A rights-based approach to the assessment of global health initiatives

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Governments, non-government organisations and academics are increasingly recognising the synergistic relationship between health and human rights as critical to their work in public health. A rights-based to health includes taking the core principles of human rights and using them as a framework for developing and evaluating health policy or programs. This article provides an overview of human rights; illustrates the relationships between health and human rights and explores what this interface means in practice; and finally reviews the literature on global health initiatives, particularly those invoking public–private partnerships.

Introduction

The links between health and human rights were first articulated just over a decade ago by the late Jonathan Mann and collaborators (Mann et al 1994). These links bridged a perceived gap between the two worlds of health and human rights. One can refer to the HIV/AIDS pandemic as a catalyst for beginning to define the connections between health and human rights, as well as a series of international conferences for further clarification of these connections. Governments, non-government organisations (NGOs) and academics are increasingly recognising the synergistic relationship between health and human rights as critical to their work in public health (Gruskin and Tarantola 2002). One method of applying this relationship is through adopting a rights-based approach (RBA) to health. Rights-based approaches enjoy a wide range of subjects, of which health is one. An RBA *to health* includes taking the core principles of human rights and using them as a framework for developing and evaluating health policy or programs. This article applies an RBA to a significant area of public health — global health initiatives (GHIs) — and documents the lessons learned.

GHIs mobilise the world's resources towards improving access to health treatment and programs in developing countries. Critical to many GHIs is the partnership of public and private actors. Partnership may occur at a foundational level or be utilised as a mechanism within the GHI's operations. GHIs often collaborate with

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governmental and intergovernmental entities such as the United Nations (UN). These entities have obligations to uphold human rights principles, both in their own policies and programs and in their collaboration with non-state actors. Thus, through partnership with such entities, GHIs can be subject to human rights analysis. Furthermore, GHIs engage in international assistance and cooperation, target vulnerable populations and aim to improve health — characteristics relevant to the components of an RBA to health. Finally, the increasing significance, power and influence of these GHIs demand particular attention by health and human rights workers to prevent neglect or violations of human rights and to improve health outcomes and processes. Assessing GHIs through a health and human rights lens intends to verify the extent to which these entities comply with both the public health and the human rights principles which they claim to uphold. The purpose of this study is therefore to draw attention to the need to assess strategies and programs put in place by GHIs; develop and apply an RBA to these analyses; document the lessons learned; and stimulate further work on this topic, in particular on the further development and application of a method herein proposed.

Human rights

The basic premise of human rights is that they are indeed inherent to every individual, regardless of place and context, by virtue of the fact they are human. Human rights are principally concerned with the relationship between the individual and the state.

Human rights are contained in declarations, as well as international and regional treaties. Adopted in 1948 as a common standard of achievement for all nations, the Universal Declaration of Human Rights (UDHR) forms the basis for the content of all human rights. Although it is not legally binding, nations have endowed it with tremendous legitimacy through their actions. Since the UDHR, more than 20 multilateral treaties have been formulated, including the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the International Covenant on Civil and Political Rights (ICCPR). These treaties create legally binding obligations on the nations that have ratified them, thereby giving them the status of international law. General comments or recommendations are authoritative interpretations of rights endorsed by the treaty monitoring body in question and which form the basis of the treaty monitoring body's formal understanding on the content of a particular right or issue.

Core human rights principles include non-discrimination, participation, accountability and transparency, and attention to vulnerable populations. Participation is defined as the active and informed participation of individuals and

communities in decision making that affects them (UNECOSOC 2006). The principle of non-discrimination and equality is fundamental to human rights thinking and practice. Within the international human rights framework, discrimination is a breach of governments' human rights obligations (Bilder 1992). Adverse discrimination occurs when a distinction is made against a person due to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status, which results in the person being treated unfairly or unjustly (ICCPR, Art 2). Accountability and transparency are crucial to the realisation of all human rights, in particular those subject to progressive realisation. Governments' activities must be transparent and monitored in order for them to be held accountable to their right obligations.

Finally, at its core, human rights are concerned with attention to vulnerable populations. First established in response to the rights abuse of the oppressed, those in conflict, the poor and diseased, human rights are about paying particular attention to the rights of vulnerable populations, including children, women, those in conflict and those in remote areas.

States have an obligation to respect, protect and fulfil human rights (Eide 1995a; 1995b).

- *Respect* means that a state cannot violate rights directly.
- *Protect* means that a state has to prevent and take measures against violations of rights by non-state actors.
- *Fulfil* means that a state has to take all appropriate measures towards the fulfilment of a right, including an obligation to promote the right in question.

These obligations therefore extend beyond the realm of direct state action towards people. They also require a state to comply with and promote human rights in all its activities with non-state actors; prevent non-state actors from violating or neglecting human rights; and, if necessary, engage non-state actors to fulfil human rights. This feature of the human rights regime is particularly relevant to alliances between state and non-state actors, such as public–private partnerships (PPPs) that characterise several ongoing GHIs and are the focus of this article.

States also have an obligation to take steps, individually and *through international assistance and cooperation,* towards the full realisation of rights, including the right to health. The responsibility of those states that are in a position to assist and to engage in international assistance and cooperation is recognised in the ICESCR, the UDHR, the CRC and elsewhere (UNECOSOC 2006).

Health and human rights

Critical to the relationship between health and human rights is the right to health (ICESCR, Art 12), embodied in numerous legally binding international and regional human rights treaties. Every state is party to at least one international human rights treaty, all of which having some degree of relevance to health, either explicitly or implicitly (OHCHR 2006). As defined in the ICESCR, the right 'to the highest attainable standard of physical and mental health' entails obligations understood to encompass both underlying conditions necessary for health and the provision of medical care (Hunt 2006; Toebes 1999, 19). The right to health can be understood as a right to an effective and integrated health system, encompassing health care and the underlying determinants of health, which are responsive to national and local priorities and accessible to all (UNECOSOC 2006). To be integrated means first, that interventions are designed to coordinate with each other; and second, that all interventions should form part of a regular health system (UNECOSOC 2006).

The right to health and other economic, social and cultural rights are subject to progressive realisation, taking into account the capacity of states to realise this right, in particular with regards to resource availability (UNCESCR Gen Com No 3). These provisions impose immediate obligations on states to set measurable objectives and establish mechanisms for reporting on the progress made towards the fulfilment of these rights. The principle of progressive realisation does not apply to rights enshrined in the ICCPR — the right to non-discrimination among others – as these impose immediate obligations.

General Comment No 14 of the United Nations Committee on Economic, Social and Cultural Rights defines the right to health as one that gives particular attention to vulnerable populations and contains the following interrelated and essential elements.

- *Availability:* Structures, goods and services have to be made available.
- *Accessibility:* Structures, goods and services have to be accessible to everyone without discrimination. Accessibility has four dimensions: non-discrimination, physical accessibility, economic accessibility and information accessibility.
- *Acceptability:* Structures, goods and services are to be respectful of medical ethics and culturally appropriate.
- *Quality*: Structures, goods and services are to be scientifically and medically appropriate and of good quality.

While the relationships between health and human rights are entrenched in documents such as the UDHR and ICESCR, Mann and collaborators (Mann et al

1994) first articulated them just over a decade ago. Anchoring public health strategies in human rights can enrich the concepts and methods used to attain health objectives through drawing attention to principles such as participation, attention to vulnerable populations and non-discrimination (Tarantola and Gruskin 2008). For example, in most cases a local community will have a keen sense of its health priorities; it is entitled to participate in the identification of priorities and targets that underlie health policy that affects them (UNECOSOC 2006). The exercise of rights improves health status outcomes and participation is instrumental to such outcomes (Scott-Samuel and O'Keefe 2007). Thus, the integration of human rights in the design, implementation and evaluation of health policies and programs is necessary not only because of government human rights obligations, but also in purely pragmatic public health terms.

Responsibilities for health are largely carried out through policies and programs by the state. Core human rights principles are relevant to all stages of health policy and programs, including their development, implementation and evaluation.

The major determinants of health are increasingly understood to lie outside the health system and to include the fulfilment of an array of rights (Carrin and Politi 1996). Nearly every human right can be understood to have clear implications for health (Mann et al 1994).

Consequently, both the number and the diversity of actors in the field of health are growing, and so is the uncertainty about the actual locus of decision making on global health priorities and resource allocation. Human rights can help to provide an approach for redefining the ways in which governments and the international community as a whole are accountable for what is done about the health of people (Mann et al 1994).

A rights-based approach to health

In practice, health and human rights are concerned with optimising the relationship between the two disciplines. A crucial step in optimising this relationship is determining to what extent government policies and programs are respectful of human rights and are of benefit to public health (Gruskin and Tarantola 2002). Another pressing challenge is to integrate the right to health into all health-related policies and programs (Hunt 2006). This can be done by instituting human rights through policy-making bodies relevant to health, including the use of rights language in the policy documents that emanate from them. It can also be done by deliberately implementing human rights in health programming, including the design, implementation, monitoring and evaluation of health programs. The

Box 1: UN Statement of Common Understanding of the Human Rights-Based Approach to Development

1. All programs of development co-operation, policies and technical assistance should further the realization of human rights as laid down in the UDHR and other international human rights instruments.
2. Human rights standards and principles guide all development cooperation and programming in all sectors and phases of the programming process.
3. Development cooperation contributes to the development of the capacities of 'duty-bearers' to meet their obligations and/or of 'rights-holders' to claim their rights.

implementation of rights may be evident also through the use of human rights language in policy documents.

A rights-based approach is one method of optimising and applying the relationship between health and human rights and achieving the challenges identified above. Initially conceptualised as a rights-based approach to development, RBAs now enjoy a wide range of subjects, of which health is one. The UN Common Understanding (Box 1) defines a rights-based approach as one that uses human rights norms and standards to prevent violations from occurring and involves implementing one or several core rights concepts. Concepts include participation; attention to vulnerable populations; non-discrimination; accountability and transparency; and those embodied in the right to health (Gruskin and Tarantola 2002).

A human rights-based approach to health is about optimising the synergistic relationship between health and human rights in order to gain maximum public health gains. Crucial steps towards this goal are to assess policies and programs for compliance with human rights; institute human rights through policy-making bodies; and implement human rights at all stages of health programming.

A rights-based approach to GHIs

GHIs mobilise the world's resources towards improving access to health treatment and programs in developing countries. Their significance, power and influence demand particular attention by health and human rights workers to prevent neglect or violations of human rights and to improve health outcomes and processes. Critical to many GHIs is the partnership of public and private actors. Partnership may occur at a foundational level or be utilised as a mechanism within the initiative's operations. GHIs often collaborate with governmental and intergovernmental entities such as UN agencies, funds and programs engaged in health, in particular

WHO, UNICEF and the World Bank. Most GHIs also have a representation of a panel of governments on their board, as financial and technical support to countries is commonly extended under the oversight of governments or through them. These entities have obligations to uphold human rights principles, both in their own policies and programs and in their collaboration with non-state actors. States and the UN should sustain their human rights obligation to respect, protect and fulfil human rights through their participation in GHI policies and programs on both the international and local levels.

Global health partnerships are defined as a:

> … collaborative relationship which transcends national boundaries and brings together at least three parties, among them a corporation and an intergovernmental organization, to achieve a shared health-creating goal based on a mutually agreed division of labour. [Buse and Walt 2000a, 550.]

Partnerships have been analysed individually (Muraskin 2004; Vian et al 2007) and in groups according to the disease or country they are addressing (Caines and Lush 2004; Capoor 2005; Newell et al 2005; Dewan et al 2006; Sinanovic and Kumaranayake 2006). Analyses reveal what makes the partnership arrangement uniquely attractive: they are described as an attractive means to achieving public health goals because they leverage the strengths of both governmental and non-governmental sectors (Nwaka and Ridley 2003; Jamali 2004; Nishtar 2004; Batson 2005; Croft 2005; Moran et al 2005; Newell et al 2005; Widdus 2005; Vian et al 2007; Wechsler 2006) and they help reduce and share the costs and risks associated with health development across both sectors.

Partnerships have been evaluated against operating metrics to measure internal performance; and output metrics to quantify potential public health impacts (Ziemba 2005). Evaluations are overwhelmingly positive (Shretta et al 2001; Widdus 2001; 2005; Nwaka and Ridley 2003; Caines and Lush 2004; Jamali 2004; Peters and Phillips 2004; Croft 2005; Hale et al 2005; Moran et al 2005; Scheffler and Pathania 2005; Widdus 2005; Dewan et al 2006). They have either been deemed a success or are predicted to be so. Despite these evaluations, there remains a considerable lack of evidence on partnership performances and sustainable impacts, and no evaluations have been conducted using human rights criteria (Barr 2007).

Criticisms of partnerships concern accountability and participation (Buse and Walt 2000b). There is a lack of accountability of partners to each other and to the public, due to the absence of a regulatory framework applicable to PPPs (Nishtar 2004). There is poor representation of developing countries in decision-making processes of

PPPs (Bennett et al 1997; Caines and Lush 2004; Nishtar 2004; Muraskin 2005; Ziemba 2005; Kieny and Serdobove 2006), and PPPs have been criticised for ignoring the capacity of developing countries and neglecting their needs (Bennett et al 1997; Shretta et al 2001; Muraskin 2004). Human rights can provide an approach for evaluating partnerships, and thus GHIs, and for enhancing their accountability and participation.

Assessing GHIs through a rights-based approach

Aims

This project aims to develop and apply a rights-based approach to GHIs, with a focus on those invoking PPPs. It will assess policy and processes for compliance with human rights; measure the extent to which human rights are instituted and implemented in policies and programs; and document the lessons learned. It will also assess governments' and the UN's stated compliance with their obligations to protect, fulfil and promote human rights in the activities of GHIs. It will also compare the extent to which GHIs chosen as examples protect and promote human rights against the degree of UN involvement.

Assumptions

The first assumption underlying this study is that a rights-based approach to GHIs will enhance public health outcomes and the processes of GHIs and hold governments and the UN accountable to their human rights obligations. The second assumption is that sufficient clarity prevails in published GHI policy and strategic documents to assess their compliance with human rights norms and standards.

Method

Three GHIs were chosen for this analysis, based on the following criteria. The GHI:

- aims to improve developing world health;
- fulfils this aim through partnership with public and private sectors — namely, governments and to varying degrees the UN;
- mobilises a significant amount of resources;
- maintains significant coverage of developing world populations; and
- publishes sufficient amounts of information for analysis.

GHIs chosen for analysis were the United States President's Emergency Plan for AIDS Relief (PEPFAR); the GAVI Alliance (GAVI); and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM).

A literature review sought to document and analyse the various views on the nature and value of GHIs and, more specifically, those invoking PPPs, as well as the outcome of internal and external evaluations of the chosen GHIs.

An RBA was developed based on a review of the literature on RBAs to health. It draws on suggestions made by Gruskin and Tarantola (2002), Hogerzeil (2006), Hunt (2006), and Tarantola and Gruskin (2008). The rights-based approach applied to this analysis was intended to serve more as a rudimentary assessment model needing further development than as a fully functional measurement tool (Table 1).

A meta-analysis was conducted of all policy and strategy documents, as well as information regarding initiative processes published on or linked to initiative websites.

The extent to which GHIs respect human rights is assessed by a stated commitment in policy and strategy documents to uphold the right in question. This stated commitment may be implicit and explicit. Human rights principles assessed include participation; attention to vulnerable populations; non-discrimination; accountability and transparency; and those embodied in the right to health.

To further assess GHIs for respect of human rights, this RBA assesses the implementation and monitoring of human rights through a review of initiative processes, including organisational structure, application forms and board composition.

Government's compliance with its obligation to fulfil and protect human rights is assessed according to engagement in international assistance and cooperation and measures taken to ensure funded projects respect human rights.

Promotion of human rights is assessed by the support of programs that advocate human rights and by the use of human rights language in policy and strategy documents.

The use of human rights language is also used to assess the incorporation of human rights into health work through policy and the implementation of human rights into the policy and processes of GHIs.

Table 1: Rights-based approach to GHIs

Human rights principles	Question	Indicator
Participation (policy)	Do policy and strategies state a commitment to the participation[1] of developing countries in decision making[2] within the initiative?	Low — developing countries are identified as 'partners' Moderate — developing countries are identified as 'partners' and the participation of developing countries is described High — developing countries are identified as 'partners', the participation of developing countries in initiative activities is described, and the participation of developing countries in decision making within the initiative is described
Participation (processes)	Does board composition facilitate participation? Are there special structures[3] in place to facilitate participation?	Low — single representation on any board Moderate — plural representation on boards involved in decision making and specialised structures in place High — equal representation on boards involved in high-level decision making and special structures in place
	Do reports, evaluations and meeting minutes refer to participation? Is participation being monitored?	Low — participation of developing countries in decision making is referred to in evaluative reports and in meeting discussions Moderate — participation of developing countries in decision making is referred to in evaluative reports and in meeting discussions and is followed by a recommendation to improve participation High — participation of developing countries in decision making is referred to in evaluative reports and in meeting discussions and is followed by a recommendation to improve participation and a decision that adopts the recommendation
Attention to vulnerable populations (policy)	Do initiative goals target[4] vulnerable groups[5]? Is there intent to provide for the specific needs of vulnerable populations within the target population?	Low — initiative goals do not target vulnerable populations Moderate — initiative goals target vulnerable populations High — initiative goals target vulnerable populations and there is intent to provide for the specific needs of vulnerable populations within the target community

Table 1: Rights-based approach to GHIs continued

Human rights principles	Question	Indicator
Attention to vulnerable populations (processes)	Are there special structures to provide the specific needs of vulnerable populations within the targeted community?	Yes/No
Non-discrimination and equality (policy)	Do policy and strategies state a commitment to non-discrimination and equality?	Low — does not mention non-discrimination, equity or equality in policies and strategies Moderate — mentions non-discrimination, equity or equality High — mentions non-discrimination, equity or equality in policies and strategies
Non-discrimination and equality (processes)	Are there special structures or reporting mechanisms to promote non-discrimination and equality?	Yes/No
The following results all have yes/no indicators		
Accountability and transparency (policy)	Do policy and strategies state a commitment to transparency and accountability?	
Accountability and transparency (processes)	Do specialised structures and mechanisms exist to promote accountability? Do reports, evaluations and meetings refer to accountability and/or transparency?	
The right to health	**Question**	
Availability	Do initiatives increase the availability of goods and services?	
Accessibility	Do initiatives increase the accessibility of goods and services to everyone without discrimination?	
Acceptability	Are initiative goods and services respectful of medical ethics and culturally appropriate?	
Quality	Are goods and services scientifically and medically appropriate and of good quality?	
Effective health system (policy)	Is there a stated commitment to supporting an integrated, effective health system of the host country?	
Effective health system (processes)	Do structures exist to strengthen health systems? Is there monitoring and evaluation of health system strengthening?	

Table 1: Rights-based approach to GHIs continued

Fulfil and protect human rights	**Question**
International assistance and cooperation (policy)	Does the initiative claim to coordinate international efforts to provide international assistance to developing countries[6]?
International assistance and cooperation (processes)	Are other countries and international bodies represented on major boards? Are recipient countries developing countries?
Do the grant application documents refer to human rights?	Yes/No
Promote human rights	**Indicator**
Do policies and strategies refer to human rights?	Low — no use of 'rights' language Moderate — reference to 'human rights' or use of 'rights' language[7] High – direct reference to 'human rights' in policies and strategies
Does the initiative fund projects that explicitly advocate human rights?	Yes/No

Notes: 1. 'Participation' refers to active involvement. This study focuses on the participation of developing countries as they are most affected by the GHI decisions because they are the GHI's beneficiaries. This study limits developing country participation to the active involvement of representative national governments. 2. 'Decision making' refers to the activity of making decisions. It can also include activities that imply or encompass decision making. 3. 'Structures' are any component of the initiative's organisational and operational structure. 4. 'Target' is a group/individual identified as the primary recipient. 5. 'Vulnerable groups' include women, children, the poor, the stigmatised, those in remote areas or those in conflict or emergency situations. 6. Developing countries defined as those self-identified as the least developed countries under the UN. 7. Human rights language includes words that describe the foundations of the human rights discourse, such as 'rights', 'human dignity' and 'inherent' human worth.

Indicators were used to obtain discreet and aggregate results that span a spectrum of low, moderate or high performance. Where the indicator was 'yes' or 'no', 'yes' corresponded to a high result and 'no' corresponded to a low result. Where results depended on more than one indicator, discreet results were averaged to give the final aggregate result. Where there was insufficient information for criteria to develop a result, the result was noted as not available (N/A). If a result is dependent on more than one indicator, and one indicator is N/A, the N/A result is subtracted from the sample used to average results.

Finally, promotion of human rights through the use of rights language and support of programs that advocate human rights was assessed against the level of UN involvement in each particular GHI (Table 2).

Table 2: UN involvement in GHIs

Initiative	UN involvement
PEPFAR	**Low:** PEPFAR is committed to harmonisation in its efforts with UNAIDS and other multilateral organisations. It also supports the UNAIDS. However, the UN is not represented in the organisational structure of the initiative.
GFATM	**Moderate:** The UN was critical in the formulation of the Fund. UNAIDS is a non-voting member. UNICEF is mandated by the United Nations General Assembly to advocate for the protection of children's rights. It is guided by the Convention on the Rights of the Child and strives to establish children's rights as enduring ethical principles and international standards of behaviour towards children.
GAVI	**High:** UNICEF is currently a partner in the GAVI Alliance and represented on the Alliance board by the executive director of UNICEF, former chair of the GAVI board. UNICEF chairs the Alliance executive board, alternating terms with the WHO. UNICEF also chaired the GAVI Task Force on Advocacy, which was responsible for coordinating global advocacy and communications efforts of the GAVI partners. UNICEF plays a key role in supporting countries in their application for GAVI funds, and subsequent implementation and monitoring of GAVI-related immunisation activities.

Table 3: GHI respect of human rights principles

Human rights principles	PEPFAR		GFATM		GAVI	
	Policy	Processes	Policy	Processes	Policy	Processes
Participation	✓	✘	✓	✓	✓	~
Vulnerable populations	✓	✓	✓	✓	✓	✓
Non-discrimination and equality	✓	✓	✓	✓	✓	✘
Accountability and Transparency	✓	✓	✓	✓	✓	✓
Key: ✓ high; ~ moderate; ✘ low						

Results

GHIs varied in their performance against the different aspects of the rights-based approach. Results are presented in tabulated form with corresponding supporting comments.

GHIs make an implicit commitment to respect human rights, and implement and monitor human rights through processes.

GHIs by their nature and mission are attentive to the health of vulnerable populations. All three GHIs assumed the primary goal of improving the health and

access to treatment of the poor. GHIs are also tailoring their programs to suit specific groups within their target communities. GHIs have established structures and developed programs specifically to cater for the vulnerability of groups such as women, children, orphans, those in remote areas, the diseased and the stigmatised.

GHIs performed well against the principle of non-discrimination and equality in their policy and mostly in their processes. All GHIs articulated a commitment to reducing adverse discrimination and promoting equitable access to health treatment and programs. PEPFAR and GFATM are committed to and exhibit processes designed to reduce adverse discrimination and stigma of the people living with diseases. PEPFAR stated a commitment and exhibited structures and reporting mechanisms to mitigate the harmful effects of social and economic gender inequalities, and promote gender equity in access to services. PEPFAR and GFATM have established reporting mechanisms to monitor discrimination; in particular, PEPFAR disaggregates data according to gender and other status to monitor discrimination. By design, GHIs offer equitable access to health treatments and programs to the most deprived population. As such, positive discrimination in GHI policies and strategies is deliberately applied though program focus and resources allocation as a special response measure.

GHIs performed well against accountability and transparency, articulating commitments in policy and strategic documents and exhibiting special structures and reporting mechanisms to implement and monitor accountability and transparency in the GHI's operations.

GHIs do not always implement and monitor the right to participation and the right to non-discrimination and equality through processes.

All three GHIs articulated a commitment to participation in their foundational documents, yet in practice only GFATM received a correlating score. There was no international representation in the decision-making levels of PEPFAR's organisational structure and GAVI exhibited plural developing country representation on decision-making boards but not equal to developed country representation.

GAVI did not exhibit special structures or reporting mechanisms to promote non-discrimination and equality.

GHIs make an implicit commitment to respect the right to health, and implement and monitor its content through processes.

Table 4: GHI respect of the right to health

Right to health	PEPFAR	GFATM	GAVI
Availability	✓	✓	✓
Acceptability	✘	✓	✓
Accessibility	✓	✓	✓
Quality	✓	✓	✓
Effective health system	✓	✓	✓

Key: ✓ high; ~ moderate; ✘ low

Table 5: Human rights fulfilled and protected in GHI policies and processes

Fulfil and protect human rights	PEPFAR	GFATM	GAVI
Does the initiative engage in international assistance and co-operation?	~	✓	✓
Do grant application documents refer to human rights?	N/A	✓	✘
Key: ✓ high; ~ moderate; ✘ low			

PEPFAR neglects acceptability under the right to health in that its policy restricts the funding of projects that engage in activities that 'support' drug use or prostitution, such as needle exchange programs.

GHIs state a commitment to international assistance and cooperation and facilitate it through processes.

These results indicate that 'international assistance' is not facilitated by international representation within PEPFAR's organisational structure.

GHI application documents for funding did not always refer explicitly to human rights.

GAVI did not refer to human rights in its application documents for funding and GFATM application forms made explicit reference to human rights principles but did not articulate 'human rights'.

GHIs made implicit reference to human rights in policy and strategy documents.

GHIs did not refer to human rights in their policy or strategy documents; at the least, PEPFAR and GFATM used human rights language.

Table 6: Human rights promoted in GHI policies and processes

Promote human rights	PEPFAR	GFATM	GAVI
Do policy and strategy documents refer to human rights?	~	~	✓
Does the initiative support programs that advocate for human rights?	✘	✓	N/A

Key: ✓ high; ~ moderate; ✘ low

Table 7: Promotion of human rights against UN involvement

Initiative	UN involvement	Human rights promoted*
PEPFAR	Low	Moderate — high
GFATM	Moderate	Low — moderate
GAVI	High	Low

***** Result an average of results from Table 5.

GHIs did not always support programs that explicitly advocated for human rights.

PEPFAR was the only initiative to support programs that advocated for human rights.

Explicit promotion of human rights was not associated with UN involvement.

The explicit or implicit promotion of human rights does not match the degree of UN involvement in GHI governing bodies.

Discussion

A rights-based approach to health is about optimising the relationships between health and human rights. This project contributes to this goal by developing and applying a rights-based approach to GHIs. It assesses policy and processes for compliance with human rights; measures the extent to which human rights are instituted and implemented in policies and programs; and documents the lessons learned.

GHIs varied in their performance against the different aspects of a rights-based approach. In general, GHIs respect human rights through an implicit commitment in policy and implementing and monitoring human rights in processes. This positive result further supports pre-existing literature where GHIs are evaluated according to health outcomes and internal operations.

However, there is a tension with regards to respect of an effective health system, and transparency and accountability. The policies of GHIs claim these principles as central to their operations and they are implemented and monitored in GHI processes, yet existing literature would suggest that these principles are not exhibited in practice. Indeed, GHIs have been criticised for ignoring the capacity of developing countries and neglecting their needs (Bennett et al 1997; Shretta et al 2001; Muraskin 2004) and for a lack of accountability and transparency in their operations (Richter 2003; Nishtar 2004).

Further assessment of these GHI practices against a rights-based approach, and investigation into why compliance in policy and processes does not correlate with compliance in practice, is required to optimise the application of the health and human rights relationship and to ensure that governments are fulfilling their human rights obligations.

Neglect or violation of rights principles occurred in the processes of GHIs and concerned the right to participation. For example, there was no developing country representation in the decision-making levels of PEPFAR's organisational structure and GAVI exhibited plural developing-country representation on decision-making boards, but not equal to developed country representation. This result is consistent with the literature in that GHIs have been criticised for not responding to the needs of local communities and for imposing vertical interventions without the participation of the affected community (Bennett et al 1997; Shretta et al 2001; Caines and Lush 2004; Muraskin 2004; Nishtar 2004; Ziemba 2005; Kieny and Serdobove 2006).

A rights-based approach reveals that GHIs respect human rights through an implicit rather than explicit commitment in policy and implementation and monitoring in processes. Monitoring and implementation of the principles of participation, non-discrimination and equality, and acceptability should be improved to enhance health processes and outcomes and ensure fulfilment of human rights obligations.

GHIs did not make explicit reference to human rights in all the documents reviewed for this analysis. At most, some GHIs used human rights language in policy documents to imply a commitment to human rights. This finding has several implications.

First, it suggests that human rights have not been instituted or deliberately implemented into GHI policies and processes.

Second, these results may reflect an inability or unwillingness of governments and the UN to promote human rights through the use of rights language and through the

institution and implementation of human rights in GHI activities. The absence of explicit reference to human rights in grant application forms used by GAVI and PEPFAR indicates that governments and the UN are neither promoting nor protecting human rights. The GFATM application forms make explicit reference to human rights principles, including non-discrimination and equality, gender and vulnerable populations. Interestingly, the explicit or implicit promotion of human rights does not match the degree of UN involvement in GHI governing bodies: of the three GHIs assessed, GAVI, the initiative with the highest UN involvement, was the least explicit about the inference of human rights to its policies, strategies and monitoring mechanisms. This is significant, given the commitment by UN institutions to mainstream human rights in all their activities.

Limitations

Among the limitations of this study are that only three GHIs were assessed; assessment was limited to policy and strategy documents; assessment was based on a stated commitment to human rights; and, finally, the information available for meta-analysis was limited and diverse. Although the three GHIs chosen are among the largest and most influential of all GHIs, this sample is not large enough to be indicative of GHIs in general, nor to their respect of human rights.

Limiting the RBA to a review of policies and processes reduces the validity of these results. The results may not be a true reflection of GHI respect of human rights because initiative practices were not assessed, although an attempt was made to measure the extent to which human rights had been implemented and monitored in processes.

The absence of explicit reference to human rights was a constraint to the external assessment of respect for human rights, since 'respect' was primarily assessed by a stated commitment in policy and strategy documents. The absence of an explicit commitment made it difficult to measure the extent to which GHIs respected human rights. An attempt was made to measure implicit commitment to the content of these rights, but this was difficult to measure because of the scope of rights and the diversity in terms that refer to them. This has implications for the validity of the measurable outcome of this analysis.

It is necessary to continue to assess GHI policy and strategies to advocate for and monitor compliance with human rights. GHIs must articulate a commitment to the human rights in the policies and strategies they intend to uphold, thereby lending themselves to evaluation of processes and outcome, as they relate to both health and human rights.

The limit and diversity of information on GHI policy and processes available for meta-analysis reduced the validity of these results. Given their multiplicity on global, regional, national and local levels, not all relevant instruments were reviewed in this analysis. Diversity in information made it difficult to develop common, standardised performance assessment criteria reflective of GHI compliance, and some principles could not be assessed. Diversity in information is partly a consequence of the differences in GHI structures and approaches. Thus, criteria must be developed to allow for such diversity in information and in GHIs, and be sufficiently sensitive and specific to accurately reflect a GHI's compliance with human rights.

Conclusions

The principle purpose of this study was to underscore the importance of assessing GHI policies and processes through a health and human rights lens. The application of a crude method was proposed as an example of how this could be done. The outcome of this RBA is not as relevant as the proposal to apply a human rights framework to the review of GHIs. Thus, this project's merit may not be in the results of the RBA assessment, but rather in determining how it can be improved both as a concept and as a method.

The following lessons were learned in applying an RBA: first, meta-analysis of policy and strategy documents must be more systematic and thorough; second, criteria for assessing compliance with human rights must be more sensitive and specific; and third, methods must extend to an assessment of GHI practices in conjunction with the assessment of policy and processes. Finally, it is necessary to continue to assess the policies and strategies of GHIs for compliance with human rights. A prerequisite for such assessments is that GHIs and other PPPs should be more specific about the human rights principles they intend to uphold. In order for the relationship between health and human rights to benefit both processes and outcomes, human rights must continue to be incorporated into the design, implementation, monitoring and evaluation of all health policies and programs. Further studies should continue to develop the proposed RBA and extend it to the assessment of GHI practices. ●

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