

# Germany's Experience in Supporting and Implementing Human Rights-Based Approaches to Health, plus Challenges and Successes in Demonstrating Impact on Health Outcomes

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The right to health is a human right. Every person has the right to enjoy the highest attainable standard of health. However, for many people, enjoyment of this right is far from reality—for example, many do not have access to effective and affordable medicine and treatments or to safe drinking water, adequate food, and basic sanitation.

Some progress has been made, such as in women's and children's health: since 1990, maternal deaths have been cut by almost half.<sup>1</sup> There have been substantial increases in preventing mother-to-child transmission of HIV, in oral rehydration therapy, and in exclusive breastfeeding. Important gains have been achieved with regard to antenatal care, skilled birth attendance, and postnatal care.<sup>2</sup>

The international community is ready to further step up its efforts. Gavi, the Vaccine Alliance, is a case in point: on January 26–27, 2015, the “Reach Every Child” Pledging Conference hosted by the German government was held in Berlin to replenish Gavi's resource needs for 2016–2020. Germany alone pledged €600 million. Altogether, 31 public and private sector donors pledged over US\$7.5 billion for Gavi. With this funding, Gavi will be able to immunize an additional 300 million children in developing countries by 2020, protecting them against some of the world's deadliest diseases and saving up to six million lives.

Access to adequate health care for the poor, and protection from the financial, health, and social risks associated with disease are a core element of human development and poverty reduction. The right to health is enshrined in various human rights conventions and is internationally recognized. Every country that has ratified the relevant covenants must respect, protect, and guarantee the right to health.<sup>3</sup> The basic causes of morbidity and mortality in developing countries arise from the failure to meet commitments relating to the human right to health.<sup>4</sup> However, supporting the efforts of poor countries to fulfill their state duty to realize the human right to health remains an ongoing challenge and a priority for the international community.

Human rights are a guiding principle for German development cooperation.<sup>5</sup> They play a significant role in all priority areas—such as equal rights for women, land and water rights for indigenous peoples, affordable health services, and access to education for the poor.<sup>6</sup>

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Competing interests: None declared.

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In its Human Rights Action Plan for 2014–2016, the German government has reinforced its political commitment to the focused, systematic, and trans-sectoral strengthening of human rights within the framework of German development policy.<sup>7</sup> The Federal Ministry for Economic Cooperation and Development (BMZ) has established the goal of ensuring that all German development cooperation projects contribute as much as possible to strengthening human rights, be they economic, social, cultural, political, or civil rights.<sup>8</sup>

Just as important as the outcomes of the projects is the process for achieving these results. Here, the human rights-based approach (HRBA) plays a decisive role. An HRBA entails a shift in perspective in terms of the strategic focus of cooperation: partner states' institutions are now duty-bearers and must be enabled to fulfill their human rights obligations, while “target groups” and “people in need” become rights-holders who must be empowered to claim their rights effectively.<sup>9</sup> An HRBA requires the promotion, in all development processes, of the human rights principles of non-discrimination and equality of opportunity; participation and empowerment; and accountability and transparency.<sup>10</sup>

BMZ's strategy paper *Human Rights in German Development Policy* reaffirms the need to systematically integrate an HRBA into all sectors and levels of German development cooperation.<sup>11</sup> The strategy contains binding requirements that the organizations KfW Development Bank (the German government's organization in the field of financial cooperation) and Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) must adhere to. In addition, it serves as a frame of reference for the business activities that these organizations undertake at their own risk. It also provides guidance for the work of civil society organizations (churches, political foundations, private agencies, and agencies concerned with “social structure assistance”), and the private sector.<sup>12</sup>

The strategy pursues a dual approach based on the promotion of specific human rights programs and the mainstreaming of an HRBA in all sectors and priority areas of cooperation.<sup>13</sup> The HRBA is

already firmly embedded in the BMZ's health sector strategies and in its position papers on health and human rights, sexual and reproductive health and rights, and population dynamics, as well as in BMZ's sector strategy on social protection.<sup>14</sup> These documents provide overall directives for promoting an HRBA in Germany's health-related development cooperation with national and international partners.<sup>15</sup>

Acting on behalf of the BMZ, GIZ provided financial support for the World Health Organization's monograph *Women's and Children's Health: Evidence of Impact of Human Rights* and related research.<sup>16</sup> Furthermore, GIZ is conducting an assessment of its health programs to determine how they have taken HRBAs into consideration.

GIZ's *Practitioners' Tool: Health and Human Rights* offers development practitioners guidance on how to assess and strengthen the human rights orientation of health programs in order to create a solid basis for developing and implementing an HRBA across the health sector, as required by the BMZ.<sup>17</sup> In addition, GIZ offers the tutored online course “Putting Human Rights to Work in Development Cooperation.” The online course comprises a basic module on human rights, as well as two advanced modules on the right to water and the right to health.

An HRBA provides tools for understanding and addressing the multi-dimensional root causes of poverty and conflict, including discrimination, powerlessness, lack of political participation, and lack of access to basic resources and services. It ensures that development efforts address the most vulnerable by focusing on promoting the rights of women and marginalized groups, including children, ethnic minorities, migrants, and persons with disabilities. It thus complements and reinforces other development agendas, such as poverty reduction, gender equality, crisis prevention, good governance, and sustainable development.<sup>18</sup>

Our experience indicates that an HRBA improves the outcome of programs in the health sector. For example, accessibility is one of the core elements of the right to health. Illness, chronic

disease, and disabilities often result in poverty in countries without adequate access to health care. Worldwide, about 150 million people a year face catastrophic health care costs because of direct payments like user fees, while 100 million are pushed below the poverty line as a result of such expenses.<sup>19</sup> The ultimate goal of an HRBA in German development cooperation in the health sector is, therefore, to improve the access of the whole population—and of extremely poor and disadvantaged groups in particular—to health services, health information, and healthy living conditions.<sup>20</sup>

### Improved access to health care for India's poor

Since 2008, on behalf of the BMZ, GIZ (the German government's implementing organization in the field of technical cooperation) has been intensively supporting the Indian government in extending the Rashtriya Swasthya Bima Yojana (RSBY) health insurance scheme.<sup>21</sup> Despite the country's positive economic growth, health care expenses are a major reason why people become impoverished in India. Ill health is a leading cause of indebtedness among the poor, with more than 3% of households becoming impoverished each year due to catastrophic health costs.<sup>22</sup> In 2007, the Indian government set up the national RSBY health insurance system to ensure that the poor can also exercise their right to health and have access to the requisite health services.

The RSBY system is designed to provide families living below the poverty line with state-subsidized secondary hospital care. The potential recipients of such health care are provided with information on the state-funded health insurance scheme and given a smart card containing their data and fingerprints. The smart card, which can store the data of a family of up to five people living in one household, is loaded with an annual balance of up to Rs 30,000 (€400) for hospital care and ambulance services. There are no age limits. Pre-existing conditions are covered. Each family pays a fee of Rs 30 (€0.40) to join the scheme. When anyone insured under the RSBY system has to visit

a hospital, the respective fees are deducted directly from the card. In this way, those unable to read or write are saved from having to fill out complicated forms. In addition, the card's use of fingerprints and cashless transactions reduces the risk of bribes.

The smart card is valid in all state and private sector hospitals registered with the RSBY. The flexible smart card system benefits migrant workers in particular, since they often have to change their place of residence to find work. Starting in 2011, RSBY eligibility was extended to new categories of informal workers, including street vendors, domestic workers, rag-pickers, taxi and auto-rickshaw drivers, and mine workers. The cashless and paperless smart card is regarded as an exemplary social insurance system, and its extension to pension and accident insurance is being discussed.

In six years, RSBY, which is a voluntary scheme, has grown to cover 37.2 million families (approximately 120 million beneficiaries) in 28 states and union territories. More than 10,000 hospitals (60% of them private) belong to the scheme. Since 2008, RSBY has covered some 7.2 million cases of hospitalization.

Several evaluations have shown that families enrolled in RSBY have lower direct expenditures on inpatient care than those who are not enrolled. Most of the households surveyed in evaluations are satisfied with the scheme and intend to renew their enrollment.

This example shows that the human right to health can be realized only on the basis of a health system that provides accessible and affordable quality health care for all. RSBY demonstrates that a government-supported social security scheme, designed in close partnership with public and private sector actors and guided by a business model, can be successful in extending protection against catastrophic health costs in a country as large and complex as India. Its success lies in part in the decision to tailor the scheme to the needs of its target audience by making it cashless, paperless, and portable. RSBY provides its beneficiaries with access to public and private hospitals, thus significantly widening the network of health care providers

for the poor and empowering them with greater choice. A focus on strong technological systems has helped combat fraud, enabled the swifter settlement of claims, and allowed close monitoring of the scheme's performance.

### Improved access to health care for vulnerable groups in Cambodia

Acting on behalf of BMZ, KfW Development Bank has supported its partner agency in Cambodia, the Ministry of Health, through financial contributions for its health voucher program for reproductive health care and for other vulnerable groups, such as the elderly and people with disabilities.<sup>23</sup> The vouchers are booklets with several coupons that provide people in need with direct access to quality services. Voucher promoters visit all villages in the program provinces. During village meetings with the beneficiaries or through face-to-face counseling, the promoters explain, for instance, the danger of giving birth without professional health support and talk about how the vouchers can be used to help people access free reproductive health care. Furthermore, the voucher scheme can be used for the reimbursement of other costs associated with treatment, such as transportation and food, since these costs can be prohibitively high for poor households. All in all, more than 250,000 people have benefited from the scheme.

The voucher scheme is a demand-side financing mechanism. It informs beneficiaries about their rights to free health services and goods. Having a voucher in hand confers purchasing power on the people. To help reinforce this mechanism, the promoters continue to act as point people for patients during their treatment in order to guarantee complete and satisfactory use of the services. Thus, the vouchers strengthen patient demand in cases where individuals would otherwise not seek such standardized quality treatment due to a lack of financial resources and a lack of knowledge about the importance and availability of quality health services, as well as about their human rights entitlements.

Furthermore, the voucher scheme improves the quality of services by encouraging

competition between public and private service providers. Participating health care facilities are selected according to a scoring system operated by the Ministry of Health that rates facilities' training, equipment, and practices. An incentive to participate in the program is furnished by the dependable income for the operating health facility. This means that more equipment can be acquired and better wages can be paid to employees. Additionally, the scheme has an effect on the transparency of the health management system at the local level, since the services must be documented and robust accounting procedures document and verify all expenses.<sup>24</sup>

### Social auditing in Nepal: Participation, empowerment, accountability, and transparency

Evidence shows that programs that consider the human rights principles of non-discrimination, equality, participation, empowerment, accountability, and transparency have better outcomes.

In Nepal, German development cooperation has been involved in the introduction of social auditing to enhance citizens' ability as rights-holders to participate in decision making about their health services at the facility level.<sup>25</sup> During the past decade, Nepal has made measurable progress on a variety of health indicators. Nonetheless, at the local level, public health facilities across the country are facing daunting problems, including insufficient drug supplies, a lack of basic equipment, chronic understaffing and frequent staff absenteeism, poor provision of water and electricity, and a low level of accountability. Acting on behalf of the BMZ, GIZ has been providing technical advice and funding for social audits in the Nepalese health sector since 2009.

The basic social audit is a five-day process that includes extensive investigation, analysis, and reporting in order to audit the performance of a given health facility. A two-day process is used in subsequent years to monitor the facility's progress in achieving the action plan agreed to in the initial audit.

Independent organizations—usually non-governmental organizations—are hired through

an open tender to carry out the process for chosen health facilities within a given district. The tender is conducted by a social audit committee at the district level, which is responsible for overall implementation within the district. Once hired, the successful nongovernmental organization works directly with individual health facility management committees, which are chaired by representatives of the village development committee. Members include the health facility director, community representatives (including from marginalized ethnic groups and castes), and a female community health volunteer.

Social audits begin by examining the records that are kept by the facility. Voluntary “exit interviews” are conducted with recently delivered mothers as they leave the facility. Using a standardized questionnaire, female social auditors take 10–20 minutes to conduct the interviews in private. The social auditors also organize focus groups where they meet with local women and with representatives of disadvantaged ethnic groups and castes.

The results of the various information-gathering activities are presented at a public meeting where community members air their concerns, ask questions addressed to care providers and decision-makers, and participate in forming an action plan. The auditor also prepares a final social audit report. The report and action plan provide a road map for the following year, identifying problems that need to be resolved and ways to improve the quality of services. While the most immediate user of the results is the health facility itself, recommendations are also passed on to the local and district levels of government.

So far, 752 facilities have held social audits, and the government has allocated an additional 10% of funding to social audits for 2015. GIZ is currently providing technical assistance in six districts, while other external development partners—including United Nations agencies, international nongovernmental organizations, and bilateral agencies—are providing additional support.

Among the advances achieved thanks to social audits are increased citizen participation, social inclusion, and mutual accountability. The audits have also helped fill vacant positions through temporary

contracts, improved the conduct of health workers, made facilities more responsive to patients’ needs, and helped reform or re-energize health facility management committees.

### A patients’ rights charter in Cambodia: Participation and empowerment

An HRBA implies that rights-holders know their rights and duty-bearers their obligations. The BMZ has been funding comprehensive health programs in Cambodia since 2003.<sup>26</sup> Article 72 of Cambodia’s Constitution recognizes the right to health and stipulates that free medical consultation must be available to poor citizens in public hospitals, infirmaries, and maternity units. However, since the civil war and the Khmer Rouge era, services within the public health sector have been insufficient, especially for the poor. The utilization rate in most public health facilities is low because facilities are poorly equipped, lack drugs, and are generally of a low quality. The medical staff are undertrained and underpaid, and often behave in a discriminatory way toward poor patients. Although treatment fees are lower compared to private clinics, there is a lack of transparency. For example, in many cases, patients do not know how much they have to pay for their treatment until they receive the final bill. Price lists are often confusing, and in some cases bills include additional fees that are not on the price list.

Cambodia’s 2003–2007 health strategy identified a number of underlying problems responsible for inadequate standards in health care. Among them was the lack of awareness on the part of both health care users and providers regarding each groups’ rights and responsibilities. This leads to lack of trust, which, in turn, causes the underutilization of medical facilities among residents. Taken together, all these aspects contribute to unnecessarily high morbidity and mortality. The notion of clients’ and providers’ rights was therefore incorporated into the strategy’s implementation plan. The Cambodian-German Health Program supported this initiative and facilitated the development of a patients’ rights charter.

In February 2004, a participatory rapid ap-

praisal revealed deficits in the implementation of existing clients' rights. To address these deficits, in July 2004, a multidisciplinary working group of specialists was established to draft a charter on patients' rights, as well as accompanying operational guidelines and codes of conduct and ethics for health care providers.

Over the course of several consultative meetings, a broad array of stakeholders reviewed, revised, and finally adopted the charter. Meetings involved the Cambodian Ministry of Health, nongovernmental organizations, patients' representatives, the nurses' association, the medical doctors' association, trade unions, lawyers, and human rights groups.

The Ministry of Health officially endorsed the charter in May 2007. With support from what was then GTZ, the ministry began disseminating the new ideas: workshops were held for ministry officials, health care providers, and communities, and posters were displayed in all public health centers and clinics in the two pilot provinces. Using the experiences from the initial launch, the initiative has been scaled up to other provinces, with the support of the government and health partners.

The Cambodian charter on patients' rights is a groundbreaking document that creates a policy framework for advancing and promoting the right to health for patients, as well as the roles and responsibilities of providers. Supported by promotional activities in the communities, it has contributed to an increased awareness of clients' rights among the population and a demand for quality health care.

Client satisfaction surveys and feedback mechanisms have further contributed to transparency and client responsiveness in subnational governance of the health sector. Quality assessments have shown that 90% of public health facilities supported in Kampot and Kampong Thom Provinces have noticeably improved their services. This also suggests that patient feedback informs practice. Local councils and grassroots organizations are increasingly involved in subnational decision-making processes in the health sector.

In areas where the charter has become widely known, it has helped improve services. Staff members treat patients, including the poor, in a more respectful and professional manner, and patients' trust in providers has increased. Demand for services in public clinics has also increased. The higher utilization rate has generated higher revenues for public clinics, which have partly been distributed as bonuses for staff, thereby enhancing their motivation. Patients, especially members of the health insurance scheme, have also demanded better quality in the health services provided. Efforts to include poor people in the insurance scheme have begun.

The participatory and consensus-oriented process in developing the charter helped stakeholders understand and respect one another's positions and interests. Communication between them has sustainably improved and has facilitated other decision-making processes in the health sector.

During the process of developing the charter, stakeholders made references to human rights standards and state obligations. Though the charter does not make such explicit references, it applies human rights standards and principles *de facto*. A more explicit reference to international human rights standards could possibly have helped create a greater sense of obligation and accountability on the part of the government. However, the Ministry of Health's official endorsement of and support for the charter has already significantly facilitated its implementation.

Increased awareness of the entitlements of rights-holders and obligations of duty-bearers can lead to empowerment and changes in behavior, which in turn can result in improved public services. In order to effectively realize rights and shift power toward rights-holders, accountability mechanisms, such as participatory monitoring and reporting and complaint mechanisms, are needed. Participation by a wide range of stakeholders is essential for the quality and broad ownership of the outcome. Support from those at higher levels of political responsibility is crucial.

## A human rights-based approach at all levels at all levels: Inclusion of marginalized groups in Kenya

The GIZ-supported program to strengthen the Kenyan health sector includes an explicit human rights approach.<sup>27</sup> The program aims to ensure that all Kenyan citizens have and can exercise equal rights to health information and services, irrespective of gender, sexual orientation, or disability.

Although health care provision in Kenya has improved in many respects, the socially stigmatized and marginalized are often excluded from health services. Persons with disabilities and other minorities are stigmatized for looking different or behaving in ways that do not conform to accepted norms. Many do not dare visit health facilities for fear of discrimination by the staff. Moreover, gender-based violence is a massive but hidden problem in Kenya, as the topic is largely taboo.

Since 2005, the GIZ program has been working on a number of levels—the structural level (laws and policies), the systemic level (monitoring and responding to rights infringements), and the operational level—to advise political actors, promote civil society networks, and support marginalized groups. To name but a few examples: The Kenyan Ministry of Health has revised the national guidelines for dealing with gender-based violence. As a result, women who are victims of gender-based violence can access better medical and psychosocial care. In addition, the Gay and Lesbian Coalition of Kenya has developed its own strategies to secure access to acceptable levels of health care, especially with regard to HIV/AIDS. The Kenya Union of the Blind is another cooperation partner. It has founded a center for young people where the blind and visually impaired can access special software that enables them to search for information independently. Furthermore, support for civil society and faith-based organizations and for their participation in policymaking processes has increased the capacity of these groups to advocate for the rights of marginalized people. For example, people living in areas where only faith-based health facilities are

accessible can now access treatment, following the inclusion of these facilities in Kenya's new health services funding mechanism (the Health Sector Services Fund).

The GIZ program's multi-level approach has made HRBAs multi-directional and thus more effective. In addition, promoting dialogue between several stakeholders (the government, civil society, and faith-based organizations) has allowed more Kenyans to have access to information on health-related human rights and to benefit from improved services. Finally, thanks to increased awareness and progressive laws enshrining human rights—such as the Kenyan Constitution—citizens now can, and increasingly do, demand that they be given the treatment to which they are entitled. In terms of project management, it has become clear that in order to achieve sustainable impacts, human rights need to be integrated at the onset of project planning, and measurable indicators for human rights need to be included within monitoring and evaluation frameworks.

## Impact of human rights-based approaches

Experience shows that mainstreaming an HRBA does not necessarily mean a radical shift in program strategy, as many health-related programs are already aimed at improving the health of poor and disadvantaged groups.<sup>28</sup> However, multiple barriers that prevent vulnerable groups from enjoying their health-related rights still exist, such as socio-cultural norms and practices, cost of health care, lack of access to information, and discriminatory treatment of patients by health professionals.<sup>29</sup>

The above examples demonstrate that applying an HRBA effectively helps enhance the access of poor, vulnerable, and marginalized groups to health-related services, and helps improve the quality of health care. It helps create a more conducive environment for overcoming discriminatory laws and practices. It also strengthens good governance in the health sector by placing more attention on accountability and transparency, as well as on the

meaningful participation of civil society in decision-making processes.

Therefore, it is important to systematically integrate an HRBA at all levels of development cooperation in the health sector and to further develop the capacity of government and civil society actors to include a human rights focus in their planning, implementation, and evaluation of health strategies and programs. Not only will human rights be strengthened as a result, but health programs will also provide better health outcomes.

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