Decision-makers that are representative of the population enjoy greater legitimacy and often ensure that the rights, interests and needs of different groups are considered, thus contributing to equal and non-discriminatory services.	CEDAW General Recommendation 23, para. 45(c); CESCR General Comment 20; Beijing Platform for Action: Strategic Objective H; Beijing Platform for Action, paras. 181–195; MDG 3; ICPD Chap. 4

Analysis questions	Findings	Rationale	Selected relevant documents
10. Is there a recognition of structures, mechanisms, or guidelines that address human rights and gender equality with respect to:			
a. Research and data collection?		Such structures, mechanisms and guidelines ensure that inputs such as evidence for planning and service delivery reflect human rights and gender equality principles.	CESCR General Comment 14, paras 57-58; CESCR General Comment 16, paras. 3, 8, 11, 14; Report of the Special Rapporteur on violence against women, its causes and consequences (A/HRC/7/6), paras. 28, 45; CESCR General Comment 20, paras. 19–26; ICPD Chap. 4; MDG 3; Beijing Platform for Action, paras. 89–111, 196–209, 286–344
b. Capacity building for the health work force, including health policy makers?		Building specific expertise in gender equality and human rights – and their connection with health – ensures that policies and services are respectful of, and promote, human rights and gender equality.	CESCR General Comment 14, para. 12c; CEDAW General Recommendation 24, paras. 15(b), 31(f); ICPD Chap. 4; MDG 3; Beijing Platform for Action, paras. 89–111, 210–233
Equality and non-discrimination			
11. Are strategies outlined to address the specific health needs of vulnerable and/or marginalized groups?		Vulnerable and marginalized groups in societies bear an undue proportion of health problems. Overt or implicit discrimination violates fundamental human right principles and often lies at the root of poor health status. In practice, discrimination can manifest itself in inadequately targeted health programmes and restricted access to health services.	CESCR General Comment 20; CEDAW, General Recommendation 24, para. 26, and General Recommendation 25, para. 12
12. Are gender norms, roles and relations or gender inequality acknowledged as a barrier to good health?		While there may not appear to be formal barriers to access health services, gender norms, roles and relations may lead to inequalities that affect access to services.	Program of Action-ICPD, Chap. VII– VIII; MDG 3, 4; Beijing Platform for Action: Strategic Objective C.1(i); ICPD Chap. 4

Analysis questions	Findings	Rationale	Selected relevant documents
Participation and inclusion			
13. Is there mention of any mechanism which enables women, men, girls and boys (rights-holders) to participate in decision-making in the governance of the health system?		<p>Affected rights-holders should highlight the most vulnerable individuals, groups and communities in societies, those usually invisible, and CSOs in which most vulnerable groups express their voices (advocacy-oriented CSOs, watch-dogs, etc.).</p> <p>Typical ways of engagement include participatory research methods, public meetings, focus group discussions, representation in decision-making fora, participatory implementation and monitoring mechanisms.</p>	CESCR General Comment 14, para. 54; Report of Special Rapporteur on the Right to Health (A/60/348), para. 74; Beijing Platform for Action, paras. 89–111, 181–195
14. Is collaboration between the Government and a broad range of actors promoted (including CSOs representing specific population groups such as people with disabilities or people living with HIV)?		<p>Broad participation is vital for the implementation of the strategy. Actors may include representatives of other state institutions and sectors, including parliamentarians, the judiciary, national human rights institutions, public and private service providers, development agencies and NGOs. In order for participation to be sustainable, mechanisms that sustain collaborative frameworks are required.</p>	CESCR General Comment 10 (E/C.12/1998/25); Implementation of GA resolution 60/251 (A/HRC/5/3), para. 47; (A/HRC/4/8) 7 Feb. 2007, para. 32; Report of Special Rapporteur on the Right to Health (A/HRC/4/28), paras. 12–16; ICPD Chap. 13, 15; Beijing Platform for Action paras. 196–209, 286–344
Accountability and transparency			
15. Are monitoring mechanisms of health system performance identified?		<p>Monitoring mechanisms ensure transparency throughout the work process, which in turn ensures that different levels of the health system are held accountable for their respective performance levels.</p>	CESCR General Comment 14; CESCR General Comment 16, para. 21; Report of Special Rapporteur on the Right to Health (A/60/348), paras. 14, 53, 68, 80; ICPD Chap. 8; Beijing Platform for Action, para. 89–111
16. Does the plan include indicators (structural, process and outcome indicators), clear and measurable baselines, benchmarks and targets?		<p>Clear and measurable baselines, benchmarks and targets are essential to achieving results and ensuring the progressive realization of the right to health.</p>	Report on Indicators for Promoting and Monitoring the Implementation of Human Rights, International Human Rights Instruments (HRI/MC/2008/3); Beijing Platform for Action, paras. 89–111, 196–209, 286–344

Analysis questions	Findings	Rationale	Selected relevant documents
17. Are data in the plan adequately disaggregated to reflect different population groups?		Disaggregation of data is necessary to move beyond national averages and identify differences between specific groups. Types of disaggregation include sex, age, ethnicity, disability, rural and urban.	Report of Special Rapporteur on the Right to Health (A/HRC/7/11), para. 94; Report of the Special Rapporteur on violence against women, its causes and consequences (A/HRC/7/6), paras. 26, 28, 30, 34; Beijing Platform for Action, paras. 89–111, 196–209, 286–344
18. Are there indicators measuring the following human rights and gender equality considerations:			
a. The availability, accessibility, acceptability and quality of health services, goods and facilities?		These are elements of the right to health.	CESCR General Comment 14, para. 12; CEDAW General Recommendation 9; Report of the Special Rapporteur on violence against women, its causes and consequences (A/HRC/7/6), paras. 26, 28, 30, 34; Beijing Platform for Action
b. The existence of legal and institutional frameworks, as well as budgets, to progressively realize the right to health?		Structural indicators are important to reflect legal and policy commitments to the right to health.	CESCR General Comment 16, para. 39; CESCR General Comment 14, paras. 53, 57, 58; Report of the Special Rapporteur on violence against women, its causes and consequences (A/HRC/7/6), paras. 26, 28; Beijing Platform for Action
c. Participation, non-discrimination, accountability, transparency and gender mainstreaming (e.g., sex parity, equal participation, etc.)?		Unless these elements are included in the monitoring process, they may be neglected in practice.	CESCR General Comment 16, para. 39; Report of the Special Rapporteur on violence against women, its causes and consequences (A/HRC/7/6), paras. 26, 28; Beijing Platform for Action
19. Are reporting and mid-/end-term evaluation requirements outlined?		Reporting and evaluation requirements ensure that the relevant parties are regularly provided with accounts of performance levels. They also help address data gaps and help analysts and supervisors attain standards of performance efficiency.	Report of Special Rapporteur on the Right to Health (A/HRC/7/11), para. 96; Report of Special Rapporteur on the Right to Health (A/62/214), paras. 37, 89; Beijing Platform for Action
20. Is the dissemination of the monitoring and evaluation data and reports considered?		A broad range of actors should preferably be involved in monitoring efforts and data, and reports should be widely available and accessible.	Report of Special Rapporteur on the Right to Health (A/HRC/7/11), para. 96; Beijing Platform for Action
Issues for follow up via either interview, additional document review or otherwise			



WHERE TO FIND THE INFORMATION

- This table addresses questions of leadership and governance as reflected in the health strategy document itself. The issues raised in the analysis tables are important human rights and gender equality issues and may therefore be addressed in the strategy. However, you may need to consult additional documents and staff members of the planning or monitoring units of the MoH for clarifications on activities and processes not explicitly addressed in the strategy.
- Many health sector strategies have a section on monitoring (sometimes a separate document), including indicators. Additional sources of information may include the planning and monitoring units in the MoH.



ANALYSIS TIPS AND NOTES FOR DRAWING GENERAL CONCLUSIONS: LEADERSHIP AND GOVERNANCE

- ☞ There will be a range of different responses for each of these questions. Analysis of such responses should not focus on a mere "yes" or "no" answer; rather users should focus on ways that Ministries of Health can assume their stewardship role.
- ☞ **Use the points listed in the Background Information as an analytic framework** when summarizing the table. To do so, users may need to re-group questions from the analysis table. For example, to address the right to health and gender equality, leadership and governance issues should address *mechanisms for meaningful participation of relevant male and female stakeholders in all of the above tasks, including CSOs such as patient advocate groups, health professional associations and representative groups of marginalized populations.*

As per leadership and governance functions, users can summarize questions to draw general conclusions:

- **Questions 1–4** can be summarized to determine the vision and direction of the overall health system. Note if the right to health and gender equality are specifically mentioned – or if broader principles of social justice are used.
- **Questions 5–8** give an overview of **mechanisms such as oversight, coalition building, regulation and accountability.**
- **Questions 9–10** describe the **design of the health system** and provide some insights into the **vision and direction of the overall health system.**
 - > If possible, note where and how elements such as research and training are based on consideration of human rights and gender equality.
- **Questions 11–20** help to determine specific details about the **development and monitoring of strategic policy frameworks.**
 - > Users should note if the plan places emphasis on some leadership and governance functions over others. For example, if little can be found in the document on monitoring frameworks there may be challenges ahead in achieving the plan's objectives.

- **Coherence between assessment levels** can be explored by comparing findings here to obligations and commitments outlined in **Assessment level 1 (analysis tables 1–4)** and **analysis tables 5–8 (Assessment level 2)** to see if State obligations and commitments at international and national levels are reflected in the health sector strategy.
 - > Note where coherence can be detected and where adherence to existing State obligations and commitments could enhance the health sector strategy.
 - > The health sector strategy may reflect a commitment to the right to health and gender equality without equivalent commitments in Assessment levels 1 or 2. For example, the national development plan (analysis table 7) may be silent on gender equality but the health sector strategy may promote gender-responsive health policies. Users may want to note such discrepancies in coherence among the assessment levels – and explore the reasons and process behind this. It could be that the health sector strategy was developed in accordance with gender mainstreaming methods and therefore reflects a commitment that the national development plan does not. Such process issues are important to note and share during the dissemination of the report towards catalysing future actions towards overall policy coherence.



GENERAL CONCLUSIONS: LEADERSHIP AND GOVERNANCE

- The strategy sets out an overall commitment to human rights and gender equality in the following ways:
- Oversight, coalition building, regulation and accountability are ensured in the following ways:
 - > Attention to inter-sectoral action in responding to health challenges is expressed in the following ways:
- The overall vision and direction of the health system encompasses human rights and gender equality in the following ways:
- The development, implementation and monitoring of strategic policy frameworks are addressed in the following ways:
 - > Participation of groups of women and men and of vulnerable and/or marginalized population groups, as well as civil society, are/are not addressed:
- The following gaps and entry points were identified:

3.3 Health systems building block: service delivery



BACKGROUND INFORMATION

A key issue of concern in relation to service delivery is a commitment to ensuring universal access, paying particular attention to marginalized groups and ensuring population health needs are addressed.

Ensuring that human rights and gender equality are adequately reflected in service delivery requires: attention to the **establishment of specific entitlements** of the population through the identification of a basic package or several basic packages tailored to specific groups; **ensuring that the design of service delivery is respectful of human rights** and protects the dignity of women, men, girls and boys, and that service delivery is guided by **consideration of the differential needs and life circumstances of women and men of various groups**. With respect to service delivery, these are some of the specific human rights and gender equality aspects to consider⁷:

- ✓ Established entitlements of the population through identification of a basic package of services
- ✓ Attention to privacy and confidentiality in delivery of services
- ✓ Efforts to ensure accessibility of information to everyone
- ✓ Accessibility of services to both rural and urban populations, with particular attention to marginalized groups
- ✓ Attention to cultural diversity, gender norms, roles and relations
- ✓ Services that promote women's health from a holistic and life-course perspective
- ✓ Efforts to identify and address barriers to equitable access to services.

Analysis table 11: Service delivery

Analysis questions	Findings	Rationale	Selected relevant documents
1. Is there a basic package or packages of services identified or referred to? If so, which does it include? <i>If so, are gender norms, roles and relations that may lead to different experiences and outcomes for women and men acknowledged (to be addressed under each sub-question)?</i>			
a. Child, including infant, health?		All children should enjoy their rights to health-care services and preventive care. Areas of attention include diminishing infant and child mortality; provision of necessary medical assistance and health care to all children with emphasis on the development of PHC; ensuring appropriate prenatal and postnatal health care for mothers, provision of adequate nutritious foods and clean drinking-water, abolishing harmful traditional practices and ensuring access to health information.	ICESCR, Art. 12; CRC, Art. 24; CEDAW, Art. 12; CESCR General Comment 12; CESCR General Comment 14, paras. 14, 22–24; ICPD Chap. 7, 8; Beijing Platform for Action, paras. 89–111, 259–285
b. Adolescent health?		Adolescents are more likely to engage in risky behaviour and be exposed to sexual violence and sexual exploitation. They are vulnerable to early and/or unwanted pregnancies, STI, including HIV/AIDS. Adolescents' right to health is therefore dependent on information and education on sexual and reproductive health, and health care that respects confidentiality and privacy and includes appropriate mental, sexual and reproductive health services and information. Programmes need to ensure the best interests of the adolescent by recognizing their evolving capacity (age and stage of development). The views of the adolescent should be given due weight in accordance with his/her age and maturity.	ICESCR Art.12; CRC Art. 24; CEDAW Art. 1; CRC General Comment 9, para. 59; CESCR General Comment 14, paras. 22 –24; Beijing Platform for Action, paras. 89–111; Declaration of Alma-Ata, paras. V–VIII; Programme of Action ICPD, Ch. VII– VIII; FWCW declaration.

Analysis questions	Findings	Rationale	Selected relevant documents
<p>c. Sexual and reproductive health?</p>		<p>Sexual and reproductive health is a key aspect of women's right to health. States should enable women to have control over and decide freely and responsibly on matters related to their sexual and reproductive health free from coercion, discrimination and violence. Men and women have a right to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth. Health-related education and information, including on sexual and reproductive health, is an important element of the right to health.</p> <p>The following programme areas need attention: adolescent sexual and reproductive health and development; maternal health (pre- and postnatal care); emergency obstetric care; family planning (information, counselling and services); unwanted pregnancies; STI; HIV; abortion (therapeutic, sex-selective or other); and IEC (information, education, communication) programmes.</p>	<p>ICESCR Art. 10, para. 2, and Art. 12; CEDAW Art. 12, General Comment 24, para. 27; CESCR General Comment 14, para. 8, 12, 14, 21, and 44(a); Declaration of Commitment on HIV/AIDS; International Guidelines on HIV/AIDS and Human Rights (2006), p. 85; MDG 5; Beijing Platform for Action: Strategic Objective C.3; ICPD Chap. 7</p>

Analysis questions	Findings	Rationale	Selected relevant documents
d. Health care and programs for people with disabilities?		<p>Appropriate measures are needed to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation. Areas of attention include ensuring non-discrimination of access to affordable quality health care, including in the area of sexual and reproductive health and population-based public health programmes; providing services needed by persons with disabilities, including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities, including among children and older persons; providing such health services as close as possible to people's own communities, including in rural areas; ensuring free and informed consent, strengthening comprehensive habilitation and rehabilitation services and programmes and the provision of assistive devices.</p>	<p>CRPD Art. 25; CESCR General Comment 5 (Persons with disabilities) (E/1995/22); CESCR General Comment 14, para. 26; ICPD Chap. 8; Beijing Platform for Action, para. 89–111</p>
e. Mental health treatment and care?		<p>Another important consideration is that mental health services are integrated into general health care and, as far as possible, provided in the community.</p>	<p>CRPD Art. 25–26; CESCR General Comment 5 (Persons with disabilities); Report of Special Rapporteur on the Right to Health (A/60/348); Beijing Platform for Action: Strategic Objective C.1(q); ICPD Chap. 8</p>

Analysis questions	Findings	Rationale	Selected relevant documents
f. Neglected tropical diseases (when relevant)?		NTD affect the most vulnerable groups, often poor people in rural areas. Despite the number of people affected, and the suffering caused by these diseases, NTD are often not given sufficient attention in health sector strategies. NTD are sometimes localized and may therefore not be perceived as a national health concern.	Report of Special Rapporteur on the Right to Health (A/HRC//7/11/Add.2)
g. Gender-based violence?		GBV is associated with a range of physical and psychological health consequences, such as injuries, STI including HIV/AIDS, unwanted pregnancy, depression and post-traumatic stress. GBV includes acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty. Such acts can include interpersonal, domestic and sexual violence, female genital mutilation and other harmful practices.	CEDAW General Recommendation 19, para. 7; CEDAW General Recommendation 24, para. 15; Report of Special Rapporteur on violence against women, its causes and consequences (A/HRC/7/6); The due diligence standard as a tool for the elimination of violence against women (E/CN.4/2006/61), paras. 25, 27, 28, 37; ICPD Chap. 4, 7, 8; MDG 3; Beijing Platform for Action: Strategic Objective D.1
2. Is women's access to appropriate, affordable, quality health care, information and related services throughout the life-course addressed?		Attention must be given to women's access to health care, information and related services across the lifespan. Along the life-course, the impact of women's lower social status on health often becomes apparent.	CEDAW General Recommendation 24, paras.7, 21, 27; ICPD Chap. 4, 7, 8; MDG 3, 5; Beijing Platform for Action: Strategic Objective C.1; Beijing Platform for Action, paras. 89–111
3. Is accessibility addressed with respect to:			
a. Rural and urban populations?		Physical distance is often a barrier to the realization of equal access to health services. People in rural areas, and those who do not have fixed physical domiciles, often have greater indirect expenditures for health care, including loss of income when travelling to distant health facilities.	CESCR General Comment 14, para. 12(b)(ii); CEDAW General Recommendation 24, para. 7; Report of Special Rapporteur on the Right to Health (A/60/348), para. 33; ICPD Chap. 7, 8; Beijing Platform for Action: Strategic Objectives C.1(c); Beijing Platform for Action, para. 89–111

Analysis questions	Findings	Rationale	Selected relevant documents
b. Marginalized groups (nomadic groups, migrant communities, etc.)?		Marginalized groups are not the same in every society or community. In order to ensure equality and non-discrimination, it is necessary to identify which groups have least access to health services and underlying determinants of health.	CESCR General Comment 16, para. 5, and General Comment 20, paras. 18-35; HRC, General Comment 18, and General Comment 28, para. 30; CEDAW, General Recommendation 24, para. 26, and General Recommendation 25, para. 12
c. People with disabilities (e.g. making facilities accessible)?		Without such strategies, there can be no guarantee that people with disabilities will have equal access to health services.	CRPD; CESCR General Comment 5 (Persons with disabilities); CESCR General Comment 14, para. 26; Beijing Platform for Action: Strategic Objectives C.1(c); ICPD Chap. 7,8
4. Are community-based health services promoted?		Community health services often play a vital role in the health of a population. Community health workers are often well trusted and well-informed about the health risks historically faced by the community at large, as well as those faced by particular groups.	CESCR General Comment 14, paras. 12(b), 17, 44; ICPD Chap. 7, 8; Beijing Platform for Action, paras. 89–111
5. Is attention paid to health information being accessible in:			
a. Local, simple, culturally accessible ways – including for the visual and hearing impaired?		In order for health information to be equally accessible to all, appropriate provisions must be made. Without such provisions, the right to information of several communities, such as linguistic minorities, people with disabilities and less educated populations will be compromised.	CESCR General Comment 14, paras. 18, 26; (A/HRC/4/8) 7 Feb. 2007, para. 32; CESCR General Comment 20, para. 21; CEDAW General Recommendation 23, para. 45(c); Beijing Platform for Action, paras. 89–111

Analysis questions	Findings	Rationale	Selected relevant documents
6. Is cultural diversity acknowledged and addressed?		People of different cultures often have different health needs due to a variety of factors, including but not limited to diet, environment, and gender norms. Effective delivery of health services depends on an appreciation for cultural diversity within a population.	CESCR General Comment 14, para. 26; CEDAW General Recommendation 19, para. 20; CEDAW General Recommendation 21, para. 3; CEDAW General Recommendation 24, para. 9; Beijing Platform for Action, paras. 89–111; ICPD Chap. 8
7. Is the importance of gender norms, roles and relations reflected in plans for service design and delivery (women and men)?		Health services need to meet the needs of different groups of women and men. Gender norms, roles and relations impact on access to health services.	CESCR General Comment 16; CEDAW General Recommendation 15; ICPD Chap. 4; MDG 3; Beijing Platform for Action, paras. 89–111
8. Is the right to privacy addressed in the delivery of health services?		Privacy plays an essential role in the effective delivery of health services, without which diagnoses suffer, and community illness patterns are missed, among other problems. Marginalized groups, such as women and minorities, have an even greater need to be assured of their right to privacy because of the gender-related and other stigma (e.g. HIV) attached to certain diseases and conditions.	CESCR General Comment 14, para 2; Beijing Platform for Action: Strategic Objective C.1; CEDAW General Recommendation 24, para. 12
9. Are specific measures to improve the quality of service provision identified?		States have an obligation to make quality health care available, and if that health care is to be provided by third parties, then the State has an obligation to not only keep the quality of third-party care up to par, but also to make sure that measures are being taken to improve upon that standard.	CESCR General Comment 14, para. 12(d), 21, 35; CEDAW General Recommendation 21, para. 23; CEDAW General Recommendation 24, paras. 22, 29(d); Beijing Platform for Action, para. 89–111
10. Is capacity building of community health workers promoted?		As community health workers often play a vital role in the delivery of health services, their capacities must be increased such that they can be formally recognized as part of the health workforce with requisite recognition.	CESCR General Comment 14, paras. 12d, 36 and 44(e); CEDAW General Recommendations 11, 14; CEDAW General Recommendation 19, para. 24(b); CEDAW General Recommendation 24, paras. 15(b), 29(f); Report of Special Rapporteur on the Right to Health (A/60/348), para. 74; Beijing Platform for Action, paras. 89–111

Analysis questions	Findings	Rationale	Selected relevant documents
Equality and non-discrimination			
11. Are specific health needs of women and men identified?		As men and women have different health needs, it is important for a service plan to identify them, especially needs that are particular to one sex or the other.	CESCR General Comment 14, paras. 20–21; ICPD Chap. 4, 7, 8; MDG 3, 5; Beijing Platform for Action, paras. 89–111
12. Are the health needs of the following groups identified?			
<i>Notes: Indicate if women and men are not specified among the various groups or if women are treated as a homogenous "vulnerable" group.</i>			
a. Elderly		Areas of attention commonly posing challenges include access to food, shelter, health care and income-generating activities.	UN Principles for Older Persons; CESCR General Comment 6, esp. para. 20; ICPD Chap. 8; Beijing Platform for Action, paras. 89–111
b. Prisoners		States must ensure that those in prison also have equal access to health services as the general population.	Standard Minimum Rules for the Treatment of Prisoners; CEDAW General Recommendation 24, para. 27; ICPD Chap. 8; Beijing Platform for Action, paras. 89–111
c. Sexual minorities (e.g. lesbian, bi-sexual, gay, transgender and intersex)		Sexual minorities often face stigma and discrimination in health service delivery.	CESCR General Comment 20 ICPD Chap. 8; Beijing Platform for Action, paras. 89–111
d. People living with HIV		Services should address prevention, treatment, care and support for HIV/AIDS.	International Guidelines On HIV/AIDS and Human Rights (2006); CESCR General Comment 14, para. 36; CEDAW General Recommendation, 24 paras. 17, 18, 31; ICPD Chap. 7, 8; Beijing Platform for Action, paras. 89–111
e. People with physical, psycho-social and intellectual disabilities		Areas of attention include access to devices that enable independence, medications, psychological services, linguistic support and nursing staff.	CESCR General Comment 5 (Persons with disabilities); ICPD Chap. 7, 8; Beijing Platform for Action, paras. 89–111
f. Children		Areas of attention include prenatal and postnatal care, nutrition, family planning, protection from harmful traditional practices, as well as child abuse and neglect.	ICESCR Art.12; CRC Art. 24; CESCR General Comment 14, paras. 14, 22 –24; MDGs 1, 4; ICPD Chap. 8; Beijing Platform for Action, paras. 89–111

Analysis questions	Findings	Rationale	Selected relevant documents
g. Adolescents		Areas of attention include access to sexuality education, family planning, protection from harmful traditional practices, nutrition and protection from harmful labor practices.	CRC Art. 24; CEDAW Art. 12; Declaration of Alma-Ata, paras. V–VIII; CESCR General Comment 14, paras. 22–24; Program of Action ICPD, Chap. VII–VIII; FWCW, Beijing Declaration; ICPD Chap. 7, 8
h. Migrants and refugees		Areas of attention include access to preventive curative health information which is accessible to services as well.	Convention relating to Status of Refugees; Protocol relating to Status of Refugees; ICPD Chap. 7, 8, 10; Beijing Platform for Action, paras. 89–111
i. Internally displaced groups		Areas of attention include essential services, emergency care, life-cycle services, psychological services, and sanitary quarters.	Guiding Principles on Internal Displacement; CESCR General Comment 14, para. 40; CEDAW General Recommendation 24, para. 6; ICPD Chap. 7, 8, 9, 10; Beijing Platform for Action, paras. 89–111
j. Nomadic groups		Points of access to health-care facilities, nutrition, and sanitation	ICPD Chap. 7, 8, 9, 10; Beijing Platform for Action, paras. 89–111
k. Other (please specify)		Every country has specific population groups which face an undue burden of discrimination, marginalization and exclusion. They should be specifically identified and addressed in the strategy.	
Participation and inclusion			
13. Is the role of local health authorities and communities addressed:			
a. In identifying health needs and priorities?		As local health authorities and communities are often better apt to identify community health needs and prioritize them, accordingly they should have a clearly stated role.	CESCR General Comment 14, paras. 11, 17, 26, 42; ICPD Chap. 7, 8; Beijing Platform for Action, paras. 89–111

Analysis questions	Findings	Rationale	Selected relevant documents
b. In links to the formal health-care system?		Recognition and linkage to the formal health-care system is necessary in order to ensure that both systems are working in parallel towards similar goals. Informal care givers are mostly women and the burden of caring for the sick and the elderly has an impact on women's participation on the labour market and on their own health.	CESCR General Comment 14, paras. 9, 11, 17, 42, 44; ICPD Chap. 7, 8; Beijing Platform for Action, paras. 89–111
c. In requiring equal representation of men and women?		As men and women have different health needs, it is important that these needs be represented equally on all levels of service delivery.	CESCR General Comment 14, para. 12(d); CESCR General Comment 16; CEDAW General Recommendation 15; CEDAW General Recommendation 23, paras. 2, 4, 25, 27, 29; ICPD Chap. 4, 7, 8; Beijing Platform for Action, para. 89–111; MDG 3
Accountability and transparency			
14. Are any mechanisms for complaints and redress from rights-holders (patients, family members, etc) – such as, for example, client satisfaction surveys, patient charters or suggestion boxes – addressed?		Such mechanisms help to ensure that rights-holders (patients, family members, etc) are capable of expressing their opinions and of holding duty-bearers to account.	CESCR General Comment 16, para. 21; Beijing Platform for Action, paras. 89–111
Issues for follow up via either interview, additional document review or otherwise			



WHERE TO FIND THE INFORMATION

- The issues raised in the analysis tables are important human rights and gender equality issues and may therefore be addressed in the strategy. However, you may need to consult additional documents and staff members of the planning or delivery units of the MoH for clarifications on activities and processes not explicitly addressed in the strategy.



ANALYSIS TIPS AND NOTES FOR DRAWING GENERAL CONCLUSIONS: SERVICE DELIVERY

- ☞ There will be a range of different responses for each of these questions. Analysis of such responses should not focus on a mere "yes" or "no" answer; rather users should focus on ways that Ministries of Health can improve service delivery.
- ☞ **Summarize the findings of questions 1–2** to clarify the **specific entitlements** outlined in the strategy. Note if and how these entitlements appear to be different for specific population groups. For example, look at when and how women and men are referred to in descriptions of basic packages of health services; note if they are discussed separately for all entitlements, or only those related to specific health areas (e.g. sexual and reproductive health). Users may draw upon other existing health data that may indicate that gender or sex differences exist in other health areas that require attention (e.g. NTDs or mental health) to identify gaps in the plan. If no sex-disaggregated data exist in the plan, nor are there any plans to incorporate such data, users can raise the issue as a gap for future research and enquiry.
 - ☞ **Coherence can be explored between specific service entitlements, Assessment level 1 (analysis table 1 and 2)**, in particular looking for commitments to health such as in the MDG, ICPD and Beijing Platform for Action.
- ☞ **Summarize the findings of questions 2, 7, 11–13** to identify examples of how **service delivery respects and promotes human rights and gender equality**. Note which aspects of service delivery seem to have a stronger human rights or gender equality component. This can be compared to local trends and patterns, and also used to identify other areas of service delivery that could benefit from increased adherence to human rights and gender equality principles.
 - ☞ **Explore coherence with service delivery and Assessment levels 1 and 2 (analysis tables 1, 2, 5–7)**. Coherence with leadership and governance functions (analysis table 10) can be explored by comparing findings with those from questions relating to the design of the health system and mechanisms such as oversight and regulation.

- ☞ **Summarize the findings of questions 2, 7, 11–12** to determine how the strategy considers the **differential needs and life circumstances of women and men of various groups**. Note if differentiation between women and men of different groups is systematic, or only on certain issues (such as trafficking).
- ☞ **Compare findings with analysis table 9** (Assessment level 3) to see if process issues of developing a plan can influence the content of the plan with respect to specific issues. For example, if the plan was not developed based on consultation (see questions 1–3 in analysis table 9), it may be unlikely to find that service delivery reflects the consideration of differences in women's and men's lives. Users should note such issues, as they are important indicators of the importance of adhering to human rights and gender mainstreaming approaches in *the process* of designing, implementing and monitoring health strategies.
- ☞ In addition to the three areas outlined in the Background, aspects pertaining to the quality of health service delivery are addressed in **questions 9, 10 and 14**. Summarize findings from these questions for an idea of core elements that may require strengthening.
- ☞ When answering question 11, identify which specific health needs are documented for women and for men. Often, it will only be sexual and reproductive for women – to the exclusion of male health needs and the vast array of health conditions women face.



GENERAL CONCLUSIONS: SERVICE DELIVERY

- The strategy establishes the following specific entitlements of the population:
- The strategy ensures that the design of service delivery is respectful of human rights and gender equality in the following ways:
- The following examples were identified of how the differential needs and life circumstances of women and men of various groups have been considered:
- The following gaps and entry points were identified:

3.4 Health systems building block: health workforce



BACKGROUND INFORMATION

The health workforce is comprised of health service providers, health managers and support workers. A well-performing health workforce is defined as one that works in ways that are responsive, fair and efficient to achieve the best health outcomes possible, given available resources and circumstances. There should be sufficient, evenly distributed staff with a mix of skills within the country and between rural and urban settings. Quality of health-care delivery is the guiding principle when determining range and skill mix of health-care workers⁴.

With respect to gender equality and human rights, the following areas must be considered:

- ✓ **Recruitment and retention** policies must take into consideration issues of both gender equality (equal access to training opportunities) and gender equity (fairness in professional structures among women and men). This means paying attention to both numbers of women and men in terms of recruitment as well as their respective access to decision-making and management positions^{4,8}.
- ✓ In terms of **skill mix**, many health systems consistently rely on informal, unpaid (or poorly paid) health workers (such as community health workers and home-based care givers). In most settings, women are more highly represented among these cadres of health workers⁹ – mirroring the overall gender-based division of labour. Such health workers often do not benefit from the same employment benefits and opportunities (including in-service training)¹⁰ as paid or formal health-care workers.
- ✓ **Pre- and in-service training** of the health workforce must reflect and promote the principles of gender equality and the right to health. Health curricula can project and promote masculine and biomedical standards of practice leading to ineffective health-care interventions. Health curricula need to be revised to reflect both human rights and gender in the context of patient care^{9,11} – as well as examining health in a holistic manner (i.e. going beyond biomedical analyses).
- ✓ **Deployment** of health workers should consider gender norms, roles and relations as well as protections for the health and safety of health workers⁸. This could mean considering the safety of health workers to be placed in isolated areas or the need for institutional policies on abuse of health workers by colleagues and patients alike.
 - > Given the fact that some cultural contexts require "sex-matching" of health-care workers to patients (i.e. female patients must be seen by female health-care workers)¹², attention to issues of gender equality and gender equity among the health workforce is required.

Analysis table 12: Health workforce

Analysis questions	Findings	Rationale	Selected relevant documents
1. Is there a human resources policy?		A human resources policy helps clarify priorities and identify targeted steps to improve access and quality health care for the population. It is indeed important that the human resources policy is also human rights / gender sensitive and incorporates the four key areas of education of health workers: recruitment and retention, skill mix and deployment. It should also address the three main employment dimensions in the labour force: occupation, working time and earnings.	CESCR General Comment 14, paras. 12b and d
2. Is the ratio of filled to unfilled available posts at different levels of care identified at the following levels:			
a. Primary health-care facilities?		A baseline of filled-to-unfilled posts, collected and reported by cadre, sex, geographical region, public or private facility, can help to establish:	CESCR General Comment 14, para. 12(d) and 43; CEDAW General Recommendation 15; CEDAW General Recommendation 23, paras. 2, 4, 25, 27, 29; ICPD Chap. 7, 8; Beijing Platform for Action, para. 89–111
b. Secondary health facilities?		<ul style="list-style-type: none"> what functions male and female health workers occupy in the health workforce; key understaffed areas that can then be juxtaposed against identified health needs; 	
c. Tertiary health facilities?		<ul style="list-style-type: none"> whether or not an adequate skill mix has been achieved; increased transparency in hiring practices; 	CESCR General Comment 14, paras. 16, 20, 43 and 57; CEDAW General Recommendation 17; CEDAW General Recommendation 2,3 paras. 48(d), 50(a); CEDAW General Recommendation 24, para. 9; ICPD Chap. 7, 8; Beijing Platform for Action, paras. 89–111
3. Is the data in the baseline, referred to in question two, broken down by		<ul style="list-style-type: none"> whether the workforce is being compiled in a non-discriminatory fashion; and whether deployment of health-care workers is adequate for covering population health needs. 	
a. Cadre (e.g. nurse, midwife, doctor)			
b. Sex			
c. Geographical region			
d. Public/private facility (specify)			
e. Other?			

Analysis questions	Findings	Rationale	Selected relevant documents
4. Are targeted steps and benchmarks to address gaps in the number of health workers per population described?		A strategy to achieve health workforce objectives with respect to recruitment, skill mix and deployment without targets and benchmarks cannot be monitored for progress. These targets and benchmarks should be developed in ways that reflect issues of non-discrimination, gender equality (equality of access and opportunity) and gender equity (fair distribution of management and decision-making roles).	CESCR General Comment 14, esp. para. 12 a and b; CEDAW General Recommendation 15; CEDAW General Recommendation 23, paras. 2, 4, 25, 27, 29; ICPD Chap. 7, 8; Beijing Platform for Action, paras. 89–111
5. Are there provisions for health workers that are posted in rural or isolated settings? <i>Notes: Include how the provisions noted in the rationale column are described for male and female health-care workers.</i>		Retaining qualified health workers in rural or isolated areas has proven challenging in many contexts. Factors that can be attributed to this include emigration ("brain drain"), lack of social benefits for families and dependents of health workers (e.g. quality schools), housing allowances, adequate salary incentives and basic health infrastructure required to perform expected duties.	Report of Special Rapporteur on the Right to Health (A/60/348), paras. 84–85; ICPD Chap. 7, 8; Beijing Platform for Action, paras. 89–111
6. Are the human rights of the health workforce protected through one or more of the following measures: <i>Notes: Include how these provisions are described for male and female health-care workers.</i>			
a. Non-discrimination (e.g. on the basis of sex, age or ethnicity, people living with HIV, physical disabilities, etc.)?		The health sector must take precautions to safeguard the rights of patients as well as those of health workers. Threats to health workers can emerge from supervisors, colleagues or patients.	Report of Special Rapporteur on the Right to Health (A/60/348), para. 78; CESCR General Comment 16, para. 21; ICPD Chap. 4, 7, 8; Beijing Platform for Action, paras. 89–111, 112–130
b. Sexual harassment or employee abuse policies?		Ensuring that staffing policies provide protections and recourse for male and female staff members is an important measure to ensure their safety, and promote principles of non-discrimination and gender equality across the areas of recruitment, retention, training and deployment.	
c. Provisions to treat and protect health workers (e.g. ARVs for health workers living with HIV, ensuring relevant immunizations, etc.)?		Staffing policies must also include clinical practice protections to minimize risk and vulnerability of health workers while providing care. Often, as nurses are front line health-care workers (and are predominantly female), their health is at direct risk if adequate protocols and equipments are not in place.	

Analysis questions	Findings	Rationale	Selected relevant documents
<p>7. Is the role of community health workers addressed among the following:</p> <p><i>Notes: Indicate whether the information provided relates to paid or unpaid community health workers (or both).</i></p>		<p>As many health systems increasingly rely on informal or community health services, it is important to determine who provides these services and under what conditions. Formal recognition of community health services, often performed by lesser-educated women (and in some cases men), can provide a platform to ensure payments and access to training opportunities for these health workers – as well as protections when working outside of health facilities where risks may be higher for things such as abuse or lack of sterile equipment.</p>	<p>CESCR General Comment 14, para. 12d; Report of Special Rapporteur on the right to health; (A/60/348), paras. 8–17, 80; Beijing Platform for Action: Strategic Objective C.1; ICPD Chap. 7, 8</p>
a. Support and monitoring from local health centres?			
b. Benefits from training programmes?			
c. Compensation (e.g. transportation costs, salary, education grant)?			
<p>8. Is in-service training addressed? If so, are the following areas addressed:</p>		<p>In-service training is important to enhance health worker skills, and may tend to focus on clinical procedures (e.g. cardio-pulmonary resuscitation or integrated management of childhood illnesses), and management issues (e.g. patient safety policies or new patient management data systems). In-service training is also an optimal time to address broader health issues – such as human rights, gender equality and cultural diversity – for their direct impact on health outcomes, patient care (diagnostic and therapeutic treatments) and the functioning of the health system (policies, programmes and interventions that address broader determinants of health). The health workforce must be equipped with the knowledge and skills to perform tasks and activities, ranging from clinical practice to the management of a health facility, to do so.</p>	<p>CESCR General Comment 14, para. 12d; Report of Special Rapporteur on the Right to Health (A/60/348), para. 83; Beijing Platform for Action: Strategic Objective C.1(g); ICPD Chap. 4, 7, 8; Beijing Platform for Action, paras. 89–111</p>
a. Human rights			
b. Gender equality			
c. Cultural diversity			

Analysis questions	Findings	Rationale	Selected relevant documents
9. Is the importance of a representative workforce addressed, in terms of:			
a. Various population groups, such as disadvantaged populations, indigenous peoples, and minorities?		Based on the principles of non-discrimination and gender equality, the health workforce should be open to all members of the population – who are entitled to equal benefits and protections once hired. In order to achieve such a balance, the health system may need to invest in addressing vulnerable groups with respect to educational opportunities, targeted recruitment campaigns and/or providing incentives for enrolment in health training (either at the formal or informal level).	CEDAW Arts. 4 and 11; CRPD, Arts. 5 and 27; Indigenous and Tribal Peoples Convention, 1989 (No. 169); ICPD Chap. 4, 7, 8; CESCR General Comment 14, para. 27; Beijing Platform for Action para. 89–111, 181–195; MDG 3
b. Women and men?		It is important to pay attention to the employment dimensions of occupation, working time and earnings. Occupational segregation by gender can correspond to either vertical clustering (differentials in job status) or horizontal clustering (sex differentials according to specialization). Working time can affect workers' economic position, especially when it results in lower monetary and non-monetary compensation among part-time workers compared to their full-time counterparts, as well as less job security and fewer opportunities for promotion.	
10. Is there a goal to increase the capacity of duty-bearers in the health system at all levels of the State administration? (outcome level)		Possible capacity gaps: knowledge, organizational and coordination skills, authority (roles and responsibilities), resources, and technical skills and abilities. Important categories of duty-bearers: a. Policy-makers b. Managers/coordinators c. Service providers d. Monitors/inspectors	CESCR General Comment 14, 36, 44(e); CEDAW General Recommendation 14; CEDAW General Recommendation 19, para. 24; CEDAW General Recommendation 23, para. 15; CEDAW General Recommendation 24, paras. 15(b), 31(f); ICPD Chap. 7, 8; Beijing Platform for Action, paras. 89–111, 181–195

Analysis questions	Findings	Rationale	Selected relevant documents
11. Is the education and training of health workers promoted (health workers includes both those based in facilities and in communities)? Is there a regulatory mechanism that maintains quality of:			
a. Education/training of health workers and community workers? If so, are there specific ways to address human rights and gender equality within quality control activities?		Similar to licensing and accreditation, regulation of health curricula (pre or in-service) is necessary to ensure quality. Regulation also provides an entry point for regular updating on ways that human rights and gender equality impact health outcomes and service delivery.	CESCR General Comment 14, 36, 44(e); CEDAW General Recommendation 14; CEDAW General Recommendation 19, para. 24; CEDAW General Recommendation 23, para. 15; CEDAW General Recommendation 24, paras. 15(b), 31(f); ICPD Chap. 7, 8; Beijing Platform for Action, paras. 89–111
b. Practice of health workers? If so, are gender equality and human rights addressed in quality control measures of health-care practice?		There are often ethical codes of practice. However, to ensure accountability of health-care workers, these codes need to be enshrined in law and incorporate human rights and gender equality principles.	CESCR General Comment 14, 36, 44(e); CEDAW General Recommendation 19, para. 24; General Recommendation 24, paras. 15(b), 31(f); ICPD Chap. 7, 8; Beijing Platform for Action, paras. 89–111; MDG 3
Equality and non-discrimination			
12. Is the issue of equitable distribution of male and female health professionals addressed? Notes: Indicate the proposed distribution within the country and between urban and rural areas.		The health workforce should be representative of the population and aim for both gender equality (equality of access and opportunity) and gender equity (fair distribution of management and decision-making roles) in its distribution and deployment.	Report of Special Rapporteur on the Right to Health (A/60/348), para. 79; CEDAW General Recommendation 15; ICPD Chap. 4, 7, 8; Beijing Platform for Action, paras. 89–111, 181–195; MDG 3
Participation and inclusion			
13. Is equal male and female participation in decision-making roles recognized?		Principles of gender mainstreaming, non-discrimination and participation underline the importance for equal and meaningful involvement of women and men in decision-making mechanisms in different functions. Health workers of both sexes should be meaningfully involved in decisions related to the health workforce as well as overall service delivery issues.	Report of Special Rapporteur on the Right to Health (A/60/348), paras. 87–106; CEDAW General Recommendation 15; CEDAW General Recommendation 19, para. 11; CEDAW General Recommendation 23; ICPD Chap 4, 13, 15; Beijing Platform for Action, paras. 89–111, 181–195; MDG 3

Analysis questions	Findings	Rationale	Selected relevant documents
Accountability and transparency			
14. Is there mention of a "code of conduct" for health-care workers and how such a code is disseminated to the public?		Transparency of deontological codes is an important way to ensure that patients are aware and informed of minimum standards of practice so as to accept or denounce types of treatment that may be contrary to the code.	Beijing Platform for Action: Strategic Objective C.1; ICPD Chap. 7, 8
15. Are complaints mechanisms for health workers addressed?		The health sector must take precautions to safeguard the rights of patients as well as those of health workers. Threats to health workers can emerge from supervisors, colleagues or patients. Ensuring anonymous complaint mechanisms for health workers facilitates dialogue with management on issues raised by health workers, and can serve to raise breaches in human rights and gender equality (such as sexual harassment) for further action.	CESCR General Comment 14, para. 51; CEDAW General Recommendation 19, para. 24; CEDAW General Recommendation 24, para. 15(c); Beijing Platform for Action, paras. 89–111, 112–130
16. Are charges of sexual harassment or abuse by health-care providers or patients addressed?			
Issues for follow up via either interview, additional document review or otherwise			



WHERE TO FIND THE INFORMATION

- This table addresses health workforce issues as reflected in the health strategy document itself. The issues raised in the analysis tables are important human rights and gender equality issues and may therefore be addressed in the strategy. However, you may need to consult additional documents and staff members of the planning or human resources units of the MoH for clarifications on activities and processes not explicitly addressed in the strategy.
- Many ministries of health have developed health workforce policies/strategies. Such a document may provide relevant background information or needed clarifications.



ANALYSIS TIPS AND NOTES FOR DRAWING GENERAL CONCLUSIONS: HEALTH WORKFORCE

- ☞ There will be a range of different responses for each of these questions. Analysis of such responses should not focus on a mere "yes" or "no" answer; rather users should focus on strengths and weaknesses with respect to the four areas of analysis outlined in the Background Information.
- ☞ In order to ensure that a rights-based and gender equality approach are applied to the health workforce, users can use the bullet points (see Background Information) as a guiding framework for summarizing the findings. The general conclusions (after the table) are structured around four areas of analysis: **recruitment and retention, skill mix, training, and deployment**.
 - ☞ **Recruitment and retention** can be explored by **summarizing questions 4, 6, 8, 12–13**. Note if and how specific guidance is included in the plan for women and men separately. If so, note if this specificity is with respect to cadre and/or staffing goals.
 - ☞ Issues around existing or planned **skill mix** can be **summarized with findings from questions 3, 8 and 13**. Again, note if and how male and female health-care workers are represented and if any inequalities can be detected.
 - ☞ **Questions 8, 10 and 11** describe pre- and in-service **training** of the health workforce. When summarizing these responses, note if and how opportunities may be differentially provided to health workers depending on sex, cadre, location or other factors.
 - ☞ **Questions 2, 5 and 12** capture issues around **deployment** of health workers. Indicate if certain groups of health workers (either by sex or cadre) appear to have privileged postings as compared to others.
- ☞ **Questions 14–16** look at mechanisms required to ensure that the principles of accountability and transparency are upheld. Summarize these answers, **comparing them to findings from analysis table 10** on specific leadership and governance functions (see questions on mechanisms on oversight, coalition building, regulation and accountability).
- ☞ There is some overlap between those questions suggested for recruitment and retention and those for deployment, as deployment could also include working conditions for the health workforce.

- ☞ Questions for summarizing findings on recruitment and retention also have implications for skill mix and pre- and in-service training. Users should draw from all three clusters of questions when summarizing these areas of analysis.
- ☞ **Coherence** can be explored between what the plan says about the health workforce, Assessment level 1 (**analysis tables 1 and 2**), in particular looking for obligations and commitments to CEDAW, ICPD and Beijing Platform for Action. **Coherence with the national legal and policy framework** (Assessment level 2) may be explored by comparing findings from the health section questions in **analysis table 7**.



GENERAL CONCLUSIONS: HEALTH WORKFORCE

- Retention and recruitment issues address human rights and gender equality in the following ways:
 - > Further attention may be required in the following areas:

- Attention to gender equality and human rights when determining an adequate and appropriate skill mix in the health workforce is demonstrated in the following ways:
 - > Further attention may be required in the following areas:

- Pre- and in-service training address the right to health and gender equality as follows:
 - > Further attention may be required in the following areas:

- Deployment of the health workforce integrates a rights-based and gender equality approach by:
 - > Further attention may be required in the following areas:

3.5 Health systems building block: medical products, vaccines and technologies



BACKGROUND INFORMATION

A well-functioning health system ensures equitable access to essential medical products, vaccines and technologies of assured quality, safety, efficacy and cost-effectiveness, and their scientifically sound and cost-effective use. A key issue of concern is that products, vaccines and technologies are chosen with respect for cultural appropriateness and life-course requirements⁴.

Within these parameters, the following areas require specific attention to ensure a HRBA and attention to key gender and health issues:

- ✓ Gender inequality and other discriminatory practices affect timely and effective **access and use** as well as the **quality and safety** of medical products, vaccines and technologies in the following ways¹³:
 - "Son preference", or the privileging of boys, has been demonstrated to affect access and use of medicines and vaccines in several settings. This disadvantages the health of girls.
 - Poverty impacts the ability to pay for medicines, vaccines and other technologies, which can affect both women and men of different social groups. However, many women bear a higher burden of illness due to lack of decision-making power within the household (on household expenses) and often do not benefit from social protections such as private employer insurance to access such medical products (where applicable); these factors may create higher obstacles to efficient and effective access and use by women of lower socioeconomic status.
 - > Poverty also impacts access and use through indirect costs such as transportation costs to a pharmacist or specialist centre for use of medical technologies such as X-rays.
 - Some studies find that women use more medications than men, and may even be targeted differently through advertisements¹³, which may detract from effective use of medicines (e.g. "rational use of medicines").
 - Stigma related to using certain types of medical products may contribute to decreased access and use among vulnerable groups, such as people living with HIV or those with mental disabilities.
 - Inclusion of sex-specific health issues (pregnancy, cervical or prostate cancer, exam equipment such as specula for gynaecological exams, etc.) on the essential drugs list can help to facilitate access for women and men.
 - Clinical trials should include male and female participants from different social groups to ensure safe medical products for both sexes across the life course (this includes attention to how the safety and efficacy of medical products affect, or are affected by, pregnancy).

Analysis table 13: Medical products, vaccines and technologies

Analysis questions	Findings	Rationale	Selected relevant documents
1. Is the development and/or effective implementation of a national medicines policy mentioned?		A national medicines policy helps ensure access to quality medicines.	ICESCR Art. 12c-d; CESCR General Comment 14, paras. 41, 43(d)
2. Is the development and regular updating (approximately every two years) of a national list of essential medicines mentioned? <i>If so, is there consideration of the differential needs of groups of men and women in relation to the national essential medicines list?</i>		Essential medicines lists and technologies should address and reflect health conditions for women and men of different social groups across the life course in order to respond to their specific and distinct health needs. The WHO Model List of Essential Medicines provides guidance.	ICESCR Art. 12c-d; CESCR General Comment 14, paras. 41, 43(d); (A/HRC/4/10) 3 January 2007, para. 63; Beijing Platform for Action, paras. 89–111, 181–195
3. Is the issue of the availability of essential equipments defined at different levels of the health system? <i>If so, does the strategy recognize the need to tailor equipments to the differential health needs of men and women?</i>		Delivery of essential medicines and technologies also needs to consider issues of access such as user fees, transportation or discrimination in order to sustain equitable access among different population groups.	CESCR General Comment 14, para. 12(a), 43; (A/HRC/4/10) 3 January 2007, para. 63; ICPD Chap. 7, 8; Beijing Platform for Action, paras. 89–111, 181–195
4. Is the accessibility of medicines addressed, including:		When examining issues of access to medicines, it is important that the strategy defines and/or identifies groups within the population that may have difficulty in procuring such medicines. The location of dispensers, and their accessibility on physical, monetary or economic and socio-cultural grounds, must be considered.	CESCR General Comment 14, paras. 12(b), 18, 19; CEDAW General Recommendation 24, paras. 2, 7; ICPD Chap. 7, 8; Beijing Platform for Action, para. 89–111
a. The affordability for lowest income quintiles?			
b. Physical accessibility?			
5. Are statistics on access to and use of essential medicines disaggregated by sex, age and for urban and rural populations?		Disaggregation of data is key to monitor differences in access and use of different health services (in this case, essential medicines). Once data with appropriate and feasible disaggregation are available, further analysis can be conducted to determine if sex or age-based differences are avoidable (and hence unfair).	CESCR General Comment 14, para. 12 and 57; CEDAW General Recommendation 24, para. 7; Report of Special Rapporteur on the Right to Health (A/60/348), paras. 26, 52, 64; ICPD Chap. 7, 8; Beijing Platform for Action, paras. 89–111

Analysis questions	Findings	Rationale	Selected relevant documents
6. Are medical products and technologies selected with respect to:			
a. The health needs of different population groups?		Essential medicines lists and technologies should address and reflect health conditions for women and men of different population groups, across the life course in order to respond to their specific and distinct health needs.	CESCR General Comment 14, para. 12(c); ICPD Chap. 7, 8; Beijing Platform for Action, paras. 89–111, 181–195
b. The different needs and circumstances of groups of women and men?			CESCR General Comment 14, paras. 18, 19; ICPD Chap. 7, 8; Beijing Platform for Action, paras. 89–111, 181–195; MDG 3, 5
7. Is the integration of regulated traditional, complementary and alternative medicines into the health system addressed? <i>If so, are there any restrictions that may harm women or men from specific groups?</i>		Many patients (male and female) consult a range of health services when seeking treatment – ranging from alternative to allopathic treatments. The reasons for consulting alternative therapies may differ; health sector strategies should address use of alternative therapies so as to reduce harmful effects – effects that may differ either due to biological or socio-cultural factors for men and women.	CESCR General Comment 14, para. 26; WHO Medicines Strategy 2004-2007: Countries at the Core; Beijing Platform for Action: Strategic Objectives C.4(b) & K(1)(c); ICPD Chap. 7, 8
8. Are quality and safety of medicines addressed through adequate standards? <i>If so, do these standards reflect consideration for human rights and gender equality?</i>		Issues of standard setting, quality and safety of medical products must be based on evidence that is representative of male and female groups across the life course. When looking at developing protocols for quality and safety, ethical issues with respect to informed consent for participation in tests and clinical trials must be monitored. Testing for safety and quality must include male and female participants of different ages.	CESCR General Comment 14, paras. 12(b)(ii & iii) and 12(d); ICPD Chap. 7, 8; Beijing Platform for Action, paras. 89–111, 181–195
Equality and non-discrimination			
9. Is access to essential medicines promoted for specific marginalized population groups? <i>If so, does the strategy provide for essential medicines to be available in prisons, refugee camps, and other excluded isolated areas?</i>		In order to ascertain equitable access issues, there must be an understanding of the population profile, health needs and constraints to accessing medical products. This may be specific to a condition, based on needs, or could be related to a specific population (such as prisoners), based on geographical or political barriers to access.	CESCR General Comment 14, paras. 17, 19; Report of Special Rapporteur on the Right to Health (A/60/348), paras. 26, 52, 64; ICPD Chap. 4, 7, 8; Beijing Platform for Action, paras. 89–111; MDG 3

Analysis questions	Findings	Rationale	Selected relevant documents
10. Is equal access of medical products and technologies for men and women of different groups addressed?		Based on the principles of non-discrimination and gender equality, the health system is to provide equal chances to women and men of different social groups to access and use medical products and technologies.	CESCR General Comment 14, paras. 17–20; CEDAW General Recommendation 24; ICPD Chap. 4, 7, 8; Beijing Platform for Action, paras. 89–111; MDG 3
Participation and inclusion			
11. Are mechanisms for consulting relevant stakeholders on policy formulation in relation to the adoption of technologies and/or establishing/updating the list of essential medicines addressed? <i>If so, do such consultation processes refer to both women and men from different stakeholder groups such as rural communities, NGO, patient and consumer groups or representatives of vulnerable groups (specify which ones)?</i>		Public consultations, along with analyses of health trends, are important ways to determine national health goals, priorities and health systems components. Women, in many settings, may not always be asked or able to participate in such consultations due to gender norms around social mobility and gender relations on male decision-making authority.	CESCR General Comment 14, paras. 53–56; Beijing Platform for Action: Strategic Objectives C.1(s); ICPD 12, 15.6; Beijing Platform for Action, paras. 89–111, 196–209
Accountability and transparency			
12. Have indicators and targets been identified to monitor access to essential medicines?		Access to essential medicines must be monitored in order to ascertain if equitable access goals are achieved. Indicators should be gender-sensitive and include disaggregation that will reveal vulnerable groups and facilitate further analysis as to their barriers in accessing essential medicines.	CESCR General Comment 14, paras. 57–58; CEDAW General Recommendation 9; (E/CN.4/1999/48) 29 January 1999, para. 85; Report of Special Rapporteur on the Right to Health (A/60/348), paras. 26, 52, 64; ICPD 7, 8, 12
Issues for follow up via either interview, additional document review or otherwise			



WHERE TO FIND THE INFORMATION

- This table addresses medical products, vaccines and technologies as reflected in the health strategy document itself. The issues raised in the analysis tables are important human rights and gender equality issues, and may therefore be addressed in the strategy. However, you may need to consult additional documents and staff members of the planning or medicine units of the MoH for clarifications on activities and processes not explicitly addressed in the strategy.
- Many ministries of health have developed medicines policies/strategies. Such a document may provide relevant background information or needed clarifications.
- The WHO Model Lists of Essential Medicines has been updated every two years since 1977. The current version, the 16th list, updated in March 2010; see <http://www.who.int/medicines/publications/essentialmedicines/en/>



ANALYSIS TIPS AND NOTES FOR DRAWING GENERAL CONCLUSIONS: MEDICAL PRODUCTS, VACCINES AND TECHNOLOGIES

- ☞ In order to focus on key human rights and gender equality issues, users are encouraged to analyse findings around themes of **access and use** of medical products and their **quality and safety**. This will allow for general categorization and summarization in two areas of analysis.
- ☞ **Summarize questions 1–6, 9–10, 12** to determine how **access and use** of medical products are addressed. Note how attention is given to human rights and gender equality.
- ☞ **Questions 1, 7–8** can be summarized to identify how **quality and safety** are addressed. Note the linkages to human rights and gender equality.
- ☞ **Question 11** addresses the element of participation while **question 12** captures the issue of accountability and transparency in relation to indicators.
- ☞ When findings are "no" answers, highlight these findings as potential avenues for further attention.
- ☞ **Coherence** can be explored by comparing findings between what the plan says about the health workforce, **Assessment level 1 (analysis tables 1 and 2)**, in particular looking for obligations and commitments to CEDAW, ICPD and Beijing Platform for Action. **Coherence with the national legal and policy framework (Assessment level 2) may be explored by comparing findings from the health section questions in analysis table 7.**



GENERAL CONCLUSIONS: MEDICAL PRODUCTS, VACCINES AND TECHNOLOGIES

- Access to, and use of, medical products, vaccines and technologies uphold a rights and gender-based approach in the following ways:
 - > Further attention may be required in the following areas:

 - > Quality and safety of medical products, vaccines and technologies uphold a rights and gender-based approach in the following ways:

 - > Further attention may be required in the following areas:

3.6 Health systems building block: information



BACKGROUND INFORMATION

A well-functioning health information system is one that ensures the production, analysis, dissemination and use of reliable and timely information on determinants of health, health status and health system performance¹⁴. A key area of concern is disaggregating data by sex, age, ethnic affiliation and socio-economic condition, as appropriate, to ensure reliable tracking mechanisms^{4,14}.

A general rule of thumb when thinking of what to measure is to remember that *what gets measured gets done*. In other words, if health information systems cannot measure and generate information to facilitate the availability, accessibility, acceptability and quality (AAAQ) of health services, goods and facilities, efforts in other building blocks may be hampered. Ensuring that gender equality and human rights are adequately reflected in health information systems requires attention to the following areas:

✓ Selection and development of indicators

- It is important that the **selection of indicators** within the health information system includes the "right information" needed to conduct both a rights and gender-based analysis. This includes^{15,16}:
 - > quantitative information from basic health status indicators as well as determinants of health data such as measures of intimate partner violence, unemployment or literacy rates.
 - > qualitative indicators that can measure perceptions of illness or health (e.g. self-rated health), perceived quality or satisfaction with health services and/ or treatment options for men and women of different groups¹⁷. Such information may be found in data sets outside of the health information system.
 - > adequate disaggregation of data is necessary; a bare minimum is to have the data disaggregated by sex and age (where appropriate). If the health information system in question has sufficient capacity, health data should also be further broken down by place of residence (urban versus rural), and socio-economic status (household income, educational achievement and occupation status)^{5,18}.
 - > indicators on health system performance should also incorporate measures of the right to health and gender mainstreaming to ensure that tracking of progress in these areas is possible^{17,19,20}.
- Development of new indicators should be based on principles of participation. When developing indicators, it is important to bring together both users and producers of data to determine data needs (within and beyond the health sector) as well as appropriate and sound methods of data collection and analysis²¹.
- Capacity-building activities on both the development and selection of health indicators²⁰.

- ✓ **Analysis of health information** should be done in a broader determinants of health framework that includes rights and gender-based analysis methods. Limiting the analysis of health information to statistical reporting or biomedical frameworks will not yield necessary information to develop and implement health strategies in a human rights and gender-based approach^{5,22}.
 - In order to conduct a rights or gender-based analysis of health information, data from other sectors (representing determinants of health) are required. This means that coordination and effective use of data generated across sectors is necessary.
- ✓ **Dissemination of health information** should constitute a two-way process in that both the health system and its beneficiaries have access to health information. This requires reporting health information with appropriate disaggregation in formats that all stakeholders can access (e.g. in simple, popular communication methods with due attention to delivery methods and sites, linguistic considerations and ways in which groups will use the information for advocacy, programming, policy-making or otherwise)^{15,16}.
 - Health information should also be communicated within the health system, across different levels within the country (district, sub-national and national) and within health facilities (primary, secondary and tertiary levels of care).

Analysis table 14: Information

Analysis questions	Findings	Rationale	References
1. Is the need for different sources of information outside the health sector and beyond health status indicators addressed? <i>For example, linkages with the national civil registration system, census bureau, national statistics office, etc.</i>		Given the fact that many underlying determinants of health may be measured outside of the health information system, it is necessary to draw upon multiple sources of information to generate adequate health analyses.	CESCR General Comments 4, 7, 12, 13, 15, 18 and 19; HRC General comments 6, 7, 8, 9, 10, 14, 19, 20, 25, 27; CEDAW General Recommendation 9; (A/HRC/5/3) 31 May 2007, para. 47; ICPD 12, 13; Beijing Platform for Action, para. 89–111
2. Are strategies to improve the availability and quality of population-based data on births, deaths and causes of death promoted?		Quality health information (with adequate disaggregation) is necessary for generating sound analyses to inform health policies, programs and services.	CEDAW General Recommendation 9; (A/HRC/4/8) 7 Feb. 2007, para. 32; Report of Special Rapporteur on violence against women, its causes and consequences (A/HRC/7/6), paras. 26, 28, 30, 34; ICPD 12, 13; Beijing Platform for Action, paras. 89–111, 206(a)

Analysis questions	Findings	Rationale	References
<p>3. Is the need for a mix between health status, determinants of health and health system performance measures reflected?</p> <p><i>Note: Users should indicate "yes" to all three areas, a "partial yes" if to one or more, and "no" only if there is no mention made whatsoever of an adequate mix of health indicators.</i></p>		<p>An adequate mix of measures and methods is required within health information to identify health status and outcomes for the population. This makes it possible to identify root causes of illness and track the performance of the health system.</p>	<p>WHO Core Health Indicators; Implementation of GA Resolution 60/251 of 15 March 2006 entitled "Human Rights Council" (A/HRC/5/3) 31 May 2007; (A/HRC/4/8) 7 Feb. 2007, para. 32; ICPD Chap. 7, 8, 12; Beijing Platform for Action, paras. 89–111</p>
<p>4. Is the importance of measuring the prevalence, causes and health consequences of violence against women promoted?</p>		<p>Violence against women, a human rights violation rooted in practices of gender inequality, contributes to multiple health problems. Prevalence measures (included in specialized surveys or optional modules of population health surveys) are a means of determining the magnitude of the problem, identifying health-related consequences and developing appropriate health sector responses.</p>	<p>CEDAW General Recommendation 24, para. 15; Beijing Platform for Action: Strategic Objective D.2; Report of Special Rapporteur on violence against women, its causes and consequences (A/HRC/7/6), paras. 26, 28, 30, 34; ICPD Chap. 4, 8, 12; Beijing Platform for Action, paras. 112–130</p>
<p>5. Is a facility-based health information system at all levels supported?</p>		<p>Strengthening facility-based health information (or patient records) systems in both public and private facilities is a key element towards having sub-national and national health information that can then identify vulnerable groups and health inequities – and develop sound health sector responses.</p>	<p>CESCR General Comment 14, para. 36; (A/HRC/4/8) 7 Feb. 2007, para. 32; ICPD Chap. 12; Beijing Platform for Action paras. 89–111</p>
<p>6. Are provisions included for data collection on private health-care services?</p>			<p>General Comment 14, para. 35; ICPD Chap. 12; Beijing Platform for Action, paras. 89–111</p>

Analysis questions	Findings	Rationale	References
<p>7. Is data collection on economic accessibility for users provided or encouraged?</p> <p><i>If so, does the strategy indicate aspects of socio-economic status/affordability and differences for women and men of different ages and groups?</i></p>		<p>Given the fact that underlying determinants of health such as socio-economic factors are often measured outside of the health information system, it is important to factor in indicators that can determine if and how economic factors (at both household and individual levels) may influence access to health services by different groups of women and men. Such information is often gathered at the household level, which may mask intra-household differences with respect to access to household resources necessary to seek timely health care for men and women of different ages and in different areas.</p>	<p>Beijing Platform for Action: Strategic Objective A1; Report of Special Rapporteur on the Right of everyone to the enjoyment of the highest attainable standard of health (A/60/348), para. 87; ICPD Chap. 12; Beijing Platform for Action, paras. 89–111, 206–208</p>
<p>8. Is research and/or the dissemination of information on women's health promoted?</p> <p><i>Note: Users should indicate if both research and information dissemination is included, or if only one of the two.</i></p>		<p>Health research contributes to both improved data collection methodologies and indicator development. Such research must adopt both a human rights and gender-based approach to conceptualizing the health of different groups of women and men. As the health of women has often been understood based on male norms of symptomology and experience and/or limited to sexual and reproductive health, it is important to promote broader understandings of determinants of women's health and women's health outcomes through research and knowledge sharing.</p>	<p>CEDAW General Recommendation 24; Beijing Platform for Action: Strategic Objective C.4; ICPD Chap. 4, 8, 12</p>
<p>9. Is reference made to gaps in existing health information?</p> <p><i>If so, indicate if the gaps mentioned highlight the need for information on determinants of health.</i></p>		<p>Identifying gaps in information is a first step towards developing plans to address them. For example, if the current situation is one that only has aggregate mortality and morbidity data, the plan should indicate that further disaggregation is required as well as an inclusion of other health measures (underlying determinants of health and health system performance).</p>	<p>CESCR General Comment 14, paras. 16, 63; (A/HRC/4/8) 7 Feb. 2007, para. 32; Report of Special Rapporteur on the Right to Health (A/60/348), para. 87; ICPD Chap. 12; Beijing Platform for Action, paras. 89–111, 206–208</p>

Analysis questions	Findings	Rationale	References
10. Is the need to involve various stakeholders in the creation, analysis and dissemination of health information mentioned?		Addressing determinants of health, such as gender equality, requires a multi-sectoral approach. Within the field of health information, this is even more crucial in order to determine sound ways to include measures of human rights and gender equality. Bringing together users and producers of health information from various sectors will also ensure that the type of information generated can serve multiple interests.	Implementation of GA Resolution 60/251, (A/HRC/5/3) para. 47; (A/HRC/4/8) 7 Feb. 2007, para. 32; ICPD 12, 15.6; Beijing Platform for Action, paras. 89–111, 206–208
11. Is there reference made to the need for a rights or gender-based analysis of health data?		Limiting the analysis of health information to statistical tabulations or mortality tallying will not yield necessary information to develop and implement health strategies that reduce health inequities and realize the right to health.	CESCR General Comment 20; CEDAW General Recommendation 9; CEDAW General Recommendation 24, para. 26; ICPD 4, 8, 12; Beijing Platform for Action, paras. 89–111, 206–208
12. Are capacity gaps identified to strengthen the quality of data and health information systems? <i>If so, is enhancing human rights and gender-related capacities included in the identified gaps?</i> <i>Note: Users should indicate if capacity gaps address both human rights and gender equality, or one of the two. Specify which area is included.</i>		Identifying capacity gaps for quality health data and overall health information systems could be considered a proxy indication of the State's commitment to building national or sub-national capacities to address human rights and gender equality within the health system through generating information that will yield evidence-based policies, programmes and services reflective of the right to health and gender equality.	CEDAW General Recommendation 9; CEDAW General Recommendation 10; (A/HRC/4/8) 7 Feb. 2007, para. 32; Report of Special Rapporteur on the Right to Health (A/60/348), para. 74; ICPD Chap. 12; Beijing Platform for Action, paras. 89–111, 206–208
13. Is the importance of ensuring that all levels of health facilities (primary, secondary and tertiary) have equal access to health information mentioned?		District and sub-national health planners and health workers require access to health information on both the specific situation of the communities in which they work as well as the broader range of health information. Such access can help systems support better quality services targeted towards the needs of the population.	CEDAW General Recommendation 24, para. 10, 13, 17; CEDAW General Recommendation 22; ICPD Chap. 12; Beijing Platform for Action, paras. 89–111, 206–208

Analysis questions	Findings	Rationale	References
Equality and non-discrimination			
14. Is the importance of disaggregated data mentioned? If so, are the following levels of disaggregation mentioned:			
<i>Note: Users should identify if disaggregation is mentioned for data collection, analysis and dissemination. Note if "yes" for all three, or indicate for which levels. If no disaggregated data is available, indicate if mention is made of the need to disaggregate data through strengthening health information systems.</i>			
a. Sex disaggregated data?		It is close to impossible to conduct a quality gender or rights-based analysis of health data without basic disaggregation of data. Analysis of disaggregated data can identify health inequities and is therefore a powerful tool for the health sector. If the data is not available, alternate sources of information may be used, but this should be clearly indicated.	CESCR General Comment 14, paras. 12(b)(iv), 20, 63; CESCR General Comment 20; CEDAW General Recommendation 9; CEDAW General Recommendation 23, para. 48(d); ICPD Chap. 4, 12; MDG 3; Beijing Platform for Action, paras. 206–208
b. Age disaggregated data?			CESCR General Comment 14, para. 12; CESCR General Comment 20; ICPD Chap. 12; Beijing Platform for Action, paras. 206–208
c. Data disaggregated by region of residence (e.g. urban vs. rural)?			CESCR General Comment 14, para. 12(b)(iv); CESCR General Comment 20; Beijing Platform for Action, paras. 206–208

Analysis questions	Findings	Rationale	References
Participation and inclusion			
<p>15. Is dissemination and sharing of health information with the public and other stakeholders addressed?</p> <p><i>If so, indicate if any consideration is given to the ways that gender norms, roles and relations may affect women's or men's ability to access such information.</i></p>		<p>Facilitating access to health information is an important function of the health system. As action on determinants of health requires multi-sectoral collaboration, such information sharing must involve multiple stakeholders – including ways to inform the general public. Dissemination plans must consider a range of factors according to the target audiences of health information – including the use of simple, popular communication methods with due attention to delivery methods and sites, linguistic considerations and ways in which groups will use the information for advocacy, programming, policy-making, etc.</p>	<p>CESCR General Comment 14, para. 12(b)(iv); Beijing Platform for Action: Strategic Objectives C.2(e); ICPD 12, 15.6; Beijing Platform for Action, paras. 89–111, 206–208</p>
Accountability and transparency			
<p>16. Is evidence-based decision-making promoted?</p> <p><i>If so, are ways to enhance the evidence base on the right to health and gender equality in health mentioned?</i></p>		<p>Health information should not only be used to measure burden of disease to determine programmatic priorities. It should also contribute towards the identification of health inequities and the development and/or modification of policies, programmes and services to enable the State to respect, promote and fulfil the right to health and deliver on gender equality obligations and commitments.</p>	<p>CESCR General Comment 14, para. 12(b)(iv); The Due Diligence Standard as a tool for the elimination of violence against women (E/CN.4/2006/61), para. 37</p>
Issues for follow up via either interview, additional document review or otherwise			



WHERE TO FIND THE INFORMATION

- This table addresses health information reflected in the health strategy document itself which can provide important insights into the quality of data and analysis used to prepare the strategy as well as goals/targets established within. However, you may need to consult additional documents and staff members of the planning or information/statistics units of the MoH for clarifications on activities and processes not explicitly addressed in the strategy.



ANALYSIS TIPS AND NOTES FOR DRAWING GENERAL CONCLUSIONS: INFORMATION

- ☞ There will be a range of different responses for each of these questions. Analysis of such responses should not focus on a mere "yes" or "no" answer; rather users should focus on ways that Ministries of Health can improve information systems.
- ☞ Information and data are essential for planning and ensuring accountability. This table enables answers to the following question: *How far does the government make a well-functioning information system a priority in the strategy and how far does such a system incorporate human rights considerations, such as disaggregated data?*
- ☞ **Summarize the findings of questions 1–4, 7–8, 10, 14** for how the strategy relates to the **selection and development of indicators**. Note in particular how gender equality and human rights are reflected in developmental issues of new indicators (for example, questions 3, 4 and 8).
 - ☞ Users may want to compare what the plan says about health information and the actual sources of information used to develop the plan (see analysis table 9, Assessment level 3). The use or lack of appropriately disaggregated data and incomplete indicators used in the development of the plan may be indicative of the quality of existing health information and can therefore be highlighted as capacity gaps for health information systems.
- ☞ **Summarize the findings of questions 11, 14 and 16** to determine the basis for **analysis of health information**. Note if and how explicit mentions of gender analysis are used in the plan. If gender analysis is not mentioned, note what kind of "social justice analysis" could be deduced from the plan – if any.
- ☞ **Summarize the findings of questions 13, 15–16** to clarify strategies for **dissemination of health information**. Note groups of stakeholders that may be excluded from receiving or understanding health information as set out in dissemination plans. Such exclusion may be stated explicitly or implicitly in the plan. Users may use such notes for broader discussions on health policy-making processes and the need for information sharing in evidence-based decision-making.
- ☞ **Coherence** across all three categories can be explored by comparing findings to **Assessment level 1 (analysis tables 1 and 2)**, in particular looking for obligations and commitments to CEDAW, MDG and Beijing Platform for Action. **Coherence with the national legal and policy framework (Assessment level 2)** may be explored by comparing findings with the national development plan (**analysis table 7**) and the institutional framework (**analysis table 8**), in particular regarding monitoring mechanisms for human rights and gender equality as this may be indicative of a national commitment on statistics.



GENERAL CONCLUSIONS: INFORMATION

- The following human rights and gender equality considerations are incorporated in the selection and development of indicators:
- The strategy sets the following directions for analysis of health information in terms of human rights and gender equality:
- Dissemination of health information encompasses human rights and gender equality considerations in the following ways:
- The following gaps and entry points were noted:

3.7 Health systems building block: financing



BACKGROUND INFORMATION

A good health financing system raises adequate funds for health, in ways that ensure people can use needed services, and are protected from financial catastrophe or impoverishment⁴. Universal coverage of health care means that everyone in the population has access to appropriate promotive, preventive, curative and rehabilitative health care when they need it and at an affordable cost. Universal access implies equity of access and financial risk protection²³. With respect to human rights and gender equality, health financing must promote reduced inequalities in health status between individuals and favour the most disadvantaged. These elements are also referred to as horizontal and vertical equity criteria²⁴.

Three interrelated functions are involved in order to achieve universal coverage: (1) how financial contributions to the health system are collected from different domestic and external sources (revenue collection); (2) how revenue/contributions are pooled so that the risk of having to pay for health care is not borne by each person individually (risk pooling); and (3) how these funds are spent on health services (purchasing)⁴. Risk pooling links to the principle of financial-risk protection, to ensure that the cost of care does not put people at risk of financial catastrophe. A related objective of health-financing policy is equity in financing, which means that households contribute to the health system on the basis of ability to pay²³. Expenditures in health need to prioritize health service with a high overall health impact while ensuring fair distribution of benefits, instead of disproportionately benefiting rich or urban populations²⁴.

Specific human rights and gender equality aspects to consider with respect to all health financing functions (**revenue collection, risk pooling and purchasing**) include:

- ✓ Services, goods and facilities should have adequate funding allocations
- ✓ Contributions to the health system on the basis of individuals'/households' ability to pay with attention to both direct and indirect costs
- ✓ People are protected from financial catastrophe or impoverishment, avoiding out-of-pocket expenditures with due attention to how gender inequality may affect different groups
- ✓ Particular attention to needs and life circumstances of women and men to ensure vulnerable groups have access to needed services
- ✓ Promoting transparency and accountability in health financing systems
- ✓ Development of financing schemes should be based on a participatory process
- ✓ Attention to the need for free/subsidized care for certain conditions, such as maternal health as stipulated in CEDAW, to avoid financial burdens for biological and social roles of women or men.

Analysis table 15: Financing

Analytical questions	Findings	Rationale	Selected relevant documents
<p>1. Are there references to health financing mechanisms that support entitlements to universal affordable health care?</p> <p><i>If so, do they consider differences between women's and men's health financing needs?</i></p>		States have an obligation to take concrete and targeted steps to ensure that health systems are established to provide adequate access to health services for all. The State must use maximum available resources and identify effective health financing mechanisms to ensure that health facilities, goods and services are accessible and affordable for all.	ICESCR Art.2; CESCR General Comment 14, paras. 12(b), 19; CESCR General Comment 19, paras. 4, 13; CESCR General Comment 3; Report of Special Rapporteur on the Right to Health (A/HRC/7/11), para. 96; Beijing Platform for Action: Strategic Objectives C.1(i); ICPD Chap. 8; Beijing Platform for Action, paras. 109–111, 345–361
<p>2. Does the strategy address the funding sources for health services including out-of-pocket expenditure and/or schemes such as social health insurance?</p> <p><i>If so, are the implications of these policy options on different social groups or women and men considered?</i></p>		Financial contributions to the health system need to be collected in ways that ensure that low-income households are not disproportionately burdened with health expenses as compared to richer households. With respect to the right to health, States should provide those who do not have sufficient means with the necessary health insurance and health-care facilities.	ICPD Chap 8; Beijing Platform for Action, paras. 109–111, 345–361
<p>3. Are strategies included to minimize out-of-pocket spending?</p> <p><i>If so, is there an overview of the kinds of out-of-pocket expenditure, and to whom and for what reasons out-of-pocket expenditures are incurred?</i></p>			CESCR General Comment 14, paras. 12, 19; CESCR General Comment 19, para. 4; CEDAW General Recommendation 24, para. 9; ICPD Chap. 8; Beijing Platform for Action, paras. 109–111, 345–361

Analytical questions	Findings	Rationale	Selected relevant documents
<p>4. Is there a clarification as to whether the strategy has been costed?</p> <p><i>If so, is information provided as to whether the estimated costs for implementing the strategy are within the resource envelope as defined by the Ministry of Finance?</i></p>		<p>The strategy needs to identify how available resources will be used to attain defined objectives. Costing is an important element to ensure that concrete and targeted steps are taken to achieve agreed-upon priorities.</p>	<p>CESCR General Comment 14, paras. 12, 53; CEDAW General Recommendation 24, para. 30; Report of Special Rapporteur on the Right to Health (A/HRC/7/11), para. 96; ICPD Chap. 13, 15; Beijing Platform for Action, paras. 109–111, 345–361</p>
<p>5. Are services in connection with maternal health (including medicines and other equipments) provided free of charge (when necessary)?</p>		<p>On the basis of equality of men and women, States need to ensure access to appropriate services in connection with maternal health, granting free services where necessary to alleviate the financial burden on women due to their biological and social roles as mothers.</p>	<p>CEDAW Art. 12; ICESCR, CESCR General Comment 19, para 19; CESCR General Comment 14, para.44; Declaration of Alma-Ata, para. V–VIII; Programme of Action–ICPD, Ch. VII and VIII; FWCW Declaration; Beijing Platform for Action para. 109–111, 345–361</p>
Equality and non-discrimination			
<p>6. If the formal health system is based on both public and private services, do financing schemes support equal access to both services?</p>		<p>Services need to be affordable for all, including socially disadvantaged groups. Payment for health-care services, as well as services related to determinants of health, must be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all.</p>	<p>CESCR General Comment 14, para. 12; CEDAW General Recommendation 24, para. 9; ICPD Chap. 7, 8, 13; Beijing Platform for Action, paras. 109–111, 345–361</p>
<p>7. Are measures outlined to avoid catastrophic payments by households?</p> <p><i>If so, does the plan acknowledge that such measures may need to be different for female versus male-headed households?</i></p>			<p>ICPD Chap. 7, 8, 13; CESCR General Comment 9; CESCR General Comment 19; Beijing Platform for Action, paras. 109–111, 345–361</p>

Analytical questions	Findings	Rationale	Selected relevant documents
Participation and inclusion			
8. Is there reference to the importance of ensuring that health financing reforms, strategies and action plans are based on the principle of participation, ensuring consultation with women and men of vulnerable groups?		People have a right to participate in the organization of the health sector, the insurance system, and in political decisions relating to the right to health taken both at the community and national levels. It is important that health financing reforms, strategies and action plans are guided by how affected populations experience the effects of how financial contributions are collected.	CESCR General Comment 14, para. 17 and 54; ICPD Chap. 4, 7, 8, 13; Beijing Platform for Action, paras. 109–111, 345–361
Accountability and transparency			
9. Are State accountability mechanisms to ensure effective use of resources (with respect to ensuring universal affordable access) addressed?		Accountability in health financing systems is important to ensure effective use of resources. Monitoring improves the effectiveness of Government spending, which is key to improved access to health services.	CESCR General Comment 14, para. 55; CESCR General Comment 16, para. 21; ICPD Chap. 7, 8, 13; Beijing Platform for Action: Strategic Objectives C.5(e)
10. Are mechanisms to ensure transparent purchasing processes addressed?		Transparent purchasing processes confer legitimacy by allowing access to the information on which decisions were based and clarifying the rationale for purchasing. It can also help reduce the scope for corruption.	CESCR General Comment 14, para. 18 and 55; ICPD Chap. 7, 8, 13; Beijing Platform for Action, paras. 109–111, 345–361
11. Does the strategy address availability and accessibility of purchasing information to ensure independent auditing and social auditing?		Appropriate availability and accessibility of purchasing information confers legitimacy to the auditing process and potentially reduces corruption.	CESCR General Comment 14, para. 55; ICPD Chap. 13; Beijing Platform for Action, paras. 109–111, 345–361
Issues for follow up via either interview, additional document review or otherwise			



WHERE TO FIND THE INFORMATION

- This table addresses financing issues as reflected in the health strategy document itself. The issues raised in the analysis tables are important human rights and gender equality issues and may therefore be addressed in the strategy. However, you may need to consult additional documents and staff members of the planning or health financing units of the MoH for clarifications on activities and processes not explicitly addressed in the strategy.
- Many Ministries of Health have developed health financing policies/strategies. Such a document may provide relevant background information or needed clarifications.



ANALYSIS TIPS AND NOTES FOR DRAWING GENERAL CONCLUSIONS: FINANCING

- ☞ There will be a range of different responses for each of these questions. Analysis of such responses should not focus on a mere "yes" or "no" answer; rather users should focus on strengths and weaknesses with respect to the functions of the health financing system.
- ☞ When findings are "no" answers, highlight these findings as potential avenues for further attention.
- ☞ Use the functions and the points listed in the Background Information as an analytic framework when summarizing questions in table 15.
 - > **Summarize the findings of questions 1, 2, 3 and 8** to determine the strategic directions for **revenue collection**.
 - > **Summarize the findings of questions 1, 2, 6 and 7** to identify examples of how the strategy addresses equality and non-discrimination through **risk pooling**.
 - > **Summarize the findings of questions 4, 9, 10 and 11** to clarify how the strategy gives attention to **priority setting, and accountability and transparency**, in selecting interventions and paying for services and service providers.
- ☞ **Coherence with the national legal and policy framework** (Assessment level 2) may be explored by comparing findings of analysis table 7.



GENERAL CONCLUSIONS FOR ANALYSIS TABLE 15: FINANCING

- Human rights and gender equality are addressed in the following ways with respect to revenue collection:
 - > Further attention may be required in the following areas:

- Human rights and gender equality are addressed in the following ways with respect to risk pooling:
 - > Further attention may be required in the following areas:

- Human rights and gender equality are addressed in the following ways with respect to purchasing:
 - > Further attention may be required in the following areas:

Endnotes

- 1 These are the International Convention on the Elimination of all Forms of Racial Discrimination (CERD), the International Covenant on Economic, Social and Cultural Rights (ICESCR), the Convention on the Elimination of all forms of Discrimination against Women (CEDAW), the Convention on the Rights of the Child (CRC), the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (ICRMW), and the Convention on the Rights of Persons with Disabilities (CRPD).
- 2 Terminology differs between countries; some of the terms used include National Development Plans, Poverty Reduction and Growth Strategies or Action Plans.
- 3 Terminology may vary between countries (strategy/plan/strategic plan, etc.).
- 4 *Everybody's business – strengthening health systems to improve health outcomes: WHO's framework for action*. Geneva, World Health Organization, 2007; available at: http://www.who.int/healthsystems/strategy/everybodys_business.pdf (accessed 25 March 2010).
- 5 *Guide for analysis and monitoring of gender equity in health policies*. Washington, DC, Pan American Health Organization; available at: http://new.paho.org/hq/index.php?option=com_docman&task=doc_download&gid=1518&Itemid= (accessed 25 March 2010).
- 6 Siddiqi S et al. Framework for assessing governance of the health system in developing countries: gateway to good governance. *Health Policy*, 2007, 90:13–25.
- 7 Sen G, George A, Östlin P. *Unequal, unfair, ineffective and inefficient: gender inequity in health. Why it exists and how we can change it. Final report to the WHO Commission on Social Determinants of Health*. Geneva, World Health Organization, 2007 (http://www.who.int/social_determinants/resources/csdh_media/wgekn_final_report_07.pdf, accessed 15 January 2010).
- 8 Zurn P et al. Imbalance in the health workforce. *Human Resources for Health*, 2004, 2:13.
- 9 George A. Nurses, community health workers, and home carers: gendered human resources compensating for skewed health systems. *Global Public Health*, 2008, 3(S1):75–89.
- 10 Reichenbach L, Brown H. Gender and academic medicine: impacts on the health workforce. *British Medical Journal*, 2004, 329:792–795.
- 11 *Integrating gender into the curricula for health professionals: meeting report, 4–6 December 2006*. Geneva, World Health Organization, 2007; available at: www.who.int/gender/documents/GWH_curricula_web2.pdf (accessed 25 March 2010).
- 12 Rivzi N, Nishtar S. Pakistan's health policy: appropriateness and relevance to women's health needs. *Health Policy*, 2008, 88:269–281.
- 13 Baghdadi G. Gender and medicines: an international public health perspective. *Journal of Women's Health*, 2005, 14:82–86.
- 14 The WHO (Health Metrics Network) Assessment Tool for “Assessing the National Health Information System” provides specific guidance on the collection, reporting and use of health information by countries and global agencies to support effective national health information systems. See Health Metrics Network. *Assessing the national health information system: an assessment tool*. Version 4.00. Geneva, World Health Organization, 2008; available at: http://www.who.int/healthmetrics/tools/Version_4.00_Assessment_Tool3.pdf (accessed 25 March 2010).
- 15 Beck T. *Guide to gender-sensitive indicators*. Hull, Canadian International Development Agency (CIDA), 1997.
- 16 Beck T. *Using gender-sensitive indicators: a reference manual for governments and other stakeholders*. London, Commonwealth Secretariat, 1999.
- 17 Ben Abdelaziz F. Consensus building for developing gender-sensitive leading health indicators. *International Journal of Public Health*, 2007, 52:S11–S18.
- 18 Cwikel JG. Applications and development possibilities – moving beyond the WKC project to incorporate cultural diversity. *International Journal of Public Health*, 2007, 52:S7–S8.
- 19 Lin V et al. Comparative evaluation of indicators for gender equity and health. *International Journal of Public Health*, 2007, 52:S19–26.
- 20 Standing H. Gender equity and health indicators in the context of health reforms. *International Journal of Public Health*, 2007, 52:S5–S6.
- 21 Fong M. Gender health indicators for whom? Responding to the needs of different users. *International Journal of Public Health*, 2007, 52:S9–S10.
- 22 Laurie M, Petchesky RP. Gender, health and human rights in sites of political exclusion. *Global Public Health*, 2008, 3(S1):25–41.
- 23 Carrin G, Evans D, James C. *Achieving universal health coverage: developing the health financing system*. Geneva, World Health Organization, 2005 (Technical Briefs for Policy Makers nr. 1); available at: http://www.who.int/health_financing/documents/pb_e_05_1-universal_coverage.pdf (accessed 25 March 2010).
- 24 James C et al. Clarifying efficiency-equity tradeoffs through explicit criteria (LDC focus). *Health Care Analysis*, 2005, 13:35–51.

ANNEXES

Annex 1

OHCHR and UNDG Resources on Health and Human Rights, HRBA and Gender Equality:

Human Rights and Poverty Reduction: A Conceptual Framework (HR/PUB/04/1)

<http://www.ohchr.org/Documents/Publications/PovertyReductionen.pdf>

Frequently asked questions on a human rights-based approach to development cooperation (HR/PUB/06/8)

<http://www.ohchr.org/Documents/Publications/FAQen.pdf>

Principles and Guidelines for a Human Rights approach to Poverty reduction strategies

<http://www.ohchr.org/Documents/Publications/PovertyStrategiesen.pdf>

Claiming the MDGs: A human rights approach

http://www.ohchr.org/Documents/Publications/Claiming_MDGs_en.pdf

Human Rights and the Millennium Development Goals in Practice: A review of country strategies and reporting

<http://www.ohchr.org/Documents/Publications/HRAAndMDGsInPractice.pdf>

Human Rights, Poverty Reduction and Sustainable Development: Health, Food and Water

<http://www.ohchr.org/Documents/Publications/HRPovertyReductionen.pdf>

More information on a HRBA to development programming is available at the following URL:

<http://www.undg.org/index.cfm?P=221>

For more information and knowledge on HRBA, you can also subscribe to HuriTalk: 'the HRBA portal' at:

http://hrbaportal.org/?page_id=2077

E-learning kit on the UN Common Programming Process, including core modules on HRBA and Gender Equality, is available at the following URL:

<http://www.unssc.org/home/activities/un-common-country-programming-processes-e-learning-toolkit>

More information on Gender Equality in development programming is available at:

<http://www.undg.org/index.cfm?P=222>

Handbook on HIV and Human Rights for National Human Rights Institutions (published jointly with UNAIDS)

<http://www.ohchr.org/Documents/Publications/HandbookHIVNHRIs.pdf>

International Guidelines on HIV/AIDS and Human Rights-2006 Consolidated Version

<http://www.ohchr.org/Documents/Publications/HIVAIDSGuidelinesen.pdf>

Fact sheet No. 33 – Frequently Asked Questions on Economic, Social and Cultural Rights

<http://www.ohchr.org/Documents/Publications/FactSheet33en.pdf>

WHO resources on National Health Sector Strategies:

Strengthening Health Systems to Improve Health Outcomes – WHO's Framework for Action

http://www.who.int/healthsystems/strategy/everybodys_business.pdf

Key component of a well functioning health system

http://www.who.int/healthsystems/publications/hss_key/en/index.html

Making Health Systems Work Series (link to a number of WHO publication)

<http://www.who.int/management/mhswork/en/index.html>

Consultations on the development of the WHO Global Health Sector Strategy for HIV 2011-2015

http://www.who.int/hiv/aboutdept/strategy_consultation/en/index.html

International Health Partnership (IHP+)

<http://www.who.int/healthsystems/ihp/en/index.html>

More resources on Health System Strengthening (HSS)

http://www.who.int/healthsystems/gf_round10/en/index.html

Monitoring the building blocks of health systems: a handbook of indicators and their measurement strategies

<http://www.who.int/healthinfo/systems/monitoring/en/index.html>

Health Systems Development – National Health Planning and Health Financing (SEARO)

<http://www.searo.who.int/en/Section1243/Section1307.htm>

WHO Health Systems Strategy

<http://www.who.int/healthsystems/strategy/en/>

Health Systems- Governance

<http://www.who.int/healthsystems/topics/stewardship/en/index.html>

WHO resources on Gender, Health and Human Rights:

Women's health and human rights: Monitoring the implementation of CEDAW

http://www.who.int/reproductivehealth/publications/gender_rights/9789241595100/en/index.html

25 Questions and Answers on Health and Human Rights

<http://www.who.int/hhr/activities/publications/en/index.html>

A Human Rights-Based Approach to Health (jointly with OHCHR)

http://www.who.int/hhr/activities/hrba_to-health_infosheet.pdf

The Right to Health, Fact Sheet No. 31 (jointly with OHCHR)

http://www.who.int/hhr/activities/Right_to_Health_factsheet31.pdf

Fact Sheet on the Right to Health

http://www.who.int/hhr/Right_to_health-factsheet.pdf

Fact Sheet on the Right to Health (EMRO)

http://www.who.int/hhr/Right_to_health.pdf

The Right to Water, Fact Sheet No. 35 (jointly with OHCHR and UN HABITAT)

<http://www.ohchr.org/Documents/Publications/FactSheet35en.pdf>

The Right to Water, Issue No.3

http://www.who.int/docstore/water_sanitation_health/Documents/righttowater/righttowater.pdf

Fact Sheet on the Health of Indigenous Peoples

<http://www.who.int/hhr/activities/Fact%20Sheet%20Indigenous%20Health%20Nov%202007%20Final%20ENG.pdf>

Fact Sheet on A Human Rights-Based Approach to Neglected Tropical Diseases

<http://www.who.int/hhr/activities/NTD%20information%20sheet%20-%20English.pdf>

WHO's Contribution to the World Conference Against Racism, Racial Discrimination, Xenophobia and Related Intolerance: Health and Freedom from Discrimination

http://www.who.int/hhr/activities/q_and_a/en/Health_and_Freedom_from_Discrimination_English_699KB.pdf

International Migration, Health and Human Rights

<http://www.who.int/hhr/activities/en/FINAL-Migrants-English-June04.pdf>

Human Rights, Health and Poverty Reduction Strategies (jointly with OHCHR)

http://whqlibdoc.who.int/hq/2008/WHO_HR_PUB_08.05_eng.pdf

Women and health: today's evidence tomorrow's agenda

<http://www.who.int/gender/documents/en/>

10 Facts on Women's Health

http://www.who.int/gender/documents/10facts_womens_health_en.pdf

Q&A – What is a gender based approach to public health?

<http://www.who.int/features/qa/56/en/index.html>

Transforming Health Systems: Gender and Rights in Reproductive Health. A Training Curriculum for Health Programme Managers

http://www.who.int/reproductivehealth/publications/gender_rights/RHR_01_29/en/index.html

Integrating Poverty and Gender into Health Programmes: A Sourcebook for Health Professionals (Module on Mental Health)

http://www.wpro.who.int/publications/pub_9290612983.htm

Integrating Poverty and Gender into Health Programmes: A Sourcebook for Health Professionals (Foundational Module on Gender)

http://www.wpro.who.int/NR/rdonlyres/C93DEB19-91A0-4EA5-A1EF-50B26072410A/0/Foundational_module_on_gender.pdf

Integrating gender into HIV/AIDS programmes in the health sector

<http://www.who.int/gender/documents/hiv/9789241597197/en/>

Policy approaches to engaging men and boys in achieving gender equality and health equity

http://www.who.int/gender/documents/men_and_boys/9789241500128/en/

Gender, women and primary health care renewal

http://www.who.int/gender/documents/women_and_girls/9789241564038/en/

Sex, gender and influenza

http://www.who.int/gender/documents/women_and_girls/9789241500111/en/

Strategy for integrating gender analysis and actions into the work of WHO

<http://www.who.int/gender/documents/gender/9789241597708/en/index.html>

WHO page on Gender and Health:

http://www.who.int/management/district/basic_principles/en/index.html

WHO page on Gender, Women and Health

<http://www.who.int/gender/documents/en/>

WHO page on Gender and Rights

http://www.who.int/reproductivehealth/topics/gender_rights/en/index.html

Annex 2

Feedback questionnaire

Your feed-back is important for future tool improvements. Your inputs to future revisions are very appreciated and can be compiled in the following form and sent anonymously by regular mail, or by email at: genderandhealth@who.int or humanrights@who.int. Please ensure to include “Review comments on human rights and gender equality in health sector strategies: how to assess policy coherence” in the subject field.

Thank you for taking the time to send us your comments and suggestions.

1. In what context was the tool used (during a review of, or preparation for a new health sector strategy or a separate study; in its entirety or only selected parts, etc.)?

2. Which stakeholders participated in:
 - a. The review team?
 - b. The planning of the review?
 - c. Discussions about the findings?

3. Overall, was the practical guidance on how to use the tool helpful? What additional guidance would have supported your review?

The centrality of human rights and gender equality to health and development has been upheld by world leaders at the Millennium Summit and other more recent global events. This tool is designed to move from rhetoric to practice.

It supports a multi-stakeholder process aimed at ensuring that national health sector strategies comply with human rights and gender equality. It does so by posing critical questions and providing guidance when reviewing an existing – or developing a new – national health sector strategy.

The World Health Organization (WHO), the Swedish International Development Cooperation Agency (Sida) and the UN Office of the High Commissioner for Human Rights (OHCHR) are pleased to collaborate in strengthening efforts to realize the enjoyment of the highest attainable standard of health - a fundamental human right that belongs to every man, woman and child.

For more information, please contact:

World Health Organization (WHO)

20 Avenue Appia
CH-1211 Geneva 27
Switzerland

Website: www.who.int/hhr
www.who.int/gender

Email: hhr@who.int

**Office of the High Commissioner
for Human Rights (OHCHR)**

Palais des Nations
8-14 avenue de la Paix
CH-1211 Geneva 10
Switzerland

Website: www.ohchr.org

**Swedish International
Development Cooperation
Agency (Sida)**

Valhallavägen 199
SE-105 25 Stockholm
Sweden

Website: www.sida.se

ISBN 978 92 4 156408 3

