

**CONCEPTUALIZING HUMAN RIGHTS APPLICATION TO HEALTH WORK:
A TYPOLOGY OF RIGHTS-BASED APPROACHES TO HEALTH**

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I. Abstract

Over the past twenty years, public health academics and development actors have come to a largely shared perspective that a so-called rights-based approach is the way to go about health development worldwide. However, the range of articulation and projects claiming relevance to it is incredibly diverse and diffuse. In this study, I attempt to answer the question what exactly is a rights-based approach to health. Particularly, the goal is to organize what has been conceptualized of RBA thus far into a more comprehensible conceptual framework for RBA. By grouping into clusters some of the most influential discussions of RBA to health based on their distinct characteristics and emphases and by cross referencing real-life applications, I suggest that there may in fact be two different types of rights-based approaches. Conceptions that fall under the first category perceive RBA strictly as a programming tool that incorporates principles of participation, non-discrimination, and accountability into health policy, program, and system design. Conceptions that fall under the second, on the other hand, focus on health rights advocacy using lobbying, litigation, and social mobilization to get governments to change existing policies and health system infrastructure. In the long run, a better understanding of RBA will be useful to informing applications of the approach to a broader set of health or other development issues. It can also hopefully shed light on designs of future studies to assess the potential of RBA to improve not only attainment of health rights, but, ultimately, people's health as well.

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III. Abbreviations and Acronyms

3AQ	Accessibility, Availability, Acceptability, Quality
ARV	Antiretroviral Drug
CESCR	Committee on Economic, Social and Cultural Rights
EML	Essential Medicine List
ESC	Economic, Social, Cultural (Rights)
HRBA	Human Rights Based Approach
IGO	Inter-Governmental Organization
NGO	Non-Governmental Organization
OHCHR	Office of the High Commissioner for Human Rights
RBA	Rights-Based Approach
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDG	United Nations Development Group
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

IV. Introduction

Over the past twenty years, it has become an increasingly shared view among development actors and public health professionals that a rights-based approach is the right way to go about health policy and practice (Gruskin et al., 2010). Even though common elements of RBA to health have increasingly been made clear by repeated articulations of the subject, broad generalization over vastly different issues and contexts as well as unaddressed overlap with broader human rights frameworks still leave the conception of rights-based approaches as applied to health vague and ambiguous. UN agencies, for example, tend to narrowly define RBA as a set of strategies used for programming and decision-making. In fact, elaborate manuals have been developed to provide step-by-step instructions to help implementers operationalize the approach. But in practice, health policies and projects display variations along the spectrum from rights-based-like approach to the totally non-rights-based end. Beyond the UN world, there exist much more diversity and confusion. Academics and public health practitioners who zealously expand the model beyond its function as a programming tool tend to include discussions of other human rights frameworks such as advocacy and application of legal standards. Attempts at linking RBA to a wider range of health issue without a firm grasp of what the concept of RBA means also contributes to the chaos. The inconsistency among these different conceptions of RBA presented an immense challenge to the original intention of this study: to examine the efficacy of rights-based approach to improving health.

To further complicate things, this question is also inherently problematic because existing formulations of RBA tend to mean different things when they use the word 'outcome': some mean the broader biological health of the human species, others mean distribution of health goods and services, still, another group means non-health related outcomes such as increased

ability of citizens to participate in health policy decision making. The more fundamental question that needs to be answered in order to move forward with such a study; disregarding for a second the availability of downstream empirical data; is what a rights-based approach to health really is. A useful model to guide our understanding of RBA and the projects which conceptions of RBA attempt to describe is to think of it as a mechanism to achieve certain desirable outcomes. The outcome is of course directly determined by the type of RBA activities that constitute the mechanism. For example, the outcome of UN rights-based programming activities is the strengthened capacity of individual rights-holders to claim their rights, and for duty-bearers to fulfill their obligations (WHO & OHCHR, n.d.). These activities and their intermediate outcomes will then contribute, either directly or in the long run, to the goal of furthering the realization of people's right to the highest attainable standard of health. Under this model, health policies and projects can be grouped either into the RBA or the non-RBA category. While it is important to note what does not make a particular project a well match to a RBA conception for the purpose of defining more lucidly the boundary of the framework, we will not be concerning ourselves with the types of non-RBA approaches to health development. My goal in this study, however, is not to devise a model that can describe all health policies, programs, or actions in the world today. It is to organize what has been conceptualized of RBA thus far in order to make better sense of them.

In the process of conceptualizing RBA as a mechanism to promote health rights, it is also useful to know the contents of the right of health itself. This will help us define what a particular articulation of RBA or the project it describes actually constitute a RBA to health as opposed to a generic RBA to other development issues. General Comment 14 developed by Committee on Economic, Social, and Cultural Rights defines the right to health to encompass four elements in

relation to health goods and services: availability, accessibility, acceptability, and quality (*The right to health*, 2012). Descriptions of these elements can be found in the appendix. At the same time, the General Comment also asserts that the right to health extends beyond timely and appropriate health care to include underlying determinants of health, “such as access to safe and portable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including sexual and reproductive health” (*The right to health*, 2012). These health-related rights, in particular, impose definitional challenges to where the boundary of health can be drawn as one tries to conceptualize RBA to health. In the later sections, I will try to address some of these issues by referencing what is most frequently observed in real world applications of the approach of interest.

In this study, I suggest that rights-based approach in fact comes in two different flavors: programming and advocacy. I do so by grouping into clusters some of the most influential discussions of RBA to health based on their distinct characteristics and emphases. Conceptions that fall under the first category perceive RBA strictly as a programming tool that incorporates principles of participation, non-discrimination, and accountability into development processes and is thus purportedly more effective than traditional approaches to development at addressing structural causes underlying health disparities in a society. Furthermore, Type-I-like approaches can be found across programming efforts of various scales and complexity: from capacity building activities by IGOs and NGOs revolving around a single health issue to national health policy and system reform by individual countries themselves. In distinct contrast, conceptions that fall under the second category focus on health rights advocacy using lobbying, litigation, and social mobilization to get governments to change existing policies and health system

infrastructure in order to advance people's right to the highest attainable standard of health. Sample strategies and case studies from UNFPA, UNAIDS, UNICEF, and WHO are also referenced in the process of refining the proposed categories. By clarifying what those conceptions entail, what they may look like in practice, and what they are not, I strive to create a more comprehensible conceptual framework for RBAs. In the long run, this will hopefully be useful to inform applications of RBAs to a broader set of health or other development issues. It is also my hope that a better understanding of RBAs to health can shed light on designs of future studies if one were to assess the potential of RBA to improve not only attainment of health rights, but to the ultimate betterment of people's health as well.

V. Methods

The task, in short, was to organize the sundry existing conceptions of rights-based approaches to health into more lucid and distinguishable categories that can be used to analyze health-related policies and projects today. In Part I, a literature search using the phrase "rights-based approach to health" was conducted in three public policy and global health databases: PAIS International, ScienceDirect, and WebofKnowledge-CABI to look for academic articulations and influential discussions of the broader topic between health and human rights from 2006 to 2012. This particular time frame was chosen because I noticed in the initial scoping literature review that the term "rights-based approaches to health" was not widely used among academics until after 2006. Search results were then manually sorted to filter out those that did not provide in-depth discussions of 'rights-based approach' or the possibly related ideas such as a 'human rights framework'. Fifteen articles were pulled from six main academics; Sofia

Gruskin, Leslie London, Alicia Yamin, Paul Hunt, and Elvira Beracochea; to establish the initial proposed categories of rights-based approaches to health.

In Part II, I further refined the proposed categories by including RBA conceptions developed by UN agencies. These included the 2003 UN Common Understanding on Human Rights Based Approach to Development Cooperation, UNFPA's practical guide on HRBA programming, and the joint publication on Human Rights Based Approach to Health by WHO and OHCHR, among other health development strategies such as UNAIDS' global road map for HIV/AIDS response. Applications of RBA were also sought to provide illustrative examples for the purpose of clarifying what those different conceptions of RBA might look like in practice. Four UN agencies; UNFPA, UNAIDS, UNICEF, and WHO; were chosen for this part of the study because they, among the list of UN agencies involved in the development of human rights based approaches, were either known for being involved in health work or had health-related case studies published on the UN Practitioner's Portal on Human Rights Based Approaches to Programming. I also chose UN agencies instead of others because of the availability and accessibility of information. Sources of the wanted information were primary websites of these organizations and the HRBA Portal. Search strategies differed by websites. For the most part, each organization's model of rights-based approach and general description of related work in human rights and health were found through manual navigation on the website. Strategies, policy statements, case studies, and other relevant publications were found using the website's built-in search engines. When available, built-in filters were used to sort the results based on date and relation to health. The top twenty results were examined for the extent to which they related to the organization's proposed RBA model or how well they mapped onto any of mine. Search on the WHO website was an exception. Because WHO works on a wide variety of health issues, the

top fifty search results were taken to capture possible case studies and a more representative range of the issues where RBAs might be applicable.

VI. Type I: Health Policy, Program, and System Design

The essence of a Type I approach lies within the systematic integration of fundamental human rights principles such as participation, non-discrimination, and accountability into the process of health policy, program, and system creation or reform (Appleyard, 2002; Gruskin et al., 2010). Typical articulations of a Type I approach also emphasizes that priorities in program design are to be given to traditionally marginalized and vulnerable populations. To do so and to identify structural problems underlying health inequalities, disaggregate data must be collected and assessed accordingly. In practice, Type I RBA describes a tool that can be used by IGOs or NGOs in their individual-health-issue-based programming activities to help governments meet their obligations to relevant health rights and citizen rights-holders to claim their rights. A subset of the conceptions also describes how Type I RBA can be used by States themselves in their national level health system planning. As most conceptions that fall under Type I tend to surround the first kind of programming activities, I will use them to map out what a Type I RBA is, what it may look like in practice, and what it is not. I will also discuss a RBA to national health system design as another illustrative example and how linkage to the contents of the right to health may create definitional challenge to the conceptual framework.

A. Capacity Building Activities by IGOs and NGOs

1. What RBA Is

Originated from a set of strategies the UN Development Program formulated in the mid 1990s for development programming, human rights-based approaches have since been applied

across diverse public health efforts from HIV/AIDS response to access to medicines (Gruskin & Tarantola, 2008). Within the UN World, organizations that have purportedly adopted a Type 1A RBA to health; which they take on the label “Human Rights Based Approach”; unanimously cite the UN Common Understanding (2003) as the foundation for their work. Far from being a concrete formula to guide operationalization, the common understanding at least painted a rough sketch of some characteristics of the said approach. Pooled from UN agencies applications across vast development issues and contexts at that time, a HRBA was vaguely understood as describing development projects that 1. directly instead of incidentally further the realization of one or more human rights, 2. are guided by human rights standards and principles derived from the Universal Declaration of Human Rights and other international human rights instruments, and 3. contribute to the strengthening of duty-bearers’ capacity to meet their obligations and of rights-holders’ capacity to claim their rights (UNDG, 2003).

Since then, HRBA as a formula for development programming has been made much clearer by refinement to its definition and creation of practical guides within the UN world. In the context of health, this is supposed to mean that programs are designed to further health and related human rights as laid down in national and international legislation (WHO & OHCHR, n.d.). In relation to the Committee on Economic, Social and Cultural Rights’s authoritative interpretation of the right to health, HRBA further dictates that such programs are to address the 3AQs: availability, accessibility, acceptability, and quality of health goods and services (WHO & OHCHR, n.d.; Gruskin & Tarantola, 2008). However, not all development agencies share the same view. The United Kingdom’s Department for International Development (DFID), for example, views the realization of human rights as an incidental outcome of development (Gruskin et al., 2010). Though UN agencies and public health academics often claim that there is

‘simultaneous interest’ in both the process and outcome of development when talking about HRBA to health, HRBA emphasizes far more than anything else the importance of development processes conforming to fundamental human rights standards and principles (Gruskin et al., 2010). A piece of the puzzle that doesn’t fit well to this semantics is the idea of capacity building. Academics that tend to lump a Type I approach with other non-programming-related human rights approaches to health tend to mean broad improvement in health when they talk about outcome. UN agencies, on the other hand, mean strengthened capacity of rights claims and obligations fulfillment when they use the word outcome. Furthermore, this does not just mean, for example, the number of people signed in for a particular training session, but an assessment of which is determined by a more elaborate system of measurement and analysis using human-rights based indicators.

A Type I approach thus really refers exclusively to programming activities, which; when not done by national governments themselves; often coincide with capacity building activities by international, intergovernmental, or non-governmental organizations to advance health rights of the most marginalized groups and populations. The programming mostly occurs at the country level, where organizations such as the UN Population Funds provide technical assistance to their national counterparts in operationalizing elements of the approach (UNFPA, 2010). But it can also be programming at the global level to device a strategic plan for HIV/AIDS prevention and treatment. What makes Type I RBA different from other development approaches that can achieve the same outcome is the systematic integration of participation and inclusion, equality and non-discrimination, and accountability into the design, implementation, monitoring, and evaluation of health programs and interventions (Appleyard, 2002; Gruskin et al., 2010). In the original common understanding, UNDG cites a longer list including principles of universality

and indivisibility of human rights. But in practice, only the three aforementioned and the requirement of analyzing structural causes for health disparities as well as identifying vulnerable populations are commonly found in projects matching the overall characteristics of a Type I conception. In the next section, I will discuss in depth what each of those principles mean in the minds of those whose articulations I have grouped into the Type I category. I will also provide examples from real-life applications to illustrate how those elements may be operationalized.

2. What RBA Looks Like

a. Participation and Inclusion

The concept of participatory development stems from the idea that “people [are to be] treated not as passive recipients of goods and services but as [active agents] in decisions that affect their well-being” (Melo, 2006; Yamin, 2008a). In order for people to actually have control over these decisions, they need to be involved in the process of development from identifying the overall strategy, to the design, implementation, and holding duty bearers accountable for the services they are expected to deliver (WHO & OHCHR, n.d.; London, 2012). It is both an end in itself and intended to be a safeguard to ensure that policies and programs are responsive to the needs of the people they intend to benefit. Traditionally, participation of disadvantaged groups is limited to surveys and questionnaires (UNFPA, 2010). The actual decision-making process and “benefits of development often go to national and local elites and to those that are the easiest to reach, such as urban populations” (UNFPA, 2010). In order to include marginalized groups in the process, conceptions falling under Type I often require that, as a pre-requisite and integral part of any (health) development project, proactive measures need to be taken to reach out to those groups. People living in remote areas, women, children, and the indigenous population are all examples of the most forgotten stakeholders in traditional forms of programming (UNFPA,

n.d.). In terms of securing the necessary conditions for meaningful participation, transparency needs to be increased and policy or project information needs to be made accessible, for example, in formats and minority languages (Yamin, 2008a; UNFPA, n.d.). Channels sensitive to social and cultural contexts need to be created for participation, and “budgeting for capacity-building and community organization activities to strengthen civil society” is recommended (UNFPA, n.d.). The stakeholders should also be informed of their rights and entitlement (Melo, 2006). The UNFPA-supported Choose a Future Program in Nepal is one such example. Adolescent girls are given a 10-week course in which they meet two hours a day to learn about their reproductive health and rights as well as important problem-solving and negotiation skills (UNFPA, n.d.). The objective of the program is to both counter gender-based threats to women’s health in Nepal and to empower adolescent girls with the knowledge and the skills to become future leaders in community-based organizations.

In terms of the degree to which participation should be elicited in program design, activities to consider include taking into account the views, opinions, and understanding the needs and goals of the disadvantaged populations (Melo, 2006). Community input is also important in monitoring progress of development and efficacy of the existing programs to inform changes that need to be made as demonstrated in the best-practice case study of Ecuador’s User Committees. Originally created by Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) – German Technical Cooperation – to promote sexual and reproductive health, User Committees have since been adopted by the Ecuadorian Ministry of Public Health to get citizens involved in maternal health responsibilities and to monitor implementation of the national Free Maternity Law that provides free coverage for all maternal health service from pregnancy to post partum period including the child’s health care until five years of age (UNFPA, n.d.). Currently,

UNFPA partners with the ministry among other relevant Ecuadorian government agencies to provide technical support on policy and strategy revision as well as to train committee members on how to best collect data. On the ground, the User Committees, which span across five provinces including places with large indigenous populations, connect community members to the authorities making and implementing the law by visiting community groups, holding public forums, and having in-depth discussions with people waiting to be seen by doctors at local health clinics about expenses, budgeting, and community satisfaction with public health services. And, in distributing information about the new law as well as publicizing government records on maternal mortality within communities, the User Committees provide additional avenues for people to participate in the efforts to realize their right to health.

b. Equality and Non-Discrimination

Citing the UN General Comment 20, Alicia Yamin describes discrimination as “any distinction, exclusion, restriction, preference or other differential treatment that is directly or indirectly based on the prohibited grounds of discrimination and which has the intention or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing of ICESCR” (2009). A doctor refusing to provide any health service to his patient who is a sex worker living with HIV/AIDS would constitute a direct discrimination. Alternatively, punitive policies and community stigma can cause indirect discrimination. For example, employers terminating the contract of an employee following a positive HIV test result can discourage potential carriers from getting tested and incidentally hinders the prevention and treatment of the epidemic. Although Type I conceptions of RBA often insist that redress mechanisms must be in place to deal with incidences of such violations, they do not describe activities that directly combat discrimination and stigma in existing laws, policies, or social norms. As such, stand-

alone anti-discrimination or anti-stigma strategies such as the Sangha Metta Project in Thailand where faith-based NGOs design programs and seminars to open conversation on AIDS reality within communities, and to foster a more open and compassionate environment for people living with AIDS to be integrated into communities, would not be considered a Type I approach (UNAIDS, 2005).

What a Type I articulation of RBA would require is that marginalized groups and populations enjoy equal access and entitlement to health rights compared to the more advantaged members of the overall population. In programming, this means that attention and priority must be given to those suffering discrimination and disadvantage in any given context (UNFPA, n.d.) so that programs can be designed accordingly to tackle the observed disparities. Gender-equality, for example, should be more mainstreamed in program designs. And in order to achieve effective, non-discriminatory programming, organizations and their partners need to strengthen their own capacity to gather data that are “disaggregated as far as possible on the grounds of race, sex, geographic location, and other relevant characteristics” (UNFPA, n.d.). Other mechanisms to achieving equality and non-discrimination in the programming process overlap a great deal with those associated with operationalizing participation. Striving for gender balance and proportionate representation from the socio-economic and ethnic groups, especially in representing the interests of indigenous people and Afro-Ecuadorians, User Committees in Ecuador make its membership as reflective and as possible of the communities they serve as the first step to ensuring principles of equality in their work (UNFPA, n.d.). As the User Committees go about communities disseminating information about the new law and eliciting participation of community members in the discussion of maternal health care, they also assume an important role in data collection to draw out problems of discrimination in health service delivery. When

patients of marginalized groups reported at high frequency that health care providers tend to manifest discrimination towards them by “making them wait longer for services, giving them substandard care, and failing to offer them free medicines and other resources that are intended for all community members”, corrective measures were pursued to bring about improvement in those local hospitals and to lessen impunities in regard to “providers’ deficiencies and irregularities in their professional relationships with patients” (UNFPA, n.d.).

c. Accountability

In the Ecuadorian example, the process in which the User Committees actually acts on the complaints of discrimination they receive is closely tied to its primary accountability-seeking role. Transparency in regards to project information, how priorities are given to specific issues, and budgeting are obviously part of the concept of accountability. But, within the framework of a Type I approach, accountability refers to mechanisms; for redress or monitoring purposes; to be built into the design of the program. And their existence is to ensure that duty-bearers are held responsible for their decisions and actions. In Ecuador, there is a law guaranteeing free health care for pregnant women and the children born post partum. The law outlines an obligation for the State to provide free health care and, within the hospital setting, for health care professionals to comply by not charging their pregnant patients for services they receive. This of course is not always the case, as can be seen from the cases of discrimination described in the section above. Assuming that the original UNFPA project was to get Ecuador to incorporate its obligation to the international human right to health into its domestic law via this Free Maternity program, then the User Committees would be the built-in mechanism to monitor performance of the implementers; in this case, local governments and doctors. And, in the event of a violation, the

User Committees act as a redress mechanism for the victims by receiving complaints and issuing sanctions such as firing the doctor that has allegedly been not doing his job (UNFPA, n.d.).

The User Committees only illustrates how the accountability mechanism exists internally¹ to the program, it does not, however, provide us with too much detail on the types of mechanism the User Committees actually employ to measure progress or to provide redress. Furthermore, a range of other accountability mechanisms can be used to hold duty bearers accountable as well. Health Commissioners, democratically elected local health councils, public hearings, patients' committees, impact assessments, maternal death audits, judicial proceedings, are only a few among a laundry list of options to choose from. In countries where the right to health has been incorporated into domestic law, courts can also be used to provide redress for individual incidences of such violations. As part of the development of the broader idea of rights-based approaches to health, the former Special Rapporteur, Paul Hunt, suggests that impact assessments using human rights indicators should be used to determine the progress any particular health program makes towards the realization of health rights (2006). He proposes that elements of the right to health, including but not limited to, the 3AQs of health goods and services in addition to the degree of participation and access to information should be measured (2006). Nevertheless, the idea of rights-based indicators is not completely clear and is definitely in need of further development.

3. What RBA Is Not

To emphasize the importance of the “process of development,” academics and UN agencies whose articulations of RBA fall under Type I often contrast rights-based approach with needs-based approach that focuses on charity-driven initiatives to meet the needs of the majority

¹ An accountability mechanism such as monitoring and advocacy by NGOs existing outside of the original program design may fall under Type II descriptions of RBAs.

(UNFPA, 2010; Beracochea et al. 2011b). In theory, the needs-based approach that is traditionally used in development is everything that is not revolutionized by RBA. But the main difference for our purpose of demonstrating what makes RBA unique is that the former focuses exclusively on the outcomes of development. For example, a primary donor looking to scale up HIV prevention programs often focuses on the

“numbers of people receiving prevention information and services, such as the number of people attending training sessions on HIV and reproductive health; the number of educational pamphlets on HIV distributed; the number of people who claim to be using condoms; and so forth. And if the number of people attending training sessions regularly increases, the programme is seen as successful” (UNFPA, 2010, p. 93).

A rights-based approach, on the other hand, asks that the donor look at how prevention programmes are implemented. For example, who are the leaflets for? Are they reaching the most marginalized groups who may need them the most? “Do they have genuine options to change their behaviors in the long run?” (UNFPA, 2010).

Hence, labeling a project rights-based does not automatically mean that the process of programming will indeed be any different than it was before. The biggest challenge underlying whether a certain project actually matches the Type I conception in practice lies within the operationalization of participation, non-discrimination, and accountability. As all of these principles overlap in function and mechanism of realization with each other, it is hard to say definitively whether any particular project focusing only on one of the three principles would still be characterized as a Type I RBA. It is certainly possible that the formulation mapped out in the previous sections does not constitute a one-size-fit-all. Variations in the degree to which elements of real life Type-I-like applications conform to the conception highly probably exist.

For example, the fact that the adolescent reproductive health program in Nepal only seems to reflect characteristics of mechanisms used to achieve participation as an outcome in and of itself may dislodge it from qualifying as a Type I approach, but more information about the detail of the design and implementation of the program may show otherwise. It can in fact be a part of a bigger capacity building program that strives to advance women's reproductive right; which is part of the right to health according to UNFPA; with all the other human rights principles incorporated via other sub-projects. Likewise, a set of health development strategies, such as the UNAIDS Combination Approach to Prevention (2007), may display very recognizable characteristics of a Type I RBA; such as a human rights based situation analysis, and attention to vulnerable populations among others; in part of the overall scheme albeit not flagging itself as such. In other words, the application of a Type I approach to development does not have to be explicit and conscious. Being able to characterize it as such will be valuable for the analysis of what's being done by the project and to establish a set of parameters to measure its efficacy. Conversely, just because a health development project explicitly labels itself a rights-based approach does not mean that it will indeed be so practically and substantively. Analyses will have to be run to check for existence of mechanisms built into the program that ensure participation, non-discrimination, and accountability to the process of development and the extent to which they are actually operationalized.

B. National Level Planning by National Governments Themselves

Under the same broader framework of programming, a close sibling to the Type I approach described in the previous section characterizes governmental efforts to design national health policies or to reform health systems in order to fulfill its obligations to the right to health. This subset of Type I conceptions, however, should not be seen as describing pure

operationalization of the right to health, but one that is achieved with the same approach aforementioned requiring decision-making and evaluation processes to be participatory, non-discriminatory, and governments to be held accountable for its actions and obligations in the area of health. And, intermediate to the process and the long term goal is 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). The intermediate outcome of development activities by IGOs and NGOs, in contrast, is strengthened capacity of rights-holders to claim rights and of duty-bearers to meet their obligations. The two development processes are fundamentally the same. But, instead of global health interventions or capacity building activities, articulations on RBA to health system focuses on the primary duty bearers; namely, the national government; and their domestic level programming as well as health system reform initiatives. The subtle differences may be generalized into differences in the scale and complexity of health programming. The interesting part is that linking the concept of RBA as a programming tool to the State’s obligations to health rights the way Paul Hunt does under what he calls the “Right to Health Approach to Health System Strengthening” blurs the line between what used to be two distinct ideas (2008). This subsequently opens up room for confusion and gaps in the understanding of those that I have loosely grouped along with UN conceptions of HRBA to programming into the Type I category.

One of divergent idea is that a health system needs to be respectful of cultural differences (Hunt & Backman, 2008). Cultural sensitivity in terms of taking into account traditional preventive care, healing practices and medicines is encompassed in the concept of acceptability, is one of the elements of the 3AQs of health goods and services. And although UNFPA (2010) claims that it is, along with gender equality, an integral part of rights-based approach to

programming, it is not an idea found across all other conceptions that fall under Type I. The focus on underlying determinants of health also blurs the boundary of whether something can be considered health, or not health in a given development project or policy design. The comparative analyses across rights-based health system reforms Meier et al. conducted seem to support Hunt and Backman's claim that a social determinants approach is not part of the broader Type I RBA framework (2011). But, if reform efforts in the area of safe food, water, adequate nutrition, sanitation, among other underlying determinants of health employs a participatory approach with mechanisms to ensure non-discrimination and accountability, and if the efforts are being framed as part of a broader set of policy to better health and health rights among a certain known marginalized population, then the policy can be said to have employed a Type I RBA.

Resource constraints stemming from discussions of progressive realization, is, on the other hand, a huge concern for the operationalization of this subset of Type I. Hunt argues that a Type I RBA is not meant to be a panacea for all health problems, nor is it going to provide neat answers to questions on whether money should be spent on one super important health project over another given finite budgets, but it does require choices to be made in a fair, transparent, and participatory way "taking into account explicit criteria such as the well-being of those in disadvantage, instead of claims of powerful interest groups" (2008). Furthermore, such procedural safeguards of decision-making are to be applied across all six "building blocks" of a health system: health services, health workforce, health information system, medical products and technologies, health financing, and governance (Meier et al., 2011; Hunt & Backman, 2008). However, as health systems are traditionally technocratic and removed from the people they are meant to serve, essential building blocks may all be in place without features required by a human rights framework (Hunt & Backman, 2008). The context of essential medicines within the

building block, “medical products, vaccines, and technology,” for example, involves the use of an essential medicines list (EML), an effective supply system, and rational use of medicines based on treatment guidelines (Beracochia & Lee, 2011). The EML is a list of scientifically proven medicines selected by a WHO expert committee. At the country level, the EML is adopted and updated according to each country’s unique epidemiological needs which are also determined by expert committees within the individual countries. The resultant list is then used by the government to “prioritize procurement of medicines’ and to determine levels of use by “trained, accredited and efficient [health care] providers” (Beracochea & Lee, 2011). The entire process, including financing strategies for all relevant activities, are usually left to experts who may fail to notice structural problems underlying disparities in the access to medicines and disaggregate needs (Beracochea & Lee, 2011; Hunt & Backman, 2008). Reflecting on public health efforts in Nepal to combat infant mortality, Beracochea and Lee noted that many infants died from the lack of malaria treatment because the government did not “anticipate the needs of its citizens and did not procure the right quantities of the right medicines and/or did not distribute them in a timely manner to the health facilities” (2011). The lack of procurement, in turn, was caused by the lack of a prioritized and updated list of essential medicines. The solution, as Hoyerzeil (2006) suggests in the WHO Bulletin, is a Type-I-like approach that starts by having countries assess the existing situation within its national essential medicine programs with five simple questions:

1. Which essential medicines are covered by the right to health?
2. Have all beneficiaries of the medicine programme been consulted?
3. Are there mechanisms for transparency and accountability?
4. Do all vulnerable groups have equal access to essential medicines? How do you know?

5. Are there safeguards and dress mechanisms in case human rights are violated? and to revise the programs accordingly (p.373-374). And lastly, just as Hunt and Backman (2008) suggest, States should make use of accountability mechanisms beyond traditional ones such as health impact assessment. On top of monitoring its own progress via self-developed benchmarks and indicators, States should also consider “reporting regularly on the progressive realization of the right to health, for example, disaggregated statistics on access to essential medicines,” to international human rights bodies such as the CESCR (Hunt & Backman, 2008; Hogerzeil, 2006).

VII. Type II: Health Rights Advocacy

Along the same line of perceiving RBA as a mechanism to go about fulfilling the right to health, some articulations of a seemingly broader “human rights approach” note that there can be none or all of the things discussed in the previous sections yet a human rights framework can still be used to achieve the same goal (London, 2008). One such description emphasizes the enforceability of legal standards surrounding the right to health and the potential of litigation to bring about more justice to health beyond providing individual redress (Yamin, 2011). On the other hand, UNAIDS (2011), while reflecting on the success story of AIDS response in the past two decades, accredits community mobilization and strategic advocacy for their important roles in surfacing injustice and making it a global agenda. Citing South Africa’s Treatment Action Campaign (TAC) and its renowned success in strengthening claims to ARV treatment through mutual reinforcement of civil society mobilization and targeted court action, at the same time contrasting it with Cape Town’s failure to account for delivery of change post judicial ruling of access to housing, London (2008) connects the legal and advocacy frameworks in relation to

human rights application to health by arguing that civil society action is the ultimate transformative ingredient that pushes paper commitments into actual change. Examination of real-life projects that fit these conceptions further suggests that there may exist a Type II RBA describing advocacy activities that employ specific techniques to either directly or indirectly lead to the advancement of health rights. In the next few sections, I attempt to map out the three elements I have observed across Type II conceptions of RBA: the advocacy framework involving two actors; the advocate and the target; what is being advocated for, and the types of techniques Type-II-like approaches tend to use to achieve those desirable outcomes. Even though the boundary between Type II RBA and non-Type-II advocacy cannot be drawn as distinctly as that between Type I RBA and non-Type-I programming due to the limitation of the research methods used in this study, the attempt at a Type II conceptualization can still provide us with a set of tools to recognize those among the sea of RBA articulations that clearly don't fall into Type I.

A. The Concept of Advocacy

UNICEF (2010) defines advocacy, in the context of their work, as

“[the deliberate process involving] delivering evidence-based recommendations to decision makers, stakeholders and/or those who influence them. Advocacy is a means of seeking change in governance, attitudes, power, social relations and institutional functions. It supports actions which are taken at scale, and which address deeper, underlying barriers to the fulfillment of children's rights. The goal of advocacy can be to address imbalances, inequity and disparities, promote human rights, social justice, a healthy environment, or to further the opportunities for democracy by promoting children's and women's participation. Advocacy requires organizing and organization. It

represents a set of strategic actions and, at its most vibrant, will influence the decisions, practices and policies of others”.

The bare backbone of advocacy really boils down to one actor, or group of actors doing something to change the behavior of another. Within the broader human rights framework, health is viewed as a legal entitlement. This makes the target of advocacy efforts the duty-bearer who holds the obligation to respect, protect, and fulfill the right to health (WHO & OHCHR, n.d.). Categories of duty-bearers range from various levels of governments to non-state actors such as health professionals (Gruskin et al, 2010). The advocate, on the other hand, could either be individual right-holders or organizations supporting a cause on their behalf. In cases where litigation is used as a technique for advocacy of health rights, individual rights-holders themselves can bring cases to the court to effect change in, for example, government services in medicine provision (UNAIDS, 2006). IGOs and NGOs can also be involved to lobby national governments to ratify treaties or to incorporate health and health-related rights into domestic law. They may even employ different advocacy techniques to get governments to adopt a Type I approach to health policy and system programming. Although the latter may sound like yet another capacity building activity where development approaches recommended by international organizations are merely disseminated down to country levels, it differs from Type I in that there are two actors; an advocate and a target; as opposed to one in addition to the beneficiary of the project. Type II also describes activities that are also visibly different from those characterized by Type I RBA in the mechanism used to achieve their respective desirable outcomes.

B. Goals and Outcomes of Advocacy

As aforementioned, Type I RBAs are not really set out to improve biological health outcomes, but to better the social and structural conditions imperative to the realization of

everyone's right to the highest attainable standard of health. Similarly, because the basis and power of a Type II approach lies within the fact that health is framed by human rights paradigms as an entitlement and that disparities in health distribution are violations by duty-bearers, the Type II label should be reserved for advocacy activities associating with health rights promotions. For example, advocacy for essential diabetic medicines to be paid for by government services is a clear Type II project. Advocacy for gun control on the grounds that guns can endanger life and thus, in a roundabout way, endanger health, is not. This is because the conception of health in the latter example is too broad. The right to health itself does not mean the right to be healthy, or immortal, but it does require governments to "put in place policies and action plans that will lead to available and accessible health care for all" (WHO, 2002). Advocacy for comprehensive sex education in high schools framed as advocacy for adolescent's reproductive rights and reproductive health, for another example, would match a Type II description of RBA because the relevant right being advocated for has been increasingly mainstreamed into the normative contents of the right to health. On the other hand, although General Comment 14's definition of the right to health encompasses social determinants of health beyond medical care, advocacy for safe water, food, shelter among other such underlying determinants probably won't align with conceptions grouped under Type II unless the end goal is framed explicitly as advancement of the right to health (Hunt & Backman, 2008). Likewise, advocacy for budget allocation for specific healthcare service provisions or even for the State to adopt a Type I approach² to its health programming will all fit the characteristics of a Type II

² One can think of this as a Type I approach nested in a Type II approach because the former is the outcome of the latter. A complement also exists: a rights-based approach to advocacy (UNICEF, 2010). In this case, even though the outcome of the project is a Type II approach, the mechanism used to get there is a Type I. Aside from the blurring between participation and civil society action, the way UNICEF (2010) envisions this RBA to advocacy is that UN agencies (or other NGOs) will create the space, channels, and provide information and resources for children to "learn about issues, take up issues that affect them, and advocate on those issues".

approach, because both are considered instrumental to realization of health rights and are thus desirable rights-based development goals themselves. The People's Health Movement Gruskin and Tarantola (2008) describes in their articulation of the advocacy framework applied to health is one such example. The PHM, although created as "a civil society initiative to bring together individuals and organizations committed to the implementation of the Alma Ata Declaration on Primary Health Care (1978), campaigns for an "equitable, participatory, and intersectoral movement" to addressing health as a rights issue.

Simply by engaging in conceptual exercises, one can come up with an even longer list of advocacy efforts that may or may not match a Type II description. Articulations that I have grouped under Type II actually don't draw a clear boundary between Type-II advocacy project and broader health or health-related advocacy efforts. In the context of health-rights-related litigations, some would argue that in certain contexts, even "administrative law, private actions against providers, and malpractice cases" would be relevant as well (Yamin, 2011). Surveying across a wider range of RBA applications by international NGOs and community-based health advocacy organizations, one may find that the Type II boundary is actually more inclusive of advocacy beyond health rights. Depending on the purpose of the categorization or parameters of the study, one can also change the criteria to include or exclude certain types of advocacy. I am certainly not arguing that the attempted conceptualization above captures all of reality, as the research method used in this study only yielded a subset of supposed Type II RBA applications. But, combining with a third set of characteristics observed from the data — advocacy techniques — Type II can be a relatively faithful model in describing the types of health and human rights projects that are clearly not Type I or rights-based in general.

C. Techniques of Advocacy

In discussing techniques of advocacy useful to advancing social, economic, and cultural rights, Kenneth Roth (2004) argues that the most effective tool to generate public outrage is to investigate, expose, and shame a specific violation where the violator and remedy to the violation are clear. Incidences where arbitrary or discriminatory governmental actions are identifiable, the violation are the easiest to name and shame. Although many real-world advocacy projects do center around issues of discrimination, typical descriptions of RBAs to health by those who don't believe that the approach should be limited to being a programming tool do not tend to mention naming and shaming as the premiere technique for advocacy (Aggleton et al., 2005). Instead, the techniques observed across Type-II activities are those that strive to effect more systematic structural change rather than addressing individual incidences of violations. Among these are lobbying, litigation, and social mobilization. Discussed in the next few sections are some illustrative examples pooled both from Type II conceptions and real-world projects.

1. Lobbying

One of the techniques Roth deems less effective is promoting legislations that would make it possible to enforce ESC rights in courts. And indeed, litigation is believed by many in the Type II category to be a useful tool to bring more justice to health. But in terms of lobbying, Type II conceptions tend to mean what Leonard Rubenstein (2004) would call proactive activities that aim at influencing designs of systems and services. UNFPA, for example, engage in a variety of advocacy activities to lobby for the mainstreaming of reproductive rights and gender as well as cultural sensitive approaches into UN agendas on health development (UNFPA & OHCHR, n.d.). Civil society organizations can also engage in lobbying efforts within a country to institute health rights or for governments to provide means of citizen participation in health policy decision making. The 2001 passage of Guatemala's Social Development Law

aimed at improving maternal healthcare among other family planning services is an example of the product of lobbying by a coalition of different civil society organizations from church groups to the business sector (UNFPA, *Guatemala*). The potential crossover between the advocacy story here and activities described by a Type I conception of RBA is that these different partners in the project are brought together by UNFPA. In the descriptions of its other advocacy efforts surrounding health and health rights issues, UNFPA also mostly assumes a role in capacity strengthening—for example, disseminating rights-based analyses to support stakeholders carrying out the advocacy efforts on the ground (UNFPA & OHCHR, n.d.). It can certainly be argued that UNFPA is indirectly advocating for the passage of the Guatemalan law to advance reproductive health by assisting local organizations in their effort to lobby the government. However, depending on what techniques UNFPA uses to choose which advocacy organizations to help, what their project constitute may fundamentally be a Type I or some approaches not defined by Type II characteristics to go about doing their work.

2. Litigation

Litigation appears in discussions of both Type I and Type II RBAs rather frequently because courts can be used as both an accountability mechanism to provide redress for individuals in the event of a violation to their right to health by any kind of duty-bearers or as an advocacy technique to get governments to step up their duty to provide for health services. It is certainly a popular technique for people to demand for access to antiretroviral treatments in the first wave of HIV/AIDS response. South Africa's TAC case is one such example. Individuals themselves can also bring cases to courts and result in decisions that produce change in government policies regarding provision of essential medicines or other elements of health rights. For example, in Columbia in 1992, "Alonso Munoz Ceballos filed an application for a

writ of protection of fundamental constitutional rights to seek an order that he was entitled to continue to receive necessary medical treatment, including for HIV and AIDS, paid for by the Institute of Social Security” beyond the 180-day limit Social Security imposed (UNAIDS, 2007). The case was actually one of the first cases in Latin America where “contents and enforceability of the right to health was considered in the context of a claim by a person living with HIV challenging discriminatory denial of health care coverage” (UNAIDS, 2007). But, litigation does not always bring about direct change. Nevertheless, it can be used to lay ground work for concurrent or future advocacy efforts. Around the same time as the renowned TAC case, there was also another case surrounding the topic of essential medicines: Pharmaceutical Manufacturer’s Association and 41 Others v. President of South Africa and 9 Others (UNAIDS, 2007). PMA claimed that South Africa’s Medicines Act violated its obligations to the WTO. The two parties were ordered by the court to settle in the end. Although TAC was not involved in the settlement, it participated in the process of litigation by submitting a wide range of affidavits describing “personal experiences of people living with HIV and physicians struggling in the face of medicines priced out of reach”, they were able to “put forward to the public at large the fundamental challenges to [PMA’s abstract legal arguments]” (UNAIDS, 2007).

3. Social Mobilization

Some conceptions under the Type II category would favor litigation over other types of advocacy techniques because “without some ability to vindicate legal entitlements through judicial enforcement, the right to health is ultimately hollow” (Yamin, 2011). London, on the other hand, argues that judicial enforcement alone would not suffice (2008). Citing South Africa’s Treatment Action Campaign (TAC) and its renowned success in strengthening claims to ARV treatment through mutual reinforcement of civil society mobilization and targeted court

action, at the same time contrasting it with Cape Town's failure to account for delivery of change post judicial ruling of access to housing, London argues that civil society action is the ultimate transformative ingredient that pushes paper commitments to rights into actual change (2008). Indeed, even the litigation of the TAC case alone is brought about only after four years of sustained efforts in lobbying for PMTCT programs. The actual success of the case, on the other hand, is brought about by mass demonstrations and other strategic advocacy efforts that dramatically changed government policies even during the litigation (Kapczynski & Berger, 2009). What these conceptions don't go into detail is the range of techniques that are employed to mobilize society. UNFPA's rendition of the of Guatemala's successful case study only hints at the use of media to increase discussions of maternal health issues. It does not particularly praise the use of media as a technique to generate public pressure. TAC, on the other hand, engages in a wide variety of tactics from civil disobedience to "community-based treatment literacy work that has educated tens of thousands of people around the country about the science of HIV prevention and treatment" (Kapczynski & Berger, 2009). The list can certainly go on. They also do not represent defining characteristics of a Type II RBA. But, discussions of how human rights advocacy techniques can single-handedly bring about change in government fulfillment of their obligation to health rights surface an interesting point that "community agency [reinforcing] rights mechanisms" does not equate total substitution of "government obligations with NGO or community action" (London, 2008). In fact, articulations that fall under the Type II category often lumps together the idea of civil society action and participatory development (London, 2008). Perhaps, then, although the two frameworks of RBA allow us to identify conceptions and the projects they categorize as separate strategies to go about health work, they are encouraged to be used in conjunction with each other in practice.

VIII. Conclusion

As can be seen from the diversity of ideas where human rights can be used to reshape health policies and programs, the same diversity can also be a shortcoming for implementation. Designs of efficient programs, whether it is to address health needs of a society or to advocate for health rights, may be compromised by the lack of understanding of what a rights-based approach to health actually requires different actors do. Looking across a range of existing conceptions and real-world health projects seemingly fit those descriptions, I am able to sort the eclectic range of rights-based approaches into two distinct categories. One type of conceptions views RBA as a programming tool requiring development processes to be participatory, non-discriminatory, and accountable. Even though the types of programming activities can vary in scale and complexity, health-issue-specific or health system planning Type-I-like RBA applications are fundamentally united by the same specific set of procedural requirements. The conceptual framework is hopefully more lucid after clarifications on what a RBA is, how it contrasts with non-RBA approaches such as needs-based approach, and how RBA may be operationalized on the ground. Although the second type of RBA conceptions gives us a framework that can help identify health rights-related projects that are clearly distinct from those characterized by Type I, the attempted conceptualization is rough. Pooling articulations by those who include advocacy into their discussions of RBA and case studies that seem to describe the relevant kinds of activities, I suggest that a Type II RBA can be defined by an advocacy framework in which specific techniques of lobbying, litigation, and social mobilization, can be used to demand for people's right to health.

But even from the rough overview of the types of vision these different RBAs have for health work, it can be seen that human rights frameworks offer a lot of potential to reshape unjust

distributions of power that underlie inequalities and discriminatory practices hindering people's attainment of better health. The hard part, it seems, is to define the boundary of what can be called a rights-based approach to health instead of a generic rights-based approach that can be applied to any development issues. To develop a framework that can be used to analyze health projects today, one will have to strike some kind of balance between generalization and specificity. Sorting articulations into more narrowly-defined categories may be a step forward for creating a more refined framework of RBA to health, but it may also lead us into conceptual rabbit holes that are not exactly constructive to goals of producing a formula that is not only good for characterizing projects as rights-based but can actually provide guidance to develop projects as well. A possible next step to refining these frameworks is to test them against more real world applications to see how well they capture the sundry health initiatives and strategies that claim to be different from traditional public health approaches. In this study, sample strategies and case studies from UN agencies involved in health work and development of HRBA are only examined for the purpose of providing examples for the clarification of conceptual frameworks. For future studies where time and other resources permit, a more systematic and across-the-board examination of IGOs, NGOs, and governmental articulations and health initiatives would perhaps be more informative to the refinement of RBA to health categorization. Ultimately, a more developed conception of RBA will be invaluable to its applications to a wider range of development issues. Hopefully, it will also help researchers design studies to investigate the actual efficacy of rights-based approaches to better not only attainment of health rights, but health in general as well.

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Appendix A. The Right to Health in Relation to Goods and Services (the 3AQ)

The table below is adapted from WHO (2012)'s *Right to Health* factsheet and Gruskin et al. (2010)'s Table 1 of *Rights-based approaches*

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