# Human rights, health and development

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Human rights, health and development represent interdependent sets of values, aspirations and disciplines. Drawing on these domains, this article offers a theoretical and practical framework for the analysis, application and assessment of health, justice and progress. It provides a simple conceptual framework illustrating the interdependence of these domains and highlights their key features and underlying principles. It then describes the reciprocal interactions between health, development and human rights and suggests how these linkages can be analysed and applied in practice. A health, human rights and development impact assessment approach is proposed to guide and monitor policies and programs towards maximising synergy.

## Introduction

Those who work on the implementation of human rights, improved health for all and human development have common aspirations to improve human welfare, the relationships between people and the environments in which we live. Each reflects shared individual and collective aspirations for a better life, and is grounded in both moral and instrumental values revolving around fundamental concepts of dignity, justice, equity and equality, wellbeing and progress. While all three areas have long histories of struggle, the events of the last two centuries have underlined their global significance; the need for deepening our understanding of their links; and the importance of developing analytical tools to identify and manage the potential offered by a human rights approach to improving health and the process of development.

These events include the 19th-century industrial revolution in Europe and the resulting expectations of an improved quality of life, contrasting dramatically with

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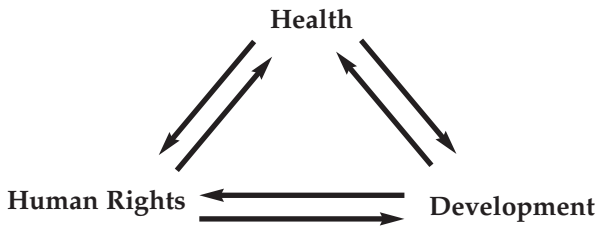
**Figure 1: Health, human rights and development**




the health and social inequalities increasingly visible in the streets and factories of mushrooming cities (Frank and Mustard 1994). Public health and medical advances followed, seeking through human ingenuity to apply science to address emerging problems. States that had built their industries competed with one another for economic and political influence and several states extensively exploited poorer ones through colonial domination. The atrocities of World War II led to recognition of a compelling need to set out the obligations of governments towards their populations, as well as towards each other (Lauren 1998). The process of decolonisation in the 1960s, the end of the cold war in the 1990s (Tarantola 2008) and the subsequent emergence of new independent states as the process of economic globalisation rapidly escalated (Benedek et al 2008) drew more political and public attention to global inequalities in health, disparities in wealth and the need for realisation of human rights. The unabated spread of HIV since the early 1980s and the global response to the epidemic launched in 1987 advanced the understanding of the interdependence of health and human rights. In particular, the response highlighted the fact that those subjected to discrimination and violations of other human rights — especially those living in poverty — were disproportionately affected by HIV (Mann and Tarantola 1996).

This article explores the links between human rights concerns, improving the health of individuals and communities, and the goals and processes of development that are central to improving people's living standards and life chances. It builds its analysis around a simple conceptual framework (Figure 1), which illustrates the interdependence of health, development and human rights. It highlights the underlying principles, values and prominent features of human rights, health and development as independent domains, and then describes their interactions. It focuses particular attention on how these linkages can be analysed and reinforced in practice. This article also proposes that a health, human rights and development impact assessment (HHRDIA) may be a practical approach that builds on the synergies between the three

domains, providing structured and transparent monitoring and evaluation mechanisms to enhance accountability for progress, while revealing shortcomings in policy and program processes, and improve human welfare outcomes.

## Human rights, health and development: aspirations, values and disciplines

The strong causal links between human rights, health policies and programs and progressive development approaches can be demonstrated through a variety of perspectives. These include starting with human rights (their origins and constitution being explored below); their human value (aimed at improving people's lives); social relevance (consideration of the individual as part of social constructs); normative content (standards and directions for national governance and international cooperation); instrumental application (frameworks of analysis, policy formulation, program development and evaluation); disciplinary base (exploration, documentation, research and teaching of theory and practice in separate academic institutions); and the ways in which they engage communities (building on community awareness-raising, participation and leadership). Although it risks oversimplification, for clarity of exposition we refer to human rights, health and development below as three 'domains'. This section summarises the key features of each domain, in order to set out the common, cross-disciplinary information base necessary for identifying and building upon their inter-relationships — the main objective of this contribution.

## Human rights

In the modern world, human rights are often invoked to justify a variety of fundamental political, social, economic and cultural claims. The origins of rights (whether anchored in natural law, positive law, a theory of human needs, capabilities and flourishing, or some other theoretical position) and their justifications are diverse. There is, nevertheless, considerable international consensus about a central core of human rights claims, in particular those embodied in explicit international obligations accepted by nation states in the principal United Nations and regional human rights instruments adopted since World War II (see, for example, Centre for the Study of Human Rights 2005). This is so notwithstanding the challenges of cultural relativism and the need for universal human rights to be realised in the specific contexts of different communities (Baxi 2002; Steiner and Alston 2000). Challenges to dominant discourses of human rights have come in waves, with new claims to the enjoyment of universally guaranteed rights being brought by marginalised groups (racial and ethnic minorities, women, children and persons with disabilities, among others), who realise both the promise of rights and the

**Box 1: Nature of human rights and a typology of states' obligations**

Fundamental human rights are posited as *inalienable* (individuals cannot lose these rights any more than they can cease being human beings); as *indivisible* (individuals cannot be denied a right because it is deemed a less important right or something non-essential); and as *interdependent* (all human rights are part of a complementary framework, the enjoyment of one right affecting and being affected by all others) (Vienna Declaration 1993).

Currently, the most influential approach at the international level to understanding the different dimensions of human rights is a tripartite typology of the nature and extent of states' obligations: in relation to all rights, governments have obligations to respect, protect and fulfil each right (Maastricht 1997). First, states must *respect* human rights, which requires governments to refrain from interfering directly or indirectly with the enjoyment of human rights. Second, states also have the obligation to *protect* human rights, which requires governments to take measures that prevent non-state actors from interfering with the enjoyment of human rights, and to provide legal and other appropriate forms of redress which are accessible and effective for such infringements. Finally, states have the obligation to *fulfil* human rights, which requires states to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realisation of human rights, thus creating the conditions in which persons are able to enjoy their rights fully in practice. This typology has proved particularly useful in elaborating the specific content of many economic and social rights — including the right to health.

shortfall in their practical enjoyment. Enriched by new perspectives, human rights today play an important role in shaping public policies, programs and practice aimed at improving actual and potential individual and social welfare.

### *Human rights as state obligations*

Human rights constitute a set of normative principles and standards which can be traced back to antiquity, although they received their particular modern imprint through the work of political philosophers and leaders of some 17th-century European countries (Tomuschat 2003), and those who developed and expanded upon their ideas. The atrocities perpetrated during World War II gave rise, in 1948, to the Universal Declaration of Human Rights (UDHR) and later to a series of treaties and conventions which codified the aspirational nature of the UDHR into instruments which would be binding on states through international human rights law. Among these are the International Covenant on Civil and Political Rights

(ICCPR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR), both of which entered into force in 1976. Similar developments have also been seen at the regional level, frequently with more effective institutions for the monitoring and enforcement of those norms.

Human rights are often described as claims that individuals have on governments (and sometimes on others, including private actors such as corporations), simply by virtue of being human. In the case of the international human rights treaties and under many domestic legal systems, these entitlements are embodied in legal instruments which are formally binding on states and their institutions. The formal guarantee of a right does not of itself mean that the rights-holder enjoys the right in practice and, despite their formal entitlements, people are often constrained in their ability to realise those rights fully, or indeed at all. Those most vulnerable to violations or neglect of their rights are often those with the least power to contest the denial of their rights. As a result, their wellbeing and heath may be adversely affected (Farmer 2004).

The relationship between the individual or group who is the rights-holder and the state is central to the concept and practical enjoyment of human rights, and it is the nature and scope of the state's obligations (including in relation to the actions of private actors) which are integral to the understanding of how human rights may be promoted and protected in practice (Box 1).

It has been common to distinguish between civil and political rights (sometimes called 'negative rights' or liberties), and economic, social and cultural rights (sometimes referred to as 'positive rights'). This approach has been debunked as inaccurate and outdated (Vienna Declaration and Programme of Action 1993, Art 2). All rights may involve the allocation of resources (for example, the classical civil right to a fair trial is premised on the existence of a legal system resourced with judges, court buildings and legal aid). Even those rights traditionally thought of as subject only to progressive realisation have elements which require immediate action to be taken (for example, in relation to ensuring that all enjoy the right to education, carrying out a baseline analysis, the development of a plan which should be 'deliberate, concrete and targeted as clearly as possible towards meeting the obligations') (UN CESCR, General Comment 3) and may have justiciable elements (Eide 1995).

### *The right to health*

The right of everyone to the enjoyment of the highest attainable standard of physical and mental health — or the right to health, as it is commonly referred to — appears

in one form or another in many international and regional human rights documents. Furthermore, nearly every other Article in these international instruments also has clear implications for health. The right to health builds on, but is not limited to, Art 12 of the ICESCR. Most of the other principal international and regional human rights treaties contain provisions relevant to health — for example, the International Convention on the Elimination of All Forms of Racial Discrimination (CERD), the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), the Convention on the Rights of the Child (CRC) and the Convention on the Rights of Persons with Disabilities (CRPD).

The right to health does not mean the right to be healthy as such, but embodies an obligation on the part of the government to create the conditions necessary for individuals to achieve their optimal health status. In 2000, the United Nations Committee on Economic, Social and Cultural Rights adopted a General Comment explicating the substance of government obligations relating to the right to health (UN CESCR, General Comment No 14). In addition to clarifying governmental responsibility for policies, programs and practices influencing the conditions necessary for health, it sets out requirements for the delivery of health services, including their *availability, acceptability, accessibility* and *quality*. The General Comment lays out directions for the practical application of Art 12 and proposes a monitoring framework indicating the ways in which the state's responsibility can be implemented through national law. Currently, over 100 national constitutions have recognised a right to health and this number continues to increase as constitutions are rewritten or updated (Kinney 2001).

The interrelatedness of human rights, development as a process and improved health status as a measure of development can be seen clearly in the context of the right to health. Rights relating to autonomy, information, education, food and nutrition, freedom of association, equality, participation and non-discrimination are integral and indivisible elements of the achievement of the highest attainable standard of health. So too is the enjoyment of the right to health inseparable from the enjoyment of most other rights, whether they are categorised as civil and political, economic, social or cultural (for example, the enjoyment of the right to work, the right to education or the right to family life) (Leary 1994). This recognition is based on empirical observation and on a growing body of evidence which establishes the impact that lack of fulfilment of these rights has on people's health status — education, non-discrimination, food and nutrition epitomise this relationship (Gruskin and Tarantola 2001). Conversely, ill-health may constrain the fulfilment of all rights, as the capacity of individuals to claim and enjoy all their human rights may depend on their physical, mental and social wellbeing. For example, when states fail to fulfil their obligations, ill-health may result in discrimination — as is commonly

seen in the context of HIV, cancer or mental illness. It may cause arbitrary termination or denial of employment, housing or social security, and limit access to food or to education, with the consequence that social and economic development potentials may not be achieved.

The tripartite typology of human rights obligations — to respect, to protect and to fulfil — originally developed in the context of economic and social rights (Eide 1995), has been particularly useful in indicating what steps a government should take in relation to each dimension of its obligations. In the context of the right to health, the obligation to *respect* means that no health policy, practice, program or legal measure should directly violate the individual's right to health — for example, by exposing individuals to a known health hazard. Policies should ensure the provision of health services to all population groups on the basis of equality and freedom from discrimination, paying particular attention to vulnerable and marginalised groups (Hunt 2008). The obligation to *protect*, in relation to the right to health, means that governments must appropriately regulate such important non-state actors as the health care industry (including private health care and social services providers, as well as pharmaceutical and health insurance companies) and, more generally, national and multinational enterprises whose contribution to market economies can also significantly affect the lifestyle, work life and health of both individuals and communities. The array of non-state actors is diverse and growing. It includes commercial enterprises whose activities have a major impact on the environment — such as energy-producing companies, manufacturers and agricultural producers — as well as the food industry and the media. Each of these actors has the capacity to promote and protect, or to neglect and violate, the right to health (and other rights) within their field of activity. Finally, the obligation to *fulfil* the right to health includes a duty to put into place appropriate health and health-related policies which ensure human rights promotion and protection with an immediate focus on vulnerable and marginalised groups where the value of health and other benefits to individuals and groups may be higher.

### *The right to development*

In 1986 the UN General Assembly adopted the Declaration on the Right to Development, Art 1 of which states that 'the right to development is an inalienable human right by virtue of which every human person and all peoples are entitled to participate in, contribute to, and enjoy economic, social, cultural and political development, in which all human rights and fundamental freedoms can be fully realized' (Declaration on the Right to Development). The human person is identified as the beneficiary of the right to development, as of all human rights. The right can be invoked both by individuals and by peoples and imposes obligations on individual states to ensure equal and adequate access to essential resources, and on

the international community to promote fair development policies and effective international cooperation. The Vienna Declaration and Programme of Action, adopted by the 1993 World Conference on Human Rights, recognised that democracy, development and respect for human rights and fundamental freedoms are interdependent and mutually reinforcing (Art 8). The Vienna Declaration reaffirmed the right to development as a universal and inalienable right and an integral part of fundamental human rights. It also made clear that, while development facilitates the enjoyment of all human rights, a lack of development may not be invoked to justify the abridgement of other internationally recognised human rights (Art 10).

The declaration of the right to development has been controversial because some critics have seen it as having the potential for abuse by the state, which may use it to suppress concrete human rights ostensibly in order to ensure the realisation of the more amorphous right to development. Critics have also expressed concern that the state, rather than individuals or peoples, may in effect become the rights-holder, with low-income states being entitled to claim assistance from higher-income ones (see Kirchmeir 2006). Nevertheless, there is clearly a close relationship between the right to development and the right to health — enjoyment of the right to an adequate standard of health is both a goal of the exercise of the right to development and a means to contributing to achieving development (Sengupta 2002; Marks 2005).

## Health in transition

Perspectives on health reflect the rapidly changing realities and opportunities in today's globalised world. Responding to health needs is ultimately determined by how we address the issue of rights and access to power and resources. This section seeks to identify core achievements of public health; the methods and approaches which have underpinned such achievements; and the challenges of engaging with transforming policy making and service delivery structures.

The World Health Organization defined health in 1948, in its constitution, as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (WHO 1948, 1). The definition has been modified to also include the ability to lead a 'socially and economically productive life'. Sen (1999) has identified health as a key determinant of the ability of an individual or group to benefit from a broader set of rights and entitlements.

Public health, defined as 'the art and science of preventing disease, promoting health, and prolonging life through the organised efforts of society' (Acheson 1998), describes well the challenges facing the field. It also reinforces widespread

recognition that promoting health requires multisector and 'upstream' efforts to address the determinants of health, much more than simply improving access to health care (Baum and Harris 2006; Baum 2007).

Over the past two centuries, better education, improved nutrition and environmental advances — including better water and sanitation, safer working conditions and improved housing — have enhanced health outcomes (Frank and Mustard 1994; WHO 1999). Life expectancy has greatly increased in many medium- and high-income countries and major causes of mortality in early childhood, in particular, have been, or have the potential to be, addressed. Technologies have been developed to tackle infectious diseases, injuries and non-communicable diseases, as well as to treat and manage ill-health. Despite these significant achievements in dealing with exposures which pose a risk to life, including childbirth itself (see, for example, Freedman et al 2007), the benefits of economic advances, human security and access to health care have not been shared equally, and significant disparities exist both within and between countries (WHO 1995). Preventable child mortality remains unacceptably high in many poor nations, in particular in Africa (Black et al 2003). In some countries, notably those mired in conflict or under repressive regimes, population health has deteriorated (Zwi et al 2002) and the poorest communities are often significantly worse off.

In the past half century, the ability to control many potentially lethal infectious diseases has been achieved through better understanding of their causes; the development of technologies to interrupt exposure or prevent occurrence; improved diagnosis, treatment and management; and, in the case of smallpox, the ability to eradicate an organism. Prevention and control of non-communicable diseases has been much less successful. Smoking-related diseases, obesity, cancer and injuries are all on the increase; mental health problems too, at a population-wide level, have not been effectively addressed (Boutayeb 2006). Many countries need to simultaneously confront both communicable and non-communicable diseases (Lopez et al 2006).

While the new public health, as enunciated in the Ottawa Charter on Health Promotion, highlighted efforts to build healthy public policy, create supportive environments, strengthen community action and reorient health services towards a health-promoting perspective, the achievement in these areas has been limited (Wise and Nutbeam 2007; Leger 2007). The Ottawa Charter's definition of health as being 'created by caring for oneself and others, by being able to take decisions and have control over one's life circumstances, and by ensuring that the society one lives in creates conditions that allow the attainment of health by all its members' (Art 3) is a reality not experienced by many worldwide).

The role of the state in health services provision and in securing the basic needs required for health and development has been challenged and in many cases undermined. Increasingly, the private sector and other non-state actors have been brought into the process of providing care, often within an economic and ideological framework which positions health care as yet another commodity, without recognising the existence of significant market failures.

Powerful non-state actors are increasingly involved in shaping the agenda around public health (Cohen 2006). Multilateral organisations, private foundations and the World Bank have in most cases become more influential than the World Health Organization in shaping public health policies and health-care service responses in low- and middle-income countries (Martens 2003).

New supranational funds, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, provide substantial financial resources, but also may end up determining how countries address major health problems (Garrett 2007). Public–private partnerships have proliferated, securing public investment to produce new technologies and programs, but also shaping what services are available and under what circumstances (Buse and Walt 2000a; 2000b; Richter 2004). Private foundations, such as the Bill and Melinda Gates Foundation, make available more funds to health development activities than any other bilateral or multilateral agency, determining priorities and shifting health and research resources with limited or no system of accountability to those often most affected by such decisions (Okie 2006). A casualty of the changed mechanisms through which development funding is made available has been in failing to strengthen health systems and human resource capacity not only to deliver specified programs, but to provide a comprehensive framework within which improved health, equity of access, better outcomes and greater participation can be secured. Strengthening health services has become urgent, given the gap between investments and the actual benefits that have been observed (WHO 2007).

### *Determinants of health*

Key health issues and challenges are increasingly presented as technical issues, requiring the engagement of 'experts'. This is contested by commentators and civil society organisations, such as the People's Health Movement, which draw attention to the pivotal role of communities, non-governmental organisations and the state in constructing the environment in which rights to health and broader development can be promoted and secured (People's Health Movement 2006).

While health is increasingly understood as related to a wide range of determinants, and there is recognition that health is far more than health care, strategies to secure

the commitment and resources required to overcome inequities in access to these determinants of health is lacking. The ability to shape and frame how inequalities and inequities are seen, the way in which they are defined and tackled, and from where the resources to address them should come, remains crucial. Rights, politics and power are arguably moving to centre stage (Farmer 2004).

## Human development

Human development is a qualitative as well as a quantitative improvement in the level and standards of individual and collective welfare — which includes elements contributing to self-sustenance, self-esteem and freedom and is a general goal sought by individuals, groups, nation states and the international community. It is also specific and can be targeted at people whose level of welfare lags below that of others and is below their potential (Thirlwall 1999). For general improvement in measures of individual and collective welfare and development to occur, factors — such as the status of human rights — that play a role in determining the capacity of individuals and groups to realise it must be considered.

The means adopted to achieve improvements in individual and social welfare have evolved unevenly over time as human knowledge, economic capacity and institutional sophistication have grown. It is also clearly recognised that the status of any individual or group of people is dependent for its existence on the recognition and respect exercised by others and therefore, to be successful, a process of development should incorporate a 'rights' perspective (Frankovits et al 2001).

### *Development and change*

The process of change and development, as noted by economists from Adam Smith onwards, has never been regular, linear or evenly distributed. Indeed, it became more uneven with the advent of capitalism, as social, cultural and political innovation (with an accompanying decay of traditional social, economic and political systems), capital accumulation, market development, technological change and associated nation state building accelerated in northern Europe and spread outwards. The process of development can be seen as a qualitative change in conditions and an essential prerequisite to quantitative change measured as growth. Joseph Schumpeter described this as 'creative destruction', accelerating first in the most developed countries and spreading in irregular waves across the world (Schumpeter 1969, 253). Processes of change have seen the destruction and displacement of significant parts of pre-existing values (cultures) and patterns of social and economic relations, including embedded rights, in households, rural and urban settlements and nation states. New personal and social systems of rights

(including property), relations, production systems and governance structures emerged to change the distribution of income and systems of social, economic and political authority (see North in Atkinson et al 2005).

### *From liberal to neo-liberal model of development*

The growing differences in living standards between individuals and states that emerged with the agricultural, industrial and service revolutions in Europe almost immediately led to the study of the internal factors that contributed to the success of the first industrialised country, Britain, to see how this could be emulated in other countries and extended to the growing economic, social and political integration between countries (Cohn 2008, 8). The model of development that emerged in the 18th century, based on the early insights of John Locke and Adam Smith, focused on the importance to the emerging system of the extension of private property relations to facilitate the exercise of liberalism: the pursuit of individual economic self-interest; the building of universal and secure financial systems; the establishment and extension of competitive market systems; and limits on the capacity of state policy and programs to restrict market development (Cohn 2008, 73). The objectives embedded in the dominant economic and political (liberal) policy model exercised in wealthier countries were in turn advocated in developing countries as a solution to their development problems. These objectives became part of the so-called neo-liberal approach to policy reform characterised best in relation to developing countries, in the 10-point shopping list of reforms called the 'Washington Consensus' (Stiglitz 2002; Stiglitz in Atkinson et al 2005, 16; Williamson 1990).[1] The goal of the Washington Consensus, through adopting policies such as reducing regulation, taxation and public expenditure (Rodrik in Atkinson 2005, 212), was to lend weight to the call to deregulate and open up to the international economy the domestic economies of developing countries, extend market exchange and achieve the most

1 The 10 points of the Washington Consensus are: (1) fiscal policy discipline; (2) redirection of public spending from subsidies ('especially indiscriminate subsidies') towards broad-based provision of key pro-growth, pro-poor services such as primary education, primary health care and infrastructure investment; (3) tax reform — broadening the tax base and adopting moderate marginal tax rates; (4) interest rates that are market determined and positive (but moderate) in real terms; (5) competitive exchange rates; (6) trade liberalisation — liberalisation of imports, with particular emphasis on the elimination of quantitative restrictions (licensing, and so on); any trade protection to be provided by low and relatively uniform tariffs; (7) liberalisation of inward foreign direct investment; (8) privatisation of state enterprises; (9) deregulation — abolition of regulations that impede market entry or restrict competition (except for those justified on safety, environmental and consumer protection grounds) and prudent oversight of financial institutions; and (10) legal security for property rights.

efficient allocation of resources possible, and consequently maximise levels of individual welfare at any given level of financial income.

### *Failure of the Washington Consensus*

The ideas embodied in the Washington Consensus and its predecessors have been criticised as being based on limited simplistic assumptions that reflect little consideration for what actually contributes to the development process. Claims in the Washington Consensus that the extension of property rights, the only rights mentioned there, are sufficient for development were criticised. As Sen has pointed out, the 'freedoms' embodied in such ideas are insufficient in themselves to achieve real development, which involves a process of establishing a broader set of conditions for people to develop their own 'capabilities' for personal development (Sen 1999). In other words, the pursuit of property rights alone was not sufficient to achieve the multiple objectives of 'balanced' multi-sectoral growth that can deepen and spread development (see Thirlwall 1999, 323). To achieve these requires the extension of a much wider range of rights than those for securing property. At a fundamental level, the neo-liberal model also failed to understand the important role of institutions, defined as informal values and rules in governing behaviour (see North 1990; North in Atkinson et al 2005, 1) or the important role of institutions as formal organisations through which the capacity for change of individuals and communities is mediated and managed (see Jutting 2003; Rodrik in Atkinson 2005, 209). As Sachs has summed up, the Washington Consensus is focused primarily on realising the interests (and associated ideologies) of powerful developed countries at the expense of developing ones and has not addressed the widening 'gap' in living standards between the developed and the developing world experiencing high levels of poverty (Sachs 2005).

### *Bridging the development gap*

The campaigns of the last three centuries to liberate individuals and communities from formalised authoritarian systems of control, such as those of feudalism and slavery, have been the foundation for creating better states of psychological, health, social and material welfare, as well as opening up the potentials for further improvements (Grayling 2007; Ishay 2004). Development studies recognised that this process was dynamic, characterised by lags between individuals, groups and particularly nation states, in different places establishing basic human rights, improving human capacities such as health, and building the institutions and the productive systems that create the potential for development. This perspective is also contested, as revealed by the discussion of the Washington Consensus.

The problem of the development gap between the early industrial economies and other countries identified by Sachs (2005) was not new. A concern with identifying the specific development requirements necessary for the 'backward' countries to bridge the development gap and 'catch-up' has been recognised as important for a long time (see, for example, Myrdal 1975, 65). In addition to the question of the development gap itself, longer-term questions exist as to the role of other historical factors, such as the continuing effects of colonial inheritance and the 'dependency' of the developing world on the developed for technology, capital and markets (see, for example, Acemogolu et al 2001 in relation to colonialism). Achieving development depends on attaining a much more complex set of goals, changes to processes and institutional system-building, and it is now accepted that there could be a number of different paths to development (see, for example, Chang 2003; Rodrik in Atkinson 2005; Sengupta et al 2005). If the choice of any specific pathway to development is subject to question, what is not in doubt is the growing recognition of the importance of development as a general goal — this being reflected also in human rights discourse being extended to cover a broader range of rights, including the right to development itself.

## Reciprocal relationships between health, development and human rights

### *A theoretical framework*

The interactions between human rights, health and development can be illustrated by the reciprocal linkages that exist between any two of these domains. The aim is not only achieving the highest possible realisation of rights, health or development, but amplification of the synergies between them, resulting in overall benefits substantially greater than the sum of the parts. Recognising these reciprocal relationships and synergies does not imply that *any* policy or action in *any* of the three domains will positively impact the others: an untested development program may have negative effects on health or the environment; the protection of the right to health without attention to other human rights may be harmful to some individuals or communities; and disproportionate investments in a narrowly targeted health intervention may temporarily constrain progress in other health areas. The basic premise underlying our framework is that optimal policies and programs must simultaneously consider the implications for health, development or human rights, maximising overall benefit and minimising pitfalls and potential harms.

### *Health and development*

Health is an important prerequisite for, and desirable outcome of, human development and progress. Health is 'directly constitutive of the person's wellbeing

and it enables a person to function as an agent, that is, to pursue the various goals and projects in life that she has reason to value' (Anand 2004). Health is also the most extensively measured component of wellbeing — it benefits from dedicated services and is often seen as a sine-qua-non for the fulfilment of all other aspirations (WHO 2002a).[2] It can be considered to be 'a marker, a way of keeping score of how well the society is doing in delivering well-being' (Marmot 2004).

Fifteen years ago, the World Bank acknowledged the reciprocal dependency between progress in health and economic development (World Bank 1993). This acknowledgment was not an earth-shaking revelation — particularly to those who were working in health and development in Africa, where the HIV pandemic was already taking a heavy toll. Yet the 1993 *World Development Report* marked a turning-point in the World Bank's lending policy, while the nascent global movement towards poverty alleviation consistently emphasised the importance of health in the fight against poverty. It was not until 2001 that the international community, through the WHO Commission on Macroeconomics and Health, documented that poverty leads to ill-health, but also that ill-health leads to poverty (WHO 2001). The eight Millennium Development Goals (MDGs) — which set targets for 2015 to, among other things, halve extreme poverty, halt the spread of HIV/AIDS and improve health and education — have been agreed to by all the world's countries and leading development institutions (UNDP 2005). Arguably, all MDGs[3] are linked to health, either by their direct bearing on health outcome and the needed services (for example, through efforts to reduce child and maternal mortality, HIV, malaria and other diseases), or by underscoring principles central to public health policy (for example, gender equality), or by calling for the creation of policies addressing the underlying conditions for progress in health (for example, education, environmental sustainability, global partnerships) (Dodd and Cassels 2006). The MDGs highlight a number of important health indicators that deserve attention, but are not in themselves sensitive to the distribution of these indicators within countries and may promote a focus on improving indicators by directing services to those easy to reach,

2 'The role of health in economic growth has been greatly undervalued. Evidence presented by the Commission [the WHO Commission on Macroeconomics and Health] suggests that each 10 per cent improvement in life expectancy is associated with an increase in economic growth of about 0.3 per cent to 0.4 per cent per year, other growth factors being equal' (WHO 2002a).

3 The eight Millennium Development Goals are: eradicate extreme poverty; achieve universal education; promote gender equality and empower women; reduce child mortality; improve maternal health; combat HIV/AIDS, malaria and other diseases; ensure environmental sustainability; and develop a global partnership for development (<www.un.org/millenniumgoals/goals.html>).

with little attention to those most marginalised or disempowered (Gwatkin 2005). Attention to process — including the provision of information, improving access, enhancing accountability and sensitivity to cultural and gender concerns — may be overlooked as efforts are directed simply at increasing the numbers of people served or activities undertaken. Research which enhances the visibility of those least able to access services, as well as the ability of users of services to help shape them, deserves more attention, as do studies of the unanticipated impact of large-scale development initiatives on individuals, communities and systems operating within resource-poor countries.

### *Health and human rights*

Viewed as a universal aspiration, the notion of health as the attainment of physical, mental and social wellbeing implies its dependency on, and contribution to, the realisation of all human rights. From the same perspective, the enjoyment by everyone of the highest attainable standard of physical and mental health is a human right (UN CESCR, General Comment 14). From a global normative perspective, health and human rights remain closely intertwined in many international treaties and declarations and are supported by mechanisms of monitoring and accountability (the efficiency of which can be questioned) drawn from both fields.

Health and human rights individually occupy privileged places in public discourse, political debates, public policy and the media, and both are at the top of human aspirations. There is hardly a proposed political agenda that does not refer to justice, security, health, housing, education and employment opportunities. These aspirations are often not framed as human rights, but the fact that they are nevertheless contained in human rights treaties and often translated into national constitutions and legislation provides policy and legal support for efforts in these areas.

Incorporating the relationship of health and human rights into public health policy therefore responds to the demands of people, policy makers and political leaders for outcomes that meet public aspirations. It also creates an opportunity for helping decipher how all human rights and other determinants of wellbeing and social progress interact, by allowing progress to be measured towards these goals, as well as shaping policy directions and agendas for action.

Anchoring public health strategies in human rights can enrich the concepts and methods used to attain health objectives, by drawing attention to the legal and policy context within which health interventions occur, as well as bringing in rights principles such as non-discrimination and the participation of affected

communities in the design, implementation, monitoring and evaluation of health programs and interventions (Gruskin et al 2007). The introduction of human rights into public health work is about approaches and processes and their application towards maximising public health gains (Gruskin and Tarantola 2001). It does not preordain how the work is done or what its ultimate outcome will be. For example, using human rights standards with a focus on health systems requires attention to their availability, accessibility, acceptability, quality and outcomes among different population groups (UN CESCR, General Comment 14). The added value of human rights for health is in systematising attention to these issues, requiring that benchmarks and targets be set and ensuring transparency and accountability for what decisions are made and their ultimate outcomes (Gruskin et al 2007).

### *Development and human rights*

Most authorities agree that achieving development implies a qualitative change in environmental, social, economic or political conditions (which may or may not generate economic growth as conventionally measured) that improves the welfare of individuals, communities and nation states (Remenyi in Kingsbury et al 2004, 22; Sen 1999, 1; Stiglitz in Atkinson et al 2005, 17). Welfare can be measured individually and collectively in various potentially problematic ways: as status (for example, measured as income or health status), capacity (for example, as human capital in the form of knowledge and skills), participation (for example, as individuals' access to employment and capacity to engage with institutions) and possibilities (for example, as the presence of pathways to future development). All these measures are intertwined with human rights — for example, for the poor to participate in the benefits of development — as is evidenced by the close relationship between the MDGs and human rights (Alston 2005). Development-specific knowledge is also required, for example, about the presence, range and roles of the different institutions — social, economic and political — that are engaged in the development process. The specificities of different societies in terms of history, culture, technology and institutions, and how these differences both can and should translate into varied 'local' responses to regional or global processes, and varied strategies for development, also require attention.

## Bringing it together

Human rights, health and development intersect in a number of ways which, for practical purposes, can be considered on three levels: the national and international context within which policies are developed; the outcomes of these policies; and the processes through which they are developed, applied and monitored.

### *Context*

A distinction exists between development policy affecting health (most of them do) and public health policy (often emerging from, or on the initiative of, public health governmental authorities). Development policies affecting health — for example, those related to gender, trade, intellectual property, the environment, migration, education, housing or labour — are contingent upon national laws and international treaties or agreements which often overlook — by omission or commission — their potential health consequences (Kemm 2001). Public policy should aim for achieving the optimal synergy between health, development and human rights, building on the premise that the highest quality of a public health and development policy is attained when the highest possible health outcome, the greatest prospects for economic and societal development and the fullest realisation of human rights are attained. This requires close interaction between public health professionals, those engaged in economic and social development work, human rights practitioners and concerned communities.

As it is generally formulated and monitored by the state, public policy operates in the context of the obligations of the state under international human rights treaties and national law. Central to these obligations are those to *respect*, *protect* and *fulfil* all human rights, including the rights to participate in public affairs, to equality and non-discrimination, and to dignity. When a state is implementing its international obligations or international standards derived from treaties or other instruments in areas as diverse as international trade or climate change (for example, under the 2005 Kyoto Protocol and instruments adopted by the World Health Assembly, the World Trade Organization (WTO) or other international organisations), it should do so in a manner which avoids conflict between the various standards and pursues mutually supportive implementation. For example, membership in the WTO implies that members must become party to the Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS). The constraints imposed by TRIPS on developing countries with regards to intellectual property protection with respect to pharmaceuticals in particular only became known in the late 1990s, as new proven therapies for HIV/AIDS were reaching the international market. Civil society movements and some international organisations embarked on a campaign to overcome the constraints set by TRIPS to the production or importation of generic medicines by developing countries, which needed them most ('t Hoen 2002). It was not until 2002, however, that the WHO and the WTO jointly produced a document on WTO agreements and public health (WTO and WHO 2002). In most developing countries, ministries of health had not been consulted, were not in a position to make an assessment, or underestimated the possible health impacts of joining the WTO. Whether by oversight or through lack of capacity, states placed themselves in a situation which privileged one set of benefits while undermining others — a failure

less likely to have occurred had open, transparent and participatory processes been established.

### *Process*

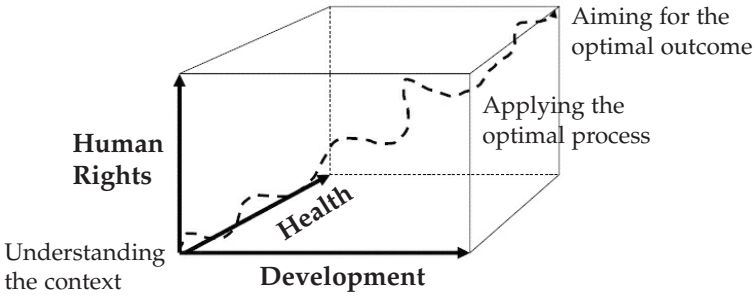
The human rights to information, assembly and participation in public affairs imply, among other practical steps, the engagement of communities in decisions affecting them. As highlighted earlier, the history of health and human rights established that community representation in decision-making bodies increases the quality and impact of public health measures. Similarly, the experience, successes and failures in development have amply demonstrated that success is more likely when people are recognised as subjects and not merely objects of development (Sanoff 2000). In the last two decades, stimulated by the response to HIV in particular, non-governmental organisations have played key roles in drawing attention to policies which were, or could be, detrimental to health (for example, restrictions in access to medicines, denial of sex education to young people, lack of access to harm reduction methods among substance users) (Akukwe 1998). Civil society has also been instrumental in the development field, drawing attention, for example, to marginalised communities and low-income countries, environmental degradation, the marketing of unhealthy foods and global inequities in trade, agriculture and access to technology (Howell and Pearce 2002). It is important, however, to determine who can legitimately speak on behalf of concerned communities.

The process of bringing together health, human rights and development in policy and program efforts extends beyond broad participation and transparency. It requires also verifying that decisions made and priorities set abide by human rights norms and standards, including but not limited to guarantees of non-discrimination (for example, relating to gender and vulnerable populations) and accountability.

### *Outcome and impact*

Human rights, health and development policies emphasise the importance of outcome and impact, crudely measured in public health terms by the reduction of mortality, morbidity and disability and in development terms by the improvement of quality of life, along with economic measurement enabling an assessment of 'value for money' (Hyder and Morrow 2006). The extent to which the outcomes measured include the fulfilment of human rights is seldom factored in. For example, one would like to see the value of policies which promote sex education in schools measured not only in terms of reduction of teenage pregnancy or the incidence of sexually transmitted diseases, but how the right of the child to information is fulfilled in this way, how it affects further demands for health-related, life-saving information, and

**Figure 2: Seeking optimal synergy between health, development and human rights — context, process and outcome**




how access to this information prepares young people to benefit fully from economic and social development. Likewise, when assessing the effects of policies that prioritise childhood immunisation, one would want to know not only how immunisations make people healthier, both early and later in their childhood, but also how the right of the child to growth and development, and the right to education by improving attendance and performances at school, are factored in (Leslie and Jamison 1990; Behrman 1996).

Bringing health, development and human rights together means examining the context in which they function, seeking to identify opportunities for the elaboration of sound policy and programs, and recognising and addressing the tensions and pitfalls in their interactions. It requires ensuring that the processes of policy and program development, implementation and monitoring are informed by best knowledge and practice relevant to the three domains. Ideally, this can provide a vision of human development where policies and programs achieve the highest possible outcome and impact is measured and accounted for in health, development and human rights terms. (Figure 2).

Monitoring process and measuring outcome and impact from a combined health, development and human rights perspective implies measurement indicators which are neither fully developed nor fully tested. One of the constraints is that measurement at the national, aggregate level is not sensitive to disparities that may exist within nations — for example, as a result of discrimination. As the health and development fields are becoming more strongly rooted in robust human rights and sound public health and development principles, the concepts of a 'Rights-based Approach to Development' (UNDP 1998) and 'Rights-based Approach to Health' have emerged (WHO 2002b). Although these approaches will not be discussed here,

they have generated much thinking and work on how the contributions of these respective domains to strategic development, monitoring and evaluation can be brought together (WHO 2005). It is of particular importance, however, not only to implement, monitor and evaluate, but also to anticipate the reciprocal impacts policy and programs developed in each of these domains may have on one another through use of an assessment process.

## Projecting the impacts of policies and programs: towards a health, development and human rights impact assessment

The links between health, human rights and development described above suggest that the incorporation of human rights and development considerations into a health impact assessment (HIA) may provide a structured and transparent process for incorporating understanding of the social determinants of health in the development of healthy public policy. HIA is:

> A combination of procedures, methods and tools by which a policy, program or project may be judged as to its potential effects on the health of the population, and the distribution of those effects within the population. [European Centre for Health Policy 1999, 4.]

HIA has been extensively implemented in many countries in the last two decades as a practical tool for shifting the rhetoric of healthy public policy into action (Banken 2001). During the same period, efforts have been made to develop methods and instruments for human rights impact assessment (HRIA). HRIA is:

> … a systematic process to ensure the integration of human rights aspects in decision making throughout the policy formulation, implementation, checking and adapting process. It includes a continuous system of monitoring and evaluation of the results of policy measures in terms of actual human rights observance. [Radstaake and Bronkhorst 2002, 5.]

HRIA has been developed predominantly as a tool for assessing macro-level policies of government, such as foreign policy, and assessment of activities of transnational business corporations and multilateral bodies.

To date, HIA has developed primarily with an 'internal' and local focus, whereas HRIA has focused primarily on 'external' policy and projects. While addressing different levels of institutional activity, HRIA and HIA both have at their core a systematic and transparent analysis as the basis for strategy development, policy decisions, project definition, monitoring and evaluation. The primary output in

either case is 'a set of evidence-based recommendations geared towards informing the decision making process' (Taylor and Quigley 2002, 2).

In 1994, Gostin and Mann proposed an approach to the human rights assessment of health policy aimed at defining the optimal balance between health goals and compliance with human rights principles and standards (Gostin and Mann 1994). Yet to be explored is the reciprocal potential that adding a focus on human rights to HIA may have for enhancing assessment of internal policies, programs and projects. Other authors have suggested that human rights, including the right to health and the related rights to education, information, privacy and decent living and working conditions, can provide a framework for the health sector to address conditions that limit achievement for optimal health in the population (Gruskin and Tarantola 2001). O'Keefe and Scott-Samuel (2002) and later Hunt and McNaughton (2006) proposed the linking of human rights with HIA. Subsequently, as the UN Special Rapporteur on the Right to Health, Hunt introduced to the UN General Assembly an impact assessment of the right to health as a means to strengthen national and international policies (United Nations 2007). The commonality of core processes, widespread support for HIA and the utility of HIA in 'value adding' to decision-making processes (Wismar et al 2006) suggests that human rights-based HIA may be successfully developed and may enhance the development of healthy foreign and global policy (Scott-Samuel and O'Keefe 2007). HIA may usefully provide well-accepted processes for valuing evidence, making values and assumptions explicit and assuring transparency in decision making.

### *Towards a health, human rights and development impact assessment*

This article builds on, but extends beyond, the above proposals. It suggests that the impact assessment of development policies and programs (that is, social, economic and structural) should be carried out in view of their anticipated impacts on health and other chosen human rights. Theoretically, in most situations, greater investment in health will contribute to greater realisation of other rights, including equality, education and employment. In reality, however, choices between two or more policy options may be guided by gains anticipated in health and other sectors of development, favouring mixed investments in both health and education. Similarly, a development policy may be assessed from its isolated impact on development or health or from the broader perspective of its impacts on development, health and other human rights. This article suggests that the latter approach is most likely to reveal possible tensions resulting from selective investments in one sector, whereas a mix of investments may, together, result in advancing health along with other human rights more effectively. This fits well with HIA's recognition that the health of a population is determined by a wide range of economic, social, psychological and

environmental influences, often referred to as the social determinants of health (Dahlgren and Whitehead 1991), and can lead to a health, human rights and development impact assessment (HHRDIA). Incorporating these considerations into an HHRDIA would thus encourage greater consideration of the impact on health of macroeconomic, political, societal and environmental structures (the macro-determinants of health).

HRIA and HIA have clear areas of overlap in both process and understanding of the causes of health. Reciprocal inclusion of one with the other offers opportunity to greatly enhance both HRIA and HIA. At a global level, HHRDIA would be enhanced by building on the widespread acceptability of HIA and of human rights to improve the development of healthy global policy. Similarly, at a local level HIA would be enhanced by the use of human rights and development as a framework for incorporating macro-level conditions during assessment to improve the development of healthy public policy. To realise this enhanced potential at both the global and local levels, however, capacity and new methods and tools will need to be developed.

## In conclusion: progress through practice and research

Individually, the domains of health, development and human rights are currently on the forefront of political and policy debates. This is reflected in civil society movements around the world, as well as in political statements heralding greater global equality, eradicating poverty, improved democratic governance and the protection of public health and security — all in the context of geopolitical shifts, economic globalisation and environmental changes. These trends have emerged as knowledge and practice in each of the three domains have advanced almost independently, along with the recognition of bridges between them. This article is a first attempt to bring health, development and human rights together, structuring their relationship around a conceptual framework conducive to the analysis of their reciprocal interactions.

Importantly, this article has proposed an approach incorporating health, development and human rights in the formulation and implementation of policies and programs and their monitoring. Stemming from the experience accumulated over the last decade in the application of impact assessment methods selectively to health, human rights and development programs, an approach is proposed to incorporate the three domains. To broaden and harmonise the application of impact assessment methods raises a number of concerns. First, empirical evidence shows that impact assessments are more likely to produce quality outcomes when they are focused and able to inform decisions promptly. To overburden impact assessments

by broadening their scope may affect their timeliness and quality. Second, the relationships between health, development and human rights are not yet well understood. It is our collective hope that this knowledge gap will be bridged by the experience to be gained from the practice of rights-based approaches to health and development and impact assessment, and that this will guide and monitor policies and programs towards maximising synergy into the future. ●

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