Inclusive Development: Education, Health; Climate Change:

1. The role of higher education in sustainability;
2. The human right to health; Poverty and disease;
3. Sustainable Livelihood Model;
4. Policies and Global Cooperation for Climate Change

- Define inclusive development and Issues in achieving inclusive development.
- Health and Education: Issues of Inequalities and disparities in education and health for inclusive development
- Climate Change and development (Refer to article by D. McGregor in V. Desai and B.T. Potter (Eds) The companion of development studies, p.282-287).
- The role of higher education in sustainable development.
- The human right to health for inclusive development
- Poverty and disease: Issues of poverty and disease in inclusive development.

Inclusive development is a pro-poor approach that equally values and incorporates the contributions of all stakeholders - including marginalized groups - in addressing development issues. It promotes transparency and accountability, and enhances development cooperation outcomes through collaboration between civil society, governments and private sector actors.

UNDP promotes inclusive and sustainable growth, and works to reduce poverty in all its dimensions by:

- Assisting governments in the formulation of development planning strategies that incorporate interventions to promote inclusive sustainable development;
- Providing policy advice and tools to fight exclusion and marginalization in areas such as social protection and job creation;
- Advocating for an enhanced public investment and economic governance to ensure that everyone has access to vital public services without exclusion and marginalization;
- Enhancing developing country productive capacities, sustainable consumption and production patterns, to better integrate into the global economic system in a way that prioritizes sustainable development and reduces poverty and inequality.

Health and Education:

Issues of Inequalities and disparities in education and health for inclusive development

Inclusive education means that all students attend and are welcomed by their neighbourhood schools in age-appropriate, regular classes and are supported to learn, contribute and participate in all aspects of the life of the school.

Key Elements of Inclusive Education

1. **Inclusion**:
2. **Accessibility**
3. **Non-discrimination :**
4. **Reasonable accommodation**
5. **Physical accessibility**
6. **Availability**:
7. **Acceptability**:
8. **Adaptability**:

Key Elements of Inclusive Education

1. **Inclusion**: All children should have the opportunity to learn together, should have equal access to the general education system, and should receive individual accommodation where needed based on disability or other difference. Inclusion in the CRPD (**Convention on the Rights of Persons with Disabilities)** favours transition from separate, segregated learning environments for persons with disabilities to schooling within the general education system with the necessary supports to make inclusion meaningful. The principle of inclusion is a component of accessibility, availability, acceptability and adaptability.
2. **Accessibility**: Educational institutions and programmes must be accessible to persons with disabilities, without discrimination. Accessibility, reflected in Article 9 of the CRPD, has three overlapping dimensions, including non-discrimination together with reasonable accommodation; physical access; and economic access.
3. **Non-discrimination** and reasonable accommodation in education requires that education be accessible to all persons, including the most vulnerable persons with disabilities, without discrimination on the basis of disability. Non-discrimination also requires that persons with disabilities be accommodated in accessing their right to education at all levels (primary, secondary and university education, along with tertiary education.
4. **Reasonable accommodation** is defined in the CRPD as “necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human

5 **Physical accessibility** as applied to education means that schools must be within safe physical reach and they must be accessible for persons with disabilities, both in terms of getting to the school, and moving around within the school building and all facilities. Physical reach may mean access through attendance at some reasonably convenient geographic location (e.g. a neighbourhood school) or, provided not used as a means of segregation, it can encompass access via modern technology (e.g. access to a "distance learning" programme provided by a university). Education must be economically accessible in the sense that it must be affordable to persons with disabilities. International law requires that primary education be available "free to all," which must apply equally to students with disabilities. In the case of secondary and higher education, States are required to achieve access on the basis of progressive realization.

6 **Availability**: the concept of availability in securing the right to education implies that functioning educational institutions and programmes for students with disabilities must be available in sufficient quantity within the jurisdiction of a State. This is often a problem for students with disabilities who may need to travel to a distant urban area to find a school that is able to accommodate their needs.

7 Acceptability: The concept of acceptability relates to the form and substance of education. As emphasized by the Special Rapporteur on the right to education, the realization that socialization is a key element of an acceptable education means that inclusiveness is highly prioritized over segregation. Other aspects of acceptability include choice of the language of instruction. For children with disabilities this could include, for example, provision of sign language. It could also encompass the provision of instructional materials in alternative formats such as Braille or plain language or easy-to-read formats. Curricula and teaching methods must be provided in the most appropriate languages and modes and means of communication for the individual student. This might include, for example, teaching in sign language for students who are deaf or providing educational materials in Braille or audio formats for students who are blind.

8Adaptability: The concept of adaptability as applied to education for persons with disabilities pertains to flexibility to meet the needs of students with disabilities. At least two aspects of adaptability are essential in order to meet the needs of students with disabilities. These include: (1) the provision of reasonable accommodation, where needed, to meet individual student needs; and (2) the provision of support within the general education system to facilitate education. Adaptability also requires responsiveness to the

Human rights and health

Fact sheet

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of health as a fundamental right of every human being.

•Understanding health as a human right creates a legal obligation on states to ensure access to timely, acceptable, and affordable health care of appropriate quality as well as to providing for the underlying determinants of health, such as safe and potable water, sanitation, food, housing, health-related information and education, and gender equality.

•A States' obligation to support the right to health – including through the allocation of "maximum available resources" to progressively realise this goal - is reviewed through various international human rights mechanisms, such as the *Universal Periodic Review*, or the *Committee on Economic, Social and Cultural Rights*. In many cases, the right to health has been adopted into domestic law or Constitutional law.

•A rights-based approach to health requires that health policy and programmes must prioritize the needs of those furthest behind first towards greater equity, a principle that has been echoed in the recently adopted *2030 Agenda for Sustainable Development* and Universal Health Coverage. (1)

•The right to health must be enjoyed without discrimination on the grounds of race, age, ethnicity or any other status. Non-discrimination and equality requires states to take steps to redress any discriminatory law, practice or policy.

•Another feature of rights-based approaches is meaningful participation. Participation means ensuring that national stakeholders – including non-

Introduction

- “The right to the highest attainable standard of health” implies a clear set of legal obligations on states to ensure appropriate conditions for the enjoyment of health for all people without discrimination.
- The right to health is one of a set of internationally agreed human rights standards, and is inseparable or ‘indivisible’ from these other rights.
- This means achieving the right to health is both central to, and dependent upon, the realisation of other human rights, to food, housing, work, education, information, and participation.
- The right to health, as with other rights, includes both freedoms and entitlements:
  - Freedoms include the right to control one’s health and body (for example, sexual and reproductive rights) and to be free from interference (for example, free from torture and non-consensual medical treatment and experimentation).
  - Entitlements include the right to a system of health protection that gives everyone an equal opportunity to enjoy the highest attainable level of health.

Focus on disadvantaged populations

- Disadvantage and marginalization serve to exclude certain populations in societies from enjoying good health. Three of the world's most fatal communicable diseases – malaria, HIV/AIDS and tuberculosis – disproportionately affect the world's poorest populations, and in many cases are compounded and exacerbated by other inequalities and inequities including gender, age, sexual orientation or gender identity and migration status. Conversely the burden of non-communicable diseases – often perceived as affecting high-income countries – is increasing disproportionately among lower-income countries and populations, and is largely associated with lifestyle and behaviour factors as well as environmental determinants, such as safe housing, water and sanitation that are inextricably linked to human rights.
- A focus on disadvantage also reveals evidence of those who are exposed to greater rates of ill-health and face significant obstacles to accessing quality and affordable healthcare, including indigenous populations. While data collection systems are often ill-equipped to capture data on these groups, reports show that these populations have higher mortality and morbidity rates, due to noncommunicable diseases such as cancer, cardiovascular diseases, and chronic respiratory disease. These populations may also be the subject of laws and policies that further compound their marginalization and make it harder for them to access healthcare prevention, treatment, rehabilitation and care services.

- **Violations of human rights in health**
- Violations or lack of attention to human rights can have serious health consequences. Overt or implicit discrimination in the delivery of health services – both within the health workforce and between health workers and service users – acts as a powerful barrier to health services, and contributes to poor quality care.
- Mental ill-health often leads to a denial of dignity and autonomy, including forced treatment or institutionalization, and disregard of individual legal capacity to make decisions. Paradoxically, mental health is still given inadequate attention in public health, in spite of the high levels of violence, poverty and social exclusion that contribute to worse mental and physical health outcomes for people with mental health disorders.
- Violations of human rights not only contribute to and exacerbate poor health, but for many, including people with disabilities, indigenous populations, women living with HIV, sex workers, people who use drugs, transgender and intersex people, the health care setting presents a risk of heightened exposure to human rights abuses – including coercive or forced treatment and procedures.
- **Human rights-based approaches**
- A human rights-based approach to health provides a set of clear principles for setting and evaluating health policy and service delivery, targeting discriminatory practices and unjust power relations that are at the heart of inequitable health outcomes.

Core principles of human rights

- In pursuing a rights-based approach, health policy, strategies and programmes should be designed explicitly to improve the enjoyment of all people to the right to health, with a focus on the furthest behind first. The core principles and standards of a rights-based approach are detailed below.

- **Accountability:**States and other duty-bearers are answerable for the observance of human rights. However, there is also a growing movement recognising the importance of other non-state actors such as businesses in the respect and protection of human rights.
- **Equality and non-discrimination:**The principle of non-discrimination seeks '…to guarantee that human rights are exercised without discrimination of any kind based on race, colour, sex, language, religion, political, or other opinion, national or social origin, property, birth or other status such as disability, age, marital and family status, sexual orientation and gender identity, health status, place of residence, economic and social situation'.
- Any discrimination, for example in access to health care, as well as in means and entitlements for achieving this access, is prohibited on the basis of 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, which has the intention or effect of impairing the equal enjoyment or exercise of the right to health.
- The principle of non-discrimination and equality requires WHO to address

- **Participation:** Participation requires ensuring that all concerned stakeholders including non-state actors have ownership and control over development processes in all phases of the programming cycle: assessment, analysis, planning, implementation, monitoring, and evaluation. Participation goes well beyond consultation or a technical addition to project design; it should include explicit strategies to empower citizens, especially the most marginalized, so that their expectations are recognised by the State.
- Participation is important to accountability as it provides "…checks and balances which do not allow unitary leadership to exercise power in an arbitrary manner".
- **Universal, indivisible and interdependent:** Human rights are universal and inalienable. They apply equally, to all people, everywhere, without distinction. Human Rights standards – to food, health, education, to be free from torture, inhuman or degrading treatment – are also interrelated. The improvement of one right facilitates advancement of the others. Likewise, the deprivation of one right adversely affects the others.

- **Core elements of a right to health**

- **Progressive realization using maximum available resources**
- No matter what level of resources they have at their disposal, progressive realisation requires that governments take immediate steps within their means towards the fulfilment of these rights. Regardless of resource capacity, the elimination of discrimination and improvements in the legal and juridical systems must be acted upon with immediate effect.
- **Non-retrogression:**States should not allow the existing protection of economic, social, and cultural rights to deteriorate unless there are strong justifications for a retrogressive measure. For example, introducing school fees in secondary education which had formerly been free of charge would constitute a deliberate retrogressive measure. To justify it, a State would have to demonstrate that it adopted the measure only after carefully considering all the options, assessing the impact and fully using its maximum available resources.
- **Core components of the right to health:**The right to health (Article 12) was defined in General Comment 14 of the Committee on Economic, Social and Cultural Rights – a committee of Independent Experts, responsible for overseeing adherence to the Covenant. (4) The right includes the following core components:
- **Availability:**Refers to the need for a sufficient quantity of functioning public health and health care facilities, goods and services, as well as programmes

- **Accessibility:**Requires that health facilities, goods, and services must be accessible to everyone. Accessibility has four overlapping dimensions: such as ; non-discrimination; physical accessibility; economical accessibility (affordability); information accessibility.
- Assessing accessibility may require analysis of barriers – physical financial or otherwise – that exist, and how they may affect the most vulnerable, and call for the establishment or application of clear norms and standards in both law and policy to address these barriers, as well as robust monitoring systems of health-related information and whether this information is reaching all populations.
- **Acceptability:**Relates to respect for medical ethics, culturally appropriate, and sensitivity to gender. Acceptability requires that health facilities, goods, services and programmes are people-centred and cater for the specific needs of diverse population groups and in accordance with international standards of medical ethics for confidentiality and informed consent.
- **Quality:**Facilities, goods, and services must be scientifically and medically approved. Quality is a key component of Universal Health Coverage, and includes the experience as well as the perception of health care. Quality health services should be:
  - **Safe** – avoiding injuries to people for whom the care is intended;
  - **Effective** – providing evidence-based healthcare services to those who need them;
  - **People-centred** – providing care that responds to individual preferences, needs and values;

WHO response

- WHO has made a commitment to mainstream human rights into healthcare programmes and policies on national and regional levels by looking at underlying determinants of health as part of a comprehensive approach to health and human rights.
- In addition, WHO has been actively strengthening its role in providing technical, intellectual, and political leadership on the right to health including:

•strengthening the capacity of WHO and its Member States to integrate a human rights-based approach to health;

•advancing the right to health in international law and international development processes; and

•advocating for health-related human rights, including the right to health.

- Addressing the needs and rights of individuals at different stages across the life course requires taking a comprehensive approach within the broader context of promoting human rights, gender equality, and equity.
- As such, WHO promotes a concise and unifying framework that builds on existing approaches in gender, equity, and human rights to generate more accurate and robust solutions to health inequities. The integrated nature of the framework is an opportunity to build on foundational strengths and complementarities between these approaches to create a cohesive and efficient approach to promote health and well-being for all.

Disadvantage and marginalization serve to exclude certain populations in societies from enjoying good health. Three of the world's most fatal communicable diseases – malaria, HIV/AIDS and tuberculosis – disproportionately affect the world's poorest populations, and in many cases are compounded and exacerbated by other inequalities and inequities including gender, age, sexual orientation or gender identity and migration status. Conversely the burden of non-communicable diseases – often perceived as affecting high-income countries – is increasing disproportionately among lower-income countries and populations, and is largely associated with lifestyle and behaviour factors as well as environmental determinants, such as safe housing, water and sanitation that are inextricably linked to human rights. A focus on disadvantage also reveals evidence of those who are exposed to greater rates of ill-health and face significant obstacles to accessing quality and affordable healthcare, including indigenous populations. While data collection systems are often ill-equipped to capture data on these groups, reports show that these populations have higher mortality and morbidity rates, due to noncommunicable diseases such as cancer, cardiovascular diseases, and chronic respiratory disease. These populations may also be the subject of laws and policies that further compound their marginalization and make it harder for them to access healthcare prevention, treatment, rehabilitation and care services.

Violations of human rights in health

Violations or lack of attention to human rights can have serious health

- Good health stands at the center of sustainable development. Good health is at the center of wellbeing and is vital for everything else.

- It also enables a workforce to be productive. Thus, good health enhances the ability of a community to develop human capital, undertake economic activities, and attract investment.

- Health has also long been regarded as a basic human need and basic human right. Technically the goal is the “highest attainable standard of physical and mental health.”

- The highest attainable health refers to what is possible given current knowledge and technology. The world is far from this practical standard.

- Around 6 million children die each year before their fifth birthday, almost all of them in developing countries, and almost all as the

- Since the beginning of the United Nations itself, the priority of health has been clear. In 1948, the Universal Declaration of Human Rights (UDHR) made it clear that health is a human right and basic need; and that even when these kinds of rights cannot be achieved immediately, they should be progressively realized.
- When the World Health Organization (WHO) was created, also in 1948, it declared in its central constitution that the highest attainable standard of health is a fundamental human right "without distinction of race, religion, political belief, economic or social condition." But we have yet to achieve this goal.
- One notable global effort after 1948 to achieve universal health was launched in 1978 in Alma-Ata, now Almaty, Kazakhstan. World health officials gathered and adopted the important Alma-Ata Declaration, which called for universal health by the year 2000.
- Instead, there were pandemics and poor health outcomes in many parts of the world. It is an estimated 36.1 million people infected with the HIV virus. Malaria, a tropical killer disease, rose tremendously in number of infections and in number of deaths, because the first-line medicine used in Africa to treat malaria lost its efficacy—the parasite had become resistant to the chloroquine drug.
- The year 2000 was a very bleak year for malaria, with a surging death toll—around 985,000 people. The year 2000 was also a bleak year for tuberculosis, another horrific scourge of humanity that claims millions of lives each year. The tuberculosis surge was partly riding on the HIV/AIDS pandemic, because immunocompromised individuals suffering from AIDS died in very large numbers from tuberculosis. Like malaria, there was a crisis of drug resistance.

- In other words, the year 2000 did not meet the hopes and aspirations of the health

- It is notable that three of the eight MDGs, which seek to end extreme poverty, are centrally about health. MDG 4 is about reducing child mortality. MDG 5 is about reducing maternal mortality. MDG 6 is about controlling epidemic diseases, including AIDS and malaria. All of the other goals, such as ending poverty and hunger, having children in school, and gender equality, are also goals in which health plays an important role, both as a determinant of outcomes and also as one of the main objectives.

- The great progress of public health, like economic development itself, is one of great achievement in the modern era. At the time of the Industrial Revolution, worldwide *life expectancy at birth* (LEB) was perhaps 35 years.

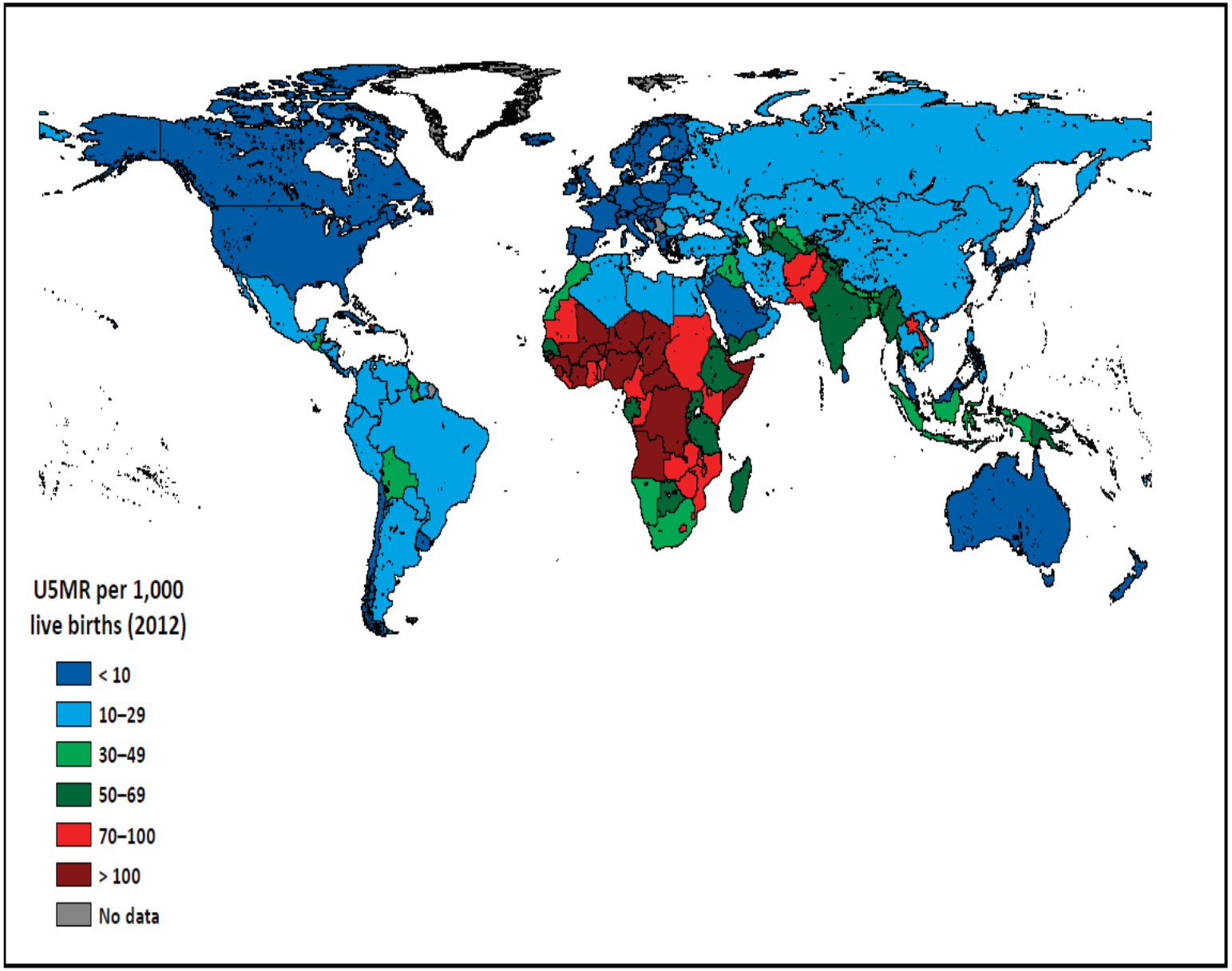
- United Nations estimated that during the five-year period from 1950 to 1955, the worldwide LEB was around 46 years.

- In the developed regions, LEB was already around 65 years, while in the least-developed countries (LDCs) LEB was still only around 40 years, not much different from the estimated LEB for the preindustrial world.

- As of 2010–2015, world life expectancy has increased to 70 years, roughly twice the life expectancy from the start of the Industrial Revolution. This is one of the great achievements of modern humanity, of modern science, and of economic development.

- Nonetheless, there are still enormous health gaps between the developed and developing countries. In the developed countries, life expectancy is almost 80 years, whereas in the LDCs LEB is only 60 years, and less in many LDCs. In other words, there is roughly a two-decade gap in average life expectancy between the richest and poorest countries. These two decades of survival offer an indication of how much can be done to improve the health of the poorest countries.

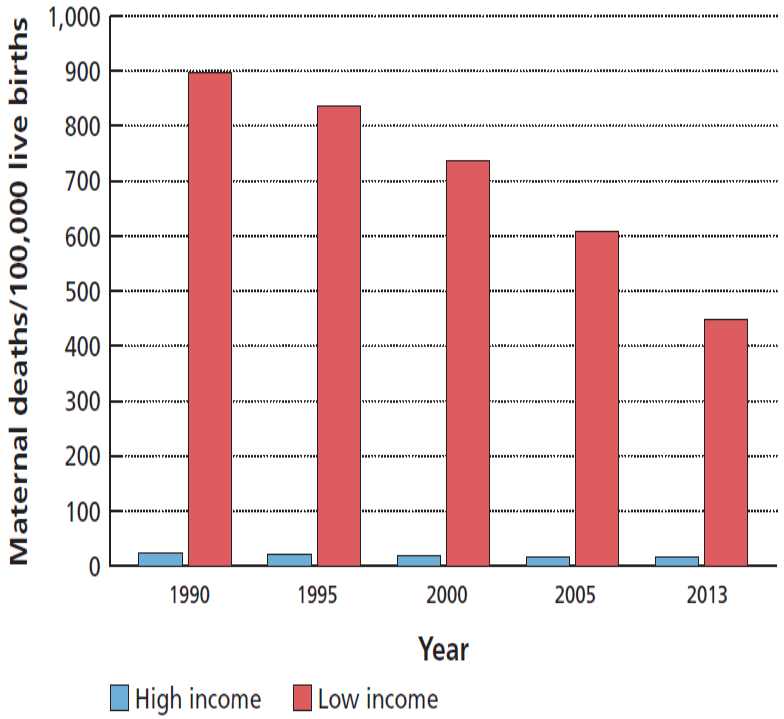
- Figure 9.3 maps out the under-5 mortality rate (U5MR), which signifies how many children under the age of 5 die for every 1,000 live births (World Bank 2014c). The world



9.3 Under-5 mortality per 1,000 births (2012)

Source: World Bank. 2014. "World Development Indicators."

- Figure 9.4 shows another very crucial aspect of public health: maternal mortality (World Bank 2014b). This is measured as the number of pregnancy-related deaths (typically at childbirth but also earlier during pregnancy) for every 100,000 live births. Pregnancy-related deaths have huge variation between countries, since very few women die of pregnancy-related causes in rich countries (16/100,000) compared with poor regions like sub-Saharan Africa, where around 500 women die for every 100,000 births. However, the maternal mortality rate (MMR) in the low-income countries is falling sharply. It was around 900 deaths per 100,000 live births back in 1990, but as of 2013 is at 450 deaths per 100,000 live births, an enormous achievement in saving women's lives.
- In general, the reasons for death in rich and poor countries differ. The poor die from many of the same causes that the rich do: cancer, cardiovascular diseases, and metabolic disorders such as diabetes. But the poor also die of conditions that rich people no longer die of, especially communicable diseases such as measles, malaria, or other kinds of infections. One basic principle of health is that undernutrition leads to the weakness of the immune system to resist infections (known as immunosuppression). For that reason, children in very poor countries, who are more likely to be undernourished, die of diarrheal diseases or respiratory infections that would not kill a better-nourished child in a richer country.



9.4 Maternal mortality for high-income and low-income countries (1990–2013)

Source: World Bank. 2014. "World Development Indicators."