

# Assessing the Impact of a Human Rights-Based Approach across a Spectrum of Change for Women's, Children's, and Adolescents' Health

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## Abstract

Global momentum around women's, children's, and adolescents' health, coupled with the ambitious and equalizing agenda of the Sustainable Development Goals (SDGs), has exposed a tension between the need for comprehensive, multi-actor, rights-based approaches that seek to “close the gaps” and a growing economic and political imperative to demonstrate efficiency, effectiveness, and returns on specific investments. To address this challenge, this paper proposes a framework to measure “results” in a way that offers a more nuanced understanding of the impact of human rights-based approaches and their complexity, as well as their contextual, multi-sectoral, and evolving nature. We argue that the impact of human rights-based approaches is best measured across a spectrum of change—at the individual, programmatic, structural, and societal levels. Such an analysis would allow for more accurate assessments of the cumulative effect of these changes. The paper also underscores the long-overdue need to better define the parameters of a human rights-based approach to health. This is an important part of the research agenda on human rights and health in the context of the SDGs and the Global Strategy for Women's, Children's and Adolescents' Health, and amid calls for better measurement and greater accountability for resources, results, and rights at all levels. While this paper focuses on women's, children's, and adolescents' health, the proposed framework can apply as readily to other areas of health and provides a new frame of reference for assessing the impact of human rights-based approaches.

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## Introduction

Governments, health and development partners, private sector, civil society, and community groups worldwide are scaling up their efforts to advance the health of women, children, and adolescents through the adoption of a new Global Strategy for Women's, Children's, and Adolescents' Health 2016–2030.<sup>1</sup> At the heart of this strategy is a renewed commitment to integrate human rights, including gender equality, into health policies and programs.

The Global Strategy has three main objectives:

1. Survive: End preventable mortality.
2. Thrive: Enhance health and well-being.
3. Transform: Expand enabling environments.

The Global Strategy has a multi-partite accountability framework, with an independent accountability panel, that aims to track resources, results, and rights across these objectives. Progress toward these objectives is inextricably tied to efforts to meet the new Sustainable Development Goals (SDGs), including those pertaining specifically to health (Goal 3), but also those on the associated determinants of health—nutrition and food security (Goal 2), education (Goal 4) gender equality (Goal 5), water and sanitation (Goal 6), and global inequalities within and across countries (Goal 10).

Both the Global Strategy and the SDGs embrace the importance of a human rights-based approach (HRBA) to health as a framework for reducing inequalities and advancing the enjoyment of human rights.<sup>2</sup> Such an approach helps policy makers and programmers more effectively localize and target inequalities that are the result of social, economic, and cultural disparities, and makes a priority of reaching those with the greatest need.

At the same time, the Millennium Development Goals (MDGs) confirmed the adage that “what gets measured gets done.” As the world slowly recovers from a global financial downturn, the need for *proven* interventions, *guaranteed* returns

on investment, and clear and measurable results has become more pronounced. And herein lies the challenge. Human rights-based approaches, by their nature, cut across sectors and draw from multiple strategies. They might require legal or policy reform to create “enabling” environments; the identification and capacity-building of “rights holders”; comprehensive programs for education, health, and human rights literacy, advocacy, and empowerment; or the elaboration of more participatory accountability and oversight mechanisms. Human rights-based strategies are designed to redress deeply ingrained inequalities, and they aim to enable everyone to participate fully in economic, social, and cultural affairs toward the progressive realization of rights. As such, HRBAs need to be woven comprehensively into health- or education-sector programs, and they take time to deliver measurable change. Furthermore, such approaches have not traditionally been designed with strong monitoring and evaluation components, and as a result, they lack convincing evidence for health policy makers of their impact on health.

In short, there is a clear and growing tension between complex, multi-actor, rights-based approaches that seek to close the gaps in health and development, and a growing economic and political imperative to demonstrate results for investments. This pressure is driving the need for a new research agenda into evidence of impact, at the heart of which is a need to reconcile the still very disparate ways in which we look at human rights and health. Reporting on the MDGs focused on human rights as a way to highlight social inequities, barriers, and violations, while health outcomes were used as a benchmark of progress made in and by the health sector. This paper argues that it is time to better apply our understanding of human rights. We need to use this understanding to develop more effective ways to trace and assess the many and varied contributions human rights make to improving health, rather than focusing solely on the extent to which human rights violations undermine it.

## Evolving perspectives on assessing evidence of the impact of human rights-based approaches

The World Health Organization's monograph *Women's and Children's Health: Evidence of Impact of Human Rights* began to address this challenge in 2013 and reinforced the need for further research on methods for evaluating the impact of HRBAs. Moving beyond the status quo of traditional methods, the authors argue for a more nuanced and holistic definition of what constitutes evidence of impact—one that takes into account the contributory and cumulative effect of human rights interventions.<sup>3</sup>

Building on this shift, this paper looks at existing health and human rights indicators and explores their adequacy and usefulness in assessing impact against a broadly defined HRBA.<sup>4</sup> It also draws attention to a major underlying challenge: the very absence of a standardized definition—or specifically, any clear delineation—of what does and does not constitute a rights-based approach.

The elements of an HRBA have been well es-

tablished for over a decade, following the adoption of the United Nations (UN) Common Understanding in 2003 that marked the beginning of a shift toward the further “operationalization” of human rights (see box). The exact formula for designating an approach as “rights-based,” however, has been left open to interpretation.

As a result, advocates who wish to emphasize the impact of HRBAs face the additional challenge of the lack of a clear and standardized definition against which to measure the effect(s) of these approaches, on top of the already considerable challenges of causality and endogeneity.

Indeed, while most researchers and health policy makers and programmers are able to identify, and often report on, at least some elements of an HRBA (such as participation, accountability, non-discrimination, and the identification of rights-holders and duty-bearers), the question remains as to what combination of these elements is enough to identify it as an HRBA. For example, is an approach that promotes community participation sufficient to be categorized as rights based? This question is all the more pertinent as we see increasing convergence between human rights and public health concepts such as “people-centered health care,” “adolescent-friendly” services, and “progressive universalism.” These concepts, while clearly inspired by human rights values and principles, do not make this link explicit, leaving them open to interpretation, weakening their applicability (and justiciability) as universal human rights “standards,” and further raising new challenges about whether an approach is deemed “rights based.”<sup>5</sup> At some point, to assess evidence of the impact of HRBAs, it will be important to clarify both what is an HRBA and what combination of components of an HRBA sets this approach apart from a “standard” public health approach.

Recognizing then, the complexity of HRBAs and the significant variations in how this concept is defined and understood, we propose a framework that unpacks the HRBA into more measurable elements.

### WHAT IS A HUMAN RIGHTS-BASED APPROACH?

*Goal:* “All programmes of development co-operation, policies and technical assistance should further the realization of human rights as laid down in the Universal Declaration of Human Rights and other international human rights instruments.”<sup>5</sup>

*Process:* “Human rights standards contained in, and principles derived from, the Universal Declaration of Human Rights and other international human rights instruments guide all development cooperation and programming in all sectors and in all phases of the programming process.”<sup>6</sup>

*Principles:* “A human rights-based approach is based on seven key principles: availability, accessibility, acceptability and quality of facilities and services, participation, equality and non-discrimination, and accountability.”<sup>7</sup>

*Output:* “Development cooperation contributes to the development of the capacities of ‘duty-bearers’ to meet their obligations and of ‘rights-holders’ to claim their rights.”<sup>8</sup>

Drawing on existing examples, including those presented in this special issue, of “human rights-based approaches to health,” we examine the different types of “impact” that may occur as a result of a rights-based approach. Different interventions effect change at different points on a spectrum, including at the individual level, structural level, programmatic level, and societal level. They also occur at different points in time, described here as a spectrum of change. We also consider related methods for assessing impact at each point on this spectrum. In this regard, we view impact not as an isolated event but as a series of changes occurring as a direct result—and mirroring the complex and multi-layered nature—of HRBAs.

### Assessing impact on women’s, children’s, and adolescents’ health: Health and human rights indicators

*Accurate and timely health data are the foundation to improving public health. Without reliable information to set priorities and measure results, countries and their development partners are working in the dark.*

—Margaret Chan, Director General,  
World Health Organization<sup>10</sup>

Health and human rights have long been recognized as sharing common goals. Efforts to measure the effect of human rights-based interventions, such as community participation, empowerment, or changes to laws and policies, have tended, however, to rely on health indicators—such as reductions in maternal and child mortality rates or improvements in child growth—for evidence of their effect.

Indeed, while the World Health Organization’s current list of Core Global Health Indicators includes a number of indicators that reflect an HRBA (for example, the availability of health services, medicines, and personnel), it largely ignores other critical determinants of health outcomes, such as the contributions made by communities, enabling laws and policies, education, gender- or culture-appropriate programs, and efforts to overcome socio-economic barriers.<sup>11</sup> Yet these very

contributions are what often have a determining effect on the success or failure of biomedical health interventions.

The objective of monitoring and measuring health outcomes is also very different from that of evaluating the impact of human rights interventions. Health outcomes—as performance indicators—are not designed to determine what went right; they merely confirm whether improvements are being made and where, and are therefore largely unsuited to identifying specific factors for success.

The consequences of such an approach are clear from the global inequalities that have been revealed and arguably accentuated under the MDGs, in spite of the alignment of those goals to key human rights, such as health, education, development, and gender equality. Measurement frameworks for the health-related MDGs—lauded for providing careful monitoring and adjusting of progress toward health outcomes—tended to focus on “averages” rather than distribution and thus had the effect of masking the inequalities that HRBAs aim to address.<sup>12</sup> These measures also largely overlooked the requirement of rights-based interventions to set clear priorities in accordance with international human rights standards and to prioritize the needs of the worst off.

There have nonetheless been some noteworthy examples reported of the effect of human rights-related interventions on health. The multi-disciplinary, multi-country series of studies *Success Factors for Women’s and Children’s Health* revealed that up to 50% of the gains made in reducing child mortality were a result of health-enhancing investments in other sectors—such as education, women’s participation, the environment, governance, and poverty reduction—that emphasized the indivisibility of human rights. It also identified commonalities across the strategies adopted by the low- and middle-income countries that had made the most progress, many of which drew from human rights principles (such as community mobilization, participation, and accountability) or were explicitly rooted in a commitment to promoting human rights (for example, through constitutional and policy reform).<sup>13</sup>

Similarly, in the HIV response, efforts have been made to triangulate health and human rights indicators through the inclusion of the National Composite Policy Index, which collects qualitative data pertaining to the policy environment, government commitment, the participation of affected communities, and legal barriers.<sup>14</sup> This data is meant to be used in conjunction with core health indicators in order to allow for a more approximate assessment of measures and effect.<sup>15</sup> While an analysis of findings from the index has flagged the significant potential of legal systems, for example, as an enabling factor in ensuring access—particularly for criminalized and stigmatized populations—the index does not allow for a more precise correlation of how such laws and policies can or have been instrumental in enhancing access. A more detailed understanding of the other factors at play—factors that would need to be more carefully mapped out to be fully understood—is needed.

Recognizing these shortcomings, voices from within and beyond the human rights community have called for the development of measurable indicators and benchmarks to monitor progress on civil, political, economic, social, and cultural rights.<sup>16</sup> Paul Hunt, former UN Special Rapporteur on the right to health, has put forward the notion of using “structure, process, and outcome” indicators to assess structural change, processes, and outcomes that reflect commitment, effort, and results over time, in line with the principle of “progressive realization.”<sup>17</sup> Further iterations of this approach have also emerged, including the landmark publication by the Office of the United Nations High Commissioner for Human Rights on quantitative and qualitative indicators for measuring progress in the implementation of international human rights norms and principles, as well as the Center for Economic and Social Rights’ OPERA Framework. The OPERA Framework triangulates governmental policy actions and resource allocations and proposes a broad contextual analysis of other constraints in order to offer a sense of the progressive realization of a particular right, all the while relating this progress back to the normative standard encapsulated in the relevant human

rights framework.<sup>18</sup> At the country level, the South African Human Rights Commission, in its report to the High Commissioner for Human Rights on progress to reduce preventable maternal mortality and morbidity, reported drawing on the targeted design of the MDGs, meshing together these goals with national-level indicators for a human rights assessment of progress.<sup>19</sup> Brazil, in an endeavor to strengthen human rights protections in the context of its UPR commitments, adopted and adapted the “structure-process-outcome” framework developed by the Special Rapporteur, described above.<sup>20</sup>

In parallel, a rapid increase in public-private financing institutions and mechanisms, along with the expansion of private sector actors and services, has been accompanied by a rise in efforts around corporate social responsibility, including the adoption of the UN Guiding Principles on Business and Human Rights.<sup>21</sup> While international human rights law does not identify private sector actors as duty-bearers per se, this movement reflects a growing acceptance of the need for—at a minimum—impact assessments to anticipate and evaluate the potential and likely impact of actions of the private sector and business on the enjoyment of human rights. The United Kingdom, for example, has adopted this model as part of its National Health Service, requiring all new health policies to include an equality impact assessment to consider any unintended consequences for particular groups and to ensure that these policies will be fully effective for all target groups.<sup>22</sup>

With their focus on key principles, these models provide another potential source of impact assessments that may help evaluate the effect of interventions on the advancement of the right to health. However, while useful for their ability to capture the complex nature of human rights interventions, these frameworks are designed primarily to assess *compliance* with human rights obligations laid out in international normative frameworks (such as treaties, conventions, and protocols). To that end, they focus on whether the responsible state party or duty-bearer is meeting its obligations to ensure the right to health, and not on whether the actions taken have contributed to any change

in health outcomes. Equally, impact assessment tools, even though they were initially designed to identify both positive and negative effects, tend to be designed with a view toward anticipating and offsetting the potentially negative impact of a given action on the enjoyment of human rights, rather than looking at and measuring the possible positive effects of this action on human rights.<sup>23</sup> Neither of these approaches, then, adequately addresses the need to provide evidence of impact.

It is clear that neither health indicators nor human rights frameworks provide for an actual, measurable effect of HRBAs. However, they do provide a useful starting point to inform our understanding of ways to identify the impact of rights-based interventions on health. Building on these existing tools, we propose an alternative way to assess the impact of rights-based interventions on the health of women, children, and adolescents.

### A framework to assess human rights impact across a spectrum of change

This section draws on the concept of impact frameworks to monitor changes that may occur following a rights-based intervention and to identify which of these changes positively affect health.<sup>24</sup>

Developing a human rights impact framework requires identifying when, on whom, and how HRBAs might have an effect. A spectrum of change would also focus on the impact or change that could occur at different levels, including the individual level (an individual or a small group of individuals in a particular social context); structural level (the legal, political, and economic environment, including social institutions); programmatic level (planning, practice, and services); and societal level (the social system, including gender and power dynamics, socio-cultural norms, and overall health and development outcomes).

By looking at change across a spectrum, we can create a stronger link between a specific intervention, its potential impact, and the resulting change. Such a spectrum of change would draw on the key characteristics of an HRBA, as outlined in Table 1. These characteristics, long seen as abstract principles, are

increasingly being unpacked and translated into practical steps—particularly in the fields of HIV and reproductive, maternal, and child health—with a focus on improving the integration of human rights principles and standards throughout key stages of the policy cycle (planning, budgeting, implementation, and monitoring and evaluation).<sup>25</sup>

Table 1 provides examples of impacts—categorized according to each level of the spectrum of change described above—that have been documented as a result of HRBAs to women’s, children’s, and adolescents’ health. Possible methods for assessing these impacts at each level are signaled in the right-hand column. A mix of methods will enable the production of a broader array of evidence for understanding the contributory and cumulative effects of human rights interventions on the health of women, children, and adolescents.

### An illustration of human rights impact: Skilled birth attendance

We have selected skilled birth attendance, as it is one of the core maternal and newborn health intervention indicators, to highlight the relationship between the impact of various human rights-based approaches at and across different levels on a spectrum of change.

Under SDG 3, states have committed to reducing the global maternal mortality rate to less than 70 deaths per 100,000 live births and to reducing the newborn mortality and stillbirth rate to 12 per 1,000 live births by 2030.<sup>26</sup> As is well documented, the majority of maternal and newborn deaths occur during or immediately after childbirth.<sup>27</sup> There is a growing consensus on the key health and human rights interventions needed, at different points of the policy cycle, to reduce the risk of preventable yet often fatal health complications at this time.<sup>28</sup>

Noting the insufficient numbers of births attended by skilled health personnel, a human rights analysis of qualitative information calls attention to whether maternal health services are available, accessible, acceptable, and of good quality, including in those places where coverage is lowest. Barriers reported include the negative individual

perceptions of pregnant women and their families concerning pregnancy and childbirth in institutional settings, the perceived poor quality of health services, and the comparative ease of home births.

Taking some of the characteristics of an HRBA as our starting point, let us examine how theoretical interventions to address these challenges would play out across the spectrum.

An HRBA is rooted in a close understanding of the underlying determinants of health and specific barriers to the enjoyment of the right to health, paying particular attention to the views of those for whom services are intended. Interventions could begin to address the aforementioned barriers by ensuring that human rights principles (such as dignity, respect, informed choice, and confidentiality) are embedded into facility-based deliveries, both in principle (on the books) and in practice (in the minds and behavior of health workers) and by establishing accountability for these principles

through a supportive legal and regulatory environment, adequately designed programs, and widely accessible mechanisms for monitoring and sanctioning violations.

Similarly, human rights capacity-building programs and efforts to improve rights awareness among women, their families, communities, and health care providers will have a direct repercussion on women's demand for services and on their perception of the adequacy and appropriateness of health care. This can serve to strengthen and enhance trust and raise incentives to use facility-based care. Naturally, actual investment in and assurance of the quality and acceptability of care would also be critical for addressing negative perceptions of care that deter facility-based births.

The specific impact of each of the human rights measures described above could then be mapped on the spectrum, thus allowing the "before and after" to be traced.

TABLE 1. Human rights impact framework across a spectrum of change, with illustrative examples of impacts and methods

Spectrum of change	Illustrative type of impact	Assessment methods and examples
<i>Individual level:</i> an individual or a small group of individuals in a particular social context, including families, households, and neighborhoods	<ul style="list-style-type: none"> <li>Attitudes and perceptions</li> <li>Knowledge (for example, human rights and health literacy)</li> <li>Behavior change</li> </ul>	<ul style="list-style-type: none"> <li>Surveys on knowledge, attitudes, and practice</li> <li>Patient satisfaction surveys</li> <li>Observational studies</li> <li>Ethnography</li> <li>Case studies</li> <li>Participatory action research</li> </ul>
<i>Structural level:</i> the legal, political, and economic environment, including social institutions	<ul style="list-style-type: none"> <li>Legislative, policy, or regulatory measures to promote human rights (for example, repeal of overly broad laws or the introduction of patients' rights charters)</li> <li>Accountability and oversight mechanisms</li> <li>Cross-sectoral action or engagement</li> <li>Participation and empowerment mechanisms</li> </ul>	<ul style="list-style-type: none"> <li>Legal and policy analysis</li> <li>Organizational behavior studies</li> <li>Reports from accountability mechanisms and other accountability indexes</li> </ul>
<i>Programmatic level:</i> planning, practice, and services	<ul style="list-style-type: none"> <li>Delivery of information, goods, or services</li> <li>Planning for HRBAs to health</li> <li>Budget allocations</li> <li>Staff capacity</li> <li>Health and development outcomes</li> </ul>	<ul style="list-style-type: none"> <li>Program monitoring and evaluation</li> <li>Epidemiological data, including on deaths and disease</li> <li>Policy and implementation analyses</li> <li>Budget tracking</li> <li>Reviews of fiscal space and maximum available resources</li> <li>Human rights costing tools</li> </ul>
<i>Societal level:</i> the social system, including gender and power dynamics, socio-cultural norms, and overall health and development outcomes	<ul style="list-style-type: none"> <li>Participation</li> <li>Gender equality and non-discrimination</li> <li>Cultural change</li> <li>Improved power relations</li> <li>Sustainable use of resources, including natural resources</li> </ul>	<ul style="list-style-type: none"> <li>Sample surveys, trend analyses, and historical analyses</li> <li>Sociological and anthropological studies</li> <li>Case studies</li> <li>Resource-use analyses</li> <li>Participatory action research</li> </ul>

- *Individual-level change* might be noted in terms of the target populations' perception of care and in terms of their knowledge or ability to articulate and claim their rights—for example, to dignified and respectful care administered by a skilled birth attendant. Such information could be captured through ethnographic and participatory action research approaches; knowledge, attitude, and practice surveys; or qualitative reviews (these surveys and reviews have not traditionally been subject to any “grading” of their reliability or quality and are therefore often treated with skepticism, but new tools are emerging—such as CerQual—that are designed precisely to allow for a more accurate assessment of the evidence against a set of clear indicators).<sup>29</sup> Such impact was described by the My Health, My Voice pilot project in India, where a grassroots women's forum set up a hotline allowing women to report health workers' requests for informal payments for health services (see article by Schaaf et al. in this issue). Monitoring and evaluation of the hotline revealed that the project had enhanced women's knowledge of their rights, as well as their confidence to claim these rights.
- *Structural changes* might lead to better investments and stronger institutions to ensure that every woman and newborn has access to skilled care at the time of childbirth and that prevailing national and local laws and regulations provide for quality services that respect confidentiality, informed consent, and privacy, and provide appropriate forms of remedy, including through accountability and oversight mechanisms.
- *Programmatic change* might include changes in the way that childbirth services are available, accessible, acceptable, and of high quality. This might require improvements in confidentiality, privacy, access to food and fluids, information on patients' rights, and standards of clinical care, or the building of the capacity and human rights literacy of the health workforce.<sup>30</sup> In the context of skilled birth attendance, such interventions might be measured through process indicators, examining quantitative figures such as the proportion of primary health care facilities in a

country offering a minimum package of sexual and reproductive health services, with appropriate quality of care.<sup>31</sup>

- *Societal change* might be seen when family, community, and socio-cultural norms change to allow women to become more involved in decision making around their reproductive health and in the delivery of health services, particularly in contexts where socio-cultural norms and traditions play a significant role in determining women's access to reproductive health care. The role of the family and community in supporting such a shift will be paramount to changing the stigma around facility-based births and in claiming the rights of women and newborns for respectful and high-quality care at the time of childbirth. Such shifts could be examined through anthropological studies, participatory action research, or specific qualitative methods, such as focus group discussions.

Once compiled, the different elements of change that occur can be triangulated to provide a more substantive and nuanced analysis of the factors that contributed to the achieved health outcomes. The findings would provide a multi-level understanding of recommended and required actions that would clarify to a much greater extent the evidence of impact provided by a rights-based approach.

## Conclusion

From the discussion above, drawing from the fields of health and human rights, three initial conclusions can be drawn. First, human rights terminology and indicators are often used to monitor and measure noncompliance with international standards but rarely used to demonstrate the positive effect of applying human rights approaches to health. Conversely, while health outcomes are the key reference for progress, taken on their own, they largely fail to measure the contributions made at the individual, structural, programmatic, and societal levels.

The framework described above focuses on change as it occurs across a spectrum and allows for a more direct causal link between human rights



interventions that are, by their nature, tailored to address these different individual, structural, programmatic, and societal issues, and the subsequent changes that may affect health. This approach also provides a more flexible framework that accommodates differing levels of progress in adopting HRBAs across different contexts. Some programs or policies may have already taken steps to advance change at the programmatic level but have yet to address broader structural causes that affect access to or the enjoyment of health by women, children, and adolescents. The spectrum of change approach allows policy makers to identify a variety of possible interventions at different levels, in accordance with country needs and capacities. A more detailed “human rights impact framework” could help policy makers better understand and optimize the potential impact of HRBAs on health. Second, HRBAs are complex and multi-layered, promoting specific principles, processes, and partners. The lack of explicit guidance as to what constitutes an HRBA is a critical obstacle to assessing the impact of human rights, especially when applied by a discipline that relies on precision and exactitude. This is something that the UN system as a whole should bear in mind as it explores how to anchor human rights firmly in the SDG era. Only by setting such parameters at the outset of an agenda (as UNAIDS did in the past with an HRBA to HIV) can we hope to valuably measure the impact of these interventions.<sup>32</sup> Interestingly, the concept and value of equity has gained increasing traction in health and development in recent years, not least for its robust articulation of the “theory of change” it seeks to invoke. Human rights would do well to learn from this. The accountability frameworks for the SDGs and the Global Strategy for Women’s, Children’s and Adolescents’ Health offer important opportunities to apply, test, and further develop the assessment of human rights impact using the spectrum of change approach.

Finally, while an impact framework is a useful methodology for tracing and linking human rights-shaped interventions to health outcomes, we also know that evidence of impact alone often is not enough. Realizing health and human

rights goals requires a powerful mix of factors, strategic moments of political and social change, evidence-based investments and interventions, an alignment of shared values and collective action. But it is an important string to our bow and worthy of our attention.

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