



**INTERNATIONAL ASSISTANCE  
AND COOPERATION IN SEXUAL AND  
REPRODUCTIVE HEALTH: A HUMAN  
RIGHTS RESPONSIBILITY FOR DONORS**

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Cover photograph © Don Hinrichsen/UNFPA. Women waiting to be treated at a UNFPA-supported reproductive health camp in Nepal, which has been devastated by ongoing civil unrest. The camps treat up to 1,000 women and adolescents over a five-day period. 2005.

# INTRODUCTION

In recent years, donors have adopted significant measures to integrate human rights, including the rights to sexual and reproductive health, into their policies and programmes.<sup>1</sup> This trend has been driven by increasing awareness that respect for human rights can enhance development.<sup>2</sup> It has also been influenced by international commitments which promote a human rights-based approach to development, including sexual and reproductive health, such as the Programme of Action of the International Conference on Population and Development (1994), as well as by parallel moves by international organisations and civil society to integrate human rights into development cooperation.<sup>3</sup>

Traditionally, the practice of human rights has focused on States' domestic implementation of their responsibilities, including those derived from ratification of international human rights treaties. However, as is increasingly recognised, States' obligations under some international treaties extend beyond their national borders to international assistance and cooperation for human rights, including the rights to sexual and reproductive health, in other countries.<sup>4</sup> The International Covenant on Economic, Social and Cultural Rights (1966), the Convention on the Rights of the Child (1989) and the Convention on the Rights of Persons with Disabilities (2006) are among those treaties which give rise to such a responsibility. In view of this, international human rights bodies and civil society are increasingly demanding accountability of States for the impact of their activities on sexual and reproductive health in other countries.

The human rights responsibility of international assistance and cooperation has implications for



donors, including in relation to their activities in the area of sexual and reproductive health. Donor countries should support other countries to meet their obligations. Donors also have an obligation themselves, deriving from their own ratification of international human rights treaties, to contribute to the progressive realisation of the rights to sexual and reproductive health in other countries. It means that they must take systematic, concrete and targeted steps towards this objective and may be held to account in this respect.

This briefing paper focuses on what is expected of donors. It is aimed particularly at policy and programme staff working for donor agencies to help them ensure that their policies, programmes and other activities are consistent with their human rights responsibility of international assistance and cooperation in sexual and reproductive health. The publication includes illustrative case studies and aims to offer practical suggestions. Where possible, case studies focus on sexual and reproductive health. However some case studies focus on other health issues. It aims to show what States are already doing which helps them meet this obligation, as well as what more they may be expected to do.

This briefing paper has five chapters. Chapter one focuses on important definitions and concepts in relation to the rights to sexual and reproductive health. Chapter two briefly sets out the state of sexual and reproductive health worldwide, and outlines donors' existing political commitments to improving the rights to sexual and reproductive health. Chapter three explains the source and nature of the human rights responsibility of international assistance and cooperation in sexual and reproductive health and how this can reinforce political commitments. Chapter four looks at the principles of the Paris Declaration on Aid Effectiveness (2005), and how

these relate to international assistance and cooperation. Chapter five is comprised of a set of recommendations to donors and to developing countries in relation to their interactions with donors.

The authors wish to conclude this introduction with four important points.

Firstly, until recently the nature and scope of the human rights responsibility of international assistance and cooperation was unclear. However, recent attention to this issue by the international community, including human rights bodies and civil society, has provided important analysis of, and insights into, the nature of the human rights responsibility of international assistance and cooperation.

Secondly, as with many elements of human rights, some issues remain unclear and contested. While this publication highlights these uncertainties, it focuses primarily on the positions taken by independent United Nations human rights mechanisms which are mandated by the international community of States to clarify the right to the enjoyment of the highest attainable standard of physical and mental health ("right to the highest attainable standard of health" or "right to health"), including the rights to sexual and reproductive health, and obligations on States in this respect. These mechanisms include the Committee on Economic, Social and Cultural Rights, and the Special Rapporteur on the right to the highest attainable standard of health.

Thirdly, to the authors' knowledge, this is the first time that a publication has focused on the human rights responsibility of international assistance and cooperation in relation to sexual and reproductive health. Our analysis is based primarily on what human rights bodies have said about the human rights responsibility of international assistance and cooperation in general, or more specifically in health. We have applied this analysis to the sexual and reproductive health context. Where we have referred to sexual and reproductive health issues and situations we have done so for illustrative purposes, aiming to suggest the sorts of actions which are required rather than purporting to provide precise prescriptions.

Fourthly, our analysis focuses on the role and responsibility of donor countries. There are many other important international actors in the field of international development and sexual and reproductive health, including international non-governmental organisations, private grant-making bodies, pharmaceutical and other corporations and international organisations, such as the World Bank and the International Monetary Fund (IMF). Our analysis focuses on States, since they carry the primary duty under international human rights law. In relation to the World Bank and IMF, we give some attention to the role and responsibilities of countries in the context of their membership of these organisations. However, we hope that some of the analysis and recommendations may still be useful to these other organisations.



Photograph © 2004 Samuel Makaka, Courtesy of UNFPA. Mothers and children in Djibo, on the border with Mali, Burkina Faso.



# I. WHAT IS MEANT BY THE RIGHTS TO SEXUAL AND REPRODUCTIVE HEALTH?

The rights to sexual and reproductive health are vital components of the right to the highest attainable standard of health. This fundamental human right is recognised in the majority of the core set of international human rights treaties, including the International Covenant on Economic, Social and Cultural Rights (ICESCR), the Convention on the Elimination of All Forms of Racial Discrimination (CERD), the Convention on the Rights of the Child (CRC) and the Convention on the Rights of Persons with Disabilities (CRPD). It is also reflected in the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). All States have ratified at least one international treaty recognising the right to the highest attainable standard of health. This human right is also recognised in regional human rights treaties and in numerous national constitutions worldwide.<sup>5</sup>

There are a number of different terms used in the area of sexual and reproductive health and rights, including sexual health, reproductive health, sexual and reproductive health, sexual and reproductive health rights, the right to sexual and reproductive health, the rights to sexual and reproductive health, and reproductive rights and sexual rights. These terms reflect important differences.

In this briefing paper we refer to the rights to sexual and reproductive health. As well as being a vital element of the right to health, the right to sexual health is an important sexual right. Similarly, the right to reproductive health is also an important reproductive right. Box 1 outlines concepts and definitions for sexual health and rights and reproductive health and rights which we use in this publication.



Photograph © William A. Ryan/UNFPA. A UNFPA-supported mobile maternal and child health clinic on the road to the isolated village of Mastana Gali, in Pakistan-administered Kashmir. 2006.

## Box 1: The rights to sexual and reproductive health: definitions and concepts

### Sexual health

Sexual health is a state of physical, emotional, mental and social well-being related to sexuality, not merely the absence of disease, dysfunction or infirmity.<sup>6</sup> Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.<sup>7</sup>

### Sexual rights

The outcome document of the Fourth World Conference on Women includes an important affirmation of the right of women to have control over their sexuality, including their sexual health.<sup>8</sup> Human rights bodies have taken significant steps towards addressing sexuality and human rights, confirming, among others, entitlements to sexual health services, and the prohibition of discrimination on grounds of sexual orientation.<sup>9</sup> The correct understanding of fundamental human rights principles (such as non-discrimination, the rights to equality, privacy and bodily integrity) as well as existing human rights norms, leads ineluctably to the recognition of sexual rights as human rights.<sup>10</sup> The term "sexual rights" serves as a short hand for the bundle of specific norms that emerge when existing generic human rights are applied to sexuality. The right to sexual health is an important sexual right.

### Reproductive health

The ICPD Programme of Action recognises that:

"Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in the last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth, and provide couples with the best chance of having a healthy infant. In line with the above definition of

reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems," (paragraph 7.2).

### Reproductive rights

Placing particular emphasis on the right to the highest attainable standard of sexual and reproductive health, the ICPD Programme of Action defined reproductive rights in the following terms:

"Reproductive rights embrace certain human rights that are already recognised in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents," (paragraph 7.3).

### The rights to sexual and reproductive health

The ICPD programme of action identified sexual health as an element of reproductive health.<sup>11</sup>

However, many aspects of sexuality are non-reproductive. Sexuality is a distinct dimension of human well-being and often not linked to reproduction. Because sexual and reproductive health are distinct, this publication talks about the rights (plural) to sexual and reproductive health.

Our analysis focuses on the rights to sexual and reproductive health, rather than sexual and reproductive rights since much of our analysis is derived specifically from the human rights responsibility of international assistance and cooperation in health, of which the rights to sexual and reproductive health are integral elements. However, we also wish to emphasise that international assistance and cooperation is equally an important responsibility in relation to other sexual and reproductive rights.



Photograph © Don Hinrichsen/UNFPA. A pregnant woman at a UNFPA-supported health clinic in Yen Bai Province, in northern Viet Nam. She has come to the clinic for a prenatal exam. September 2004.

## II: INTERNATIONAL POLITICAL COMMITMENTS AND UNMET NEEDS: THE STATE OF SEXUAL AND REPRODUCTIVE HEALTH WORLDWIDE

Poor access to sexual and reproductive health remains a major problem worldwide, particularly in developing countries. Death and disability due to sexual and reproductive ill-health account for 18 per cent of the overall global disease burden and 32 percent of the disease burden among women of reproductive age (15–44).<sup>12</sup> In 2005, an estimated 536,000 women died in pregnancy or childbirth; 99 per cent of these deaths occurred in developing countries.<sup>13</sup> Nearly 20 million unsafe abortions took place in 2003,<sup>14</sup> 98 per cent of them in developing countries with restrictive abortion laws.<sup>15</sup> Every year an estimated 65,000–70,000 deaths occur as a result of

unsafe abortion.<sup>16</sup> The estimated number of people living with HIV/AIDS worldwide in 2007 was 33.2 million; Sub-Saharan Africa was the most seriously affected region, with AIDS being the leading cause of death.<sup>17</sup>

Responding to the scale of the crisis, the international community has made a number of important commitments to improving sexual and reproductive health worldwide, including at the International Conference on Population and Development (ICPD: Cairo, 1994), the Fourth World Conference on Women (FWCW: Beijing, 2005), the Millennium Summit (New York, 2000) and the World Summit (New York, 2005).

### Box 2: International development commitments on sexual and reproductive health and the role of donors

#### International Conference on Population and Development

Chapter XIV of the ICPD Programme of Action focuses on international cooperation and includes a commitment by the international community to strive to fulfil the agreed target of 0.7 per cent Gross National Product (GNP) for official development assistance, and to endeavour to increase the share of funding for population and development programmes commensurate with activities needed to achieve the objectives of the Programme.

The Programme of Action estimated that to meet its key objectives, \$17.0 billion would be needed in 2000, \$18.5 billion in 2005, \$20.5 billion in 2010 and \$21.7 billion in 2015, of which two-thirds should be met by countries themselves and one-third by donors.<sup>19</sup> These estimates focused on four components: family planning; reproductive health; sexually-transmitted infections and HIV/AIDS; and basic research, data and population and development analysis. The Programme does not include a costing of all its objectives, neither does the costing include key sexual and reproductive health activities, such as the strengthening of primary health care systems or improving women's status.

In 2006, the Millennium Project stated: "It is clear that resource requirements for the basic [sexual and reproductive health] package will be significantly

higher than estimated over a decade ago. By 2015 the required annual costs will be about US\$14 billion more than originally anticipated, reaching US\$36 billion. The magnitude and share of required HIV/AIDS prevention investments are substantial."<sup>20</sup>

#### Millennium Development Goals

The Millennium Development Goals (MDGs), which derive from the Millennium Declaration (2000), include important commitments in the area of sexual and reproductive health, such as: addressing safe motherhood and child survival, prevention of HIV/AIDS, and promoting gender equality and empowering women. The Goals also encompass a commitment to develop a global partnership for development. Targets to meet this Goal include commitments in the fields of development cooperation, trade, market access, debt sustainability and access to medicines. Progress towards meeting the Goals is slow and uneven: the targets for maternal health are particularly off-track.

#### World Summit

The 2005 World Summit emphasised the centrality of the MDGs to international development. However, it also highlighted the importance of a broader development dialogue for poverty elimination, and identified issues, including reproductive health, which have an important role to play in this respect.





Photograph © 2001 Guillaume M. Bakadi/CCP, Courtesy of Photoshare. Advocacy is the key to getting people involved; Adolescent Reproductive Health Campaign in Guinea. Building coalition is one strategy used to give more responsibility to people to fight HIV/AIDS. The prefect, a parliament representative, and a representative of Kelefas SERES address the crowd at the campaign launch. Among participants are religious leaders, NGO representatives, SERES members, and government officials.

Consensus documents adopted at these conferences recognised the crucial role of donors in supporting efforts by developing countries to improve sexual and reproductive health (see Box 2). The outcome documents of the ICPD and FWCW also set out a vision of a human rights-based approach to sexual and reproductive health and recognise the centrality of the right to the highest attainable standard of sexual and reproductive health.<sup>18</sup>

While sexual and reproductive health is prominent on the development agenda, this has not been translated into the action required to meet internationally agreed

targets. This is for a range of reasons, including a lack of political commitment among both donors and aid recipients. For their part, donors have largely failed to meet international development targets, such as the target of 0.7 per cent of GNP to official development assistance (ODA).<sup>21</sup> Only five countries have met this target (Denmark, Luxemburg, the Netherlands, Norway and Sweden). At the Gleneagles Summit in 2005, leaders agreed to double aid to Africa by 2010, but disbursements to the region only increased by 2 per cent by 2006.<sup>22</sup> Donors have also failed to allocate agreed resources to sexual and reproductive health (see Box 3).

### Box 3: Comparative donor contributions to sexual and reproductive health

"Donor countries vary in how much of ODA they contribute to population assistance. Denmark, Luxemburg, the Netherlands, Norway and the United Kingdom were the leading contributors to population assistance as a share per million dollars of gross national income (GNI) in 2003 ... In 2003, only five countries gave more than the 4 percent of ODA to population activities agreed at the ICPD: Finland, Luxemburg, the Netherlands, Norway and the United States. The number of countries providing 4 percent of ODA to population

activities has decreased since 2002 where nine countries gave more than 4 percent (UNFPA, UNAIDS and NIDI 2005). In 2003, the United States was the leading contributor in absolute terms and in its share of ODA going to population assistance (11.5 percent). However, relative to the size of its economy it is only in the middle range of donor countries."

*From UN Millennium Project, Public Choices, Private Decisions: Sexual and Reproductive Health and the Millennium Development Goals, 2006.*

### III. THE SOURCE AND NATURE OF THE HUMAN RIGHTS RESPONSIBILITY OF INTERNATIONAL ASSISTANCE AND COOPERATION IN SEXUAL AND REPRODUCTIVE HEALTH

#### A. THE SOURCE OF THE RESPONSIBILITY

Three international treaties recognising the right to health – ICESCR, CRC and CRPD – include a responsibility of international assistance and cooperation in health, including sexual and reproductive health (see Box 4). While CEDAW does not include such a provision, the body charged with monitoring and interpreting the treaty, the Committee on the Elimination of Discrimination Against Women, considers that responsibilities under the treaty do extend to States' international

assistance and cooperation policies.<sup>23</sup>

These treaty obligations are supported by important references to international cooperation in a range of other international treaties and declarations. Articles 55 and 56 of the United Nations Charter establish a responsibility on States to engage in international cooperation for the achievement of human rights. The Universal Declaration on Human Rights (UDHR) recognises the entitlement of each individual to the realisation of his or her

#### Box 4: Treaty protections of the human rights responsibility of international assistance and cooperation

##### International Covenant on Economic, Social and Cultural Rights (1966), article 2.1

"Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realisation of the rights recognised in the present Covenant by all appropriate means, including particularly the adoption of legislative measures."

##### Convention on the Rights of the Child (1989), article 24.4

"States Parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realisation of the right [of the child to the highest attainable standard of health]. In this regard, particular account shall be taken of the needs of developing countries."

##### Convention on the Rights of Persons with Disabilities (2006), article 32

"1. States Parties recognise the importance of international cooperation and its promotion, in support of national efforts for the realisation of the purpose and objectives of the present

Convention, and will undertake appropriate and effective measures in this regard, between and among States and, as appropriate, in partnership with relevant international and regional organisations and civil society, in particular organisations of persons with disabilities. Such measures could include, inter alia:

- a. Ensuring that international cooperation, including international development programmes, is inclusive of and accessible to persons with disabilities;
- b. Facilitating and supporting capacity-building, including through the exchange and sharing of information, experiences, training programmes and best practices;
- c. Facilitating cooperation in research and access to scientific and technical knowledge;
- d. Providing, as appropriate, technical and economic assistance, including by facilitating access to and sharing of accessible and assistive technologies, and through the transfer of technologies.

2. The provisions of this article are without prejudice to the obligations of each State Party to fulfil its obligations under the present Convention."



economic, social and cultural rights “through national effort and international cooperation” (article 22). The Declaration on the Right to Development recognises, among others, that as a complement to efforts by developing countries, international cooperation is essential to provide these countries with appropriate means and facilities to foster their comprehensive development; and States have a duty to co-operate with each other in ensuring development and eliminating obstacles to

development (articles 3 and 4).

Treaty obligations reinforce political commitments made to international cooperation for the rights to sexual and reproductive health including at the ICPD, FWCW and the Millennium and World Summits (see Boxes 1 and 2). At the same time, commitments made at these conferences can provide guidance on how to interpret the responsibility of international assistance and cooperation in the context of sexual and reproductive health.

## B. TERMINOLOGY

ICESCR requires States to engage in “international assistance and cooperation” for the realisation of the rights recognised in this treaty. CRC and CRPD use the phrase “international cooperation”. Debate on these responsibilities, as well as similar responsibilities deriving from other instruments including the International Covenant on Civil and Political Rights, is also varyingly framed in the following terms: “transboundary”, “transborder”

“international” or “transnational” responsibilities.<sup>24</sup> While there are different nuances associated with each term, they are often in practice used interchangeably. Given that the central international protection of the right to the highest attainable standard of health is found in ICESCR (article 12), this paper refers to the human rights responsibility of “international assistance and cooperation”.

## C. THE NATURE AND SCOPE OF THE RESPONSIBILITY

Like many elements of human rights, the parameters of the human rights responsibility of international assistance and cooperation in health, including sexual and reproductive health, are not yet settled. However, the recent focus of the human rights community on the transboundary application of human rights, including the right to the highest attainable standard of health, has helped clarify the responsibility.

The following sections explain key conceptual elements of international assistance and cooperation which have been elaborated by the human rights community. In particular, the following sections draw on an analysis of international assistance and cooperation in health by the

first UN Special Rapporteur on the right to the highest attainable standard of health, Paul Hunt (2002-2008).<sup>25</sup> The briefing paper also highlights particular areas of contention.

### Responsibilities to seek and provide assistance

States have a responsibility to seek assistance and cooperation where domestic capacity is not sufficient for the realisation of the rights to sexual and reproductive health. It also includes a responsibility on States in a position to assist to provide appropriate assistance and cooperation (see Box 5).

#### Box 5: The responsibilities to seek and provide cooperation and assistance

##### The responsibility to seek assistance and cooperation: the Concluding Observations of the Committee on the Elimination of Discrimination Against Women on Tanzania, 2008

“The Committee calls upon the State party to strengthen its system of data collection, including the use of measurable indicators to assess trends in the situation of women and of progress towards women’s de facto equality, and to allocate sufficient budgetary resources for that purpose. It invites the State party, as necessary, to seek international assistance for the development of such data

collection and analysis efforts.”<sup>26</sup>

##### The responsibility to provide assistance and cooperation: the Committee on Economic, Social and Cultural Rights Concluding Observations on France, 2008

“The Committee recommends that the State party increase its official development assistance to 0.7 per cent of its GDP, as agreed by the Heads of State and Government at the International Conference on Financing for Development, held in Monterrey (Mexico) on 18-22 March 2002.”<sup>27</sup>

### A supplementary responsibility

A State's sexual and reproductive health responsibilities at the domestic level are not curtailed by other States' responsibilities of international assistance and cooperation. For example, a developing country Government which is not doing all it can to realise the rights to sexual and reproductive health cannot legitimately point the finger of blame at the international community for its own shortcomings. The responsibility of donors is supplementary to the responsibility of developing countries.

### Progressive realisation and resource availability

Under ICESCR, States are required to take targeted steps to progressively realise the right to health, subject to the maximum available resources.<sup>28</sup> This includes resources available from the international community. Hence the responsibility of a developing State to seek appropriate international assistance and cooperation.

Equally, however, the human rights responsibility to provide international assistance and cooperation is also subject to the resources available to a donor. This gives rise to difficult questions. For example, how much should a donor be expected to contribute in the light of its resource availability? In this respect, it is instructive to look at the record of comparable donors, as well as international political commitments relating to the share of development assistance that should be devoted to sexual and reproductive health (see Box 3).

In General Comment 14, the Committee on Economic, Social and Cultural Rights confirms that donors should give particular priority to helping low-income countries realize their "core obligations" arising from the right to health. This includes the provision of health services on a non-discriminatory basis, essential drugs and the adoption of a national public health strategy and plan of action. The Committee has emphasised that reproductive, maternal and child healthcare is an obligation of comparable priority, which should therefore also be a key concern for donors.

### Financial assistance

The human rights responsibility of international assistance and cooperation includes a duty on donors to urgently take deliberate, concrete and progressive

measures towards devoting a minimum of 0.7 per cent GNP to ODA.<sup>29</sup> The ICPD, which reaffirms this target, also commits States to increase the share of funding for population assistance.<sup>30</sup>

### Non financial dimensions of assistance and cooperation

International assistance and cooperation must not be narrowly understood as a duty to provide financial assistance. The international community also has an important responsibility to play in relation to technical cooperation, among others, through the contribution of international organisations such as UNFPA, WHO, UNICEF and the World Bank (see Box 6). The promotion and protection of sexual and reproductive health by donors also includes measures which are not resource intensive. For example, a donor has a responsibility to refrain from engaging in activities which may jeopardise sexual and reproductive health in developing countries.

### Coherence

The rights to sexual and reproductive health must be applied consistently and coherently across all relevant national and international actions. In addition to international development efforts, States have a responsibility to work actively towards an equitable multilateral trade, investment and financial system conducive to the reduction of poverty and the realisation of human rights, including the rights to the highest attainable standard of sexual and reproductive health (see Box 7). Donor agencies should work with other relevant ministries from their own and partner Governments, including the Ministries of Health, Finance, Trade, Women, and Foreign Affairs, to ensure a consistent approach promoting and protecting the rights to sexual and reproductive health.

In the context of development, a State must do all it reasonably can to ensure that the rights to sexual and reproductive health are consistently and coherently integrated into its international development policies and all activities at the international, national and local levels. It should, for example, ensure this responsibility informs its activities and dialogue with other donors and aid

#### Box 6: Sida's support for a human rights officer in WHO's country office in Uganda

Sweden supported the employment of an Associate Professional Officer as a Health and Human Rights Officer in the WHO country office in Uganda. This is one example of how a donor can support technical cooperation on human rights through contributions to an international organisation.

Photograph © Don Hinrichsen/UNFPA. Residents of a UNFPA-supported shelter for victims of domestic violence in Chisinau, Moldova. 2005.





## Box 7: Coherence

### Mainstreaming human rights in Sweden's foreign policy

In *Human Rights in Swedish Foreign Policy*, the Government of Sweden pledges to integrate human rights into all areas of foreign policy, including development cooperation, and to mainstream human rights into the work of global and regional organisations. In 2002, in *Shared Responsibility: Sweden's Policy for Global Development*, the Government of Sweden confirmed that the human rights perspective would be mainstreamed across all areas of policy relating to international development.

Source: *Human Rights in Swedish Foreign Policy*, Government Communications 1997/98:89, 2003/04:20.

### Guaranteeing the rights to sexual and reproductive health in the World Bank's Health, Nutrition and Population Strategy

In 2007, the World Bank adopted a new ten year

Health, Nutrition and Population Strategy. The first and second drafts of the Strategy, prepared by World Bank staff, included a watered down version of the Bank's longstanding commitment to the rights to sexual and reproductive health. However, the Executive Board of the World Bank, which is composed of Executive Directors representing the Member States of the organisation, rejected these drafts, and was able to ensure that the Strategy reaffirmed support for the rights to sexual and reproductive health including commitments made at the International Conference on Population and Development. Protests by several European members of the Bank, including Belgium, France, Germany, Italy and Norway, were instrumental in this decision and were consistent with their human rights responsibility of international assistance and cooperation in sexual and reproductive health.

recipients (both Governments and non-governmental organisations), and its activities in the context of membership of international organisations to which it belongs (see Box 7).<sup>31</sup>

### Obligations to respect, protect and fulfil

The right to health gives rise to three layers of obligations on States: to *respect*, *protect* and *fulfil*. In turn, the obligation to *fulfil* includes an obligation to *facilitate*.<sup>32</sup> In the context of international assistance and cooperation in sexual and reproductive health, States must ensure that their actions *respect* sexual and reproductive health in other countries. They must also, so far as possible, *protect* against third parties undermining sexual and reproductive health in other countries if they are able to influence them through political or legal means (see Box 7). Depending on available resources, States should

*facilitate* access to essential sexual and reproductive health facilities and services in other countries and provide the necessary aid where required.<sup>33</sup>

### Procedural fairness

The requirements of procedural fairness extend to international assistance and cooperation. For example, donors have a responsibility not to withdraw critical funds for the rights to sexual and reproductive health without first giving the recipient reasonable notice and opportunity to make alternative arrangements (see Box 8). This responsibility means that donors must be as predictable as possible in their actions in developing countries. Integrating the rights to sexual and reproductive health and other human rights into agreements with partners can help improve predictability and provide a basis for open and transparent dialogue.<sup>34</sup>

## Box 8: Donors in the Occupied Palestinian Territories

For many years, donors provided indispensable support to the health sector in the Occupied Palestinian Territories, amounting to almost 50 per cent of the Ministry of Health's budget. In 2006, after the democratic election of Hamas, and Hamas's refusal to renounce violence, some major donors turned off their life-saving assistance without notice. They gave the Palestinian Authority no reasonable prior opportunity to put in place alternative funding mechanisms. In this way, they seriously affected the

ability of the Ministry of Health to deliver healthcare services and maintain public health programmes. Donors' actions threatened the most vulnerable – the sick, infirm, elderly, children, and pregnant women. In short, some donors acted in breach of their responsibility to provide international health assistance in the OPT.

Source: UN Press Release, 22 June 2006, *UN Health Rights Expert criticizes Donors for Failing to Fulfil their Humanitarian Responsibilities in the Occupied Palestinian Territories*

### A binding legal obligation

The Committee on Economic, Social and Cultural Rights has argued that international assistance and cooperation is a binding obligation under ICESCR. Many developing States agree with this position, while developed States do not.<sup>35</sup> The first UN Special Rapporteur on the right to the highest attainable standard of health has argued: "if there is no legal obligation underpinning the human rights

responsibility of international assistance and cooperation, inescapably all international assistance and cooperation fundamentally rests upon charity. While such a position might have been tenable in years gone by, it is unacceptable in the twenty-first century."<sup>36</sup> The policies of some donors recognise the legally binding nature of international human rights law in relation to their operations (see Box 9).

#### Box 9: The German Federal Ministry for Economic Cooperation and Development: Development Policy Action Plan on Human Rights, 2008-10

"Human rights provide us with legally binding standards to which we, in common with our partner countries, have committed ourselves inside and outside our borders. We have jointly ratified international human rights treaties and so it is our

joint responsibility to work for the respect, protection and fulfilment of human rights. By meeting our obligations, we want to help our partners specifically and effectively to meet theirs."

### Key features of the rights to sexual and reproductive health which international assistance and cooperation should support

Donors must undertake a range of actions in order to comply with their human rights responsibility of international assistance and cooperation in sexual and reproductive health. They must ensure that the realisation of the rights to sexual and reproductive health is an objective of their policies and programmes at the international,

regional, national and local levels. This objective must inform budgetary allocations, dialogue and partnerships with aid recipients and arrangements with other donors. Donors must also adopt a range of measures to ensure that their staff members are supported to integrate the rights to sexual and reproductive health into their work, including training opportunities and drafting of support manuals (see Box 10). The following paragraphs highlight key features of the right to the highest attainable standard of sexual and reproductive health which must be reflected in these activities.

Photograph © 2007 Virginia Lamprecht, Courtesy of Photoshare. Community-based distribution agents for family planning services from a small village near Blantyre, Malawi, greet special visitors from USAID and the Adventist Health Services.





## Box 10: Enhancing capacity in donor agencies

### German Federal Ministry for Economic Cooperation and Development (BMZ): Human Rights Training

"In association with the German Institute for Human Rights, we support specialist events and in-house training courses for the BMZ and its implementing organisations on the practical implementation of the human-rights-based approach in the priority areas of German development co-operation. We are working hard to get the subject of human rights made part of key standard in-house training courses and to ensure that the links with poverty alleviation, gender equality and good governance are emphasised."

Source: German Federal Ministry for Economic Cooperation and Development: *Development Policy Action Plan on Human Rights, 2008-10.*

### The UK Department for International Development (DFID): Guidance to its advisors and programme managers on integrating human rights and responsibilities into reducing maternal mortality

In 2005, DFID published a guidance note for its advisors and programme managers working on maternal health providing information on how to put a rights-based approach into practice. *How to Reduce Maternal Deaths: Rights and Responsibilities* describes a rights-based approach, how to apply this approach to strengthening health systems, and includes information on other important strategies for sexual and reproductive health which the organisation can support, including increasing women's knowledge and social mobilisation and increasing state accountability for maternal health. It also provides suggestions for integrating human rights into aid instruments.<sup>37</sup>

## > Freedoms and entitlements

Freedoms include the right to be free from discrimination and the right to control one's health and body. Sexual violence including rape, non-consensual contraceptive methods and female genital mutilation are all a serious affront to this freedom.<sup>38</sup>

Entitlements encompass medical care and underlying determinants of health, such as safe drinking water and adequate sanitation. Given the broad scope of sexual and reproductive health, many different interventions are required to realise these rights. Specific entitlements in relation to sexual and reproductive health include: information on sexual and reproductive health; access to health services in connection with pregnancy as well as family planning services; and access to voluntary testing, counselling and treatment for HIV/AIDS, other sexually transmitted infections and breast and reproductive system cancers. Other key interventions are also needed to analyse, tackle and evaluate action in relation to social determinants of sexual and reproductive health, including gender relations and access to education.<sup>39</sup>

Therefore, in addition to health-sector interventions, actions will be required in other sectors including education, water and sanitation. Donors should ensure that the rights to sexual and reproductive health inform, and are supported in, their programmes in a range of sectors.

The realisation of the rights to sexual and reproductive health is dependent on an accessible and strong health system. While many sexual and reproductive health interventions were traditionally funded vertically and not integrated into basic health packages, the ICPD emphasises that services for sexual and reproductive health should be integrated within

the health system. It is important that sexual and reproductive health interventions strengthen health system capacity. Likewise, it is important that the provision of sexual and reproductive health services and information, including for marginalised groups, are given attention in the context of health system strengthening.

In recent years, new financing mechanisms, including sector-wide approaches and direct budget support, have been widely adopted by donors and their partners. It is vital that donors and their partners support the rights to sexual and reproductive health, and health system strengthening, in the context of these arrangements (see Box 11).<sup>40</sup> Dialogue with partner Governments, and support to civil society or international organisations, are among the actions which can help ensure that the rights to sexual and reproductive health are not neglected. This is especially important where there is a risk that the rights to sexual and reproductive health might be sidelined.



Photograph © HRU/Josef Maerien. June 2003

### Box 11: Sweden's International Policy on Sexual and Reproductive Health and Rights (2006)

"The way in which the right to sexual and reproductive health is included in strategies for fighting poverty and sector plans is particularly important when cooperation with a country takes the form of sector programme support. In these cases, Sweden will attach great importance to the analysis and follow-up of sector programmes and reform processes from an SRHR perspective which also includes HIV and AIDS. Sweden will ensure that the follow-up systems produced for the health sector by cooperating countries include SRHR aspects."

Source: Ministry for Foreign Affairs, Sweden: *Sweden's International Policy on Sexual and Reproductive Health and Rights, 2006.*



#### > Equality and non-discrimination

These are integral to the rights to sexual and reproductive health. In their international policies, States should give particular attention to securing the rights to sexual and reproductive health for marginalised individuals, communities and populations, such as persons living in poverty; women; adolescents; lesbian, gay, bisexual and transgender persons; indigenous peoples; persons with disabilities; persons living with HIV/AIDS; and commercial sex workers. States should also ensure that their policies and programmes do not reinforce marginalisation of these groups.

A further question for donors is with which countries should they engage in cooperation? The human rights principles of equality and non-discrimination suggest that disadvantage is a critical consideration in this respect. For example, donors should provide resources to support the rights to sexual and reproductive health in least developed countries, where domestic resources for health are often

extremely inadequate. However, given the vast inequalities in many middle-income countries, donors should not neglect support for the rights to sexual and reproductive health of marginalised communities in these countries.

#### > Participation and culture

Those affected are entitled to participate in health-related policy making and implementation. Thus, in developing countries, donors should promote such participation, especially by those who are marginalised. Also, donors' policies, programmes and other activities should themselves be designed and implemented with the participation of such groups.

In order to develop and deliver sexual and reproductive health interventions, local contexts, including cultural contexts, must be taken into account. The engagement, consultation and participation of communities, including indigenous communities and marginalised individuals

### Box 12: UNFPA, UNICEF and civil society programmes in Guinea-Bissau on Female Genital Mutilation/Cutting

In Guinea-Bissau ... recent (2006) indicators show that Female Genital Mutilation (FGM) is still widely practised: 44.5 per cent of girls and women aged 15 to 49 years are affected. Following a number of failed initiatives to end FGM, the United Nations Children's Fund (UNICEF) and UNFPA partnered with Tostan, a non-governmental organisation (NGO) with a good track record in Senegal, Guinea, Gambia, Burkina Faso and Mauritania. Tostan's approach is to engage the community in respectful

discussions on human rights. People are also encouraged to talk about concerns within the area and to review problem-solving approaches. This process of engagement often culminates with a collective decision to abandon FGM. Community acceptance avoids social pressures on individual families and girls.

Source: UNFPA, *State of the World's Population 2008: Reaching Common Ground: Gender, Culture and Human Rights, 2008.*





Photograph © UNFPA.

within those communities, are vital in order to develop successful interventions. This participation can help ensure cultural sensitivity, which is necessary for identifying approaches and local partners for the realisation of sexual and reproductive health (see Box 12).<sup>41</sup>

Supporting civil society organisations working to improve engagement of poor and marginalised communities in policy making is an important way for donors to ensure that their policies and programmes respect the principle of participation (see Box 12).

### > Monitoring and accountability

The human rights principles of monitoring and accountability include a responsibility for donors to make themselves more transparent and accountable, including to rights-holders in the countries where they

work.<sup>42</sup> This responsibility is reflected in the Millennium Declaration, the Monterrey Consensus on Financing for Development, the Johannesburg Declaration on Sustainable Development and the Paris Declaration on Aid Effectiveness: all of these commitments call for donor accountability to partner countries.<sup>43</sup>

At the international level, there are a number of human rights bodies that can help enhance donor accountability. UN treaty bodies, which monitor States' reports, have often requested information from donors about their activities and have made recommendations in this respect. Some civil society organisations have started to provide reports on States' obligations of international assistance and cooperation to the treaty bodies, which these bodies can use for reference when reviewing States' reports.<sup>44</sup>

Special Rapporteurs, such as the Special Rapporteurs on the right to health, violence against women and education can play an important role in holding donors to account for their responsibilities. For example, Special Rapporteurs undertake official visits to countries and institutions to monitor the realisation of human rights, and these visits can play a role in holding donors to account (see Box 13).

Donors must make sure that information about their policies and activities is available and accessible, not just to the international community, but also to rights holders in countries where they operate. Donors and their Government and other partners should establish forums for holding donors to account in these countries. This may include parliamentary processes or scrutiny by a national human rights institution or civil society.

Donors often support monitoring and accountability of their partner Governments to rights-holders in these countries. Donors can play an important role supporting the development of health information systems, including data disaggregation capacities, which are key to building up a picture of the realisation of the rights to sexual and reproductive health. Their programmes can also support civil society organisations which perform vital roles including: promoting demand for the rights to sexual and reproductive health through awareness raising and social mobilisation; monitoring the state of the rights to sexual and reproductive health; and advocacy with the Government and other institutions (see Box 14). National human rights institutions are independent bodies established by a Government to further the promotion and protection of human rights, including in some cases the right to health. Donors are an important source of funding for national human rights institutions in developing countries. Where the rights to sexual and reproductive health are entrenched in the national constitution, the judiciary can also play an important role in their legal protection and enforcement.

### Box 13: Promoting accountability of Sweden's international development cooperation: the Special Rapporteur on the right to health

In October 2006, the first UN Special Rapporteur on the right to the highest attainable standard of health undertook a mission to the World Bank and IMF in Washington D.C. to meet with the Executive Directors representing Sweden at the institutions. The aim of the visit was to understand how Sweden contributes to the realisation of the right to health in the context of its membership of these organisations.

In February 2007, he undertook a mission to Uganda to examine how Sweden, especially the Swedish International Development Cooperation Agency (Sida), contributes to the right to health in

Uganda. During the mission, the Special Rapporteur held extensive meetings with Sida, the Government of Uganda, international organisations, other donors and civil society.

In 2008, the Special Rapporteur presented a report on these visits to the Human Rights Council, the United Nation's primary inter-governmental human rights body. The report commended the Swedish Government on some of its policies and actions, but also included a number of recommendations on how Sweden can better fulfil its human rights responsibility of international assistance and cooperation in health.<sup>45</sup>

**Box 14: CARE Peru — Improving the Health of the Poor: A Rights-based Approach**

Improving the health of poor and marginalised groups in countries of high inequality like Peru will not be achieved by technical interventions alone. Significant, sustainable change can only happen if the poor have much greater involvement in shaping health policies, practices and programs, and in ensuring that what is agreed actually happens. Increasing this "voice" and oversight of the poor, and making sure it is more effective, is at the core of CARE Peru's programme; "Improving the Health of the Poor: A Rights-based Approach". This programme, which has been supported by the UK's Department For International Development, seeks ultimately to improve the relations between State and society to promote the fulfilment of poor people's right to health.

In order to promote public accountability for health policy, CARE has supported a variety of social reporting mechanisms and a wide range of civil society allies. These have included support to ForoSalud, Association for Human Rights (APRODEH), and a National Coalition on Health Rights and Sexual and Reproductive Surveillance Group. This supported the collaboration of nearly fifty different organisations in a participatory process of drafting a civil society shadow report to the UN Special Rapporteur on the right to health and drawing on recommendations made by the Special Rapporteur to the Peruvian Government following his mission to the country in 2004. CARE has also raised awareness about the situation of the right to health through a nationwide report on the Actionability of Sexual and Reproductive Rights and Access to HIV/AIDS Treatment and a study on maternal mortality and avoidable deaths, assessed through a rights-based analysis by Physicians for Human Rights. These reports, together with a series of studies by national academic and research institutions, have been

important for promoting specific issues in public debate, and have provided important tools for advocacy.

At the national level, CARE has supported the Ministry of Health Shared Administration Program, through which citizens elected by the local community become members of the management committee of health facilities at the primary care level. It has also worked together with other networks to support civil society engagement and advocacy in the formulation of a legislative proposal on health service users' rights and responsibilities, which will ultimately help hold the Government accountable for service delivery.

At the regional and local levels, CARE has supported the development of citizen and civil society-based accountability mechanisms, promoting citizen surveillance of health services in Piura and Puno regions. These programmes have linked Quechua and Aymara women community leaders to regional offices of the human rights Ombudsperson to monitor women's health rights, particularly their right to good quality, appropriate maternal health services. The women monitor healthcare, including through dialogue with service users and providers, and report their findings to the Ombudsperson's office, who in turn reports the findings back to the health facility manager. This process has exposed some obstacles to sexual and reproductive health, such as the fact that traditional vertical birth delivery, although institutionalized by the Ministry of Health, is not provided in Puno hospitals. It has also revealed positive developments, including improved attitudes of health service providers towards women who use the services.

*Source: A. Frisancho, A Rights-based Approach to Promote Ownership and Accountability Within the Peruvian Health Sector, March 2008.*



Photograph © 1996 CCP, Courtesy of Photoshare. A Health Promoter interviews a woman about community health needs in Puno, Peru.



## D. WHAT DIFFERENCE DOES THE HUMAN RIGHTS RESPONSIBILITY OF INTERNATIONAL ASSISTANCE AND COOPERATION MAKE TO DONORS?

The International Conference on Population and Development and the Fourth World Conference on Women included important commitments by the international community, including donors, to a human rights-based approach to sexual and reproductive health.

Over the past decade, many donors have taken significant steps to integrating human rights, including the rights to sexual and reproductive health, into their work. This includes policy statements on sexual and reproductive health and rights, guidance notes on particular issues, such as maternal mortality and human rights, and programmes which support partners at the international, national and local levels to undertake important work relating to the rights to sexual and reproductive health.

What therefore does it add, or change, for donors to address sexual and reproductive health as a human rights responsibility of international assistance and cooperation, rather than as an international policy commitment?

The human rights responsibility of international assistance and cooperation does not entail a dramatic departure from what many donors are already doing. Rather, by providing a legal foundation, it supports and reinforces donors' good practices. However, where donors are not supporting the rights to sexual and reproductive health, or are undertaking policies or programmes which are harmful in this respect, it requires them to take measures to redress this situation. The human rights responsibility of international assistance and cooperation also emphasises particular themes compared to international political commitments and donor policies, such as coherence the importance of holding donors to account in respect of their responsibilities. Finally, it alters the emphasis from political commitment to legal obligation, although as previously mentioned, the legally binding nature of international assistance and cooperation is disputed by a minority of countries.



Photograph © Sven Torfinn/Panos/UNFPA. Women and children waiting in the reception area of a maternal health clinic located on the outskirts of a huge camp for internally displaced persons. UNFPA is among the international organizations assisting camp residents. In addition to supplying reproductive health supplies and equipment, UNFPA is supporting the training of skilled health care providers. Zam Zam camp for internally displaced persons, Darfur, Sudan. June 2007.

## IV. AID EFFECTIVENESS AND PROTECTING THE RIGHTS TO SEXUAL AND REPRODUCTIVE HEALTH

In 2005, the Paris Declaration on Aid Effectiveness was agreed by over one hundred Ministers, Heads of agencies and other senior officials. The Declaration is a commitment to scale up aid and enshrines five key principles: national ownership of development by partner countries; alignment of donors with partners' development strategies, institutions and procedures; harmonisation and transparency of donors' actions; managing resources and improving decision-making for results; and mutual accountability of donors and their partners for development results.

The Declaration is a commitment to changing relations and modalities in the field of development cooperation between and among donors, partner Governments and civil society. Its five principles have become highly influential in shaping development cooperation in many countries.

The principles have important implications for how

donors can promote and protect the rights to sexual and reproductive health in their development cooperation. While the Declaration was silent on human rights, in 2008, at the Third High Level Forum on Aid Effectiveness, held in Accra, States agreed that "Developing countries and donors will ensure that their respective development policies and programmes are designed and implemented in ways consistent with their agreed international commitments on gender equality, human rights, disability and environmental sustainability."<sup>46</sup> This is important. While the Paris Declaration has the potential to enhance the enjoyment of human rights, if human rights are not taken into account in the context of new aid modalities they risk being sidelined. In the following paragraphs, we highlight a range of opportunities and challenges for the promotion and protection of the rights to sexual and reproductive health in the context of aid effectiveness principles.

### A. NATIONAL OWNERSHIP

According to the Paris Declaration, partner States commit to exercise leadership in developing and implementing their national development strategies through a broad consultative process. Donors commit to strengthen respect partner countries' leadership and strengthen their capacity to exercise it.

All developing countries have international sexual and reproductive health commitments deriving from ratification of international treaties and from inter-governmental agreements including the ICPD and FWCW as well as adherence to the MDGs. Many have also signed up to regional, and adopted national, legal and policy protections of the rights to sexual and reproductive health.<sup>47</sup> Developing countries have a responsibility to ensure these commitments form a key framework for nationally owned development policies.

The principle of national ownership means donors' support should be responsive to these human rights obligations, and should in no way jeopardise the ability of a partner country to meet its obligations. Equally, given that partner countries have agreed to respect, protect and fulfil the rights to sexual and reproductive health, as signalled by international treaty ratifications and policy commitments, it is entirely legitimate for donors to engage with their partners to encourage them to promote and protect these rights, including through policy dialogue and ensuring the rights to sexual and

reproductive health are protected in development cooperation agreements.

Sometimes, States – and others – argue that the rights to sexual and reproductive health conflict with local culture and are inapplicable. This is particularly the case in relation to issues such as safe abortion, and the rights to sexual and reproductive health of particular groups, such as adolescents, and gay, lesbian, bisexual and transgender individuals. This leads to policies which do little to respect, protect and fulfil these aspects of the rights to sexual and reproductive health. The principle of national ownership may seem like an obstacle to donors in relation to such sensitive issues. However, it is important to remember that the UDHR recognises that "All human beings are born free and equal in dignity and rights", and that the international community of States has recognised that all human rights, including the rights to sexual and reproductive health, are universal.<sup>48</sup> While human rights are universal, it is vital for donors and others to be sensitive to cultural considerations in implementing sexual and reproductive health.<sup>49</sup> Investing time in knowing a culture, listening to what the community has to say, working with local allies and using language sensitively are among the actions which can help ensure culturally sensitive approaches to sexual and reproductive health. This is often important when working with partner Governments.



## B. ALIGNMENT

Donors commit to base their overall support, including country strategies, policy dialogues and programmes, on partners' national development strategies.

When making decisions about alignment, donors must consider whether or not a recipient Government's development strategies support the rights to sexual and reproductive health. They must also consider whether the strategy is inclusive and responds to the needs of different groups. Donors must be aware of how decisions are made and priorities are set, including whether participatory processes have been adopted.

These contexts should inform donors' choice of aid

instruments and the balance of support to the State and civil society.<sup>50</sup> If a national strategy does not promote and protect the rights to sexual and reproductive health for all, then donors should think about ways to support the rights to sexual and reproductive health of excluded groups. This may involve dialogue with a partner Government or support to civil society or international organisations. In relation to civil society, supporting the demand side of human rights, including advocacy organisations and service providers working with marginalised groups, is an important way to promote and protect the rights to sexual and reproductive health.

## C. HARMONISATION

Donors commit to implement, where feasible, common arrangements at the country level for planning, funding, disbursing, monitoring, evaluating and reporting to Governments on aid flows. Donors also commit to delegate authority to lead donors for the execution of programme activities and tasks.

Without a concerted effort to protect and integrate the rights to sexual and reproductive health there is a risk that these rights will be sidelined. There is a risk that the Paris Declaration will lead to the "lowest common denominator", whereby consensus is achieved at the expense

of the promotion and protection of sexual and reproductive health issues. There is a particular risk of neglect in relation to sensitive issues, such as safe abortion and the rights to sexual and reproductive health of adolescents and of gay, lesbian, bisexual and transgender persons.

All donors – and their partners – have ratified international human rights treaties which can therefore serve as an important and impartial framework for alignment and harmonisation, together with international political commitments such as ICPD and FWCW.

## D. MANAGING FOR RESULTS

Managing for results means managing and implementing aid in a way that focuses on the desired outcomes and uses information to improve decision making.<sup>51</sup>

The rights to sexual and reproductive health can and should be used to define the results to be achieved and the strategies needed to achieve them.<sup>52</sup>

## E. MUTUAL ACCOUNTABILITY

Partner countries and donors are required to enhance accountability and transparency in the use of development resources. For their part, donors must provide timely information on aid flows. This briefing paper has already emphasised that the principle of accountability is central to the rights to sexual and reproductive health. Not only does international human rights law require donors to enhance their accountability to rights holders including those in developing countries affected by their development cooperation, but it is also supported by a set of accountability procedures which may be helpful to hold donors – and their partner countries – to account, such as United Nations treaty bodies and Special Rapporteurs (see p15).



Photograph © Peter Bruyneel/UNFPA. Women waiting in line to register for a UNFPA-supported reproductive health camp in Safebagar, Nepal. Mobile medical teams set up camp for a few days at a time in remote towns and villages, focusing on family planning, prenatal exams and treatment for sexually transmitted infections. March 2007.

## V. RECOMMENDATIONS

What can and should States do to ensure that they comply with their human rights responsibility of international assistance and cooperation in international development assistance?

The following recommendations are for the most part addressed to donors.<sup>53</sup> This includes the OECD/DAC donor countries and also other donors, including developing country donors. However, we begin with several recommendations for developing countries

receiving development cooperation.

The recommendations are grounded in (a) States' sexual and reproductive health obligations under treaties including ICESCR, CRC and CEDAW; (b) commitments adopted by States at the International Conference on Population and Development, the Fourth World Conference on Women, the Millennium Summit, the World Summit and Third High Level Forum on Aid Effectiveness.

### A: RECOMMENDATIONS TO DEVELOPING COUNTRIES

1. Developing countries must ensure that their policies and programmes are designed and implemented consistently with their international and national commitments on the rights to sexual and reproductive health.
2. Where a developing country does not have sufficient national capacity or resources to meet its obligations in relation to the rights to sexual and reproductive health, it has a responsibility to seek assistance and cooperation from the international community, including financial and technical cooperation as required.
3. Developing countries should remind donors that their cooperation should be aligned with their (i.e. developing countries') international and domestic rights to sexual and reproductive health commitments.
4. Developing countries should recognise and respect that donors have ratified international human rights treaties which commit them to protecting the rights to sexual and reproductive health in their activities.
5. Many of the following recommendations addressed to donor countries are also relevant to South-South cooperation.

### B: RECOMMENDATIONS TO DONORS

1. Donors should recognise that they have a legally binding international human rights responsibility of international assistance and cooperation in sexual and reproductive health.
2. In view of commitments made at ICDP, FWCW and the Millennium and World Summits, as well as their human rights obligations, donors should make the realisation of sexual and reproductive health a key objective of development cooperation.
3. Donors must coherently respect, protect and fulfil the

Photograph © 2001 Virginia Lamprecht, Courtesy of Photoshare. Indigenous midwives in Guatemala listen during a training workshop designed to increase their knowledge and skills. The midwives serve communities where resources and access to quality maternal and newborn care is very limited. The training was sponsored by Midwives for Midwives, a US-based NGO based in Antigua, Guatemala.



rights to sexual and reproductive health in their policies, as well as other activities at the international, national and local levels, including in:

- positions taken during negotiations at international development conferences;
- positions in the context of Executive Board membership of organisations such as the World Bank and International Monetary Fund, and positions in the context of multilateral development arrangements;
- country strategies, programmes, projects and agreements with governmental, inter-governmental and non-governmental partners, including decisions on alignment and aid instruments;
- decisions on harmonisation with other donors.

4. Donors must ensure that the rights to sexual and reproductive health are taken account of in all stages of the programme cycle, including situation analysis, impact assessment, implementation, monitoring and review.

5. Donors must ensure that they promote non-discrimination and equality through particular attention to the rights to sexual and reproductive health of marginalised groups and communities, such as persons living in poverty; women; adolescents; persons affected by disabilities; persons living with HIV/AIDS; indigenous persons; commercial sex workers; elderly persons; and lesbian, gay, bisexual and transgender persons.

6. Donors should respect the right of developing countries to determine their own policies and laws to realise the rights to sexual and reproductive health, through a broad consultative process. Therefore, donors must not attach conditions to development assistance which would undermine a developing country's ability to guarantee the rights to sexual and reproductive health.

7. As well as supporting the realisation of the rights to sexual and reproductive health, donors must support programmes to enhance demand for these rights. Through supporting civil society, donors can help enhance awareness of rights and support marginalised groups to claim their rights and hold duty bearers to account.

8. Donors must uphold international development funding targets, including the commitment to contribute of 0.7 per cent GNP to ODA. Donors should ensure that they honour the commitment made at ICPD to increase the proportion of ODA for sexual and reproductive health.

9. Donors must ensure that international organisations, such as the UN Population Fund and the World Health Organisation, are resourced to support technical assistance and other implementation needs relating to the rights to sexual and reproductive health.

10. Donors must guarantee participation of affected populations and their representatives in the design, planning, implementation and review of their policies, programmes and projects on the rights to sexual and reproductive health.

11. Donors must support monitoring of, and accountability for sexual and reproductive health in developing countries. This may include support:

- for the demand side of human rights. An active and empowered civil society helps enhance monitoring and accountability;
- to enhance capacity for monitoring the rights to sexual and reproductive health, including through the improvement of data. Particular attention needs to be given to building capacity to disaggregate data in order to monitor equality and non-discrimination;
- to national actors and institutions which play an important role in monitoring and accountability, including civil society, national human rights institutions, parliaments

and the judiciary.

12. Donors should also support monitoring of, and enhance accountability for, their own international development policies. They must not only be accountable to their own voters, but also to populations in developing countries. With this in mind they should: make available information about their policies and programmes and other activities, including to affected communities in developing countries; integrate information on the rights to sexual and reproductive health into existing international development accountability processes including MDG country reports, health sector analyses and reviews and OECD/DAC peer review process reports; submit information on their development assistance activities, including relating to the rights to sexual and reproductive health, in their periodic reports to UN treaty bodies, including the Committee on Economic, Social and Cultural Rights; and identify and engage in accountability processes in partner countries, including parliamentary and civil society processes.

13. Donors should provide training on the rights to sexual and reproductive health to their staff, with a view to enhancing capacity to recognise their applicability, relevance and impacts.



Photograph © 2007 Julianna Kohler, Courtesy of Photoshare. A census employee in Nigeria fills in a census form as a woman responds to the questions.



# ENDNOTES

- 1 See, for example, OECD DAC, *The Development Dimension: Integrating Human Rights into Development: Donor Approaches, Experiences, Challenges*, 2008; Government of Sweden, *International Policy on Sexual and Reproductive Health and Rights*, 2006; UK Department For International Development (DFID), *How to Reduce Maternal Deaths: Rights and Responsibilities*, 2000.
- 2 See, for example, United Nations Development Programme (UNDP), *Human Development Report 2000: Human Rights and Human Development*, 2000.
- 3 For example, in the UN system, the UN Secretary-General's *Programme for Reform* (1997), and its second phase, *An Agenda for Further Change* (2001), called upon UN Agencies to make human rights a cross-cutting priority for the UN system, including in the field of development. In 2003, at an Inter-Agency Workshop held in Stamford, UN Agencies committed to integrating human rights into their national development cooperation programmes by adopting a "Common Understanding" of a *Human Rights-Based Approach to Development*.
- 4 For a recent review of developments see S. Skogly, *Beyond National Borders: States' Human Rights Obligations in International Cooperation*, Intersentia, 2005.
- 5 E. Kinney, B. Clark, "Provisions for Health and Health Care in the Constitutions of the Countries of the World," 37 *Cornell International Law Journal*, 2004.
- 6 Report to the Commission on Human Rights of the UN Special Rapporteur on the right to the highest attainable standard of health, Paul Hunt, UN doc E/CN.4/2004/49, para. 53
- 7 The Fourth World Conference on Women recognised the right of women to "have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence." See paragraph 96 of the Platform for Action of the Fourth World Conference on Women, 1995, A/CONF.177/20/Rev.1.
- 8 A/CONF.177/20, para. 96 (see note 7).
- 9 Committee on Economic, Social and Cultural Rights (CESCR), General Comment 14, 2000.
- 10 E/CN.4/2004/49, (see note 6).
- 11 Programme of Action of the International Conference on Population and Development, 1994, A/CONF.171/13, para. 7.2.
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- 13 WHO, UNICEF, UNFPA and the World Bank *Maternal Mortality in 2005: Estimates Developed by WHO, UNICEF, UNFPA and the World Bank*, 2007.
- 14 WHO, *Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2003: 5th Edition*, 2007.
- 15 *Ibid.*
- 16 *Ibid.*
- 17 UNAIDS, WHO, *AIDS Epidemic Update*, 2007.
- 18 A/CONF.171/13, (see note 11), Principle 8.
- 19 *Ibid.*
- 20 UN Millennium Project, *Public Choices, Private Decisions: Sexual and Reproductive Health and Millennium Development Goals*, 2006.
- 21 This target was first agreed in a General Assembly resolution in 1970. It has since been reaffirmed many times, including at the International Conference on Population and Development (1994), International Conference on Financing for Development (2002) and World Summit on Sustainable Development (2002).
- 22 OECD, *Final Aid Flows in 2007*, 2007.
- 23 See, for example, Box 4.
- 24 See Skogly (see note 4).
- 25 Report to the Human Rights Council of the Special Rapporteur on the right to the highest attainable standard of health on his missions to the World Bank and International Monetary Fund in Washington D.C. and Uganda, 5 March 2008, A/HRC/7/11/Add.2, chapter 2.
- 26 Concluding Observations of the Committee on the Elimination of Discrimination Against Women: Tanzania, 18 July 2008, UN doc. CEDAW/C/TZA/CO/6, para. 53.
- 27 Concluding Observations of the Committee on Economic, Social and Cultural Rights: France, May 2008, UN doc. E/C.12/FRA/CO/3, para. 32.

- 28 ICESCR, article 2.1.
- 29 See, for example, Box 5.
- 30 A/CONF.171/13, (see note 11), section 14.11.
- 31 There is a separate debate, which we do not elaborate here, on whether international organisations, such as the World Bank and IMF are themselves bound by international human rights law. For discussion on this issue, see M. Darrow, *Between Light and Shadow: The World Bank, the International Monetary Fund and International Human Rights Law*, Hart, 2006.
- 32 General Comment 14, (see note 9), para. 33.
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- 34 OECD DAC, *Action-Oriented Policy Paper on Human Rights and Development*, 2007, DCD/DAC(2007)15/FINAL.
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