UNITED NATIONS

E

Economic and Social Council

Distr.
GENERAL

E/CN.4/2006/48
3 March 2006

Original: ENGLISH

COMMISSION ON HUMAN RIGHTS
Sixty-second session
Item 10 of the provisional agenda

ECONOMIC, SOCIAL AND CULTURAL RIGHTS

Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt*

* The present report is submitted late so as to include as much up-to-date information as possible.

GE.06-11469 (E) 100306

Summary

The present report reflects on the activities of, and issues of particular interest to, the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health ("the right to health"), since his interim report to the General Assembly (A/60/348), undertaken pursuant to Commission resolution 2002/31.

The first section explains that the right to health can be understood as a right to an effective and integrated health system, encompassing health care and the underlying determinants of health, which is responsive to national and local priorities, and accessible to all.

Referring to the Millennium Development Goals and the World Summit of September 2005, the Special Rapporteur urges health ministers in low-income and middle-income countries to prepare health programmes that are bold enough to achieve the health Goals. Both North and South have a responsibility to take concerted measures to develop effective health systems in developing countries and economies in transition.

Underpinned by the right to health, an effective health system is a core social institution, no less than a court system or political system.

The second and most substantial section sets out a human rights-based approach to health indicators, as a way of measuring and monitoring the progressive realization of the right to health. By way of illustration, the human rights-based approach to health indicators is applied to the reproductive health strategy endorsed by the World Health Assembly in May 2004.

CONTENTS

Introduction

1. In resolution 2002/31, the Commission on Human Rights established, for a period of three years, the mandate of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (the "right to health"). At its sixty-first session, the Commission welcomed the annual report of the Special Rapporteur (E/CN.4/2005/51) and decided to extend the mandate of the Special Rapporteur for a further three years. Commission resolution 2005/24 articulates the mandate of the Special Rapporteur and requests him to submit an interim report on his activities to the General Assembly, as well as an annual report to the Commission. The present report is submitted in accordance with resolution 2005/24.

2. In addition to those activities already detailed in his interim report to the General Assembly (A/60/348), in September 2005 the Special Rapporteur travelled to India to deliver a keynote address at the annual meeting of the International Federation of Health and Human Rights Organisations entitled "Engendering health and human rights: maternal mortality as a violation of the right to health". In New Delhi, he delivered the valedictory address at the 10th International Women and Health Meeting, and attended meetings with officials from the Ministry of Health, the National Human Rights Commission of India, the regional office of the World Health Organization (WHO) and a number of non-governmental organizations (NGOs). Later in September, he attended a meeting in Montreal, Canada, on "Human rights and access to essential medicines: the way forward". The Montreal meeting, which gathered together government representatives, academics, international organizations and civil society groups, concluded with the adoption of an important statement on the human right to essential medicines.[1] The Special Rapporteur intends, in a forthcoming report, to look closely at the issues raised in the Montreal Statement on the Human Right to Essential Medicines. In October, he attended a meeting in Geneva which was organized by the Ethical Globalization Initiative on corporate responsibility, human rights and the pharmaceutical sector, in which he emphasized the importance of clarifying the responsibilities of States and the pharmaceutical sector in relation to essential medicines. While he was in New York to present his report to the General Assembly, the Special Rapporteur participated in a briefing session on his mandate, which was organized by the Office of the United Nations High Commissioner for Human Rights (OHCHR) and the International Service for Human Rights, in cooperation with the François-Xavier Bagnoud Center for Health and Human Rights of the Harvard School of Public Health. In November, the Special Rapporteur presented his work on right to the health indicators, and on prioritization and the right to health, at an informal consultation on health and human rights for WHO regional and country offices.

3. During 2005, the Ethical Globalization Initiative and the Special Rapporteur organized a high-level statement on the right to health. Over 30 former Heads of State and Government, as well as other prominent figures from across the world, have endorsed a "Leaders' Call to Action" on the right to health; for more information see paragraph 18 below. On 9 December 2005, the British Medical Association hosted the London launch of the Call to Action, which is now open to signature by all those committed to its content.[2] It is anticipated that in 2006 there will be other regional launches of the Call to Action. The Special Rapporteur wishes to thank Ethical Globalization Initiative very warmly for its invaluable work on this important project. He also wishes to thank all the signatories for their indispensable support.

I. THE RIGHT TO AN EFFECTIVE, INTEGRATED HEALTH SYSTEM ACCESSIBLE TO ALL

4. The right to health can be understood as a right to an effective and integrated health system, encompassing health care and the underlying determinants of health, which is responsive to national and local priorities, and accessible to all.

5. The health system must encompass both health care *and* the underlying determinants of health, such as adequate sanitation, safe drinking water and health education.

6. It must be accessible to all, not just the wealthy, but also those living in poverty; not just majority ethnic groups, but minorities and indigenous peoples, too; not just those living in urban areas, but also remote villagers; not just men, but also women. The health system has to be accessible to all disadvantaged individuals and communities.

7. Further, it must be responsive to both national *and* local priorities. Properly trained community health workers such as village health teams know their communities' health priorities. Also, inclusive participation can help to ensure that the health system is responsive to the particular health needs of women, children, adolescents, the elderly and other disadvantaged groups. Inclusive, informed and active community participation is a vital element of the right to health.

8. The health system must also be effective and integrated; it should be more than a bundle of loosely coordinated vertical interventions for different diseases.

9. A health system cannot simply be understood in terms of an individual's access to doctors, medicines, safe drinking water and adequate sanitation. The social and economic conditions of the population served by a health system have a dramatic impact upon the population's health. Known as the social determinants of health, these are the conditions, such as poverty and unemployment, which may make people ill in the first place. When the Special Rapporteur talks about the underlying determinants of health, he is not referring only to determinants such as safe drinking water and adequate sanitation, but also to the social determinants of health. These determinants are presently the focus of the WHO Commission on Social Determinants of Health that the Special Rapporteur briefly highlighted in his last report to the General Assembly.[3]

10. Fundamentally, this is what the right to health is all about: an effective, integrated, responsive health system, encompassing health care and the underlying determinants of health, accessible to all.

World Summit, September 2005

11. One of the most striking features of the Millennium Development Goals is the prominence they give to health: reducing child and maternal mortality; controlling HIV/AIDS, malaria and tuberculosis; providing access to sanitation and safe drinking water; and so on.[4] Moreover, the first Goal - to eradicate extreme poverty and hunger - cannot conceivably be

accomplished if the health Goals are not achieved. Societies burdened by large numbers of sick and dying individuals cannot escape from poverty. In short, the Goals cannot be achieved without effective health systems that are accessible to all.

12. It was for this reason that, at the World Summit in September 2005, 170 Heads of State and Government committed themselves:

> To improve health systems in developing countries and those with economies in transition with the aim of providing sufficient health workers, infrastructure, management system and supplies to achieve the health-related Millennium Development Goals by 2015.[5]

13. The Millennium Declaration and the 2005 World Summit Outcome are crystal clear that both developing *and* developed countries have a crucial role to play in establishing effective, inclusive health systems in North and South. Goal 8 - a global partnership for development - is vitally important.[6]

14. World leaders at the World Summit also agreed to:

> adopt, by 2006, and implement comprehensive national development strategies to achieve the internationally agreed development goals and objectives, including the Millennium Development Goals.[7]

15. In light of this commitment, the Special Rapporteur urges health ministers in low-income and middle-income countries to prepare national health programmes that are bold enough to achieve the health Goals. Carefully prepared and costed, national programmes should reflect what is actually needed to develop effective, integrated health systems accessible to all. The programmes should not reflect what donors say can be paid for - they should say what is really financially required to achieve the health Goals. These national health programmes should then form a central part of the development strategies mandated by the 2005 World Summit for adoption in 2006.

16. The Special Rapporteur is asking no more than that the world honour what it signed up to in 2000 and re-affirmed in September 2005. This is extremely important because, over the last two decades, many health systems have been seriously neglected. Many have suffered from chronic under-investment. Far from being improved and strengthened, many health systems have been undermined and weakened.

17. In summary, North and South must, as a matter of urgency, take concerted measures to establish effective, inclusive health systems accessible to all, in developing countries and economies in transition, in line with the United Nations Millennium Declaration, the global partnership for development reflected in Goal 8 of the Millennium Development Goals, and the 2005 World Summit.

The Leaders' Call to Action on the right to health

18. Today, as never before, prominent world figures and grass-roots organizations are urging respect for the right to health, as well as greater investment in health systems. As already discussed in paragraph 3, December 2005 saw the London launch of a Leaders' Call to Action on

the right to health. This Call to Action has been endorsed by Jimmy Carter and Bill Clinton (former Presidents of the United States of America), Fernando Henrique Cardoso (former President of Brazil), Hong Koo Lee (former Prime Minister of Korea), Mary Robinson (former President of Ireland and former High Commissioner for Human Rights), the Most Reverend Desmond Tutu (Anglican Archbishop Emeritus of Cape Town), His Royal Highness Prince El Hassan bin Talal of Jordan, Gro Harlem Brundtland (former Prime Minister of Norway and former Director-General of WHO), Wangari Maathai (2004 Nobel Peace Prize Laureate), Vaclav Havel (former President of Czechoslovakia and the Czech Republic) and many others.

19. In their Call to Action, the leaders "urge governments, as well as international organizations, civil society groups, private companies, communities and individuals, to fulfil their responsibilities in ensuring the realization of the fundamental human right to health for all" and they "call for systemic changes to build strong health systems".

20. Increasingly, it is being grasped that an effective health system is a core social institution, no less than a court system or a political system.[8] The right to a fair trial underpins a good court system. The right to vote underpins a democratic political system. And the right to health underpins the call for an effective health system accessible to all.

21. In the next two years, working in close collaboration with others, the Special Rapporteur hopes to have sufficient resources to identify and examine the key features of a health system that is reflective of the international human right to health.

II. A HUMAN RIGHTS-BASED APPROACH TO HEALTH INDICATORS

22. For many years, the human rights community - that is, those actively working for the promotion and protection of human rights - has considered the possible role of indicators in relation to human rights. According to international human rights law, economic, social and cultural rights are subject to progressive realization.[9] Those in the human rights community focusing on economic, social and cultural rights have given particular attention to indicators because they provide a way of monitoring progressive realization. Indeed, it is in this context that the Vienna Declaration and Programme of Action (1993) emphasizes the importance of indicators:

> To strengthen the enjoyment of economic, social and cultural rights, additional approaches should be examined, such as a system of indicators to measure progress in the realization of the rights set forth in the International Covenant on Economic, Social and Cultural Rights.[10]

23. Unfortunately, progress towards formulating such "a system of indictors" has been desperately slow. Numerous conceptual and other obstacles have been encountered. However, for a variety of reasons, not least the renewed attention that OHCHR has devoted to this issue, the rate of progress in the last couple of years has accelerated.

24. The Special Rapporteur has already devoted two chapters to indicators and the right to health in his reports.[11] In his first report to the General Assembly (2003), he examined this issue "with a view to developing gradually a practical, realistic and balanced approach".[12] When preparing his first report, the Special Rapporteur was thinking in terms of identifying a number

of right to health indicators. The following year he reported to the General Assembly on his "work in progress", concluding that it was more helpful to think in terms of a human rights-based approach to health indicators.[13]

In general terms, what is a human rights-based approach?

25. In recent years, it has become clear that a human rights-based approach to particular issues, such as development, poverty reduction and trade, brings certain valuable perspectives that otherwise tend to be neglected. Very briefly, in general terms a human rights-based approach requires that special attention be given to disadvantaged individuals and communities; it requires the active and informed participation of individuals and communities in policy decisions that affect them; and it requires effective, transparent and accessible monitoring and accountability mechanisms. The combined effect of these - and other features of a human rights-based approach - is to empower disadvantaged individuals and communities.

26. Accordingly, a human rights-based approach to health indicators not only monitors key health outcomes, but also some of the processes by which they are achieved. Crucially, many commonly used health indicators have an important role to play in a human rights-based approach to health indicators - provided a few reasonable conditions are met. For example, many existing health indicators may be used, provided they are disaggregated on various grounds, such as sex, race and ethnicity. Disaggregated indicators can reveal whether or not some disadvantaged individuals and communities are suffering from de facto discrimination. For the most part, existing health indicators are rarely designed to monitor issues like participation and accountability, although these are essential features of a human rights approach. Thus, a human rights-based approach to health indicators requires the addition of some new indicators to monitor these essential human rights features.

27. A human rights-based approach to health indicators is not a radical departure from existing indicator methodologies. Rather, it uses many commonly used health indicators, adapts them so far as necessary (e.g. by requiring disaggregation), and adds some new indicators to monitor issues (e.g. participation and accountability) that otherwise tend to be neglected. In short, a human rights-based approach to health indicators reinforces, enhances and supplements commonly used indicators.

28. This is the approach set out in this chapter and summarized in paragraphs 49-50. Later in this report, by way of illustration, the human rights-based approach to health indicators is applied to the reproductive health strategy endorsed by the World Health Assembly in May 2004.

There is no alternative to indicators, but their role should not be overstated

29. Although some members of the human rights community have hesitated to utilize indicators in their work, the Special Rapporteur wishes to emphasize that there is no alternative but to use indicators to measure and monitor the progressive realization of the right to the highest attainable standard of health. While a key question used to be "*Is* there a role for indicators in relation to the right to the highest attainable standard of health?", today the crucial question is

"*How* can indicators be most appropriately used to measure and monitor this fundamental human right?" The human rights-based approach to health indicators set out in this chapter provides an answer to this crucial question.

30. Additionally, the human rights-based approach to health indicators includes features, such as its emphasis on disaggregation, participation and accountability that, if integrated into health policies and programmes, are likely to enhance their effectiveness.

31. One of the central messages of this report is that indicators have an important role to play in measuring and monitoring the progressive realization of the right to health. Nonetheless, the importance of their role should not be exaggerated. No matter how sophisticated they might be, indicators will never give a complete picture of the enjoyment of the right to health in a specific jurisdiction. For the most part, they provide useful indications regarding the enjoyment of the right to health in a particular national context. Just as it is misguided to deny that indicators have an important role to play in relation to the right to health, it is also misplaced to expect too much from them.

32. This chapter builds upon, but does not repeat, the analysis and discussion in the Special Rapporteur's two previous General Assembly reports on indicators and the right to health.

33. The Special Rapporteur has repeatedly sought - and gratefully received - comments on his reports. Over the years, he has participated in numerous workshops and consultations on indicators and the right to health. He is extremely grateful to WHO, OHCHR, United Nations Children's Fund, United Nations Population Fund and many other experts acting in their personal capacities, who have unselfishly provided him with the benefit of their expertise.

The importance of indicators

34. As already observed, the international right to the highest attainable standard of health is subject to progressive realization. Inescapably, this means that what is expected of a State will vary over time. With a view to monitoring its progress, a State needs a device to measure this variable dimension of the right to health. The most appropriate device is the combined application of indicators and benchmarks. Thus, a State selects appropriate indicators that will help it monitor different dimensions of the right to health. These indicators might include, for example, maternal mortality ratios and child mortality rates. Most indicators will require disaggregation, such as on the grounds of sex, race, ethnicity, rural/urban and socio-economic status. Then the State sets appropriate national targets or benchmarks in relation to each disaggregated indicator.[14]

35. In this way, indicators and benchmarks fulfil two important functions that underpin much of the discussion in this chapter. *First*, they can help the State to monitor its progress over time, enabling the authorities to recognize when policy adjustments are required. *Second*, they can help to hold the State to account in relation to the discharge of its responsibilities arising from the right to health, although deteriorating indicators do not necessarily mean that the State is in breach of its international right to health obligations, an important point which is discussed further below. Of course, indicators also have other important roles. For example, by highlighting issues such as disaggregation, participation and accountability, indicators can enhance the effectiveness of policies and programmes.

36. Not only States, but also other actors are expected to integrate human rights into their policy-making. This was most recently affirmed by 170 Heads of State and Government at the 2005 World Summit:

> We resolve to integrate the promotion and protection of human rights into national policies and to support the further mainstreaming of human rights throughout the United Nations system, as well as closer cooperation between the Office of the United Nations High Commissioner for Human Rights and all relevant United Nations bodies.[15]

37. The integration or "mainstreaming" of human rights into national and international health policies is a major undertaking that demands a range of measures from a variety of actors. One such measure is the adoption of a human rights-based approach to health indicators. The Special Rapporteur hopes that specialized agencies and other United Nations bodies working on health issues will find this chapter useful as they strive to enhance their effectiveness and integrate human rights into their work.

38. In summary, in the context of the right to health, indicators can help:

(a) National public officials working on health issues;

(b) Legislative bodies as they monitor the performance of the executive;

(c) Courts, human rights institutions and other national bodies responsible for adjudicating whether or not the State is discharging its right to health duties;

(d) Specialized agencies and other United Nations bodies working in partnership with States on health issues;

(e) United Nations human rights treaty bodies and other international bodies responsible for monitoring whether or not States are discharging their right to health duties;

(f) Non-governmental organizations working on health issues.

An illustration: using the proportion of births attended by skilled health personnel as an indicator

39. By way of illustration, this section shows how one disaggregated indicator - the proportion of births attended by skilled health personnel - can be used in relation to the right to health. The section does not set out a human rights-based approach to health indicators. After showing the role of this indicator (and its benchmarks) in relation to the right to health, subsequent sections introduce a human rights-based approach to health indicators.

40. Sexual and reproductive health are integral elements of the right to health.[16] So States need a way of measuring whether or not they are progressively realizing sexual and reproductive health. There are many relevant indicators, including the proportion of births attended by skilled health personnel. A State may select this indicator as one of those it uses to measure its progressive realization of sexual and reproductive health rights.

41. The national data may show that the proportion of births attended by skilled health personnel is 60 per cent. When disaggregated on the basis of rural/urban, data may reveal that the proportion is 70 per cent in urban centres, but only 50 per cent in rural areas. When further disaggregated on the basis of ethnicity, data may also show that coverage in the rural areas is uneven: the dominant ethnic group enjoys a coverage of 70 per cent but the minority ethnic group only 40 per cent. This highlights the crucial importance of disaggregation as a means of identifying de facto discrimination. When disaggregated, the indicator confirms that women members of the ethnic minority in rural areas are especially disadvantaged and require particular attention.

42. Consistent with the progressive realization of the right to health, the State may decide to aim for a uniform national coverage of 70 per cent, in both the urban and rural areas and for all ethnic groups, in five years' time. Thus, the indicator is the proportion of births attended by skilled health personnel and the benchmark or target is 70 per cent. The State will formulate and implement policies and programmes that are designed to reach the benchmark of 70 per cent in five years. The data show that the policies and programmes will have to be specially designed to reach the minority ethnic group living in the rural areas.

43. Annual progress towards the benchmark or target should be monitored, in light of which annual policy adjustments might be required. At the end of the five-year period, a monitoring and accountability mechanism will ascertain whether or not the 70 per cent benchmark has been reached in urban and rural areas and for all ethnic groups. If it has, the State will set a more ambitious benchmark for the next five-year period, consistent with its obligation to realize progressively the right to health. But if the 70 per cent benchmark for all has not been reached then the reasons should be identified and remedial action taken.

44. Importantly, a failure to reach a benchmark does not necessarily mean that the State is in breach of its international right to health obligations. The State might have fallen short of its benchmark for reasons beyond its control. However, if the monitoring and accountability mechanism reveals that the 70 per cent benchmark was not reached because of, for example, corruption in the health sector, then it will probably follow that the State has failed to comply with its international right to health obligations.

45. International assistance and cooperation is an important element of the right to health. Donors have a responsibility to provide financial and other support for the policies and programmes of developing countries regarding, inter alia, sexual and reproductive health. Moreover, donors should be held to account in relation to the discharge of their responsibility. So, in relation to the example set out in the preceding paragraphs, indicators are needed to measure what donors have done to help the State deliver sound sexual and reproductive health policies. Also, a monitoring and accountability mechanism is needed to address the question: has the donor community done all it reasonably can to help the State deliver sound sexual and reproductive health policies, enabling it to reach its benchmark of 70 per cent?

46. Of course, these issues - indicators and accountability mechanisms for the donor community - raise challenging questions. Nonetheless, indicators and accountability mechanisms that focus exclusively on the responsibilities of developing countries and do not also encompass the responsibilities of the donor community are unfair, flawed and lack credibility.

47. In summary, a disaggregated indicator, such as the proportion of births attended by skilled health personnel, when used with benchmarks, can help a State identify which policies are working and which are not. Moreover, it can also help to hold a State to account in relation to its responsibilities arising from the right to health. Of course, one indicator, even when disaggregated, cannot possibly capture all the dimensions that are important from the human rights perspective. For this, other indicators are needed; these are discussed below. Nonetheless, this illustration shows how a disaggregated indicator, when used with a benchmark, can provide some useful information about the progressive realization of the right to the highest attainable standard of health.

A human rights-based approach to health indicators

48. Health professionals and policy makers constantly use a very large number of health indicators, such as the proportion of births attended by skilled health personnel, the maternal mortality ratio, and the HIV prevalence rate. Is it possible to simply appropriate these health indicators and call them "human rights indicators" or "right to health indicators"? Or do indicators that are to be used for monitoring human rights and the right to health require some special features? If so, what are these special attributes?

49. As the Special Rapporteur concludes in his report to the General Assembly (2004), health indicators may be used to monitor aspects of the progressive realization of the right to health provided:

(a) *They correspond, with some precision, to a right to health norm*. There has to be a reasonably exact correspondence - or link - between the indicator and a right to health norm or standard. In the case of the proportion of births attended by skilled health personnel, for example, there is a reasonably precise correspondence with several human rights norms, including the rights to health and life of mother and child e.g. article 24, paragraph 2 (a) of the Convention on the Rights of the Child;

(b) *They are disaggregated by at least sex, race, ethnicity, rural/urban and socio-economic status*. Human rights have a particular preoccupation with disadvantaged individuals and groups. This preoccupation is reflected in numerous provisions of international human rights law, not least those enshrining the principles of non-discrimination and equality. While a health indicator might or might not be disaggregated, from the human rights perspective it is imperative that all relevant indicators are disaggregated. A more difficult issue is: on which grounds should the indicators be disaggregated? From the human rights perspective, the goal is to disaggregate in relation to as many of the internationally prohibited grounds of discrimination as possible.[17] However, the collection of disaggregated data remains an enormous challenge for many States. Because of limited capacity, reliable disaggregated data are often unavailable. There is another complication: vulnerability and discrimination are contextual. While a group might be especially vulnerable in one context, it might not be in another. Thus, in a particular national context, there might be a case for giving priority to the collection of some disaggregated data rather than others. Further, some health issues will demand disaggregation on particular grounds; for example, in the context of sexual and reproductive health, disaggregation on the grounds of age is crucial because of the importance of *adolescent* sexual and reproductive health.

While keeping these observations in mind, the Special Rapporteur suggests that relevant indicators should usually be disaggregated, as a minimum, by sex, race, ethnicity, rural/urban and socio-economic status. However, these grounds of disaggregation will have to be reviewed in the light of (i) capacity (ii) context (iii) the relevant health issue in question;

(c) *They are supplemented by additional indicators that monitor five essential and interrelated features of the right to health*:[18]

(i) *A national strategy and plan of action that includes the right to health.* Because the right to health demands that a State has a strategy and plan of action that encompasses the right to health, including universal access, indicators are needed to measure this essential feature;[19]

(ii) *The participation of individuals and groups, especially the most vulnerable and disadvantaged, in relation to the formulation of health policies and programmes*. Because participation is an essential feature of the right to health, indicators are needed to measure the degree to which health policies and programmes, including the quality control of services, are participatory;[20]

(iii) *Access to health* information, *as well as confidentiality of personal health data.* Because access to health information is an essential feature of the right to health, indicators are needed to measure the degree to which health information is available and accessible to all. Health information enables people to, inter alia, promote their own health and claim quality services from the State and others. Clearly, other essential features of the right to health, such as meaningful participation, depend upon the accessibility of reliable information on health issues. Additionally, because of the requirements of confidentiality regarding personal health data, indicators are also needed to measure the degree to which such confidentiality is respected;

(iv) *International assistance and cooperation of donors in relation to the enjoyment of the right to health in developing countries*. The right to health places an obligation on developed States to take measures that help developing countries realize the right to health.[21] Thus, indicators are needed to measure the degree to which donors are fulfilling this responsibility;

(v) *Accessible and effective monitoring and accountability mechanisms.* Because the right to health requires that all those holding right to health duties are held to account for their conduct, indicators are needed to measure the degree to which accessible and effective monitoring and accountability mechanisms are available.[22]

50. It is not possible for one indicator to possess all these features. Thus, rather than searching for individual right to health indicators, it is more helpful to think in terms of a human rights-based approach to health indicators. In other words, while it is impossible for one indicator to possess all the features signalled in the preceding paragraph, it is possible to identify *a range* of indicators that *together* have these features. In combination, various indicators can help a State monitor the progressive realization of the right to health. In short, a combination of appropriate indicators may together constitute a human rights-based approach to health indicators.

The problem of terminology

51. The literature reveals a multitude of health indicators. But there is a more fundamental difficulty. There is no commonly agreed and consistent way of categorizing and labelling different types of health indicators. For example, the following categories and labels for indicators can be found: performance, statistical, variable, process, conduct, outcome, output, result, achievement, structural, screening, qualitative, quantitative, core and rated. The same indicator may appear in several categories. This multiplicity of overlapping labels is very confusing. Crucially, it confines meaningful discussion to a small elite of health experts. The lack of a common approach to the classification of health indicators represents a challenge to those who wish to introduce a simple, consistent and rational system for human rights-based health indicators.

52. If progress is to be made, there must be a degree of terminological clarity and consistency. In 2003, the Special Rapporteur suggested that special attention should be devoted to the following three categories of indicators: *structural, process and outcome indicators.* While there is no unanimity in the health literature, these categories and labels are widely understood. They are also relatively straightforward. They are used by some departments in WHO, such as the Department of Essential Drugs and Medicines Policy. Since 2003, OHCHR and others have also begun to use these three terms. Eibe Riedel, Vice-Chair of the Committee on Economic, Social and Cultural Rights, has adopted these terms and categories. In the Special Rapporteur's view, these labels will serve as well as (if not better than) others. Since consistent terminology will greatly assist States, intergovernmental organizations, civil society groups and others, he recommends that when formulating human rights indicators in relation to health they be categorized as structural, process and outcome indicators.

53. In the following paragraphs, the Special Rapporteur provides definitions of structural, process and outcome indicators. He accepts that it is not always easy to draw a neat line between these categories. No doubt the definitions will need further tightening. Nonetheless, he suggests that what follows will serve as working definitions.

54. *Structural indicators* address whether or not key structures and mechanisms that are necessary for, or conducive to, the realization of the right to health, are in place. They are often (but not always) framed as a question generating a yes/no answer. For example, they may address: the ratification of international treaties that include the right to health; the adoption of national laws and policies that expressly promote and protect the right to health; or the existence of basic institutional mechanisms that facilitate the realization of the right to health, including regulatory agencies.

55. *Process indicators* measure programmes, activities and interventions. They measure, as it were, State effort. For example, the following are process indicators: the proportion of births attended by skilled health personnel; the number of facilities per 500,000 population providing basic obstetric care; the percentage of pregnant women counselled and tested for HIV; the percentage of people provided with health information on maternal and newborn care, family planning services and sexually transmitted infections; the number of training programmes and public campaigns on sexual and reproductive health rights organized by a national human rights institution in the last five years. Such process indicators can help to predict health outcomes.

56. *Outcome indicators* measure the impact of programmes, activities and interventions on health status and related issues. Outcome indicators include maternal mortality, child mortality, HIV prevalence rates, and the percentage of women who know about contraceptive methods.

57. While structural indicators will often be framed as a question generating a yes/no answer, process and outcome indicators will often be used in conjunction with benchmarks or targets to measure change over time. However, there is no conceptual reason why all three types of indicators cannot *either* generate a yes/no answer *or* be used with benchmarks to measure change over time.

58. The Special Rapporteur is especially interested in those indicators that can be used by States and others to measure the progressive realization of the right to health. Thus, he is especially interested in indicators that, when used with benchmarks, measure change over time. Nonetheless, indicators that generate only a yes/no answer may also provide useful information about a State's commitment to the implementation of the right to health. Such indicators have the added advantage that the necessary information can usually be rapidly collected by way of a cost-effective questionnaire.

59. Sometimes, plausible links may be established between a structural indicator (Is there a strategy and plan of action to reduce maternal deaths?), a process indicator (the proportion of births attended by skilled health personnel), and an outcome indicator (maternal mortality). However, outcome indicators often reflect many complex interrelated factors. It will often be difficult to establish firm causal links between structural, process and outcome indicators - that is, between a policy, an intervention, and a health status outcome.

60. As the Special Rapporteur has emphasized elsewhere, it is misguided to expect too much from indicators. For example, a structural indicator is: does the State constitutionalize the right to health? If the answer is "yes", this is a useful piece of information. But if a constitutionalized right to health neither generates any successful litigation nor is taken into account in national policy-making, this particular constitutional provision is of very restricted value. With this in mind, the Special Rapporteur suggests that the answer to any indicator may be supplemented by a brief note or remark (a "narrative"). For example, in the above example the answer might be: "Yes - but the right has yet to be integrated into health policy-making." Of course, a brief note of this sort does not dispel the manifold limitations of indicators. Nonetheless, it can help to provide a fuller picture of the right to health in the relevant State than a bare yes/no or numerical answer.

61. Additional specific examples of structural indicators, process indicators and outcome indicators are found in the annex.[23]

III. CONCLUSIONS AND RECOMMENDATIONS

The right to an effective, integrated health system accessible to all

62. **The right to health can be understood as a right to an effective and integrated health system, encompassing health care and the underlying determinants of health, which is responsive to national and local priorities, and accessible to all.**

63. **One of the most striking features of the Millennium Development Goals is the prominence they give to health. The Goals cannot be achieved without effective health systems that are accessible to all. The 2005 World Summit confirmed that developing and developed countries have a crucial role in establishing effective, inclusive health systems in both North and South. During the World Summit, leaders agreed to adopt, in 2006, "comprehensive national development strategies" to achieve, inter alia, the Millennium Development Goals.**

64. **The Special Rapporteur urges health ministers in low-income and middle-income countries to prepare national health programmes that are bold enough to achieve the health Goals. Reflecting what is actually financially required to develop effective health systems accessible to all, these health programmes should form a central part of the "comprehensive national development strategies" mandated by the World Summit. North and South must, as a matter of urgency, take concerted measures to develop effective health systems in developing countries and economies in transition.**

A human rights-based approach to health indicators

65. **Many *existing* health indicators, already commonly used by health ministries and others, have an important potential role to play in measuring and monitoring the progressive realization of the right to the highest attainable standard of health.**

66. **Health indicators may be used to monitor aspects of the progressive realization of the right to the highest attainable standard of health provided:**

(a) They correspond, with some precision, to a right to health norm;

(b) They are disaggregated by at least sex, race, ethnicity, rural/urban and socio-economic status; the grounds of disaggregation should be reviewed in the light of capacity, context and the relevant health issue in question;

(c) They are supplemented by additional indicators that monitor five essential and interrelated features of the right to health:

(i) A national strategy and plan of action that includes the right to health;

(ii) The participation of individuals and groups, especially the most vulnerable and disadvantaged, in relation to the formulation of health policies and programmes;

(iii) Access to health information, as well as confidentiality of personal health data;

(iv) International assistance and cooperation of donors in relation to the enjoyment of the right to health in developing countries;

(v) Accessible and effective monitoring and accountability mechanisms.

67. **While it is impossible for one indicator to possess all the features signalled in the preceding paragraph, it is possible to identify *a range* of indicators that *together* have these features. Thus, rather than searching for individual right to health indicators, it is more helpful to think in terms of a *human rights-based approach to health indicators*.**

68. **The human rights-based approach to health indicators is not only a tool to help States, and others, measure and monitor the progressive realization of the right to health. Additionally, the approach includes features, such as disaggregation, participation and accountability that, if integrated into health policies and programmes, are likely to enhance their effectiveness.**

69. **So far as necessary, States should adapt their existing indicators (e.g. by introducing appropriate disaggregation), and identify new indicators (e.g. on participation and accountability), so their practice conforms to the human rights-based approach to health indicators outlined in this chapter.**

70. **With a view to assisting their partner States, specialized agencies and other United Nations bodies should also adapt their existing indicators, so far as necessary, and identify new indicators, in conformity with the human rights-based approach to health indicators outlined in this chapter.**

71. **In their reporting guidelines, "constructive dialogue", concluding observations and other documents, human rights treaty bodies are urged to adopt - and to encourage States parties to adopt - the human rights-based approach to health indicators outlined in this chapter.**

72. **OHCHR should continue to play its crucial pivotal role in the development of a human rights-based approach to indicators generally, and a human rights-based approach to health indicators specifically.**

73. **Non-governmental organizations should adopt the human rights-based approach to health indicators outlined in this chapter.**

74. **While this chapter sets out a methodology for a human rights-based approach to health indicators, further work is needed to make the methodology fully operational. In particular, further attention should be given to:**

- **Developing indicators that measure the five essential features of the right to health: a national strategy and plan of action; participation; health information, as well as confidentiality of personal health data; international assistance and cooperation; and monitoring and accountability;[24]**

- **Exploring how the human rights-based approach to health indicators might best reflect the right to health analytical framework of accessibility, availability, acceptability and quality.[25]**

75. **Throughout his work, including when on country mission, the Special Rapporteur will promote the human rights-based approach to health indicators outlined in this chapter. He invites comments on the approach. In the light of experience and comments received, he will continue to refine the human rights-based approach to health indicators.**

76. **The existing multiplicity of terms for different categories of health indicators is extremely confusing and a major obstacle to a consistent, coherent and rational approach to health policy. With a view to developing a common approach which is comprehensible to the non-specialist, the Special Rapporteur strongly recommends that the human rights-based approach to health indicators adopts the following basic terms and categories: *structural indicators, process indicators,* and *outcome indicators*. He accepts that the definitions of structural, process and outcome will need revising and refining in the light of experience. He also accepts that there might be exceptional cases where additional categories of indicators are needed. Nonetheless, he strongly recommends that the existing obscurantist proliferation of multiple overlapping terms is replaced, as a general rule, by structural, process and outcome indicators.**

77. **Finally, for well over a decade there have been interminable discussions about human rights and indicators. It is imperative that these discussions steadily move beyond the theoretical to the practical. Thanks to the work of innumerable health and human rights experts over many years, the essential features of a human rights-based approach to health indicators are becoming increasingly clear. Of course, this approach will develop and mature further. Nonetheless, the Special Rapporteur strongly recommends that all parties begin to adopt the human rights-based approach to health indicators outlined in this chapter, as a way of measuring and monitoring the progressive realization of the right to the highest attainable standard of health, and enhancing the effectiveness of health policies and programmes.**

78. **By way of illustration, the annex to this report provides a table that applies a human rights-based approach to indicators, as set out in this chapter, to the reproductive health strategy endorsed by the World Health Assembly in May 2004.**

Notes

[1] The statement is available at http://www.accessmeds.org/Statement.html.

[2] The Leaders' Call to Action can be accessed, and signed, at http://www.realizingrights.org.

[3] A/60/348, paras. 5-7.

[4] The Special Rapporteur's report of 2004 to the General Assembly explained how the right to health reinforces the Goals and could contribute to their achievement (A/59/422).

[5] See 2005 World Summit Outcome (A/RES/60/1, para. 57 (a), also 68 (i)). Also see the United Nations Millennium Project's "Investing in Development: A Practical Plan to Achieve the Millennium Development Goals" and the Project's Task Force report "Who's Got the Power? Transforming Health Systems for Women and Children".

[6] See the Special Rapporteur's report of 2004 to the General Assembly, especially paragraphs 32-35 and 42-46.

[7] Paragraph 22 (a). Also see paragraph 22 (c).

[8] See L. Freedman, *Achieving the MDGs: Health Systems as Core Social Institutions*, DEVELOPMENT 2005, pp. 1-6.

[9] See, e.g. International Covenant on Economic, Social and Cultural Rights (ICESCR), article 2, paragraph 1.

[10] Paragraph 98.

[11] See A/58/427; A/59/422.

[12] A/58/427, para. 6.

[13] A/59/422, paras. 81 and 83. This approach is informed by the principle confirmed in article 5 of the Vienna Declaration and Programme of Action: "All human rights are universal, indivisible and interdependent and interrelated."

[14] Progressive realization is also an implicit feature of the Millennium Development Goals. Indicators and benchmarks are needed to monitor progress towards the achievement of the Goals.

[15] 2005 World Summit Outcome, A/RES/60/1, para. 126.

[16] As confirmed by the Commission on Human Rights in resolution 2003/28, preamble and paragraph 6.

[17] According to the Committee on Economic, Social and Cultural Rights (CESCR), the prohibited grounds include "race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status". General comment No. 14, paragraph 18.

[18] The following paragraphs (i)-(v) are intended only to signal the five essential features. While work has been done elsewhere to explore each feature, more is needed.

[19] CESCR, general comment No. 14, paragraph 43 (f).

[20] See, e.g., E/CN.4/2004/49/Add.1, paragraph 27; E/CN.4/2005/51, paragraphs 59-61.

[21] See, e.g., A/59/422, paragraphs 32-35.

[22] Ibid., paragraphs 36-46.

[23] Also see the Special Rapporteur's General Assembly reports of 2003 and 2004 (A/58/427 and A/59/422).

[24] The starting point for further developing such indicators is to clarify the scope - or normative content - of each of the five essential features.

[25] This framework derives from CESCR's general comment No. 14 and has been elaborated upon and applied by the Special Rapporteur in several of his reports e.g. E/CN.4/2005/51 paragraph 46.

Annex

A HUMAN RIGHTS-BASED APPROACH TO INDICATORS IN RELATION TO THE REPRODUCTIVE HEALTH STRATEGY ENDORSED BY THE WORLD HEALTH ASSEMBLY IN MAY 2004

1. The following table should be read with the chapter "A human rights-based approach to health indicators" in the report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (E/CN.4/2006/48, 23 January 2005). The table applies the human rights-based approach to indicators, as set out in that chapter, to the reproductive health strategy developed by the World Health Organization (WHO) and endorsed by the World Health Assembly in May 2004.

2. WHO's reproductive health strategy identifies five priority or "core" aspects of reproductive and sexual health. Each is separately addressed in the following table. Human rights, including the right to the highest attainable standard of health, are a "guiding principle" of WHO's strategy.

3. If the Special Rapporteur were to prepare a reproductive health strategy, it would have some features that are not found in WHO's strategy (generally, see his report E/CN.4/2004/49, 16 February 2004). Nonetheless, for present purposes, he is taking WHO's strategy and endeavouring to provide a preliminary response to the question: "Which indicators would be needed if a human rights-based approach to indicators were to be applied to WHO's reproductive health strategy?"

4. As explained in the chapter to which reference has already been made, a health indicator may be used to monitor aspects of the progressive realization of the right to the highest attainable standard of health on certain conditions, one being that the indicator corresponds, with some precision, to a right to health norm. All the health indicators in the following table correspond with sufficient precision to one or more right to health norms, including the following: article 24, paragraph 2 (a), (d) and (f) of the Convention on the Rights of the Child, article 12, paragraph 2 (a), (c) and (d) of the International Covenant on Economic, Social and Cultural Rights, article 5 (e) (iv) of the International Convention on the Elimination of All Forms of Racial Discrimination, and article 12 of the Convention on the Elimination of All Forms of Discrimination Against Women.

5. It is important that a human rights-based approach to indicators does not generate an excessive number of indicators. It is also crucial that the indicators are relatively straightforward and within the capacity of most States to collect. There is no point identifying a large number of indicators many of which lie beyond the capacity of most States. Thus, the indicators should either be commonly available, or available without considerable additional expense. Each indicator may be supplemented by a very brief explanatory note or comment.

6. The indicators in the following table are neither exhaustive nor definitive. A State might wish to add to, or subtract from, the table. Nonetheless, the Special Rapporteur hopes that the following indicators will assist those States, and others, who are committed to monitoring the realization of the right to health.

7. The Special Rapporteur will gratefully receive comments on how to strengthen the human rights-based approach to health indicators as set out in the accompanying chapter and applied in the following table. He is extremely grateful to all those - especially the WHO Department of Reproductive Health and Research - who provided indispensable advice regarding this annex. While preparing the table, the Special Rapporteur has drawn from - and warmly recommends - *Using Human Rights for Maternal and Neonatal Health: A tool for strengthening laws, policies and standards of care*, co-published by the Department of Reproductive Health and Research, World Health Organization, and the Program on International Health and Human Rights, François-Xavier Bagnoud Center for Health and Human Rights, Harvard School of Public Health (2005). He will especially welcome suggestions on how to strengthen indicators regarding the five essential features of the right to health identified in paragraph 49 (c) of the accompanying chapter.

Table

RIGHT TO HEALTH INDICATORS

	Structural Indicators	Process Indicators	Outcome Indicators
Basic Legal Context	S1. Has the State ratified the following international treaties recognizing the right to health: (a) ICESCR? (*yes/no*) (b) CRC? (*yes/no*) (c) CEDAW? (*yes/no*) (d) ICERD? (*yes/no*) S2. Does the State's constitution include the right to health? (*yes/no*) S3. Does State legislation expressly recognize the right to health, including sexual and reproductive health rights? (*yes/no*)	P1. Number of reports the State has submitted to the treaty-based bodies monitoring the following treaties: (a) ICESCR (b) CRC (c) CEDAW (d) ICERD P2. Number of national judicial decisions that considered sexual and reproductive health rights in the last five years	
Basic Financial Context	S4. Does the State have a law to ensure *universal access* to sexual and reproductive health care? (*yes/no*)	P3. Percentage of government budget allocated to health P4. Percentage of government *health budget* allocated to sexual and reproductive health	

Table (*continued*)

	Structural Indicators	Process Indicators	Outcome Indicators
Basic Financial Context (*continued*)		P5. Percentage of government *health expenditure* directed to sexual and reproductive health P6. Per capita *expenditure* on sexual and reproductive health	
National Strategy and Plan of Action	S5. Does the State have a national sexual and reproductive health strategy and plan of action? (*yes/no*) S6. Does the strategy/plan of action provide for *universal access* to sexual and reproductive health care? (*yes/no*) S7. Does the strategy/plan of action: (a) expressly recognize sexual and reproductive health rights? (*yes/no*) (b) clearly identify: (i) objectives? (*yes/no*) (ii) time frames? (*yes/no*) (iii) duty holders and their responsibilities? (*yes/no*)	P7. Does the State collect data adequate to evaluate performance under the strategy/plan of action, particularly in relation to vulnerable groups? (*yes/no*)	

Table (*continued*)

	Structural Indicators	Process Indicators	Outcome Indicators
National Strategy and Plan of Action (*continued*)	(iv) reporting procedures? (*yes/no*) (c) specifically include measures to benefit vulnerable groups? (*yes/no*)		
Participation	S8. Does the strategy/plan of action establish a procedure for the State to regularly consult with a wide range of representatives of the following groups when formulating, implementing and monitoring sexual and reproductive health policy: (a) non-governmental organizations? (*yes/no*) (b) health professional organizations? (*yes/no*) (c) local governments? (*yes/no*) (d) community leaders? (*yes/no*) (e) vulnerable groups? (*yes/no*) (f) private sector? (*yes/no*)	P8. Does the State regularly consult with a wide range of representatives of the following groups when formulating, implementing and monitoring sexual and reproductive health policy: (a) non-governmental organizations? (*yes/no*) (b) health professional organizations? (*yes/no*) (c) local governments? (*yes/no*) (d) community leaders? (*yes/no*) (e) vulnerable groups? (*yes/no*) (f) private sector? (*yes/no*)	

Table (*continued*)

	Structural Indicators	Process Indicators	Outcome Indicators
Information	S9. Does State law protect the right to seek, receive and impart information on sexual and reproductive health? (*yes/no*) S10. Does the State have a strategy/plan of action to disseminate information on sexual and reproductive health to the public? (*yes/no*) S11. Does the strategy/plan of action establish a procedure for the State to regularly disseminate information on its sexual and reproductive health policies to: (a) non-governmental organizations? (*yes/no*) (b) health professional organizations? (*yes/no*) (c) local governments? (*yes/no*) (d) media accessible in rural areas? (*yes/no*)	P9. Percentage of people exposed to information on: (a) maternal and newborn care (b) family planning services (c) abortion/post-abortion care (d) prevention and treatment of sexually transmitted infections (e) prevention and treatment of cervical cancer and other gynecological morbidities P10. Does the State regularly disseminate information on its sexual and reproductive health policies to: (a) non-governmental organizations? (*yes/no*) (b) health professional organizations? (*yes/no*) (c) local governments? (*yes/no*) (d) media accessible in rural areas? (*yes/no*)	O1. Percentage of women who know about contraceptive methods (traditional or modern) - *Disaggregated by at least age, race, ethnicity, socio-economic status and rural/urban* O2. Percentage of people ages 15-24 who know how to prevent HIV infection - *Disaggregated by at least sex, race, ethnicity, socio-economic status and rural/urban* O3. Percentage of people who believe that personal information disclosed to health professionals remains confidential - *Disaggregated by at least age, sex, race, ethnicity, socio-economic status and rural/urban*

Table (*continued*)

	Structural Indicators	Process Indicators	Outcome Indicators
Information (*continued*)	S12. Does State law protect the confidentiality of personal health information? S13. Does State law require informed consent of the individual to accept or refuse treatment?	P11. Percentage of health facilities with protocols on the confidentiality of personal health information P12. Percentage of health professionals who have received training on: (a) the confidentiality of personal health information (b) the requirement of informed consent to accept/refuse treatment	
National Human Rights Institutions	S14. Does the State have a national human rights institution with a mandate that includes sexual and reproductive health rights? (*yes/no*)	P13. Number of the following activities the institution has run on sexual and reproductive health rights in the last five years: (a) training programmes (b) public campaigns P14. Number of complaints concerning sexual and reproductive health rights the institution has considered in the last five years	

Table (*continued*)

	Structural Indicators	Process Indicators	Outcome Indicators
International Assistance and Cooperation (these indicators are for donors)	S15. Is the State's overseas development assistance policy rights-based? (*yes/no*) S16. Does the State's overseas development policy include specific provisions to promote and protect sexual and reproductive health rights? (*yes/no*)	P15. Percentage of overseas development assistance directed to sexual and reproductive health P16. Do the State's reports to the human rights treaty-based bodies include a detailed account of the international assistance and cooperation it is providing, including in relation to sexual and reproductive health? (*yes/no/not applicable*) P17. Does the State provide a country-specific annual report of its international assistance and cooperation, including in relation to sexual and reproductive health: (a) to the government of the recipient country? (*yes/no*) (b) to the public of the recipient country? (*yes/no*)	

Table (*continued*)

	Structural Indicators	Process Indicators	Outcome Indicators
Priority Aspect 1: Improving antenatal, delivery, post-partum and newborn care	S17. Does the State have a strategy and plan of action: (a) to reduce maternal deaths and their causes? (*yes/no*) (b) to ensure a universal system of referral for obstetric emergencies? (*yes/no*) (c) for access to care, treatment and support for HIV-infected pregnant women? (*yes/no*)	P18. Number of facilities per 500,000 population providing: (a) basic obstetric care (b) comprehensive obstetric care P19. Percentage of births attended by skilled health personnel* - *Disaggregated by at least age, race, ethnicity, socio-economic status and rural/urban* P20. Percentage of pregnant women counselled and tested for HIV/AIDS - *Disaggregated by at least age, race, ethnicity, socio-economic status and rural/urban* P21. Percentage of pregnant women screened for syphilis - *Disaggregated by at least age, race, ethnicity, socio-economic status and rural/urban*	O4. Percentage of women with *access* to antenatal, delivery, post-partum and newborn care - *Disaggregated by at least age, race, ethnicity, socio-economic status and rural/urban* O5. Maternal mortality ratio (number of maternal deaths per 100,000 live births)* - *Disaggregated by at least age, race, ethnicity, socio-economic status and rural/urban* O6. HIV prevalence among pregnant women (15-24 years old)* - *Disaggregated by at least race, ethnicity, socio-economic status and rural/urban* O7. Syphilis prevalence among pregnant women (15-24 years old) - *Disaggregated by at least race, ethnicity, socio-economic status and rural/urban*

Table (*continued*)

	Structural Indicators	Process Indicators	Outcome Indicators
Priority Aspect 1: Improving antenatal, delivery, post-partum and newborn care (*continued*)			O8. Neonatal mortality rate (number of infant deaths within one month of birth per 1,000 live births) - *Disaggregated by at least age, race, ethnicity, socio-economic status and rural/urban*
Priority Aspect 2: Delivering High Quality Services for Family Planning	S18. Does State law: (a) require third-party authorization for women to receive family planning services? (*yes/no*) (b) specify that only married women may receive family planning services? (*yes/no*) S19. Does the national essential medicines list include: (a) condoms? (*yes/no*) (b) hormonal contraceptives, including emergency contraceptives? (*yes/no*)	P22. Percentage of primary health-care facilities providing comprehensive family planning services (full range of contraceptive information, counselling and supplies for at least six methods, including male and female, temporary, permanent and emergency contraception)	O9. Percentage of people with *access* to comprehensive family planning services - *Disaggregated by at least age, sex, race, ethnicity, socio-economic status and rural/urban* O10. Percentage of women at risk of pregnancy who are using (or whose partner is using) a contraceptive method (all methods)* - *Disaggregated by at least age, race, ethnicity, socio-economic status and rural/urban*

Table (*continued*)

	Structural Indicators	Process Indicators	Outcome Indicators
Priority Aspect 2: Delivering High Quality Services for Family Planning (*continued*)			O11. Percentage of women at risk of pregnancy who desire to avoid pregnancy, but who are not using (and whose partner is not using) a contraceptive method - *Disaggregated by at least age race, ethnicity, socio-economic status and rural/urban*
Priority Aspect 3: Eliminating Unsafe Abortion	S20. Does State law allow abortion: (a) on request? (*yes/no*) (b) for economic or social reasons? (*yes/no*) (c) for the physical and/or mental health of the woman? (*yes/no*) (d) to save the life of the woman? (*yes/no*) (e) for cases of rape or incest? (*yes/no*) (f) for fetal impairment? (*yes/no*) (g) in no circumstances? (*yes/no*)	P23. Percentage of service delivery points providing abortion and/or post-abortion care P24. Percentage of practitioners trained in abortion/post-abortion care	O12. Percentage of women with *access* to abortion and/or post-abortion care - *Disaggregated by at least age, race, ethnicity, socio-economic status and rural/urban* O13. Abortion rate (number of abortions per 1,000 women of reproductive age) - *Disaggregated by at least age, race, ethnicity, socio-economic status and rural/urban*

Table (*continued*)

	Structural Indicators	Process Indicators	Outcome Indicators
Priority Aspect 3: Eliminating Unsafe Abortion (*continued*)	S21. Does State law criminalize abortion? (*yes/no*) S22. Does the State have a strategy and plan of action to: (a) prevent unsafe abortion? (*yes/no*) (b) provide post-abortion care? (*yes/no*)		O14. Percentage of maternal deaths attributed to unsafe abortion - *Disaggregated by at least age, race, ethnicity, socio-economic status and rural/urban*
Priority Aspect 4: Combating Sexually Transmitted Infections, Cervical Cancer and Other Gynecological Morbidities	S23. Does the State have a strategy/plan of action: (a) to prevent sexually transmitted infections, including HIV? (*yes/no*) (b) to treat sexually transmitted infections? (*yes/no*) (c) to make antiretroviral treatment available for people living with HIV? (*yes/no*) (d) to prevent cervical cancer? (*yes/no*)	P25. Number of condoms available for distribution nationwide (during the preceding 12 months) per population aged 15-49 years P26. Percentage of family planning service delivery points offering counselling on dual protection from sexually transmitted infections/HIV and unwanted pregnancies	O15. Percentage of people with *access* to: (a) health care for sexually transmitted infections (b) preventative care for cervical cancer and other gynecological morbidities *- Disaggregated by at least age, race, ethnicity, socio-economic status and rural/urban*

Table (*continued*)

	Structural Indicators	Process Indicators	Outcome Indicators
Priority Aspect 4: Combating Sexually Transmitted Infections, Cervical Cancer and Other Gynecological Morbidities (*continued*)		P27. Percentage of women screened for cervical cancer within the past five years - *Disaggregated by at least age, race, ethnicity, socio-economic status and rural/urban*	O16. Percentage of people with self-reported or diagnosed symptoms of sexually transmitted infections, classified by condition - *Disaggregated by at least age, sex, race, ethnicity, socio-economic status and rural/urban* O17. HIV prevalence in subpopulations with high-risk behaviour - *Disaggregated by at least age, sex, race, ethnicity, socio-economic status and rural/urban* O18. Percentage of women with cervical cancer - *Disaggregated by at least age, race, ethnicity, socio-economic status and rural/urban*
Priority Aspect 5: Promoting Sexual Health Including for Adolescents	S24. Does State law require comprehensive sexual health education during the compulsory school years? *(yes/no)*	P28. Percentage of people ages 15-19 years who have received comprehensive sexual health education in school - *Disaggregated by at least sex, race, ethnicity, socio-economic status and rural/urban*	O19. Percentage of people ages 15-19 years who know how to prevent HIV infection

Table (*continued*)

	Structural Indicators	Process Indicators	Outcome Indicators
Priority Aspect 5: Promoting Sexual Health Including for Adolescents (*continued*)	S25. Does the State have a strategy/plan of action to promote adolescent sexual and reproductive health? *(yes/no)* S26. Does State law prohibit sexual violence, including marital rape? (*yes/no*) S27. Does State law prohibit female genital mutilation and other harmful traditional practices? (*yes/no*) S28. Does State law prohibit marriage for both men and women prior to age 18? (*yes/no*) S29. Does State law require full and free consent of the parties to a marriage? (*yes/no*)	P29. Number of incidents of sexual violence, including marital rape, reported to law enforcement and/or health professionals in the past five years	O20. Age-specific fertility rate (15-19 and 20-24 years) - Disaggregated by at least race, ethnicity, socio-economic status and rural/urban O21. Age at marriage - *Disaggregated by at least sex, race, ethnicity, socio-economic status and rural/urban* O22. Percentage of women who have undergone female genital mutilation - *Disaggregated by at least sex, race, ethnicity, socio-economic status and rural/urban*

Key

ICESCR = International Covenant on Economic, Social and Cultural Rights

CRC = United Nations Convention on the Rights of the Child

CEDAW = Convention on the Elimination of All Forms of Discrimination Against Women

ICERD = International Convention on the Elimination of All Forms of Racial Discrimination

* Indicates a Millennium Development Goal indicator