The right to health in practice

a framework to guide the design of aid-funded health programmes

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Abstract

More than 60 years have passed since the nations of the world united in acknowledging the inherent freedom, dignity and equality of all people in the Universal Declaration of Human Rights. Incongruously, 'development', another contemporaneous international movement, failed to embed these rights into its practices. As a result, millions of people in developing countries are still denied such rights as freedom from avoidable ill health and premature mortality, with development projects having focused instead on varying economic growth strategies.

However, the past decade has witnessed a commendable global effort to reduce health inequities, with vast increases in health aid funding, particularly from the non-state sector to combat specific diseases. But after decades of neglect, the health systems of developing countries are struggling to accommodate these increased resources and many risk collapse. Without well functioning health systems, the right to health cannot be realised.

In this thesis, health rights are investigated to seek solutions to these global health issues. I use a right-to-health framework to guide the design of aid-funded health programmes that meet health rights obligations, by working with and strengthening health systems. The thesis describes the development of a set of tools to design activities, then to identify their likely impact on a health system. The tools are derived from reviews of the literature and are tested for validity against case studies in Papua New Guinea. The three tools focus on:

- *respecting* health rights by designing with a full understanding of the health system
- *fulfilling* health rights by designing available, accessible, acceptable and quality services
- *protecting* health rights by conducting a health systems impact assessment.

The case studies revealed that the tools were relevant and feasible, and provided a means of early identification (and subsequent avoidance) of negative programme outcomes.

Health rights offer a new global health diplomacy; a means by which all parties can be accountable and transparent in their legal duties to respect and protect health systems, so health rights can be fulfilled. Importantly, this framework provides a means of demonstrating that interventions, at the health systems level, do no harm.

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Abbreviations

AAAQ	Available, Accessible, Acceptable, Quality (a framework for the right to health, developed from General Comment 14)
ADB	Asian Development Bank
ARVs	Anti retrovirals
AusAID	Australian Agency for International Development
CEDAW	Convention of the Elimination of All Forms of Discrimination against Women
CRC	Convention on the Rights of the Child
DAC	Development Assistance Committee of the OECD
DAH	Development Assistance for Health
GAVI	Global Alliance for Vaccines and Immunisation
GDP	Gross Domestic Product
GHI	Global Health Initiative
GNI	Gross National Income
GNP	Gross National Product
GSK	GlaxoSmithKline
HDI	Human Development Indicators
HIA	Health Impact Assessment
HIS	Health Information Systems
HRIA	Human Rights Impact Assessment
HSIP	Health Sector Improvement Program (PNG)
ICESCR	The International Covenant of Economic, Social and Cultural Rights
IMF	International Monetary Fund
MDGs	Millennium Development Goals

MTDS	Medium Term Development Strategy
NDOH	National Department of Health, Papua New Guinea
NGO	Non-Government Organisation
NZODA	New Zealand Official Development Assistance
NZAID	New Zealand Agency for International Development
ODA	Official Development Assistance
OECD	Organisation for Economic Co-operation and Development
PMGH	Port Moresby General Hospital, Papua New Guinea
RBA	Rights-based Approach
SWAp	Sector-Wide Approach
TRIPS	The WTO Agreement on Trade-Related Aspects of Intellectual Property Rights
UDHR	Universal Declaration of Human Rights
UNDP	United Nations Development Programme
UPNG	University of Papua New Guinea
USAID	US Agency for International Development
WDI	World Development Indicators (World Bank)
WHO	World Health Organization
WTO	World Trade Organization

Chapter 1 Introduction

1.1 The right to health

It is now over 60 years since the nations of the world came together in a spirit of global cooperation and peace to form the United Nations (UN). Its founding document, The Universal Declaration of Human Rights, was written while the world was still reeling from the horrors of the Second World War and it was the first global statement of the inherent dignity and equality of all human beings (Ki-moon, 2008). The World Health Organization (WHO), an agency of the UN, from its outset framed health as a human right. The WHO Constitution states, "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition" (World Health Organization, 1946).

> The Universal Declaration of Human Rights laid the foundations for the international legal framework for the right to health. Since then, the right to health has been codified in numerous legally binding international and regional human rights treaties (United Nations, 2004, para 15).

Defining documents on the right to health include Article 12 of the International Covenant of Economic, Social and Cultural Rights, (United Nations High Commissioner for Human Rights, 1966), The Alma-Ata Declaration (World Health Organization, 1978), and the UN General Comment 14 (United Nations, 2000b).

Despite repeated global agreements that all people have a right to health and that this right includes access to quality health care, vast inequities in health remain between and within countries. Although there has been extraordinary progress in combating disease and improving the quality and length of life, these gains have not been uniform. There are still millions of people in the world who have no access to health service whatsoever and over 100 million people fall into poverty each year paying for health care (World Health Organization, 2008b).

Concern at the failure of global commitments to improve health for all people is not a recent phenomenon. The Alma-Ata conference in 1978 was called to address the "gross inequality in the health status of the people particularly between developed

and developing countries" (World Health Organization, 1978). The resulting Alma-Ata Declaration identified primary health care as the means through which the right to health is best fulfilled. This Declaration prioritised health systems and the central role of primary health care within them. It had a specific objective and timeline to achieve "an acceptable level of health for all the people of the world by the year 2000" (World Health Organization, 1978, para x). As history attests, that ambitious goal was not achieved.

However, the year 2000 saw two other significant events that had a major bearing on global health[1]. The first was the adoption of the UN General Comment 14 that spelled out in considerable detail the entitlements and obligations of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. This comment provides practical guidance on the operationalisation of the right to health.

> Although neither complete, perfect, nor binding, general comment 14 is compelling and groundbreaking. The comment shows a substantive understanding of the right to health that can be made operational and improved in the light of practical experience. The influence of Alma-Ata on general comment 14 is explicit and clear. (Backman et al., 2008, p.2048)

The other significant event was the acceptance of the Millennium Declaration by the 189 UN Member States, and the adoption of the eight Millennium Development Goals (MDGs). These included specific targets to eradicate extreme poverty, reduce child and maternal mortality, and combat HIV/AIDS, malaria and other diseases by 2015. The Declaration also made six millennium human rights commitments (United Nations, 2000a).

1.2 Global health since 2000

In the decade since 2000 there has been a significant increase in the volume of aid funding that is directed to health. Total aid funding from the bilateral State donors rose from US$52 billion in 2001 to $121 billion in 2008 (OECD, 2009). It is estimated that aid spending on health in 2007 was US$21 billion (Ravishankar et al., 2009), compared with only US$5.6 billion in 2001 (Lane & Glassman, 2007). While

[1] Global health is the term used in this thesis to refer to "collaborative trans-national research and action for promoting health for all" (Beaglehole & Bonita, 2010); it therefore implies the inclusion of all parties, state and non-state, working to promote health in developing countries.

this is, on the face of it, a much-welcomed response to the obvious need for improved health care, the scale of the increase carries risks. There are serious concerns that after decades of neglect, the health systems in many developing countries are not sufficiently robust to accommodate the additional funding (Farmer & Garrett, 2007; Freedman, 2009; Garrett, 2007b). These countries are often desperately short of health workers and lack facilities and distribution systems for the supply of medicines. Aid donors putting significant portions of their funding towards specific diseases, especially HIV/AIDS and malaria, can further compound this situation. They are able to attract the few resources away to their specific services, leaving the health system even weaker and less able to provide basic health care. The MDGs themselves pose such risks because of their disease-specific focus, and their failure to address underlying health systems.

> The right to health requires, inter alia, the development of effective, inclusive health systems of good quality. For the most part, the health-related Millennium Development Goals are disease specific or based on health status — malaria, tuberculosis, HIV/AIDS, maternal health and child health — and they will probably generate narrow vertical health interventions. Specific interventions of this type are not the most suitable building blocks for the long-term development of health systems. Indeed, by drawing off resources and overloading fragile capacity, vertical interventions may even jeopardize progress towards the long-term goal of an effective, inclusive health system (United Nations, 2004, para 27).

Along with the increasing scale of funding in global health, there has also been a change in governance. Non-state actors, namely global health initiatives (GHIs) and non-government organisations (NGOs), have become influential in both the funding and the delivery of global health care programmes. They now account for over 25 per cent of the spending on health in developing countries (Ravishankar et al., 2009). However, there is considerably less accountability and transparency with their programme expenditure and monitoring than there has been for the bilateral and multilateral donor agencies. As these non-state organisations have also been those most likely to engage in disease specific interventions, their potential impact on health systems has been a cause for concern (Biesma et al., 2009; Freedman, 2005; Ooms, Van Damme, Baker, Zeitz, & Schrecker, 2008).

1.3 Human rights and international health programmes

This thesis examines these current global health issues through a right-to-health lens. It explores the view that human rights locate aid for health within international human rights law, and this changes aid for health from a philanthropic, voluntary or optional action, to a legal duty. This perspective holds that health rights obligations go beyond the State to include the State's international partners, including non-state partners. (However, States are reluctant to concede they carry *legal* obligations to assist other States to meet their rights duties (United Nations, 2007; Yamin, 2010).) Such a rights-based view offers solutions to those current debates about the lack of accountability of the non-State sector. It also supports the calls for a new global health diplomacy in which all parties working in global health must demonstrate that their programmes work to respect, protect and fulfil the right to health (Kickbusch, Hein, & Silberschmidt, 2010; Silberschmidt, Matheson, & Kickbusch, 2008).

A new global health governance mechanism that requires transparent accountability of international health interventions, including demonstration that all programmes respect, protect and fulfil health rights, would be a helpful step towards acknowledging health rights obligations.

Despite the six-decade all-nation support for human rights and the right to health, there has been little evidence of health rights becoming embedded in international health programmes or policies. This is partly explained by the legal discourse of rights, which has presented a barrier for those trained in health disciplines (Asher, 2004). Health workers and NGOs have appeared uncertain as to how to translate 'engaging with the right to health' into programme activities. This has resulted in a dearth of literature demonstrating the operationalisation of health rights, which in turn means there is little guidance available for those NGOs or GHIs who wish to become more immersed in rights-based programming.

1.4 Aims and structure of the thesis

This thesis aims to address the need for guidance in designing rights-based health programmes. Specifically, it aims to develop a rights-based framework with tools that can help international programme planners to undertake a process of programme development that will respect, protect and fulfil the right to health. Key

elements in the process are working with human rights concepts, and respecting and protecting the health system as the core institute through which the right to health is fulfilled. The framework within which the tools will be located requires three steps: to respect health rights by gathering considerable detail about the context within which the programme will be operating; to fulfil health rights by designing a programme that is available, accessible, acceptable, and of good quality; to protect health rights by undertaking a health systems impact assessment of the programme prior to its implementation.

The research and development of the framework in this thesis followed an iterative process that is presented in Part One (Chapters 2-5). The research question at the start of the process was: *what are the essential elements of an aid-funded health project to ensure it is implemented and sustained within a fragile economy?* Following some initial research on the history of aid, this question was subsequently rephrased as explained below. Further refinements were made to the research framework during the course of an in-depth review of the literature.

1.4.1 Part one

The groundwork for this research commenced by tracing the 60-year history of aid to identify whether there were documented periods of success. It was reasoned that key elements of successful periods might be identifiable. In the process of exploring the history of aid, interesting issues emerged. In particular, the nature of aid programmes followed the economic and political trends of donor countries, rather than responding to needs in donor countries. Furthermore, it has only been in the past 10 years that health has become prioritised as a focus for aid funding. Importantly, during this decade, non-state actors have been playing a significant role in driving the health agenda.

This historical reflection, presented in Chapter 2, also explored whether the right to health had been adopted widely as an aid modality that could respond to people's health needs. Perhaps surprisingly, given international commitment to various treaties and instruments of international law, health rights have never become a dominant paradigm in development assistance.

After this initial investigation into health aid and history, the right to health was selected as the framework through which the rest of the thesis would be viewed.

This re-shaped the research question to become: *can the right to health be used to guide the design of aid-funded health programmes?*

Chapter 3 explains the methods employed throughout this thesis. It discusses the literature reviews that informed the rights-based framework, and the search for literature to guide the development of tools and indicators to operationalise the right to health. The process of selecting the indicators is also explained before proceeding to outline the ways in which the drafted tools would be tested against case studies from Papua New Guinea (PNG).

In Chapter 4, the first part of the literature review investigates the right to health as a framework to guide the design of aid-funded health programmes. The impetus for this investigation came from the understanding that rights are part of international law. Therefore, if aid donors are seen to be international partners with health rights obligations, then aid for health could be reconstructed as not just philanthropic, or ethical, but also as a legal duty. Drawing on the work of leading rights theorist and economist, Amartya Sen, the right to health is positioned in this work as a means of achieving development. The literature review also identified General Comment 14 (United Nations, 2000b), and its interpretation by the first UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health in his many reports, as being of particular importance. The central role of health systems, and the identification of availability, accessibility, acceptability and quality of health services, emerged as key elements in the rights-based framework developed in this chapter.

The final chapter of Part One reviews research and programmes that had employed rights-based approaches in practice. The chapter explores this relatively small field of literature to identify commonalities in their approaches, and to allow these to inform the selection of indicators in the framework's tools. Because the earlier chapters had identified health systems as critical to meeting health rights, indicators to assess and protect health systems were especially important.

On completion of Part One, the thesis had developed a draft rights-based framework, with three tools, to guide the design of aid-funded health programmes.

1.4.2 Part two

The second part of this work undertakes a detailed examination of the framework and its tools in practice. The tools are tested to assess their reliability, appropriateness, relevance and ease of use with an actual or planned programme. There are five questionnaires making up the three tools, and in each of Chapters 6-10, one of those questionnaires is examined to assess how useful it would have been during the design phase of two programmes.

Two different case studies are used and both pertain to PNG. The first three questionnaires that make up Tool One are tested on the first case study. Tools Two and Three, using the fourth and fifth questionnaires, are tested against the second case study. If the tools are valid, they will elicit information about the local context in PNG, including the health system, which would guide programme designs to avoid the difficulties as encountered in both programmes. The case studies specifically selected those two programmes because they did not achieve their objectives, and one did not even receive approval to proceed to implementation. They therefore offer a good opportunity to test tools to determine if a rights-based design tool could avert the identified problems in the designs.

Testing the tools enables feedback about the selection of indicators, and refinements are made to each of the questionnaires.

Demonstrating the use of the tools on these case studies may play a role in encouraging health workers and NGOs to adopt rights-based approaches. The processes employed, and the indicators in the questionnaires are neither unfamiliar nor difficult for practitioners in health and development.

1.4.3 Part three

The concluding part of the thesis consists of two chapters, the first of which presents the complete and tested rights-based framework and its tools. In the final chapter conclusions are drawn about the importance of the right to health in global health. The thesis returns to the research question and answers in the affirmative that the right to health can indeed guide the design of aid-funded health programmes. It also reviews other issues in global health where this work, and future research, may make a useful contribution.

1.5 Focus on health care programmes

The right to health is not limited to a right to health care, and nor is it a right to be healthy. Good health cannot be ensured by a State, although the State does have responsibility to provide health care when it is required, and to protect against every possible cause of harm to health (United Nations, 2000b). Included in these protections are the underlying determinants of health, including potable water and sanitation, shelter and adequate nutrition. The State has a duty to ensure these determinants of health are available, accessible, acceptable, and of good quality. Although these are essential for the attainment of good health, and a vital component of health rights, they lie outside the scope of this thesis. The framework and tools developed in this work specifically address the design of health programmes to deliver health care services rather than the underlying determinants. It is imperative however that assessment of the underlying determinants is included in building an understanding of the context in which health programmes are located. As such, questions on these issues are included in the first tool of the framework.

1.6 Health and development discourse

Throughout this thesis, the discourse of health and development is favoured over legal discourse. In large part, this reflects the background of the author. But importantly, it was a deliberate choice to help bridge the divide between those who understand human rights from a legal perspective, and those who are faced with the actualities of health failings in developing countries.

General Comment 14 was also instructive in the choice of common terms for this work. For example, the use of the terms ‘developed’ and ‘developing countries’ follows from the Comment, as does the term Member States rather than ‘countries’.

The thesis proposes that adopting a rights-based approach to health programmes in developing countries is not a leap into the unknown. The rights concepts are familiar to those who already work with best practice and participatory approaches to development.

The framework as it develops over the next few chapters is one that has practical application. The tools promote acknowledgement of the essential role and fragility of health systems in developing countries. They gather contextual information by way of respecting rights. They apply this information and human

rights concepts to the programme design as a means of fulfilling rights. The final tool in the framework measures the impact of the proposed programme on the health system before it is implemented. This is a new and distinctive feature of the rights-based framework, which protects the right to health, and lends itself to the edict: first, do no harm.

PART ONE: THEORY AND FRAMEWORK

Chapter 2 Background

Good health is a precious commodity, with its value noticed more by its absence than its presence. Yet for billions of people in the world today, especially those 1.4 billion living in extreme poverty (World Bank, 2010a), good health and access to quality health care services, remain unattainable. Not only does poverty limit access to health care, but poor health can lead to poverty: it is estimated an additional 100 million people fall into poverty each year paying for health care (World Health Organization, 2008b). This is in sharp contrast to the ever-improving health and longevity experienced by those living at the opposite end of the wealth spectrum.

Health systems that ensure quality health care is available, accessible and acceptable to all are an essential component in addressing the health of the population. The International Covenant on Economic, Social and Cultural Rights (ICESCR) and other international treaties in recognising the need for functioning health systems have made it incumbent upon States to provide them. Official development assistance (as aid is classified by States) could well make a significant contribution towards improving health systems. Indeed, as is examined later, assisting States to meet their rights obligations is also a legal and ethical duty of other States.

This thesis explores the relationship between aid and health and endeavours to develop a framework to guide the design of sustainable, effective and appropriate aid-funded health interventions. Historically, health has long been a shared concern between States because of the risk of contagious diseases spreading rapidly across borders. European states gathered for the first international health conference in 1851 to discuss cooperation on cholera, plague, and yellow fever. The concern continues to this day, and the recently revised International Health Regulations (World Health Organization, 2005a), adopted by 194 States, greatly expand the range of events that states must notify to the World Health Organization (WHO). The revisions address increasing global health threats and the need to respond with more effective surveillance and control practices (Baker & Forsyth, 2007; Fidler & Gostin, 2006). In an increasingly globalised world, trade agreements and States' foreign policies have also been recognised as having potential to impact on the health of people in other

States. Accordingly, there have been calls to consider this impact before adopting any new foreign policies (Feldbaum, Lee, & Michaud, 2010; Fidler & Gostin, 2006; Kickbusch, Novotny, Drager, Silberschmidt, & Alcazar, 2007; Ministers of Foreign Affairs of Brazil France Indonesia Norway Senegal South Africa and Thailand, 2007).

Currently, there is a sense of urgency surrounding aid and health debates, because of vast increases in funding being directed into health in developing countries via aid programmes from a multitude of donors. As the following chapters reveal, there is no simple relationship between increased funding for health programmes and improved health outcomes in developing countries. In fact, there is evidence that increased funding can even worsen overall health outcomes and weaken health systems (Freedman, 2009; Garrett, 2007b; World Health Organization Maximizing Positive Synergies Collaborative Group, 2009).

There is, therefore, every reason to develop a framework that will assist programme planners to avoid activities that are unlikely to improve health on a sustainable basis, or that will weaken health systems.

2.1 Aid for health

Official development assistance has become a well-funded industry over the past 60 years, with an estimated US$2.3 trillion having been spent on aid programmes since the early 1950s (Easterly, 2006). In 2006, OECD donor countries provided US$103 billion in aid, of which about 10 per cent was allocated to health. Aid spending on health was estimated at US$21 billion in 2007, and total aid allocations were US$121 billion in 2008 (OECD, 2007, 2009; Ravishankar et al., 2009).

The effectiveness of this investment in developing countries is frequently debated (Backman et al., 2008; Garrett, 2007b; Hughes, 2004; Sachs, 2007). It will never be possible to state categorically whether such a large investment in aid over 60 years has been effective. As there is no counter-factual, there is no way of knowing what would have happened if $2.3 trillion had not been invested in aid. Nor can the impact of this funding be looked at in isolation from the economic effects of conditions that have often been placed upon aid recipients.

Of relevance to this thesis, because of the absence of reliable data on health expenditure, is the fact that actual spending on aid, and on health aid, is in fact unknown. Despite the data cited above that demonstrate large increases in health aid

allocations over the past 10 years, information systems are simply not in place in many developing countries to verify that the allocations were expended as planned, or even expended in the health sector. There is no accurate single methodology that accounts for all aid spending. It is also possible that some aid commitments are counted more than once, particularly those made by non-government organisations (NGOs) or global health initiatives (GHIs) that often function as implementers of already-counted donor government ODA.

Aid for health has swung in and out of favour over the past 60 years, generally following the same trends as overall development assistance (Feldbaum et al., 2010). Each of the six decades since the 'development era' began has had significantly different approaches to, and objectives for, the development and health agenda. This history of aid shows that it is all too easy to invest in aid programmes that then fail to make a difference to those living in desperately poor, marginalised and unhealthy circumstances. That history is now explored to reveal the trends and shifting focus of aid over time. Australian and New Zealand aid to the Pacific Islands and Papua New Guinea is used to illustrate the history, and to set the scene for the case studies in the second half of the thesis.

2.2 The beginning of aid and the development era

The modern era of aid and development dates its commencement to 1949, when US President Harry Truman, in his second term inaugural speech said, "We must embark on a bold new program for making the benefits of our scientific advances and industrial progress available for the improvement and growth of *underdeveloped* areas. The old imperialism – exploitation for foreign profit – has no place in our plans. What we envisage is a program of *development* based on the concepts of democratic fair dealing" (Truman, 1949). (emphases added)

Development discourse theorists claim that the concept of 'underdevelopment' began with Truman's speech, which had the effect of immediately categorising two billion people as underdeveloped (Esteva, 1992). It also launched relationships between developed and developing countries around the provision of aid for those development projects that developed countries believed would promote economic growth.

However, security issues were also a driving force for development assistance at that time. Australia and New Zealand's adoption of the Colombo Plan in 1950, which focused on economic development in South and South East Asia, was grounded in the belief that improved living standards would foster political stability, prove a counter to communism in the region, and encourage friendly governments in the region (Department of Foreign Affairs and Trade, 2005) (Ministry of Foreign Affairs and Trade, 2001). Similarly, in creating the US Agency for International Development (USAID) in 1961, US President John F Kennedy acknowledged US interests in the role of aid in preventing the economic collapse of developing country governments, "which would be disastrous to our national security, harmful to our comparative prosperity, and offensive to our conscience" (US Agency for International Development, 2010). President Nixon was even more blunt when he said in 1968, "Let us remember that the main purpose of American aid is not to help other nations but to help ourselves" (Opeskin, 1996, p.21).

The relationship between aid donor and recipient States in the 1960s was not dissimilar from a welfare state relationship between government and citizen. The discourse reflects the assumed superiority of the donor country, in the same way that the word 'developed' reflects superiority over 'underdeveloped'. No recognition of values other than those of the donor nation were acknowledged. Aid was given to enable more people to live out their lives and have the chance to add their quota to human achievement (Department of External Affairs, 1966). This suggests that donor States were prioritising economic or trade contributions above all others.

Internationally, the types of projects supported by aid in the 1950s and 60s were education, (provision of teachers), agriculture, (providing farmers and tractors) and infrastructure development (building hospitals, roads, wharves) (Department of External Affairs, 1966). In the 1960s and early 1970s colonialism was drawing to an end in the Pacific and elsewhere in the world. Most Pacific Islands gained independence from their colonial rulers throughout this period (with Samoa first in 1963 and Papua New Guinea in 1975). Prior to gaining independence, Pacific Islands did not receive aid as such, but had budgetary support from the colonial heads of state. As they gained independence, Pacific Islands then started receiving aid not just from their former colonisers, but also from other donors, bilateral and multilateral, and received both grants and loans from the World Bank and the Asian Development Bank (ADB).

Along with this increasing number of aid donors to recipient States came a change in the nature of aid projects. For example, in the agricultural sector, aid programmes became less likely to provide farmers and more likely to provide advisors to the agricultural ministries to develop policy and promote the growth of export commodities (Ministry of Foreign Affairs, 1974a, 1974b).

2.3 The neo-liberal approach to aid

Globally, neo-liberalism became the dominant political and economic paradigm from the mid 1980s. The era was characterised by a shift to deregulated, market-led economies, downsizing the public sector and promoting private sector growth; in all, it removed the social out of the state. These tenets were reflected in changing aid modalities, partnerships and programmes. Previously aid discourse reflected donors' social responsibility and their concerns for political security. The new paradigm saw the discourse change to a language of contracts, with responsibilities for both parties specified, and out-clauses introduced for donors if recipients failed to fulfil contractual obligations (Ministry of External Relations and Trade, 1993). At the same time, despite commitments in the early 1980s by OECD countries to move towards providing 0.7 per cent of their GNI in aid, aid budgets started shrinking, justified on the grounds of fiscal stringency.

Throughout the 1990s, developing countries underwent structural adjustment programmes imposed by the international banks and supported by donor governments. These programmes involved establishing neo-liberal economic principles, and adopting the principles of 'good governance'. Consultants specialising in public sector reform, economic management, human resource development and training were prominent in Pacific Island and PNG aid programmes, as they were elsewhere in the world.

Governance dominated much of the aid agenda in the 1990s, and it conveyed far more than good management. It embedded technologies of performance which enabled regulation at a distance, enforced through the terms of loans and aid projects themselves (Dean, 1999). Unless countries incorporated good governance into their economic management, then future funding from development agencies was withheld. The World Bank published research demonstrating that aid spent in countries with sound policy and good management was more than twice as effective as aid in

countries without such virtues. “Governance matters in the sense that there is a strong causal relationship from good governance to better development outcomes such as higher per capita incomes, lower infant mortality and higher literacy” (Kaufmann, Kraay, & Zoido-Lobaton, 1999, p1). These findings, although contested subsequently, (Easterly, 2006) were used to support World Bank reform policies.

Public sector and governance reform projects routinely involved strengthening the role of democracy, fighting corruption, separating the functions of public service and Parliament, reducing the size of the public service, privatising state enterprises, developing the private sector and strengthening the market economy. Thus it was quite clearly a neo-liberal project.

In the Pacific region, ADB loans and grants were conditional on the demonstration of good governance. The ADB determined that the technologies of good governance (efficient public sector management, promotion of private enterprise, privatisation of social services and balanced budgets) were lacking in Pacific nations, and policy reform to enable better governance became the key strategy of ADB funding in the late 1990s. Aid projects focused on training the public sector in good governance techniques, and there was a concomitant reduction in support for social services. “During the period 1995-98, the strategic focus of the ADB’s operations in Pacific Development Member Countries shifted from sector and project lending to support for macroeconomic stabilization and structural adjustment, and public sector and governance reform” (Knapman & Saldanha, 1999, p1).

Aid projects were expected to deliver the right environment for future aid to become more effective. The Bank considered it important to first assist Pacific nations to get their economic policy and governance environments right, thus ensuring that follow-up sector and project investments would achieve due returns (Knapman & Saldanha, 1999).

2.3.1 Neo-liberalism in PNG

Although all Pacific Islands were subjected to the changes in aid and economic policies as described above, the situation in PNG is examined because it offers a good example of the neo-liberal structural adjustment policies and is also the country from which the case studies are drawn in this thesis.

The latter half of the 1990s brought a rapidly declining economic situation in PNG. The GDP in 1999 was only 3 per cent higher than in 1994, not enough to compensate for population growth, which was not less than 2.5 per cent per annum. In 1997-1998 the economy was hard hit by drought, the effects of the Asian financial crisis and low commodity prices (AusAID, 2005). The PNG currency (kina) came under pressure from substantial unbudgeted public expenditure in December 1998 and January 1999, and the Government's failure to secure anticipated external finance from commercial sources, the International Monetary Fund (IMF) and the World Bank. As a result, the government borrowed beyond legal limits from the Bank of Papua New Guinea (BPNG), demonstrating poor governance. Inflation then soared to 16 per cent and further political instability followed. The newly elected PNG government agreed to structural adjustment programmes in order to receive ADB and IMF loans. The year 2000 Budget that elaborated the Government's structural reform programme was said to have gained widespread support from the PNG and international communities, and resulted in the immediate provision of a stand-by loan agreement from the IMF (Asian Development Bank, 2006).

AusAID, PNG's major donor partner, in its aid framework for PNG in 2002 prioritised governance, blaming declining standards of governance for the reversals which in the country's economic prospects (AusAID, 2002).

2.4 Fiscal austerity and its impact on health

Structural adjustment policies dictated fiscal austerity in indebted nations. In the health sector they specifically placed strict limits on public employment - creating particular hardships for doctors and nurses - and through the introduction of user fees and closure of many health facilities added to the difficulties of access to health care for patients. While attention to building a sufficiently large and well-trained health workforce in developing countries was never explicitly on the aid agenda at any time, it was most explicitly off the aid agenda throughout the 1980s and 1990s. The WHO Global Health Workforce Alliance in 2007 commented that in this period of structural adjustments and health sector reforms the health workforce was seen as a fiscal liability (Global Health Workforce Alliance, 2006).

Dr Paul Farmer, the founder of US NGO Partners in Health and a leading international campaigner for the right to health for people in developing countries,

discussed the effect of structural adjustment policies in an interview in 2007. He described their impact as further weakening the colonial health structures, resulting in worse health indicators than 40 years previously, before independence. “In many countries, health and education programs and outcomes weakened steadily in recent years - years that coincide pretty neatly with structural adjustment programs” (Mullan, 2007, p.1064).

Through structural adjustment programmes, indebted developing countries had little choice but to repay debts and cut budgets, necessarily resulting in less funding for social programmes, including health (Meier, 2006; Meier & Mori, 2005; Millen, 2000). “This dramatic scaling back of the government’s role in providing health services has reversed many of the health gains achieved in developing countries, leaving debilitated national public health infrastructures” (Meier & Mori, 2005, pp 109-110).

An example of the impact of neo-liberal policies comes from the Safe Motherhood Initiatives. These sprang from movements in the late 1980s, especially the Nairobi Safe Motherhood Conference, to address the high rate of maternal mortality in developing countries. At the time WHO estimated over 500,000 women died in pregnancy or childbirth every year. The closing statement at the Nairobi conference encompassed the need to “improve women’s status, educate communities, and strengthen and expand core elements of maternal health – antenatal care, delivery care, and postpartum care – at the community and referral levels” (Starrs, 2006, p.1130). However, Safe Motherhood interventions were generally implemented vertically through programmes outside national health systems, often with user fees, with much duplication and little cohesion between them. Emphasis was placed on screening women to identify those at risk of complications in pregnancy, and on training traditional birth attendants, both of which have now been shown to have little impact on maternal mortality. Maternal deaths were not reduced, and nor was the significant inequity in access to lifesaving health care. De Pinho (2009) claimed that these failings cannot be divorced from a political context shaped by a broader set of neo-liberal macro-economic policies that framed the associated health sector reforms underfoot in the 1990s. She described these reforms as decreased government spending on health services while at the same time expanding the role for the private sector and markets with user fees masked as community participation. “In essence, these policies represented a technical response that embraced the commodification of

health care as a product to be bought and sold, benefiting those 'consumers' with resources" (de Pinho, 2009, p.115). She stated that 20 years after the Safe Motherhood initiatives began, WHO estimates the same number of women are dying each year as a result of obstetric complications.

2.5 The Millennium Development Goals

In September 2000, 189 countries signed the Millennium Declaration agreeing to work together to reduce extreme poverty. This signalled a significant move away from the neo-liberal paradigm. UN Member States committed to reduce poverty throughout the world. The Declaration had eight goals with 27 targets, known as the Millennium Development Goals (MDGs), specifically produced so that aid could be well targeted, monitored and its impact measured.

By 2015 all 189 United Nations Member States have pledged to:

Goal 1: Eradicate extreme poverty and hunger

Goal 2: Achieve universal primary education

Goal 3: Promote gender equality and empower women

Goal 4: Reduce child mortality

Goal 5: Improve maternal health

Goal 6: Combat HIV/AIDS, malaria and other diseases

Goal 7: Ensure environmental sustainability

Goal 8: Develop a global partnership for development (United Nations, 2000a).

The specific duties of developed countries under Goal 8 are discussed more fully in Chapter 4. The MDGs give a prominence to health that it had never achieved previously on the development agenda. Three of the goals, numbers four, five and six, are health specific, and goal seven includes a target to improve access to safe drinking water. But the remaining goals also depend upon improved health. Thus, health started to become more prominent in the development sector from 2000 onwards. Bilateral aid partnerships offered greater percentages of their overall support for the health sector because it was becoming recognised that "breaking the vicious cycle of poverty and ill health is an essential precondition for sustainable pro-poor development" (NZAID, 2006).

Further commitment was made to the MDGs in 2003 when the OECD's development division established a working party on aid effectiveness. The purpose of the working party was to identify and monitor the actions needed to promote a global partnership for development and accelerate progress towards the MDGs. This led to the Paris Declaration on Aid Effectiveness, endorsed on 2 March 2005 (OECD, 2005). This declaration is an international agreement adopted by over 100 countries to increase efforts to meet the MDGs. Particular emphasis was placed on donor harmonisation, alignment and managing aid for results with a set of actions and indicators that could be measured and monitored.

The Paris Declaration attempts to be more than a statement of general principles, claiming to lay down a practical, action-orientated roadmap to improve the quality of aid and its impact on development. However, its 12 indicators measure the mechanisms of aid delivery rather than the effectiveness of the aid to produce the agreed outcomes. In this sense, the Paris Declaration is more a tool of governance than a means of measuring improved human development.

2.6 Measuring the effectiveness of health aid

Following the various changes to the development agenda over the years it is worth considering whether there has been measurable success associated with any or all of the different eras. However, there is little agreement on what constitutes success in development, or in development assistance for health. National economic growth is frequently cited as an indicator for development - in fact there is a rough correlation between GNP per head and life expectancy. Indeed some countries have been able to simultaneously raise GNP and life expectancy, for example, South Korea and Taiwan, but not all, Brazil being such a case. Some countries have very low GNPs and high life expectancies; Cuba and Costa Rica are examples. Others, such as the USA and Australia, have high GNPs and pockets of poverty where life expectancy is worse than in many developing countries. "Indeed, with poverty and public expenditure on health as explanatory variables on their own, the connection between GNP per head and life expectancy appears to vanish altogether…. Much depends on how the fruits of economic growth are used" (Sen, 1999, p.621). There is also evidence from some countries that an increase in development assistance is followed by cutbacks on

domestic health spending and budget allocations, the net result being less health spending in that country (McCoy, Chand, & Sridhar, 2009).

Throughout the early 2000s the debate around the overall effectiveness of development assistance in promoting economic growth (and by neo-liberal extension, reducing poverty) continued without resolution. Health researchers argued that the wrong outcomes were being assessed. "If the donors' objective is to reach the MDGs, then assessing their assistance's effectiveness should examine whether aid flows have a positive impact on selected HDIs [human development indicators]" (Masud & Yontcheva, 2005, p.3). Their research investigated the impact of aid on two HDIs: infant mortality and education. It also differentiated between bilateral aid and NGO aid. The authors found that although increased health expenditure per capita reduced infant mortality, there was no significant relationship between total bilateral aid and infant mortality. This result is consistent with that found a decade earlier: "that aid does not significantly increase investment, nor benefit the poor as measured by improvements in human development indicators, but it does increase the size of government" (Boone, 1996, p.289).

Masud and Yontcheva (2005), however, found that NGO aid was associated with significantly reduced infant mortality in the 51 countries included in the 11-year study period. They postulated that NGO assistance may be more effective than government actions in reaching out to the poor, and improving infant mortality may be more efficiently done at grassroots levels. The study also found that bilateral aid was more likely to target countries that had lower infant mortality, whereas NGOs were more likely to work in countries with higher infant mortality.

The concern with this latter finding is that indicators of the Paris Declaration on Aid Effectiveness put greater emphasis on reducing the percentage of aid that goes to countries that do not meet set criteria, such as adhering to public financial management systems. The impact of this could well be that those countries least able to manage their financial systems, and possibly most at risk of not spending in health and education sectors, are also least likely to attract donor support. Therefore, it could be argued that those people most at risk of early death are least likely to benefit from development assistance.

Analysis of health aid allocations from global health spending in 2005 shows that health aid was positively related to disease burden. A one per cent increase in disease burden was associated with a one per cent increase in health aid per capita

(Lane & Glassman, 2007). Using the Economic Freedom Index and the share of health in government spending, a correlation was also found: "aid responds positively to improvements in country capacity, commitment to health, and improvements in economic freedom" (Lane & Glassman, 2007, p.938). The authors expressed concern that size of population was an important factor in aid per capita, with every one per cent increase in population resulting in a 0.4 per cent decrease in health aid per person, suggesting either aid delivery in countries with small populations carried a high cost or that less was given to larger populated countries. Thus, countries with large populations and poor fiscal management are those most likely not to receive global health aid allocations. As a result, the people in such countries were again those most at risk of not benefiting from aid assistance.

While proponents have long argued that development assistance saves lives, and there are numerous case studies of success in the literature, there had been little combined data to support these claims and very little evidence that aid in general promoted economic growth. However in 2007, a retrospective analysis of health aid spending over the years 1970-2004 across 118 countries found that increased health aid spending was associated with a reduction in infant mortality. It was estimated that doubling health aid reduces infant mortality rates by two per cent (Mishra & Newhouse, 2007). The authors noted that this effect was small relative to the MDG goal of reducing child mortality by two thirds by 2015. The research was unable to demonstrate that general aid, unlike health aid, resulted in any improvement in infant mortality. Health aid represented a share of between 0.5 and 7 per cent of overall aid, and while funding spent on health aid increased throughout the 1973-2004 period, both health aid and overall aid decreased in per capita terms after 1975. This research also importantly demonstrated a five-year lag between health aid spending and measurable improvements in health outcomes.

2.7 Increases in aid for health

As mentioned earlier, health aid has attracted large increases in funding since the beginning of the new millennium. Globally, official development assistance for health commitments doubled from US$5.6 billion in 2001 to $11.2 billion in 2005, and actual disbursements increased from $4.6 billion in 2002 to $8.5 billion in 2005 (Lane & Glassman, 2007). If water and sanitation commitments were included in

health funding, the increase between 2001 and 2005 was from $7.2 to $15.7 billion (Kates & Lief, 2007). These estimates are based on OECD statistics and only include their members' official sources (government bilateral and multilateral) of funding. More recent research has attempted to combine public and private spending, and it has been estimated that $21.8 billion was allocated to health aid in 2007 (Ravishankar et al., 2009).

What is of particular interest in this research is the analysis of the donors for health aid over the 17-year timeframe of the research. In 1990, the UN agencies, including WHO, contributed just under one-third of the total funding (US$5.59 billion) for health aid. By 2007, their contribution of just over $3 billion made up only 14 per cent of total health assistance. Similarly, bilateral funding decreased from 46.8 per cent in 1990 to 27.1 per cent in 2001, but then increased again to 34 per cent by 2007. In particular, Canada, the European Commission, the USA, Japan, France, Sweden and the UK all committed significant increases in aid funding for health from 2003 (Ravishankar et al., 2009).

NGO funding for health aid increased from 13.1 per cent of total health aid expenditure in 1990 to 24.9 per cent in 2006 (Ravishankar et al., 2009, p.2113). GHIs such as the Global Fund for AIDS, Tuberculosis and Malaria (Global Fund) and the Global Alliance for Vaccines and Immunisation (GAVI) first appeared in the expenditure tables in 2002, contributing one per cent of total health aid spending each. Five years later, their contributions increased to 8.3 per cent and 4.2 per cent respectively. Collectively, these non-state actors have become a major influence in development assistance for health, especially in addressing specific diseases.

Much of the additional health spending in developing countries went towards HIV/AIDS prevention, and prevention and treatment of communicable diseases. HIV/AIDS in 2007 received 23.3 per cent of all health aid expenditure. Programmes addressing tuberculosis and malaria between them received 3.5 per cent. Despite increasing recognition that health systems required financial and technical support, less than 5 per cent of health aid was directed to health system strengthening in 2007. The authors commented that despite the consensus that greater funding needed to be directed to general health-sector support, the data suggested that it remains a very small part of development assistance for health (DAH). "The difference between the rhetoric and reality emphasises the value of resource tracking" (Ravishankar et al., 2009, p.2122).

The diminishing role of the UN agencies in global health, and the significant influence of private funds, GHIs and NGOs, usually spent on specific diseases and especially HIV/AIDS, have provided yet another significant change in the health aid environment. That nearly a quarter of all health spending goes to HIV/AIDS projects, and that a similar proportion is spent by NGOs and GHIs, resulted in calls for a re-think on global health governance mechanisms.

> While those concerned with the world's health will be glad that development assistance for health has risen from $5.6 million in 1990 to $21.8 billion in 2007, they will also be concerned that the influence of intergovernmental agencies is being crowded out by donor-driven funding patterns that may not be fully responding to country needs (Lancet, 2009, p.2083).

The *Lancet* editorial referred to the mixed report card from WHO's first assessment of the effects of GHIs on health systems (World Health Organization Maximizing Positive Synergies Collaborative Group, 2009). It cited both positive and negative impacts of the large-scale initiatives. While it should not be assumed that NGOs and GHIs are likely to have greater negative impacts on overall health in a developing country than other funders, the concerns are more that these relatively new and significant funding non-state actors are outside the governance mechanisms that apply to the bilateral and multilateral donors. There are no global governance mechanisms to hold this segment of development assistance for health to account. Nor is there any overall, democratic, transparent coordination on all aspects of international health (Silberschmidt et al., 2008).

As a result, recommendations to GHIs such as those made by WHO's Maximising Positive Synergies Collaborative Group towards strengthening the health systems in the countries in which they work, are not enforceable. GHIs are not members of WHO and are not directly bound by UN treaties or human rights frameworks. In addition to the risks posed by lack of coordination and duplication of effort to health systems and services in developing countries, an even greater threat to global health arises from the overall lack of accountability and international governance of the non-state actors in international health: there is no mechanism to prevent implementation of harmful programmes.

2.8 Funding increases, health systems and MDGs

Weak health systems have been identified as a major barrier to the achievement of the MDGs (Reich, Takemi, Roberts, & Hsiao, 2008; Singh, 2006) and there has been a call to strengthen health systems (Travis et al.; World Health Organization, 2004b). In the WHO Ministerial Summit on Health Research in November 2004, the first three of the 10 key messages were

1. Health systems must be strengthened so that the world's poor have access to interventions and services that can improve their health and wellbeing.

2. The link between development, health, and knowledge has been clearly established. Inter-sectoral research is needed to examine factors outside the health sector that have a significant impact on health.

3. The knowledge that is lacking in allowing faster progress towards the MDGs and other health goals can be derived from learning how health systems work and why they do not. Significantly more funding is required for research that is focused on health systems and how to make them stronger (World Health Organization, 2005b, p.i).

The major health system constraints to achieving the health-related MDGs include the grossly inadequate health workforce, lack of donor coordination, and weak information systems (World Health Organization, 2004a). The disease-specific focus of the MDGs, combined with large injections of funding from GHIs to specific diseases from the early 2000s, have raised concerns that weak health systems might be further compromised if the scarce number of health workers were drawn to well-funded initiatives, leaving other sectors, and health management, even more under-resourced (Garrett, 2007b; Travis et al., 2004). The UN Special Rapporteur voiced similar concerns about MDGs in one of his reports (United Nations, 2004), and this is examined in more detail in Chapter 4.

The overall increase in funding allocations to health aid, while extraordinary and unprecedented (Farmer & Garrett, 2007; Garrett, 2007b; Lane & Glassman, 2007; Sachs, 2007), may well leave historically neglected health systems unable to cope. "After 20 years of neglect in favor of vertical health programs, community-based small-scale projects, and donor-directed thematic health investments, strong health systems are again seen by policy makers and donors as essential to achieving and sustaining health gains" (Kruk & Freedman, 2008, p.264).

Health systems are defined by WHO as "all the activities whose primary purpose is to promote, restore, or maintain health" (World Health Organization, 2000, p.5). WHO divides the health system into six building blocks - a perspective that promotes a good understanding of the essential role that the health system plays in enabling any health activity, irrespective of whether the activity is predominantly located in a public or private health setting. The six building blocks are: health services, goods and facilities; health workforce; health information systems; medical products, vaccines and technologies; national financing; and governance and leadership (World Health Organization, 2007).

WHO has stated that poor health system performance makes a profound difference to the quality, value and length of people's lives (World Health Organization, 2000). Research supports this claim, with evidence that HIV prevention programmes fare worse in countries with poor governance (Menon-Johansson, 2005) or weak infrastructure and training programs (Garrett, 2007b; Singh, 2006). Increasing inputs into health systems, even such inputs as more doctors, does not necessarily lead to better performance of health services, because all six building blocks of the health system need to function well in order for health services to be available, accessible, acceptable, and of quality (Reich et al., 2008). When issues of health system organisation and function are not addressed, service delivery often falls short of potential (Bryce et al., 2003; Islam, 2007).

Failing health systems can create or reinforce poverty. They are also the foundation upon which policies to achieve the health MDGs would build (Freedman, 2005). Recognition of this led to calls for a balanced approach of specific-disease and health system-based interventions in all health programmes (Freedman, 2005, 2009; Reich et al., 2008; Singh, 2006). As a result, towards the end of the first decade after the Millennium Declaration, there was an increasing acceptance, in principle at least, that assessing the strengths and weaknesses of health systems was an important aspect of programme design. Without such assessments, health programme outcomes were unlikely to be maximised and sustained.

The impact of aid funding on the health workforce, one of WHO's six building blocks of the health system, was particularly concerning as large programmes attracted disproportionate numbers of health workers to them. The overwhelming shortage of health personnel in developing countries, estimated at over 4.3 million health workers (World Health Organization, 2006), was acknowledged as a major

contributor to poor health service in these nations. Without health workers to manage and deliver health care services, programmes were doomed to failure. Training health workers, especially doctors and nurses, takes many years, and requires ongoing funding for their employment. Planning for training and employment of health workers are functions of the health system that are essential for the success of any aid activity, but were factors with which aid donors had generally not engaged. Exit strategies for aid programmes must include development of local capability to transfer ensure ongoing delivery of health services to local people. "…Develop exit strategies, in other words, so as to avoid either abrupt abandonment of worthwhile programs or perpetual hemorrhaging of foreign aid" (Garrett, 2007b, webpage).

Both short and long term goals of health aid are seriously compromised by a lack of capable and trained staff in clinical, community and management roles in health. The consistent gap between financial resources committed to health programmes and those actually dispersed is a result of incapacity within the health systems and services in recipient countries. The World Bank, amongst many others, claims that physical and human shortages in local health services represent a huge bottleneck to aid (Lancet, 2007).

Garrett agrees, saying that the escalation in global generosity has come at a breathless pace. "But it is being executed chiefly by devastated local government systems, underpaid and overburdened health-care workers"(Garrett, 2007a). Farmer and Garrett argue that job creation and health worker training are essential to address poor health in developing countries, and these are critical to the successful implementation of all the health initiatives that increased health aid can support. The key to success in employing local people to fill the gaps in health service delivery comprises two elements: paying decent wages and targeting women for the jobs (Garrett, 2007b).

2.9 Health workforce funding

There is a demonstrable link between the number of health professionals employed in a country and its health indicators (Watters & Scott, 2004; World Health Organization, 2006). Having the capacity to train and employ more health workers is also normally associated with high GNI and high per capita state health expenditure (usually above US$1500). Cuba, however, stands out as an exception. In 2003 the per

capita total expenditure on health in Cuba was US$211, yet it had a medical workforce of 5.91 doctors for every 1000 people (World Health Organization, 2006). In comparison, the US spent $5711 and had 2.56 doctors per 1000 people. Interestingly, health indicators scarcely vary between the two countries. Life expectancy at birth in Cuba is 78 years, and six children per 1000 born will die before their 5th birthday. Respective US statistics are 78 years and eight children per 1000 (World Health Organization, 2006).

Analysis of health aid spending by sub-sector shows that despite the large increase in donor spending in health over the past decade, little, if any, of the increase has been directed towards training medical and health personnel. Surprisingly, more was spent on health training and personnel development ($0.2 billion) in 2001 than in 2005 ($0.1 billion) (Kates & Lief, 2007). Yet unless people are trained to be able to provide those health services which are attracting large increases in donor funding, dependence on developed country expertise for service implementation and human resources will continue. When there are too few health workers to meet a country's basic health needs, the impact of those workers leaving the primary health care system to work in specific-disease programmes can be huge.

Examples of the detrimental impact of a large scale focus on HIV/AIDS (with associated large sums of donor funding) come from Haiti and Ghana, where, according to Garrett (2007b), prenatal care, maternal health programs, the treatment of guinea worm and measles vaccination all declined as a result of health workers being attracted to the better funded HIV/AIDS and malaria projects. A review of the impact of the Global Fund on the health systems in Benin, Ethiopia and Malawi found that employment of staff on short-term contracts with salaries substantially higher than regular government employees had led to the exodus of technical staff from the ministry of health to the Global Fund (Drager, Gedik, & Dal Poz, 2006). At the health service delivery level, health workers were observed moving into the Fund's higher-paid disease-specific positions. This could potentially weaken community-based services that are not related to one of the three target diseases addressed by the Global Fund.

2.10 Disease-specific focus in aid programmes

Conceptualising health programmes in terms of diseases, rather than focusing on the health system through which all health service is provided, conforms to an epidemiological approach to public health (Freedman, 2009). Freedman described this as a technocratic, largely top-down process, in which 'business-as-usual' consists of a familiar sequence of steps:

> 1 Select priority diseases/conditions (usually according to burden of disease)
>
> 2 Document the proximate causes of death from those conditions
>
> 3 Identify technical interventions to address those causes
>
> 4 Do demonstration projects to prove effectiveness and cost-effectiveness of the interventions and to identify "best practices" in delivering them
>
> 5 Disseminate information about best practices
>
> 6 Call for "scale-up"
>
> 7 Advocate for "political will" to get the job done (Freedman, 2009, p.410) .

Freedman and Garrett maintain that the risk of such approaches, favoured by the GHIs and many international NGOs, is that the end result is a collection of discrete, theoretically cost-effective interventions, each focusing on a specific disease: "For most interventions, high-mortality, resource-poor countries are stranded at step 5 with levels of coverage dangerously low and inequitably distributed. Virtually all commentators working from within this paradigm agree that delivery at scale is the challenge" (Freedman, 2009, p.410).

The debate about these discrete, single-disease focused programmes (vertical interventions) versus programmes integrated into health systems and providing health system support (horizontal interventions) added to the growing recognition that more support for health systems was needed. By 2008 even the single-disease focused GHIs agreed to commit funding into health system strengthening to build the overall capacity of health systems, including the health workforce (Drager et al., 2006; GAVI Alliance, 2007).

Some commentators still argued that vertical programmes automatically strengthened the health system. For example, leading MDG campaigner Jeffrey Sachs claimed that health practitioners were clear on the point that vertical programs for AIDS and TB control actually helped to build health systems (Sachs, 2007). He

argued that, contrary to Garrett's view that more funding was being put into health programming than could be absorbed and delivered upon, far more aid was necessary to address the health issues that contribute vastly to poverty. "We are not overspending on AIDS but underspending on the rest" (Sachs & Pronyk, 2009, p.2111). They did, however, agree with Garrett that training and overall public health system building require comprehensive effort.

Garrett takes this recommendation further by urging a different approach to global health issues, to move beyond a charity model. She suggests donors and those working on the ground must build effective local health infrastructures as well as local industries, franchises, and profit centers that can sustain and thrive from increased health-related spending. "For the day will come in every country when the charity eases off and programs collapse, and unless workable local institutions have already been established, little will remain to show for all of the current frenzied activity" (Garrett, 2007b). This is not a dissimilar call from that of health rights campaigners who argue the need to look beyond the health system, and even the social determinants of health, to address fundamental inequalities and imbalances of power in society in order to effect improvements in health.

The context of development assistance for health was thus moving closer to social justice movements with many donors becoming more accepting of the need to engage with public health and health systems to effect long term change. Paul Farmer stated, "Even some of the mainstream international financial institutions that had been unenthusiastic about these efforts now seem to be on board. The policy environment has changed: Ideas about social justice linked to access to medicine and public health now have a chance to grow" (Mullan, 2007, p.1064).

2.11 Reframing health aid around health rights

After 60 years of foreign assistance to support health for all in developing countries, there is still an overwhelming failure to meet the human right expressed in the preamble to the WHO Constitution, written in 1946:

> the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic, or social condition.

The right to health has since then been affirmed in the Universal Declaration of Human Rights (UDHR), and further clarified and expanded in the ICESCR General Comment 14.

> Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

Throughout these past 60 years, the modalities of aid delivery, the programmes supported, and the donors themselves have varied in response to changing economic and political priorities. Still the health needs of the majority of people in aid recipient countries have not been met, and in some of these countries health indicators have worsened in the past 15 years. Developing countries have by far the greatest health needs, and the least capacity to meet those needs. The least developed countries spend less than $25 per capita per year on health, which compares meagrely to the US$1500-$5000 spend in developed countries (World Health Organization, 2008b). The US spends more than $5000 per capita on health care - 50 per cent more than any other country (Gostin & Archer, 2007).

The changing mechanisms and programme modalities of development assistance have not succeeded in meeting health needs consistently and universally. By framing funding for health in developing countries as development assistance, donors have been free to pick and choose whether or not to provide funds for health purposes. Decisions of health aid funding have been at the mercy of the current philosophical and economic paradigms and the impact of the lack of funding for health aid during the neo-liberal decades lives on. The resulting inadequacy of health systems severely curtails health service delivery a decade after neo-liberal policies were abandoned in principle, and despite the vast concurrent increases in health funding.

2.12 Shifting the paradigm from donor needs to people's rights

In the past decade another re-framing of health aid began through the ascendancy of a human rights-based approach to development interventions. Although the WHO Constitution (1948) and Declaration of Alma-Ata (1978) both affirmed the

right of individuals to the highest attainable standard of health, this had not been widely used as a framework to promote health and access to health care within the development sector. By 2009, although the right to health was a common advocacy tool within the health and development sector, there was still little evidence of it actually being used to shape health interventions. The legal fraternity more readily embraced health rights than did the health sector.

In many respects this awakening of a rights-based approach to development assistance for health was embedded in the broader human rights ascendancy.

> Human rights have become a more important aspect of development policy and programming since the end of the Cold War. The 1993 Vienna World Conference on Human Rights, the 2000 Millennium Summit, and the 2005 World Summit all recognise that development and human rights are interdependent and mutually reinforcing. The UN Secretary Generals conception of 'in larger freedom' encapsulates the inter-linkages between development, security and human rights (Piron & O'Neal, 2005, p.v)

Health rights proponents welcomed the adoption in 2000 of General Comment 14 by the UN Committee on Economic, Social, and Cultural Rights, claiming that this comment deepened an understanding and practice of the right to health (Backman et al., 2008).

It was also argued that it was only in the 10 years to 2008 that the content of the right to the highest attainable standard of health had developed to a level that allowed application in an operational, systematic, and sustained manner (Hunt & Backman, 2008). The tardiness in adopting a rights-based approach to health aid had at least three significant contributing factors: a failure of the people in the human rights and health fields to understand each other's language, priorities and concerns (Asher, 2004); the positioning of State governments as the exclusive duty bearers in the right to health; and a lack of leadership from WHO to mainstream the right to health and embrace changes in global health governance (Meier, 2010; Silberschmidt et al., 2008).

Of the first factor, little more will be said in this thesis except, as mentioned earlier, all human rights are framed in legal discourse and structures. The failure to operationalise these rights has made engagement with them at a practical level extremely difficult for those not familiar with legal process and language. This leads to the second issue, because historically non-state actors and health workers were not

seen as having rights obligations. Instead, they were positioned as being the watchdogs of rights obligations. “Human rights begin with individuals and groups who have entitlements, and with governments which have corresponding obligations. States that ratify human rights treaties freely agree to assume responsibility for guaranteeing that people can enjoy the benefits of the right to health. It is the job of NGOs to hold them to this responsibility” (Asher, 2004, p.2). But as NGOs and GHIs take on ever-increasing roles as funders and implementing agencies of health programmes in developing countries, they are also becoming duty bearers.

It is no longer sufficient that the NGO role is to hold governments responsible for meeting human rights. They have stepped into influential positions themselves, where their actions in the funding, design and delivery of health programmes demand that they too must respect, protect and fulfill the right to health. There is a lack of accountability for GHIs, international NGOs and the private sector to measure, monitor, and report on the impact of their activities in developing countries. The internal governance mechanisms and legal and financial reporting requirements to their own governments do not provide a satisfactory audit function of the local impact of NGO and GHI activities. It is in response to this, and to the lack of coordination by all health actors - especially those who are outside the membership of the WHO - that the WHO has been called upon to create and manage a Global Health Forum (Silberschmidt et al., 2008). Recognising that GHIs and other non-state actors were responsible for a quarter of all development assistance for health by 2007, the WHO Maximizing Positive Synergies Collaboration Group acknowledged the potential of harm to basic health care and health systems resulting from large sums of money being spent on specific diseases. This group drew up recommendations for GHIs and other non-state actors, especially to coordinate and better measure and report their impacts on health systems (World Health Organization Maximizing Positive Synergies Collaborative Group, 2009).

2.13 A legal framework for health

Proponents of a rights-based approach to development argue that legal entitlements take people’s right to health into the arena of international law. Because human rights can be claimed, individual and community access to quality health care becomes a legal entitlement. As detailed in General Comment 14, States have core

obligations under the right to health to ensure that national plans and pathways to improved health care are developed and progressively realised.

The legal framework for health rights includes monitoring and enforcement mechanisms at international and national levels. This provides a means of international oversight and redress, which is absent in other frameworks for provision of development assistance for health. Currently these mechanisms are only binding on States, leaving NGOs and GHIs ungoverned by transparent mechanisms.

The benefit of framing health as a human right is that it elevates provision of international donor support for health from charity or philanthropy to a legal duty, in the same way that all States have legal obligations nationally to ensure their citizens have access to quality health care. Rights can serve as guiding principles for international relations, including relations beyond development partnerships. For example, trade deals could be examined through a human rights lens to protect a community's right to health care. The Oslo Declaration is an example of this approach. It is a joint statement by ministers of foreign affairs (not ministers of health) from seven countries (Brazil, France, Indonesia, Norway, Senegal, South Africa and Thailand) that urges States to analyse their foreign policies for impact on health, even though it is not expressed in terms of rights. The Commission on the Future of Health Care in Canada made a similar suggestion that all Canadian foreign policy should ensure access to health care is made a key objective (Oldring & Jerbi, 2009).

The OECD's Development Assistance Committee (DAC) in February 2007 adopted an Action-Oriented Policy Paper on Human Rights and Development that endorsed a series of principles for elevating the role of human rights within development assistance and integrating rights more systematically into aid processes. The paper links the Paris Declaration's key principles with human rights and states that three of the 10 principles endorsed by the DAC strengthen connections between human rights and aid effectiveness. These include: considering mutual reinforcement between human rights and aid effectiveness principles; considering human rights in decisions on alignment and aid instruments; ensuring that the scaling–up of aid is conducive to human rights (Development Assistance Committee, 2007).

2.14 Conclusions

After 60 years of development assistance, poor health still plagues developing countries. Their health indicators reveal shockingly high rates of premature and preventable death and disease. However, the past 10 years has seen a global effort to reduce these health gaps between developed and developing worlds, with significantly increased aid funding directed to health initiatives. Much of this funding has been allocated to specific diseases, in particular to HIV/AIDS prevention and treatment. Over the same period, and linked to this disease-specific focus, a change in global health has been evident with GHIs and NGOs assuming important roles as funders and implementers of health programmes in developing countries. Up to 25 per cent of health aid is now channelled through these entities, often for vertical, disease-specific interventions.

There has also been a growing recognition that these health interventions are at risk of failing because recipient States have weak health systems, including an insufficient and inadequately trained health workforce, to support aid-funded programmes. This in turn leads to further compromises of the health system, and lessens provision of other health services not supported by the disease-specific initiatives. Accordingly, there has been an increasing call for all health aid programmes to include health system strengthening in their activities. GHIs and NGOs are presently not accountable to global governance mechanisms, resulting in a lack of coordination, transparency and mandatory monitoring and reporting on their activities.

There is increasing acknowledgement in the human rights and social justice movements that it is legally and ethically incumbent upon those countries that can afford to do so to support partner countries to meet their health rights obligations. In particular this requires support for health systems because a strong health system is the core institution through which the right to health is realised. A right to health framework views all parties in aid-funded health programmes as duty bearers. They have the responsibility of respecting, protecting and fulfilling the right to health, and are accountable for breaches of this duty.

An aim of this thesis is to develop a framework in which there are tools to assist in the design of aid funded health programmes. This is essentially a practical guide to incorporating the right to health in programmes. The thesis plans to promote

a thorough understanding of the rights context within which the programme will be located, to guide a rights-based assessment of the design, and to conduct an impact assessment of the design on the health system. It is only through careful engagement with these processes that all parties with rights obligations can demonstrate that they are protecting, respecting and fulfilling the right to health in the countries in which they engage.

In the next chapter, the methods employed to research and write this thesis are explained.

Chapter 3 Methods

3.1 Introduction

The previous chapter outlined the history of aid for health over the past 60 years and concluded that the health needs of people in developing countries have been poorly served. It was argued that when aid donors view health as a development project, the resulting programmes reflect the donors' political and economic agendas. These agendas do not necessarily reflect the needs of developing countries to meet health rights obligations.

History also revealed changes in global health over the past decade that have resulted in NGOs and GHIs becoming major donors and implementing agencies of health programmes. However, they operate in the absence of appropriate governance structures to coordinate, guide, and monitor their activities. These non-state agencies favour disease-specific aid interventions that threaten to further weaken fragile health systems.

It was proposed that the right to health offers a means of addressing these major issues in global health: namely, resolving the threats imposed by disease specific programmes; introducing transparent accountability for non-state actors and prioritising the health needs of people in developing countries.

In this chapter, I describe the methodology adopted in the thesis. To provide context to the approach taken, I begin with a brief section in which I reflect on the process through which I arrived at the thesis topic and the approach I have used.

I then describe the research methodology. The process was an iterative, step-wise one: first, my reading of the literature informed the development of a rights-based framework. Next, I developed tools to operationalise the framework and then tested these tools for relevance and robustness against case studies set in PNG. After case study testing, the tools were refined into their final state. Table 3.1 shows this process in summary form.

Table 3-1 Methodology of the research

1	Conducted a literature review
2	Developed a rights-based framework for designing health programmes
3	Created tools to operationalise the framework
4	Tested the tools on case studies
5	Refined the tools
6	Drew conclusions about the right to health as a framework to design aid-funded health programmes

3.1.1 Reflections

I began this research with what could perhaps be described as the intent of finding a holy grail: a tool that could guide international partners through the messy realities and complexities of developing country health systems to design effective and sustainable health programmes. It was, of course, a somewhat ambitious undertaking.

The idea for the research came to me as I observed a workshop in Dili, Timor-Leste, in my capacity as an employee of a health NGO. About 30 health workers from around the country had gathered to discuss and debate (at length) plans for a national eye health strategy. The meeting was inspirational. It was conducted in the local lingua franca, Tetum, of which I do not understand a word. Nonetheless, I was moved by the engagement, enthusiasm, seriousness and verbosity of all who were there. This meeting was in sharp contrast to ones I had attended the previous week in another country, PNG, which were characterised by poor attendance and deafening silences. I was intrigued by these differences, pondered whether they were a reflection of different cultures, or the product of different processes in the development of a health programme in their respective countries.

This experience planted the seed of the idea for this research: why do similar strategies for health programmes have completely different responses and results in different contexts? I wondered whether there were key elements that were essential for any programme to become successful. If so, could a tool be developed which could 'walk' programme planners through a process that would ensure those essential steps were not skipped over?

I was guided in this research by the conviction that good health is fundamental to an individual's enjoyment of life, and his or her capacity to flourish. A child needs

to have good health to gain an education; adults need good health to participate in their communities, be that earning a living, working on the land, or bearing and raising children. Health is, therefore, deeply connected to individual, community and state wellbeing. The poor health of the poor, and the marked health inequities within and between countries, are not a natural phenomenon, but are caused by "a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics" (World Health Organization, 2008a, p.35).

Inequalities around access to health care in our world are deeply unjust. But in the face of so much inequality and unfairness, why should health be singled out for special attention? Amartya Sen argued that health is central to our being alive and happy. "But it cannot possibly be all that there is to say in addressing the question. There are further issues that link the opportunities of having good health to some of the basic freedoms of human life" (Sen, 2010, p.viii).

The research that guided this thesis is grounded in the view that health is a basic human right, and it is linked, as Sen suggests, to basic freedoms. It seemed pertinent therefore to explore aid-funded health initiatives from within a human rights context, and to examine the role of aid and development programmes in achieving the right to health.

3.2 Literature review

3.2.1 History of aid

I undertook a qualitative literature review to document the history of aid for health throughout the 60-year development era. I tracked the various phases where different approaches to development were adopted. The literature search included New Zealand and Australian government publications on official development assistance, PNG official documentation on aid flows and expenditures, database searches on the history of development, and using the references within all the literature to identify further material (forward and backward searches). OECD and international financial institution statistics and historical data were available from 1975, and these were also used.

3.2.2 Right to health documents

The next stage of the review was undertaken to document the history and significance of the right to health as a human right, in legal terms, in practice, and as a theory of social justice. The right to health is documented in various UN treaties and declarations, in particular the ICESCR, and General Comment 14 (United Nations, 2000b).

The history of the use of the right to health, and its translation into policy and practice was investigated through database searches, and UN and WHO reports. Reports from the UN Special Rapporteur were most instructive. Again forward and backward searches of the references in the literature were the main methods employed.

3.2.3 Right to health as a theory

The literature was searched via Medline and ScienceDirect databases with key words ('health rights'; 'theory of health rights'; 'social justice and health'; 'ethics and health rights'; 'international duty and health rights'), followed by backward and forward searches through the references. This process identified leading commentators on health rights as a theory, and on health aid as social justice and ethical duty.

3.2.4 Right to health in practice

The final stage of the literature review aimed to identify research and reports on the practicalities of incorporating right-to-health approaches in development programmes or policies. Keyword searches were used in Medline and ScienceDirect databases, including: 'health rights'; 'international health'; 'health and human rights'; 'rights-based approach'; 'health system'; 'public health'; 'development'; 'health programmes' and 'programme design'. Relevant references in the resulting articles were also used. UN and WHO reports, academic reports and grey literature were included in the searches, and were major sources of information on the topic.

There were over 200,000 articles that made reference to the right for health, of which about 20,000 related to international health. Special attention was paid to 'Health and Human Rights: overview' (S Gruskin & Tarantola, 2008, p.4), and 'Human Rights Approach to Public Health Policy' (Tarantola & Gruskin, 2008), and

in particular to the journal *Health and Human Rights*. These publications were instructive as they placed an emphasis on research that had adopted a rights-based approach rather than manuscripts that refer to health rights in an advocacy context, or a secondary issue in the provision of health care. As before, I undertook further searches using the references in these articles.

3.3 Developing a rights-based framework

All aspects of the literature review informed the overall right-to-health framework and the subsequent tools to guide the design of an aid-funded health programme. The framework needed to provide a logical and thorough process, utilising three key steps in developing a health programme to ensure as far as possible it was: 1) appropriate for the context, 2) designed using crucial rights concepts to ensure the resulting services were available, accessible, acceptable and of quality (AAAQ), and 3) amenable to assessment of its impact on the health system. This process is described in more detail in the section following. It is also presented schematically in Box 3-1.

The framework provides a sequential process through the three steps. Each step informs the next: the in-depth understanding of context developed in Step One feeds into the design of programme activities in Step Two; then Step Three assesses the impact of those activities on the health system, of which a thorough understanding has also been developed in Step One.

Box 3-1 Rights-based programme design framework

Step One
Assess international and national human rights and health rights obligations, through ratification of UN Treaties and other legally binding commitments

Assess the national level context: domestic policies and practices to observe the State's operationalisation of its right to health duties.

Conduct a rights-based assessment of the health system

Step Two
Design and assess the programme, using the AAAQ plus six concepts* assessment framework

Step Three
Assess the impact of the programme on the health system using the rights-based health system impact assessment tool

Refine programme accordingly

* See Table 3-2

Box 3-2 The AAAQ plus six concept framework

AAAQ	**Four essential elements of the right to health**
Available	Health goods, facilities and services must be *available* in sufficient quantity everywhere in the country
Accessible	Health goods, facilities and services must be *accessible* to everyone without discrimination.
Acceptable	Health goods, facilities and services must be culturally *acceptable,* to all people
Quality	Health goods, facilities and services must be scientifically and medically appropriate and of good *quality*.
Six concepts	**Six concepts crucial to the right to health.**
Progressive Realisation	The right to health is subject to *progressive realisation.* This means that States must take clear steps toward realising the right to health for all
Core Obligation	States have a *core obligation* for the right to health that applies now. It requires, at least, essential primary health care, and a national health strategy and plan
Equality and Non-Discrimination	The right to health prohibits discrimination in access to or provision of health care
Participation	The right to health requires *participation* by the population in all health-related decision-making at the community, national and international levels.
Information	Access to health *information* is also essential to the right to health. States must ensure that health information is available and accessible to all
Accountability	The right to health demands access to effective mechanisms of *accountability.* This includes judicial remedies at national and international levels.

Source: (Hunt & MacNaughton, 2006)

3.3.1 Tool for Step One: understanding context

The methods used to design the tool for Step One in the framework were again literature searches constructed around an understanding that the health and well-being of people is dependent on many factors. These determinants of health are illustrated as layers of influence (Figure 3-1), which, especially in a globalised world, extend beyond State borders. The layers conceptualised for this framework were:

- ***International*** – including rights treaties and international contracts that would have an impact on the State's capacity to realise the right to health
- ***National*** – State policies and practices, economy, capacity and commitment to health and human rights
- ***Health system*** – including each of the six building blocks of the health system (Figure 3-3).

The literature was searched in detail within each of these categories to identify the key elements necessary to include in tools to develop a full understanding of that layer's influence on the right to health.

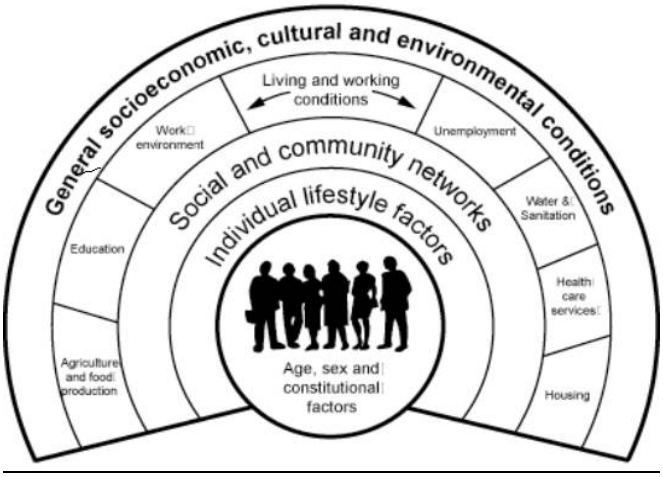


Figure 3-1 Determinants of health
(Source: Dahlgren and Whitehead, 1991)

Box 3-3 WHO's six building blocks of health systems

1 Good **health services** are those which deliver effective, safe, quality personal and non-personal health interventions to those that need them, when and where needed, with minimum waste of resources.
2 A well-performing **health workforce** is one that works in ways that are responsive, fair and efficient to achieve the best health outcomes possible, given available resources and circumstances (i.e. there are sufficient staff, fairly distributed; they are competent, responsive and productive).
3 A well-functioning **health information** system is one that ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health system performance and health status.
4 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.
5 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 impoverishment associated with having to pay for them. It provides incentives for providers and users to be efficient.
6 **Leadership and governance** involves ensuring strategic policy frameworks exist and are combined with effective oversight, coalition building, regulation, attention to system-design and accountability.
(World Health Organization, 2007)

The purpose of the first tool is to gather data to fully understand the local context in which a programme will be operating. The tool therefore needed to have three questionnaires. Each questionnaire corresponded to one layer of influence on context: international, national and health systems. Each needed a list of indicators to guide the collection of the necessary contextual information.

A review of literature assessing health system performance had been recently published (Kruk & Freedman, 2008). These authors identified and reviewed 118

papers on health system effectiveness, 90 on equity, and 97 dealing with efficiency. They identified indicator groups under the headings effectiveness, equity and efficiency.

I conducted a narrower literature search, specifically for indicator-based assessments of local health contexts that would gather data relevant for each of the three layers in the tool. Database searches using key words 'health systems' 'health rights' 'indicators' 'developing countries' were conducted on Medline and PubMed, International Encyclopedia of Public Health, referencing forward and backward.

There was only one publication that assessed health systems (not programmes) from a rights perspective (Backman et al., 2008). One other publication was also instructive as an indicator-based health system assessment, so it was also selected for use although it was not designed from a rights perspective (Islam, 2007). The indicators from these two publications were compared to the overall indicator groups identified by Kruk and Freedman. This revealed that the Backman and Islam papers had included indicators covering the range in the comprehensive review paper. On this basis, it was decided to use the combined indicators from Backman and Islam to populate the three questionnaires in the first tool.

3.3.2 Tool One: indicator selection

Every indicator presented in the Backman and Islam assessments was considered for allocation to one of the three questionnaires in Tool One. If the indicator sought additional information regarding the State capacity, commitment, and progress towards fulfilling the right to health, it was allocated to one of the three questionnaires. Care was taken that there was no duplication of indicators so if both papers had the same indicator, it was only entered into the tool once. The goal of the questionnaires was to have the least number of indicators possible to produce a comprehensive understanding of the context.

The Backman paper had 72 indicators for assessing right-to-health features of health systems. These were divided into 15 groups covering, inter alia, health system building blocks, underlying determinants of health, human rights concepts and national health plans. The Islam manual contained a core module of 17 indicators to build a picture of the population socioeconomic dynamics. Then there are another 174 assessment indicators for each of the six building blocks: 40 indicators to assess

governance, 18 for finance, 31 for health service delivery, 20 for human resources, 39 for pharmaceuticals and 26 for information systems. In total, Islam had 191 health system indicators. There were then, between the two papers, 263 indicators.

They were allocated to one of the three questionnaires using a process of 1) division into categories of international, national and health system building blocks, 2) no duplication, 3) only including indicators that provided additional information regarding the State capacity, commitment, and progress towards fulfilling the right to health.

Questionnaire 1 (international layer) was allocated 13 indicators (Table 6-1). These addressed recognition and record of human rights and other international agreements and commitments. Questionnaire 2 (national layer) had 27 indicators, addressing local demographics and State politics (Table 7-1). Questionnaire 3 (health system assessment) had 70 indicators to examine core obligations measures and capacity of each of the six building blocks of the health system (Table 8-1). Therefore, in total, the first tool, prior to testing it against the case studies, had 112 indicators.

When tested in this research against a case study (Chapters 6-8), the data collection process to populate these three questionnaires is conducted over two time periods, five years apart. This enables trends to be identified to gauge whether the right to health is being progressively realised. As retrogressive measures in relation to the right to health are not permissible, and if taken, the "State party has the burden of proving that they have been introduced after the most careful consideration of all alternatives" (United Nations, 2000b, para 32), it is important that declining health indicators are documented.

The questionnaire that assesses the health system examines each of the six building blocks to assess its capacity to fulfil the right to health (Figure 3-3). The same approach was used in the USAID health system assessment (Islam, 2007). This view of the health system is maintained throughout the thesis, and is used again in the health system impact assessment.

Tool One, with its three questionnaires, is tested against a case study from PNG following which refinements to the questionnaires were made. These refinements included deletion of indicators if they were shown to be unnecessary; amendments to make them more appropriate; or the addition of new indicators where

the case study showed existing indicators had failed to identify an important element of context. This process is explained more fully in section 3.5.

3.3.3 Tool Two: programme design

The right to health elements of AAAQ plus six crucial human rights concepts (Table 3-2) informed the methods of developing the tool to design a health programme. The AAAQ elements had been outlined in General Comment 14, especially paragraph 12, and then further consolidated into a framework in subsequent literature (Hunt & MacNaughton, 2006). The methods to develop the tool involved determining a process that would result in proposed health services being available, accessible, acceptable, and of high quality.

It was intended that Tool Two could guide the design and could equally be used to assess the design. Specifically, the tool could be used to check that the design process had engaged with health rights and rights concepts, while structuring an initiative resulting in AAAQ elements. The tool was not designed to assess technical, clinical or project-specific elements of the programme.

An exhaustive review of the literature failed to locate an indicator-based assessment of a health programme design from a rights perspective. Consequently, this tool, more than the other two in the framework, contains original indicators selected by addressing means of determining whether due consideration had been given to each of the elements in the AAAQ framework. Although not directly transferable, some research was especially helpful in drafting this tool. In particular, these included Hunt and MacNaughton's (2006) health policy impact assessment, Mayhew et al's (2006) framework for NGOs engaged in service delivery, and Kruk and Freedman's (2008) health system performance indicators.

Tool Two adapted the AAAQ plus six crucial human rights concepts framework as employed by Hunt and MacNaughton (2006). Each of the indicators from the health systems assessment questionnaire in Tool One (Questionnaire 3 – Table 8-1) was categorised according to whether it was measuring availability, accessibility, acceptability or quality. Then, working through the six building blocks of health systems, indicators that sought information about whether the design of the programme addressed AAAQ elements were drafted.

Availability - 12 indicators were selected to measure whether the design had determined the resource requirements of the programme, in particular, whether the health system can meet the programme's resource needs. The first five indicators concern the planning, training, employment and retaining of health workers; the remaining seven cover infrastructure, support services, medicine supplies, health information and monitoring systems, financial planning and national health plans.

Accessibility – 10 indicators were selected to measure whether the design had assessed people's awareness, willingness, and ability, including financial ability, to use the services provided. Indicators needed to allow demonstration that the design process had engaged meaningfully with local people, had gained an understanding of local barriers to care, and presented solutions to access issues.

Acceptability - three indicators were selected to measure whether the design had determined how it would assess the cultural appropriateness of the service, including protection of patient information and provision of informed consent.

Quality - five indicators were selected to measure whether the design had determined how quality of the service would be measured and monitored. Specifically, the indicators were chosen to examine whether the design included establishment of systems to monitor treatment outcome data, patient satisfaction, continuing education, ongoing training, monitoring and supervision.

Human rights concepts – 17 indicators were selected to demonstrate that crucial rights concepts were used throughout the design process. This required evidence that the community, without discrimination against gender, ethnicity, age, disability, or any other factor, had participated in the planning process and would continue to engage with programme monitoring. Indicators were also drafted to seek evidence of the provision of programme-related information, including plans for the ongoing provision of information, transparent reporting and demonstrating accountability. They were also chosen to assess whether the programme was designed within the context of the State's health rights and obligations, its progressive realisation of rights, fulfilment of core obligations and capacity of the health system to meet health rights.

In summary, 47 indicators were selected for Tool Two to be used to assess programme design. The Tool is presented in Table 9-1. Development of the method for testing this tool is explained in Section 3.6, and the test against a PNG case study is undertaken in Chapter 9.

3.3.4 Tool Three: programme impact on the health system

A final tool to be developed for the framework was needed to examine the impact of the proposed health programme on the health system itself. A literature search again revealed that there was little to draw on to develop this tool. However, it is an essential part of a rights-based approach to health programmes, because it allows programme planners to check and demonstrate that proposed activities will not have a negative impact on the core institution through which the right to health can be realised. It is via this process that a programme can ensure it is protecting and respecting health rights. If the health system is weakened by programme activities, this limits its capacity to fulfil the right to health.

The most comprehensive research to inform this tool was Hunt and MacNaughton's (2006) report to UNESCO on the incorporation of human and health rights into impact assessment. The tools in that report could be applied to any type of intervention, especially non-health interventions, to determine the impact the intervention would have on the availability, accessibility, acceptability and quality of health goods, services and facilities. For this research, it was necessary to develop a tool that specifically assessed the impact of health services on all the blocks of the health system. General programmes (non health) would not be expected to have an impact on some elements of the health system, for example, finances or pharmaceutical supply. However, health programmes would have an impact on these. For this reason, while still using the general framework and methodology developed by Hunt and MacNaughton, a deeper investigation of the entire health system was required. Thus, indicators relating to each of the six building blocks of the health system were selected to assess whether the programme was likely to strengthen or weaken that block.

By examining the indicators used in Questionnaire 3 for the initial health system assessment, it was possible to divide those indicators into broader groups. For example, all the indicators in Questionnaire 3 under the 'health services, facilities and goods' block which related to physical facilities and services could be grouped together and addressed with one indicator in the health system impact. That indicator is: "does the programme enhance or jeopardise the availability, accessibility, acceptability and quality of all health goods, services and facilities". Indicators were also selected to assess whether the programme would impact on the sustainability of

health services, goods and facilities, and on those service priorities to meet the core obligations. This process of selection continued for the other five blocks. Within each block, indicators were chosen that would allow the impact of the programme to be assessed on those components deemed essential for the right to health to be progressively realised. A total of 18 indicators were selected (Table 10-1).

The final questionnaire, Tool Three, is tested in Chapter 10.

3.4 Testing the framework and tools: preparing for case studies

On completion of the design of the framework and the three tools, it was then necessary to gather data to assess their relevance and feasibility. Two different case studies from PNG were used. Validity was measured by examining whether the information gathered through the use of the tools closely matched information gathered through primary and secondary sources. In particular, valid indicators would prompt the collection of information that would identify barriers to improved health care. The practicality of the tools was assessed by determining how many of the indicators elicited useful, relevant, non-duplicated information. Ease of use was also important. The goal was to have the least number of indicators necessary to gather the essential information for programme design. Time spent collecting data that is of no use to a programme would be a barrier to the continued use of the tools.

3.4.1 Case study selection

Two case studies are used in this thesis and both pertain to eye health in PNG. I had worked for an international NGO on an eye health programme in PNG since the programme's inception in 2003. I was therefore very familiar with the country and its health system, and the NGO was a rich source of information on eye health, the health sector and health system in PNG. It had been represented at or facilitated many health and eye health meetings and workshops, and undertaken a provincial eye health survey in 2005. This involved testing the vision of 1190 people, and conducting over 30 focus groups within communities in the National Central District to discuss barriers to their uptake of health care and eye health services. The organisation had documented internal evaluations of its work, and had also published papers on eye health, and barriers to care in PNG (Garap, Sheeladevi, Brian et al., 2006; Garap, Sheeladevi, Shamanna et al., 2006; Williams, Ramke, & Brian, 2008). The

programme had been internally assessed after its first four years and the achievements were documented and analysed against its original objectives and targets. Subsequently, information had been gathered from local stakeholders and combined with the information already gained from the community focus groups conducted during the eye health survey, to gain insight into why the programme had failed to meet many of its targets (Williams & Brian, 2008).

The first case study is a document analysis of that eye health programme. The documents analysed included the internal evaluation and other reports including health workers', staff and community explanations for the programme's failure to reach its targets. This programme was selected specifically for the very reason it had **not** achieved its objectives. This provided the opportunity to test the design tools to determine whether these tools would have predicted the situations that eventually limited the programme's achievements. Therefore, this would suggest that use of the tools at the outset of the programme would have resulted in an improved programme design.

Written permission was obtained from the board of the international NGO for use of their documents and reports for this thesis. The community focus groups and eye health survey had ethics approval from the Medical Research Advisory Committee (MRAC no. 05/13). The community barriers to eye health care had been published as a book chapter, of which I was the first author, and I had also presented the data at a conference, so this material was in the public domain (Williams et al., 2008).

Ethics approval was granted by the University of Auckland Human Participants Ethics Committee, reference 2008/077, and also by the Medical Research Advisory Committee, PNG in June 2008, to conduct participant interviews in PNG. I was fortunate to be invited by the National Department of Health PNG to attend national health planning workshops in my dual capacities as an NGO representative, and also as a doctoral candidate. The data (written and oral) gathered from these meetings was particularly useful in compiling the health system assessment of PNG, although much of the information gathered is also in the public domain or in grey literature.

The second case study is another document analysis of a proposed plan to address eye health in PNG. It was selected because it provided an opportunity to test the framework and tools on a disease-specific programme in its planning stage. This

proposed programme included activities that I considered beyond the scope of the health system in PNG to support, and so it offered an opportunity to test the tools to establish whether the tools could identify and remedy the design faults.

The proposed plan, hereafter called the Plan, was developed by a consortium of Australian NGOs. This case study focuses on a period of time when the consortium was designing eye health interventions within a model of health care delivery that had already won political and financial commitment. However, the funding for specific programmes of activities had not been allocated at this time. This Plan overall had attracted a significant amount of Australian funding, AUD 45 million over two years, of which about $10 million would be allocated to the PNG activities (Australian Labor Party, 2007). This had the potential to have a significant impact on the health system in PNG. Total expenditure on health in PNG in 2007 was about AUD 220 million, of which $70 million came from aid donors (PNG National Department of Health, 2009c). The scale of the Plan's workforce development alone posed threats to the health system as it aimed to train within two years up to 30 doctors to work as full time eye doctors. The number of doctors in PNG at the time totalled 330. Therefore, there was an opportunity to test the new framework's second and third tools, to determine whether they could identify the risks the Plan posed to the entire health system.

Using this Plan as a case study, Tools Two and Three are tested as stand alone assessment questionnaires in advance of programme implementation. Tool Two would be tested on its success at measuring the likelihood of the health service being available, accessible, acceptable, and of good quality. Tool Three is tested to determine if it can measure the likely impact of the Plan on the health system. The second case study documents for analysis were in the public domain, on websites, and in the NGO's document files (Australian Labor Party, 2007; Vision 2020 Australia, 2007a, 2007b).

3.5 Testing the framework: Tool One

Tool One comprised the three questionnaires, each measuring one layer of influence – international, national and the health system. They were tested to determine whether their indicators were adequate to gather the information most pertinent to understanding the context within which health programmes are located in

PNG. The process is explained below, and the use of this Case Study is presented in Chapters 6-8.

3.5.1 Populating the questionnaires

The questionnaires were populated with the relevant available data from PNG. The sources of the data were identified but they did not need to be sources that could be used for all countries, such as data arising from UN or WHO databases. It was more important that the data were accurate and current, given the purpose of this data collection was to capture the actualities of the PNG health context to guide programme design, not to make international comparisons.

3.5.2 Compiling country context

More detailed information about PNG was collated and written up in narrative form in each of the case study chapters (Chapters 6-10), as pertinent to that chapter. This information included PNG's human rights and health rights records and reports, international contracts and partnerships with donor governments, political context, functionality of its health system, and barriers to improved delivery and uptake of health. Secondary sources were used, including published papers and books on PNG, national workshop reports, annual reports from various health sector divisions in PNG, and NGO documents. These were analysed to identify key characteristics of the health system, from which its strengths and weaknesses were identified. Particular attention was paid to the stated barriers to improved health care delivery in PNG, because these problems were considered the most likely to limit the success and sustainability of a new health programme.

3.5.3 Comparing questionnaires with country context

The objective of this exercise was to refine the tool so that it would contain the most pertinent indicators, with the least amount of repetition, to elicit the maximum amount of critical information on local context. The information obtained from application of the questionnaires' indicators was examined against the information about PNG obtained from secondary sources. In particular, it was critical to determine whether the health system assessment questionnaire elicited similar information about the constraints on health services as those revealed through the secondary sources.

Where an inconsistency was identified, and where secondary sources had identified significant information not obtained through application of the indicators, changes, additions or deletions to the indicators were made.

3.5.4 Examining the first case study

Document analysis of the programme for the first case study was undertaken. Particular attention was paid to the reasons proffered by eye health workers and staff as to why the programme failed to achieve many of its targets. The barriers to eye health service had also been discussed in the community focus groups. All these explanations were collated as the documentation of barriers to the achievement of programme targets. For example, if the health workers stated that surgical numbers did not reach their target because equipment was missing, then 'missing equipment' was identified as a barrier to improved health services. Two tables of these barriers were created. One listed the barriers identified by the eye care workers and staff, the other those identified by the community.

3.5.5 Assessing the indicators against the case study

Each of these barriers was examined to determine whether early application of any of the questionnaires in the tool could have predicted that particular problem. In other words, did the questionnaires include indicators that would have alerted programme planners to the barriers to health services that the programme would need to address?

At the end of this process, it was possible to document which indicators, from each of the three questionnaires, had proved useful in generating information that could have informed an improved programme design. At this stage, it was also possible to consider whether the suggested changes and additions to the indicators (proposed as refinements when the questionnaire data was compared with other contextual information) could have also improved the programme design.

After all three questionnaires had been examined in light of the barriers to care in PNG, it was possible to check whether all the programme failings could have been predicted by at least one of the indicators in the three questionnaires. A good tool should aim to prevent programmes from failing, so it was important to demonstrate

that all failings could have been avoided if all of the information gathered by the indicators was incorporated into the initial programme design.

Finally, the three questionnaires were refined to accommodate the results from the case study cross-checks. These final questionnaires are presented as the first rights-based tool for designing health programmes, in Chapter 11 (Table 11-1).

3.6 Testing the framework: Tool Two

Tool Two is used to guide or assess programme design process from a rights-based perspective. It was tested against the second case study, using the process outlined below. The tool and its application to the case study are presented in Chapter 9.

3.6.1 Populating the questionnaire

The questionnaire assessing the design of the case study was completed. This process does not involve value judgements or technical expertise as the questionnaire only seeks information as to whether the indicators have been addressed in the design. For example, there is no requirement to determine whether information regarding the need for a service is accurate, rather it is only necessary to determine whether the need for the service is fully addressed in the design document. The indicators are scored according to whether they have been fully addressed, partially, or not at all.

The tool adopts the AAAQ plus six crucial concepts framework. That is, in the first section there are indicators for availability, accessibility, acceptability, and quality of the proposed health service. In the second section, which assesses integration of human rights concepts into the design of the programme, there are six elements: progressive realisation, core obligations, equality and non-discrimination, participation, information and accountability.

3.6.2 Assessing relevance of indicators

The results of the questionnaire were then analysed for relevance in the PNG context. This analysis considers whether a low score in any of the sections would likely translate into a programme failure. Each of the scores in the questionnaire was assessed for relevance by referring to the information on the PNG context obtained by Tool One. For example, a low score in the availability part of the questionnaire would

prompt a review of Tool One to see if availability of resources is a barrier to improved health care in PNG. If so, then the programme will almost certainly encounter problems about availability.

Each indicator that had been only partially addressed, or not addressed at all, was assessed to determine whether the missing information would have benefited the design process of the case study. If so, that indicator was considered essential. When there was duplication of information arising from separate indicators, it was recommended that one of those indicators be deleted from the questionnaire.

The final version of the tool after its assessment against the case study is presented in Chapter 11.

3.7 Testing the framework: Tool Three

Tool Three, final tool in the framework, is an examination of the programme's impact on the underlying health system. The tool's questionnaire was tested against the second case study, and is presented in Chapter 10. The methodology employed is explained below.

3.7.1 Populating the questionnaire

The questionnaire was applied to the same case study that was used to test Tool Two. The Plan in the case study was assessed against each of the indicators ascribed to the six building blocks of the health system. Each indicator called for an assessment to be made as to whether the Plan would strengthen or weaken that aspect of the health system. A justification for each assessment was also required, and was documented in a column alongside the decision. The assessment process drew on the information gathered in Tool One - the health system assessment, as well as the first two questionnaires that provided contextual data. So, for example, to make assessments in the section regarding availability of services, it was necessary to know that all resources, including health workers, were in very short supply in PNG.

3.7.2 Assessing questionnaire relevance

To assess whether the questionnaire had captured the most pertinent and relevant information about the Plan's impact on the health system, the known challenges to the system were examined. These had been identified by health workers

and were first documented in Chapter 8 (Table 8-2) and by the community and documented in the annexed Case Study in Chapter 6 (Table 6-6). If the questionnaire was relevant it would identify the threats to the health system that would result from placing additional stress on an already weak aspect of the system. Therefore, the weaknesses of the health system as identified by health workers and now presented in Table 10-2, and the community, Table 10-3, were used in this process:

1. A judgment was made, and explained, as to whether the Plan would improve or harm each of these documented weak aspects of the health system.
2. The health system impact questionnaire was checked to assess whether it had also captured this likely impact
3. The number of the indicator that had captured that information was documented in the barriers tables (Tables 10-2, 10-3)
4. The results were also examined to explore whether all the indicators contributed some information of relevance to the impact assessment, and which indicators provided the greatest amount of useful information. This was done by counting the number of times each indicator was cited as providing information to the assessment (Table 10-4).
5. Refinements were then made to the questionnaire according to the relevance of the indicators.

   The final version of Tool Three is presented in Chapter 11 (Table 11-5).

3.8 Finalising the rights-based programme design framework

By applying each of the three tools to practical case studies, the questionnaires were able to be refined. The goal was to test the validity of the tools by demonstrating the collection of the most relevant information for a rights-based programme design with the least amount of duplication or redundancy.

The final three tools, one for each of the three steps in the rights-based framework to designing aid-funded health programmes, are presented in Chapter 11. The relevance and feasibility of the framework are discussed in the concluding chapter.

Chapter 4 The right to health as a lens on development

> In seeing health as a human right, there is a call to action now to advance people's health in the same way that the 18th-century activists fought for freedom and liberty.
>
> Amartya Sen (Sen, 2008)

4.1 Introduction

Chapter 1 briefly traced the history of aid and its engagement with health in developing countries. In this chapter health and human rights literature is reviewed. The right to health is examined as a framework through which development assistance for health can be viewed, operationalised and held accountable. However, the chapter does not attempt to provide a comprehensive overview of human rights law. Nor does it provide a detailed history of the development of the right to health. Rather, it draws upon the major documents that enshrine the right to health, and interprets these in such a way that may be helpful for people and organisations working in the health sector of developing countries. It also examines a theory of the right to health.

4.2 A history of health rights

The right to the highest attainable standard of health is a fundamental human right enshrined in various international covenants and treaties, as well as in many State constitutions. Important documents in gaining international recognition of the right to health are the Universal Declaration of Human Rights 1948 (Box 3-1), the preamble to the WHO Constitution 1948 (Box 3-2), Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) 1966 (Box 3-3), and the Alma-Ata Declaration on primary health care in 1978 (Box 3-4). Each of these documents has been adopted, ratified or signed by nearly all States, and it is universal acceptance of their terms that makes them compelling, unique and legally enforceable.

Box 4-1 Universal Declaration of Human Rights

Article 1.

All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.

Article 2.

Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. Furthermore, no distinction shall be made on the basis of the political, jurisdictional or international status of the country or territory to which a person belongs, whether it be independent, trust, non-self-governing or under any other limitation of sovereignty.

Article 3.

Everyone has the right to life, liberty and security of person.

Article 25.

(1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

(2) Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

(United Nations, 1948)

Box 4-2 The preamble to the WHO Constitution 1948

... the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic, or social condition.

Box 4-3 Article 12, International Covenant of Economic, Social and Cultural Rights

1 The States parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

2 The steps to be taken by the States parties ... to achieve the full realization of this right shall include those necessary for:

(a) The provision for the reduction of the still birth rate and of infant mortality and for the healthy development of the child;

(b) The improvement of all aspects of environmental and industrial hygiene;

(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;

(d) The creation of conditions which would assure to all medical services and medical attention in the event of sickness

Box 4-4 The Alma-Ata Declaration on Health for All by 2000 (1978)

1 The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

2 The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.

5 Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.

6 Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self- reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

Human rights were first codified in 1948, with the adoption by the UN General Assembly of the Universal Declaration of Human Rights (UDHR). The purpose of the Declaration was to set a common standard pertaining to rights and freedoms to which all UN Member States should aspire and adhere, and which all people could claim. Although the UDHR itself is not binding under international law, and it has the status and authority of international customary law, and the principles contained in the UDHR were converted into legal obligations through treaties in 1966.

The principles of civil and political rights, and those of economic, social and cultural rights are addressed under two different treaties: the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights. Both treaties were adopted by the UN General Assembly in 1966, and collectively they are referred to as the International Bill of Rights, from which has evolved most principles contained in the body of international human rights law. These treaties are binding on States that ratify them. Treaty monitoring committees provide international supervision of States' compliance with treaties' obligations. Five additional international treaties seek to establish and protect human rights (Box 4-5).

Box 4-5 International human rights treaties

Treaty	**Known as**	**Adopted**
International Convention on the Elimination of All Forms of Racial Discrimination	ICERD	1965
International Covenant on Civil and Political Rights	ICCPR	1966
International Covenant on Economic, Social and Cultural Rights	ICESCR	1966
Convention on the Elimination of All Forms of Discrimination Against Women	CEDAW	1979
Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment	Torture Convention, or CAT	1984
Convention on the Rights of the Child	CRC	1989
International Convention on the Protection of the Rights of All Migrant Workers and Their Families	MWC	1990

Within each of these seven treaties lie principles that are concerned with health issues. Each has a treaty monitoring committee, allowing an internationally recognised system to monitor that States are meeting their citizens' right to health (amongst other rights). However, although laid out in some detail in the Alma-Ata Declaration, the actual duties of States remained somewhat unspecified in the monitoring committees until more recently. The Alma-Ata Declaration was a WHO-led conference and international declaration, but it never had the status of an International Framework Convention or an International Health Regulation and thus was not legally binding on WHO members. It was impressive in its political boldness and level of detail, and did not shy away from criticism of inequity in health between developed and developing countries. It advocated for the redirection of resources spent on armaments and military conflicts to health care (paragraph *x*). It recognised the importance of health systems in improving health, the underlying determinants of health, and participation of local people, and can thus be seen to have human rights embedded in its framework.

The Alma-Ata Declaration has also been described as WHO's attempt to reclaim the mantle of human rights after having neglected rights-based strategies over the previous two decades (Meier, 2010). "With the Health for All strategy providing a rights-based vision reflective of public health discourse, the Declaration of Alma-Ata would provide international consensus for national primary health care systems consistent with WHO's vision of health and human rights" (Meier, 2010, p.39-40).

Unfortunately the enthusiasm for the Alma-Ata commitment to primary health care waned almost as soon as the Alma-Ata Conference ended, not least because of the changes in economic philosophy which led to the replacement of primary health

care by 'health sector reform' (Hall & Taylor, 2003). In addition, two other philosophical shifts that are pertinent to human rights occurred with respect to the Alma-Ata Declaration and primary health care. Firstly, "Politicians and aid experts from developed countries could not accept the core PHC [primary health care] principle that communities in developing countries would have responsibility for planning and implementing their own health care services" (Hall & Taylor, 2003, p.18). Secondly, instead of prioritising the role of the health system in achieving health for all, donor agencies and governments switched to support "vertical, definable, time-limited programs that could be changed every few years" (Hall & Taylor, 2003, p.19). Meier (2010) attributes the abandonment of the Declaration to WHO's historical weaknesses in the development and implementation of human rights frameworks. He argues that although WHO's Health for All strategy was conceptualized in human rights terms, human rights were depicted as a general humanitarian imperative rather than a specific legal obligation. Without regulations to clarify and operationalise this right through legal obligations, its effectiveness was left dependent on the goodwill of national ministries. He laments that "it is difficult to envisage such generality being an effective advocacy tool or being sufficiently specific to assess health policy and practice" (Meier, 2010, pp.44-45).

It is interesting to observe that without embedding its goals and remedies into international human rights law, the Declaration was simply not binding. As a result, the neo-liberal agenda slipped easily into global health, removing the Alma-Ata focus on redistribution of wealth to achieve public health and primary health goals, and replacing it with an ethos of individual responsibility for health. This went hand in hand with international development support for medical interventions rather than primary health programmes and health systems development. The absence of WHO and rights discourse is also apparent in the international community's commitment to the MDGs, which is discussed further in Section 4.5.1.

4.3 General Comment 14 clarifies right to health duties

Although WHO failed to provide the necessary leadership to embed human rights in global health, support came from other quarters to promote the understanding and operationalisation of health rights. Firstly, in 2000, UN Member States adopted the ICESCR General Comment 14 (United Nations, 2000b) which provided much

needed detail on the meaning of 'the right to the highest attainable standard of health'. Secondly, in 2002 the UN Commission on Human Rights adopted a resolution to establish a Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (UN High Commissioner for Human Rights, 2002). The purpose of this appointment was to help States better promote and protect the right to the highest attainable standard of health (Hunt & Leader, 2010). The Special Rapporteur identified three main objectives to the role: "to raise the profile of the right to health as a fundamental human right; to clarify the contours and content of the right to health; and to find practical ways of operationalising the right to health" (Hunt & Leader, 2010, p.2).

It is interesting to note that even at the end of his tenure in 2008, WHO was still not engaging directly with the right to health, and the Special Rapporteur reported that despite his request no WHO Director General had met with him. "Of course, this would not matter if the World Health Assembly, Executive Board and others were considering the right to the highest attainable standard of health in a reasonably systematic way. But the record confirms that they are not" (United Nations, 2008a, para 60).

These two events proved of value to the translation of the right to health into meaningful practice. General Comment 14 promoted the development of a framework to measure and monitor health services and the underlying determinants of health by assessing their availability, accessibility, acceptability and quality (Box 4-6). It also documented States' general legal obligations arising from the ICESCR, in particular that they ensure the progressive realisation of the right to health, and to respect, protect and fulfil health rights.

> The obligation to respect requires States to refrain from interfering directly or indirectly with the enjoyment of the right to health. The obligation to protect requires States to take measures that prevent third parties from interfering with article 12 guarantees. Finally, the obligation to fulfil requires States to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health (United Nations, 2000b, para 33).

Box 4-6 General Comment 14, AAAQ elements

The right to health in all its forms and at all levels contains the following interrelated and essential elements, the precise application of which will depend on the conditions prevailing in a particular State party:

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

(b) *Accessibility.* Health facilities, goods and services have to be accessible to everyone without discrimination, within the jurisdiction of the State party. Accessibility has four overlapping dimensions:

Non-discrimination: health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds.

Physical accessibility: health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS. Accessibility also implies that medical services and underlying determinants of health, such as safe and potable water and adequate sanitation facilities, are within safe physical reach, including in rural areas. Accessibility further includes adequate access to buildings for persons with disabilities.

Economic accessibility (affordability): health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.

Information accessibility: accessibility includes the right to seek, receive and impart information and ideas concerning health issues. However, accessibility of information should not impair the right to have personal health data treated with confidentiality.

(c) *Acceptability.* All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.

(d) *Quality.* As well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires, *inter alia*, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.

The comment lists specific legal obligations incumbent on the State and notes international obligations. These refer to the Alma-Ata Declaration and the essential role of international cooperation in improving health inequities across borders.

> In this regard, States parties are referred to the Alma-Ata Declaration which proclaims that the existing gross inequality in the health status of the people, particularly between developed and developing countries, as well as within countries, is politically, socially and economically unacceptable and is, therefore, of common concern to all countries (United Nations, 2000b, para 38).

This document provides specific examples as to what protecting the right to health within a State can mean, including that States should pay greater attention to agreements with the international financial institutions to protect the right to health. It clarifies that while States are the parties ultimately accountable for compliance with

the right to health, responsibilities also fall on all members of society, including individuals, health professionals, intergovernmental and NGOs, as well as the private business sector (United Nations, 2000b, para 42).

Importantly, General Comment 14 provides guidance as to the meaning of core obligations (Box 4-7), and encourages the development and monitoring of right to health indicators and benchmarks. In particular, States must make functioning public health and health-care facilities, services and programmes available and accessible to everyone without discrimination. States must ensure these facilities are acceptable to all cultures in the community, sensitive to gender and that they must provide a quality service, with skilled medical personnel and adequate drugs and equipment. The Comment acknowledges the right to health embraces a wide range of underlying health determinants that enable health to be realised, including availability of food and nutrition, housing, access to potable water and adequate sanitation, and decent working conditions.

These core obligations are non-derogable (which means that they must be respected even in a time of crisis), and States cannot justify non-compliance or retrogression. The comment clarifies that violations of the right to health can occur through the direct action of States or other entities. “When examining the reports of States parties and their ability to meet the obligations under article 12, the Committee will consider the effects of the assistance provided by all other actors... the Committee will also consider the role of health professional associations and other non-governmental organizations in relation to the States' obligations under article 12” (United Nations, 2000b, para 64).

Box 4-7 General Comment 14: core obligations

43. In General Comment No. 3, the Committee confirms that States parties have a core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights enunciated in the Covenant, including essential primary health care. Read in conjunction with more contemporary instruments, such as the Programme of Action of the International Conference on Population and Development, (28) the Alma-Ata Declaration provides compelling guidance on the core obligations arising from article 12. Accordingly, in the Committee's view, these core obligations include at least the following obligations:

(a) To ensure the right of access to health facilities, goods and services on a non- discriminatory basis, especially for vulnerable or marginalized groups;

(b) To ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone;

(c) To ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water;

(d) To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs;

(e) To ensure equitable distribution of all health facilities, goods and services;

(f) To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process; they shall include

methods, such as right to health indicators and benchmarks, by which progress can be closely monitored; the process by which the strategy and plan of action are devised, as well as their content, shall give particular attention to all vulnerable or marginalized groups.

44. The Committee also confirms that the following are obligations of comparable priority:

(a) To ensure reproductive, maternal (pre-natal as well as post-natal) and child health care;

(b) To provide immunization against the major infectious diseases occurring in the community;

(c) To take measures to prevent, treat and control epidemic and endemic diseases;

(d) To provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them;

(e) To provide appropriate training for health personnel, including education on health and human rights.

45. For the avoidance of any doubt, the Committee wishes to emphasize that it is particularly incumbent on States parties and other actors in a position to assist, to provide "international assistance and cooperation, especially economic and technical" (29) which enable developing countries to fulfil their core and other obligations indicated in paragraphs 43 and 44 above.

This clarification is particularly meaningful when drawing on the right to health to frame analyses of aid-funded initiatives and the responsibilities of bilateral, multilateral and non-state parties when engaging with health programmes in developing countries. Paragraph 45 provides guidance on the role of development assistance to States for health. "[T]he Committee wishes to emphasize that it is particularly incumbent on States parties and other actors in a position to assist, to provide 'international assistance and cooperation, especially economic and technical' which enable developing countries to fulfil their core and other obligations." It is important to note that 'other actors' are equally called upon to work within States' own national plans and timeframes to assist them to meet their right to health obligations.

There are vast differences between countries as to what is affordable for each to provide to its citizens to meet right-to-health obligations, and this is acknowledged within General Comment 14. All States have immediate obligations that are not excused by resource constraints. These include that the right to health is exercised without discrimination of any kind, and that deliberate, concrete and targeted steps are taken towards the full realization of the right (United Nations, 2000b, para 30). Core obligations outline the very least that States must do to ensure their citizens have the fundamental necessities for minimum standards of health, and this includes provision of basic health care. The minimum cost of maintaining a fundamental and functional health system has been estimated at US$50 per capita per year (World Health Organization, 2000). This is beyond the resource capability of many developing countries and accordingly, it is not expected that these States can immediately meet all the core obligations. They must however adopt measures on non-discrimination, as

well as develop a national health strategy to demonstrate a pathway to the progressive realisation of the right to health. Such a plan can include legislation, policy plans and implementation, and gradual allocation of resources, including funding for health care, and development of the health workforce. Thus, national health and health workforce strategies are essential elements of the core obligations, and meeting core obligations needs to be acknowledged and a goal of the national health strategies.

Finally, General Comment 14 addresses remedies and accountability at both national and international levels, stating that victims of violations to the right to health "should be entitled to adequate reparation, which may take the form of restitution, compensation, satisfaction or guarantees of non-repetition" (United Nations, 2000b, para 59). States have a responsibility to demonstrate their progress towards realising the right to health and to be accountable in this process. "Human-rights accountability is concerned with ensuring that health systems are improving, and the right to the highest attainable standard of health is being progressively realised, for all, including disadvantaged individuals, communities, and populations" (Backman et al., 2008, p.2053). Those States that have ratified the ICESCR report to the Committee on their progress every five years.

4.4 Reframing international assistance for health as a legal duty

Before examining the practical meaning of the right to health and the Special Rapporteur's interpretations of General Comment 14, it is useful to consider legal duties associated with international assistance for global health. The principles contained in the seven relevant human rights treaties elevate health and an individual's right to the highest attainable standard of health and health care from an ethical to a legal issue. There are then legal mechanisms established to monitor and seek redress for violations, at both national and international levels.

> While ethics are vital, human rights are both vital and binding …When health is not described simply in terms of needs but also in terms of rights, governments find it far more difficult to justify the withholding of basic provisions and services on account of alleged financial constraints or because of discriminatory priorities (Paul Hunt in, Asher, 2004, p.iii)

The definition of health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (World Health

Organization, 1946) has contributed to the complexity of translating health rights into legal duties. If States have the capability to assist less developed States to reduce health inequities, to what extent do they have a well-defined legal or ethical responsibility to do so? General Comment 14 has made clear States do have a responsibility to help, derived from international law and political commitments, but the international law does not "enable States to operationalize this responsibility in specific cases and in a transparent manner. As a result, trans-national cooperation by States tends to be ineffectual and inconsistent" (Gostin & Archer, 2007, p.527).

The recently revised International Health Regulations that have a stated purpose to prevent, protect against, control and provide a public health response to the international spread of disease, require specific undertakings for international assistance in health (World Health Organization, 2005a). In particular, States that have ratified the International Health Regulations have to respond promptly and effectively to public health risks and emergencies of international concern. At the 58th World Health Assembly in 2005 Member States were urged to mobilize the resources necessary and to provide support upon request to build and strengthen public health capacities (Fidler & Gostin, 2006). Articles in the International Health Regulations require Member States to assist developing countries in particular (Article 5.3) and "help mobilize financial resources for developing countries" (Article 6.7) (Gostin & Archer, 2007, p.528).

General Comment 14 paragraph 39 stipulates that States should facilitate access to essential health facilities, goods and services in other countries, wherever possible and provide the necessary aid when required, depending on their own resources (United Nations, 2000b). However, actual duties are neither precise nor accountable. Although they concede that these obligations are not binding in practice and are therefore ineffectual, Gostin and Archer (2007) hold the view that because States have agreed by treaty to assist developing countries, this provides a foundation for a system of international cooperation that could have practical and operational effect. Furthermore, they argue that the commitments made by States add to the obligations to achieve humanitarian and human rights objectives.

It was the lack of enforcement through international law that prompted Ruger to develop a philosophical approach to the right to health, rather than a judicial one, claiming that a philosophical justification makes the right to health meaningful, operational and in the end 'justiciable' so that it can be enforced through international

law. By treating the right to health as an ethical demand for equitable health care, it will likely involve legal instruments for enforcement, and compliance with a right to health in international human rights policy and law (Ruger, 2006, p.278).

The MDGs further contribute to a shared understanding that States carry obligations to work internationally to promote some aspects of health rights, although these obligations are not framed around human or health rights. Only three of the eight goals (Chapter Two, Section 2.5) are health explicit, although another two have strong health implications. Within Goal 8 (Box 4-8), which promotes international partnerships for development, target 8e is specifically health related: In cooperation with pharmaceutical companies, [international partnerships must] provide access to affordable essential drugs in developing countries (United Nations, 2000a).

The MDGs are not the only commitments made outside rights frameworks for States to offer support to the health sector in developing countries. In November 2001, Members States of the World Trade Organization (WTO) promulgated a Declaration relating to the Agreement on Trade-Related Aspects of Intellectual Property rights (TRIPS) and Public Health. “In this Declaration, States recognized that resource-poor countries face major public health problems (eg, HIV/AIDS, tuberculosis, and malaria) and called for ‘flexibilities’ to protect the public’s health by promoting access to essential medicines” (Gostin & Archer, 2007, p.529). The G8 made pledges to reduce the global HIV/AIDS resource gap nationally and internationally, the Global Plan committed to Stop TB, and the Gleneagles commitment to Universal Access to HIV/AIDS treatment by 2010, and promises for vaccine development, was made. “In summary, a majority of States has made legal undertakings and political commitments to help protect the health of people in all countries (not just their own)” (Gostin & Archer, 2007, p.529).

Box 4-8 MDG Goal 8: Develop a global partnership for development

Target 8a: Develop further an open, rule-based, predictable, non-discriminatory trading and financial system Includes a commitment to good governance, development and poverty reduction – both nationally and internationally **Target 8b: Address the special needs of the least developed countries** Includes: tariff and quota free access for the least developed countries' exports; enhanced programme of debt relief for heavily indebted poor countries (HIPC) and cancellation of official bilateral debt; and more generous ODA for countries committed to poverty reduction **Target 8c: Address the special needs of landlocked developing countries and small island developing States (through the Programme of Action for the Sustainable Development of Small Island Developing States and the outcome of the twenty-second special session of the General Assembly)** **Target 8d: Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term**
Some of the indicators listed below are monitored separately for the least developed countries (LDCs), Africa, landlocked developing countries and small island developing States. **Official development assistance (ODA)** 8.1 Net ODA, total and to the least developed countries, as percentage of OECD/DAC donors' gross national income 8.2 Proportion of total bilateral, sector-allocable ODA of OECD/DAC donors to basic social services (basic education, primary health care, nutrition, safe water and sanitation) 8.3 Proportion of bilateral official development assistance of OECD/DAC donors that is untied 8.4 ODA received in landlocked developing countries as a proportion of their gross national incomes 8.5 ODA received in small island developing States as a proportion of their gross national incomes **Market access** 8.6 Proportion of total developed country imports (by value and excluding arms) from developing countries and least developed countries, admitted free of duty 8.7 Average tariffs imposed by developed countries on agricultural products and textiles and clothing from developing countries 8.8 Agricultural support estimate for OECD countries as a percentage of their gross domestic product 8.9 Proportion of ODA provided to help build trade capacity **Debt sustainability** 8.10 Total number of countries that have reached their HIPC decision points and number that have reached their HIPC completion points (cumulative) 8.11 Debt relief committed under HIPC and MDRI Initiatives 8.12 Debt service as a percentage of exports of goods and services
Target 8e: In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries
8.13 Proportion of population with access to affordable essential drugs on a sustainable basis
Target 8f: In cooperation with the private sector, make available the benefits of new technologies, especially information and communications
8.14 Telephone lines per 100 population 8.15 Cellular subscribers per 100 population 8.16 Internet users per 100 population

Exploring the reasons that developed countries choose to support health initiatives in poorer countries, Gostin and Archer proffer that governments and most political leaders recognise they have ethical responsibilities to those who are less fortunate, both in their own countries and internationally. These ethical responsibilities are conflated globally into an overarching duty of care. "Human rights law provides an authoritative, complete framework of officially recognized ethical principles that address issues of global equity. …The framework's ability to provide a

shared international language of negotiation in this area gives it tremendous potential value" (Gostin & Archer, 2007, pp.529-530).

International commitments are less politically vulnerable when they align with national interests, not least because a State's first duty is to protect its own citizens. Gostin and Archer suggest that if the national interest were to be defined more broadly it would offer a compelling rationale for greater commitment to international assistance across a range of health issues. They make the argument that global health protection relies on the ability of national and sub-national governments to engage in speedy and accurate surveillance and response to health threats, which requires support from wealthier states. "No country can insulate itself from infectious diseases or other global health threats. It is thus in the government's self-interest to provide technical and financial assistance to build capacity in poorer countries" (Gostin & Archer, 2007, pp.530-531).

The authors concede that there is a risk in positioning national security as a rationale for international assistance because by extension, support may be limited to those health interventions that pose a threat to health security in developed countries. This could leave health problems that are no risk to other States receiving no international support, for example, maternal and child health. However, the redress to this would be the observation of negative rights, as proposed health interventions must respect and protect the right to health. Therefore, partners proposing interventions aimed to address specific diseases (that may be of greater political or security concern to potential funders), need to demonstrate that they are not weakening the health system by attracting resources away from essential services.

4.4.1 Strengthening legal frameworks for international health

There have been calls for a Framework Convention on Global Health that would establish a legal base for international commitment to reduce the vast inequities in health. Gostin suggests that the absence of a principled ethical argument for international duty may well be "because it is so hard to craft" (Gostin, 2008, p. 347). He is critical of WHO's lack of leadership in international health law and does not think the organisation is up to the task of addressing the overwhelming disparity of health care between poor and wealthy countries.

> It might not matter whether the WHO was a prime mover on matters of global health if extant international norms were adequate. However, international health law is not up to the hard task of health improvement for the world's poorest people (Gostin, 2008, p.370).

Gostin also argues that right to health duties, as specified in General Comment 14, are insufficient to address global disparities because the legal obligation falls primarily on each State to address the right to health for its own population.

> Although the ICESCR posits that all States have duties to assist and cooperate in achieving economic and social rights, the obligation to assist other States' populations cannot become primary. Second, the right to health itself is expressed as 'progressive realization', so there can be little agreement as to when a State has breached an obligation to its people, let alone to people in far away places (Gostin, 2008, p.382).

The net result, argues Gostin, is that the duty to improve the health of the world's unhealthiest and most disadvantaged people falls on States with the least means to do so. Making the case that a Framework Convention on Global Health could resolve this issue, he proposes a global health governance scheme that:

- Builds capacity – so that all countries have enduring and effective health systems
- Sets priorities, so that international assistance is directed to meeting basic survival needs
- Engages stakeholders, including State and non-State actors
- Coordinates activities
- Evaluates and monitors progress (Gostin, 2008, pp.383-384).

General Comment 14, paragraph 45, states, "For the avoidance of any doubt, the Committee wishes to emphasize that it is particularly incumbent on States parties and other actors in a position to assist, to provide 'international assistance and cooperation, especially economic and technical' which enable developing countries to fulfil their core and other obligations". Nevertheless, developed countries maintain that they have no 'legal' obligation to assist developing countries to meet rights obligations. If there is no legal obligation for developed countries to assist developing countries, then commitment to official development assistance by developed countries will always remain uncertain, subject to political and economic influence, and viewed as philanthropy, not duty.

Sweden, which has an excellent record in aid assistance and human rights, does not accept it has a legal duty to provide official development assistance. The Special Rapporteur conducted a mission to Sweden and in his report concluded: "...if there is no legal obligation underpinning the human rights responsibility of international assistance and cooperation, inescapably all international assistance and cooperation is based fundamentally upon charity. While such a position might have been tenable 100 years ago, it is unacceptable in the twenty-first century" (United Nations, 2007, para 113).

4.4.2 MDGs, international duty and the right to health

The adoption of the UN Millennium Declaration in 2000 by 189 member States should have provided a means of enforcing international commitments to assisting health in developing countries. The Declaration states that

> In addition to our separate responsibilities to our individual societies, we have a collective responsibility to uphold the principles of human dignity, equality and equity at the global level. As leaders we have a duty therefore to all the world's people, especially the most vulnerable and, in particular, the children of the world, to whom the future belongs (United Nations, 2000a, para 2)

In particular, Goal 8, Global Partnership for Development, calls on developed countries to commit to specified actions to help meet the targets in Goals 1-7 (Section 2.5). These actions cover trade, debt, technology transfer and aid. Goal 8 therefore contains the possibility of being more measurable, and accountable, than the international obligations contained in the ICESCR and General Comment 14. Goal 8 has been described as providing a framework through which developed countries can be held accountable (Fukuda-Parr, 2006). This would assist the reframing of development from voluntary or ethical assistance to one bound by international law. Despite a growing literature and more programmes promoting a rights-based approach to development, the focus has still failed to fully embrace the "international dimension of state obligations. Conceptually, development cooperation is still rooted in the logic of charity rather than the logic of shared responsibilities in a global community" (Fukuda-Parr, 2006, p.968). Even if Fukuda-Parr is correct that the MDGs provided a framework for accountability, they did not provide a practical mechanism.

Despite acknowledging human rights in the UN Millennium Declaration, the Goals themselves are not framed around human rights. As a result there is an absence of human rights concepts, such as equality and non-discrimination, participation and accountability, in the discourse and measurement of the Goals. Therefore, it is possible to meet aggregate targets and still fail to address the needs of people who are the most disadvantaged and marginalised.

> On their own, there is nothing in the formulation of the MDGs to require that strategies to accelerate maternal mortality reductions be based upon anything but aggregate maximization, that is, best outcomes. In contrast, under a human rights framework we would be concerned with redressing the historic and ongoing patterns of discrimination these communities face, reflected by their relative maternal mortality ratios, among other things (Yamin, 2009, p.8)

The MDGs also lost an opportunity to hold international partners to account for their essential role in the achievement of the goals. The Special Rapporteur addressed this issue in a report to the UN stating that human rights have much to offer the Goals (United Nations, 2004). In particular, he addressed the crucial importance of accountability and stated that the international community and others would have to identify appropriate, effective, transparent and accessible accountability mechanisms for integration into the Millennium Development initiative. “If it does not, the Millennium Development Goals will lack an indispensable feature of human rights — and, more importantly, the chances of achieving them will be seriously diminished” (United Nations, 2004, para 41). Furthermore, he suggested that if the international community failed to address the challenge of developing appropriate accountability mechanisms, “developing countries may wish to establish their own independent accountability mechanism regarding the discharge of commitments under Goal 8 by developed countries” (United Nations, 2004, para 45). His comments on risks posed by the disease-specific nature of the Goals are discussed in the next chapter.

Fukuda-Parr also argues that the goals and indicators are weak in standards for accountability. She believes they inadequately address key human rights principles in each of the three areas where international action is required to supplement domestic efforts: lack of resources, improving the international policy environment, and addressing systematic asymmetries in global decision making processes (Fukuda-Parr, 2006). She claims the targets and indicators on Goal 8 are weak on two counts: firstly

there are no quantifiable targets and no timetable for implementation other than the ODA target of 0.7 percent of GDP. The second is that general objectives and desired outcomes are stated but without "concrete policy changes that can be monitored, even though governments have committed to specific changes in the Monterrey consensus and in subsequent agreements such as the Paris Declaration" (Fukuda-Parr, 2006, p.985). She contends that from a human rights perspective, the most glaring omissions concern priority attention to countries in greatest need, protecting human rights against violations by others, especially on the issues of corporate behaviour, and the systemic issue of greater transparency and equality by promoting developing country participation in global governance processes.

However, the acceptance by all developed countries that they have obligations to assist other states to achieve humanitarian goals by 2015, including halving poverty and promoting child and maternal health, is important. As is recognition with the targets of Goal 8 that non-state actors, pharmaceutical companies (8e), and the private sector (8f), have responsibilities (Box 4-8).

4.4.3 Non-state parties and international obligations

General Comment 14 provided clarity on the obligations of international partners towards alleviating the "gross inequality in the health status of all people, particularly between developed and developing countries" (United Nations, 2000b, para 38). It set out an obligation on States that they had to respect the right to health in other countries, and to prevent third parties from violating the right to health, using legal or political means. Furthermore, quite specifically, in paragraph 42, compliance with health rights is extended to all members of society, including NGOs and the private business sector, even though States are ultimately accountable for compliance.

Therefore it was within the mandate of the Special Rapporteur to make recommendations about non-state actors with respect to the right to health. Accordingly, he submitted reports on the pharmaceutical sector, and the World Bank and IMF (United Nations, 2008b, 2009). It would be reasonable to expect that, given the changes in global health, and the increased and significant space that NGOs and GHIs occupy in global health, their actions and policies in developing countries would also come under the gaze of human rights champions and future Special Rapporteurs. All actors in global health need to demonstrate that their work in

developing countries is compliant with international obligations to respect, protect and fulfil the right to health.

It is also worthy of note that General Comment 14 was adopted at the UN in 2000, before the rise to prominence of GHIs. It is possible that if it had been drafted a decade later, the General Comment may well have made further mention of the obligations of these non-state actors with regard to the right to health. There is increasing recognition of the urgent need for accountability mechanisms for all actors, " – public, private, national, and international - working on health-related issues" (Backman et al., 2008, p.2053).

Because GHIs and NGOs are contributing up to one quarter of all aid funding for health (Bloom, 2007), and are implementing agencies in many countries, they can have considerable impact on whether developing countries are able to meet their health rights obligations. Working within an agreed right-to-health framework would not only help coordination of development assistance and improve local control of health service, but just as importantly, it could protect and respect health rights. In particular, this offers an opportunity to protect and strengthen health systems.

The Special Rapporteur addressed the importance of non-state actors in meeting health rights (United Nations, 2008b, 2009). In these reports, he made it clear that other parties, especially pharmaceutical companies and the international financial institutes, carry obligations towards respecting, protecting and fulfilling the right to health. He recommended that the IMF and the World Bank adopt human rights policies: "this would give legitimacy to difficult and contested programme choices, and strengthen programme coherence and coordination among donors" (United Nations, 2008b, para 105). The Special Rapporteur, who stated that bank policies could positively or negatively affect human rights outcomes in developing countries, did not underestimate the institutions' impact. "Their policies and programmes can reinforce societal divisions and exacerbate conflict if issues such as race, ethnicity and gender are not taken into consideration" (United Nations, 2008b, para 124).

Similarly, he addressed the duties of pharmaceutical companies with respect to health rights. Sidestepping the contested territory of legal obligation, the Special Rapporteur undertook a mission and made many recommendations to the world's largest pharmaceutical company GlaxoSmithKline (GSK).

> Whether its right-to-health responsibilities are legal, ethical or both, GSK must strengthen its accountability in relation to access to medicines and the right to health… As one step in the right direction, it may wish to establish an independent mechanism that focuses on one particular dimension of access to medicines and the right to health, such as disclosure of information. Critically, GSK needs an accountability mechanism that uses right-to-health standards and is independent, accessible, transparent, and effective (United Nations, 2009, para 105).

The Special Rapporteur did not limit his comments on the pharmaceutical sector to GSK. Rather, he said all pharmaceutical companies have a responsibility to take reasonable measures to redress the historic neglect of poverty-related diseases. "All pharmaceutical companies should either provide in-house research and development for neglected diseases, or support external research and development for such diseases" (United Nations, 2009, para 93). He describes the neglect of poverty-related diseases as one of the most serious human rights issues confronting the world.

For the purposes of developing a human rights framework to guide the design of health initiatives in developing countries, the Special Rapporteur's missions to the pharmaceutical company, IMF and the World Bank are instructive. His recommendations to these entities, and to the UN General Assembly, are based on an understanding that such organisations cannot work in a rights-vacuum. These recommendations recognise the important role of these institutions and companies within global health, and therefore, whether or not the entities themselves have rights obligations per se, becomes a moot point. Rather, their actions have the potential to respect, protect and fulfil the right to health, or not. Although activities of non-state parties are governed and regulated by their internal governance arrangements, and the governments of the countries in which they are based or operate, there is usually little external transparency or accountability. For example, with regard to the recommendation that pharmaceutical companies conduct research into neglected diseases, it is unlikely to be audited in the country in which the company is registered. There is therefore an urgent need for transparent monitoring, just as there is for State parties, given the large place non-state actors hold in global health.

Recognising these issues, the Special Rapporteur has called for increased accountability regarding the right to health, in particular from the IMF and World Bank, as well as from the pharmaceutical sector. He describes accountability as a vital feature of human rights, including the right to health.

> Donors' accountability moves in two directions. Firstly, they are accountable to their taxpayers, usually through Parliament. Secondly, they are accountable to recipients and the international community… For recipients the key question is: has the donor honoured its pledges and policies? In other words, has the donor discharged its human rights responsibility of international assistance and cooperation in health? (United Nations, 2008b, para 77)

It is in keeping with these recommendations that there are calls for other non-state actors, such as GHIs and NGOs, to start working and reporting within a human rights framework.

> Government roles and responsibilities are increasingly delegated to non-state actors (eg, biomedical research institutions, health insurance companies, health management organisations, the pharmaceutical industry, and care providers) whose accountability is defined poorly and monitored inadequately. No objective measures are available of the commitment and capacity of governments to ensure that actions taken by the private sector and other players, including civil society, are informed by and comply with human rights (Sofia Gruskin, Mills, & Tarantola, 2007, p.453).

The use of human rights can provide a remedy to social injustice, but only if there is enough substance in the measurement and monitoring of compliance within States and including the actions on the non-state parties. In 1999 internationally agreed guidelines specifying minimum standards of care, and minimum access to service, were advocated as a means of putting substantive content into human rights instruments (Yamin & Maine, 1999). Subsequently, through General Comment 14, and the appointment of the Special Rapporteur, much progress was made to that end. Even more is required now to ensure that all parties in global health not only fulfil the right to health, but also respect and protect it.

4.4.4 Human rights concepts in international agreements

The WTO Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) to extend access to patented medicines during a public health emergency was used to illustrate international obligations to respect, protect and fulfil human rights (Fukuda-Parr, 2006). Addressing each of the dimensions in turn, Fukuda-Parr provided the following examples.

> ***Respecting the right to health***: shown when a State refrains from obstructing another State from pursuing the use of flexibilities in TRIPS to protect public health. Several

> years ago, a group of multinationals sued the South African government over this issue. Their home governments could have refrained from backing the multinationals position, considering that HIV/AIDS affects over a fifth of the country's adult population.
>
> ***Protecting the right to health***: to take measures to encourage multinationals producing HIV/AIDS retrovirals to refrain from standing in the way of using compulsory licensing to allow generic production of the drugs
>
> ***Fulfilling the right to health:*** investing in vaccines for HIV/AIDS, which are urgently needed to stem the spread of this pandemic (Fukuda-Parr, 2006, p.974).

Fukuda-Parr uses four key human rights principles in her examination of international relations: non-discrimination, participation, adequate progress and effective remedy. She suggests that non-discriminatory policies should aim to achieve greater equality. "Policies aimed at achieving greater equality implies greater priority to improvement of the most deprived and excluded" (Fukuda-Parr, 2006, p.974). This is consistent with Ruger's capability and health theory examined in Section 4.8, which posits a mechanism (shortfall equality) to achieve greater equality at societal and individual levels. "… [I]n implementing a right to health, we should be concerned with reducing inequalities in health capabilities among individuals and groups" (Ruger, 2006, p.292).

The implications of the principle of non-discrimination to equal achievement are not insignificant when applied to MDG Goal 8. The discriminatory rules in the international trading system and institutional procedures can be examined in this light. "It is arguably a matter of human rights obligation on the part of rich countries to dismantle tariffs on developing country exports and subsidies on farm products that compete with developing country exports" (Fukuda-Parr, 2006, p.975). Under the other human rights concepts, developed countries have an obligation via 'participation' to ensure that voices of developing countries are heard in multilateral trade negotiations; adequate progress requires the agreement of a framework for benchmarking progress between developed and developing countries, but there is little to address remedy, save the WTO dispute settlement procedure. "Enforcement mechanisms at the international level rely on peer pressure, and naming and shaming" (ibid, p.976).

There is little disagreement that achieving the MDGs and reducing global health inequities require considerable commitment from international partners.

Fukuda-Parr claims there are three categories of obstacles beyond the reach of national action: resource constraints – both human and financial; international policies which impose constraints on developing countries in the form of commodity prices, unfavourable trade rules, poor access to technology including for medicines and crops; and asymmetry in global governance. In the case of the latter, she argues that developing countries have weak bargaining power in WTO multilateral trade negotiations, resulting in trade rules favouring the interests of rich and powerful countries, and that developing country representation is weak in other institutions such as the World Bank, IMF and the Basel Committee (Fukuda-Parr, 2006).

4.4.5 Measuring the cost to health in trade deals

Trade negotiation imbalance is also addressed by Gostin and Taylor (2008) in their examination of the hazards posed by contemporary globalisation on human health. They argue a need for global health law to facilitate effective multilateral cooperation in advancing the health of populations equitably. Claiming that the forces of globalization have exacerbated health disparities, they state:

> Indeed, some of the most significant impacts of globalization on health can be understood, in part, as perpetrating and deepening global inequity by compelling poor countries to, *inter alia,* privatize, impose user fees and adopt trade liberalization policies in areas, including health services and pharmaceutical distribution. In this globalized era, the world is more unequal than ever before (Gostin & Taylor, 2008, p.54).

The Special Rapporteur examined the Peru-US trade negotiations that took place in 2004. He encouraged the Government of Peru to make use of the safeguards available under the TRIPS Agreement and the Doha Declaration to protect public health and promote access to medicines. His mission to Peru urged the country to take its human rights obligations into account when negotiating the bilateral trade agreement.

> Before any agreement is finalized, assessments should identify the likely impact of the agreement on the enjoyment of the right to health, including access to essential medicines and health care, especially of those living in poverty…Also, in accordance with its human rights responsibility of international cooperation, the United States should not apply pressure on Peru to enter into commitments that either are

> inconsistent with Peru's constitutional and international human rights obligations, or by their nature are 'WTO-plus' (Hunt, 2006, p.606).

The Peruvian Ministry of Health's impact assessment found that unless the health budget increased, the proposed US-Peru trade agreement would result in up to 900,000 people being unable to access medicines. It was estimated that the agreement would require an additional increase in spending of US$34.4 million in the first year of the agreement, of which $29 million would fall on families and the rest on the Ministry. The Special Rapporteur issued a press release welcoming the Ministry of Health's impact assessment, warning all parties of the effects of the bilateral trade agreement on the right to health, and urging the Peru Government to introduce complementary measures to protect the poor from bearing the costs of the trade agreement. The Ministry of Health proposed the creation of a fund for medicines drawn from sectors benefiting from the agreement.

It is not just trade agreements that can have an impact on health in developing countries. The Oslo Declaration (Ministers of Foreign Affairs of Brazil France Indonesia Norway Senegal South Africa and Thailand, 2007) which urged nations to analyse their foreign policy for its impact on health, looked beyond trade agreements. "What brought the ministers together was the realization that the state of global health has a profound impact on all nations and is deeply interconnected with trade and environment, economic growth, social development, national security, human rights, and dignity" (Mogedal & Alveberg, 2010, p1). The converse also holds, that each of those issues has a profound impact on global health, and hence there is need for policy coherence within and between states to protect everyone's right to health. This is reflected in part in the Adelaide Statement on Health in All Policies which emphasizes that government objectives are best achieved when all sectors include health and wellbeing as a key component of policy development (World Health Organization & Government of South Australia, 2010). Despite WHO taking the lead in the Health in All Policies initiative, the statement fails to include foreign policy or international development in its examples of government action and focuses on internal policy matters.

4.5 Rights-based approaches align with good development practice

There is much alignment between good development practice and rights-based approaches to development. Both endorse the principles of equality and non-discrimination, fully informing local people, meaningful participation of local people, and accountability. Development programmes that attempt to fulfil the right to health will also be well placed to achieve public health goals because the right to health depends upon a capable health system which functions well enough to deliver accessible, acceptable and quality health services. Public health, whose goal is to promote the health of the population, is also dependent upon effective health systems and universal access to the underlying determinants of health. Rights-based programmes do not aim solely to *fulfil* the right to health, they also adopt rights-based processes, which is to say, they *respect* and *protect* health rights. Called 'crucial concepts', these processes were embedded in all the Special Rapporteur's analyses, in addition to the AAAQ framework. The crucial concepts include core obligations, progressive realisation, equality and non-discrimination, participation, information, and accountability, which were included as principles in General Comment 14 (United Nations, 2000b) (see Box 3-2).

The health of people in developing countries has been viewed in terms of development ever since the development era began in the 1950s. In Chapter One the changing political and economic climates were shown to have greatly influenced the shape of development assistance. The neo-liberal primacy of economic growth and minimising the state involvement in social services was a feature of the development agenda throughout the 1980s and 1990s, with its associated negative impact on health systems in developing countries. As referred to in Section 4.2, WHO did not engage adequately with human rights, and this allowed the organisation to be viewed as a technical and medical advisory organisation rather than a rights-based leader in international health.

> But without any sustained WHO participation in the development or implementation of human rights, health rights would be left without normative frameworks and accountability standards from the world's pre-eminent health agency, denying states the guidance necessary to realize underlying determinants of health pursuant to the human right to health (Meier, 2010, p.35).

Although WHO had tried to re-engage with the right to health in the early 1970s, as shown in the discourse and content of the Alma-Ata Declaration, it failed to embed this approach in a legal framework, which is described as a particularly disempowering omission (Meier, 2010, p.44). This allowed two situations to unfold: firstly, health interventions in developing countries tended to remain or become disease specific, and secondly, the health agenda in development was captured by the World Bank and other international financial institutions. Therefore, in as much as health was on the development agenda at all in the neo-liberal-dominated decades, it was there only because a healthy population was seen to be an enabling factor in economic growth.

Viewing health within the economic development agenda leaves it not only subject to changes in policy and politics of donors, but at risk of having top-down technocratic and disease-specific programmes imposed. The Special Rapporteur referred to the health targets of the MDGs in this manner (United Nations, 2004). Viewing the health needs of people in developing countries as rights not only brings about legal duty, but it also carries good development practice principles.

> The right to the highest attainable standard of health is the only perspective that is both underpinned by universally recognized moral values and reinforced by legal obligations. Properly understood, the right to the highest attainable standard of health has a profound contribution to make toward building healthy societies and equitable health systems (Hunt & Backman, 2008, p.90).

4.5.1 Key features of participation and sustainability

The purpose of drawing attention to the similarities of approach between good development practice and human rights concepts, and between the aims of health rights and public health, is to allay any concern that adopting a rights-based approach to health programmes is a departure into unknown territories.

> A human rights approach to health emphasizes that the effective and sustainable provision of health-related services can only be achieved if people participate in the design of policies, programmes and strategies that are meant for their protection and benefit... Community action and involvement is the key to the empowerment that is essential to understanding and claiming human rights, including the right to health. Effective community action also contributes to achieving better health (Asher, 2004, p.20).

So rather than adopting new and arcane methodologies to engage with the right to health in practice, in fact, the frameworks will be familiar territory for good practitioners. What is added is grounding in international law that brings weight to health programmes and policies. For example, by adopting a rights-based view of health, governments cannot be allowed to trade off measures to improve maternal or child mortality for tax cuts to promote economic growth. Asher argues that rights bearers, in this example being women and children, are entitled to health interventions to protect their lives (birth attendants, immunisations, access to health facilities), and these should not be viewed as an optional act on the part of benevolent governments or philanthropists (Asher, 2004).

This is not to deny, however, that there has been a difficult relationship between rights and development, with the two being regarded at times as quite separate forces and activities. "This division was often associated with the view that 'development' was a *precondition* of respect for human rights in accordance with the slogan 'bread first, freedom later'" (Freeman, 2002, p.149). Freeman maintains that the notion that human rights could be traded off for development was replaced by an emphasis on good governance (in the 1980s-1990s) because the trade off was clearly associated with failed development. Good governance, as discussed in Chapter 2, promoted democracy but also was linked closely with neo-liberal reforms. "This makes the protection of economic and social rights very difficult" (Freeman, 2002, p.151). Good governance and neo-liberal reforms are an integral aspect of globalisation, and an increasingly interconnected world. General Comment 14 is clear that the right to health duties and claims also extend beyond state borders, no matter how reluctant international partners may be to accept this.

4.6 Human rights, freedom and development

The Universal Declaration of Human Rights, Articles 1-3 (Box 4-1) is fundamentally about freedom. The Declaration proclaims that all people are born free and equal, and have equal rights to life, liberty and security. For the billions of people born into poverty and a life without liberty or security, however, this is blatantly not the case. Thus, the principal ends of development may indeed be viewed as the achievement of those freedoms.

'Freedom from want', as stated in the preamble to the Universal Declaration of Human Rights, and in Article 25, brings poverty and health directly into a human rights framework. The link between development and human rights is, at the very least, that development is both a process and an outcome providing people with an escape from a life without the freedom to choose to live fully, with dignity, and with access to health care and education. Wealth may, for some, enable a full life. But it is not in itself the goal of development. This is a far broader perspective on development than the economic view that has had primacy throughout the development era.

Amartya Sen frames development as a means to enable people to lead lives without misery and 'unfreedom'. In arguing that development is limited by adopting a narrow economic view on the subject, Sen claims the "usefulness of wealth lies in the things that it allows us to do – the substantive freedoms it helps us to achieve" (Sen, 2000a, p.14). He argues that a concept of development must extend beyond measures of income and GNP. From a human rights perspective, poverty can be viewed as a subset of 'freedom from want'. When a person is 'unfree', there is a strong correlation to denial of their health rights, evidenced in particular by the poor health indicators associated with developing countries. Lack of freedom is the antithesis of, and greatest barrier to, the right to development. "And among the most important freedoms that we can have is the freedom from avoidable ill-health and from escapable mortality" (Sen, 1999, p.620).

In an economic model, improved health is seen as both a by-product of, and contributor to, economic growth, and for that reason it has value. However this model fails to view health as a human right, and it is not usually measured in a manner that considers whether the benefits of economic growth are reaching those people who most need it, in particular, women, children and ethnic minorities or those most marginalised and disadvantaged. By viewing health in developing countries through a rights lens, rather than through the lens of economic or socio-economic development, it is possible to hold governments and their international partners accountable for actions that impact on the rights of their citizens. Economic models of development do not provide such accountability and continue to view development as economic growth.

Sen claims that freedom is central to the process of development for two distinct reasons.

1 *The evaluative reason*: assessment of progress has to be done primarily in terms of whether the freedoms that people have are enhanced;

2 *The effectiveness reason*: achievement of development is thoroughly dependent on the free agency of people (Sen, 2000a).

This view of development is broad, oriented towards the individual, and the 'freedoms' available for individuals to enjoy a full life. That is, this theoretical view of development does not define or judge development at a national level by economic measures of GNP, social or technological advances. Freedoms depend on, *inter alia*, access to education and health care, political and civil rights. Locating freedom (and human rights) in this context of a broad view of development is not unfamiliar territory in the health sector. For example, the social determinants of health are recognised as being complex and multilayered, encompassing a broad cross-section of international and national policies and procedures, social, economic, genetic and lifestyle factors. These include, but are not limited to, access to health care and education, conditions of work and leisure, infrastructure within the community – and generally, a person's ability to lead a flourishing life. Inequity in health is not viewed as a 'natural' phenomenon but is "the result of a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics" (World Health Organization, 2008b, p.1).

To view development purely in economic terms is to reduce it to a less than meaningful measure, simply comparing one country's economic performance against others. This measure does not reflect the quality of people's lives within a country. There are nations with high GNPs, such as the USA and Australia, which encompass pockets of real deprivation and poor health; similarly there are low GNP economies with very good health indicators. Cuba and Costa Rica are such examples. Further, as Sen has illustrated, there are examples of countries in the past 20 years which have rapidly increased their GNP and also made rapid progress in improving health indicators (Taiwan and Korea), while Brazil, for example, increased income but did not similarly improve health (Sen, 1999, 2000b).

Human rights treaties provide frameworks that allow measurement and monitoring of people's access to freedoms. The most expansive description of the right to health is provided through General Comment 14, which establishes the fundamental AAAQ and crucial human rights concepts as a framework for viewing health rights. The AAAQ framework provides a mechanism to monitor people's

access to quality health care, and to the underlying determinants of health. Put another way, it is examining whether people have the freedom to benefit and flourish from health services and the underlying determinants of health.

Sen (2000a) views development in terms of expanding substantive freedoms. This, he claims, directs attention to the ends that make development important, rather than merely to some of the means that play a prominent part in the process, such as greater wealth. Because human rights are about freedom, framing development in a rights perspective promotes the end whereby all people have the freedom to choose a life that is dignified. It holds then, that by respecting and fulfilling each individual's human rights, this framework promotes a concept of development with individuals at the centre, in contrast to other development theories that may view economic growth as the development process and end game. This is to say that once a nation has achieved a certain measure of economic growth, it can be considered developed, irrespective of whether the wealth is fairly distributed, or whether there are large pockets of neglect and diseases of poverty.

When viewed as freedom, which is attained through realisation of all human rights, development becomes a comprehensive process of achieving freedom, rather than an end measured by health, education and income targets. The place of human rights in this process of development is through the provision of the agreed freedoms to which all people are entitled, and the accompanying obligations that are placed, primarily, but not exclusively, on governments to allow global citizens those freedoms.

> Freedoms are not only the primary ends of development, they are also among its principal means. In addition to acknowledging, foundationally, the evaluative importance of freedom, we also have to understand the remarkable empirical connection that links freedoms of different kinds with one another. Political freedoms (in the form of free speech and elections) help to promote economic security. Social opportunities (in the form of education and health facilities) facilitate economic participation. Economic facilities (in the form of opportunities for participation in trade and production) can help to generate personal abundance as well as public resources for social facilities. Freedoms of different kinds can strengthen one another (Sen, 2000a, p.10).

That freedoms of different forms can strengthen one another supports the concept of the indivisibility of human rights: without all, there is none.

4.7 A theory of human rights and capability

There is debate in philosophical and legal literature as to whether there exists a theory of human rights, per se. A theory of human rights can position both state and non-state actors as having legal and ethical obligations to respect, protect and fulfil the right to health. Ruger (2006) puts forward a theory, which accommodates an ethical (philosophical) demand for health rights. She claims that

> sustaining the effort to realize a right to health requires individual and societal commitments to what I call *public moral norms*. In other words…I argue for treating the right to health as an ethical demand for equity in health. This ethical demand will likely involve legal instruments for enforcement, but more likely will require individuals, states, and non-state actors to internalize *public ethical norms* to enhance implementation and compliance with a right to health in international human rights policy and law (Ruger, 2006, p.278). (emphases in original)

Ruger grounds a theory of human rights in Aristotle's political theory and Sen's capability approach. The latter views health capabilities as the key element in assessing the equity and efficiency of health programme and law. She argues that universal attention should focus on people's capability to avert premature mortality and address avoidable morbidity, and this should be the morally central or prior objective of health programme and law. She claims there is a special social obligation to develop these capabilities above and beyond society's obligation to ensure non-central health capabilities. "The focus on central health capabilities – the capability to avoid premature mortality and address escapable morbidity – as morally privileged stems from the need to ensure certain *critically important functionings up to certain minimally adequate levels*" (Ruger, 2006, p.287). (emphasis in original)

Thus, capability theory offers a means of determining priorities within health care. Ruger argues that a capability view is an advance over medical and social ethics, because it allows a view of people's capability to flourish as an end of political activity, and it provides a framework to analyse public programmes to assess whether justice and efficiency can be achieved. Capability provides the link back to the view of development as freedom, that is, the ability to lead lives without 'unfreedom'. "Capability is thus a kind of freedom: the substantive freedom to achieve alternative functioning combinations (or, less formally put, the freedom to achieve various lifestyles)" (Ruger, 2006, p.295).

Sen (1992) describes a process of weighting and ranking freedoms and capabilities, and Ruger further develops the operationalisation of the process. This process may be helpful in addressing a prioritisation of health needs, and thus could be applied to an assessment of the fulfilment of health rights (a positive right). Whereas, respecting and protecting health rights are negative rights (ensuring actions do no harm, rather than undertaking specific actions to fulfil a right), in which prioritising actions matters less than observing that rights are not being violated. For example, it is important to have a process in place to determine priorities in the delivery of finite health resources, such as prioritising emergency Caesarean surgery over elective cardiac surgery. But such a process is not required to determine that the sale of an emergency obstetric clinic to reduce government debt is not protecting the right to health of women who will require obstetric services. Nor is it protecting women's right to health if they are imprisoned for speaking out against the sale of such an emergency service.

Ruger's theory of a right to health also emphasises the need for cost minimisation and cost effectiveness, so that maximum health is obtained for minimal use of resource. Her capability and health theory emphasises prevention and treatment, "favoring those most deprived in health and at risk of health deprivation" (Ruger, 2006, p.326). This theory strongly focuses on individuals – not just as the claimants of health rights, but also as the duty bearers. She argues that there is an ethical obligation on all individuals to commit to the right to health for all, and without this commitment the necessary redistribution of resources to fulfil the right will not be possible.

In contrast, other proponents of the right to health structure health rights around collective rights claims, claiming globalisation has reduced individuals' control over their own health. The globalised era "has transformed health and disease, diminishing individual control over health status while magnifying the impacts of societal determinants of health" (Meier & Mori, 2005, p.102). They argue that the human right sought to be protected is a collective right. "Rather than relying solely upon an individual right to medical care, envisioning a collective right to public health – employing the language of human rights at the societal level – would alleviate many of the injurious health inequities of globalization" (Meier & Mori, 2005, p.102).

Ill health is contextualised as having escalated as a result of neo-liberal economic policies, and therefore in need of addressing through a rights-based

approach to public health. Meier and Mori further suggest that a set of rights is needed to control the spread of disease and to combat the 'insalubrious' effects of the neo-liberal policies.

> Thus, in analyzing health in the context of globalization, health policies cannot be viewed solely through the lens of medicine, but must encompass topics ranging from economic development and gender equality to agricultural sustainability and cultural practice. To participate in development policy and analyze the broad range of political, social, economic, and medical issues that underlie societal determinants of health, health scholars need the normative backing of a human right to public health (Meier & Mori, 2005, p.102).

It is interesting that both these approaches accept that States' governments are not the only duty bearers of health rights. Ruger extends the ethical duty to individuals, while Meier and Mori position the right to health as a collective right via public health responsibilities, which demands an international duty. They state that in response to globalization, many international organizations will need to explore multilateral health governance structures as a means to safeguard public health. They cite the Framework Convention on Tobacco Control as a valuable precedent for future international delegation in public health.

4.8 Rights connect global to local

Writing about Haiti (long before the earthquake in 2010), Paul Farmer of US NGO Partners in Health questions why there is so much sickness there. He notes that many official explanations for poor health favour local factors and local actors, suggesting that poor health among Haiti's majority is caused entirely by circumstances originating within the country (Farmer & Bertrand, 2000). Such views refer to the country's poverty, culture and violent political history. Farmer claims that the people of Haiti, especially the poor, argue that the poor health indices are a result of forces from outside the country, including land displacement from a hydroelectric dam development project, US-backed coups, and structural adjustment programmes.

Farmer believes a broader review of the large-scale social forces that have shaped sickness and death in rural Haiti highlight the hypocrisies of development. Just as Meier looked at the impact of globalisation on health, Farmer considered the inculcation of neo-liberal ideology into public health. These economic ideologies are crafted in developed countries' financial institutes and universities, at considerable

distance from where their impact is felt most acutely: by the poor in remote developing countries.

> Those ideologies were not crafted by or for the people we seek to serve. People actually living in 'resource-poor settings' do not clamor for 'cost-effective' solutions to their problems; they want first and foremost *effective* solutions. They want equitable access to health, educational, and other services (Farmer, 2008, p.2). (emphasis in original)

Hence these ideologies ignore the rights of people in developing countries. Farmer urges a return to a broader view of social justice, which he said once inspired public health, and also to consider such prosaic issues as supply chains. Farmer returns in many of his essays to this need to address ideologies and practices at the global level, as well as responding to local needs (1999, 2008).

> The two dimensions nourish and sustain each other. To achieve its objectives, action on the ground must be guided by rigorous conceptual work. To remain relevant, conceptual analysis must be nourished by contact with communities' real needs, and with concrete policy-making and implementation processes (2008, p.9).

Identifying all the contributors to health status in a community, from international geo-politics, to water and sanitation systems, to considering access, availability, acceptability and quality of health care, is difficult. But Farmer argues not to look beyond clinical causes of bad health outcomes is to engage, witting or unwittingly, in delusion or obfuscation (Farmer, 1999).

A health rights framework can resolve the issue of bridging the layers between the local and the global. By placing an individual at the centre of the paradigm, and acknowledging this person has the right to health, then all activities and policies can be viewed from the perspective of how they will impact on that person's access to acceptable, quality health care. This is neither impossible nor unreasonable; rather, the right to health is every person's entitlement.

> People do not simply have a 'need' for the goods, services and conditions that promote health. They have a 'right' to claim that these be provided by their governments based on the inherent dignity of all human beings, and a legal world order that recognises that protecting and preserving this dignity is the first job of governments (Cooper, 2008, p.13).

Although, as seen in Chapter 2, there has been a growing move towards a rights-based approach to aid-funded health programmes, there is no one definition of what this entails (Sofia Gruskin, Mills et al., 2007). Many different approaches have been used to incorporate the right to health into all aspects of the programme cycle. However, core components of rights-based approaches have been identified: as examining the laws and policies under which programmes take place and systematically integrating core human rights principles into policy and programme responses. A focus is always maintained on key elements of the right to health – "availability, accessibility, acceptability, and quality when defining standards for provision of services" (Sofia Gruskin, Mills et al., 2007, p.452).

4.9 A rights framework for global health

Global health has undergone significant change in the past decade, with the non-state sector having a far more significant role in the funding and delivery of health programmes. These new actors in global health carry a duty to protect, respect and fulfil the right to health, because they are interacting with rights holders (the people in communities with which they engage). Traditional governance has not kept pace with this shift in global health diplomacy, leaving a lack of accountability for the impact that non-state programmes are having on both individual health, and on health systems.

This makes it all the more important that a right-to-health framework is adopted for all stages of health programming, but especially when programmes are being designed so that any potential harm can be identified and mitigated before programmes start. Right-to-health frameworks can be applied to international policy and to health programme design, by essentially examining what the impact of the policy or programme will be on the health system. The purpose of the health system, the core institution through which the right to health is fulfilled, is to make quality health services available, accessible and acceptable to all people.

> Although the right to health adds power to campaigning and advocacy, it is not just a slogan, it has a concise and constructive contribution to make to health policy and practice. Health workers can use the right to devise equitable policies and programmes that strengthen health systems and place important health issues higher up national and international agendas (Backman et al., 2008, p.2048).

NGOs have changed their roles significantly in this past decade. They traditionally held a strong position as advocates for the right to health, and they can certainly still maintain that role. However, NGOs and GHIs need to recognise that as their role also now includes the funding and provision of health services, they must turn the watchdog lens back on their own activities. They, like the health workers referred to in the quote above, must design available, accessible, acceptable, and quality health programmes, and assess impact on the health system prior to implementation. Any programme that weakens the health system is violating the right to health; because "a strong health system is an essential element of a healthy and equitable society" (Backman et al., 2008, p.2047), as it is the core institution through which the right to health is fulfilled.

This chapter substantiates the existence of a right to health – a right which has been codified in international treaties and which has meaning in international and domestic law. It also has a meaning in practice, which has been demonstrated largely through the work of the Special Rapporteur. Furthermore, the right to health has application to all parties working in global health, not just State parties. The key principles of the right to health align well with good development practice and therefore do not pose a threat to development practitioners. Instead, they can bring a legal justification to sound methodologies. And finally, the right to health holds a place in social justice or development theory. It presents a rationale as to why health inequities are unjust, and supports rights-based mechanisms that strive to balance this overwhelming disparity in our world.

Chapter 5 Examining the literature

5.1 Introduction

Chapter 4 explored the use of the right to health as a lens through which development assistance for health could be examined. It was argued that while various development paradigms have been in and out of fashion throughout the 60-year development era, the right to health has remained constant and grounded in international law. Rights therefore can shift the way aid is viewed, from philanthropy to legal duty. This change in perspective could also reshape the governance of global health; all parties, including non-State actors, are seen to be duty-bearers who must respect, protect and fulfil health rights.

This chapter draws on the literature to inform the development of a systematic and rights-based approach to designing an aid-funded health programme. The evidence base is presented for a three-step rights-based framework, each step incorporating an indicator-based tool to aid programme design. All indicators are selected following careful consideration of rights-based programmes and reports in the literature.

5.2 Informing the structure of a rights-based framework

Previous chapters viewed an individual's health as the result of several layers of impact. As depicted in the Dahlgren diagram (Dahlgren & Whitehead, 1991) (Figure 3-1), these layers included general socio-economic, cultural and environmental matters. Programmes that provide health care must be cognisant of such conditions. WHO attributes the burden of illness that causes much premature loss of life to the conditions in which people are born, grow, live, work and age.

> In their turn, poor and unequal living conditions are the consequence of poor social policies and programmes, unfair economic arrangements, and bad politics. Action on the social determinants of health must involve the whole of government, civil society and local communities, business, global fora, and international agencies. Policies and programmes must embrace all the key sectors of society not just the health sector (World Health Organization, 2008a, exec summary).

In practice, health workers are well aware that delivering a successful health programme involves much more than the provision of care to individual patients. The community must know about the service, elect to use it, and value it. If the local community cannot communicate with the health care workers, if they cannot physically access or afford the service, or if the service does not provide quality of care in a culturally appropriate way, then the programme is unlikely to be sustainable.

Much research has been conducted to identify the barriers that prevent the community from utilising available health services, including in the Pacific (Duke, 1999; Fletcher et al., 1999; Larsen, Lupiwa, Kave, Gillieatt, & Alpers, 2004; Palagyi, Ramke, Du Toit, & Brian, 2008; Williams et al., 2008). Health programmes are also linked into, and dependent on, other aspects of society, from the underlying health system, through to national politics. A programme cannot start without staff who are trained to deliver a quality service or without having found a place from which it is legally entitled to provide that service. Other requirements are: systems of integration with existing health care and social services; supplies of medicines and policies on prescription fees and subsidies; and adequate and ongoing income, whether that is from the State or patients or insurance companies.

From the outset, even at this simplistic, practical level, it is apparent that a health programme is never isolated from the community, the health system, and broader State politics. It is not feasible to design an effective and sustainable health programme in isolation from the local context. Even privately funded health services are embedded in the broader social system as they operate within the State's regulatory environment, compete with the public health sector for their workforce needs, and engage with referral systems involving shared patient care with other providers. Therefore, weak health systems limit the capacity of any health intervention to achieve its objectives, irrespective of whether it is a public, private or a mix of the two (Ooms et al., 2008; Reich et al., 2008; Travis et al., 2004). Just as a patient is never simply a person with a disease, nor can a programme design be exclusively disease-specific and technically focused.

This broader view of health programmes is well aligned with a human rights perspective on health whereby people are placed at the centre (Asher, 2004). Programme planning which adopts a rights-based approach addresses the complexity of health and all its determinants. These multi-layered frameworks explore issues at global and national levels to gauge the impact of health determinants on the wellbeing

of people. "By adopting this multidisciplinary model of health, HIA [health impact assessment] recognises that most policies or programs, including those in non-health sectors, have the potential to impact significantly through these layers of influence" (Gay, 2007, p.35-36). Gay adds that a multidisciplinary approach to health expands the responsibility for health to a range of sectors that would not otherwise give explicit consideration to health-related issues.

It is also possible to demonstrate the impact of international programmes or policies established by donor States on the determinants of health in a recipient country, and the subsequent influence on the health rights of that country's population.

Acknowledging that a health programme cannot be conceptualised as a stand-alone or vertical initiative is an essential starting point in designing a rights-based health programme. The design process must therefore commence by gaining an understanding of the connective layers within the State's society and beyond. Without this understanding, developed through the application of human rights concepts, a new health programme has little chance of respecting, protecting or fulfilling the right to health.

5.2.1 Common elements in all rights-based design frameworks

Throughout his tenure, the Special Rapporteur developed an analytical framework that he applied in all his reports on the right to health. The framework had 10 aspects to it:

- National and international human rights laws, norms and standards
- Resource constraints and progressive realisation
- Obligations of immediate effect (core obligations)
- Freedoms and entitlements
- Available, accessible, acceptable and good quality
- Respect, protect, fulfil
- Non-discrimination, equality and vulnerability
- Active and informed participation
- International assistance and cooperation
- Monitoring and accountability (Hunt & Leader, 2010).

Similar aspects are adopted in all rights-based approaches to health, all of which are informed by General Comment 14. The most frequently expressed elements include these six of the above 10:

- Respect, protect and fulfil
- Available, accessible, acceptable and quality
- Non-discrimination and equality
- Participation
- Information
- Accountability. (Asher, 2004; Backman et al., 2008; de Pinho, 2009; Freedman, 2001; Hunt & Leader, 2010; Hunt & MacNaughton, 2006; London, 2008; Mayhew et al., 2006; Solomon, 2009; Yamin, 2007)

The purpose of many contributions to the journal *Health and Human Rights* in espousing rights-based approaches to health care was to "necessarily link health protection to questions of non-discrimination, democratic openness, and accountable government" (Yamin, 2008, p.48). Yamin examined the meaning of rights-based approaches in practice, and drew upon the various contributions to identify these commonalities:

- equity and non-discrimination are at the centre of a public health agenda
- responses are located within a functioning health system, viewed as a core social institution
- people are not passive recipients of health services but are participants in decisions that affect their well-being
- participation also gives a voice to health professionals
- there is transparency and access to information in both government and NGO programmes.

Exploring the practicalities of a rights-based approach in practice, Yamin acknowledges a paradigm shift from understanding socio-economic factors as backdrops to disease, to considering them the fundamental causes of disease.

> Therefore, in an RBA (rights-based approach), we would seek contextually-grounded strategies to chip away at these 'pathologies of power,' as Farmer terms them. … adopting an RBA would include emphasis on such measures as inter-sectoral initiatives (for example, health, education, agriculture, housing, and employment); legal, policy, and institutional reform; basic and popular education, as well as

> curriculum changes in medical and health professional schools; capacity-building in civil society as well as government; and the establishment of effective accountability mechanisms at multiple levels (Yamin, 2008, pp49-50).

There is little in the literature to guide an entire health programme design process, such as this thesis aims to develop. This new process, presented and tested within the forthcoming chapters, is therefore drawing on relevant elements of existing frameworks to a small degree and in large part, developing its own logic to the step-by-step approach. Each step in this new framework aligns with one aspect of respecting, protecting and fulfilling the right to health.

5.2.2 Step one: respecting the right to health

Rights-based programmes consistently commence their design process by developing an understanding of local context. This is described as, "analysing the specific problems in the delivery of health services in historical and political context, …identify the workings of power that have blocked progress" (Freedman, 2009, p.416) or "engaging with international and national policies and laws" (Mayhew et al., 2006). The purpose is to know the local realities at levels beyond the health system and delivery of health care.

> Ensuring the provision of appropriate services and programmes requires systematic consideration of the rights, needs and aspirations of the people involved, the larger social and economic environment, the health systems within which services will be requested and delivered, as well as the national legal and policy framework within which they operate… consideration of all of these issues will help to determine the most relevant services and how they might best be delivered (Sofia Gruskin, Ferguson, & O'Malley, 2007, p.22).

It is at this stage of the process that an understanding of the State's commitment and capacity to deliver on the right to health is also assessed. This was demonstrated in practice as the first step in the study of maternal mortality in Peru by Physicians for Human Rights (Yamin, 2007).

This initial stage of the rights-based design framework is not dissimilar from the familiar 'needs analysis' employed by most development programmes in the conception of a new programme (United Nations Environment Programme, 2005; World Bank, 2010b). However, when this 'needs analysis' is conducted within a rights-based framework, it will employ rights concepts to gather the information

where appropriate (participation, non-discrimination and equality). Furthermore, information is sought from beyond just the health sector, and will also include a full understanding of the rights context of the environment in which the programme is intended to function. It is only through having a thorough understanding of the local context, and the practicalities of operationalising rights in this context, that a programme can be designed that respects rights.

5.2.3 Step two: fulfilling the right to health

On completion of the first step of the new design framework (understanding the context), it is possible to commence the design of the health programme itself. Of particular importance to this process is ensuring that the new programme aligns and integrates with the apparatus of the system. This can be achieved by using the understanding of the underlying health system achieved through execution of step one. In addition, this process is aided by a solid understanding of the function of each of the six blocks within the health system.

The State has obligations to progressively realise the right to health. Immediate duties include that the State will undertake:

> To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process; they shall include methods, such as right to health indicators and benchmarks, by which progress can be closely monitored; the process by which the strategy and plan of action are devised, as well as their content, shall give particular attention to all vulnerable or marginalized groups (United Nations, 2000b, para 43(f)).

Paragraph 45 emphasises that it is incumbent on "State parties and other actors in a position to assist" to provide international assistance, economic and technical, to enable developing countries to fulfil the core obligations detailed in paragraphs 43 and 44 (See Box 4-7). Therefore, the design of a new health programme must be undertaken in full consideration of the State's national health strategy, with a view to assisting the State to fulfil its rights duties.

Once there is agreement between all parties that the proposed new health programme is in keeping with the State's plans, the actual design process can proceed, using those established rights-based framework principles as listed in Section 5.2.1.

5.2.4 Step three: protecting the right to health

General Comment 14 is also clear that States must not violate the right to health, and that they have a duty to prevent third parties from violating the right, using "legal or political means" (United Nations, 2000b, para 39). The health system itself is essential to delivery of health rights: "Underpinned by the right to health, an effective health system is a core social institution, no less than a court system or political system" (United Nations, 2006, summary). It follows then that any intervention that weakens the health system is reducing its capacity to fulfil health rights, and is therefore, a rights violation.

Recognising this potential for rights violation may be seen as a departure from conventional wisdom when reflecting on aid-funded health programmes. If aid is viewed from a philanthropic perspective, any intervention is likely considered beneficial. However, from a right-to-health perspective, all interventions must be assessed as to whether they are improving the availability, accessibility, acceptability and quality of all health services.

Therefore, the final step in this new framework to design aid-funded health programmes undertakes a full impact assessment of the programme on the health system. Each of the six building blocks of the health system is examined because, "The right-to-health analysis provided by General Comment 14 has to be systematically and consistently applied to health services, health workforce, health information, medical products, financing and stewardship – that is, all the elements that together constitute a functioning health system" (Backman et al., 2008, p.2050).

5.3 Literature guiding indicators for Tool One

Although the rights-based approaches to programme development identified in the literature are consistent in the view that understanding local context is the first step in starting an intervention, there is a dearth of practical and precise tools to operationalise the process.

In a review of the literature assessing health system performance in developing countries, Kruk and Freedman define the goal of a health system as "the delivery of effective preventive and curative health services to the full population, equitably and efficiently, while protecting individuals from catastrophic health care costs" (Kruk & Freedman, 2008, p.264). They note the link between this definition

and the ICESCR's obligation to ensure availability, accessibility, acceptability and quality of health services (General Comment 14). Their review of health system performance was able to categorise indicators under:

- **effectiveness** – health status, patient satisfaction, access to care, quality of care;
- **equity** – health status disaggregated by disadvantaged groups, fair financing, risk protection, access disaggregated by disadvantaged group;
- **efficiency** – adequacy of funding, administrative efficiency.

They found that in many developing countries key indicators of the health system performance included infant mortality, maternal mortality, perinatal/neonatal mortality, low birth weight and incidence of infectious diseases. In developed countries indicators extended to include survival rates from different types of cancer. Measures of access to service, covering availability, utilization and timeliness, also vary between developing and developed countries. WHO's 3x5 initiative for HIV/AIDS, which promised to place 3 million people on anti-retrovirals by the end of 2005, was cited as a well-known utilisation target. Other commonly used target indicators are: case detection rates for TB, use of malaria bed-nets, access to anti-malarials within 24 hours of onset of symptoms, contraceptive coverage, antenatal care attendance, obstetric care facilities, immunisation rates, and availability of essential drugs (Kruk & Freedman, 2008).

However, these authors and others question whether these indicators are good proxies for potential gains in health, noting in particular that ante-natal care does not have a large impact on reducing the overall maternal mortality. Rather, access to basic and comprehensive emergency obstetric care facilities has been identified as the key factor in reducing maternal mortality (Kruk & Freedman, 2008; Yamin & Maine, 1999).

It is also argued that a reduced number of indicators can just as effectively proxy the efficacy of a public health system. Garrett claims maternal mortality is an extremely sensitive indicator for the overall status of a health system "since pregnant women survive where safe, clear, round-the-clock surgical facilities are staffed with well-trained personnel and supplied with ample sterile equipment and antibiotics. If new mothers thrive, it means that the health-care system is working, and the opposite is also true" (Garrett, 2007b). She further argues that life expectancy is a good

surrogate for child survival and essential public health services. People live longer when "the water is safe to drink, mosquito populations are under control, immunization is routinely available and delivered with sterile syringes, and food is nutritional and affordable, children thrive… the major driver of life expectancy is child survival" (Garrett, 2007b).

A useful and detailed approach to conducting a rights-based assessment of health systems was developed by Backman et al (2008) and applied in 194 countries. This research selected 72 indicators to reflect right-to-health *features* of health systems, rather than *outcomes* of the health system.

> The features arise from general comment 14, including core obligations, and reflect many of the themes of the declaration of Alma-Ata, and elements of the WHO building blocks of a health system…We also relied on the framework of structure, process and outcome indicators on the right to the highest attainable standard of health, and the requirement that health facilities and services should be available, accessible, culturally acceptable, and of good quality (Backman et al., 2008, p.2054).

Their process of indicator selection (developed after ensuring a similar project had not already been undertaken) used five steps over 18 months, with numerous stages and consultations internationally. The steps are briefly explained here to demonstrate the validity of the resultant indicators that inform the first tool of the new framework developed in this thesis.

Step one: right-to health features of health systems and WHO building blocks were examined and consulted over. The wellbeing of individuals, communities and populations was focused on, recognising the importance of health-related services, facilities and goods, including underlying determinants of health, water, sanitation, food, shelter and education.

Step two: health-related services and the underlying determinants of health were examined from the standpoint that these should be available, accessible, culturally acceptable, and of good quality.

Step three: features of a health system were considered within a concept agreed by all the researchers, and indicators developed to measure these; concepts included participation, planning, quality, acceptability

Step four: merging and revision of indicators

Step five: final selection of 72 indicators, divided into 15 groups. These were then distributed for further consultation.

Another indictor-based assessment of health system performance was also helpful in the process of developing the first tool to understand local context. Although not rights-based, it had been developed as a rapid assessment tool for development practitioners working on USAID assignments (Islam, 2007). This 'how-to manual' also viewed the health system within the six building block perspective, and demonstrated a large degree of agreement with Backman's rights-based indicator selection. The manual was written to enable USAID Missions to assess a country's health system. "This assessment will diagnose the relative strengths and weaknesses of the health system, prioritize key weakness areas, and identify potential solutions or recommendations for interventions" (ibid, p.xi). The performance criteria used in this practical manual are: equity, efficiency, access, quality and sustainability.

From these two sources, indicators were selected for the first tool, as described fully in Chapter 3, Section 3.3.

5.3.1 Questionnaire 1: international layer

The purpose of the first questionnaire in the tool is to gather an understanding of the role and impact of international treaties, contracts and partners on the State health system. Thirteen indicators were selected (See Section 3.3.2). Some of these indicators sought explicit rights information, for example, which treaties had been ratified, and whether the constitution recognised the right to health. Those indicators were not included in the Islam health system assessment. However, there were overlaps between the Backman and Islam publications regarding spending of total ODA on health, and information about the extent to which the State controls international partner plans. Indicators do not necessarily have to be couched in rights language to be seeking rights information. Rather, the purpose of this tool is to assess the ability of the health system to meet health rights obligations. In effect, this is an assessment of the strength of the health system to make health services and the underlying determinants of health available, accessible, acceptable, and of quality.

5.3.2 Questionnaire 2: state capacity

The second questionnaire selected a further 28 indicators to assess the national demographic and political context. There was considerable alignment between the two assessments, again with the Backman paper using more rights discourse (for

example, *Does the constitution protect freedom of expression*, whereas Islam sought information from the World Bank-Governance indicators on similar issues.

This questionnaire promotes an understanding of the demographics of the country, its political structures and commitment to human rights, including good governance, economic capacity to support a robust health system and its degree of economic dependence on ODA. It includes indicators of the underlying determinants of health, which were intentionally not sought by the Islam assessment. "Other factors that affect the health system, but involve other sectors, such as education, environment, water, and sanitation, are not included" (Islam, 2007, p.2-2).

5.3.3 Questionnaire 3: health system

The final questionnaire in the first tool is the health system assessment. This seeks information from each of the six building blocks of the health system, in addition to information concerning the fulfilment of 'core obligation' duties. Trends are demonstrated by the collection of two sets of data, five years apart.

There was considerable alignment of indicators in the two assessments, with the exception that Backman's sought evidence of patient feedback and participation in monitoring, whereas Islam assessed the role of, and opportunity for, private sector involvement. Equity, access and quality were addressed in both sets of indicators.

The Backman assessment was designed as an international comparison tool, to gather information about health systems from 194 countries. This necessarily resulted in exclusive use of information that was consistently available for all nations. The Islam assessment was designed for use in one country to seek detailed information about a health system before commencing a programme. It encouraged interviews with stakeholders to elicit much of the information.

The tool being developed in this thesis is similarly intended for in-depth use prior to commencing a health programme, and therefore relies on a detailed understanding of local context that develops through engagement with the community. Health workers, administrators, patients and the broader members of the public all have an important contribution to make to the completion of the first tool. Community involvement at all levels was used in the application of the tool to a case study in PNG (Chapters 6-8). Each of the resultant three questionnaires for the tool is included in those three chapters as Tables 6-1, 7-1 and 8-1.

5.4 Literature guiding indicators for Tool Two

As noted in previous chapters, the role of NGOs and GHIs in funding and implementing health programmes has dramatically increased over the past decade. Previously, the NGO role in health rights was more one of advocacy than of an implementing agent. Because this change is recent, there is not yet a large body of literature reflecting the operationalisation of rights into the specifics of designing health services. However, there is a growing call to address this need for considered guidance. The changing role of NGOs, from advocacy alone to advocacy plus service delivery, means they need to be "seen as duty-bearers", upholding rights in their services and activities (Mayhew et al., 2006, p.181). These authors claim many NGOs fail to fulfil their commitments to a rights-based approach to programme activities and show an inability to operationalise rights, conceding that this process is not easy.

> Rights are not easily translated into practical activities and measures for rights-based reproductive and sexual health service delivery. Both human rights advocates and health practitioners have been slow to respond to the challenge of making the progressive realization of social, cultural, and economic rights, including the right to health, a reality (Mayhew et al., 2006, p.182).

Mayhew et al developed a rights-based approach in conjunction with partner NGOs that were delivering HIV-related services to prisoners and injecting drug users. Their framework starts by gaining a full understanding of the local rights context (as in section 5.3) and collating evidence upon which to base, then monitor, the programme. Core rights principles including equality, non-discrimination and participation are employed throughout all stages. Availability, accessibility, acceptability and quality are referred to as principles in the provision of service. The authors acknowledge that quality of care is a right, and guidelines for quality of care encompass choice of method, information given to clients, technical competence, interpersonal relations (including confidentiality), mechanisms to encourage continuity of service use, and appropriate constellation of services. The framework requires organisations to "*ensure appropriate support for staff to be able to deliver quality services and properly uphold rights"* (Mayhew et al., 2006, p.188). (emphasis in original)

The monitoring elements of Mayhew's framework provide a means of assessing change over time (progressive realisation), and information is collected in a

participatory manner, monitoring for non-discriminatory practices and promoting accountability. Although it is not explicitly stated, working within a rights-based framework and monitoring for progressive realisation also means working within the State's national health plan.

A comprehensive rights-based approach to delivering health care for people living with HIV also provides programme development guidance.

> Ensuring the provision of appropriate services and programmes requires systematic consideration of the rights, needs and aspirations of the people involved, the larger social and economic environment, the health systems within which services will be requested and delivered, as well as the national legal and policy framework within which they operate… consideration of all of these issues will help to determine the most relevant services and how they might best be delivered (Sofia Gruskin, Ferguson et al., 2007, p.22).

However, both the Mayhew and Gruskin publications are short on operational detail regarding the actual health service. The literature on maternal health provides a little more specificity on rights-based approaches to health service planning.

Physicians for Human Rights studied maternal mortality in Peru as a human rights issue. The report made a direct link between the high maternal mortality rate in two rural regions and failure to have quality emergency obstetric care available, accessible and acceptable to the women in those areas. "Failures to meet such criteria result in delays in the decision to seek care, delays in arriving at EmOC (Emergency Obstetric Care), and delays in receiving appropriate treatment, which, in turn, lead to maternal deaths" (Yamin, 2007, p.43). The report created a model to analyse maternal mortality that is also instructive as a guideline to address maternal mortality. After establishing an understanding of the local rights context, and having determined the "appropriate" actions the State must take as part of its obligations, it proposed the creation of a model to address the need for health services (in this case, emergency obstetric services) that are available, accessible, acceptable and of quality, and delivered on basis of non-discrimination.

The report called for a National Plan of Action to Reduce Maternal Mortality, based upon epidemiological evidence regarding effective interventions. It stated that the process for devising that plan should be participatory and transparent. The plan needed to be devised as part of a National Plan of Action on Health and a national health workforce plan.

Freedman also advocates improving maternal mortality through a rights-based approach to health system strengthening. She suggests this begins by understanding health systems as core social institutions, as part of the very fabric of social and civil life (Freedman, 2001). Conceding that while this is not a quick fix with pre-formed policies or standardised techniques, it does address the deficiencies of the 'business-as-usual' scenarios that were described in Chapter 2 as the epidemiological approach to public health (Section 2.10). She states that a rights-based approach to strengthening a health system puts equity as a top priority. Without being proscriptive in her approach to health system strengthening, Freedman suggests a range of interventions, within a fluid practice, that could include:

- Analysing the specific problems in the delivery of health services in historical and political context
- Using multiple forms of evidence to craft solutions
- Identifying the workings of power that have blocked progress
- Strategising ways to mobilise those directly affected (as well as those directly and indirectly responsible)
- Using the values, norms and vision of human rights to call for specific rearrangements of power and resources necessary for serious change.

Freedman provides an example of a rights-based political and social approach to health system strengthening to reduce maternal mortality. She demonstrates the use of human rights principles within maternal mortality programmes, and in the clinical setting. In regard to emergency obstetric services, Freedman says the first principle has to be access to the services that will save the woman's life. "Fulfilling this means 24 hour readiness: availability of the necessary human resources, equipment and drugs, and the ability to mobilize these on an urgent basis" (Freedman, 2001, p.56). She demonstrates that bringing human rights values of quality, acceptability, non-discrimination, community and stakeholder participation, and policy making into maternal services, greatly improves the clinical experience for patients, families and the staff.

There is little disagreement that reducing maternal mortality depends on a "functioning and sustainable health system that engages communities and facilities and that makes sure that health services are accessible to all women where the notion of accessibility encompasses principles of affordability, acceptability and availability"

(de Pinho, 2009, p112). There are few better examples of failed approaches to development assistance than that which de Pinho provided in a history of the Safe Motherhood interventions of the 1990s (see Chapter 2, Section 2.4).

de Pinho is certainly not a lone voice in the call to stop vertical approaches to health development assistance. She joins a growing movement that argues for a focus instead on a rights-based approach to strengthening the health system itself (Freedman, 2009; Sofia Gruskin, Mills et al., 2007). She gives examples of what a rights-based approach might look like in practice: Malawi's Road Map to Reduce Maternal Mortality which adopted an integrated approach, and included "scaling-up access to basic emergency obstetric care through overall strengthening of the health system – aligning health worker training, infrastructure development, procurement of drugs and supplies and attention to improved referral and communication systems" (de Pinho, 2009, p.117). Other elements that de Pinho includes in the rights-based approach to strengthening a health system include: improved health information systems which disaggregate according to social class, geographical regions, age and ethnicity; innovative solutions to the human resource crisis; and development of constructive accountability mechanisms that "create an effective dynamic of entitlement and obligation between people and their government" (de Pinho, 2009, p.117).

Each of these rights-based approaches can be seen to be working from the principles outlined in General Comment 14. They all elected to work within the health system to strengthen it and to ensure the proposed health service was available, accessible, acceptable, and of quality standards. That these programmes could draw on General Comment 14 supports the claim that; "Although neither complete, perfect, nor binding, general comment 14 is compelling and groundbreaking. The comment shows a substantive understanding of the right to health that can be made operational and improved in the light of practical experience" (Backman et al., 2008, p.2048).

The second tool of the new framework adopts the core principles of these existing rights-based approaches: that the health programme had to assist the State to meet its core obligations and would employ human rights concepts (the six crucial concepts) to design a programme that would become available, accessible, acceptable and of quality. The design would promote a programme approach that would ultimately lead to a strengthened health system. With these core principles, Tool Two uses the AAAQ plus six crucial concepts framework (see Box 3-2), assigning each of

these 10 elements a separate section, (ie, availability, accessibility, etc). Each section has indicators to demonstrate that the new service has been considered in light of the health system's capacity. For example, under availability, indicators seek to establish whether the programme has considered how many health workers the service will require, whether the country's workforce plan accommodates this need, who will employ the workers, and so forth.

The process of determining the 30 indicators for this tool was described in Chapter 3, Section 3.3.3. In Chapter 9 the Tool Two is presented (Table 9-1) then tested against the case study, following which further refinements are made.

5.5 Literature guiding indicators for Tool Three

The final step in this new framework is to measure the impact of the proposed programme on the health system. The right to health is dependent on "an effective and integrated health system, encompassing medical care and the underlying determinants of health, which is responsive to national and local priorities and accessible to all" (Hunt & Backman, 2008, p.81). Therefore, the protection of health rights necessarily demands that the health system is not weakened. If new programmes play a part in the collapse of health systems, they are contributing to "an extremely grave and widespread human rights problem" (Hunt & Backman, 2008, p82). There is no shortage of evidence, as has been referenced in this chapter and the previous, that those in a position to assist States to meet their health rights obligations, must do so. But importantly, in their efforts to do so, State and non-State actors must also make every effort to examine their actions and guard against inadvertent harmful outcomes.

> The international dimension of health systems is reflected in countries' human-rights responsibilities of international assistance and cooperation that can be traced through the Charter of the UN, the Universal Declaration of Human Rights, and some more recent international human-rights declarations and binding treaties. At least, all countries have a human-rights responsibility to cooperate on transboundary health issues and to do no harm to their neighbours (Backman et al., 2008, pp.2052-53).

The literature was searched for impact assessments of health programmes on health systems, and especially rights-based assessments. The publications referred to in the previous section provided oversight on rights-based approaches to programme design. These consistently referred to the need for transparent accountability, and

adequate collection of data to monitor the programmes. This included internal organisation audits, and development of indicators for service, monitoring and evaluation (Mayhew et al., 2006), and development of constructive accountability mechanisms (de Pinho, 2009; Freedman, 2001). NGOs have been calling for greater transparency and reporting mechanisms, including for their own work (Nelson & Dorsey, 2003), but little evidence could be found to link this accountability through to impact assessment.

Increasingly the health impact of foreign policy in developing countries is being examined because good policy can "promote equity, sustainability and healthy public policy in an unequal and frequently unhealthy world" (Scott-Samuel & O'Keefe, 2007, p212; World Health Organization & Government of South Australia, 2010). However, no publication could be identified which considered the impact of the entire programme on the whole of the health system. Rather, some rights-based approaches looked at their activities to assess whether they were fulfilling and respecting health rights, but less so to assess whether they were protecting the right to health through protecting the health system.

There was therefore no apparent health system impact assessment tool to apply to health programmes specifically. There was, however, one rights-based health impact assessment which was designed for use in mainstreaming the right to health within all policy (Hunt & MacNaughton, 2006). The authors examined three approaches to human rights impact assessments, one from each of the Norwegian Agency for Development Cooperation (NORAD), the Rights & Democracy Initiative on Human Rights Impact Assessment, and the NGO, Humanist Committee on Human Rights. Each provides a tool to measure the observation of human rights. Only the latter specifically regarded health rights. These impact assessments were developed so that proposed policies or interventions could be examined from two perspectives: the first was the State's commitment to human rights, and the second was to assess the impact of a policy or intervention on rights. There is a direct parallel here with the structure of the rights-based framework being developed throughout these chapters: that firstly the local context needs to be understood from a rights perspective, and subsequently that the programme must be assessed to gauge its impact on health rights.

The Humanist Committee on Human Rights, *Health Rights of Women Assessment Instrument* (Bakker & Plagman, 2008) "provides comprehensive and

practical instructions for a nongovernmental organization to conduct an analysis of the impacts of a government policy on the health rights of women" (Hunt & MacNaughton, 2006, p.22). The instrument is relevant to the development of a rights-based programme design tool because it can be used to analyse policies that are expected to affect the right to health, as well as those which are not specifically health related, but may have an impact on health. This is in keeping with the need for health programmes to be examined not only in terms of their capacity to fulfil health rights, but also (as for policy), for unexpected impact on other health rights.

The Humanist Committee's instrument looks at the impact that a policy will have on:

- timely and appropriate health care, including the availability, accessibility, acceptability and quality of goods and services
- the underlying determinants of health, such as safe water, adequate food and housing, healthy working conditions and access to health information, and
- violence against women.

It also examines whether women participated in the development, implementation and evaluation of health policies. It assesses potential discriminatory impact, especially on vulnerable or marginalised groups. Importantly, the assessment considers the capacity of the state to implement the policy. This reflects an understanding of actualities in developing countries where donors will frequently provide technical assistance to support the development of policy, but not for subsequent implementation. Hence, existence of policy is by no means an indication that policy is translated into action. But the instrument proposes a way of monitoring this via an accountability mechanism that links the identifiable impacts of policy against the state's commitment to various legal obligations under human rights laws.

This tool has also been designed as an advocacy tool. The final step in the process generates recommendations and actions, especially to lobby the government for policy changes if women's right to health is likely to be negatively impacted by the policy.

Key elements of the Humanist Committee's health rights assessment instrument transferable to a design tool framework are: availability, accessibility, acceptability, and quality of health care service and the underlying determinants of

health; participation, discrimination, capacity of the state to realise the policy, monitoring and accountability.

A rights-based health system impact assessment offers a more complete analysis of the health system than utilisation of health impact measurements alone. Rights-based assessments also examine the fulfilment of rights to health, such as the community's involvement in health planning, health workers' awareness of health rights, accessibility of health information, and whether the health system enables the measurement of the progressive realisation of the right to health. In her discussion of the development of a right-to-health approach to health impact assessment, Gay argues that human rights indicators are especially helpful, "as they offer the possibility of measuring the somewhat elusive concepts of progressive realisation and resource availability" (Gay, 2007, p.10).

It is difficult to determine broad and generic indicators for health impact assessment, as all health policies and projects require space for context specificity. But even so, indicators of a health system itself are essential for a rights-based approach to health programme design, so that programme partners are fully aware of the capability and capacity of the health system upon which they are basing their project.

The Special Rapporteur called for the development of a new tool - a 'health system impact assessment' - after commenting on the possible damage that vertical programmes can have on health systems.

> The right to health requires, inter alia, the development of effective, inclusive health systems of good quality. For the most part, the health-related Millennium Development Goals are disease specific or based on health status - malaria, tuberculosis, HIV/AIDS, maternal health and child health - and they will probably generate narrow vertical health interventions. Specific interventions of this type are not the most suitable building blocks for the long-term development of health systems. Indeed, by drawing off resources and overloading fragile capacity, vertical interventions may even jeopardize progress towards the long-term goal of an effective, inclusive health system. A proper consideration of the right to health, with its focus on effective health systems, can help to ensure that vertical health interventions are designed to contribute to the strengthening of good quality health systems available to all (United Nations, 2004, para 27).

The Special Rapporteur contributed to the development of a framework for a rights-based impact assessment for the right to health, using the AAAQ plus six concepts. The framework (Box 5-1) is tested on a State level programme impact assessment, with a view to integrating the right to health into impact assessments for any proposed government programme (Hunt & MacNaughton, 2006). Both positive and negative rights are addressed in this framework because of the wording, *Is the proposed programme likely to* ***enhance*** *or* ***jeopardise*** *the availability (…or accessibility… acceptability… quality) of health goods, facilities and services*. This allows assessment of not only whether the programme will fulfil health rights, but also, whether it respects and protects health rights. The latter is especially important to protect the health system.

The literature reports on studies of the health impact of non-health policies more so than of health policies and programmes. For example, the impact of trade deals, bank loan conditions and public sector reforms (including health), have been explored, especially by the Special Rapporteur (United Nations, 2005, 2008b). Health programmes have perhaps been simply assumed to improve health and have not come under such close scrutiny for negative impacts, especially that of weakening the health system.

The framework being developed to operationalise the right to health in this thesis requires a tool to demonstrate the impact of a new health programme on every block within the health system. This was achieved by extending the Hunt and MacNaughton impact assessment model to assess the impact of new health services on each of the building blocks of the health system. Each block is examined separately to evaluate whether the programme was likely to strengthen or weaken its capacity to assist the realisation of the right to health.

This tool draws considerably on the information gathered from first two tools, both of which required the adoption of human rights concepts in their application. The final questionnaire is tested on a case study in Chapter 10, and is printed in full in Table 10-1.

Box 5-1 AAAQ plus six concepts for impact assessment

AAAQ	**Health goods, facilities and services**	**Underlying determinants**
Availability	Is the proposed programme likely to enhance or jeopardise the *availability* of **all** health goods, facilities and services in the State?	Is the proposed programme likely to enhance or jeopardise the *availability* of clean water, adequate sanitation, safe housing, food, nutrition, education, fair employment conditions and/or a healthy environment?
Accessibility	Is the proposed programme likely to enhance or jeopardise the physical and economic *accessibility* of **all** health goods, facilities and services?	Is the proposed programme likely to enhance or jeopardise the *accessibility* of clean water, adequate sanitation, safe housing, food and nutrition, education, fair employment conditions & healthy environment?
Acceptability	Is the proposed programme likely to enhance or jeopardise the ethical and/or cultural *acceptability* of health goods, facilities and services?	Is the proposed programme likely to enhance or jeopardise the *acceptability* of clean water, adequate sanitation, safe housing, food and nutrition, education, fair employment conditions & healthy environment?
Quality	Is the proposed programme likely to enhance or jeopardise the *quality* of **all** health goods, facilities and services?	Is the proposed programme likely to enhance or jeopardise the *quality* of water, sanitation, housing, food and nutrition, education, employment conditions and/or the environment?
Six Concepts		
Progressive Realization	Is the proposed programme likely to enhance or jeopardise the *progressive realization* of the right to health goods, facilities and services?	Is the proposed programme likely to enhance or jeopardise the *progressive realization* of the rights to clean water, adequate sanitation, safe housing, food and nutrition, education, fair employment conditions and/or a healthy environment?
Core Obligation	Is the proposed programme likely to enhance or jeopardise the *core obligation* for the right to health care, including a national health strategy and plan of action and essential primary health care and medicines?	Is the proposed programme likely to enhance or jeopardise the *core obligation* for the underlying determinants of health, including a national health strategy and plan of action and minimum levels of water, food, housing and sanitation?
Equality and Non-Discrimination	Is the proposed programme likely to enhance or jeopardise *equality and non-discrimination* in provision of health goods, facilities and services?	Is the proposed programme likely to enhance or jeopardise *equality and non-discrimination* in provision of the underlying determinants of health, including clean water, sanitation, safe housing, food, education, fair employment conditions and healthy environment?
Participation	Is the proposed programme likely to enhance or jeopardise *participation* of the population in all decision-making related to health goods, facilities and services that affects them?	Is the proposed programme likely to enhance or jeopardise *participation* of the population in all decision-making related to the underlying determinants of health that affects them?
Information	Is the proposed programme likely to enhance or jeopardise government dissemination of *information* related to health goods, facilities and services and the rights to seek and impart such information?	Is the proposed programme likely to enhance or jeopardise government dissemination of *information* related to the underlying determinants of health and the rights to seek and impart such information?
Accountability	Is the proposed programme likely to enhance or jeopardise *accountability* for the right to health goods, facilities and services?	Is the proposed programme likely to enhance or jeopardise *accountability* for rights to the underlying determinants of health?

Source: (Hunt & MacNaughton, 2006)

PART TWO: TESTING THE FRAMEWORK

Chapter 6 Health rights and international partnerships in PNG

6.1 Introduction

In the first part of this thesis the framework for a rights-based approach to designing aid-funded health programmes was developed. This framework comprises three tools, the development of which has been described in Chapters 3 (methods) and 5 (literature review). In this second part of the thesis, the validity of the tools is tested using case studies from PNG.

There are three questionnaires in Tool 1 that aim to provide a thorough understanding of the context in which the health programme will be located. Layers of social determinants, arising from international, national and health system layers inform this local context. This chapter tests the questionnaire that examines the impact of international arrangements on the local context and the State's capacity and commitment to meet its right to health obligation.

This chapter and the next two follow this order:

1. The tool's first questionnaire is populated with data on PNG gathered over two time periods, five years apart.
2. More detailed information on health and human rights in PNG, and (in this chapter international development partnerships), is documented from primary and secondary sources, and presented in narrative form. Assessment is made as to whether there is agreement between the questionnaire and other sources on the main features that impact upon health and whether this would affect the implementation of a new health initiative. The first questionnaire is examined to check whether it had generated information that identified a matching set of key issues. Features of local context that are not generated by the indicators in the original questionnaire are noted.
3. The questionnaire is then applied to the PNG case study. The information collected in the questionnaire is examined to assess whether it painted an accurate and relevant contextual picture, and importantly, if use of that information could have prevented programme failings.

4. Those features of local context that were noted as not having been generated by the indicators in the original questionnaire are examined to assess whether they would have enhanced the case study design: would indicators seeking this information have generated additional pertinent information that would have enhanced programme design? If so, they are included in the final framework questionnaires.
5. To validate the tool, each of the explanations for programme failings should have been predicted by at least one of the indicators in one of the three questionnaires.

6.2 Applying the framework: the first questionnaire

The rights-based framework to design an aid-funded health programme commences by guiding programme planners through a process so that they fully understand the context within which the new health programme will be working. This process must be executed with rights-based principles, so that whenever possible and relevant, information is gathered in a non-discriminatory and participatory way. This means that quantitative data should be disaggregated by gender, ethnicity, urban/rural location, and qualitative information sought from women, men, people of different age groups and dwelling location, of different ethnicities and socio-economic groups. The most disadvantaged and marginalized people should be represented in consultation processes.

The information being sought in this first questionnaire in Tool One is used to ascertain the degree of commitment that the State has made to international rights treaties, through ratification and subsequent operationalisation of human rights. It also seeks information about other international contracts, to international financial institutions, or other States, which could have an impact on the State's capacity or willingness to meet rights obligations. The role of the State in controlling international development assistance and directing it towards meeting rights obligations is also investigated. The information is collected over two time periods, ideally five years apart, so that it is possible to judge whether the health and human rights context is improving over time.

The questionnaire is populated and is presented below as Table 6-1.

Table 6-1 Questionnaire 1: international rights context in Papua New Guinea

Indicator	Recognition of human rights	2004	2009
	Has the state ratified or is a signatory to:		
1	- ICESCR (acceded in 2008)	No	Yes
2	- CEDAW	Yes	Yes
3	- CRC	Yes	Yes
4	- CERD	Yes	Yes
5	Does the state's constitution, bill of rights, or other statute recognise the right to health?	No	No
	International obligations, assistance and cooperation		
6	Total government spending on debt service as percentage of GDP – (Worldbank Data)	7.9% (1)	6% (1)
7	Has the state made contractual commitments to banks or other states regarding reducing state services?	No	No
8	Does the state's international development policy explicitly include specific provisions to promote and protect the right to health?	No policy	No policy
9	Does the state's international development policy explicitly include specific provisions to support the strengthening of health systems	No policy	No policy
10	Proportion of net official development assistance directed to health (OECDData stats)	7.5% (2006) (2)	3.7% (2008) (2)
	Record on human rights		
11	In the past report to the UN in relation to the ICESCR, was there a detailed account of the international assistance and cooperation in health that the state is providing?	Not applicable	Due in 2010
12	Does the state have a national human rights institution with a mandate to monitor international assistance and cooperation?	No	No
13	Number of judicial decisions that have considered the right to health in previous five years	Not available	Not available

Sources: 1 (World Bank, 2010c), 2 (OECD, 2009)

6.3 PNG's geopolitical context

PNG is a Western Pacific democratic nation and Australia's closest neighbour. PNG had a population of 6.4 million in 2007 (United Nations Development Program, 2009), of whom about 87 per cent lived in remote rural settings, with extremely limited access to urban areas (World Bank, 2010d). The population is one of the most culturally and linguistically diverse in the world with over 700 distinct languages spoken (AusAID, 2010). The isolation of parts of the country resulted in some of PNG's population having very limited, and only recent, exposure to western culture.

Until the early 1900s, there were two territories, Papua in the south, governed by the UK, and New Guinea in the north, governed by Germany. Papua was transferred to Australian administration in 1906. During the First World War Australia occupied German New Guinea, and continued to rule both areas until PNG achieved independence in 1975. As with many Pacific nations, initial contact with foreigners had devastating health consequences as vectors of disease spread to

geographical areas that had previously been isolated from them (Denoon, 1990; Gunther, 1990).

PNG played a significant role in World War II's Pacific War, resulting in hardship for local people. PNG men fought and died alongside the Australian troops against the Japanese, who were controlling much of the country. Local people in some villages were displaced and land was used for food production for the armies. The isolation of many villages was shattered by the large-scale movement of soldiers, and this exposed people in these villages to new vectors of infection, and ill health (Denoon, 1990).

There is therefore a history of colonialism and wartime alliances that closely connects PNG and Australia. The latter has also been a significant foreign investor in PNG's oil and mineral resources and is vulnerable to any security risks (health, immigration or terrorism) that might emanate from PNG.

For all these reasons, Australia is by far the largest aid donor to PNG, providing approximately 90 per cent of all bilateral aid (Table 6-2). In 2005 this amounted to US$238 million, (OECD, 2007) and between 2000-2004 bilateral aid made up 27 per cent of PNG's total revenue.

Table 6-2 Top 10 donors of official development assistance to PNG 2005

	Country	**USD million**
1	Australia	238
2	Japan	16
3	European Community	15
4	Asian Development Bank	11
5	New Zealand	9
6	Global Fund	4
7	Germany	4
8	UNTA	3
9	UNDP	2
10	Netherlands	2

Source: (OECD, 2009)

Aid has contributed at times up to 48 per cent of the health budget, but this has varied considerably over the years (Tables 6-3, 6-4). If PNG were to lose Australia as an international donor partner, this would have a serious impact on the economy of the country. The aid modalities and sectors with which Australia chooses to engage in its aid programmes have a significant impact on the country.

Table 6-3 Volume of aid and proportion of health aid received in PNG

	2006 USD million	2007 USD million	2008 USD million
	384.2	376.1	391.6
Volume spent on health	29.1	39.4	14.6
Percentage of aid for health	7.6%	10.5%	3.7%

Source: (OECD, 2009)

Table 6-4 Aid as a percentage of health expenditure in PNG

	1996	1997	1998	1999	2000	2001	2002[1]	2003[1]	2004	2005	2006
Aid as % of health expenditure	2%	17%	24%	29%	27%	28%	37.7%	28.3%	48.5%	37.1%	11.2%

Sources: (Izard & Dugue, 2003) [1](World Health Organization, 2006)

6.3.1 Key issues not included in questionnaire

This brief examination of PNG's geo-political context highlighted two significant issues that were not captured in the first questionnaire:

1. Is there dependency on a single aid donor?
2. *What percentage of the State's total revenue comes from aid funding?*

These questions will be tested by the case study to assess whether they should be included as indicators in the final questionnaire.

6.4 UN membership and treaties

PNG has been a member of the UN since 1945. It acceded to the following UN treaties all of which carry obligations regarding the right to the highest attainable standard of health (Office of the High Commissioner for Human Rights, 2010):

- International Convention on the Elimination of All Forms of Racial Discrimination, in January 1982
- Convention on the Rights of the Child, in March 1993
- Convention on the Elimination of All Forms of Discrimination against Women, in January 1995
- International Covenant on Economic, Cultural and Social Rights, in July 2008

PNG's first report to the Committee on ICECSR is due in August 2010, two years after it acceded to the Covenant. In May 2009, the State finally filed its first report to the Committee on the Covenant for Elimination of All Forms of Discrimination against Women (CEDAW) since ratification in 1993, and in so doing,

combined its first, second and third reports (United Nations Committee on Elimination of All Forms of Discrimination Against Women, 2010). It filed its report due in 2000 on the Covenant on the Rights of the Child (CRC) in 2002 (UN Committee on the Rights of the Child, 2004). The two reports provided considerable detail about poor health in PNG, including the high infant and maternal mortality rates. The Committee on the CRC urged the State party to develop a comprehensive national plan of action that would take into account the MDGs and the Poverty Reduction Strategy. It recommended that the State seek technical assistance from, inter alia, UNICEF, and involve civil society, to prepare and implement this plan of action. This had not been reported as being underway by 2010.

A human rights commission has not yet been established in PNG, despite plans to do so for over 10 years (Talao, 2008). It is expected that a Bill will be introduced to Parliament to establish the commission in 2010. As Human Rights Commissions are tasked with educating the public about their rights, and hearing cases of rights abuse, they form an essential aspect of rights fulfilment. This questionnaire seeks information about a commission and its mandate as indicator 12.

6.4.1 Key issues not captured in the questionnaire

The questionnaire does not seek information about the timeliness of UN reports, nor whether action recommended from reports has been implemented. As these matters signal the operationalisation of rights, and State's capacity or willingness to address important rights issues, it is important to ascertain this situation. Two further indicators to be considered in the context of the case study are therefore:

3. *Has the State submitted timely reports to the UN on its treaties?*
4. *Have UN committees' recommendations been implemented?*

6.4.2 Treaty reports may not reflect local realities

The Committee on CRC commended PNG for having established a National AIDS Council and adopting the HIV/AIDS Management and Prevention Act in 2003. However, the effectiveness of the response to HIV/AIDS in the country is a different matter, with targets for universal access to diagnosis and treatment failing to be met. The draft Annual Report on the Health Sector Response to HIV/AIDS compiled by

WHO, UNAIDS and UNICEF highlights the areas where the health facilities and services are failing to deliver an accessible high quality service for the people of PNG.

> … while HIV counseling and testing was scaled up in 2008 to 107,615 tests, this represents 54% of the target, and only 44% of health facilities in the country offer counseling and testing, and only 19% of health facilities have post exposure prophylaxis services available on site... The number of pregnant women tested for HIV and receiving results rose from 3% in 2007 to 24% in 2008 and out of the reported 352 who tested HIV positive, 222 received ARV to prevent transmission. Nonetheless, these 222 represent only 6% of the potential number of HIV infected pregnant women in PNG (PNG National AIDS Council Independent Review Group, 2009, p.4).

The report also refers to the lack of quality testing throughout the country. It expressed concern that the testing algorithm may not have been correctly identifying all HIV positive people tested, and noted a high possibility that hundreds of people who were HIV positive were made to believe they were HIV negative (PNG National AIDS Council Independent Review Group, 2009, p.4).

The CEDAW Committee noted that the intent of principles of CEDAW in PNG "had not yet been incorporated into domestic law and therefore is not applicable in national courts" (United Nations Committee on Elimination of All Forms of Discrimination Against Women, 2010, para 4). This suggests that the Government of PNG has not yet operationalised its human rights obligations, as evidenced also by late, and combined, reports to the Committee. The Committee requested comments, further detail and progress reports on the following issues: access to general and mental health services for women, elderly women and girls, including those from rural areas; measures taken to reduce high maternal and infant mortality rates, including programmes in place to ensure safe motherhood as well as prenatal and post-natal assistance; low contraceptive usage; prevention of HIV/AIDS; family planning services; and decriminalization of abortion.

In its Country Assistance Strategy for PNG, the World Bank comments that although PNG has ratified CEDAW, implementation is a challenge. It notes that women have substantially poorer access to health care services, do not have equal participation in economic activity and political life, and lack access to credit, banking, and markets. Furthermore, women's rights are obstructed because "the country's law

and justice institutions are dominated by men, and women are not always able to access judicial recourse" (World Bank, 2007, p.11).

Indicator 5, *Does the State's constitution, bill of rights, or other statute recognise the right to health?* does not capture the State's commitment to respecting, protecting and fulfilling human rights after treaty ratification. There does appear to be a need for the additional indicators 3 and 4 above, gaining information about timeliness of reporting and operationalising rights. When these are answered in the negative, it should prompt programme planners to further investigate rights issues, as this will have an effect on the regulatory and social environment within which a new health programme will be established. Further investigation requires examination of reports such as, but not limited to, those of Treaty Monitoring Reports, Human Rights Watch, Transparency International and Amnesty International.

6.4.3 Human rights reports on PNG

Addressing the 'Strategies for the Future: Protecting Rights in the Pacific' Conference in 2008, PNG human rights lawyer Freda Taloa stated:

> PNG has not made much progress in advancing or protecting the rights of its people. The establishment of the human rights commission endorsed over a decade ago remains unattended to by Government. The advancement of women's rights in the country and attendance by Government to socio-economic issues lacks the zeal and drive envisioned by the founders of the Constitution (Talao, 2008, p.23).

Furthermore, Talao documented abuse of the environment and indifference by the Government that is threatening lives. "Foreign-owned companies are not being held to account for the damage they are causing. Inaccessibility to basic health and education coupled with illiteracy and lack of access to legal aid means there is no redress for the public" (ibid, p.23).

Human Rights Watch noted in its country report on PNG in 2009 that "The closure of rural aid posts and health centers, declining transportation infrastructure, failure of allocated funds to reach local governments, and a shortage of drugs, medical equipment, and trained health professionals limit access to quality health care" (Human Rights Watch, 2009, p.3). The report documented the high prevalence of HIV/AIDS with ARV therapy inaccessible to most. It stated that gender-based violence and discrimination, and poor access to health care, also fuelled the spread of

the virus. It observed that Sections 210 and 212 of PNG's penal code punish consensual homosexual conduct between men with up to 14 years' imprisonment, which is a breach of human rights.

Other human rights issues in PNG include police violence and detention of children, and violence and discrimination against women and girls.

> Violence against women and girls - including domestic violence, gang rape, and torture and murder for alleged sorcery - is pervasive and rarely punished. Police often ignore complaints, or demand money or sex from victims…Although the prime minister and other officials condemned violence against women in late 2007 following several well-publicized cases, these statements have yet to result in improved protection for women, services for victims, or an expectation of accountability for perpetrators (Human Rights Watch, 2009, p.2).

These reports provide compelling evidence that PNG is not protecting, respecting and fulfilling human rights, including the right to health, and therefore, inclusion of the indicators 3 and 4 above appears necessary to alert health programme planners to the failure of the State to meet rights obligations.

6.5 International contracts

The World Bank entered into a four-year commitment with PNG in 2008, ending a decade of a poor relationship because of what the Bank described as "a combination of factors including political instability, economic and fiscal decline, and differences of opinion between the Bank and the Government of Papua New Guinea (GoPNG)" (World Bank, 2007, p.1). The re-engagement with PNG was said to demonstrate the Bank's alignment with PNG's medium-term development strategy. This strategy, according to the Bank, "seeks to alleviate poverty through sound economic and natural resource management and through the direct delivery of services to the poor" (World Bank, 2007, p.2). The Bank however refers to a difference between documented procurement processes and actual practices. It states that waivers of competitive processes remain widespread with perceptions of corruption continuing. Furthermore, it refers to constraints on the use of policy process manuals because of insufficient dissemination and training in the use of the manuals, and that bidding documents had not been developed to support the legislation regarding procurement processes.

In 2008 PNG had received US$1,027 million in total lending assistance since joining the Asian Development Bank (ADB) in 1971 (Asian Development Bank, 2009a). The ADB 'Country Strategy and Program, PNG' acknowledged that creating good governance was at the core of PNG's development challenge, and strengthening public financial management was seen to be a key governance intervention that could drive broader public sector reform and the Government's MTDS (medium term development strategy) implementation (Asian Development Bank, 2006). Most of ADB's loans to PNG have been in the transport and communications sector (47 per cent), with the 'health, nutrition and social protection' sector having received eight loans since 1971, totalling US$114 million, making up 10 per cent of ADB's lending to PNG. In 2006 the ADB made a $15 million grant for HIV/AIDS prevention and treatment in rural development enclaves. It is also involved in a Medical Supply Distribution System, which is a private sector development activity. ADB reports its involvement in the health and HIV/AIDS sectors has been very successful "in creating a functioning public-private partnership that has considerably improved and extended health services in rural development enclaves" (Asian Development Bank, 2009a, p.2).

One of the ADB contracts with PNG is to support an increase of revenue from road user charges.

> The Government is committed to expand maintenance financing through road user charges as provided for under the NRA Act. The Government intends to (i) increase the existing levy on diesel, (ii) add a similar levy on petrol, (iii) commence collection of road damage charges on heavy vehicles, (iv) institute a mechanism to transfer resources from the tax credit scheme to the road fund, and (v) explore other potential means of enhancing cost recovery in order to finance road maintenance (Asian Development Bank, 2009b, p.2).

This is considered necessary to cover the ongoing high costs of road maintenance. However, given transport costs have been identified as a significant barrier to accessing health care, (Williams et al., 2008) there are risks that the ADB is supporting the PNG government in policy development that will have a negative impact on access to health care, and therefore on the right to health.

PNG has consistently failed to achieve the Millennium Challenge Corporation's selection criteria to access funding from the US Government's $5 billion bilateral aid programme. Selection involves being ranked at least as well as

peer-income countries in WDI Governance Indicators in three areas: ruling justly; investing in people; and economic freedom. PNG ranks below its peers specifically in control of corruption, immunisation rates, primary education expenditures, girls' primary education completion and land rights and access. The World Bank also notes poor performance scores in its *Doing Business* indicators in 2008, which placed PNG 84th overall out of 178 economies for ease of doing business, but its score for enforcing contracts put it in 162nd place. These governance and government effectiveness issues are examined in more depth in Chapter 7, Section 7.2.3. 'Democracy and governance' and are measured by indicators 23-28.

6.5.1 Key issues not captured in the questionnaire

Indicator 7, *Has the State made contractual commitments to banks or other states regarding reducing state services*, aims to gather information to determine whether the State is respecting its rights duties, even if it is indebted. However, the indicator does not capture any indirect impact on health rights, as illustrated above with the higher cost to access health care when road user charges increase. Therefore, a change of the wording to this indicator will be assessed for relevance in the case study.

The suggested change to Indicator 7 is: *Has the State made contractual commitments to banks or other states which will decrease availability, access, acceptability or quality of health care?*

6.6 International development assistance for health

PNG has several bilateral development partners, of whom AusAID is the largest (Table 6-2). In the 10 years to 2008, Australia contributed A$412 million (approximately US$395 million) to the PNG health sector (AusAID, 2009a). The percentage that aid funding comprises of the total health budget varies from year to year, ranging in recent years from 11.2 per cent in 2006 to 48.5 per cent in 2004 (Table 6-4) (OECD, 2009).

6.6.1 PNG's sector-wide approach to aid delivery in health

PNG has a sector-wide approach (SWAp) in its health sector, through which the major bilateral donors and the ADB contribute most of their funding for health

assistance. The members of the SWAp are: PNG, Australia, New Zealand, Japan, and the ADB. A SWAp is established to coordinate donors' funding and other inputs into the health sector. In principle, SWAps aim to harmonise donors in government-led programmes and policy development (Izard & Dugue, 2003; Walt, Pavignani, Gilson, & Buse, 1999). SWAps have the following features:

1 leadership by the host country or organisation

2 a single comprehensive programme and budget

3 a formalised process for donor coordination, and harmonisation of donor procedures for reporting, budgeting, financial management and procurement

4 greater use of local systems for programme design and implementation, financial management, monitoring and evaluation (AusAID, 2009a).

The principles of a sector-wide approach are not incongruous with a rights-based approach to development assistance in health. Leadership by the host country and a coordinated contribution from all donors ought to translate into support for priorities identified within the State's national health plans. Having a national health plan to progressively realise the right to health is a core obligation for States that are signatories to the ICESCR. The health sector SWAp in PNG was seen as a way to coordinate previously disparate donor inputs in line with the Medium Term Development Strategy, National Health Plan and the Medium Term Expenditure Framework. "The many small donor interventions that resulted in supply of equipment that could not always be repaired, training that was intermittent and poorly targeted have been replaced with donor commitments to programs and projects that comply with health sector priorities" (Hamblin, 2006, p.2).

Hamblin describes the fundamental structure of health delivery in PNG as one that limits the effectiveness of a SWAp. Although the National Department of Health (NDOH) manages and controls the SWAp, its implementation is dependent on provincial governments. Those governments' priorities rarely align with central government and its ministries.

> National health plans call for a priority to be given to primary care but provincial authorities afford a high priority to provincial hospital upgrade (clinical care). It is difficult therefore to see how a SWAp can work effectively in PNG if it does not inculcate the Provincial governments and their priorities in its design (Hamblin, 2006, p.4).

Participation of men and women of different ethnicities, ages, and from rural and urban locations in planning of programmes is a key human rights concept. The design of the SWAp in PNG would have benefited from a participatory approach, through which the actualities of the delivery of health care would have informed its design.

> Civil society participation in strategy and policy formulation is generally low and thus [the SWAp] generally represents top down formulation… What is important is that a SWAp is compiled after adequate consultation with stakeholders… There is a real risk with SWAps that policy formulation is designed to suit central bureaucratic concepts rather than effective service provision (Hamblin, 2006, p4).

The PNG SWAp has been responsible for:

- the Capacity Building Service Centre (A$70 million over five years) which provides technical assistance and other forms of capacity building to help the health sector achieve the goals outlined in its strategic plans.
- the Health Sector Resourcing Framework (A$60 million over six years) which guides AusAID funding to the health sector, and enables direct financing to the PNG Governments for set priorities, as well as having the discretionary funding available to support activities such as building clinics
- health program response to HIV/AIDS (A$50 million over seven years).

> Responding to HIV/AIDS in PNG is a priority for the health program. As well as the $100 million PNG-Australia HIV and AIDS Program Sanap Wantaim, Australia will also provide up to $50 million to support and expanded health sector response to HIV/AIDS in PNG. Activities include a partnership with the Clinton Foundation HIV/AIDS Initiative to increase access to life saving drugs for HIV positive people and support for the delivery of Sexually Transmitted Infection prevention and management services. Australian non-government organizations and their PNG counterparts will undertake the activity through the PNG-Australia Sexual Health Improvement Program (AusAID, 2007).

- two smaller components were contributions to the PNG Institute of Medical Research Support Program to improve diagnosis and treatment of current health sector priorities including malaria, sexual health infections and respiratory diseases, and support to the Medical Support Service Project to build institutional capacity within the UPNG medical and nursing schools (AusAID, 2007).

6.6.2 SWAp's alignment with National Health Plan

The 2001-2010 National Health Plan which was current when the SWAp was established, had priorities under these headings:

1 Health promotion – to provide technical support to facilitate community action and participation in the establishment of healthy villages and towns… healthy workplaces and hospitals as part of the Healthy Islands Settings Approach; to train health promotion officers

2 Disease control – priority diseases were identified as sexually transmitted diseases; air-borne diseases including TB; food-borne and water-borne diseases, including typhoid, dysentery and diarrhoeal diseases; diseases under surveillance including polio, leprosy, neonatal tetanus and measles, cholera, rabies, dengue fever, yellow fever and plague; mosquito-borne diseases including malaria, filariasis, dengue fever and Japanese encephalitis; lifestyle diseases, especially diabetes, heart disease and preventable cancers; and malignant diseases

2.1 Laboratory services – to redevelop the public health laboratory and blood bank and upgrade and improve public hospital laboratories.

2.2 Family health with a special focus on child health, immunisation, nutrition and sanitation; women's health and safe motherhood, focusing on reducing maternal mortality; reproductive health and nutrition

2.3 Environmental health

2.4 Food safety and quarantine

2.5 Sustainable development and healthy environment

3 Curative health services

In each category emphasis was placed on developing policy and technical capacity, replacing outdated legislation, and improving community awareness of health issues. The SWAp is therefore aligned with the National Health Plan in that the largest amount of aid funding is going to HIV/AIDS, which is the first single disease listed under Plan's disease control category, and to capacity building which the Plan states is needed across all sectors and divisions within health. Similarly, support for the medical research capacity to improve diagnosis and treatment is in keeping with the Plan.

However, just as Hamblin raised the issue of non-alignment between a SWAp and provincial government implementation, there can also be non-alignment between

national health plans and donor interests. Speaking at a national health plan workshop in 2009, the Permanent Secretary for Health in PNG stated that the development partners would be shown the draft of the 2011-2020 national health plan to "try and sell the plan to the development agencies" (PNG National Department of Health, 2009c). This begs the question as to what would happen if the development agencies did not 'buy' the plan, given that aid has contributed between 11 and 48 per cent of government health expenditure in the past 10 years.

6.6.3 Key issues not captured in the questionnaire

In principle a SWAp should give the State control over the donor partners' support of the health sector, and promote greater coordination to deliver health care according to the priorities of the National Health Plan. It is therefore important that international partners have a good understanding of any SWAp when designing new health initiatives. The questionnaire does not include an indicator covering this point, nor whether there is alignment between national and provincial governments on a SWAp. The following question should be considered for inclusion:

5: *Is there a SWAp throughout the health sector to which all bilateral and significant donors belong?*

6.6.4 Criticism of aid donors

Despite the principles on which aid agreements are made and delivered, and apparent alignment with the National Health Plan, there is criticism in PNG of the way in which aid for health is delivered. This criticism is particularly directed towards the largest donor, AusAID, for what is called 'boomerang' aid; that is, most of the funding is believed by locals to go back to Australia.

A key informant interviewed for this research elaborated on this topic:

> *You have big donors like EU, AusAID, NZAID, who come with millions of dollars in terms of health, working with the government system, and working with consultants. Most of the money gets spent on the consultants and so basically you don't have the outcomes you expect – and it gets stuck in the government system. So you don't have the outputs in the provinces and rural areas. Seventy per cent of donors' money is going back to their own countries. 70 per cent! This was said by the Minister of Foreign Affairs in PNG when*

> *speaking to donors at the health ministers' conference in Madang. So, the current system is not effective. And 30 per cent gets stuck in the system in PNG which is corrupt.*

Many PNG health professionals are frustrated at the lack of aid funding for frontline health services. These comments were expressed at National Health Planning workshops:

> *The level and extent of our dependence on foreign assistance in terms of dollars is very significant. In the areas of the health SWAp, we are overly dependent and do have a lot of advisers and consultants. Yet many of our hospitals, health centres and aid posts in the provinces and districts have very few or no doctors at all, let alone specialist doctors and nurses (PNG National Department of Health, 2009c).*

Comments from the floor at a national health planning workshop in Port Moresby, 2009, included an observation that health and education are run by [external] consultants; and that monitoring of spending on health by NGOs and churches was inadequate, in terms of how much was spent and on what activities. At the PNG Health Training Forum, May 2009, the Director of Human Resource Management referred to the low spending on human resource development by the AusAID Health Sector Improvement Program (HSIP), and stated, "this trend needs to change and more resources from the HSIP should be allocated for training of health workforce through Community Health Worker schools and schools of nursing" (Yambilafuan, 2009).

This theme recurred in a National Health Planning Workshop at which participants asked whether aid assistance was going where it should, and there were suggestions that donors were not supporting the National Department of Health. At times there was an almost hostile attitude towards aid donors. To the statement that "outsiders cannot dictate how we manage health", there was a round of applause from the PNG participants.

The CEO of a provincial hospital claimed outside interference was damaging health care. He cited, as an example, that an external consultant had advised it was too expensive to have IV fluids and oxytocin available in aid posts (primary health facilities). The CEO argued that the only way to prevent postpartum haemorrhage, and reduce the high maternal mortality death rate, was to be able to provide those

interventions at the level of health facility most accessible to most women giving birth. This example is just one of many decisions that have created an enduring attitude of frustration and bitterness with health workers towards what they consider ill informed use of international funding. The lack of meaningful participation in policy development appears to lie at the heart of much of the resentment.

Others opinions ventured at the national planning workshops included:

> *donor partners – their mindset must change; donors should not control the agenda and should stop their health systems messing with ours; our partners especially the aid donors do not see and recognise the doctors as confident managers of the health services in this country. These organisations bypass the NDOH for proper consultation, leading to duplication, overlapping and parallel services with poor outcomes.*

6.6.5 Key issues not captured by the questionnaire

The sentiments expressed by stakeholders in PNG towards development partners demonstrate attitudes that could affect the delivery of health initiatives, but which are not captured in official documents. It is therefore an important consideration for a new programme, and the questionnaire may benefit from an indicator that reflects this conflicted relationship.

6 *In the past 12 months has local criticism of aid donors been documented, for example, published in the media, academic journals, or conference proceedings?*

6.6.6 Health becomes one of AusAID's five priorities

In June 2009 Australian and PNG governments entered into a new partnership for development with five priority outcomes, one of which was health. The health outcomes had the following targets:

- An increased percentage of children receiving triple antigen and measles vaccinations;
- An increased percentage of deliveries being supervised by skilled staff;
- Reduced malaria prevalence in high malaria endemic districts;
- Reduced TB prevalence in high TB endemic districts (AusAID, 2009b).

The partnership agreement stated that there would be a strong focus on improving the performance of the primary health system by concentrating on funding the operation of rural health facilities; funding integrated outreach services and funding district drug distribution. The national level systems that were needed to enable these improvements at district level had been identified for strengthening as well and included: procurement of medical supplies; provision of medical equipment; and health worker training.

In the evaluation of its funding to health service delivery, AusAID claimed that "Important improvements have been made but, overall, the results achieved in terms of lasting improvement in the capacity of health systems have not been commensurate with the costs" (AusAID, 2009a, p.vii). There was therefore agreement between the major donor partner, Australia, and its critics, that aid for health in PNG had not had the impact partners wanted. Access to good quality and acceptable health care in PNG had not been achieved, and in many areas, had worsened in the past decade. It was apparent that for many people in PNG, their right to health was not being progressively realised.

In 2005 about 10 per cent of all aid to PNG went to the health sector, which was an increase on previous years (OECD, 2009). In fact, in some years in the 1990s, no aid was directed to the health sector at all. Indicator 10 captures this information and although it would be inappropriately rigorous to set an international benchmark on what percentage of aid should be consistently spent on health, it is fair to expect that the percentage of aid going to health should not regress while health rights are still not being met. Therefore, a decreasing percentage of aid to health in PNG would suggest that health rights are not being respected, protected or fulfilled.

Indicators 8, 9 and 11 seek information to assess whether the State controls the spending of development assistance in order to meet its rights obligations, especially through strengthening health systems. There is no such State control mechanism in PNG.

6.7 Assessment of Questionnaire 1 on the case study

The first case study used in this thesis is presented as an Annex at the end of this Chapter.

6.7.1 Does the first questionnaire provide a useful context?

A general understanding of the role of human rights, health rights and international commitments is obtained from this first questionnaire. Although it provides limited specific information that could have prevented some programme failings, the information gleaned in the process of completing the questionnaire begins to paint a contextual picture that is crucial for programme partners to understand.

In 2004 PNG had not acceded to the ICESCR, although it had to the CRC and CEDAW, both of which specify State duties regarding access to health care for women and children. Furthermore, the Universal Declaration of Human Rights, in Article 25, which all UN member countries have adopted, states;

> (1) Everyone has the right to a standard of living adequate for the health and well being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.
>
> (2) Motherhood and childhood are entitled to special care and assistance. (United Nations, 1948)

Therefore the PNG government still had obligations under international law to meet its population's right to health, even though it was not a signatory to the ICESCR until 2008. However, until it acceded to the ICESCR, PNG did not have to report to the monitoring Committee on action to progressively realise the right to health. Although the State had ratified three other UN treaties that contain clauses that pertain to women's and children's rights to health, the crucial covenant to hold the State accountable for respecting, protecting and fulfilling the right to health was not ratified. This, together with the knowledge that the Constitution and other domestic legislation did not acknowledge the right to health, would inform programme planners that there would be limited State commitment to prioritising health care above other State activities.

Furthermore, high levels of debt servicing, lack of development policy to protect and direct health interventions, and a small percentage of ODA being directed to health, add to the picture that international partners would receive little direction or resource support from the State with their programmes. Rather than reading this as a green light to bypass any bureaucratic processes, in fact it is a signal that ongoing

sustainability would likely be problematic, and that the underlying health system would be weak.

That there is no human rights institution, and a lack of readily accessed information about judicial decisions on the right to health would further inform programme planners that the State government pays little heed to human rights, including the right to health, in practice. This information should inform subsequent programme design by promoting an in depth exploration of the impact of the State's lack of stated commitment to health care. In particular, this might encourage examination of the impact on the sustainability of programmes if the State fails to honour agreements, as would appear to be the case with rights commitments.

6.7.2 Could Questionnaire I have prevented programme failings?

In total, only four of the 13 indicators provided information that could have been used in the design phase to avoid programme failings (Annex Tables 6-5, 6-6). These were from indicators one, five, eight and nine, regarding no ratification of the ICESCR, the State's lack of the recognition of the right to health in its Constitution, and the absence of a development policy through which the State could control development support for health and strengthening the health system. An additional two indicators, 12 and 13, might possibly have provided further useful contextual information regarding the absence of a human rights institute, and of information about judicial decisions on the right to health.

The programme in the case study had six objectives. Numbers one to three aimed to increase clinical services, objectives four and five were to improve ophthalmology and eye nursing education, and the final one was to develop a national eye care plan that would integrate with the overall national health plan. The information collated in this first questionnaire that is of relevance to the first three objectives derives from indicators one, five, eight and nine. Indicators one and five alert programme planners to the lack of State commitment to protecting, respecting and fulfilling the right to health, which translates to little commitment to ensure access to quality health care. Indicators eight and nine suggest that the State is not taking a lead in controlling and coordinating international partners in their programmes, nor ensuring their health interventions will respect, protect and fulfil the right to health. While this information is not explicitly addressing factors relevant to

clinical services, it does suggest there may be little support from the State to achieve the objectives.

There is no indicator in this first questionnaire to which an answer would specifically rule out the possibility of an increase in clinical service outputs. However, the information gathered from indicators one, five, eight and nine paints a picture of an environment that is unlikely to promote the availability of health care. This has an impact on objectives four and five, which addressed improving health worker education, which in turn directly affects the availability of health care, because well trained health workers are an essential resource to make health care available.

Finally, this questionnaire provides little contextual background to suggest that objective six was not achievable.

6.7.3 Could the additional indicators have improved outcomes?

Using the information gathered from primary and secondary sources to understand international commitments more fully, and the national socio-economic and political context in PNG, it is possible to identify additional questions that would have provided a more complete and useful background for programme design.

Indicator 6 - *the percentage of government spending on debt servicing* - would have alerted programme planners to the relatively high level of State spending on servicing debt in PNG. However, this statistic is more useful when compared with the percentage of State spending on health (Indicator 33 in the second questionnaire). It is proposed to bring both these indicators into the same questionnaire so the comparative data informs the design and in this case demonstrates that debt servicing receives well over twice as much State funding as health.

Awareness of the State's poor record on submitting timely reports to the UN on its treaty obligations, and its failure to take action on Committee's recommendations, could have cautioned programme planners that human and health rights were not strongly defended at State level. This is further evidenced by the lack of a human rights institute. Therefore, the question as to whether the State is submitting its reports to the UN Committees in a timely manner is useful to include. So too is the question asking whether UN Committee recommendations have been implemented.

Considered together, these indicators paint a picture of a Government that does not meet, or is not capable of meeting and implementing, its commitments and contractual obligations. Failure to submit reports on time, and implement the Committee's recommendations, should alert programme planners to a public sector culture that tolerates poor performance. This would likely impact on achievement of programme targets.

Monitoring human rights reports, such as Human Rights Watch, would also have informed the NGO of the level of violence, especially against women, and the lack of redress available via the police and judiciary system. This may have helped place greater emphasis on overcoming access issues for women and establishing safer, more efficient referral systems from primary health care facilities through to hospitals. A question is therefore added asking whether there are human rights reports that raise issues about security and safe access, especially for women, to health services.

A report from Transparency International would have been useful at the planning stage to demonstrate the disturbing level of corruption in the country, and the difficulty of starting businesses without resorting to political favour or corruption. Although the level of corruption is measured in the second questionnaire of this framework, the measure itself does not give detail about how corruption and fraud are manifested. This additional information would have encouraged more rigid accountability and security around cash handling and stock management from the start of the programme. A question is added which asks whether the most recent Transparency International report on the State specifically refers to corruption within the health sector.

The change of indicator 7 to look more specifically at State commitments that could negatively impact on the right to health is a move towards a health impact assessment of other sector policies. It enables State activities to be monitored to ensure, even if the State is indebted, that it is respecting its rights duties.

Although important, it is difficult to ascertain if the State has made commitments that will impact on health rights, because this requires examination and interpretation of many different contracts. For example, a need to demonstrate fiscal responsibility might translate in practice to reduced government spending on health services. Therefore, an added check on State commitment to health could be undertaken through an indicator that asks: *is State health expenditure increasing at a rate faster than population growth?*

It is also difficult to know what all the different donor partners (State and non-state) are delivering in the health sector, as there is no single document which provides this overview. The questionnaire failed to seek information about the international aid programmes and whether these were aligned with the national health plan. This information might have helped the NGO to coordinate human resource training and planning aspects of the programme with other donors, and would have identified early on the lack of State planning, coordination and control of development partners. Therefore, the following questions are to be added to the first questionnaire:

- *Is there a SWAp throughout the health sector to which all bilateral and significant donors belong?*
- *Is there one public document that details all donors' health related activities?*

6.8 Summary of additional indicators for Questionnaire 1

From the primary and secondary sources, and the application of the original questionnaire to the case study, the following list of additional indicators has been compiled to help provide a full picture of the rights and international commitments background in PNG:

- What percentage of GDP does the State spend on health (moved from the second questionnaire)
- Is the State is submitting its Treaty reports to the UN Committees in a timely manner
- Have UN Committee recommendations been implemented
- Have any human rights reports raised issues which would limit secure access, especially for women, to health services
- Does Transparency International's report on the State specifically refer to corruption within the health sector
- Is State health expenditure increasing at a rate faster than population growth?
- Is there a SWAp throughout the health sector to which all bilateral and significant donors belong?
- Is there one public document that details all donors' health related activities?

- What percentage of the health budget comes from overseas development assistance?
- In the past 12 months has there been documented criticism of aid donors?

Change to Indicator 7: Has the State made contractual commitments to banks or other states which will decrease availability, access, acceptability or quality of health care?

6.9 Conclusions

The assessment of the rights context and international commitments by the State provides a useful backdrop to the setting within which a new health programme will be located. The information gathered in this first questionnaire enables programme planners to know whether the State recognises and honours its obligations to respect, protect and fulfil the right to health. Furthermore, the State's record on reporting on its progressive realisation of the right to health, and respect for other human rights, is examined. This provides a good indication as to how effectively the right to health is operationalised in the local context.

In PNG this information revealed a poor rights context. Actions recommended by UN committees on covenants to which PNG had acceded had not been carried out, and there was documentation of human rights violations by the police, and a high level of corruption by politicians.

International aid donors, coordinated through a SWAp, contributed a significant percentage to State spending on health. Proposed health programmes benefit from understanding those key relationships and aid modalities, and coordinating services with them. Questions to gather this information have been included in the final questionnaire (Table 11-1).

The State offers no guidance to international partners on how to engage in the health (and other) sectors, and thus remains vulnerable to overseas development assistance that is not aligned to State priorities. As a consequence there is also increased risk that international interventions may duplicate activities, increase inefficiencies, and weaken the health system. The lack of an international development policy therefore suggests the State is not taking the lead in international partnerships. One consequence of this could well be local disappointment in the aid programmes and mechanisms through which aid is delivered. While there is evidence

of this in PNG, the questionnaire had not specifically addressed this issue. A question has been added to ascertain whether there is criticism of, or resentment towards, aid donors.

The application of the questionnaire to a case study in PNG has been useful. It illustrated that the indicators in the first version of the first questionnaire would have elicited information that provided a fuller picture of the State's comparative disregard for the right to health and other human rights. This information would have signalled early on in the health programme planning stages the lack of commitment from the health sector that the programme subsequently experienced. Further information would have been useful in alerting the programme planners to other matters of significance in the health and political sectors, and these aspects have now been added into the final questionnaire.

However, most of the reasons the programme failed to meet its targets related more to matters of national policy and practice, and the weaknesses of the health system. These will be explored in the next two chapters.

Annex. Case Study One

An eye health programme in PNG

In 2004 an international NGO entered into partnership with the PNG National Department of Health (NDOH), the Port Moresby General Hospital (PMGH), and University of PNG (UPNG) to begin a programme to build the capacity of eye health professionals to deliver quality eye health service nationally. This was a non-state sector aid initiative in partnership with the state sector, designed to avoid setting up parallel services and to complement already existing services. The programme was in response to requests from local eye care providers because they considered the visual disability and blindness burden in the country beyond their capacity and that of the health system to meet.

I worked for the NGO throughout the period covered by this assessment and led the programme development team.

The goal of the programme was "to ensure all people in PNG ultimately have access to a high quality eye health service" (Williams, 2004). Stakeholders, which at this stage was limited to eye health workers, academics and health administrators and NGO staff, determined that this could only be achieved by first putting in place a central hub of eye care delivering good outcomes in sufficient volume to meet local need, and using this to provide quality training for eye doctors and eye nurses. From this hub, as workers were trained and infrastructure developed, services would be extended into the provinces, where most people live. Therefore, the programme initially concentrated on improving the infrastructure and teaching programmes at PMGH and UPNG, while increasing access to, and awareness of, eye care services by the local community.

When designing the programme, the objectives and targets were set by the eye health workers and the NGO, taking into account baseline service levels, numbers of eye care workers, local conditions, achievements of another NGO working in the same sector in PNG, and outputs in eye clinics in similar settings elsewhere in developing countries. The programme did not undertake to address any aspects of the health system beyond eye service delivery and training. Programme planning did not assess the national context in terms of health and human rights, nor international or political commitments made by the PNG Government that could have had a bearing on health.

For the purposes of this case study, the objectives and outcomes of the programme are examined to determine whether a better understanding of the national rights context, and PNG's commitments to its international partners, could have altered and improved the design.

The results of the programme were taken from the programme documents and reports. Clinicians' explanations for the results came from workshop reports held with the eye care workers throughout the three years of the programme; community comments came from focus group meetings held during a blindness survey conducted in 2005 throughout the Central Province, and subsequently published (Williams et al., 2008).

Of the programme's objectives that interfaced with the public health sector, none was completely successful. However, some improvement in the delivery of eye care and training of eye health workers was achieved, although little was sustained. In 2007 the NGO set up another training initiative in another province in PNG, taking into account what had been learned in this programme.

Objectives and outcomes of the programme

Objective 1: Increase capacity of Port Moresby Eye Clinic to double patient consultations to 15,000 per year by December 2007

The medical eye clinic outpatient consultations increased by 8 per cent, from 7457 in 2004 to 8064 in 2007. A new refraction room (Eye Glass Clinic) was opened as part of the programme in 2005, and was accessed by 1300 patients in 2007. Therefore the total number of patient consultations in 2007 was 9364, a 26 per cent increase over 2004, but this failed to achieve the objective.

Objective 2: Double the capacity of day theatre in Eye Clinic so that the number of cataract operations increases to at least 500 by December 2007

The target of 500 cataract operations per year was not reached, despite increased surgical capacity being created with more equipment and consumables for the theatre. More doctors joined the surgical training programme, resulting in an increase in the number of surgeons from four to seven. There was no corresponding increase in the number of eye nurses and in 2007 there were only two nurses for the entire clinic including the operating theatre.

Cataract surgery numbers increased 35 per cent from 241 in 2004 to 325 in 2007. However, the average annual number of surgeries per surgeon decreased from 59.5 to 45.9

per year throughout this period. By comparison, in another NGO programme in PNG, one surgeon completed over 1000 cataract operations in each of the years 2004-2006.

Objective 3: Refraction service for the community (target 3000 people) and sale of spectacles to 1200 per year per refractionist

A new refraction room (The Eye Glass Clinic) commenced service in mid 2005. There were 1192 clients by December 2005, 1024 in 2006, and 1184 in 2007, all falling well below the target of 3000 people per year.

Hospital management limited client access to the clinic in early 2006, but permitted greater access again in 2007. In mid-2006 the refraction staff decreased to one. The data on spectacles sales were combined between the Eye Glass Clinic and the general eye clinic, and stayed fairly consistent at 1748 in 2005, 1914 in 2006 and 1864 in 2007. Combining data on sales did not permit analysis of numbers by refractionist or ophthalmologist, so the target of 1200 spectacle sales per refractionist cannot be assessed.

Objective 4: Review and improve UPNG postgraduate training in ophthalmology

Curricula for the Diploma and Master of Ophthalmology were developed and delivered by a Visiting Professor, replacing an opportunistic and ad hoc approach to training with a formal, modular system. This included scheduled written and oral tests and examinations, and log book requirements detailing clinical experience. From 2004-2007, using the revised curricula, there were two Master of Ophthalmology graduates, and four Diploma of Ophthalmology graduates. However, after the Visiting Professor's direct input ended in 2006, PNG ophthalmologists employed at PMGH did not maintain the formal, modular-based approach to registrar education.

Objective 5: Boost numbers and quality of eye care nurses in PNG through establishment of a Diploma of Eye Care Nursing at UPNG's School of Nursing, to start delivery in 2006.

The UPNG School of Nursing and NDOH did not develop or endorse a new curriculum for eye nurse training, nor allocate resources to develop or deliver training. (The programme developed a partnership with an alternative university in PNG, designed an eye nurse curriculum, and introduced the postgraduate diploma in eye care for nurses in 2007. This was not carried out as part of the original programme.)

Objective 6: National Eye Care Plan developed and incorporated into PNG National Health Plan

A national eye care plan was not written or incorporated into PNG national health plans, although two workshops were held to work towards this objective.

Explanation for programme outcomes

Meetings were held with all the eye health workers several times each year to discuss the progress of the programme. The reasons proffered at these meetings for results of the programme were documented by the NGO. The explanations are entered into Table 6-5 below. Alongside these explanations consideration is given as to whether the indicators in each of Questionnaires 1, 2 and 3, could have helped predict the problem identified by the health workers. An answer of 'yes', 'no' or 'possible' is entered into the column. If yes or possible is selected, then the indicator number that would have alerted to this problem is also entered into the column.

During an eye health survey that the NGO conducted in 2005, 33 focus group meetings were conducted in rural areas around Central Province. Analysis was made of the reasons the men and women in the community offered as to why they did not access eye care services. The top nine most commonly offered explanations are similarly examined in Table 6-6 to assess whether the indicators in questionnaire one could have forewarned of the community's barriers to the uptake of eye health service.

In total there are 32 specific problems listed in the two tables. If any indicator from any of the three questionnaires provides information that could have alerted programme planners to this likely problem, then the overall result in the final column is entered as a 'yes'. If any indicator from any of the three questionnaires may have alerted planners to this problem, then a 'possible' is entered into the final column. If no indicator alerted to the problem, a 'no' is entered.

Table 6-5 Barriers identified by indicators

Objective	Eye care workers and NGO staff listed the following factors to explain why targets were not reached	Questionnaire able to forewarn barriers to success?*			
		Questionnaire 1 Yes/No/Possible*	Questionnaire 2 Yes/No/Possible	Questionnaire 3 Yes/No/Possible	Overall Yes/No/Possible
1	PMGH failed to honour commitment to appoint more nursing staff	Possible 1, 5, 6,12	Yes 25, 26, 28, 32, 36	Yes 62, 64, 66	Yes
	No advocacy from the eye clinic staff to the hospital or health department to address worker or patient barriers for eye care service.	Possible 1, 6, 12, 13	Possible 25, 32,	Possible 59-61, 71, 72	Possible
	Culture of change not accepted	Possible 9, 12	Possible 20, 21, 25, 27, 31	Yes 56, 59, 60, 61, 71, 72	Yes
	No leadership in the eye clinic to seek or deliver change	No	Possible 25	Possible 71, 72	Possible
	Patients' right to access quality health care not a feature of management	Yes 1, 5, 8, 9	Possible 17, 25, 43, 44, 45	Yes 56, 59-61, 85, 87	Yes
	Afternoon clinics not permitted by hospital management or nursing staff	No	No	Possible 64, 65	Possible
	Too few nurses in eye clinic	No	Possible 25, 32,	Yes 64, 65	Yes
	A limit of 40 outpatient appointments per day set by the hospital management	No	No	Possible 63, 64, 65	Possible
2	Culture of poor work ethic and lack of attendance and lack of performance management	Possible 9,10	Possible 25,26,27,28	Yes 61, 66, 67, 68, 71, 72	Yes
	Lack of eye nurses	No	Possible 25,32	Yes 64, 65	Yes
	Cost of surgery to the patient was prohibitive for many despite cross-subsidization and price reduction for needy patients, a scheme the health workers informed patients of and administered	No	Yes 17, 32, 36	Yes 59, 60, 61, 102, 103	Yes
	Stock outages of essential surgical supplies	No	Yes 28, 32, 35, 36	Yes 90, 92, 94, 95, 99	Yes
	Equipment failures not repaired efficiently	No	Yes 32, 35, 36	No	Yes
3	Eye glass clinic was difficult for patients to find and access.	No	No	No	No

Objective	Eye care workers and NGO staff listed the following factors to explain why targets were not reached	Questionnaire able to forewarn barriers to success?*			
		Questionnaire 1 Yes/No/Possible*	Questionnaire 2 Yes/No/Possible	Questionnaire 3 Yes/No/Possible	Overall Yes/No/Possible
	Safety and insecurity limited opportunities to provide spectacle services outside hospital	No	Yes 26, 39	No	Yes
	Corruption and theft of revenue limited staff numbers who could handle cash	No	Yes 26, 28	No	Yes
4	Lack of acknowledgement or recompense for any teaching provided at a postgraduate level	No	Possible 32, 33,	Yes 62, 66, 67, 68	Yes
	Lack of leadership in ophthalmology to effectively direct planning including for training and subsequent deployment	No	Possible 25	Yes 62, 66, 67	Yes
	No overall health worker plan for the nation	No	Possible 25	Yes 62	Yes
5	Confusion between UPNG and NDOH as to where responsibility lay for new course development	No	Possible 25, 27	Yes 62	Yes
	Lack of resources to fully develop the curriculum to meet PNG regulations for a postgraduate level diploma	No	Possible 32, 33, 37	Yes 62	Yes
6	Lack of leadership	No	Possible 25	No	Possible
	National health executives failed to address eye workers' calls to appoint a proactive leader with a mandate to advocate for improved service, training and delivery of eye care.	No	Possible 23, 25	Yes 62, 66, 67, 69	Yes

* Answer yes, no or possible; "possible" suggests that the information in the questionnaire should have alerted the designers that further information on that subject was needed. The number of those indicators that could have improved programme design are listed beside a 'possible' or 'yes' response.

Table 6-6 Community explanations for failure to access eye care service

People in the community referred to the following as barriers to their access to eye health services:	Questionnaire able to forewarn barriers to success? *			
	Questionnaire 1	Questionnaire 2	Questionnaire 3	Overall
Cost of hospital outpatient and surgical fees	No	Yes 17, 32, 36	Yes 59, 60, 61, 102, 103	Yes
Cost and distance of travel to hospital	No	Yes 16, 17, 32, 36	Yes 48, 59, 60, 102, 103, 108, 110, 112	Yes
Queues at the hospital	No	Possible 32,	Yes 48, 51, 61, 63, 64, 65, 102, 104	Yes
Broken or deferred appointments by medical staff	No	No	Yes 48, 51, 61, 63, 64, 65, 67, 102, 104	Yes
Difficulty communicating with clinical staff	No	No	Yes 104	Yes
Did not know eye care service was available or could restore vision	No	Possible 41	Yes 73, 104	Yes
Awareness of poor surgical outcomes	No	No	Yes 50, 56, 57, 59, 60, 61	Yes
Difficult hospital processes	No	No	Yes 48, 51, 61, 63, 64, 65, 102, 104	Yes
Fear of doctors	No	No	Yes 56, 67, 71, 104, 111	Yes

* Answer yes, no or possible; 'possible' suggests that the information in the questionnaire should have alerted the designers that further information on that subject was needed. The number of those indicators that could have improved programme design are listed beside a 'possible' or 'yes' response.

Chapter 7 State capacity to meet the right to health

7.1 Introduction

In the previous chapter PNG's human rights and health rights obligations and international development partnerships were examined. The information gathered from Questionnaire 1 in the framework's first tool was tested against primary and secondary sources of information about the PNG context, and against the case study. This then lead to a refinement of the questionnaire, with extra indicators added.

As would be expected, the international context made only a small contribution to the full contextual background needed for programme design. There were many elements that played a role in the programme's failure to meet its targets. In particular, the national socio-economic and political environment, and the health system itself, contributed to programme difficulties.

In this chapter the national demographic, political and socio-economic context of PNG is examined using Questionnaire 2 and additional primary and secondary sources.

The chapter follows the order and format of the previous one, ending with additional indicators to include in the final tool.

7.2 Capturing national trends

Questionnaire 2 seeks to elicit information on domestic policies and practices, and economic capability, to operationalise the right to health. In particular, data are now gathered on the demographic, socio-economic, governance, and political circumstances of the country. Data can be used from a variety of sources with the intent of gathering reliable, current information that reflects the domestic conditions in which a new programme will function.

As for Questionnaire 1, this information is sourced over two different time periods, ideally five years apart. This enables trends to be observed, and judgement made as to whether the State is moving towards a better health and human rights environment. The completed questionnaire is presented in Table 7-1.

Table 7-1 Questionnaire 2: national data

Indicator	Demographic data	2004*	2009**
14	Population, total	5.80m (2003) [1]	6.45mi (2008) [1]
15	Population growth (annual %)	2.42 (2003) [1]	1.95 (2008) [1]
16	Rural : urban ratio	87:13 [1]	87:13 [1]
17	Percentage of people living in poverty (less than US$2 per day)	24.6 (1996) [2]	39.6 (2005) [2]
18	Contraceptive prevalence (% of women ages 15-49)	25.9 (1996) [2]	Not available
	Political system		
19	Is the state a democracy?	Yes	Yes
20	Number and percentage of women MPs	1 - <1%	1 - <1%
21	Does the constitution protect freedom of expression?	No	No
22	Does the constitution protect freedom of association?	Yes	Yes
	Using World Bank-Governance Indicators [3], give scores for the following governance indicators (percentile ranking against other states)		
23	Voice Accountability	45.7 (2003)	51.0 (2008)
24	Political Stability	26 (2003)	27.3 (2008)
25	Government Effectiveness	26.5 (2003)	20.4 (2008)
26	Rule of Law	13.8 (2003)	18.2 (2008)
27	Regulatory Quality	24.9 (2003)	30.4 (2008)
28	Control of Corruption	18.4 (2003)	9.7 (2008)
	Non-discrimination		
29	Number of treaty-based grounds of discrimination that the state protects out of: sex; ethnic origin, race, or colour; age; disability; language; religion; national origin; socioeconomics status; social status; social origin, or birth; civil status; political status, or political or other opinion; and property	-	5/11 [4]
30	Number of non-treaty-based grounds of discrimination that the state protects out of: health status (eg, HIV/AIDS); people living in rural areas; and sexual orientation		3/11 [4]
31	General provisions against discrimination		0 [4]
	National financing		
32	Is the per capita government expenditure on health greater than the minimum required for a basic effective public-health system?	No - $US26 (2000) [5]	No - US$29 (2006) [5]
33	Total government spending on health as percentage of GDP	4.3 (2002) [6]	3.2 (2007) [6]
34	Total government spending on military expenditure as percentage of GDP	0.6 (2002) [7]	0.5 (2007) [7]
35	Percentage of total state budget from ODA	27 [8]	10.15 (2008) [8]
36	GDP per capita, current US$/constant US$	662/621 [6]	1267/680 [6]
	Underlying determinants of health		
37	What percentage of the rural and urban population has access to clean water?	32 rural 88 urban (2000) [6]	32 rural 88 urban (2006) [6]
38	What are the CO_2 emissions per capita?	0.4126 [4]	0.7 [6]
39	Prevalence rate of violence against women	Not available	67% [9]
40	Does state law require comprehensive sexual and reproductive health education during compulsory school years for boys & girls?	Not available	Not available
41	Proportion of 15- to 24-year-old boys and girls with comprehensive HIV and AIDS knowledge	Not available	Not available

* Data are from 2004 unless otherwise indicated. In all instances the data in this column attempt to be gathered five years prior to the data in the second column ** Data are from 2009 unless otherwise indicated
1 WDI Online – World Bank 2009 2 www.adb.org/PapuaNewGuinea/png-mdgs.asp 3 (World Bank, 2010e)
4 (Backman et al., 2008) 5 WHO Statistics, (WHOSIS 2009) 6 World Development Indicators, World Bank
7 http://milexdata.sipri.org/result.php4 8 Estimates of Revenue and Expenditure, Govt of PNG Budget 2005, 2009
9 National Dept of Health – planning workshop 2009

7.2.1 Analysis of unreliable data

One of the first general observations made from the information gathered in this questionnaire is that data are absent or vary from one source to another in several

of the fields. This in itself demonstrates one of the problems in the health sector in PNG, and elsewhere in the Pacific (Taylor, Bampton, & Lopez, 2005): there is a lack of reliable information. In PNG, systematic collection processes for information are not readily available to many of the people working remotely from the NDOH. It was only in 2008 that it became compulsory to enter all births and deaths into a central registry. Estimates of maternal mortality vary greatly because of these factors. The NDOH reports that the 2006 demographic household survey found a rate of 730 maternal deaths per 100,000 births, up from 370 in the previous demographic survey conducted 10 years earlier (PNG National Department of Health, 2009b). In contrast, a global report on maternal mortality reports that there has been a steady decline in maternal mortality, from 585 per 100,000 births in 1980 to 312 in 2008 (Hogan et al., 2010). The uncertainty interval in the Hogan study in 2008 was from 184 to 507, so the upper limit was still considerably lower than the statistic reported in the NDOH demographic household survey (730).

Unreliability of data is an acknowledged problem in PNG and it was referred to frequently at the national health planning workshops in 2009. One delegate commented:

> *How can we ask for what we want if we don't know what we need? We do not know what the provincial needs are because the NDOH does not collect data from the provinces.*
>
> To which another responded:
>
> *Actually we do have data, but it's disorganised.*

In the health training and health planning workshops, lack of data, or timeliness of data, was the third most frequently cited problem regarding improvement of the health sector, after too few staff, and poor management.

To minimize use of conflicting data, this research has used one source as much as possible – the World Bank World Development Indicators. The data were not always available for the same years in the same format, so as far as possible data were used that showed a five-year interval. Using the same source as much as possible also minimised differences in collection methodologies and definitions of terms.

These conflicting, varying and missing data provide programme planners with an immediate indication that new health programmes will need to establish or strengthen systems of gathering the information they need, because such systems are

unlikely to be in place, or if they are, they are not likely to be fully functional. The decentralization of health administration in PNG is often criticized, and especially so because of the poor flow of information and resources between the NDOH and the provinces, and vice versa, as the following comments made by delegates at the national health planning workshop attest.

> *Decentralization hasn't been working for 20 years; there are too many bosses as it is, and so information is not shared.*
>
> *It is a challenge for the department to take on the need for data management*
>
> *The medical board has no information, no data, no resources and no money.*

Therefore, in this research the data limitations are acknowledged, and used with caveats regarding reliability.

7.2.2 Population growth and poverty

The population growth rate in PNG has slowed a little in the past five years, but the population is still increasing at around two per cent annually, and 87 per cent of the 6.4 million people live in rural areas (United Nations Development Program, 2009). Therefore the greatest burden of ill health is found in rural areas, where access to health care is most compromised. The provision of primary health care in PNG, and particularly in rural areas, is through 'aid posts', but of the 2400 that have been established, it is estimated only between 50 and 70 per cent were operational by 2009 (Izard & Dugue, 2003; PNG National Department of Health, 2009b).

The percentage of people living in poverty has increased from a quarter of the population in 1996 to just on 40 per cent in 2005 (Asian Development Bank, 2009a). Health programme planners cannot disregard this trend, especially as access to clean water and sanitation had not improved in the 10 years to 2006 (PNG National Department of Health, 2009b). There are more people who are not having their right to the underlying determinants of health fulfilled.

In 2007 approximately 2.58 million people in PNG had an annual income below US$700. This is increasing by about 50,000 people per year. It follows that user fees for health care would present a barrier to the uptake of such services for very many people, especially the poor and rural dwellers. This view was supported in a

study which showed cost was the biggest barrier to accessing eye care services in PNG, for men and women, urban and rural dwellers (Williams et al., 2008).

The Human Development Report shows that on average PNG increased (improved) its Human Development Index by 0.98 per cent annually between 1980 and 2007. Measuring 0.541 in 2007 it still remains a long way behind the rest of the Pacific region, and is close to the levels of Sub-Suharan Africa (United Nations Development Program, 2009). This report also provides the Human Poverty Index (HPI-1), which measures severe deprivation in health by the proportion of people who are not expected to survive to age 40, the adult illiteracy rate, child malnourishment, and number of people not using an improved water source. PNG's HPI-1 value is 39.6 per cent, ranking it 121st out of the 135 countries for which the index has been calculated. This information is consistent with, and adequately reflected by, indicator 17: *percentage of people living in poverty (less than US$2 per day).*

7.2.3 Democracy and governance

Although PNG is a democracy in which women can vote and stand for Parliament, it has only one female MP, less than one per cent of MPs. This situation has remained the same for the past 10 years, with the only female MP being an Australian expatriate. PNG women have no visible place in politics. Furthermore, the constitution does not protect freedom of expression, although it does protect freedom of association.

The World Bank's Governance indicators serve the purpose of measuring the favourability of the environment for foreign investment, as well as for development assistance.

> The last 15 years have seen a veritable explosion of interest in the quality of 'governance' in the developing world. Driving this growth are people who variously seek to monitor conditions in and/or assess prospects for diverse developing countries in terms of local political stability, investor-friendliness, economic growth or effective market size, poverty reduction, respect for human rights and long term development (Arndt & Oman, 2006, p.13).

These governance indicators, which might be seen to be broader than those which pertain strictly to human and health rights, have been deliberately selected for inclusion in the questionnaire because the context which applies to foreign and private investment in a country applies no less to many aspects of establishing and

maintaining health services. For example, in the programme examined in the first case study in this research, legal entities had to be established, bank accounts opened, partnerships with government departments agreed upon and written into contracts, taxes paid, information provided to the public, and the PNG community needed to have safe access to the services. It is of little consequence in many respects whether an entity is established for profit seeking purposes, or for the advancement of the right to health; the governance context will have a similar impact on the ability of the entity to achieve its objectives.

Most recent governance indicators were compared with those calculated five years earlier, to reveal that improvements had been made with voice and accountability, the rule of law, regulatory quality, and a slight improvement was noted in political stability. However, with the exception of voice and accountability, each of the other measures of governance remained low, mainly in the bottom quartile, compared with other States. So although the trend is positive, the rule of law (at an 18.2 percentile ranking against other states) verifies that the country is lacking in both security and a responsive judicial system. This, combined with a worsening result for government effectiveness (from 26.5 to 20.4 percentile rankings) would signal to any partners in new health initiatives that contracts and memoranda of understanding with the public health sector would likely take a long time to negotiate and there would be little effective redress for breaches of contract.

The corruption index score and trend, worsening from 18.4 to 9.7 in the five years, would be of considerable concern to the development of health partnerships. It manifests itself in the health system in many ways, including through 'ghost' workers, that is, staff being paid who no longer work, (Hasfeldt et al., 2005, p.25) or through those who are significantly underperforming, and through the theft and re-sale of pharmaceuticals (AusAID, 2009a). This situation has a very real impact on the right to health, as it reduces the funding available to support the delivery of health care, and it also makes access to medicines far more problematic for the community, especially those people living in rural areas. In the review of the 10-year national health plan to 2009, the following observation was made:

> It is evident that medical supply to health facilities continues to worsen. The Ministerial Taskforce on Medical Supplies in 2008 identified a roadmap to improving supplies. This roadmap, while commenced in its implementation, has not achieved any major changes in supplies to facilities. The intended push (100% kits) system has

> not advanced past the planning stages and will not be implemented in 2009. Half the facilities in PNG at any one time are reporting inadequate supplies to meet the needs of the population (PNG National Department of Health, 2009b, p.10).

The gravity of this situation is recognised: "In the public health system, corruption adds to the dilemma. Critical shortages of drugs mean that people in rural areas die unnecessarily" (Talao, 2008, p.20).

Delegates at the National Health Planning workshops in 2009 referred to these problems with comments such as the following:

> *Systems are good but people are lacking morality, with poor work ethics and attitudes.*
>
> *There is bad governance and corruption throughout the health sector and you cannot have an effective health system without good governance, nor with corruption.*

Participants and delegates at workshops made the following observations and comments about issues of governance in PNG:

> *Good health is a constitutional right of the people and the government must deliver on this… (Minister of Health, PNG National Department of Health, 2009c)*
>
> *You need roads, bridges, education, banking and postal services, agriculture; you need policemen. We should not try to look just at the National Department of Health and ourselves, we need a lot more from other people to assist us in our programmes. Politicians need to stop sending their own people to Australia. Rather they must realize they need to fix our own system. Our systems are not working.*
>
> *We need to build management capacity. This has come through all our presentations; poor financial management, lack of accountability, absenteeism, corruption, low morale. The causes are low salaries and decentralization and how it contributes to the lack of accountability. We need to decide how to promote ethical behaviour, and what makes a good manager.*
>
> *The thing is you have to be careful when comparing private and government sectors; in the private sector, you measure success with cash – the input is the*

> *same – cash; public sector, the output is services; for this to happen, you need to have people who have values, otherwise it is difficult to see improvement; that's why we have this level of corruption – why not sell to the black market? There is no sense of national responsibility; the public sector needs discipline, punctuality. Can the public sector do well? Of course it can, but it all depends on planning and training.*

The lack of leadership and management throughout PNG, and in the health sector, is frequently commented upon in official reports and in public meetings.

> Improved leadership and management is one of the keys to solving many problems in the health system. There are obvious signs of lack of leadership and management skills at all levels, which translate into lack of control, accountability, teamwork, commitment, focus, etc. This has been recognized as a major challenge in the Strategic Plan (2006-2008), which makes it a condition that NDOH Directors and Provincial Health Advisers shall successfully complete an accredited leadership and management programme… Unless there is a commitment to address the issue of incompetent leaders… the overall result will not change much. … One can have the best policies, plans, strategies, structures and systems, but if the right people are not in place poor performance will continue. (Hasfeldt et al., 2005, p.23)

Commentators blame government ineffectiveness for failed aid programmes. Although contracts are signed readily between donor partners, including NGOs, and ministers of the Crown, there is little translation into the government fulfilling its contractual obligations.

> Donors can never fully compensate for the absence of an effective government with an appropriate budgeting and planning process. Most of the recurring problems of aid in PNG have their origin in breakdowns in these governmental functions. Thus, for example, the common failure to sustain projects after the end of donor resources is typically due to the failure to budget for recurrent expenditures in advance. Similarly the failure of aid coordination, leading to overlapping, contradictory, and redundant aid activities, is typically a consequence of the failure of the Government to integrate these activities within coherent national development budgeting and planning exercises (Hnanguie, 2003, p.4).

External commentators frequently cite corruption and government ineffectiveness as the fundamental problems that limit development in PNG.

> In the absence of secure private property rights and a significant private sector, political representation and the public service not only became the principal means of influence and power, but also of accumulating material wealth…. Leadership committed to stamping out corruption has been critical for the remarkable growth and development success of countries as different as Botswana and Singapore. Changing its moral standards is not an option for Papua New Guinea, but a necessity if it is to survive, let alone develop (Hughes, 2004, p.4).

The data collated from indicators 23-28 in the questionnaire reflect these observations made about governance in PNG in primary and secondary sources.

7.2.4 Protection against discrimination

The PNG Constitution provides treaty-based protection for the population on the grounds of sex, ethnicity, religion, national origin and political status, and non-treaty based protection for people who live in rural areas. However, there is no protection afforded to people on the grounds of their health, including HIV/AIDS status, nor for age, language, disability, socioeconomic status or civil status, or sexual orientation. By late 2009 there had been no reported judicial cases brought on the basis of discrimination by health status, but people with HIV/AIDS were anecdotally "…slowly reporting refusals of treatment. This is, however, prohibited under the HIV/AIDS Management and Prevention Act 2003" (Talao, 2008, p.21).

As noted in the previous chapter, there appear to have been no judicial cases on the right to health in PNG over the past five years. However, with ratification of the ICESCR in 2008, and with the increase in awareness of human rights in PNG through the Ombudsman Commission, this situation could well change.

7.2.5 National financing

PNG continues to spend less on health than is considered the minimum to provide a functional health system. In 2000 the per capita spend on health in PNG was US$26, and this had only increased to US$29 by 2006. This remains considerably lower than the US$50 per capita which WHO cited as being a minimum for an effective health system (World Health Organization, 2000). Furthermore, the proportion of GDP spent on health fell from 4.3 per cent in 2002 to 3.2 per cent in 2007. This confirms that health's priority within government budget allocations declined in that period even though the constant dollar GDP per capita increased from

US$621 to US$680. So while the economy generally was improving in PNG, a smaller percentage of government revenue was being directed towards health. Over twice as much was spent on servicing debt than on providing health care (WDI-World Bank data). Indicators 32-37 capture this information.

The retrogressive trend in maternal mortality at a time when the economy was improving is a situation that the Committee on the ICESCR would take seriously.

7.2.6 Underlying determinants of health

Lack of data is problematic when assessing the underlying determinants of health in PNG. Access to clean water did not improve between 2000 and 2006, with a ready source of clean water being available to less than one third of rural dwellers. The Health Sector Review stated that diarrhoea-related illnesses remain common with safe drinking water still not widely available (PNG National Department of Health, 2009b). Only 92 per cent of hospitals had a water supply in 2008, slightly down on 93 per cent in 2003 (PNG National Department of Health, 2009b, p.20).

The indicator about the CO_2 emissions per capita is not particularly relevant to PNG as air pollution is not an environmental concern. However, the environmental impact of mining and logging is well documented in PNG and poses serious public health, occupational health, and livelihood concerns to the people living and working in mining and logging regions (Greenpeace International, 2008; McKinnon, 2002). It was reported at the National Health Planning Workshop that the NDOH has been unable to develop effective policy or environmental impact monitoring processes because the environmental health division of NDOH is not prioritized, funded or staffed adequately. The questionnaire needs to elicit information about the State's commitment to reduce any environmental health hazards, rather than just air pollution. Therefore, a change in this indicator to one that seeks evidence of environmental impact assessment policy and practice will be considered with the case study.

Data for other indicators could not be adequately sourced over five-year time frames. The prevalence rate of violence against women was quoted as 67 per cent at the National Health Planning Workshop in 2009, but no data are available from earlier periods. It is well documented that violence against women is rife, and there is little help available to these women (Human Rights Watch, 2009). NDOH statistics state

that 251 women died as a result of domestic violence in 2008, and that the number of deaths continues to increase (Public Health Division NDOH PNG, 2009).

The questionnaire will be amended to seek reports on violence against women, rather than necessarily providing a prevalence rate, so that information can be used even if it is a qualitative measure.

The questionnaire did not seek information about sanitation, yet this is known to be a health issue in PNG. The Health Sector Review referred to data from 1996 that stated: "most of the population (73 per cent) used pit latrine toilets, with almost all of these being traditional pit latrines. Flush toilets (mostly private, but some shared) are used by a minimal 9 per cent of the population, and most of these will be accessible only to urban dwellers" (PNG National Department of Health, 2009b, p.64). Furthermore, about 14 per cent of the population use the bush or seashore. The number of people living without a sanitation system in urban settlements is also considered to be a significant public health issue.

Maternal health workers speaking at planning workshops described the difficulty created by having pit latrines for sanitation at health centres. One delegate said babies had died from being delivered accidentally into a pit when the mother needed to use the pit during labour. Therefore a question about sanitation would be a valuable indicator to add to the second questionnaire.

Just because data are not available to put a value on some indicators does not mean the indicator is inappropriate. For example, indicators about education on HIV/AIDS in PNG could not be answered because this information is not collected in PNG. It is useful to know the information is not collected, as HIV/AIDS is a significant health problem in PNG, with estimates of up to 2 per cent of the population being HIV positive (Cullen, 2006). Education of young people should be an important strategy to prevent HIV prevalence increasing even more. That the information is not collected is therefore an indicator that appropriate measures to prevent the spread of HIV are not being implemented, which is a failure to protect people's right to health.

Another indicator of underlying determinants of health, which was referred to at the National Health Planning Workshop, is nutrition and especially child nutrition. PNG had an objective in the 2001-2010 National Health Plan to reduce child malnutrition from 43 to 21 per cent, but data were not available to verify whether the objective was achieved. Given that access to adequate nutrition is referred to as one of

the underlying determinants of health in General Comment 14, and is therefore a core obligation that States must progressively realise, data on this should be included in the questionnaire. Measurement of malnutrition in childhood has been selected as the indicator because it is more likely to be measured than overall nutritional status, and childhood malnutrition has implications for education and learning, and adult health.

7.3 Application of Questionnaire 2 to the case study

The questionnaire is applied to the same case study of an eye health programme in PNG, as used in the previous chapter (Chapter 6, Annex). Once again, each of the barriers to improved programme success was examined to assess whether this problem could have been predicted by the information generated from the indicators in the second questionnaire. The results are included in Tables 6-5 and 6-6, in Chapter 6, Annex.

7.3.1 Does Questionnaire 2 provide a useful context?

This questionnaire captures much of the information all programmes need to design an appropriate intervention. This includes such basic information as population size and its demographic division between rural and urban areas, and a measure of poverty in the country. Irrespective of whether a programme is being designed from a rights-base perspective or not, this information is essential.

The trends that are discernable through collection of these data over a five-year period are particularly important because at this national level it starts becoming possible to assess the State's commitment to fulfilling its rights obligations. Therefore, new programme partners entering into PNG can see from this questionnaire that the percentage of people living in poverty has risen considerably in the latest five-year period, government effectiveness has weakened, corruption is twice as rife as five years earlier, and less is being spent on health by the State. The State continues to spend less in health than that considered necessary to provide a functioning health system. Underlying determinants of health have failed to improve, although the data in the original questionnaire did not provide comprehensive information on all those issues. The governance indicators signal an administration that would pay little heed to contracts and does little to operationalise rights treaties to protect vulnerable populations.

Therefore, in the design stage of a new health programme, this questionnaire flags that sustainability of the initiative will be challenging as the State is decreasing, not increasing, its expenditure on health, and is comparatively ineffective and corrupt. The population itself is unlikely to be able to cover health care costs, and increasing numbers of people each year are entering into poverty. A new health initiative must be designed with an understanding of these issues because a programme has little chance of sustaining a quality, accessible service, especially for those who are living in poverty in rural areas, without finding solutions to these barriers to health care.

7.3.2 Could Questionnaire 2 have prevented programme failings?

This second questionnaire in Tool 1 made considerable inroads into collecting data that could have prevented some of the programme's failures to meet its targets (Tables 6-5, 6-6). Of the 27 indicators (numbered from 14 to 41) nine are identified as providing information that could have helped avoid some of the programme failures. Those nine indicators, plus a further three (numbered 27, 39 and 41) are also considered to have 'possibly' been of use in preventing the disappointing results.

Indicators most consistently useful in the national context are those measuring governance and the State's financial commitments to health. The governance indicators do more than just suggest the quality of governance is lower in PNG than in similar economic climates. They demonstrate trends that are alarming, and, when considered alongside other indicators, such as violence against women, lack of knowledge about HIV/AIDS, and falling State expenditure on health, paint a picture of an extremely difficult environment for meeting the population's right to health. The poor governance indicators will almost certainly be reflected in a poorly led and managed public service, with a strong likelihood of contractual obligations by the public health sector not being honoured.

All six of the objectives in the eye health programme in the case study required the involvement of the public health sector and the health-training sector. The partnerships between the NGO and the public sector covered delivery of clinical services by health workers employed by the public sector; education of doctors and nurses through public sector entities and their staff; and planning future health services in conjunction with the health workers and National Department of Health. All of these objectives were at risk from the very start of the programme of not

meeting targets because of poor governance in a financially constrained context. Had greater attention been given to this information at programme design stage, alternative arrangements may have been structured into the programme to better reflect and accommodate these local realities. However, this questionnaire still does not provide all the information to explain all the programme's failings.

7.3.3 Additional and changed indicators

The primary and secondary sources of information on the national rights context in PNG generally showed reasonable agreement with the indicators in the second questionnaire. There were some additional questions proposed to gain a better understanding of the State's commitment and capacity to progressively improve the underlying determinants of health. These include measures of improved sanitation, environmental impact reporting, and childhood nutrition. All three of these are proxies for the State's commitment to protecting the health of the population.

Two changes were also considered for this questionnaire. Firstly, it was considered that CO_2 emissions per capita were less relevant in PNG than environmental degradation from mining and logging. An indicator about environment impact assessment would better reflect the State's commitment to protecting the community's health. Secondly, it is difficult to collate statistical data on violence against women even when it is well known such violence is widespread and results in many deaths. Therefore, again it is important to use these data to assess the State's health rights duties, so the question has been changed to ask whether reports on violence against women are documented. These two changes would have further enhanced the programme design by signalling that the State has failed to act on compelling evidence over the past 20 years that health rights pertaining to these issues are not being respected, protected or fulfilled.

After consideration of primary and secondary sources of information, and application of the questionnaire to the PNG case study, Questionnaire 2 has been refined in the following ways:

Additions:

1. *What percentage of the rural and urban population has access to approved sanitation systems?*
2. *Are environmental impact assessments made available for public viewing?*

3. *Is measurement of childhood nutrition conducted in both rural and urban areas?*

Changes:

- Indicator 38 to change to: *Does the State have legislation requiring environmental impact assessment to be conducted on all industrial developments?*
- Indicator 39 to change to: *Has violence against women been documented?*

7.4 Conclusion

Questionnaire 2 in the first tool further contributes to a thorough understanding of the local context and within that the State's commitment and capacity to fulfil its human and health rights. It extends an understanding of local context from an overview of the State's ratification of various treaties and other international commitments to deeper insight into the State's capacity and willingness to deliver on these obligations. It gathers basic demographic and political data, economic and governance performance, and examines the underlying determinants of health. These are included in Questionnaire 2 rather than Questionnaire 3 (health system assessment), because management of the underlying determinants is frequently under the purview of other state departments. For example, departments of works or environment usually manage water and sanitation. However, it is imperative that the framework considers these non-health care factors because they carry rights obligations for the State.

> … 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 (United Nations, 2000b, para 4).

On completion of the first two questionnaires, a comprehensive understanding of realities that will impact on the delivery of a health programme has been established. However, there are still failings and problems evident in the PNG case study that these two questionnaires alone would not have predicted.

The third questionnaire, which is an assessment of the health system, is explored in the following chapter to assess its role in completing a sufficiently

detailed picture of PNG to provide the basis on which a rights-based design of the programme itself can then begin.

Chapter 8 Health system capacity to fulfil the right to health

8.1 Introduction

Examination of the international and national rights context in PNG contributed a good but incomplete picture of the local situation within which a new health programme would be located. Much more information is needed to design a programme that is capable of meeting its objectives and sustaining its service.

In this chapter, the PNG health system itself is explored. The final questionnaire in Tool One examines the health system from a rights-based perspective. Once again, information from primary and secondary sources is examined to look for concurrence between the questionnaire and other sources. The questionnaire is then examined to assess whether its early use could have prevented failings in the case study programme.

The information gathered through this questionnaire is critical for a rights-based programme design because the health system is the core institution through which the right to health is fulfilled. A thorough understanding of the health system is essential to design new programmes in ways that integrate the programme into the system and strengthen the system in this process.

8.2 Conducting a rights-based assessment of the health system in PNG

Questionnaire 3 of this rights-based design framework employs the WHO six building blocks view of a health system (World Health Organization, 2007). Within each of these blocks (health services, health workforce, health information system, medical products, health financing, governance), information is sought to assess the strength or weakness of that aspect of the health system. As in the two previous questionnaires, this information is collected over two time periods, five years apart, to provide a picture of trends in the health system. Because the health system is the core institute for health rights fulfilment, it is particularly important that progressive realisation of the State's core obligations can be demonstrated within it. It is through capture of data over a period of time that progression or retrogression can be

demonstrated. The questionnaire is populated with data from PNG and is presented in Table 8-1 below.

Table 8-1 Questionnaire 3: health system assessment

	Core obligation measures	**2004**	**2009**
42	Life expectancy at birth	60 [1]	61 (2008) [1]
43	Maternal mortality rate (per 100,000 births)	300[2]	730 (2006) [2]
44	Infant mortality rate (per 1000 lives births)	68.4[1]	53 (2008) [1]
45	Percentage of births attended by skilled health personnel	38 [2]	39 (2008) [2]
46	HIV prevalence (% of population 15-49 years)	0.6 [1]	1.5 (2008) [1]
	1 Health services		
47	Proportion of women with a live birth in the last 5 years who, during their last pregnancy, were seen at least 3 times by a health-care professional, had BP checked, blood taken, and were informed of signs of complications	Not available	Not available
48	Number of primary care facilities in health system per 10,000 population	Not available	2672 aid posts = 4.14/10,000
	- urban /rural distribution		Not available
	- percentage functional		50-70% open [2]
49	Percentage of primary care facilities that are adequately equipped with water, phone, power, refrigeration	Water 93% Phone/radio 68% Power 64% Refrigeration 90% [2]	Water 92% Phone/radio 82% Power 63% Refrigeration 82% [2]
50	Availability of updated clinical standards for MOH priority areas, high burden diseases areas, and/or areas responsible for high morbidity and mortality	Unknown	Unknown
51	Number of hospital beds (per 10,000 population)	7740 total = 13.57/10,000 [2]	6412 total = 9.94 / 10,000 [2]
52	Number of obstetric beds (per 10,000 population)	1362 = 2.38 / 10,000 [2]	1709 = 2.64 / 10,000 [2]
53	Percentage of births supervised in health centre or hospital	38% (2004) [2]	39% (2008) [2]
54	DTP3 immunization coverage: one-year-olds immunized with three doses of diphtheria, tetanus toxoid and pertussis (%)	46% [3] - 62% [2]	61% [2] (2008)
55	Number of MOH vertical programs (ie, those that focus on specific interventions, funded by donor organizations)	unknown	unknown
56	Are there national policies for promoting quality of all health care services	No	No
57	Are all clinical standards documented as guidelines or manuals and used by health care providers?	No	No
58	Are district level health centres visited by clinical supervisors?	48% visited (2004) [2]	54% visited (2008) [2]
59	Presence of official mechanisms to ensure the active engagement of civil society and the community in planning and monitoring service delivery	None	None
60	Existence of official mechanism for eliciting population priorities, perceptions of quality, and barriers to seeking care	None	None
61	Is patient feedback on their experience within the health service regularly sought?	No	No
	2 Health workforce		
62	Does the state have a national health workforce strategy?	No	In process
63	The ratio and density of doctors to the population	0.05 [3]	0.05 [3]
64	The ratio and density of nurses to the population	0.53 [3]	n/a

65	Ratio of current health care professionals to estimated need for a health workforce	1:5 (2000) [3]	1:5.1 (2008) [3]
66	Are health workers employed in a transparent process and given job descriptions?	No	No
67	Is there a formal mechanism for individual performance planning and review?	No	Yes
68	Does the State law include provision for adequate remuneration for health care professionals?	No	No
69	Do the State's workforce policies or programmes include a plan for national self-sufficiency for health care workers?	No	No
70	Do the State's workforce policies or programmes provide incentives to promote stationing in rural areas?	No	No
71	Are human rights a compulsory part of the curriculum for the training of doctors?	No	No
72	Are human rights a compulsory part of the curriculum for the training of nurses?	No	No
	3 Health information system		
73	Does the State law protect the right to seek, receive, and disseminate information?	No	No
74	Does the State law require registration of births and deaths?	No	Yes
75	Does the State have a civil registration system?	No	Yes
76	Does the State disaggregate data in the civil registration system on grounds of: sex, ethnic origin, rural or urban residence, socioeconomic status, or age?	No	No
77	What proportion of births is registered?	-	unknown
78	Does the State regularly collect data, throughout the nation, for the number of maternal deaths?	Hospital deaths only	Yes
79	Does the State make publicly available these data for the number of cases of maternal deaths?	Yes	Yes
80	Does the State regularly collect data, throughout the nation, for the number of neonatal deaths?	No	Yes
81	Does the State regularly collect data, throughout the nation, for the number of deaths in children under 5 years?	No	Yes
82	How current is the official maternal mortality rate?	8 years old [2]	4 years old [2]
83	What variance is there between highest and lowest reported maternal mortality rates?	Variance = 391 /100,000 births Range 212-603, [2,4]	Variance = 550/100,000 births Range 180-730 [2,4]
84	Are data on children under 5 years who are underweight for age collected?	Yes – from clinics	Yes -— from clinics
85	Are sufficient financial resources available to support HIS?	No	No [5]
86	Is sufficient international donor support available for strengthening HIS centrally and provincially?	No	No [5]
87	Do policies and regulations mandate public and private health providers to report determined indicators?	No	No
88	Is there a current and annual national summary report of all HIS data?	Yes	Yes
89	Does the state law require protection of confidentiality of personal health data?	Yes	Yes [2]
	4 Medical products, vaccines and technologies		
90	Is access to essential medicines or technologies, as part of the fulfillment of the right to health, recognised in the constitution or national legislation?	No	No

91	Is there a published national medicines policy?	Yes	Yes
92	Is there an active national committee responsible for maintaining a national medicines list?	No	No
93	Is there a published national list of essential medicines?	Yes	Yes
94	What is the average availability of selected essential medicines in public health facilities?	n/a	<50% [2]
95	State expenditure on pharmaceuticals (per capita) in US$	n/a	US$4.50 (2009) [5]
96	Private expenditure on pharmaceuticals (per capita) in US$	n/a	n/a
97	Percentage of 1-year-old children immunised against measles	50% (2004) [2]	61% (2008) [2]
98	Percentage of 1-year-old children immunised against diphtheria, tetanus, and pertussis	61% (2004) [2]	60% (2008) [2]
99	Value of inventory loss (as % of average inventory value) over 12 months	n/a	Estimated at not less than 33% [5]
	5 National financing (additional financing indicators were included in Questionnaire 2)		
100	What is the proportion of households with catastrophic health expenditures?	Not available	Not available
101	Proportion of national health budget allocated to mental health	<1%	<1% [5]
102	Are user fees charged in the public health facilities?	Yes	Yes
103	Are there policies to protect disadvantaged groups from paying user fees?	Yes	Yes
	6 Governance and leadership (additional governance indicators were included in Questionnaires 1 & 2)		
104	Does the State have a patients' rights charter?	No	No
105	Does the State have a comprehensive national health plan encompassing public and private sectors?	Yes	Yes
106	Has the State undertaken a comprehensive national situational analysis?	Yes	Yes
107	Before adopting its national health plan, did the State undertake a health impact assessment?	No	No
108	Before adopting its national health plan, did the State undertake any impact assessment explicitly including the right to health?	No	No
109	Does the State's national health plan explicitly recognise the right to health?	Yes [6]	Yes [6]
110	Does the State's national health plan include explicit commitment to universal access to health services?	Yes [6]	Yes [6]
111	Does the State law require informed consent to treatment and other health interventions?	No	No
112	Is there a legal requirement for participation with marginalised groups in developing the national health plan?	No	No

1 World Bank WDI; 2 Health Sector Review 2009; 3 WHO World Health Report 2006; 4 Hogan et al 2010;
5 Presentations at National Health Planning Workshops; 6 National Health Plan 2000-2009; n/a = not available

8.3 Questionnaire 3 requires qualitative and quantitative information

Unlike in the two previous questionnaires, information for Questionnaire 3 was sourced from official documents and sources and from local experts. For example, indicators such as: *Are sufficient financial resources available to support HIS* cannot be answered from official sources as the data are not officially documented. However, people working within the NDOH and in provincial levels repeatedly comment that data are not available to measure health inputs and outputs. For example, the health workers training workshop was advised that the medical practitioners registration system had no funding to collect or monitor information regarding the number of doctors registered and/or practicing in PNG. It is important for programme planners to understand the information they need may not be available, and even if available, it is unreliable. Therefore, the more that planning is driven by people who understand the local context, the greater the likelihood programmes will be based on information that reflects the local actualities. This approach reflects the human rights concepts of participation and non-discrimination.

8.3.1 Does Questionnaire 3 provide relevant information?

The indicators in the health system questionnaire generate information to further confirm that there is little progression in realizing health rights in PNG. Few improvements are noted over the five-year period, and some indicators have deteriorated considerably, especially maternal mortality. As discussed in Chapter 7, Section 7.2.1, much of the data, and especially maternal mortality, should be viewed with caution, as data collection is not consistent, reliable or comparable from one source to another.

It is necessary to gain a thorough understanding of the strengths and weaknesses of the health system to design a health programme that is not dependent upon a facet of service that does not exist, despite appearing to be in place. Furthermore, the new programme must be careful not to deplete an already compromised health system, further diminishing its ability to meet the health rights of the people.

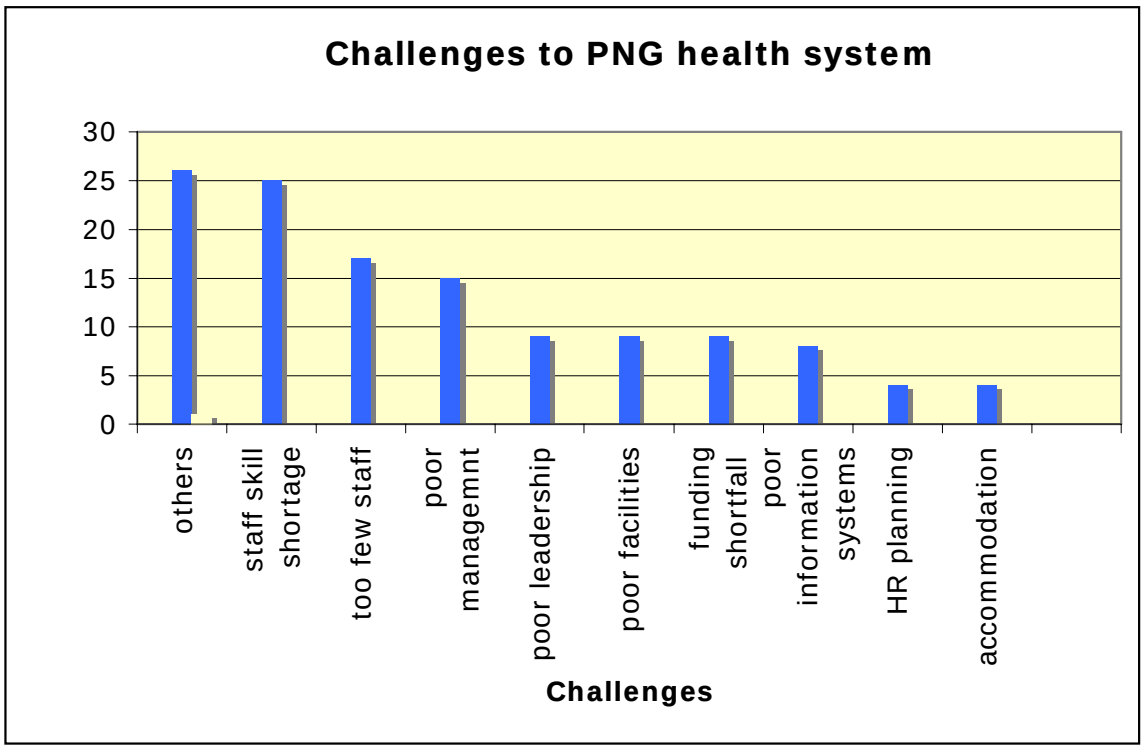
Primary and secondary sources are used to check that the indicators capture the key features of the health system. These sources are also able to verify whether the information collated from the questionnaire is consistent with how the health system is experienced by health workers, administrators and the community.

8.3.2 Strengths and weaknesses of the health system

At a national health planning workshop in 2009 (Planning Workshop PNG, 2009), participants from divisions of the health sector completed templates detailing achievements and challenges in meeting programme objectives as they had been drawn up in 2000. A total of 31 different divisions within the health system provided written reports listing these challenges. These are not presented here as a systematic representation of all blocks of the health system; rather they were the written comments from health workers who attended this one-day planning workshop. The health workers represented curative health, family health, oral and mental health, disease control, environmental health, health promotion, and health financing. From these templates, it was possible to categorize the challenges and reveal the major obstacles these people experienced in meetings their divisions' set objectives. This analysis is presented below in Figure 8-1.

The health divisions' objectives were fully achieved in a minority of health divisions, less than one-third of those reporting. Part achievement was noted in about half of the reports, and non-achievement in the remainder. At least two health divisions noted that they could not adequately report because the data were not collected or analysed.

Figure 8-1 Challenges in the PNG health system



Source: National Health Planning Workshop, 2009

Of 126 references to challenges, 42 (33 per cent) referred to staffing issues, either not being adequately trained (25) or having too few staff employed (17). Poor management and poor leadership comprised 24 responses (19 per cent), and inadequate infrastructure, nine responses (7 per cent). Making up the 'other' reasons were 15 separate challenges including, security, poor roads, community awareness, language differences, gender, lack of advocacy, poor clinical services and low staff morale (Planning Workshop PNG, 2009). This analysis is consistent with spoken comments throughout two workshops (National Health Planning and Health Workers Training Forum 2009), where the six most frequently mentioned difficulties in meeting health service objectives were, in descending order: too few staff, poor management, poor health information systems, not enough funding, poor facilities, and poor governance or corruption. The specific challenges reported to be facing the SWAp included: the staffing and institutional capacity at all levels of the health system for implementation of services; insufficient capacity to move funds to provinces and facility levels; confusion in roles and responsibilities of players; and no coherence and synchronization of policies, strategies, planning, budgeting, management, reporting and monitoring (PNG National Department of Health, 2009a).

A desk review of all PNG health sector and annual sector reports (Whittaker & Kitau, 2009) found that significant progress had been made increasing access to services for malaria prevention and treatment, TB diagnosis and treatment, HIV counselling, treatment and care, STI diagnosis and treatment, and immunisation services for children. However, progress had not been made for maternal and neonatal health. It noted that even when progress had been made, the accessibility and acceptability of these services had often not improved at the same pace as the quantitative scaling up, leading to less than anticipated improvements in disease burden. The review stated that "many sensible recommendations and strategies have arisen from these reviews, usually universally endorsed, but pace of implementation of the recommendations is often sub-optimal, even if resourced" (Whittaker & Kitau, 2009, slide 11). It drew attention to the role of other sectors, especially the Department of Personnel Management, Department of Finance and Treasury, and National Planning in enabling or hindering health sector reform.

In addition to increased delivery of some services, improvements in the health system were identified as: some key policy documents, including minimum standards for district health services, were produced; increased use of health costing and economic data to inform policy and planning; and development of the SWAp, the medium term expenditure framework and the resourcing framework for the health sector.

This research has taken the specific barriers to health system strengthening identified in the desk review, and categorised each barrier into one of the six building blocks of the health system (Table 8-2). This information is then used to examine the indicators in Questionnaire 3, to determine how many of the listed barriers would have been picked up in the process of completing the questionnaire. There were 42 barriers identified in the desk review. Indicators from Questionnaire 3 identified 29 of these. Of the 13 problems not identified by specific indicators, six were from within the national financing building block of the health system.

8.3.3 Key issues not captured in Questionnaire 3

The list of cited barriers to better health system performance is matched against indicators from Questionnaire 3 in Table 8-2. This analysis identifies gaps in

the questionnaire, which would have resulted in several barriers to improved health services not being identified by the questionnaire. These include:

- The need for funding for accessible diagnostic services
- Poor quality medical supplies
- Poor pharmaco-vigilance systems
- Poor funding flows to operational levels
- Poor payroll management
- Lack of absorptive capacity to use health funds
- Lack of HR capacity for management systems and processes
- Lack of financial data for planning and management
- Poor ratio of development funding versus recurrent funding
- Focus on policy development rather than implementation
- Limited management capacity
- Lack of governance at provincial and hospital board level.

Table 8-2 Challenges listed in desk review of PNG health system

1 Health services	Captured in questionnaires by indicator number
The need to increase the quality and quantity of clinical capacity	48, 49, 51, 52, 53, 54, 57, 58, 60
Need for appropriate locating and resourcing of laboratory and other diagnostic services	No
Need for improved clinical competency of various cadres of health staff	58
Need to update and make accessible standard treatment guidelines and standards to guide clinical pre-service and in-service training	50, 56, 57, 58, 60
Need to strengthen quality assurance and accreditation processes	50, 56, 57, 58
2 Health workforce	
Inadequacies in pre-service training capacity (quality, coverage, currency)	65, 69
Inadequacies in in-service training (quality and quantity)	65, 69
Supervision – inadequate quality, frequency, resourcing and follow-up	67
Concerns about the ability to increase or support retention and recruitment	62, 63, 64, 65, 69
Limited capacity to manage all aspects of human resources for health management	67
3 Health information system	
Concerns about the quality and timeliness of data	82, 83
Processes and capacity to manage health and management information systems neglected	85, 86
Need for data at various levels and especially its link to public health continually raised through reviews	73-89
The need for adequate harmonized M&E frameworks is a regular theme	86, 87
Lack of capacity at various levels to undertake monitoring and particularly evaluation	85, 86
Lack of supplementary monitoring and evaluation processes additional to the routine data collection such as sentinel surveillance, targeted surveys and qualitative studies	85, 86
Inadequate resources – human, infrastructure, financial and capacity development	6, 32, 85, 86
Need for M&E plan to provide minimum data set for public health action	85, 87
4 Medical products, vaccines and technologies	
Woeful state of medical supplies and logistics management	94, 99
Inadequate financing of medical supply procurement and distribution	94, 95
Partnerships with non-state actors have improved medicine systems	No
Poor quality of medical supplies	No
Poor pharmaco-vigilance systems	No
5 National financing	
Inadequate government funding to health	6, 32,
Poor fund flows to operational levels	No
Poor payroll management	No
Poor funds management	27
Poor budgeting	24
Activities not prioritized and therefore not funded	105, 106, 107
Lack of absorptive capacity (to use funds)	No
Lack of human resource capacity for management systems and processes	No
Poor transparency, accountability and corruption	27
Lack of financial data for planning and management	No
Poor ratio of development vs recurrent funding	No
Development partner funding substituting government funding	35
6 Governance and leadership	
Limited capacity for policies to influence practice or resource allocations	107, 108
Focus on policy development rather than implementation	No
Limited capacity to prioritizing plans, budgeting, using data to inform plans, or for M&E	No
Need to improve use, management and regulation of non state actors to support health sector programmes	55
Little improvement noted in hospital boards' ability to meet responsibilities	59, 60, 61
Lack of governance at provincial health and hospital board level	No
No strategy to involve community through participation	59, 60, 61,112

It is not expected that a health systems questionnaire will be able to predict every possible condition that contributes to a programme failure. However, if there is consistency across different programme areas or health divisions about the specific difficulties within the health system that fail to fulfil health rights, it is important that there are at least proxies within the questionnaire that would alert programme designers to those weaknesses.

8.3.4 Specific challenges identified by local experts

The NGO that was the programme partner in the first case study held a workshop in PNG in 2006 as part of a consultation process. The aim of the workshop was to have the participation of local health workers in the design of the next stage of its eye health programme. The participants were asked to identify and categorise the reasons that over 44,000 people in PNG were cataract blind, and nearly 200,000 visually impaired with refractive error (Garap, Sheeladevi, Brian et al., 2006; Garap, Sheeladevi, Shamanna et al., 2006). Both these conditions are readily treated if patients are able to access a quality service. Once all the reasons proffered were listed, the participants were then divided into groups according to their role within the sector (administrators, doctors or nurses) and asked to rank the reasons using a priority ranking score system. Average scores across the group were calculated, and the highest score a barrier could achieve was 12, identifying it as the top reason eye health was not available or accessed. The results are in Table 8-3.

The greatest barrier to eye health care availability for people in PNG was identified as eye nurses not being given recognition for their specialist status, followed by too few eye nurses, equipment not functioning and lack of leadership within the eye health sector. The next two most highly ranked reasons were that eye health was not a health priority and that there were too few positions for trained eye nurses.

Table 8-3 Barriers to eye health care in PNG ranked by health workers

	Priority Ranking Scores			Total	Ranking	Indicators
Specific barriers within each block of the health system	Health admin	Eye doctors	Eye nurses			
Health services						
access to service is difficult	11	10	9	30		48, 51
remoteness	12	10	7	29		48, 51, 63, 64
lack of beds or eye wards	12	11	6	29		51
no minimum standards	8	11	8	27		56, 57
limited no of patients allowed	5	7	10	22		-
hospitals don't support eyes	12	9		21		-
fear of hospitals and doctors	3	9	6	18		104, 111
no minimum equipment policies	7	1	9	17		56
bad experience with eye care	3	6	6	15		60, 61
Health workforce						
no recognition for eye nurses	12	12	11	35	1st	62
lack of nurses	12	12	10	34	2nd	64
lack of positions for eye nurses	12	12	9	33	5th	62
eye nurses not used effectively	12	7	9	28		67
lack of HR for outreach	3	12	10	25		65
lack of funding for eye doctors	3	12	8	23		32
HR plans not made	10		11	21		62
lack of training	9		6	15		-
Health information system						
lack of statistics / information	10	9	9	28		85, 87, 88
lack of awareness of service	3	11	6	20		59
fatalistic, accepting blindness	4	9	6	19		-
old people not helped to attend	0	12	6	18		-
Medical products						
lack of consumables	12	9	9	30		-
equipment not functioning	12	11	11	34	2nd	-
instruments not replaced	12	11	9	32		-
lack of equipment	11	11	9	31		-
Health finance						
costs of surgery too high	12	9	11	32		102
lack of funding for outreach	6	11	10	27		6, 32
lack of affordable spectacles	3	11	12	26		102
Governance						
lack of leadership	12	12	10	34	2nd	23, 24, 25, 27
eye care not a priority	12	11	10	33	5th	-
Eye care not in SWAP, MDGs	12	10	10	32		-
lack of an eye care plan	7	11	11	29		62, 105, 106, 107, 108

Source of original data: The Fred Hollows Foundation NZ

These barriers are categorised in Table 8-3 according to which aspect of the health system they pertain. For example, ‘too few nurses’ is a health workforce issue, and ‘lack of an eye care plan’ is a governance and leadership issue. Each barrier is then examined to determine whether any of the indicators in Questionnaire 3 would have forewarned of this problem. Of the 32 problems listed in this table, 11 were not specifically identified by the questionnaire. The medical products building block of the health system had the least number of problems identified.

8.3.5 Key issues not captured in Questionnaire 3

The reasons offered by eye health workers as to why eye health care was not more widely available and accessible to the community that were not captured by Questionnaire 3 were:

- equipment not functioning
- surgical instruments not replaced
- lack of equipment
- lack of consumables
- lack of training
- limited number of patients allowed
- hospitals not responding to requests from eye health workers
- fatalistic acceptance of blindness by the community
- lack of awareness of service
- younger people discouraging older people from attending
- eye care is not a priority
- SWAp and MDGs overlook eye care

The common factors between this list and the challenges to improved health care identified in Table 8-2 fall into three main categories: medicine and equipment supplies and maintenance; lack of management and financial management capacity; poor awareness in the community.

As services cannot be provided without essential equipment, this is a vital aspect of the availability of health care. For this reason, a question querying the availability of equipment is included in the additional indicators list.

Measurement of management capacity is difficult, although comments on this and the lack of training for management, especially at provincial level, are made

frequently in PNG. Poor financial management is also cited as the reason for the sporadic and disorganised funding flows from the NDOH through to provincial health authorities and hospitals. Indicator 68 asks whether there is a formal mechanism for individual performance, and because there is such a mechanism in PNG, it should capture some of these failings. However, in practice, the process does not take place, and poor management of the health sector is not addressed. Therefore, another question is needed so that health programmes can be designed with the knowledge that reliance upon the health administrators in PNG will be problematic, and much support needs to be given to this aspect of the programme. Measurement of the planned provincial budget expenditure versus actual expenditure should capture an outcome of management and financial management capacity.

Access to health care in PNG has always been difficult (Duke, 1999; Karel & Rasmussen, 1994; Muller, Smith, Mellor, Rare, & Genton, 1998), but in recent years the community has accessed health care even less frequently than in the past (PNG National Department of Health, 2009b). In part, this is because people do not know services are available or they are too remote from service centres to use them (Pincock, 2006; Williams et al., 2008). Indicator 42 might be considered a proxy for community awareness of health, because it seeks information about HIV/AIDS awareness. However, this indicator measures awareness of *prevention* of HIV and may not be a good proxy for a general awareness of curative and emergency health services, nor of more elderly people's understanding of health care. For this reason, another question is added to the list that seeks information about health worker visits to villages, to establish whether the health system is conducting community health education programmes.

8.3.6 Suggested additional indicators for Questionnaire 3

1. *Are equipment and medical consumables supplied and maintained in accordance with agreed minimum standards?*
2. *What percentage of the planned provincial budget expenditure was spent in the last financial year?*
3. *Are records kept of health worker visits to the community?*

8.4 Applying Questionnaire 3 to the case study

Completing Questionnaire 3 in the first tool of this design framework is a time-consuming and information-intense exercise for programme planners. It is a rights-based health system assessment, and careful completion is important so that health programme planners have a detailed understanding of all the building blocks of the health system. This understanding enables new programmes to integrate with the health system, use its processes where they exist, stay aligned with the national health and workforce plans, and help strengthen the system overall.

In the context of this first case study of an eye health programme in PNG, Questionnaire 3 provided an adequate reflection of the context that contributed to most of the programme's failings. While completion of the first two questionnaires provided information that would have alerted the programme planners to nine of the 32 barriers to programme success, by the end of Questionnaire 3 there was sufficient information to specifically identify 26 of the 32 barriers (Tables 6-5, 6-6). The information would also have raised awareness of an additional five areas of concern, marked as 'possible' answers in the tables. Only one specific issue remained outstanding, for which none of the questionnaires produced relevant information. This was that the Eye Glass Clinic was difficult for patients to find and access.

After finishing Questionnaire 3, the first step, and first tool, in the framework has been completed. Programme planners at this point have acquired a thorough understanding of the State's commitment to the right to health, as well as its capacity to fulfil health rights, and importantly, evidence as to whether these rights are being progressively realised. The data collected over the two time periods provide evidence as to whether the State is demonstrating a trend towards progressive realisation or retrogression of the right to health.

There was reasonable alignment between the problems identified from use of Questionnaire 3 as it addresses each building block within the health system, and those challenges listed in the desk review of the health system (Table 8-2). However, there were still several issues not identified by the questionnaire, particularly regarding medicine supply, equipment, and management. These issues are explored further in Section 8.4.3.

8.4.1 Does Tool One provide a broad understanding of context?

On completion of the three questionnaires, the understanding of the local context is still broad rather than specific. In the case of PNG, the major features that come to light through the questionnaires are that the health sector is increasingly under-funded and is part of a public sector that is poorly governed and regulated, and suffers from worsening corruption. Information from the Questionnaire 3 reveals there is no official plan or support to improve the quality of health care services, an extreme shortfall in the number of doctors and nurses, little reliable data on service provision, and no feedback mechanisms for the community to engage with health planning and make health services more accessible. Medicines, vaccines and medical supplies are poorly regulated, managed and distributed. Although data are often missing, there is no indication that the underlying determinants of health are improving, especially access to clean water supplies. Some improvements in health information systems are noted over the past five years, including the introduction of compulsory registrations of births and deaths, but overall, the variance in statistics on mortality rates illustrates the unreliability of all data. Health professionals receive no training on the right to health, violence against women is a public health issue, and there is no evidence that health rights have been addressed in the judicial system.

Many of the indicators in Questionnaire 3 provide information that should prompt programme planners to seek more specific information that will be relevant to their programme. For example, in the case study, one of the reasons given for failed targets was that a 'culture of change was not accepted'. The indicators in the questionnaire which suggest there is no acceptance of a change of culture are:

- 57 – No national policies for promoting quality of health care services. This indicates that the continual learning and change needed to improve services is not institutionalised.
- 60 – Absence of official mechanisms to ensure the active engagement of civil society and the community in planning and monitoring service delivery. This demonstrates a lack of openness to change service delivery to meet the community's needs.
- 61 – Absence of official mechanisms for eliciting population priorities, perceptions of quality, and barriers to seeking care. No effort is made to

change services to make them more available, to allay public concerns about quality, or to make services more accessible.

- 62 – Patient feedback is not sought on their experience within the health service. Therefore, there is no apparent willingness to respond to patients' experiences to improve the health service experience.
- 72 and 73 – Human rights training is not provided to health professionals which contributes to a lack of advocacy by these health workers for improvements in quality, accessibility and acceptability of health services.

Consequently, although there is no indicator specifically asking, *Is there a culture of change within the health sector?*, there are enough other indicators which demonstrate that change is neither actively encouraged, nor taking place.

Therefore in the context of designing a new health programme, the information from the three questionnaires has highlighted: an extreme shortage of health workers; difficulty with supply systems; lack of engagement with the community; inadequate processes of collecting data for needs analysis, monitoring and evaluation; poor governance measures; and inadequate funding to maintain a functional health system. This is evidence of an extremely challenging environment within which a new health programme plans to achieve success.

These are the issues that commentators refer to when they forewarn that after decades of neglect, additional funding alone is not likely to effect immediate transformations, rapid scale ups, or successful new health programmes (Freedman, 2009; Garrett, 2007b).

As the core institution to fulfil the right to health, the PNG health system is showing few signs of enabling the fulfilment of the State's obligations. New health initiatives would therefore have to be designed with much thought given as to how to work within the system without further weakening it, and without the current weaknesses rendering the programmes ineffective and unsustainable.

New programmes that employ human rights concepts in their design have an improved chance of addressing these difficulties because: they will actively engage with the community, including those marginalised and in most need of health services; they will be open and fully accountable; and will work with national plans to progress the realisation of health rights, including core obligations. It is this process

that adds the depth and specificity to the broad understanding developed by the questionnaires.

8.4.2 Could Questionnaire 3 have prevented programme failings?

Questionnaire 3 provided information that would have cautioned programme planners about 26 of the 32 barriers to success raised by the various stakeholders in this eye health programme. Caution may also have been signalled on other issues that led to five more barriers. For example, there was no specific indicator that sought information on whether the staff advocated for improved access to service for patients. However, there were 11 indicators that together would have alerted programme planners to the situation whereby health workers did not push for patients' rights, including indicators 71 and 72 that asked whether training in the right to health is included in medical and nursing degrees. This barrier (did staff advocate for improved access) was marked as 'possible', in that the questionnaires might possibly have alerted the planners to it.

The first three objectives in the eye health programme case study were to increase the volume of clinical services. This depended upon support from the hospital to employ more eye nurses and for the nurses to increase the number of patients seen each day. As the information from Questionnaire 3 shows, there is a drastic shortage of nurses throughout PNG. There is also a lack of commitment and funding to improve health services, ineffective government, poor regulatory control, corruption, and no evidence of the right to health being operationalised. These factors combined give a strong indication that there would likely be little capacity to increase staff numbers. Furthermore, there was no national health workforce plan, so the programme was unable to demonstrate that its requirements were in keeping with the overall planning for training and deployment of health workers throughout the country.

Questionnaire 3 reveals that the health sector does not seek feedback from patients nor community input into planning health services. There are no official mechanisms to monitor and improve the quality of clinical service. There is no evidence of a culture within the health sector that promotes improvement in service and thus, it would seem highly likely that the programme would face challenges to providing better quality care. Armed with this information, at the design stage the

programme needed to use participatory approaches to consider ways of overcoming this important issue. Ignoring the problem would not resolve it.

Objectives four and five were to achieve better training for eye doctors and eye nurses. The programme would have benefited from the understanding elicited by the questionnaire that there was no national health workforce plan, no job descriptions and no transparency or clarity as to where the responsibility lay for training. Health workers did not believe they were sufficiently well paid to warrant taking on greater responsibilities, such as training, without an accompanying salary increase. An understanding of this context suggests that the programme design for training was unduly optimistic.

Finally, the sixth objective was to develop a national eye care plan and have this incorporated into the national health plan. Given the absence of a national health workforce plan, lack of advocacy for improved services, and poor data collection upon which plans would be based, it is not surprising that a national eye health plan, including an eye health workforce plan, was not developed. Again, this information could have promoted different approaches, in particular, involving the eye health workers and other stakeholders to consider how to overcome the barriers to developing an eye health plan.

8.4.3 Would additional questions have helped improve outcomes?

Questionnaire 3 did not identify some weaknesses in the health system which were identified in both the desk review (Table 8-2) and at the eye health workshop (Table 8-3). These weaknesses related to:

- medicine and equipment supplies and maintenance
- lack of data to monitor and evaluate
- lack of management capacity
- lack of financial management capacity
- poor awareness of health care availability in the community.

The questionnaire signalled further information should be sought, but failed to specifically identify the following issues:

- lack of leadership and advocacy from the eye clinic
- no management support to improve service availability
- equipment failures.

Only one barrier remained unaddressed by all three questionnaires in the first tool. This related to the difficulty that patients had accessing the Eye Glass Clinic within the hospital. However, if patients were involved in planning, and their feedback was encouraged (indicators 59 and 61), this specific barrier would have been identified earlier on in the programme.

Therefore, there are only three indicators to be added to the third questionnaire. These seek information that has not been gathered or alluded to by any of the original indicators. This information is important because without it, there is greater chance of the programme failing to achieve its objectives.

1. *Are equipment and medical consumables supplied and maintained in accordance with agreed minimum standards?*
2. *What percentage of the planned provincial budget expenditure was spent in the last financial year?*
3. *Are records kept of health worker visits to the community?*

8.5 Conclusion

Using the final questionnaire of Tool One in the design framework, this chapter undertook a PNG health system assessment from a rights-based perspective. By crosschecking against the cited barriers to health in PNG, good alignment of Questionnaire 3's indicators was demonstrated, and the identified gaps have resulted in three more indicators being added to the final tool.

On completion of Questionnaire 3, designers of a new health initiative would have a comprehensive overview of the functionality and challenges of all six building blocks of the health system. Examining each of the blocks encourages programme planners to consider all aspects of the system even if some of those blocks may not seem immediately relevant. For example, designers of an eye health programme may not recognise that the health information system plays a role in the programme. However, the collection of data about eye disease, patient numbers attending clinics, gender and dwelling of those patients, and treatment outcomes, are important for the sustainability, monitoring and evaluation of the programme. Furthermore, one of the elements of the right to health is that information about the quality, availability, accessibility and acceptability of health services is collected and monitored.

The questionnaire itself does not provide a level of detail and specificity about sectors within the health system, such as ophthalmology or the health information services. However, it does provide sufficient information about the health system for programme planners to have gleaned an understanding as to which issues require further investigation within that sector. For example, the lack of government effectiveness, poor rule of law and abundant corruption in PNG, would strongly signal to programme planners that strong leadership and good management systems would be key elements to address in the programme design.

It is essential that all health programmes are designed to strengthen the health system, to enable it to more readily fulfil the right to health. The health system is strengthened when new health programmes align with the State's plans and processes, and are designed to help overcome its weaknesses.

After completing Tool One programme planners should have acquired a thorough understanding of the State's international commitments impacting on the right to health, as well as its national capacity, commitment and systems enabling the rights to be respected, protected and fulfilled. Equipped with this understanding of the context, programme planners enter into the next stage of the design process, whereby they work with the local community and stakeholders, using rights principles, to determine the actual shape of the programme. This process is examined in the next chapter.

Chapter 9 Applying a rights-based programme assessment

9.1 Introduction

Chapters 5, 6 and 7 tested the first tool's three questionnaires to see whether the indicators provided sufficient information to enable a programme design that could have avoided the documented failings of the first case study. The information collated from these questionnaires provides a comprehensive understanding of the context within which a health programme will be located. This information by itself however is not sufficient to design a programme that will make a quality health service available, accessible, and acceptable to the community. In order for that to be accomplished, the programme planners need to develop a programme of activities using crucial human rights concepts. This methodology will result in a programme that men and women, and those most marginalised or discriminated against, want, and that the State has incorporated into its planning processes.

Nothing guarantees the ongoing success and sustainability of a health programme. However, a full understanding of local context, and working with the support of local community and within national health plans should, at the very least, demonstrate that every precaution has been taken to first, do no harm. The second tool in the framework aims to guide programme planners or programme assessors through this process.

A second case study is used in this chapter and the next. It is presented as an Annex at the end of this Chapter. This case study involves a document analysis of a proposed eye health intervention in PNG, which was part of a Pacific regional eye health plan. A consortium of Australian NGOs who had successfully advocated for Australian Government funding to eliminate avoidable blindness proposed the regional plan. Although the Australian Government had allocated funding for prevention of blindness programmes, the particular plan for PNG did not receive funding to proceed with the activities as proposed.

As demonstrated in these two chapters, the proposed initiative did not employ a rights-based approach to its design, nor did it assess the impact these activities on the rest of the health system. It is an important and intriguing account of a proposed

health initiative that was not informed by the right to health, nor were crucial human rights concepts incorporated in its design.

If Tool Two is sufficiently robust, it will demonstrate that its use could have considerably improved the design process and resulting proposed activities.

9.2 Assessing rights principles in process and plans

Tool Two in this aid-funded health programme design framework examines programme design documents to assess whether the right to health was observed in the design process. If it was, then the availability, accessibility, acceptability and quality of the planned health service will have been comprehensively addressed. These measures of health service were specified in General Comment 14 (United Nations, 2000b) and have since become an integral part of rights-based mechanisms.

These criteria (AAAQ) cannot be met unless a thorough, participatory process has been undertaken. Availability of service depends on the capacity of the health system, including its health workforce, supply systems, financing and governance arrangements. It is not possible to design an accessible programme unless issues of geography, transport, cost, and the capacity of the health system, are studied and addressed. It may not be possible to provide a fully accessible and available service nationwide at the commencement of the programme, but the design should demonstrate plans for progressive realisation, and importantly, show that these plans for future services are in keeping with the State's national health and health workforce plans. It is not possible to design an acceptable service unless there is meaningful engagement with local stakeholders to determine what is culturally appropriate, and this will involve the participation and representation of men, women, people of all ages and ethnicities, people with disabilities, and those who are marginalized and discriminated against.

Context specific indicators will need to be developed to measure the quality of the new health service. The appropriateness of these quality indicators will result from another participatory process with health workers and the community, and the data needed to monitor this component will demonstrate, inter alia, that health information systems have been established.

Designing health programmes that will not only deliver a sustainable health service, but will also help strengthen the local health system, is an essential goal when

working within a rights-based framework. The process takes time and this is not a weakness of a rights-based approach, rather, it is one of its strengths. Quick-fix approaches to design or implementation are not possible in countries where the health system is fragile and all its building blocks are suffering from decades of neglect.

The design of any health programme cannot conform to set templates if it is to respect, protect and fulfil the right to health. Each context is unique and will require a unique response. Therefore a rights-based assessment of a health programme design will determine whether the design has taken into account local context, and has resulted from a full engagement with local people. When describing her approach to strengthening health systems, Freedman is adamant that there is no standardised technique, and the process is not fast or simple.

> It is instead a fluid practice that wrestles with very specific problems in the delivery of health services, analyzing them in historical and political context, using multiple forms of evidence to craft solutions, identifying the workings of power that have blocked progress, strategizing ways to mobilize those directly affected (as well as those directly and indirectly responsible) to use the values, norms, and vision of human rights to call for specific rearrangements of power and resources necessary for serious change… It is decidedly not a 'quick fix' (Freedman, 2009, p.418).

A rights-based assessment of health programme design serves several purposes:

- it provides a check at an early stage that the health service being designed will be available, accessible, acceptable and of good quality
- it can stop a health programme from harming other health initiatives or weakening the health system
- it provides NGOs or other non-state actors with a means of acknowledging and meeting their rights obligations
- it can bridge a gap between the opponents and proponents of vertical programmes by promoting examination of, and engagement with, the underlying health system.

9.3 Validating Questionnaire 4: programme assessment

Questionnaire 4 was developed as a programme design assessment tool, drawing on indicators from Hunt and MacNaughton's (2006) AAAQ plus six

concepts framework (see Chapter 3, section 3.3.3 for details of the methodology employed to design the questionnaire). In brief, 30 indicators were retained or selected to assess a programme's observance of critical AAAQ. Availability covered the resources required to deliver a health service; accessibility addressed the factors that would enable the community to use the service; acceptability looked at whether the service was culturally appropriate for the community to whom it was offered and quality considered the clinical and health processes and outcomes achieved by the service.

An important feature of this questionnaire is that it seeks to verify that the programme design process was appropriate for local circumstances. This is not an assessment of the technical elements of the programme itself. The case study is used to test the questionnaire to assess whether its use in the design phase would have contributed to a more comprehensive and appropriate programme.

Tool Two is tested on Case Study Two and the results are included in the Annex at the end of this Chapter. By examining the proposed activities (hereafter called the Plan) with the tool's questionnaire, there is an opportunity to assess whether a rights-based approach would have endorsed the original design or prompted a different approach to the delivery of an aid-funded eye health programme.

9.3.1 New aid-funded health programmes in the PNG context

PNG has a well-documented history of failed aid programmes (Hnanguie, 2003; Hughes, 2004). It also has a weak health system including some retrogressive health rights indicators, as discussed in the previous chapter. It is a difficult context in which to fulfil people's health rights. Into this fragile economy and weak health system, a consortium of Australian NGOs proposed the Plan of eye health activities. The Plan is an example of a region-wide, top-down approach to addressing a specific health problem (blindness). The activities that were proposed for PNG were therefore just one part of a greater regional programme. The same model of health care was proposed for each of the 16 different countries included in the regional plan.

The details of the Plan, including its political circumstances, are included in the Annex. Although the decision to fund blindness prevention was made at political levels in Australia, the Plan put forward by the Consortium had to meet the Government agency's own criteria before funding could be allocated to specific

programmes. The Plan did not meet the criteria, although the specific reasons for its rejection in the initial iteration were not made public. Nevertheless, the Consortium had succeeded through its advocacy in raising political and public expectations that with sufficient funding, blindness could be eliminated in the Pacific region using a particular model of care.

9.4 Testing Questionnaire 4 on the proposed PNG activities

The questionnaire in Tool Two is trialled on the Plan to determine its usefulness in both guiding a design process and assessing a programme design. The Plan stated that activities "will build on existing resources for eye health and vision care" and its proposed vision centres for community level eye care "can cover 25 per cent of major blinding diseases and 70 per cent of overall vision needs in the community' (Vision 2020 Australia, 2007a, 2007b). Therefore, it was envisaged the service would integrate with the public health sector eye services, and would refer patients to other eye health services. However, as becomes apparent through completion of the questionnaire, the Plan does not address most of the parameters of the health system upon which this particular health service depends.

This tool enables the Plan to be examined to ensure that the design reflects an understanding of the health system and its constraints. It assesses whether key human rights principles were employed to aid the development of an AAAQ programme. Results from the application of the questionnaire to each of these elements are now analysed in turn. A summary of results is given in Table 9-1 on the following page.

Table 9-1 Questionnaire 4: Results of the case study - assessment of Plan design

		Addressed		
		Fully	**Poorly**	**Not at all**
Availability				
1	What is the need for this service and how many health workers are required to provide it?		✓	
2	Does the country have the health workforce to meet the needs of this programme?			✓
3	Does the State's health workforce plan include this service?			✓
4	Who is employing the health workers?		✓	
5	How will health care workers be trained to provide the service?		✓	
6	From where will the service be provided?		✓	
7	Are support services in place for this service (administration, maintenance of facilities & equipment, cleaning, sterile services)?			✓
8	Are systems in place to ensure consistent availability of medicines, consumables and other supplies?			✓
9	Will the service be available throughout the country? If not, are plans in place to increase availability?		✓	
10	Is an information system planned to monitor availability?			✓
11	Does the National Health Plan include this service?			✓
12	Is the service included in State forecast budgets?			✓
SCORES		0/12	5/12	7/12
Accessibility				
13	How will all people, irrespective of gender, locality, disability, ethnicity or age, access this service?			✓
14	How will people know the service is available?			✓
15	Has a referral pathway been established from primary health centres through to secondary and/or tertiary centres?		✓	
16	Will patients be charged fees for the service?		✓	
17	Were studies undertaken to determine willingness-to-pay?			✓
18	Are the medicines for this service on the essential drugs list?			✓
19	Will patients have to pay for medicines?			✓
20	What systems are in place for people who cannot afford to pay for the service or medicines?		✓	
21	How is access measured and monitored?			✓
22	What data are required on access for the ministry of health?			✓
SCORES		0/10	3/10	7/10
Acceptability				
23	How will the programme demonstrate acceptability by patients and the community?			✓
24	How is confidentiality of patient information being addressed?			✓
25	How is informed consent being addressed?			✓
SCORES		0/3	0/3	3/3
Quality				
26	Are health information systems in place to record treatment outcomes, patient recall and follow up services?			✓
27	Is patient satisfaction measured and monitored?			✓
28	How will the programme demonstrate quality service to patients and the community?			✓
29	Are health workers provided with ongoing training programmes?			✓
30	Are monitoring visits planned to each service centre?			✓
SCORES		0/5	0/5	5/5
Human Rights Concepts				

		Addressed		
		Fully	**Poorly**	**Not at all**
Progressive realisation				
31	Does the programme make reference to the country's health rights obligations and their progressive realization?			✓
32	Does the design show that over time it will become more available, accessible, acceptable, and of increased quality?			✓
33	Was baseline data collected against which availability, accessibility, acceptability, and quality can be monitored?		✓	
34	Has a thorough health information system been installed to monitor all aspects of the programme?			✓
SCORES		0/4	1/4	3/4
Core obligations				
35	Is the service being provided one of the nation's core obligations in the right to health?			✓
36	Was a health systems assessment undertaken as part of programme design?			✓
37	Was an impact assessment of the programme undertaken?			✓
SCORES		0/3	0/3	3/3
Equality & non-discrimination				
38	Will data collected disaggregate by ethnicity, age, gender and rural/urban residency?			✓
39	How will people with disabilities access the service?			✓
40	Will information be made available in local languages?			✓
		0/3	0/3	3/3
Participation				
41	Were people of different ethnicity, age, gender, rural/urban location and those with disabilities, consulted regarding the establishment of this service?			✓
42	Will their opinions continue to be solicited regarding the service?			✓
		0/2	0/2	2/2
Information				
43	Are data being collected in the same format as that required by the national health information system?			✓
44	Are all data being provided to the national health information system?			✓
45	Is information from the service being made available to the public?			✓
		0/3	0/3	3/3
Accountability				
46	Will the ministry of health be advised annually of the total funding provided by external sources for this service?			✓
47	Is there a monitoring body for this programme which includes local people?			✓
		0/2	0/2	2/2
	Human Rights Concept total	0/17	1/17	16/17

9.5 Assessing availability elements in Case Study Two

The Plan scored poorly in the availability section of the questionnaire. It only addressed five of 12 indicators in the design of the activities, and none of those five was addressed in a way that acknowledged the complexities and restraints impacting

on the issue. The low score in the availability section of the questionnaire indicated that the Consortium did not consider the resource constraints on delivery of health services in PNG and nor did it address ways of overcoming them.

As detailed in Chapters 5-7, health services in PNG are severely constrained, under-funded, and lacking in facilities, workers and medical supplies. There is an ageing workforce, low on critical cadres such as midwives, doctors and nurses, with insufficient capacity within training facilities to produce the number of health workers needed to meet current and future demand (PNG National Department of Health, 2009b). Medical supplies to health facilities are grossly inadequate, with half the facilities in PNG at any one time reporting an absence of essential medications, vaccinations and IV fluids. Furthermore, only 63 per cent of health facilities have electricity and 36 per cent have oxygen. Management and governance of the health sector were shown to be significant barriers to improving the health system, and this contributed to the poor progress on realising the right to health. The availability of health services is challenged by all of these issues.

However, none of these was addressed in the Plan in a way that acknowledged the inadequacies of the PNG health system or considered how these difficulties would impact on the Plan.

9.5.1 Would the missing availability information have benefited the Plan?

The Plan stated there was a need for improved eye health services in PNG because of the large number of people who were blind and vision-impaired. It claimed the annual incidence of blindness in the Pacific region was 14,000 people, of whom two thirds (9300) lived in PNG. The numbers of eye health workers and vision centres deemed necessary in PNG by the Consortium are shown below in Table 9-2.

Table 9-2 Additional resource requirements for PNG as per the Plan

	Current situation	Additional need over present numbers	Immediate training goal	Training goal by 2013	% of total workforce cadre
Eye doctors	9	49	20	30	330 doctors in PNG 39/330 = 12%
Eye nurses	25	200	100	200	225/2800 = 8%
Vision technicians	0	116	116	-	Cadre not currently in PNG
Vision centres	0	116	116		None in PNG

The Plan calculated the health workforce requirements based on ratios of eye doctors to population (1:100,000), and eye nurses to population (1:25,000). Because it

provided no information to the contrary, it appears the Consortium assumed that once trained each of these eye health workers would work at full capacity, and would remain in active employment. However, as seen in previous chapters, particularly Chapter 7, there were many aspects of the PNG health system that limited the efficiency of the workforce. Other indicators in this part of the questionnaire delve into these important considerations.

Indicator 2 looks for evidence that the programme explored the national health workforce to determine whether it could supply the number of workers needed for the proposed activities. Total health workforce numbers in PNG were not addressed in the Plan at all. If they had been, it is likely the proposed activities would not have remained as first presented because it was readily apparent there was an insufficient workforce to allocate these numbers to eye care. There is little in the literature to assist ophthalmic workforce planning in low-resource settings, but one guide for the Pacific region suggests eye doctors should make up only 3 per cent of the medical workforce (Dewdney, 2001). As can be seen in Table 9-2, if the numbers of doctors were trained in eye care as planned, the ophthalmic workforce would make up 12 per cent of the total medical workforce in PNG. The impact on the health system of attracting this number of doctors into ophthalmology is considered in Chapter 10.

At the time the Plan was written, 2007, there was no national health workforce plan, and the implications of the absence of a workforce plan were not addressed. Nor did the Plan refer at all to the system of specialist training for doctors in PNG. There is a limit of 60 registrar positions available at any one time in PNG, and each registrar can take up to four years to complete his or her training programme. Therefore, in any one year, it is unlikely there would be more than 15-20 doctors entering into specialty training in PNG, across all specialties. Thus, plans to train 20 registrars in ophthalmology over two years were not in keeping with local plans or capacity. Had this indicator been addressed, the Plan would not have included targets for training that were so out of step with national plans and capacity.

Similarly, indicator 3 seeks evidence that the programme is in keeping with national plans for the particular health sector involved in the programme, or whether that sector is not included in national plans. In either case the information is relevant to a new programme. It may encourage the planners to undertake advocacy to ensure the need for the service is recognised by the State. Alternatively, if there are State plans already in place, it is important for new initiatives to coordinate with them.

The only reference made to the ongoing employment of the newly trained health workers was that the Plan's funding would cover the vision technicians' salaries for the first six to 18 months. Therefore, it must be surmised that the Plan expected the doctors and nurses who were trained in eye health to be employed by the public health sector, which employs nearly all health workers in PNG. It was not made clear in the Plan whether these workers would be new to the public health sector, or selected from those already working in it. The former would not be possible because of the limited budget allocation to the health sector, and the latter would result in workers being attracted away from other sectors in health. The ongoing employment of newly trained eye health workers is extremely important to consider, because health workers are unlikely to start a training programme if they cannot be guaranteed employment at the end of the training.

Indicator 5 seeks information on the proposed training programmes, because there is frequently a dearth of medical and nursing schools and teachers in developing countries. The Plan addressed this issue cursorily by claiming the training would take place at the University of PNG (UPNG) for 100 eye care nurses and 20 eye doctors in the first two years of the programme. However, UPNG had no training programme available for eye nurses, and an attempt to establish such a course by another international NGO had been unsuccessful (see Case Study One, Chapter 6, Annex). The Plan gave no indication it considered the very limited capacity of the associated teaching hospital to provide the necessary clinical experience for eye doctor training, and made no reference to the limited number of registrar positions available throughout PNG at any one time (see above, indicator 3). There was no information provided as to how the 116 vision technicians would be trained, although the Plan had budgeted the cost of the training at $10,000 per technician. This is a large number of people to train and employ, and to calculate the costs of doing so, without it being addressed more fully in the Plan. The Plan failed to give any indication that it engaged with the actualities of working and training in PNG. Such actualities include the inadequacies of pre- and in-service training, poor quality supervision, and concerns about the ability to increase or support retention and recruitment (Table 8-2, Chapter 8).

The location of the new services, indicator 6, was not addressed. The Plan stated that "Rooms are often donated or a nominal rental fee is paid", despite the absence of such models of service in PNG or elsewhere in the Pacific on which this

claim could be based. As revealed in the health system assessment, Chapter 8, there is a chronic shortage of health facilities in PNG, with as many as 50 per cent of primary health centres having closed over the past 20 years because of disrepair (Izard & Dugue, 2003). Hospital executives speaking at health planning workshops in 2009 frequently bemoaned the state of their hospitals and lack of clinical space, and poor facilities was one of the top five challenges to the PNG health system expressed at the planning workshops (Chapter 8, Figure 8-1). Therefore, addressing the indicator as to where 116 vision centres could be sited, and the 20-30 eye doctors and 100-200 eye nurses deployed, would have again made the programme planners consider these constraints in PNG. As the location of eye care facilities was not addressed, it is not surprising that the ongoing support for these services, such as administration and cleaning, was also left unexplained (indicator 7). Administration, access to sterile services, maintenance of equipment and cleaning services are essential to the provision of a health service and are therefore included as an indicator. The lack of maintenance, cleaning and supply lines contributed to the decline in the number of primary health centres and hospital facilities in PNG, and the management of all facilities is described as problematic. *Lack of human resource capacity for management systems and processes* is a documented problem in the desk review of all health reports (Table 8-2).

Supply of medicines and consumables (indicator 8) is another well-documented difficulty in PNG, referred to as the 'woeful state of medical supplies and logistics management' in the overview of health system reviews (Table 8-2). It will be necessary to have medicines, surgical consumables and spectacles in constant supply to provide quality eye health programmes, but this fundamental aspect to the programme, Indicator 7, was not addressed in the Plan, nor the fact that this is a known barrier to good health care in PNG. As shown in the first case study, security issues around theft of money prevented some programme activities (Chapter 6, Annex, Table 6-5). Health facilities in PNG report having essential medicines and other supplies available only 50 per cent of the time (PNG National Department of Health, 2009b).

Indicator 9, seeking information around plans to extend the service so it is increasingly available throughout the country, was addressed by implication because the goals for the numbers of eye health workers reflected the total population need. Furthermore, the Plan stated that the location of the services 'will be determined

through sensitive consultation with ministries of health, local stakeholders…'(see Chapter 9, Annex). There was no suggestion in the Plan that the difficulties other health services had encountered over increasing service availability had been considered.

Indicator 10 looks for engagement with information systems to monitor the availability of this service. It was not addressed in the Plan. Throughout PNG there are weak or absent health information systems and data collection processes. As a result, there are little data to monitor service delivery, access and availability, or to assist with planning. A poor information system was cited as one of the main challenges to the PNG health system at the National Health Planning workshops (Figure 8-1). Monitoring health programmes is essential and especially so in a country with a history of failing health services. This depends on a reliable information system. The cost and training required establishing or strengthening such systems needs to be acknowledged in any new health initiative.

The National Health Plan (indicator 11) was not acknowledged in the Plan. There is therefore a failure to demonstrate that proposed activities are part of the State's health care strategy. Had the Plan raised this matter, it would have noted that the National Health Plan does not address eye care or disability of any sort. This has serious implications for the service planned because it also suggests that the activities were not included in State budgets (indicator 12). The financial sustainability of the proposed activities was not addressed, other than in a passing reference to income from the sale of spectacles covering vision technicians' salaries in due course. Tool One revealed that funding of health care in PNG is below the level WHO considers necessary to maintain a health system. The percentage of GDP spent on health care has reduced over the past 10 years. The failure of the Plan to address the financial impact of its activities on an ongoing basis was another serious oversight.

9.6 Accessibility: more information needed in the Plan

Overall, the Plan scored poorly on accessibility indicators, with only three of the 10 addressed, and none of them comprehensively addressed.

There was no information provided to suggest that consideration has been given to how all people, especially those impoverished or discriminated against, those with disabilities or in poor health, and those living in remote areas, would be able to

access services, or know the service was available to them (indicators 13 and 14). Lack of awareness of health services, or lack of knowledge that anything can be done to help people with poor vision or who are blind is a significant barrier to the uptake of eye care in PNG and is therefore essential to address (Garap, Sheeladevi, Brian et al., 2006; Williams et al., 2008).

The Plan made mention of a system of referrals, (indicator 15) through the four-tiered model of eye health care. However, this model did not reflect the health system of PNG in theory or practice. Access issues in PNG have worsened over the past two decades with the average time to reach a health centre increasing and previous systems of transferring patients collapsing (Pincock, 2006).

Patients using the proposed services were to pay a fee, according to the Plan, but the level of payment was not addressed, and nor was any information provided under indicator 17, to suggest willingness-to-pay studies were undertaken before deciding on user fees (indicator 16). Studies in PNG reveal that the costs of accessing health care, and eye care, are the main barriers to using these health services. Had these indicators been addressed fully, especially as the Plan stated that user fees would result in the sustainability of the service, a different approach towards financial sustainability may have been considered.

The Plan did not address the need for medicine supplies, or the cost of medicines (indicator 19). As has been shown earlier, PNG has a very poor record with the supply and distribution of medicines, and theft and corruption result in many medicines being stolen (PNG National Department of Health, 2009a). The Plan would have benefited from addressing this important issue, because there are no reliable systems upon which a new programme can depend. As has been shown with the primary health centres, the community stopped using them because they were not equipped with trained health workers or medical supplies (Izard & Dugue, 2003). This same fate is likely to happen to any other health service that cannot provide all that is needed for each patient on each visit. As many people have to travel long distances at a high cost in order to reach a health centre, they are unlikely to be able to return in the hope medicines or spectacles are available on the next visit. For the same reasons, addressing the cost of medicines is essential in the design, because this cost is unlikely to be carried by the State, and is probably unaffordable for most patients.

Indicator 20 is referred to in the Plan briefly, with the suggestion that "Consultations are usually charged on a sliding scale so patients who can afford

treatment subsidise the care of others. This system of cost-recovery is a key part of the Vision 2020 model, and has been proven successful …in India where patients are charged on their capacity to pay" (Vision 2020 Australia, 2007a, p.4). If the Plan had included an analysis of the PNG situation to determine whether this economic model could work in a different setting, or if the population size and location would permit the same approach, it would have been most instructive.

Finally, had the Plan addressed monitoring systems or data collection, it would have demonstrated an awareness of the poor systems in place to measure access to health service. This might also have resulted in baseline data having been collected on which monitoring and evaluation could have been based. As it is, neither indicator 21 nor 22 was addressed.

To summarise, had these 10 components of accessibility been fully addressed, the Plan may have developed into a programme that recognised and designed around the barriers which prevent people from having their right to health fulfilled in PNG. The Plan can be seen to have had little chance of ensuring access for all in PNG.

9.7 Assessing acceptability elements in the Plan

None of these three indicators was addressed in the Plan's documents. The Plan made no reference to the community or patients, despite calculating the cost per person of the services offered. Its approach to 'eliminate' blindness described controlling major blinding conditions, conducting eye examinations, developing infrastructure and building the capacity of eye care workers. There was no mention of the people for whom the service will be provided, and therefore no discussion as to how the service could be demonstrated to be acceptable to the community.

The first indicator in this section provides programme planners with the opportunity to demonstrate they had consulted the community about how they value a health service, and whether any plans for the service would be unacceptable. This engagement allows the service to be delivered in culturally acceptable and gender-sensitive ways. It is an essential component of meeting the right to health, as well as being a serious consideration when designing for sustainability. As observed in the first case study, the community was reluctant to seek eye health services in PNG because of the hospital processes that they found difficult, and because they feared doctors and surgery.

Confidentiality and informed consent are patient rights (indicators 24, 25). Information on these issues would demonstrate a degree of engagement with the community that the questionnaire has already illustrated as absent. However, as it would be possible to engage with the community and not discuss confidentiality and informed consent, they should be retained as indicators.

9.7.1 Assessing quality elements in the Plan

The Plan made no reference to any measure or monitoring of quality; thus, none of the five indicators was addressed.

Because quality is an essential human rights concept, it is imperative that the services offered are monitored to demonstrate quality standards. Therefore, programme designers need to show within their plans that such standards will be developed, measured, monitored and reported on (indicator 26). Even at an early stage of design this is necessary, because the measurement of quality standards has cost implications, from training through to information systems and service delivery.

Patient satisfaction (indicator 27) is another aspect of quality, separate from clinical outcomes monitoring. As seen in the first case study, patients reported various elements of dissatisfaction distinct from those of clinical outcomes, although they also referred to poor surgical outcomes as one reason for not seeking eye care services. Other measures of dissatisfaction included the difficulty of communicating with health workers, queues at the hospital, and deferred or broken appointments by doctors. As each of these impairs access to health services, patients' rights cannot be fulfilled until each is addressed.

Engagement with these issues, as well as considering how to convey programme quality to the community (indicator 28), would promote a more comprehensive programme design that acknowledged the local realities. Ongoing training and supervision (indicators 29, 30) are essential to maintain high quality standards. They are of concern in PNG, as the desk review of the health system reported (Table 8-2).

While designers of a programme may argue that these quality issues are details that can be built into a programme once funding is assured and implementation begins, as was advocated in this Plan, it assumes that there is little if any cost associated with adding quality parameters later. More importantly, deferment of

discussions on quality once again bars local participation in the programme at the all-important planning stage, and results in plans that can win political or financial support when they are not appropriate health care interventions that can deliver a quality, acceptable health service.

9.8 Assessing indicators of human rights concepts in the Plan

The indicators to measure the use of human rights concepts in the design of a programme were selected with the intention of avoiding duplication with indicators measuring the AAAQ elements. As an example, in order to provide a service that is accessible to all people in the community, it will have been necessary to engage with representatives of all people in the community to fully understand the barriers to accessing care. Therefore, it would not be necessary to ask again in this human rights concept section whether engagement with all groups in the community took place.

The questionnaire included 17 indicators divided into six sections, one for each of the crucial rights concepts (Hunt & MacNaughton, 2006). In this assessment, close attention is paid to whether addressing the indicator could have added important information into the design of the Plan that had not already been elicited in the first part of the questionnaire.

Only one of the 17 human rights concept indicators was specifically addressed by the Plan and it was not addressed fully.

In the first section on progressive realisation, the questionnaire seeks to establish whether the Plan examined health rights obligations and their progressive realisation in PNG. The Plan made no reference to health rights in PNG. Addressing this issue could have provided insight into the State's capacity and commitment towards meeting its health rights obligations. In turn this gives a good indication as to whether or not the State is likely to honour any commitments made towards this particular Plan.

The next three indicators (32-34) seek information as to the Plan's intention to increase availability, access and quality of service; baseline data collection for monitoring purposes; and health information systems. Of these three, one was partially addressed in the Plan. However, other indicators in the questionnaire had already established that this Plan had not addressed these important rights issues.

Therefore, these three indicators did not add any additional information to the questionnaire.

The three indicators in the core obligations section were not addressed, and nor had previous indicators elicited this information. Consideration of indicator 35 would have informed the Plan as to whether the State includes eye health service as part of its core obligations in the right to health. If it isn't, the Plan must determine whether to advocate for inclusion, or accept eye health is not a State priority, and will not be prioritised for State resources. If it had addressed indicator 36, the Plan would have assessed the PNG health system and consequently reflected the constraints to the delivery of health care and the bearing this would have had on the proposed activities. Most importantly, had the Plan conducted an impact assessment of its proposed activities on the health system (indicator 37), it would have recognised the threat that some of its activities posed to other services in the sector. Conducting a health system assessment is crucial in terms of respecting and protecting the right to health.

Indicators for equality and non-discrimination were not addressed, but again, this information had already been established in other parts of the questionnaire that considered how all people would access the service. Similarly, it was already apparent that people were not consulted about the service, including people of different ethnicity, age, gender and location, and that no consideration had been given to future consultation with local people (indicators 41, 42).

Elsewhere in the questionnaire it was established that data collection and health information systems were not addressed (indicators 43-45).

The final section assesses accountability. Neither of the indicators had been addressed and nor had the information been sought through other questions. The transparency of the Plan's activities could have been demonstrated by committing from the design stage that the State would be advised of the total expenditure on this initiative. Similarly, by having a monitoring body that included local people, the Plan would have declared its intentions to work closely and openly with the State and to respond to local concerns or advice. As was seen in Chapter 6, there is much criticism of aid donors in PNG, in particular because there is a lack of transparency about how aid money is spent. It is therefore important to make arrangements to demonstrate accountability and transparency, and to be responsive to the local community. This not only facilitates the design of appropriate and acceptable programmes but allows

the local community (including the State and health administration) to monitor health aid spending and outcomes.

9.9 Revision of indicators for Tool Two

Testing the fourth questionnaire (Tool Two) against this case study demonstrated that all the indicators in the AAAQ section would have added information of importance to guide the design of a health programme, with no redundant indicators. However, in the human rights crucial concepts section, only six of the 17 indicators sought new information. Therefore, the final questionnaire will be reduced from 47 to 36 indicators, with all those under equality and non-discrimination, participation and information being removed. The six remaining indicators in this section are:

- Does the programme make reference to the State's health rights obligations and their progressive realisation?
- Is the service one of the State's core obligations?
- Was a health systems assessment undertaken as part of programme design?
- Was an impact assessment of the programme undertaken?
- Will the ministry of health be advised annually of the total aid funding for this service?
- Is there a monitoring body for this programme that includes local people?

9.10 Conclusion

The value of this rights-based design assessment tool is that it systematically addresses the many components that determine whether a health service is available, accessible, acceptable and of good quality. It also examines the methodology to assess whether crucial human rights concepts were employed throughout the design process. On completion of each section of the questionnaire, it is a straightforward exercise to see what elements within the AAAQ framework have been considered. If human rights concepts have been employed throughout the design process, then not only will the AAAQ factors be fully addressed, but also a thorough understanding of the right to health in the State, the functionality of the health system, and impact of the programme on the health system, will have been gained.

By testing this questionnaire on a case study, it was found that there was some repetition in the indicators, especially within the human rights crucial concepts section, and the total number of indicators was reduced accordingly.

This questionnaire forms the second tool in the rights-based framework to design health programmes. It can be used as a tool to design a health programme as readily as it can be used to assess a programme design. It is able to guide users through a rights-based process that identifies the fundamental elements of health service provision, resulting in a programme that is available, accessible, acceptable and of quality. In order to achieve, and sustain, those elements, it must be in keeping with the State's health and health workforce plans and budgets. It will also have involved consultation with, and participation of, the people in the community and especially those for whom access to health care has been most difficult. The tool will therefore result in the design of a service that is culturally appropriate and of high quality.

Had this questionnaire been employed in the development of the Plan examined in Case Study Two, a very different programme of activities would have resulted. Although it was not approved to be implemented as proposed in the Plan, it did win political support, and raised political, NGO and public expectations that Australian funding could be used to address a specific health issue (blindness), independently from the rest of the health sector. The promises made by the Consortium which designed the Plan that: sufficient money could eliminate a health problem; that large numbers of doctors and nurses were available to be trained in this sector; and that facilities could be dedicated to eye care, have been demonstrated through a rights-based assessment to be untenable. This Plan provides an excellent example of critics' concerns about the rapid increase in aid expenditure in the health sector:

> Moreover, in all too many cases, aid is tied to short-term numerical targets such as increasing the number of people receiving specific drugs, decreasing the number of pregnant women diagnosed with HIV …or increasing the quantity of bed nets handed out to children to block disease-carrying mosquitoes. Few donors seem to understand that it will take at least a full generation (if not two or three) to substantially improve public health - and that efforts should focus less on particular diseases than on broad measures that affect populations' general well-being (Garrett, 2007b).

Annex. Case Study Two

All that is needed is Australian Government leadership to make it happen (Vision 2020 Australia, 2007a)

A Plan to eliminate blindness

In 2007 a Consortium of Australian NGOs took advantage of a forthcoming general election to advocate for increased funding 'to eliminate avoidable blindness' in the South-East Asian and Pacific regions. Using an Indian model of eye care service delivery, the Consortium calculated the need and cost of these eye health activities and sought political support for a 10-year AUD 600 million programme. The advocacy was successful and shortly after winning the election, the new Labor Government made $45 million available for two years to undertake the activities.

The Labor Government, in its Policy paper, included the following initiatives that it attributed to the advice of 'experts'.

- 50 doctors could receive training in the Pacific region at the University of Papua New Guinea, Port Moresby, the Pacific Eye Institute, Fiji, or the National Institute of Health Science, Dili, East Timor; cost - $4,500,000
- 300 nurses could receive training in the Pacific region at University of Papua New Guinea, the Pacific Eye Institute, Fiji, or the National Institute of Health Science, Dili, East Timor; cost - $8,000,000 (Australian Labor Party, 2007)

At the time this political support was received, the NGOs in the Consortium had not engaged with people in the Pacific to discuss any elements of the proposal. The same model for delivery of eye care was proposed for each of the 16 States in the Pacific region alone.

As a case study, the features of this Plan were:

- It was a top-down approach to development driven by donor interests
- It presented a model of service delivery that is not specific to local context
- Local involvement commenced after funding and political decisions were already made.

Proposed programme of activities in PNG: extracts from planning documents

The following information is derived directly from extracts from the Consortium's planning documents (Vision 2020 Australia, 2007a, 2007b).

Purpose

To illustrate how avoidable blindness and vision impairment could be eliminated in South-East Asia and the Pacific with a total commitment of $600 million over 10 years.

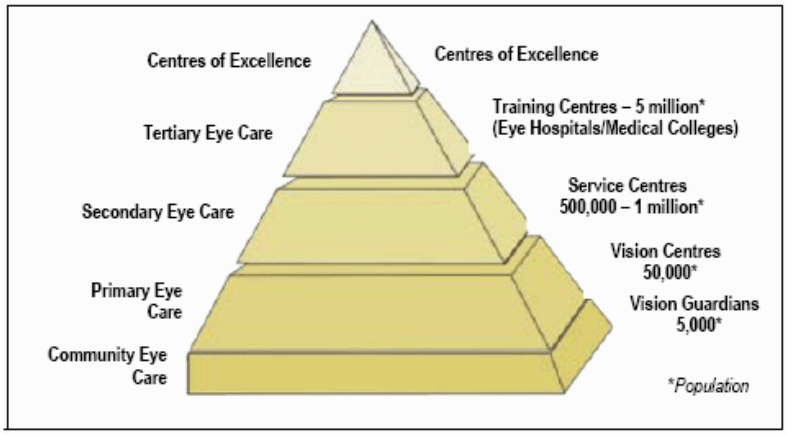
Snapshot

- Australia can lead efforts to eliminate avoidable blindness and vision impairment in our region.
- A total increase of 19% on the Australian Government's current Overseas Development Assistance (sic) will eliminate avoidable blindness in South-East Asia and the Pacific region within 10 years.
- With this plan, more than 124 million people in South-East Asia and the Pacific could have their vision improved or restored.
- Interventions to improve or restore sight are among the most cost-effective of all health care interventions.
- Given vision impairment in Australia costs A$9.85 billion a year and A$66.75 billion a year in the US, investing A$600 million over 10 years to implement VISION 2020 goals in South-East Asia and Pacific region will significantly reduce poverty in the region.
- This plan provides an indication of the facilities required for a sustainable system to eliminate avoidable blindness and vision impairment, as well as an estimate of costs. More specific scoping and costing is needed before implementing aspects of this plan.
- Australian organisations have the skills and expertise to eliminate avoidable blindness and vision impairment in the region. All that is needed is Australian Government leadership to make it happen.

The pyramid model approach

In approximating the cost of eradicating avoidable blindness and vision impairment in developing countries in South-East Asia and the Pacific, Vision 2020 Australia has adopted the model developed by the International Agency for the Prevention of Blindness. This Eye Care System model has four layers (see Figure 9-1). The concept incorporates the number of people serviced by a facility at each level, and the cost of such a facility, leading to the cost per person, worked out at each of the different levels at which service is provided.

Figure 9-1 Vision 2020 Pyramid model of eye care



Source: Vision 2020 Australia

Vision Centre

Delivering primary eye care, including screening, refraction, dispensing of glasses, disease detection, appropriate referral, community activities such as Vitamin A campaigns and non-medical aspects of trachoma control. One Vision Centre per 50,000 people. Cost US$10,000 per Vision Centre, i.e. 20 cents per person. The Centre covers 25% of major blinding diseases and 70% of overall vision needs.

In the Pacific region, Vision Centres typically operate out of single rooms in local health clinics. Rooms are often donated or a nominal rental fee is paid. Where possible, constructing a new building to serve as a Vision Centre is avoided.

Service Centre

One for every 500,000 people with each servicing 10 Vision Centres. Service Centres provide primary and secondary eye services, including optical prescribing, dispensing of glasses and cataract surgery. Cost US$100,000 per Service Centre and covers 75% of blinding disease and 90% of vision needs at a further cost of 20 cents per person.

Training Centre

Medical Colleges and Teaching Hospitals with each serving 5 million people and providing basic tertiary care for cataract, glaucoma, diabetic retinopathy and corneal scarring. The training of ophthalmologists, optometrists, optometric technicians and other mid level eye personnel, advocacy and clinical research. Costs US$1 million i.e. another 20 cents per person and covers 90% of blinding disease and 95% of vision needs.

Centre of Excellence

One for 50 million people, at a total cost of US$10 million. This centre treats 100% of blinding disease and vision needs. It does advanced tertiary eye care, new technologies, training, research, management training, Community Eye Health models and product development. The Centres of Excellence …influence government at a national level, and on to regional issues. Add in another 20 cents per person for human resource development, and you have a complete system for one dollar per person. The VISION 2020 approach works to eliminate avoidable blindness by controlling major blinding conditions, conducting eye examinations, developing infrastructure and building the capacity of eye care workers.

Based on a population of 450 million, avoidable blindness and vision impairment could be eliminated in the region at a cost of $600 million over 10 years.

Application in the region

In many areas throughout the region, infrastructure for eye health and vision care already exists. As part of this plan, facilities will build on existing resources for eye health and vision care. Facilities would also be established to strengthen national health systems.

In the region, A$600 million has the potential to establish:

- 14 Centres of Excellence
- 140 Training Centres
- 1,400 Service Centres
- 14,000 Vision Centres

The location of these centres will be determined through sensitive consultation with ministries of health, local stakeholders, VISION 2020 contacts and national VISION 2020 Committees throughout the region. Initial scoping would focus on finding cost-effective and sustainable solutions that are appropriate for local contexts.

Promoting Australia's interests

This plan will affirm Australia as a leader in global efforts to eliminate avoidable blindness. Australian researchers have helped to set realistic targets and plan necessary interventions. Australian NGOs have developed lasting infrastructure, a strong skills-base and practical training modules in countries around the region.

Sustainability

The model adopted by VISION 2020 aims to deliver comprehensive, high-quality eye care to all patients, irrespective of their ability to pay. By charging patients a small fee, facilities collect funds to purchase consumables, maintain operating equipment and allow for the purchase of new equipment. Consultations are usually charged on a sliding scale so patients who can afford treatment subsidise the care of others.

This system of cost-recovery is a key part of the VISION 2020 model, and has been proven successful at the LV Prasad Eye Institute in Hyderabad, India, where patients are charged on their capacity to pay, and where all patients receive a high standard of care in the same examination and operating rooms.

Activities proposed for PNG

- Greater investment is needed to provide eye nurse diploma training modules in Goroka and Port Moresby
- Equipment and infrastructure upgrades are required in service delivery locations throughout Papua New Guinea

- Vision centres established
- Train mid-level personnel to address primary eye care needs, including refractive error services
- Establish appropriate infrastructure at the community level, prioritising in remote and rural areas
- Support low vision services and training

Specific targets identified for PNG

Doctors to be trained as eye doctors by 2013 (5 years)	20-30
Nurses to be trained as eye nurses by 2013 (5 years)	100-200
Vision Centres required	116
Vision technicians required	116
Optical workshops required	2
Optical technicians required	4

The costs to establish the vision centres, train technicians and pay salaries for 6-18 months for the PNG part of the regional programme were estimated to be A$5,260,000 and the timeframe to implement these activities was two years.

Costs for training eye doctors (two thirds of cost for total Pacific region) was estimated at AUD3 million, and eye nurses, AUD5.3 million.
(Australian Labor Party, 2007; Vision 2020 Australia, 2007a, 2007b)

Chapter 10 A health system impact assessment

10.1 Introduction

In the previous chapter Case Study Two, (a plan for a proposed eye health programme) was used to test Tool Two (the fourth questionnaire) in the rights-based framework for aid-funded health programmes. The Plan scored poorly in the questionnaire, with none of the issues raised by the indicators having been addressed in full in the design. Had Tool Two been used to guide the design process, the resulting proposal would have reflected local realities, and would have more likely resulted in a programme that was available, accessible, acceptable, and of high quality. By testing the questionnaire against an actual proposal, its validity was demonstrated, some redundancies were observed, and refinements were made.

In a rights-based perspective, the health system is the core institution through which the right to health is realised. Policies or programmes that weaken the health system are not protecting or respecting health rights, even if these programmes are purportedly designed to fulfil a right to health. Human rights are interrelated, interdependent, and indivisible. This means that one right cannot be filled at the expense of another. Meeting one health care need cannot be justified if it results in the retrogression of other health needs, and especially if the other health needs are those considered core obligations as outlined in General Comment 14.

In this chapter, Tool 3 is tested on the Plan to assess the impact such a programme of activities would have had on the underlying health system had it been implemented. The tool consists of a health system impact assessment questionnaire. The methodology of the development of the questionnaire was outlined in Chapter 3, Section 3.3.4. If this fifth and final questionnaire were validated by the application to Case Study Two, then it would be hoped that in future it could be used not only to assess programme design, but also to help guide programmes towards implementing initiatives that strengthening health systems.

10.2 Applying Questionnaire 5: could the Plan weaken the health system?

Impact assessments of health interventions in developing countries have not been conducted routinely. This may seem a little surprising given the universally accepted health ethic of 'first, do no harm'. And even more so, because social and environmental impact assessments are routinely conducted on proposed projects in other sectors. But curiously, health interventions are perhaps given the benefit of the doubt, on the assumption that any health initiative must surely be a good thing, especially where there is significant need.

However, as discussed previously, there is a growing body of evidence that well-intentioned health interventions in poor countries can indeed do harm. Much of this evidence has surfaced in the debate over large sums of money being directed to specific diseases, via vertical programmes, and based on 'scale up' scenarios (Freedman, 2009; Garrett, 2007b). Critics of these interventions have argued that directing large amounts of funding into specific diseases is destined to failure because already fragile health systems are further weakened when disproportionate numbers of health workers are attracted to employment in those vertical programmes. As a result, State plans, including workforce plans, are disrupted, and those services that do not attract funding are left to deteriorate even further. In Chapter 8, the health system assessment of PNG demonstrated many aspects are so run down that there is a resulting lack of capacity to use the allocated health funding, let alone accommodate increases in funding from aid donors.

In his term as Special Rapporteur, Paul Hunt described failing health systems as giving rise to an extremely grave and widespread human rights problem (Hunt & Backman, 2008). Arguing that a well-functioning health system is essential to secure improved health for individuals and populations, and to fulfil the right to the highest attainable standard of health, Hunt and MacNaughton (2006) developed a rights-based impact assessment. Its purpose was to examine the impact of any proposed activity, health or non-health, on the availability, accessibility, acceptability, and quality of health goods, facilities and services and the underlying determinants of health.

That impact assessment informed the development of Tool Three for use in this rights-based framework (Chapters 3, 5). This tool examines more specifically the impact of health programmes on each building block within a health system. The

structure employed by Questionnaire 3 for an assessment of the health system (Chapter 8) is used again. The health system is viewed via WHO's six building blocks: health services; health workforce; health information system; medical products, vaccines and technologies; good health financing; and governance and leadership (World Health Organization, 2007). Examining the expected impact on each of the building blocks provides a clear demonstration of the ways in which the health system and health programmes are connected.

By conducting a rights-based impact assessment, aid donors acknowledge that they have rights obligations to the people in the countries where they are working. One means of meeting these rights obligations is by strengthening the health system. But for many NGOs and GHIs, who are increasingly funding and implementing health programmes in developing countries, there has been an uncertainty as to how to engage with health system strengthening. It is hoped that this impact assessment will promote such engagement by providing a practical guide.

10.3 Testing Questionnaire 5 on the Plan

In previous chapters through use of Tool One it was established that the health system in PNG is weak. Tool Two determined that the Plan in Case Study Two was devised without consideration of local realities or the capacity of the health system in PNG. Any weakening of the health system in PNG would exacerbate further the inability of the health system to fulfil health rights. Therefore, the purpose of this final tool is to seek information to demonstrate whether the proposed activities in the Plan would have strengthened or weakened all six building blocks of the health system.

There is no timeframe placed around the question of impact. Therefore, the impact assessment is able to take a longer-term perspective, and consider sustainability issues. For example, it could be argued that the Plan may have had no impact on the financing of the health system in the short term, because it had attracted a large sum of money for its first two years. But because the Plan proposed to train hundreds more health workers, and gave no indication it would employ these workers itself, the implication within the Plan is that they would be employed by the State. This would impact on health budgets increasingly from the end of the first year. So while a short term assessment might suggest the Plan would not impact on the

financing of the health system, a longer-term view would show a large financial impact.

10.3.1 Case Study Two impact assessment findings

Questionnaire 5 was completed and a summary of the results is presented in Table 10-1 below. Completing the questionnaire requires a comprehensive understanding of local context, such as would be acquired through completion of the previous four questionnaires.

There are 18 indicators in this health system impact assessment, divided across the six building blocks of the health system. The activities proposed in the Plan were judged likely to weaken the health system in 17 of the 18 parameters. The impact of the Plan on the remaining indicator could not be ascertained. The explanations for each decision on possible impact are documented in a column in the table. The Plan made assumptions about resource availability that were unrealistic and did not align with national plans or capability. It can be seen that had implementation proceeded, there was not one building block in the health system that would not have been further weakened.

When completing the fifth questionnaire, particular regard must be paid to those weaknesses of the health system previously identified. If additional demand is made of a weak aspect of the system, without extra support being provided, then the capacity of that building block will deteriorate even further. For example, if a proposed programme relies on new medicines to be provided by a medical supply system that is already failing to distribute essential supplies, then not only will the new medicines not be dispensed adequately, but the additional workload and cost could further compromise the purchase, distribution and supply of all other medicines.

Therefore, the purpose of this final tool is to help programme planners identify elements in the programme design that are most likely to have a negative impact on an already weak aspect of the health system. Not only does weakening the health system threaten the sustainability of any new health programme, but importantly, it is a failure to protect the right to health.

Table 10-1 Questionnaire 5: health system impact assessment of the Plan

1	**Health services, facilities and goods**	**Weaken or strengthen**	**Impact on blocks of the PNG health system**
1	Does the Plan enhance or jeopardise the availability, accessibility, acceptability and quality of all health goods, services and facilities?	Weaken	If this Plan were implemented, it could only do so by jeopardising other health services. There would be fewer human and other resources for other health services, thereby reducing overall availability; fewer facilities would be available for non-eye health services, thereby reducing accessibility. With fewer workers and medicines for other services, quality would also be reduced.
2	Does the Plan enhance or jeopardise the State's health care service priorities as specified in the core obligations, General Comment 14?	Weaken	Primary health services, maternal health and child health would be jeopardised through potential loss of health workers and facilities. This weakens the health services component of the system.
3	Does this Plan address sustainability of services and goods developed to ensure ongoing availability, acceptability, accessibility and quality?	Weaken	No; therefore the health system will be relied upon to continue to provide the services and supplies once this initial phase of aid funding ends. The resources needed and costs of doing so have not been factored into State plans and budgets. Increased unplanned costs to one sector would weaken the health services component of the health system.
2	**Health workforce**		
4	Does the state have a national health workforce strategy, and if so, is this Plan in keeping with it?	Weaken	The PNG health workforce strategy is being developed in 2010 with a fixed budget for health and its workforce until at least 2013. There is a freeze on employing extra staff and an overwhelming shortage of health workers. This Plan is not in keeping with national workforce and workforce training. The Plan would weaken the health workforce by reducing the number of staff available for other health services.
5	Will this Plan enhance or jeopardise the ratio and density of doctors available to meet Core Obligations?	Weaken	It will jeopardise the ratio if doctors are attracted into the Plan, leaving fewer available to meet the Core Obligation health services (primary health, child/maternal health). This will weaken the workforce component of the health system.
6	Will this Plan enhance or jeopardise the ratio and density of nurses to the population?	Weaken	It will jeopardise the ratio if nurses are attracted into the Plan, leaving fewer available to meet the Core Obligation health services (primary health, child/maternal health). This will weaken the workforce component of the health system.
7	What is the current ratio of health care professionals to estimated need for a health workforce?	Weaken	Based on WHO minimum ratio of 2.28 health workers/1000 population, PNG needs nearly 14,000 health workers. It has just over 3000, leaving a gap of 11,000 health workers. Attracting a large number of workers to one sector in this context will weaken the workforce component of the health system.
8	Does this Plan address costs associated with the employment of additional staff and other health workforce sustainability issues?	Weaken	The Plan suggests user fees will cover vision technician salaries. It does not address costs of employing up to 30 eye doctors and 300 eye nurses, suggesting these costs will be met by the State. Maintaining the workforce is not addressed. Unsustainable costs, and no plans to address attrition, will weaken the workforce component of the health system.

3	**Health information systems**		
9	Does this Plan address strengthening of the HIS?	Weaken	No: the absence of information suggests either the State has to implement data collection from new services, or services will not be monitored and reported on. Either situation weakens the HIS.
10	Does this Plan address collection of data and its integration into the HIS?	Weaken	As above; if data are collected that are not integrated with the national HIS, it causes duplication of data entry and reporting. This weakens the HIS component of the health system
4	**Medical products, vaccines and technologies**		
11	Will medicines and products be added to the national medicines list as a result of this Plan?	Weaken	Not addressed. However, eye health services require medicines and consumables; the Plan does not provide a budget or system of supply, so it can be presumed the State is expected to provide these. Without consultation, planning and budgeting, the burden on medical procurement and supplies will weaken this component of the health system.
12	Has the cost to the State for additional medical products been addressed in this Plan?	Weaken	Costs are not calculated or budgeted. The State has a fixed health budget so added costs will detract from other medical supplies or not be met, creating an irregular and unreliable supply line. Either situation will weaken the medical products component of the health system.
5	**National financing**		
13	Will implementation of this Plan have a financial cost to the health budget?	Weaken	Yes. As above, there are costs associated with employment of health workers, HIS, and supply of medical products. None has been budgeted for, and none is anticipated in national plans. Unplanned and increased costs will weaken the financing of the health system overall.
14	Has this cost been accepted and factored into State budgets?	Weaken	No – as above. Therefore, either the costs will not be met, or if so, it will be met at the expense of other health services. This weakens the financial management of the health system.
15	Will patients be charged user fees?	Not known	Yes.
16	Have user fees been discussed with patients and the community?	Weaken	No; as charges will be introduced without consultation, this risks damaging the community's trust of the health system. Costs are a major barrier to the uptake of health care, so additional charges could reduce use of health services generally.
6	**Governance and leadership**		
17	Is this Plan in keeping with the national health plan?	Weaken	No. Eye health and disability sectors are not addressed in the national health plan. If a large-scale intervention is supported by the State even when not planned by the State, it shows weak governance, in that the State is influenced by external agencies to change its priorities.
18	Was the PNG government or health administration consulted in the development of this Plan?	Weaken	No. If a Plan were permitted to be implemented without this consultation, it would again show weak governance, and could erode community trust in PNG health leaders.

10.4 Validating Questionnaire 5

The known challenges to the health sector as listed in Table 8-2 are examined once more. If Questionnaire 5 is relevant and robust, it should identify elements of a programme that will place additional burdens on weak blocks of the health system. Testing the questionnaire therefore involves an assessment as to whether the questionnaire had captured the likely impacts of the Plan on all parts of the health system.

This is undertaken by:

1. listing the challenges as identified in Table 8-2
2. considering whether the Plan's implementation would be hindered because this challenged aspect of the health system is fundamental to the Plan's success
3. identifying whether the Plan would weaken or strengthen that component and
4. assessing whether this information is captured in Questionnaire 5, and if so, by which indicators.

The results are presented in Table 10-2 on the following page.

There were 42 challenges identified by health workers in PNG. Of these 42, there were only two that would not have been exacerbated by the Plan. However, Questionnaire 5 did not identify 12 of these impacts on weak points of the health system. These are shown as having no associated indicator in the final column of Table 10-2.

These unidentified weaknesses were found in four building blocks of the health system: health services; medical products, vaccines and technologies; national financing; and governance and leadership. Questionnaire 5 had failed to identify that clinical competency of various cadres of health workers was poor, that training of all clinical staff needed to be improved, and minimum standards developed.

Table 10-2 Impact assessment of the Plan on challenges to the health system

1 Health services	**Will this hinder the Plan?**	**Will the Plan help overcome or worsen this challenge?**	**Did Questionnaire 5 capture this impact?**
The need to increase the quality and quantity of clinical capacity	Yes – because if more general clinical services are developed, there are fewer resources for eye health	The Plan will worsen the challenge because it requires large numbers of workers	Yes - Indictor 1
The need for appropriate location of and resourcing for laboratory and diagnostic services	Possibly through allocation of health facilities to labs, not eye health facilities	The Plan could worsen this challenge if it is allocated scarce facility space	Yes – Indicator 1
Need for improved clinical competency of various cadres of health staff	No – if all standards are improved, this is good for all health services	The Plan promotes training so may help overcome this challenge; however, the Plan is not in sync with the National Workforce plan so could also weaken training institutes	No
Need to update and make accessible standard treatment guidelines and standards to guide clinical pre-service and in-service training	No – if applied this would improve all sectors	The Plan does not address difficulties of pre- and in-service training, but it depends on quality clinical training, so could worsen this challenge	No; No indicator specifically addresses health workforce training
Need to strengthen quality assurance and accreditation processes	No – if achieved this would improve all sectors	The Plan does not address quality or accreditation processes; by taking disproportionate resources, it would worsen this challenge	Yes - Indicator 1
2 Health workforce			
Inadequacies in pre-service training capacity (quality, coverage, currency)	Yes – health workers required for the Plan will not have been well trained	The Plan could worsen the challenge by further limiting pre-service training capacity by taking resource, facilities and trainers	Yes – Indicators 1, 4, 5, 6, 7
Inadequacies in in-service training (quality and quantity)	Yes – few health workers available to provide quality training in eye health	The Plan could worsen the challenge by further limiting in-service training capacity by taking resource, facilities and trainers	Yes – Indicators 1, 4, 5, 6, 7
Supervision – inadequate quality, frequency, resourcing and follow-up	Yes – trained health workers not supported when deployed to other facilities	The Plan could worsen this challenge through leaving too few health workers in other sectors	Yes – Indicators 1, 4, 5, 6, 7
Concerns about the ability to increase/support retention and recruitment	Yes – too few staff available and motivated to stay in health sector	The Plan will worsen by wanting to attract more staff away from other health sectors	Yes – Indicators 1, 3, 4, 5, 6, 7, 8
Limited capacity to manage all aspects of human resources for health management	Yes – as the Plan depends on State-employed health workers to provide eye care service, poor management of them will impact on the Plan's service delivery and training	The Plan will worsen this challenge by imposing greater numbers of workers on the weak systems of management without providing support	Yes – Indicators 7, 8

3 Health information system	**Will this hinder the Plan?**	**Will the Plan help overcome or worsen this challenge?**	**Did Questionnaire 5 capture this impact?**
Concerns about the quality of and timeliness of data produced	Yes, because data on eye health service are not presently collected or analysed	Worsen – because more data will have to be collected, further exacerbating timeliness and quality; poor quality data will mean no baseline data can be relied on to monitor impact	Yes – Indicators 9, 10
Processes and capacity to manage health and management information systems neglected	Yes, because no processes and systems in place to collect eye service data	Worsen - data will either need to be collected by present poor systems, or won't be collected at all which exacerbates problem of health services not being monitored	Yes – Indicators 9, 10
Need for data at various levels and especially its link to public health continually raised through reviews	Yes, data are needed to link through for referrals, planning and advocacy	Worsen – as above	Yes – Indicators 9, 10
The need for adequate harmonized monitoring and evaluation frameworks is a regular theme	Yes, monitoring and evaluation needed for Plan's activities	Worsen – either separate monitoring and evaluation (M&E) framework developed (duplicating workloads), or adding to current workloads	Yes – Indicators 9, 10
Lack of capacity at various levels to undertake M&E	Yes, few people available to do M&E who have trained in this	Worsen, extra workload placed on limited capacity	Yes – Indicators 9, 10
Lack of supplementary M&E processes additional to the routine data collection	Yes, to measure impact of the Plan's activities	Worsen – further depleting limited resources	Yes – Indicators 1, 4, 9, 10
Inadequate resources – human, infrastructure, financial and training	Yes – as above	Worsen – further depleting limited resources	Yes – Indicators 1, 4, 9, 10
Need for M&E plan to provide minimum data set for public health action	Yes –data are not collected to be able to plan and measure eye health service and training need	Worsen – resources being directed to eye health without evidence of need	Yes – Indicators 1, 4, 9, 10
4 Medical products, vaccines and technologies			
Woeful state of medical supplies and logistics management	Yes – supplies of medicines, surgical consumables and spectacles are essential for the service	Worsen, because it will place greater demands on an already poor service	Yes – Indicator 11
Inadequate financing of medical supply procurement and distribution	Yes – there is no extra funding for additional supplies	Worsen – pressure on fixed budget system to supply the new service will likely cut spending on other sector supplies	Yes – Indicator 12
Partnerships with non-state actors have improved medicine systems	Yes – may put pressure on the Plan to pay and manage its own drug and consumable supplies	Neutral – if this happens, eye service supplies would move outside the system; Questions not addressed about sustainability	No
Poor quality of medical supplies	Yes, supplies frequently past use-by date or different / fake supplies	Worsen – any added stress on available funding and systems will likely result in further delays, and poor quality control	No
Poor pharmaco-vigilance systems	Yes, low quality medicines and products could be supplied	Worsen – added strain on the system	No

5 National financing	**Will this hinder the Plan?**	**Will Plan help overcome or worsen this challenge?**	**Did Questionnaire 5 capture this impact?**
Inadequate government funding to health	Yes – many activities in the Plan depend on State funding	Worsen – adds to State spending without planning	Yes – Indicators 1, 3, 13
Poor fund flows to operational levels	Yes – staff and services deployed throughout the State	Worsen – adds to workload of poor services without extra support	No
Poor payroll management	Yes – the Plan depends on State employed workers	Worsen – adds to management workload without extra support	No
Poor funds management	Yes – the Plan depends on State managing funding	Worsen – adds to management workload without extra support	No
Poor budgeting	Yes – the Plan requires State commitment to including costs in future budgets	Worsen – adds to management of budget without extra support or inclusion in Budgets	Yes, Indicator - 14
Activities not prioritized and therefore not funded	Yes – the Plan is an example of a non-prioritised activity	Worsen, by expecting funding without it having been planned and prioritised	Yes, Indicators 3, 8, 12, 13, 14, 17,
Lack of absorptive capacity (to use funds)	Yes – the Plan requires many facilities, systems, staff to deliver on funding allocated	Worsen – pressure will go on other services to use their facilities, staff, systems to meet the Plan's targets	Yes, Indicators 1, 3, 4, 5, 6, 7, 9, 14, 17
Lack of human resource (HR) capacity for management systems and processes	Yes – the Plan relies on HR capacity for management systems	Worsen – the few management HR are further overloaded and not supported	No
Poor transparency, accountability and corruption	Yes – risk that funding and other supplies will not be accounted for, or are subject to fraud and corruption	Worsen – placing more demands on the supply system without added support can further erode accountability, increase corruption	No
Lack of financial data for planning and management	Yes – will make budget planning for the Plan difficult	Worsen – added workload on overstretched services	Yes – Indicator 14
Poor ratio of development funding versus recurrent funding	Yes – it is difficult to maintain facilities and equipment	Worsen – quantity of facilities and equipment required will place burden on development funding	Yes, Indicator 14
Development partner funding substituting government funding	Yes, the Plan may be expected to cover costs of all eye health service	Worsen – after short time frame of the Plan, it is unlikely the State will have funds to cover all eye health costs	Yes, Indicator 14
6 Governance and leadership			
Limited capacity for policies to influence practice or resource allocations	Yes, unlikely that policies resulting from eye health advocacy will result in additional State funding	Worsen – the Plan will use resources not driven by policy; fewer resources left for any other needs	Partly – Indicator 18 Administration capacity not addressed
Focus on policy development rather than implementation	Yes as the Plan focuses on implementation only	Worsen – the Plan is attempting to bypass policy and still have State support; will weaken systems	Yes – Indicator 17
Limited capacity for prioritising plans, budgeting, using data to inform plans, or for M&E	Yes – the Plan requires all these functions from the State	Worsen - the Plan expects immediate implementation without consideration of the need to set these processes up	Yes – indicators 1, 4, 9, 10

6 Governance and leadership	**Will this hinder the Plan?**	**Will Plan help overcome or worsen this challenge?**	**Did Questionnaire 5 capture this impact?**
Need to better use, manage and regulate non-state actors to support health sector programmes	Yes – this is an example of a non-state programme not regulated by State	Worsen – because the programme is not in keeping with State plans	Yes - Indicators 2, 3, 4, 17, 18
Little improvement noted in hospital boards' ability to meet responsibilities	Yes – the Plan will be implemented in many hospitals, needing boards' approval to provide facilities, staff, supplies	Worsen – boards will be under pressure to provide facilities etc to a well-resourced (short-term) programme	Partly – Indicator 18 (but capacity not addressed)
Lack of governance at provincial health and hospital board level	Yes, as above; any agreements reached will need to be honoured at provincial health level	Worsen – as above	No
No strategy to involve community through participation	Yes – if the community doesn't participate in service development, barriers to their use of services are not addressed	Worsen – another service planned without community participation, and no strategy in place for ongoing participation	Yes – Indicator 16

The Plan had an objective to train a disproportionate number of eye doctors and nurses, which would have reduced the resources (funding and trainers) available to other divisions of health care. Although the questionnaire seeks information as to whether new programmes are in keeping with national health plans and workforce plans, it did not have an indicator asking whether the programme was also in concert with national health training plans.

In the medical products, vaccines and technologies building block, Questionnaire 5 did not elicit the information that the demand of the additional medicines and products for eye health would further compromise the poor quality, and quality control of all other medicines. However, indicator 11 had shown that additional burdens would be placed on this component, thus likely reducing quality. Therefore, there is probably not a strong case to be made for adding an indicator specifically addressing quality.

In the national financing section, the questionnaire failed to identify that the Plan could further weaken underperforming management systems, or promote corruption. The questionnaire did, however, identify the additional unbudgeted costs that the Plan would introduce into the health system.

Health workers had identified poor management as a barrier to improved health care in several building blocks. These included the health workforce component, health information systems, medical products, vaccines and technologies, financing, and in governance and leadership. At best, the indicators in the impact assessment only addressed these challenges to the health system obliquely. Rather than having a separate indicator within each component of the health system impact assessment, it would be less repetitious to have one indicator in the governance and leadership section that addressed management capacity throughout the whole system.

Finally, there is only one reference to the role of the community in the review of challenges to the health system. The challenges in Tables 8-2 and 10-2 were compiled from health workers' reports, and were probably more focused on availability and quality than on accessibility or acceptability. Investigation was also required into aspects of the health system that impacted on accessibility and acceptability.

10.4.1 Assessing Questionnaire 5 against community concerns

A similar process was conducted around the barriers to health care that the community had listed (Chapter 6 Annex, Table 6-6). If well designed, the impact assessment questionnaire will have included indicators that tested whether the programme will impact on the community's use of health services. The results are presented in Table 10-3.

The community had proffered nine barriers to the use of eye health services. Questionnaire 5 had indicators that would have elicited information alerting programme planners to five of these nine barriers. The four that were not identified by the questionnaire were: difficulty communicating with clinical staff; lack of awareness of eye services; awareness of poor surgical outcomes; and fear of doctors.

Of the nine barriers, the Plan was likely to improve one, make six worse, and have no impact on the other two.

It is likely that surgical outcomes would improve with additional training, although because of the limited capacity to train new surgeons, this is not a given. However, if quality training was achieved, this barrier might be overcome.

The Plan was unlikely to have any impact on the community's ability to communicate with clinical staff across all health sectors, or to improve or worsen community awareness of eye services. It has been shown in other studies that the mere presence of a health service does not result in its use; active health promotion is needed to improve the community's uptake of the service (Donoghue, 1999; Fletcher et al., 1999; Palagyi et al., 2008).

Table 10-3 Does Questionnaire 5 capture access, acceptability issues?

Community cited barrier to health care	**Will this hinder the Plan?**	**Will the Plan help overcome or worsen this challenge?**	**Did Questionnaire 5 capture this impact?**
1. Cost of hospital outpatient and surgical fees	Yes - fees will be charged in the Plan	Worsen – because the Plan will be yet another service to be paid for, adding to community belief that all health care is expensive	Yes – Indicators 15, 16
2. Cost and distance of travel to hospital	Yes – the Plan will provide services in hospitals	Worsen generally because the Plan will reduce availability of other health services, possibly making them less accessible	Yes – Indicators 1, 2, 5, 6, 17
3. Queues at the hospital	Yes – the Plan's services are provided from hospitals; payment for services, data collection, supply of medicine, tests and treatment all involve queues	Worsen – with fewer health workers available for other services, access to those services will worsen; the Plan does not strengthen HIS or medicine supplies; therefore, queues worsened	Yes – 1, 2, 4, 5, 6, 9, 10, 11, 15
4. Broken or deferred appointments by medical staff	Yes – the Plan depends on State health workers to provide its services, so this issue will create barriers	Worsen – with fewer doctors/nurses left for other services, increased workloads on them. Therefore this problem likely to worsen	Yes – indicators 1, 4, 5
5. Difficulty communicating with clinical staff	Yes – the Plan depends on clinical staff to provide its services, so this issue will create barriers	No impact	No - no indicator addresses community consultation, and access / acceptability issues
6. Did not know eye care service was available or could restore vision	Yes – the Plan needs the community to seek the services	No impact (community education was not addressed in the Plan)	No – as above (5)
7. Awareness of poor surgical outcomes	Yes – the Plan depends on the community trusting the service	Strengthen – if quality improves through training	No – as above (5)
8. Difficult hospital processes	As for 3 above	Worsen – the Plan does not address supporting hospital processes and will take staff away from other services	Yes – 1, 2, 4, 5, 6, 9, 10, 11, 15
9. Fear of doctors	Yes – the Plan depends on State employed doctors to provide the service	Worsen – fewer doctors left for other services; therefore greater workload on each doctor, leaving less time per patient	No – as above for (5)

The impact assessment indicators indirectly identified many of the community-cited barriers that would likely be worsened by the Plan. For example, the community cites queues at the hospital as a barrier. While the impact assessment did not have an indicator that specifically asked whether queues at the hospital would worsen as a result of the Plan's activities, it asked various other questions that would suggest this barrier would worsen. These explored whether:

1. the Plan enhanced or jeopardised availability, accessibility, acceptability and quality of all health services;
2. the State's health care core obligations under ICESCR were enhanced or jeopardised;
3. the Plan was in keeping with the health workforce strategy;
4. the Plan improved or worsened the ratio of doctors and nurses available to meet core obligations;
5. HIS and data collection were strengthened or weakened;
6. medicines were more or less available; user fees were to be collected.

The answer to each of these indicators demonstrates that hospital processes and queues would likely worsen, because the impact of the Plan would be, in nearly every aspect, to reduce the health workers available for general service, and thereby increase queues for those services and systems. This analysis demonstrates that although 'queues' was not a specific indicator, enough information was collected in the impact assessment to extrapolate this impact.

However, not enough information was collected to identify the four community issues as discussed in Section 10.4.1, which addressed knowledge and communication. It is therefore recommended that another indicator is included in the Questionnaire 5 to assess whether proposed programmes would likely have an impact on those aspects of accessibility and acceptability on which the community must advise. It is only by actively engaging with people in the community that the problems they experience in accessing and using health care can be understood. Knowing what these issues are is essential if new programmes are to ensure accessibility and acceptability.

10.4.2 Additions to Questionnaire 5

This analysis of problems with the health system identified by both health workers and members of the community showed that Questionnaire 5 required four additional indicators. These are:

- Health services: *Has the community been consulted to assess whether the programme will make all health services more accessible and acceptable?*
- Health workforce: *Are the training components in keeping with a national health workforce training plan?*
- Governance and leadership: *Does the State have a comprehensive national health plan encompassing public and private sectors?*
- *Are management systems and capacity sufficiently robust to accommodate any additional workload from this new programme?*

10.4.3 Were all the indicators in Questionnaire 5 needed?

This crosscheck of the impact assessment explored whether all the indicators contributed to the impact assessment, and which indicators provided the most useful information. 'Useful' is judged by being cited most frequently. The number of times each indicator was cited as having identified an impact is reported in Table 10-4.

Table 10-4 Number of times each indicator was referenced in assessment check

Indicator Number	Number of times cited
1	17
2	4
3	5
4	13
5	9
6	8
7	6
8	2
9	12
10	11
11	3
12	2
13	2
14	6
15	3
16	2
17	5
18	3

Indicators 1, 4, 9 and 10 provided the most information of relevance for detecting the weak aspects of the health system that would be most vulnerable to the impact of the Plan. These indicators covered whether: the activities would generally enhance or jeopardize the availability, accessibility, acceptability and quality of all health goods, services and facilities; the activities were in keeping with a national health workforce strategy; and if they addressed data collection and integration with the health information systems.

Of note is that all indicators were cited, but indicator 15 was only cited in the community barriers table, and indicator 16 was only referred to once in the health worker barriers table. These indicators asked whether user fees would be charged, and if so, whether patients and the community had been consulted. This suggests that health workers are more aware of weaknesses that reflect availability and quality than those affecting the community's use of the system. It is therefore important to include both views in impact assessment questionnaires.

10.4.4 Additional information gathered

Tables 10-2 and 10-3 were completed as an exercise to assess the appropriateness of the indicators in Questionnaire 5. However, by inclusion of a column that examined whether the cited barrier would hinder the implementation of the Plan, the tables demonstrate the many ways in which the weaknesses of the health system can impact on a new programme. This provides a practical demonstration of the role of the health system as an underlying institution. It illustrates the dependence of all health activities on the six building blocks of the health system.

In Table 10-2, of the 42 challenges listed, 38 of them would have hindered the implementation of the Plan's activities. In Table 10-3, all nine of the challenges would have impacted on the Plan's activities. This creates a vicious cycle, because a weak health system limits the ability of a new health initiative to achieve its objectives, and as another health initiative fails in its objectives, it will further weaken the health system. The weaker the health system becomes, the less any health programme is able to deliver a quality service that is available, accessible, and acceptable.

10.5 Conclusion

The PNG government and its international partners are bound by the ICESCR, including the duty to meet the right to the highest attainable standard of health for PNG people. It is incumbent upon the government to progressively realise the right to health, meet its core obligations, and to report to the CESCR. With all human rights, there is a duty to respect, protect and fulfil the rights, and one right cannot be fulfilled at the expense of other rights.

The Consortium of NGOs that designed the Plan in Case Study Two advocates for 'the right to sight'. This health systems impact assessment has demonstrated that even if it had been possible to deliver the activities as initially advocated, in doing so, all building blocks of the underlying health system in PNG would have been weakened. So even in the unlikely event that one health service may have improved through the implementation of this Plan, the final tool in this framework demonstrated that by weakening the health system, this Plan would not have protected and respected all other health rights. Such an outcome is a violation of the right to health. The Consortium, as an international partner with the PNG government working in the health sector, has duties to respect, protect and fulfil the right to health. This Plan, had it been implemented, would have demonstrated a failure of the Consortium to honour those duties.

The health system impact assessment can be used to guide programme planners through a rights-based process to systematically and thoroughly explore the impact of a proposed programme. It is a tool that helps consider programme effects on parts of the health system that programme designers may not have previously recognised as relevant to the programme's activities. For example, when designing the Plan in this case study, the Consortium may not have considered that the activities proposed would depend on having functioning medical supply systems in place. Disregarding this weak block of the health system would have impacted on proposed services. Supplies of ophthalmic medicines and consumables are not likely to be provided through this dysfunctional medical supplies system, and in turn, adding in unbudgeted and unplanned supply demands would further weaken it. This will then lead to an exacerbation of the current situation that already has health facilities without essential medicines about half the time (PNG National Department of Health, 2009b).

Another use to which Questionnaire 5 can be put is to provide guidance on how a new programme could strengthen the health system. The systematic approach to considering each block of the system, and having practical pointers on what will strengthen or weaken it, is useful for all partners in the provision of health care. None will find this more useful than those who are new donors in a country, or smaller NGOs or GHIs who are not included in SWAps or bilateral health programmes. For example, had the Consortium used this entire design framework including the third tool, it would have known there was an overwhelming shortage of health workers in PNG and a frozen health budget. If it had chosen to work within the national health plans, and health workforce plans, this would have provided support for the health system and kept the needs of eye health balanced with other health care needs. In doing so, this would have helped strengthen the health system. By ignoring these State plans, as has been shown, the health system would have been weakened and programmes rendered unsustainable.

On the face of it, without regard for the actualities of health service delivery in the PNG context, it is understandable that advocacy suggesting a vertical approach to delivering eye health services would have had appeal to a partner government wanting to address disability in another State. But as shown, eye health cannot be isolated from any other part of the health system, and delivering eye care services should not be thought of as separate from or any more simple than delivering any other health service.

Any assessment of the impact of the Plan's proposed activities on the PNG health system would have similarly found it to be unworkable and unsustainable. The value of a rights-based assessment is it also shows the Plan would have been a breach of international human rights law. In weakening the health system, the availability, accessibility and quality of other essential health care services would have been jeopardised. As NGOs and non-state actors become ever more significant funders and implementers of health initiatives in developing countries, they must acknowledge they are legally obliged to respect, protect and fulfill the right to health.

This Plan was part of an advocacy campaign by a group of NGOs. The rights-based assessment of both the Plan and its health system impact suggests two important steps for NGOs who wish to become rights-based agencies. The first is that from the very start of any planning, including advocacy campaigns, crucial rights concepts need to be employed that will promote engagement with the local context.

A second step is realising that working within State plans for health and the health workforce is an immediate and straightforward approach to strengthening the health system. Protecting, respecting and fulfilling the right to health all depend on a strong underlying health system.

PART THREE: PRESENTING THE FRAMEWORK

Chapter 11 Tools to guide the design of an aid-funded health programme

11.1 Introduction

Chapters 6-10 tested the rights-based tools to assist the design of aid-funded health initiatives on two case studies from PNG. Working through the framework, five different questionnaires were trialled and assessed. These questionnaires have incorporated a rights-based approach to developing an understanding of the local context and the health system, the design of the new health programme and its impact on the health system. After testing each questionnaire, refinements were made to their indicators, and these are now presented as Tables 11-1 to 11-5.

11.2 The three-step framework

The framework that has been developed through this research involves three steps:

- **Step One**: Understand the local context by:
  - Assessing international and national human rights and health rights obligations, through ratification of UN Treaties and other legally binding commitments
  - Assessing domestic policies and practices to observe the State's operationalisation of its right to health duties
  - Conducting a rights-based assessment of the health system
- **Step Two:** Design and assess the new health programme
- **Step Three:** Assess the impact of the programme on the health system.

Each of these steps has a tool to guide programme planners through the process. The tool for Step One has three questionnaires with a total of 123 indicators (Tables 11-1 - 11-3). These indicators elicit comprehensive information on the context

within which a new health initiative will be located. Step Two addresses the design of the programme itself (based around 36 indicators in Tool Two), and Step Three assesses the impact of the design on the health system (22 indicators in Tool Three). Together, these three parts can be used to guide the development of a new health initiative that will respect, protect and fulfil the right to health.

Examination of the three tools reveals that operationalising the right to health does not require a foray into different discourse or new concepts. The first tool has three questionnaires that prompt the collection of familiar information. Only 20 of the 123 indicators specifically focus on rights. Together these questionnaires enable a comprehensive picture to emerge about the State's capacity, commitment and willingness to meet its rights obligations. In particular, this understanding is developed by close examination of the six building blocks of the health system.

The second tool guides a process to design, or assess a design of, a new health programme. Again, without introducing unfamiliar concepts or processes, it aims to design a programme that delivers a service that will be available, accessible, acceptable, and of good quality. Such a programme would assist the State to fulfil its health rights obligations.

The third tool, a health system impact assessment, helps a new programme to protect the right to health. The questionnaire has 22 indicators to assess the impact of the new programme on the six building blocks of the health system. This final questionnaire demonstrates, as does the health system assessment in the first tool, that all health services depend on the health system. Programmes that weaken any aspect of the health system limit its capacity to meet people's right to health.

In summary, operationalising the right to health does not involve a departure from good development practice. It does involve:

- respecting health rights by designing with a full understanding of the local context including the health system
- fulfilling health rights by working within the State's health plans and designing to ensure the services are available, accessible, acceptable and of quality
- protecting health rights by conducting a health systems impact assessment to ensure that the programme will not weaken the health system.

11.3 The final tools

11.3.1 Tool One to assess context

Table 11-1 Tool One: Questionnaire 1 - international layer

Indicator number	**Recognition of human rights (current and five years prior)**
1	Has the state ratified or acceded to: - ICESCR?
2	- CEDAW?
3	- CRC?
4	- CERD?
5	Is the State submitting its reports to the UN monitoring committees in a timely manner?
6	Does the State's constitution, bill of rights, or other statute recognise the right to health?
	International obligations, assistance and cooperation
7	Total government spending on debt service as percentage of GDP?
8	Total government spending on health as a percentage of GDP?
9	Is government spending on health increasing at least at the rate of population growth?
10	Has the State made contractual commitments to banks or other states regarding reducing state services?
11	Does the State's international development policy explicitly include specific provisions to promote and protect the right to health?
12	Does the State's international development policy explicitly include specific provisions to support the strengthening of health systems?
13	Is there a SWAp throughout the health sector to which all bilateral and significant donors belong?
14	Does the State publish one document that details all donors' health-related activities?
15	What proportion of net official development assistance is directed to health?
16	What percentage of the health budget comes from overseas development assistance?
	Record on human rights
17	Is the published assessment of the State's human rights record good, average or poor?
18	Does Transparency International's report on corruption raise issues of concern in health?
19	How many health rights cases have been taken to national courts in previous five years?
20	Have there been media reports critical of aid donors in the past 12 months?

Table 11-2 Tool One: Questionnaire 2 - state context

Indicator number	**Demographic data (current and five years prior)**
21	Population, total
22	Population growth (annual %)
23	Rural – urban ratio of population
24	Percentage of people living in poverty (less than $US2 per day)
25	Contraceptive prevalence (% of women ages 15-49)
	Political system
26	Is the State a democracy?
27	What is the number and percentage of women MPs?
28	Does the constitution protect freedom of expression?
29	Does the constitution protect freedom of association?
	Governance Indicators – use World Bank scores
30	Voice and accountability
31	Political stability
32	Government effectiveness
33	Rule of law
34	Regulatory quality
35	Control of corruption
	Non-discrimination
36	Number of treaty-based grounds of discrimination that the state protects out of: sex; ethnic origin, race, or colour; age; disability; language; religion; national origin; socioeconomic status; social status; social origin, or birth; civil status; political status, or political or other opinion; and property
37	Number of non-treaty-based grounds of discrimination that the State protects out of: health status (eg, HIV/AIDS); people living in rural areas; and sexual orientation
38	General provisions against discrimination
	National financing
39	Is the per capita State expenditure on health greater than the minimum required?
40	Total government spending on military expenditure as percentage of GDP?
41	Percentage of total state budget from official development assistance?
42	GDP per capita, current US$/constant US$
	Underlying determinants of health
43	What percentage of the rural and urban population has access to clean water?
44	Is measurement of childhood nutrition conducted in both rural and urban areas?
45	What percentage of the rural and urban population has access to approved sanitation systems?
46	Does the State have legislation requiring environmental impact assessments on all industrial developments?
47	Are environmental impact assessments made available for public viewing?
48	Has violence against women been documented?
49	Does State law require comprehensive sexual and reproductive-health education during the compulsory school years for boys and girls?
50	Proportion of 15- to–24-year-old boys and girls with comprehensive HIV / AIDS knowledge?

Table 11-3 Tool One: Questionnaire 3 - health system assessment

	Core obligation measures
51	Life expectancy at birth
52	Maternal mortality rate (per 100,000 births)
53	Infant mortality rate (per 1000 lives births)
54	Percentage of births attended by skilled health personnel
55	HIV prevalence (% of population 15-49 years)
	Health services
56	Proportion of women with a live birth in the last 5 years who, during their last pregnancy, were seen at least three times by a health-care professional, had their blood pressure checked, had a blood sample taken, and were informed of signs of complications
57	Number of primary care facilities in health system per 10,000 population - urban /rural distribution; percentage that is functional?
58	Percentage of primary care facilities that are adequately equipped with water, telephone, power, refrigeration
59	Are updated clinical standards available for priority areas, high burden diseases areas, and/or areas responsible for high morbidity and mortality?
60	Number of hospital beds (per 10,000 population)
61	Number of obstetric beds (per 10,000 population)
62	Percentage of births supervised in health centres or hospitals
63	DTP3 immunization coverage: one-year-olds immunised with three doses of DTP3 and pertussis (%)
64	Number of MOH vertical programmes (ie, those that focus on specific interventions, funded by aid donors)
65	Are there national policies for promoting quality of health care services?
66	Are clinical standards documented as guidelines or manuals and used by health care providers?
67	Are district-level health centres visited by clinical supervisors?
68	Are records kept of health worker visits to the community?
69	Are mechanisms present to ensure engagement of the community in planning and monitoring service delivery?
70	Do mechanisms exist for eliciting population priorities, perceptions of quality, and barriers to seeking care?
71	Is patient feedback on their experience within the health service regularly sought?
	Health workforce
72	Does the state have a national health-workforce strategy?
73	What is the ratio and density of doctors to the population?
74	What is the ratio and density of nurses to the population?
75	What is the ratio of current health care professionals to estimated need for a health workforce?
76	Are health workers employed in a transparent process and given job descriptions?
77	Is there a formal mechanism for individual performance planning and review?
78	Does the State law include provision for adequate remuneration for health care professionals?
79	Do the State's workforce policies / programmes include a plan for self-sufficiency for health care workers?
80	Do the State's health workforce policies/programmes provide incentives to promote stationing in rural areas?
81	Are human rights a compulsory part of the curriculum for the training of doctors?
82	Are human rights a compulsory part of the curriculum for the training of nurses?
	Health information system
83	Does the State law protect the right to seek, receive, and disseminate information?
84	Does the State law require registration of births and deaths?
85	Does the State have a civil registration system?
86	Does the State disaggregate data in the civil registration system on grounds of: sex, ethnic origin, rural or urban residence, socioeconomic status, or age?

87	What proportion of births is registered?
88	Does the State regularly collect data, throughout the nation, for the number of maternal deaths?
89	Does the State make publicly available these data for the number of cases of maternal deaths?
90	Does the State regularly collect data, nationwide, for the number of neonatal deaths?
91	Does the State regularly collect data, nationwide, for the number of deaths in children under five years?
92	How current is the official maternal mortality rate?
93	What variance is there between highest and lowest reported maternal mortality rates?
94	Are data collected on children under five years who are underweight for age?
95	Are sufficient financial resources available to support HIS?
96	Do international donors support strengthening HIS centrally and provincially?
97	Do policies and regulations exist to mandate public and private health providers to report indicators?
98	Is there a current and annual national summary report of all HIS data?
99	Does the State law require protection of confidentiality of personal health data?
	Medical products, vaccines and technologies
100	Is access to essential medicines or technologies, as part of the fulfilment of the right to health, recognised in the constitution or national legislation?
101	Is there a published national medicines policy?
102	Is there an active national committee responsible for maintaining a national medicines list?
103	Is there a published national list of essential medicines?
104	What is the average availability of selected essential medicines in public health facilities?
105	What is State expenditure on pharmaceuticals (per capita) in US$?
106	What is private expenditure on pharmaceuticals (per capita) in US$?
107	What percentage of 1-year-old children is immunised against measles?
108	Value of inventory loss (as % of average inventory value) over 12 months?
109	Are equipment and consumables supplied and maintained in accordance with agreed minimum standards?
	National financing (other indicators pertaining to financing the health system have been asked in the second questionnaire)
110	What is the proportion of households with catastrophic health expenditures?
111	What proportion of the State health budget is allocated to mental health?
112	Are user fees charged in the public health facilities?
113	Are there policies to protect disadvantaged groups from paying user fees?
114	What percentage of the planned provincial budget expenditure was spent in the last financial year?
	Governance and leadership (some indicators for this section are in the first two questionnaires, and other sections of this questionnaire)
115	Does the State have a patients' rights charter?
116	Does the State have a comprehensive national health plan encompassing public and private sectors?
117	Has the State undertaken a comprehensive national situational analysis?
118	Before adopting its national health plan, did the State undertake a health impact assessment?
119	Before adopting its national health plan, did the State undertake any impact assessment explicitly including the right to health?
120	Does the State's national health plan explicitly recognise the right to health?
121	Does the State's national health plan include explicit commitment to universal access to health services?
122	Does the State law require informed consent to treatment and other health interventions?
123	Is there a legal requirement for participation with marginalised groups in the development of the national health plan?

11.3.2 Tool Two to assess programme design

Table 11-4 Questionnaire 4: programme assessment

Availability	**Are these issues addressed fully, poorly or not at all**
1	What is the need for this service and how many health workers are required to provide it?
2	Does the State have the health workforce to meet the needs of this programme?
3	Does the State's health workforce plan include this service?
4	Who is employing the health workers in this programme?
5	How will health care workers be trained to provide the service?
6	From where will the service be provided?
7	Are support services in place for this service (administration, maintenance, cleaning, sterile services)
8	Are systems are in place to ensure consistent availability of medicines, consumables and other supplies?
9	Will the service be available throughout the country? If not, are plans in place to increase availability?
10	Is an information system planned to monitor availability?
11	Does the National Health Plan include this service?
12	Is the service included in State forecast budgets?
Accessibility	
13	How will all people, irrespective of gender, locality, disability, ethnicity or age access this service?
14	How will people know the service is available?
15	Has a referral pathway been established from primary to secondary/tertiary health centres?
16	Will patients be charged fees for the service?
17	Were community studies undertaken to determine willingness-to-pay by the community?
18	Are the medicines for this service on the essential drugs list?
19	Will patients have to pay for medicines?
20	What systems are in place for people who cannot afford to pay for the service or medicines?
21	How is access measured and monitored?
22	What data are required on access for the ministry of health?
Acceptability	
23	How will the programme demonstrate acceptability by patients and the community?
24	How is confidentiality of patient information being addressed?
25	How is informed consent being addressed?
Quality	
26	Are health information systems in place to record treatment outcomes, patient recall and follow-up?
27	Is patient satisfaction measured and monitored?
28	How will the programme demonstrate quality service to patients and the community?
29	Are health workers provided with ongoing training programmes?
30	Are monitoring visits planned to each service centre?
Human Rights Concepts	
Progressive realisation	
31	Does the programme refer to the country's health rights obligations and their progressive realisation?
Core obligations	
32	Is the service being provided one of the State's core obligations in the right to health?
33	Was a health systems assessment undertaken as part of the programme design?
34	Was an impact assessment of the programme undertaken?
35	Will the health ministry be advised annually of the funding provided by donors for this service?
36	Is there a monitoring body for this programme that includes local people?

11.3.3 Tool Three to assess impact on the health system

Table 11-5 Questionnaire 5: health system impact assessment

	Health services, goods and facilities
1	Does the policy enhance or jeopardize the availability, accessibility, acceptability and quality of all health goods, services and facilities?
2	Does the policy enhance or jeopardize the Government's health care priorities as specified in the core obligations sections of UN ICESCR General Comment 14?
3	Does this policy address sustainability of services and goods developed to ensure ongoing availability, accessibility, acceptability and quality?
4	Has the community been consulted over this programme to assess whether it will make all health services more accessible and acceptable?
	Health workforce
5	Does the State have a national health-workforce strategy, and if so, is this policy in keeping with it?
6	Will this policy enhance or jeopardize the ratio and density of doctors available to the population to meet Core Obligations?
7	Will this policy enhance or jeopardize the ratio and density of nurses to the population?
8	What is the ratio of current health care professionals to estimated need for a health workforce?
9	Does this policy address costs associated with the employment of additional staff and other health workforce sustainability issues?
10	Are the training components in keeping with a national health workforce training plan?
	Health information system
11	Does this policy address strengthening of the HIS?
12	Does this policy address collection of data and its integration into the HIS?
	Medical products, vaccines and technologies
13	Will medicines and products be added to the national medicines list as a result of this policy?
14	Has the cost to the government for additional medical products been addressed in this policy?
	National financing
15	Will implementation of this policy have a financial cost to the health budget?
16	Has this cost been accepted by the Dept of Health and factored into future financial plans?
17	Will patients be charged user fees for this service?
18	Have user fees been discussed with patients?
	Governance and leadership
19	Does the State have a comprehensive national health plan encompassing public and private sectors?
20	Is the health care service addressed in this policy in keeping with the national health plan?
21	Were the government or health officials consulted in the development of this policy?
22	Are management systems and capacity sufficiently robust to withstand the additional workload from this new programme?

Chapter 12 Discussion and conclusions

12.1 Introduction: health rights can be operationalised

This thesis has demonstrated that a rights-based approach to programme design is practical, feasible and relevant in the difficult circumstances presented in developing countries. The tools that have been developed and tested provide a systematic and logical process to operationalise the right to health.

There is a general shortage of tools to assist in the design of aid-funded health programmes, and a complete absence of ones that could guide the process from a rights-based perspective. These new rights-based tools could assist programme planners to navigate through the layers of impact on local context, draw on this understanding of context to design an intervention, and then check the intervention does not adversely impact upon the health system. The process engages with good development practice and human rights concepts. But it brings more to a programme than just good practice: it adds the weight of international health law. By drawing on international covenants to which all States have agreed in one form or another, the right to health provides a legal framework within which aid-funded health programmes are located, whether donors acknowledge this or not.

The right-to-health framework in this thesis is premised on the understanding that rights obligations are held by all providers and funders of health care, not just States, and that individuals are central in health interventions, as the rights claimants. Therefore, all aid-funded health programmes must respect, protect and fulfil everyone's right to health.

The health sector has shown a reluctance to engage with human rights, in part because of their framing in legal discourse (Asher, 2004; Gay, 2007). The lack of translation of rights into practical means of engagement has also limited their uptake by health workers. Consequently, health rights, when considered in global health at all, have tended to be used for advocacy purposes rather than to shape programme methods and activities.

Nowhere is the need to operationalise the right to health greater than in developing countries; and at no time has the need been more urgent than now. With the vast increase in funding for global health activities, there is great pressure being applied to fragile health systems to deliver on the promises of donors. As the second case study (and other research) showed, the demands of well-funded aid programmes pose great risks to health systems, and if these systems collapse, right to health obligations cannot be met. Operationalising the right to health has much to offer in these situations. While it is not possible to fulfil all health rights overnight, the right to health does impose some obligations of immediate effect, including the requirement:

> …that a state at least prepares a national plan for health care and protection. Furthermore, the right to health requires that there are indicators and benchmarks to monitor progressive realisation and that individuals and communities have opportunities for active and informed participation in health decision making that affects them (Backman et al., 2008, p.2048).

These plans, and human rights concepts, offer the means through which global partners can begin to engage with the right to health in developing countries. However, from the design of health interventions through to the execution of individual procedures, the right to health in developing countries is seldom recognised or acknowledged by the international community. Even those States known for their commitment to aid funding are reluctant to concede they have legal obligations to provide aid (United Nations, 2007) or to be accountable for their aid interventions.

Translating the right to health into practical tools, and encouraging their use by the global health community, is one way to prevent rights violations and to promote rights fulfilment. The tools developed in this thesis focus on the design stage of programmes, so that resulting activities are well positioned to respect, protect and fulfil the right to health.

12.2 The role of health systems and aid funding for health

The past decade's growth in global health spending has been driven by donor States to meet the MDGs and by new, large and well funded GHIs and NGOs that target specific diseases (Ravishankar et al., 2009).

This focus on poor health and single diseases has not been driven by a rights agenda, nor necessarily by recipient country needs and requests. Rather, it reflects donor interests. As the history of aid has shown, donor interests can be fickle. This creates an aid environment of uncertainty and one in which planning is difficult. As long as aid funding for health in developing countries is left to the whim and mercy of distant States and organisations, the right to health in these countries is unlikely to be progressively realised. Without mechanisms of participation with, and accountability to, the rights-bearers, there can be little surety that aid-funded health interventions are directed to where they will best meet people's rights in the long term.

There is also every chance that targets will not be achieved in disease-specific aid initiatives because the health systems needed to provide quality health care are suffering from years of neglect and ongoing inadequate funding (Freedman, 2005). Failed targets lead to donor disillusionment, disappointment and withdrawal (Garrett, 2007b). Many developing countries have a dearth of health workers, deteriorating infrastructure, poor distribution systems for medicines, poorly trained management and governance executives, and little funding to help these essential building blocks of the health system function better. Rather than supporting these run-down blocks of the health system, much of the new funding for health since 2000 has gone to fight specific diseases, especially HIV/AIDS, malaria and TB (Ravishankar et al., 2009).

Scarce health workers and other resources are attracted to those well-funded specific disease programmes, leaving the rest of the health system even worse off than previously. Then the already weak health system is left with even less capacity and fewer resources to meet the rest of the State's health obligations (Freedman, 2005, 2009; Garrett, 2007b).

For these reasons, and because the health system is the core institution through which the right to health is fulfilled (Backman et al., 2008), it is imperative that all health interventions respect and protect the health system. Therefore, operationalising the right to health necessitates a strong focus on the health system: assessing it, designing programmes to work in alignment with it, and measuring the impact of programme activities on it. Respecting and protecting the health system is central to the framework in this thesis.

The essential role of the health system in enabling all health programmes was examined in Chapter 10. The second case study demonstrated that the weak aspects of the health system would have severely constrained nearly all the Plan's proposed activities. It was a practical demonstration that all health programmes, whether vertical or part of the public health system, are dependent upon the efficient functioning of all six building blocks of the health system.

12.3 A paradigm shift from philanthropy to rights

This thesis posits that working within a rights-based framework offers a means of strengthening local health systems, in particular by working with States to assist the progressive realisation of their core obligations as outlined in General Comment 14. It is not alone in seeking a paradigm shift in the framing of health aid so that it is no longer regarded as an optional, philanthropic or charitable exercise. Instead, health aid should be viewed as a legal duty incumbent upon States and other actors who can assist to meet the health rights of all global citizens.

> …under international human rights law, wealthy governments have not only moral but also legal obligations to provide 'international assistance and cooperation.' Yet efforts to advance global health and development, as well as to address humanitarian emergencies, are generally treated as issues of beneficence (Yamin, 2010).

Yamin argues human rights cannot be achieved universally until international assistance is no longer viewed as charity. "Charity allows people in the industrialized North, including governmental leaders, to feel good about themselves… without facing the long shadow of suffering that comes with their privilege" (Yamin, 2010, p.11).

This paradigm shift does not require a giant leap of faith on the part of donors into an arcane philosophy with legal discourse and challenges in international courts. Rather, as the testing of the tools developed in this thesis has demonstrated, a rights-based approach to health programmes in developing countries uses concepts already familiar to best practice in development. These include the crucial rights concepts: equality and non-discrimination, participation, information and accountability. This thesis argues, and has demonstrated, that using a rights-based framework in the design of health programmes promotes the effectiveness and sustainability of health services.

The value of a paradigm shift is that it can improve the quality of aid interventions. By placing the rights of people in developing countries central to all aid-funded health programmes, there is finally the opportunity for a coordinated global effort to make quality health care accessible and acceptable to all people. Box 12-1 illustrates the effect of the paradigm shift; it keeps the individual and his or her rights central to development of new health programmes.

Box 12-1 Shifting the paradigm from philanthropy to rights

Previous paradigm: Philanthropy	**New paradigm: Rights**
Health aid programmes delivered optionally, and as goodwill, philanthropy, or charity	Health aid programmes as a right
State government has domestic duties to citizens to provide health services	State government, its international partner governments and other international partners, *all* have duties to respect, protect and fulfill the right to health in the State
International donors can choose to support health initiatives that meet their own criteria	International donors must support health initiatives that are in keeping with the State's health plans and health workforce plans, and Core Obligations under ICESCR and General Comment 14
NGOs and GHIs as charities and philanthropists can choose to support health initiatives that will meet their own criteria	NGOs and GHIs have international obligations within the right to health and when supporting health initiatives must demonstrate that they are respecting, protecting and fulfilling the right to health
NGOs and GHIs can provide health services independently of the State health system	NGOs and GHIs must always work to strengthen the State health system, and in all new initiatives demonstrate that they are respecting, protecting and fulfilling the right to health
The State is responsible for developing and maintaining the health system	As the health system is the core institution through which the right to health is delivered, the State and all its international health aid partners have a responsibility to strengthen the health system
Patients and the community are the beneficiaries of those health services which the State or its partners are able or willing to provide	All people have a right to health; the State must progressively realise this right and meet its Core Obligations under General Comment 14. Essential health services must be available, accessible, acceptable and of good quality

12.3.1 Relevance of a rights paradigm to current debates

Rights-based approaches to health aid offer solutions to current debates in global health. One of these debates concerns whether vertical programmes strengthen or weaken State capacity to deliver health care. In a rights-based approach to health aid, all interventions would assess their impact on the health system before implementation (as demonstrated in Tool Three). This assessment sidesteps the generalised debate about the merits of vertical, diagonal or horizontal programmes. Research has shown few programmes are able to be neatly defined as 'vertical' or

'horizontal', (Atun, de Jongh, Secci, Ohiri, & Adeyi, 2010; Ooms et al., 2008), and so it is more effective to focus on each individual programme's impact. If a programme demonstrates it would strengthen the health system and assist in meeting health rights, then its classification as either vertical or horizontal is of little relevance.

Another debate surrounds changing global health diplomacy. GHIs and NGOs are now significant donors and implementing agencies in global health. These non-state actors lie outside the traditional mechanisms of health governance, such as those within WHO, other UN agencies, and State governments. Consequently, there is little transparency and accountability in their global health activities. The adoption of rights-based approaches to global health offers solutions through accountability mechanisms. Accountability is a crucial human rights concept. It requires full and transparent monitoring and reporting to all stakeholders, and especially to rights claimants, namely, the population.

> Accountability is the process which requires government to show, explain and justify how it has discharged its obligations regarding the right to the highest attainable standard of health. This process also provides rights-holders with an opportunity to understand how government has discharged its right to health obligations (Potts, 2008, p.13).

The State, as Potts argues, has ultimate responsibility for discharging rights duties. These include the responsibility of protecting the right to health by protecting the health system. Herein is the opportunity to call for transparent assessment of all global health partners, to hold them to account for their activities. This accountability would require demonstration that they are not weakening the health system. If non-state actors were to accept this rights-based obligation to be accountable for their activities in developing countries, the current lack of governance within global health would be resolved. It would be in keeping with General Comment 14, paragraph 42:

> While only States are parties to the Covenant and thus ultimately accountable for compliance with it, all members of society - individuals, including health professionals, families, local communities, intergovernmental and non-governmental organizations, civil society organizations, as well as the private business sector - have responsibilities regarding the realization of the right to health. State parties should therefore provide an environment which facilitates the discharge of these responsibilities (United Nations, 2000b).

12.4 Strengths of this research

The right-to-health view adopted by this thesis, and translated into practical tools, does not suggest health is not part of the development agenda. Rather it subscribes to a view of development as freedom (Sen, 2000a); freedom to live full and flourishing lives. The risk of placing health aid within a narrower economic development perspective is that aid is then directed to those health programmes that are considered best able to promote economic growth. History, as demonstrated in Chapter 2, shows the perils of such a perspective. Decisions on funding for health aid made on a pro-growth development agenda are not responding to the health needs and rights of individuals, nor to the State's right to health duties. As such, they repeatedly fail to improve population health.

Liberating global health from the economic development agenda and locating it within a rights arena places individuals' health needs firmly within international health law. This recognises that global health is not a philanthropic and 'optional' undertaking, but it is in fact a legal duty incumbent upon international partners, State and non-State.

However, navigation of health rights from theory to practice remains largely unchartered. Herein lies the major contribution of this research to the body of knowledge on the right to health. The literature review confirmed that a comprehensive rights-based guide to designing health programmes had not yet been developed. This work aims to fill that gap. The tools bring human rights principles to a systematic design process, focused around integrating programmes into health systems. They provide a practical mechanism for respecting, protecting and fulfilling the right to health. In particular, and perhaps the greatest contribution this research makes, Tool Three allows programme planners to demonstrate that the new programme will not weaken the health system.

This rights-based framework enables new programmes to be designed in a way that aligns with, and strengthens, the health system. Such strengthening occurs whenever new programme activities are designed to support the State's own plans to progressively realise its core right-to-health obligations. Tool Three is especially useful for those partners in international health interventions for whom engagement with the concept of 'health system strengthening' was previously bewildering.

There is little in a rights-based approach to health programme design that is not familiar to development professionals. This new rights-based framework provides a structured approach to the design process and in so doing goes some way to demystifying health rights.

The framework is by no means a 'design template', (an anathema to a rights-based approach). Rather it provides a set of questionnaires which prompt programme planners to gather the information they need. This information comes from the broader international and national political context, through to the impact of the proposed programme on the underlying health system. A new programme must be informed by an understanding of those layers of impact in order to meet a health need in a manner that is appropriate to the local circumstances. In this way, a new programme should not only assist the State to fulfil the right to health, but it can also demonstrate that it does so while respecting and protecting all other health rights.

The research in this thesis is strongly grounded in the real world of aid-funded health programmes. The observations, analyses, programme reviews and case studies all come from the author's own work and experience over the past eight years in international health programmes, including in PNG. The research takes an in-depth look into one developing country to produce tools that are practical, relevant, robust and feasible within the messy realities of a fragile health system. The complex challenges to improving health in PNG are common to many developing countries and provided a realistic testing ground for the tools.

The case studies enabled a rigorous process of testing the tools on one implemented programme, and one proposed plan. In both cases the designs were known to be deficient, and thus they provided an excellent opportunity to test the tools to determine whether they would detect and correct those design faults. It was shown they were able to do so. The research was resource-rich, drawing on many documents, analyses, published and unpublished literature on eye health in PNG, including health workers' concerns about the health system. The comprehensive eye health survey and community focus groups provided a valuable source of information about the community and attitudes towards eye health and health care. The author's participation in PNG health planning and health worker training fora was also invaluable in informing an understanding of local context.

The depth and comprehension of the tool testing is a strength of this research, demonstrating that the tools can be applied usefully in a developing country setting. They were tested for their relevance and feasibility. Not only was it shown that the information collected would have been useful to designing improved programmes, it was also shown that the indicators sought appropriate information. The application to the case studies enabled refinement of the indicators to make them more robust for future use.

12.5 Research limitations

A potential limitation of this research is that the new rights-based framework was only tested in one country. Although the indicators for the questionnaires in the tools were informed by the literature and had, for the most part, been used to survey 194 countries (Backman et al., 2008), this in-depth application of the new framework would further benefit from similar use in other locations.

This research adopted a retrospective analysis in the first case study; it endeavoured to assess whether use of the first tool would have improved programme design to achieve better outcomes. This is a subjective analysis, undertaken by the author alone. The time and resource limitations of this research determined such an approach, but it is a weakness that a more participatory analysis was not undertaken. Use of the tools in prospective studies in different contexts would be valuable to further assess their relevance. It is hoped that the tools and future research on their use will be published so that ongoing refinement will continue.

Reliable, consistent data in PNG were frequently not available. While this makes interpretation of some indicators difficult, it is not uncommon in developing countries with weak health systems. However, it may have resulted in misrepresentation of local context, and could lead to misreporting of retrogression in health rights. An attempt to compensate for this weakness was made by incorporating as much qualitative evidence as possible when testing the case studies.

The use of the tools in the two case studies resulted in further indicators being added into questionnaires, and changes made to some original indicators. It is possible that the use of different case studies could have resulted in different changes being made. In general, care was taken when analysing the results of the application to the

case studies to look at the broad, rather than the narrow, issues that emerged in the analysis and comparison with primary and secondary data. Changes were made when it was considered the findings of the feedback would have had a similar impact in other settings. For example, if there were no indicators to identify weaknesses in management capacity, this would be considered a broad issue that had application beyond PNG. Whereas, a specific matter such as patients not being able to locate one clinic was not considered broad enough to warrant its own indicator, especially as other indicators would have alluded to the underlying problems.

12.6 Recommendations

I would recommend the use of the tools in this framework be widely adopted by NGOs and GHIs wishing to embark on new health programmes in developing countries. I believe they have application even for health organisations that do not consider themselves to be 'rights-based' entities. Their use involves a detailed process that takes a considerable period of time, and requires local trust and participation. This should be viewed as a strength because in essence it is incorporating human rights concepts into the design process. Designing health programmes is never simple, least of all in severely constrained contexts where health systems are fragile.

Participants in global health interventions should be required to demonstrate that their activities will not harm the health systems in the States where they work. This could become a part of an accountability mechanism that should be incorporated into global health governance. At the very least, all parties in health interventions must become more accountable to the recipient State and its people, and this could begin with transparency about the funding for programmes, and programme outcomes.

The movement seeking changes to global health governance should be encouraged to use the facility offered by the right to health to improve coordination and accountability. A rights-based approach to aid-funded health programmes, as demonstrated by these tools, promotes the coordination of activities with a State's own plans. This is the most direct and straightforward means of avoiding duplication of effort, and ensuring that State resources are not subverted to health interventions that are not responding to local needs and rights.

Finally, to enable research to validate these tools in other settings, by other organisations, it would be useful to publish these tools, and their rationale, as a how-to manual.

12.7 Concluding comments

It has been argued in this thesis that global health programmes would benefit in many different ways if they were located within rights-based frameworks. Not only would the design of health programmes focus on the rights and needs of people in developing countries, but there would be transparency and accountability for all participants in, and beneficiaries of, global health interventions. A right-to-health paradigm in global health could enable GHIs and NGOs to sit at the table with States to participate in matters of global health governance. Such diplomacy would progress recognition that General Comment 14 confers the responsibilities of the right to health on all parties who are in a position to help States meet their obligations.

The framework that has been developed operationalises the right to health. It has created a mechanism to assist the design of programmes that will respect, protect and fulfil the right to health. It has been demonstrated through the case studies that adoption of a rights-based approach to health programmes in developing countries is not a leap into the unknown. The human rights concepts are already familiar to those who working with best practice and participatory approaches to development. A rights-based paradigm simply adds legal duty into the development agenda. This addition of legal duty replaces the previous fickle and unpredictable nature of development with the certainty that accompanies binding obligations. As a result, the global health community needs to support local health systems to meet health needs, and engage in long term planning that is no longer subject to changing fads and donor interests. The paradigm shift puts the needs and rights of people in developing countries ahead of donor interests.

The tools developed are easy to use and demystify health rights. Their use helps to respect, protect and fulfil the right to health and in so doing promotes the effectiveness and sustainability of new health programmes. The result should be health services that are more available, accessible, acceptable, and of quality.

The attention given by this framework to acknowledging the role and fragility of the underlying health systems in developing countries, and measuring health programme impact on these systems, is a new and distinctive feature which draws on the edict: first, do no harm.

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