DIGNITY COUNTS

A guide to using budget analysis to advance human rights

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fundar

INSTITUTE OF INTERNATIONAL EDUCATION

THE INTERNATIONAL BUDGET PROJECT

DIGNITY COUNTS

A guide to using budget analysis to advance human rights

Fundar – Centro de Análisis e Investigación
International Budget Project
International Human Rights Internship Program

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PREFACE

Dignity Counts: A guide to using budget analysis to advance human rights is a response to the bubbling up of interest in—indeed, enthusiasm about—the potential usefulness of budget analysis as a tool (or strategy) to protect and promote the enjoyment of human rights in general, and economic, social and cultural (ESC) rights in particular. Three organizations have taken the lead in producing *Dignity Counts*—Fundar, the International Human Rights Internship Program and the International Budget Project. Each of these organizations has come to the project for different reasons and brought to it different skills and experiences:

- Fundar – Centro de Análisis e Investigación, based in Mexico City, is involved in research, analysis, education and advocacy around issues of democracy in Mexico. Budget analysis is a key component of its work and part of that work involves analyzing the Mexican Government's budget to assess its transparency and evaluate government accountability as well as compliance with rights obligations. Fundar collaborates with other organizations in Latin America and Africa around similar issues. It also has a human rights program and collaboration between that program and its budget program was central to Fundar's work on *Dignity Counts*.

- The International Budget Project (IBP) is part of the Center on Budget and Policy Priorities based in Washington, D.C. IBP assists non-governmental organizations (NGOs) and researchers in their efforts both to analyze budget policies and to improve budget processes and institutions. The project is especially interested in assisting with applied research that is of use in ongoing policy debates and with research on the effects of budget policies on the poor. Growing out of the latter concern, IBP is committed to helping NGOs learn how to use budget analysis as a tool to advance ESC rights.

- The International Human Rights Internship Program (IHRIP) is part of the Institute of International Education and is based in IIE's Washington, D.C. office. IHRIP is devoted to facilitating the exchange of knowledge and experience among human rights organizations as well as between organizations in the human rights field and other fields. IHRIP has an ESC rights project, as part of which it has collaborated with human rights groups around the world to develop resources on ESC rights activism, four of which have included *Ripple in Still Water, A Rights-Based Approach to Budget Analysis* (authored by Ma. Socorro Diokno), *Circle of Rights* and *Out of the Shadows*.

In 2001 Fundar approached the Ford Foundation office in Mexico City with the idea for a workshop that would bring together human rights activists and applied budget analysts. The workshop's purpose was to initiate a

process of building bridges between the two fields and to explore the value that would be added to the work of each by bringing the skills and experiences together.

With the generous and enthusiastic support of the Foundation and drawing on the very efficient and warm hospitality of Fundar, that workshop became a reality in January 2002, when a group of twenty applied budget analysts, human rights activists and Foundation staff met for three days in Cuernavaca, Mexico. An initial focus of that meeting was on getting to know each other and becoming familiar with the assumptions underlying the work done in each field, the concepts and strategies each employs, and the "jargon" and tools each uses. We then explored the "value added" of collaboration through focusing in turn on four case studies. A report of the workshop, entitled *Promises to Keep: Using public budgets as a tool to advance economic, social and cultural rights*, is designed to be a resource for those interested in learning more about the value of budget work in promoting ESC rights, and many activists have found it to be just that. [1]

The Cuernavaca workshop was in many ways a transformative experience for the participants. As a result of intense discussions within and outside the workshop, participants came to see very specific and concrete ways that budget analysis could assist those concerned with advancing ESC rights. IHRIP and IBP, both of whom had helped in the planning of the meeting and were represented there, have collaborated with Fundar since on identifying ways to take the discussion further. *Dignity Counts* is a significant product of that collaboration.

As work on ESC rights grows by leaps and bounds around the world, a large number of organizations and individuals have expressed interest in learning more about how budget analysis can contribute to their work. In June 2003 a number of participants at the first international conference of the International Network for ESC Rights (ESCR-Net) attended a workshop and break-out sessions on budgets and ESC rights. These participants and others are now members of ESCR-Net's Working Group on Budgets. Members of that Working Group have, through their listserv, expressed a need for resources that will help them learn more about how to use budgets in their ESC rights work. We hope that *Dignity Counts* will go some way to meeting that need.

Dignity Counts is built around a "real life" case study developed by staff at Fundar, with the assistance of other organizations in Mexico with whom

1. A copy of the report is available on the web at: http://www.internationalbudget.org/themes/ESC/FullReport.pdf (in English); and http://www.fundar.org.mx/fundar/documentos/ddhh/promesas_que_cumplir.pdf (in Spanish).

Fundar collaborates. Without the hard work that Fundar and its colleagues put into producing the case study, there would be no *Dignity Counts*. The case study provides concrete evidence that budget analysis can be a very powerful tool for helping to assess a government's compliance with its ESC rights obligations and for highlighting specific actions that can be taken to remedy non-compliance.

The results of Fundar's research were incorporated by IHRIP into a draft of this publication. That draft was discussed by participants at a small workshop held in Washington, D.C. March 10-12, 2004. One participant at that workshop, "Babes" Ignacio, likened the spirit there to a sign hanging in the office of his human rights group in Manila: "Write with passion, edit without mercy." The many comments and suggestions made were frank and to the point, while also clearly grounded in a belief in the resource and in a warm and humorous determination to "get it right." Our deep thanks to workshop participants for giving us so much of their time, energy and support.

Finally, we extend our warmest thanks to the Mertz Gilmore Foundation for its kind and generous support of this project, and to Mona Younis, program officer at the Foundation, whose passionate commitment to ESC rights and belief in our project were so central to its realization.

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INTRODUCTION

Budgets and human rights

Respecting the human rights of its people should be one of a government's highest priorities, if not *the* highest priority, and it can do many things to meet its rights obligations. Its President, for example, may promote the right to education by making a speech about the importance of education to the well-being of individuals and of the society as a whole. A local government may gather together the people in a community to help plant this year's crops or paint a health clinic. Sometimes respecting human rights even involves a government in *not* doing something, like *not* standing in the way of girls going to school or *not* abusing detainees in the country's prisons. Meeting one's human rights obligations isn't necessarily about spending money.

At the same time, the reality is that very often it does take money for a government to properly meet its rights responsibilities. Financial resources need to be directed, for example, to training police not to abuse citizens, to training judges and maintaining courts. Funding is required to hire teachers, to build schools and to ensure decent working conditions for those laboring in factories. These are a few of the actions that are important to human rights and each requires money.

A government's determination to abide by its human rights obligations should be embodied in national (and local) policies, and government (public) budgets should, in turn, reflect those policies. A government, in other words, should "put its money where its mouth is." Those interested in determining whether a government is fulfilling its human rights obligations should thus consider looking at the government's revenue, allocations and expenditures as reflected in its budget.

No matter how sophisticated or detailed the analysis, examining a government budget won't answer all possible questions about how well a government program is being carried out. Increased funding may be directed to schools, for example, but that is no guarantee that the quality of teaching is being enhanced. Assessing the teaching requires something other than budget analysis. A government may open emergency food centers in drought-stricken areas, but what type of food is available to those in need? Does it have enough calories and nutrients? Is the food appropriate and acceptable to the population in the area? Nutritionists can give you more useful answers to those questions than can budget analysts.

At the same time, budget analysis *can* provide a great deal of information for those concerned about human rights—particularly when budget figures are considered together with other data produced by, for example,

statisticians, nutritionists, sociologists, psychologists and others. Budget analysis can offer a year-by-year picture of a government's actions and the extent to which it has carried through on earlier promises. It can be a powerful tool for pinpointing a government's failure to comply with its rights obligations and can even point to actions a government can take to better meet those obligations.

The "value added" to human rights work by budget analysis

Human rights work can very effectively be carried out without budget analysis. Large numbers of groups around the world are doing just that. At the same time, budget analysis can benefit human rights work in many ways:

- Human rights are acknowledged as being morally compelling. However, in the world of practical politics and governance, they are too often dismissed as being idealistic and unrealistic. The technical skills required for budget analysis, on the other hand, are highly valued in that same world; indeed, budget analysis has a certain mystique because of its technical nature. Bringing the moral power of human rights together with the technical power (and mystique) of budget analysis can help human rights workers forge very persuasive evidence and arguments.

- Human rights workers, particularly those in the relatively new arena of economic, social and cultural (ESC) rights, are frequently accused by governments of complaining about what's wrong while not providing concrete suggestions for what might be done to improve a situation. Budget analysis can often pinpoint inadequacies in expenditures, misdirection of funds or a "misfit" of expenditures relative to the government's stated human rights commitments—particularly with regard to its "positive" obligations (obligations to take action) rather than its "negative" obligations (obligations to desist from doing something).

- Budget analysis can help assess how efficiently government resources are being spent. Governments typically claim (often with some justification) that they don't have adequate resources to carry out this or that obligation. Since resources are always limited, it is very important that those limited resources be used to maximum effect. Budget analysis can help identify where funds have been blocked or where they have "leaked" (i.e., disappeared) as they are disbursed from one level of government to another.

- Human rights organizations may recommend that a new program or project be adopted so that a government more properly carries out its rights responsibilities. The government, on the other hand, may say

that the organizations don't understand the costs involved. If, however, the latter come to the government with the costs of a new program or project already worked out and concrete suggestions on where the necessary resources can be found in the budget, their recommendations will be taken more seriously, particularly by government ministries that fundamentally want to do the right thing.

- The results of budget analysis can be integrated into advocacy strategies that are already familiar to human rights activists, and in the process can often make those strategies more effective. Legislatures, for example, may not be well-versed in budget figures or have an adequate understanding of the implications of the government's budget. Providing explanations of the human rights implications of certain expenditures can be an aid to legislators, in turn encouraging them to be more open to proposals made by activists. Courts, too, have proven to be receptive to human rights arguments that use as part of their evidence data derived from budget analysis. But it's not just at the level of legislatures and courts that budget work strengthens advocacy. Communities too have become very engaged in actions around simple figures setting out government expenditures at the local level, because they can understand the impact these funds have in their daily lives.

Mazdoor Kisan Shakti Sangathan (MKSS)
Using budgets in community action

MKSS works with communities in Rajasthan, India with a focus on securing the livelihood of people in the community. The communities' activities include monitoring local government expenditures and holding local officials to account for funds they say have been spent. The project involves an extensive fact-finding process to determine if individuals or businesses whom the government said were given funds for different purposes did, in fact, receive those funds. The communities take their findings to public hearings where the local officials have to answer questions about apparent irregularities.

The "value added" to applied budget work by a rights framework

Budget analysts who want to use their skills to address issues of poverty or to forward social justice would, in turn, find that a rights framework—that is, using human rights standards as a "lens" through which to look at budget figures—can add very important dimensions to their work.

- A human rights framework is a useful reminder that the welfare of human beings should be the driving motivation for their work.

- Budget analysis as a skill or tool is value-neutral; it can be used for good or ill. Human rights ground budget analysis in positive values, because human rights are about what is "right" to do.

- Work that is driven by a concern about poverty and social justice literally gains legitimacy through use of a human rights framework, because human rights are recognized in national, regional and international laws.

- There are many ways for government funds to be spent. Human rights provide a way to choose among different options. At a minimum, such a framework makes clear that fiscal choices must not violate human rights. It also provides guidance for choosing among options, since human rights standards often direct governments to give priority to certain types of expenditures over others.

- Budget analysts are often concerned with issues of government transparency and accountability. The importance of these issues is underscored by the fact that transparency and accountability are required by human rights guarantees that individuals enjoy of participation in public affairs and access to information.

- A human rights framework is one that is shared among a large number of groups. Thus use of that framework will facilitate and encourage the development of collaborative relationships with other organizations and the possibility that the results of budget analysis will have a greater impact through being used in advocacy by others.

Purpose of *Dignity Counts*

The purpose of *Dignity Counts* is to provide guidance to civil society organizations (CSOs) and others on how to use budget analysis as a tool to help assess a government's compliance with its ESC rights obligations. It has been designed to provide information to both human rights activists and those involved in applied budget work, and we hope that it will be used by both groups. At the same time, recognizing that budget analysis is a technical skill, while human rights are a goal, we have sought above all to ensure that this resource will provide human rights workers with the basic information and guidance they need to start incorporating budget analysis into their ongoing work.

Dignity Counts provides general information and guidelines on both human rights and budget analysis. It sets out a step-by-step method for relating the two through looking at a particular *national budget* to assess a government's compliance with *specific elements of its obligations* related to a *specific right*.

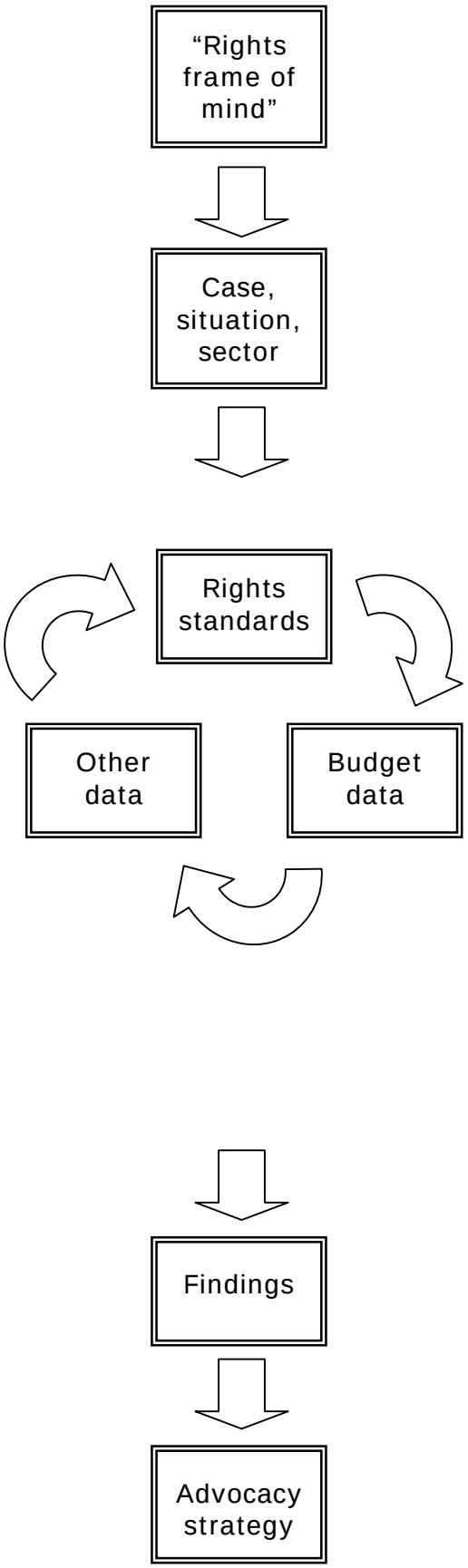
- While the case study focuses on a national government's budget (Mexico's), we believe that the process of analyzing a budget at the state, provincial or local level would follow the same line of reasoning.

- While *Dignity Counts* provides general information on human rights and more specific information on economic, social and cultural rights, it discusses only one right—the right to health—in detail. We believe that developing a detailed understanding of other ESC rights would follow the same line of reasoning we use with respect to the right to health. This resource also does not provide an exhaustive analysis of a government's human rights obligations, but focuses on three important obligations common to all ESC rights work. We believe that the process of relating those obligations to the Mexican health budget will provide useful insights for how to relate these same obligations to budget allocations and expenditures related to other ESC rights.

- The case study comes from one country, Mexico. However, we believe the approach taken in that case study will be valuable for activists in other countries, because governments around the world have similar obligations with regard to international human rights.

Chart 1

Steps for doing budget analysis within a human rights framework



Start with a "rights frame of mind", a perspective that considers a situation through the lens of rights, looking for rights issues and for strategies to advance rights.

Identify a case, a situation or a sector (e.g., health or education) of particular concern and start developing it into a full case study.

Engage in an iterative process, starting with human rights standards, to get a fuller idea of potential rights issues. Then go in either direction—gather other data or look at budget figures. You will want in either case to identify how the government's budget could be implicated in the case/situation/sector, and do some initial budget analysis to see what light budget figures shed on the rights issues. You will likely also need to gather and analyze additional, non-budget data (e.g., statistics) to develop your fuller picture. Pull these together, return to the rights standards and do a more in-depth analysis. Follow this with a fuller budget analysis and gathering of further information. Repeat this process, until you are satisfied you have arrived at a clear picture of the case/situation/sector as well as rights and budget issues involved.

Write up your findings

Develop an advocacy strategy that makes use of the findings.

Steps for doing budget analysis within a human rights framework

Organizations may initiate budget analysis in response to an individual who has come asking for help, or perhaps to a whole community that has a problem with health services or schools for the children in their village, around food availability or around housing they have been promised that has not been built. Budget analysis can be used for cases involving ESC rights that arise on both the individual and community levels.

On the other hand, while all human rights-related work should have as its core concern the welfare of individuals, and one organization may pursue its work based upon the situation of a specific individual or community, another organization may choose to examine a whole sector within a country—education, health, sanitation, housing, etc.—to determine whether government funding to that sector is in line with the latter's human rights obligations.

In either case—or in the case of an approach that falls somewhere between the extreme "micro" and "macro" ends of the spectrum—the process for using budget analysis to assess a government's compliance with its rights obligations with regard to the particular issue would be similar.

Chart 1 on the previous page sets out the steps followed in this guide. These same steps are ones we believe would be more broadly applicable, in line with the assumptions stated above.

How *Dignity Counts* is organized

Dignity Counts comprises six sections and four appendices.

Section 1: *Dignity Counts* assumes that you are already approaching your issue or situation with a "rights frame of mind," and so it starts at Step 2, with a case, situation or sector. The situation that is our focus of concern is access to health services of the "open population" in Mexico. What is the "open population"? Read this section to find out!

Section 2: After identifying the case/situation/sector, our diagram tells us to compare the facts of the case/situation/sector with human rights standards to identify what rights issues seem to be implicated. Section 2 provides a broad introduction to rights standards, at the national, regional and international levels, and a more detailed discussion of the right to health, because that is the right that has been identified as the focus of concern in the case study.

Section 3: This section talks primarily about budget analysis. It also broadly discusses additional information that may be needed to fill out the picture in any case study. Budget analysis and this additional information are two of the three boxes in the circular process diagrammed on page 6.

Section 4: Section 4 reviews and discusses a bit further the information gathering and analysis process set out in the diagram, before we go into:

Section 5: This section is the "findings" step in the process. It spells out the information and conclusions that resulted from a detailed application of budget analysis to the Mexican Government's budget for the purpose of assessing the government's compliance with certain of its obligations with regard to the right to health of the "open population" in that country.

Section 6: *Dignity Counts* concludes with a short discussion of how the findings from such a budget analysis can be used in advocacy to protect and promote human rights.

Appendix 1: A glossary of human rights terms, useful for those unfamiliar with some of the basic human rights "jargon"
Appendix 2: A glossary of terms used in the case study (Section 5).
Appendix 3: Some additional resources related to budget analysis and ESC rights
Appendix 4: A list of participants at the March 2004 workshop

SECTION 1

The right to health in Mexico: from “right-holders” to “nothing-holders”

Consuelo was only 21 when she died from complications related to giving birth. High up in the mountains in Guerrero, where Consuelo lived, no regular medical attention was available. Aided by a midwife, she suffered through endless hours of labor, and started to hemorrhage only twenty hours after giving birth to a baby girl. Her situation deteriorated quickly. Although it was clear that she needed to be moved to a hospital for emergency treatment, appropriate medical attention was available only at a distance and emergency transportation was lacking. The community did its best to bring her to the nearest hospital, but the five hours on unpaved road proved to be too long. When Consuelo arrived at the hospital, her condition was critical. She died that same day.

Mexico is a country that has incorporated into its national legal framework several provisions regarding the right to health. Some of them are duly in accordance with standards set forth at the international level; others are well ahead of them. Notwithstanding exceptional efforts to ensure, at least on paper, the right to health for every person in Mexico, nearly five women die every day due to complications arising during pregnancy, birth or in the postpartum period. These deaths, virtually all of which are preventable, happen because, in reality, the right to health is far from being consistently realized.

If an international committee for the evaluation of the right to health were to come to Mexico, they would be puzzled by the way in which the Mexican population has been divided into two, separate, categories. On one side, there is what has come to be known as the “right-holders”; on the other, is a segment of the population, amounting to more than 50 percent, that has been amorphously entitled the “open population.”

The “right-holders” are individuals and families that have at least one person working in the formal economy, paying taxes and social security fees. The “open population” is composed of people who are unemployed, informally employed, or employed on an unstable basis. Some of them pay income tax, all of them pay value-added tax, but none seems to be paying enough to access comprehensive social security benefits. Because of this, the “open population” has also been called the “nothing-holders”.

This harsh distinction has implications that have been a focus of concern for Fundar since it started working on health issues. It seems that in Mexico the right to health is not treated as a human right, indivisible from other human rights and inherent to the dignity of the person. Since comprehensive realization of the right is directly related to an individual's capacity to contribute to the social security system, which operates on the basis of employment fees, any right to health seems to depend upon the economic provisions and employment of that person.

This also implies that, counter to what is established both at the international and the national levels—where guarantees provide that the most vulnerable sectors will be paid the greatest attention—in Mexico the more vulnerable the situation a person finds herself in, the fewer guarantees she has that her right to health will be fulfilled.

Why is this so? The reason lies with the conception of the health system itself.

The Ministry of Health and Assistance (SSA) was created in 1943 when two institutions—the Ministry for Assistance and the Health Department—were merged into one.[2] Social security systems were also established during this same period—the Mexican Institute for Social Security (IMSS), the Institute for Services and Social Security for State Workers (ISSSTE), the Mexican Armed Forces Institute for Social Security (ISSFAM), and the social security services for PEMEX, the state-owned oil company—each of these entities operating independently.

The result of these simultaneous developments was that the public health system has been divided into two separate sections since its inception: health services for the general public, and social security. The social security system provides services to individuals who are legally employed and to their families. In response to the levels of employment and unemployment, the percentage of people who have access to these services varies, but in general, it hovers around 45%. This population has access to a series of comprehensive health services, both preventive and for treatment, at all three levels of care—primary, secondary or hospital care, and tertiary or specialized interventions. In addition, medication is free of charge at all three levels.

In striking contrast, the rest of the population—the "open population"—who lack formal employment, are not eligible for the social security arrangements. They are taken care of through services provided by the Ministry of Health (SSA), which also offers three levels of care and, at

[2] A. Torres Ruiz, *Descentralización en salud: algunas consideraciones para el caso de México*, Centro de Investigación y Docencia Económicas, División de Administración Pública, Documento de Trabajo número 69, México, 1997, p. 10.

least in theory, medication free of charge. However, there are certain important differences:

- The public health system is allocated only half the resources allocated to the social security system;
- It is severely understaffed;
- It has not been able to replace and improve its equipment; and
- It is very unevenly distributed across the country.

Until the 1990s these health services were managed by the Federal Government. After a decentralization process, the implementation of budget resources and supply of health services were turned over to each state. This means that the system responsible for taking care of the "open population's" health needs is made up of 32 different state health services. The SSA itself has been transformed into the regulating body of the health sector as a whole. The health sector includes the 32 state health services as well as the social security institutions.

It seems clear from various reports that, generally speaking, the higher the levels of marginalization in a state, the poorer its health services. In addition, as a result of macroeconomic adjustments undertaken in the 1980's, poverty in the country has increased in absolute terms, and the gap in income distribution has widened significantly. In 2002, the richest 20% accounted for 53.1% of the country's current income, while the bottom 20% totaled only 4.4%.[3] It is estimated that 50 million Mexicans—half of the country's population—live in poverty, and of that 50 million, 26 million live in extreme poverty.

These figures mean that a quarter of the population probably has very poor access to health services, and that up to 50 percent may face recurrent problems related to health care. For Fundar it also means that Mexico falls far short of ensuring the right to health for everyone. Furthermore, it is far from complying with the obligation to provide health services that *give preference to the most vulnerable population*, as established in the National Bill of Health. The combination of the systemic division in the health system, the weakness of the public health system, and the overall vulnerability of the "open population" triggers an automatic right to health concern. Together, these point to several issues that were of utmost importance to Fundar:

[3] Instituto Nacional de Estadística, Geografía e Informática, *Encuesta Nacional de Ingresos y Gastos de los Hogares 2002,* México.

Mexican Health Care System

Agencies providing health related services to the informally employed, underemployed and unemployed (the "open population")	**Institutes comprising social security network for the formally employed and their families**
Federal Ministry of Health (SSA) Normative body for the health system as well as provider and financer of federal programs that target people living in extreme poverty, such as: • *Extension of Coverage Program (PAC)* A program created in 1998 to extend coverage by providing a basic package of health services. • *Opportunities program* The health component of a comprehensive, extreme poverty alleviation strategy that includes education and food components run by other ministries. • *Health Program for Indigenous Groups* Concentrates mainly on reproductive and infant health. • *IMSS-Solidaridad Program* Operated in 19 states through specific IMSS infra-structure and personnel, but financed by the SSA. 32 State-level Health Ministries Providers of the health services for each state. Financed by the Health Services Contribution Fund (FASSA) from the federal budget. Created in 1998 for the purpose of decentralizing the health services. Almost all state spending on health (approx. 90%) comes from this fund, the rest comes from the states' own revenues.	IMSS The Mexican Institute for Social Security provides health care for formal sector workers. The IMSS is financed through contributions from employees, employers and government. ISSSTE The Institute of Security and Social Services for State Workers covers government workers and is financed by the employees and the government as employer. ISSFAM The Institute of Social Security for the Armed Forces covers the members of the armed forces and is financed by the military personnel and the Army budget. PEMEX The Mexican Public Oil Company has its own social security system that covers all Pemex workers and is financed by contributions from employees and from the Pemex budget. * All these institutes provide as well other services besides health care, such as pensions, child care centers, and recreation and sport facilities.

- First and foremost, despite the absence of explicit discrimination in the policy and the law, the system itself seems, in practice, to be discriminatory.
- Second, because the “open population” is generally vulnerable, they may be facing health-related problems that could be resolved if care were not differentiated in the way it is.
- Third, the difference in human, financial and material resources between the two systems may have significant impacts on access to health services—a crucial element for the realization of the right to health.
- Fourth, the socio-economic divide among the 32 states of the Republic may have additional negative impacts on the population that lives under the harshest conditions of marginalization and poverty.

These were the considerations that triggered Fundar’s work on the budget allocated to health services and the arrangement of the decentralized health system and—last but not least, Fundar’s interest in using a right to health framework.

SECTION 2

Human rights – an overview

Introduction

If you look back to the flow chart on page 6 of the Introduction, you will see that after identifying the case or situation of concern (which we have just done in Section 1), the next step is to look at the relevant human rights laws and standards that apply—and to look, in particular, at those rights relevant to the aspect of the case or situation on which you have chosen to concentrate.

Section 2 focuses on that next step through

- discussing, in broad and brief terms, the concept of human rights
- looking at the role of national guarantees in protecting human rights
- glancing at regional human rights law
- considering, in somewhat greater depth, international human rights law, and
- bringing these four parts together, through engaging in a more detailed discussion of a specific right—the right to health—which is the focus of particular concern in the case study.

What are human rights?

Human rights are about human dignity, and the human rights struggle is the struggle for recognition of and respect for this dignity. History contains a record of some of the many times over the past millennia that this struggle has taken place in the public domain. However, the large majority of the struggles—both public and those that have occurred in the private sphere—have been lost to the historical record.

Human rights belong to the human person and people own those rights whether or not the rights have been recognized in the law. Through centuries, for example, torture and slavery were not legally regarded as violations of human rights, yet who can doubt that people should never have been tortured or sold into slavery? Now there is universal condemnation of both as serious human rights violations.

The latter point underscores the fact that, while human rights are inalienable, our concept of human dignity evolves over time. What may not feel like a slight to that dignity at one point in history or in a given place may be perceived as a significant infringement at another time or in a different place.

The struggle for recognition of rights is the struggle to build a consensus that certain actions or practices—such as torture or slavery—violate human dignity. Reaching that consensus can be an uneven, stop-and-start process. At times a consensus reached can be a strong and broad-ranging one, in which case the laws that embody the consensus will be readily adopted and enforced. In other situations laws may be passed to protect human rights—either at the national or international level—for which there is not yet deep and wide support within a society. In this situation, human rights work is often directed at education and securing a broader understanding and acceptance of the rights in question and of the laws that seek to protect those rights.

The capacity of individuals, organizations and governments to enforce human rights depends to a great extent on the existence of legal provisions protecting rights. Such provisions are contained in national constitutions and laws, as well as in international and regional documents and treaties. *A close comparison of these provisions with the facts of a situation is the key analysis human rights groups undertake to identify cases of non-compliance by a government with its rights obligations.*

National constitutions and laws

Most constitutions contain a range of rights provisions. Many of these relate to civil and political rights. Some constitutions make no mention at all of economic, social and cultural rights, but others, such as those of South Africa, the Philippines and Mexico, do—and some have quite detailed ESC rights provisions.

When considering a government's compliance with its rights obligations, it is important to study the national constitution and laws to pinpoint responsibilities they place on the government. These national-level provisions provide the "first line of defense" in the case of rights abuses. They are the easiest to use, since they are widely recognized and understood by the legislature, courts and public in the country as the "law of the land."

When can you rely solely on these national provisions and when should you look to regional and international human rights laws or provisions? [4]

In all cases, it is useful to be familiar with the relevant regional and international provisions. If a government has ratified (that is, agreed to be legally bound by) a regional or international human rights treaty, it is obliged to bring its national constitution and laws into line with the provisions of the treaty. As a result, in considering a government's compliance with its regional and international commitments related to

[4] See Appendix 1 for definitions of human rights terms used in *Dignity Counts*.

specific rights, a first step is to analyze the national constitution and laws to determine whether they are in line with these rights commitments.

Chart 2, on the following page, outlines other situations where it can be helpful to use regional and international law standards and provisions:

- In some situations there are no national constitutional or legal provisions protecting ESC rights. In these situations, the only protection available may be regional or international laws.

- Typically, constitutional provisions and laws are stated in brief or vague terms. There may be legislative records or court cases that help one understand how the provisions (words or clauses) in the constitution or laws should be understood or interpreted. It is thus important to know what these records or cases say. Regional and international law, cases and other documents can also at times help to "fill out" the meaning of brief or vague terms in national laws and constitutions.

- National constitutions or laws may be weak and the related regional and international laws stronger. In such a situation, it may be useful to rely primarily on the latter.

Even if the national constitution and laws provide strong and clear guarantees of ESC rights, that does not mean, of course, that the government is respecting these provisions. This is where budget analysis comes in—to help ensure that the government is, through its actions, complying with its rights obligations!

Regional human rights law and standards

There are a few regional human rights treaties that have been developed and adopted by governments in different parts of the world. If there are such treaties in your region, we suggest that you determine if your government has ratified or acceded to them, and, if so, become familiar with their provisions, as they may also come in handy.

The principal regional treaties that relate to ESC rights are:

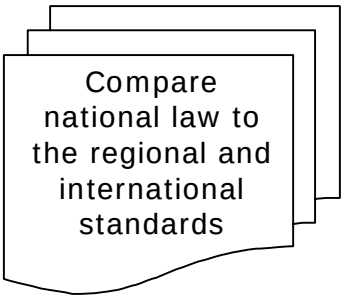
- The African Charter on Human and Peoples' Rights.[5] An inter-governmental institution, the African Commission on Human and Peoples' Rights, is responsible for supervising governments' implementation of the Charter.

[5] http://www1.umn.edu/humanrts/instree/z1afchar.htm

Chart 2

Enforcing human rights:
When do you use national human rights provisions and when regional and international provisions?

Are the national constitution and laws in line with the country's regional and international human rights obligations? →



If rights provisions in the national constitution and laws are strong and clear, use them!

If national constitution and laws provide no rights protection →

Look to regional and international laws for rights guarantees

If national rights guarantees are vague →

Use regional and international standards to "fill out" the rights

If national rights guarantees are weak →

Use the stronger regional or international standards

- The American Convention on Human Rights[6]
- The "Protocol of San Salvador,"[7] a protocol to the American Convention that focuses on ESC rights. The Inter-American Commission on Human Rights is the inter-governmental institution charged with overseeing governments' compliance with their obligations under the American Convention as well as the Protocol.

- The European Convention for the Protection of Human Rights and Fundamental Freedoms.[8] The European Commission of Human Rights reviews States' compliance with their Convention obligations.
- The European Social Charter and protocols to the Charter,[9] which focus on ESC rights. A Committee of Independent Experts reviews governments' reports regarding their compliance with the Charter.

There are no comparable regional treaties for Asia or the Middle East/North Africa regions.

Foreign debt and ESC rights

Since 1997, the Centro de Derechos Económicos y Sociales (CDES), an Ecuadorian NGO, has documented and challenged the link between budget constraints, foreign debt servicing, and economic and social rights. CDES seeks to raise awareness and encourage citizens to speak out against the violations that ensue when the government—often at the urging of international actors—prioritizes foreign debt servicing over social investment.

In 2000 CDES filed a petition before the Inter-American Commission on Human Rights arguing that, by drastically reducing its national health budget in 1998, the Ecuadorian government had violated its citizens' right to the progressive realization of the right to health. The petition claimed that the need to guarantee economic and social rights required the government to prioritize those rights over other obligations, such as debt service payments or compliance with IMF conditionalities.

– For a fuller description of CDES's work in this area, see http://www.cceia.org/viewMedia.php/prmTemplateID/8/prmID/940

6 http://www1.umn.edu/humanrts/oasinstr/zoas3con.htm
7 http://www1.umn.edu/humanrts/oasinstr/zoas10pe.htm
8 http://conventions.coe.int/treaty/en/Treaties/Html/005.htm

International human rights law and standards

While national constitutions and laws typically apply to only one country and regional treaties place obligations on governments only within a specific region, international human rights law applies to countries around the world. Because of this broad relevance, the following discussion is more detailed than the previous discussions on national and regional law. It 1) addresses the most important tenets or principles underlying international human rights law and 2) reviews the main treaty relevant to ESC rights concerns, the International Covenant on Economic, Social and Cultural Rights.

1. Most important tenets or principles underlying international human rights law

The principal tenets underlying international human rights are:

- Rights are an inherent part of being human. People have human rights because they are human beings. Rights thus cannot be taken away.

- Rights are not the same as needs. A government has an obligation to protect and fulfill a person's rights; it has no similar obligation with respect to her needs.

- Rights are something that can be claimed. An individual can seek the enforcement of his rights, and a government has an obligation to provide channels or mechanisms through which he can make such claims.

- Human rights are universal, indivisible and interdependent.

  - Universal means that they belong to every person, no matter who that person is, and no matter where she lives.

  - Indivisible and interdependent means that all rights are inter-related and the protection and fulfillment of one right depends on the protection and fulfillment of other rights. For example, for a person's right to freedom of expression to be meaningful, his right to education must have been respected, enabling him to have access to education. Similarly, if a person's right to education is to be adequately protected, he must have the right to speak out and demand an education that is appropriate to his needs and interests.

Historically, rights have been understood as claims against a State or a government. Criminal law has been the main protection for an individual

[9] http://conventions.coe.int/treaty/en/Treaties/Html/163.htm

against the acts of other individuals or non-State institutions, but criminal law doesn't normally protect individuals against acts of State agents. Human rights have been recognized as the principal source of protection individuals have against the overbearing power of the State.

Corporations and ESC rights

As the power of certain non-State actors, particularly transnational corporations, has grown dramatically in recent decades—in some cases to a size where they are economically more powerful than many States—there have been increasing calls for corporations to be held accountable to human rights standards. Despite efforts already made and those currently underway, the present state of affairs is that corporations generally are technically not legally obliged under international law to respect human rights. In the meanwhile, those concerned about the impact of corporations on ESC rights have pushed governments to provide greater protection against abuses by corporations, and have also relied on, typically voluntary, corporate codes of conduct.

2. The International Covenant on Economic, Social and Cultural Rights[10]

The principal international treaty relating to ESC rights is the International Covenant on Economic, Social and Cultural Rights (ICESCR), which was adopted by the United Nations General Assembly in 1966, and went into effect in 1976. It is directly *binding on those governments that have ratified it*.[11] It guarantees individuals the right to work and to just and favorable conditions of work; social security; an adequate standard of living; the highest attainable standard of physical and mental health; and education, among other rights. These rights are guaranteed to all without discrimination.

Other international treaties containing important ESC rights provisions include the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)[12]; the Convention on the Rights of the Child

[10] http://www.unhchr.ch/html/menu3/b/a_cescr.htm
[11] To determine if your government has ratified the ICESCR, consult: http://www.unhchr.ch/pdf/report.pdf
[12] http://www.un.org/womenwatch/daw/cedaw/cedaw.htm

(CRC)[13]; and the Convention on the Elimination of Racial Discrimination (CERD)[14].

A government's obligations: The International Covenant on Economic, Social and Cultural Rights obligates governments that ratify it to respect, protect and fulfill the rights enumerated in the Covenant. What do these terms mean?

- *Respect* means that a government must not act counter to the guarantees in the Covenant—for example, it must not deprive a person of his or her right to education.

- *Protect* means that a government must act to stop others—for example, individuals or private actors, such as corporations—from violating the guarantees in the Covenant.

- *Fulfill* means that a government has an affirmative duty to take appropriate measures to ensure that the rights enumerated—for example, the right to adequate housing—are attained.

Example — Right to adequate food[15]

Aspect of right	*Obligation to respect*	*Obligation to protect*	*Obligation to fulfill*
Accessibility of food	Not to diminish people's existing access to food	Not to let others encroach on this enjoyment (e.g., developers who take over farm land)	To enact programs to ensure greater access to food
Nutritional content of food	Not to diminish existing nutritional levels	Not to permit contamination of nutritional quality of food (e.g., by use of toxic fertilizers)	To take steps to increase nutritional intake and nutritional quality of food

[13] http://www.unicef.org/crc/crc.htm

[14] http://www.unhchr.ch/html/menu3/b/d_icerd.htm

[15] The chart is taken from *Circle of Rights—Economic, Social and Cultural Rights Activism: A Training Resource*, p. 161. See Appendix 3 for further details about *Circle of Rights*.

A key obligation in all international human rights treaties is that of non-discrimination. The rights in the ICESCR are guaranteed to all without discrimination as to race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. This is an important provision when it comes to the intersection of budget analysis and human rights, as budget analysis can be very helpful in uncovering discriminatory allocations or expenditures of funds.

The Covenant also obligates a government to take steps, utilizing the maximum of its available resources, to achieve progressively the full enjoyment of the rights in the Covenant.[16] This language reflects a recognition that not all rights can be guaranteed fully and immediately. Governments are, however, obliged to take what steps they can to move towards the fulfillment of these rights. They cannot, for example, take steps backwards in providing for education or access to housing for their people. The case study in Section 5 applies these obligations to a concrete situation.

Governments also have "obligations of conduct" and "obligations of result." In other words, a government must not only do a whole range of things to respect, protect and fulfill ESC rights ("obligations of conduct"), but its actions must also *result* in the greater respect, protection and fulfillment of those rights ("obligations of result"). The following chart, which focuses on the right to health, is helpful in understanding these two dimensions of obligations:

Example — Right to health

Concept	*Definition*	*Example*
Obligation of conduct	Obligation to undertake specific steps	Development of immunization campaigns
Obligation of result	Obligation to obtain a particular outcome	Decrease in mortality from epidemic or endemic diseases

[16] Article 2(1) of the ICESCR says: "Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.

It is important to note that a phrase such as "maximum available resources" is quite vague. While the intention is undoubtedly to encourage governments to give a high priority in the allocation of its resources to the satisfaction of ESC rights, it is typical with the development of human rights generally that it takes—and in this case, will take—a large number of situations and cases before more specific parameters for a human rights term are developed and we have a better understanding of how it can be applied in "real life" situations. The case study in Section 5 takes a practical approach to assessing the extent to which this obligation has been met.

The "content" or meaning of specific rights: What does the right to housing guaranteed in the Covenant mean? Or the right to health, education, work and so on? The ICESCR itself does not go into detail on this score. As was mentioned earlier, our understanding of human rights evolves over time through situations and cases, and, ideally, through the development of broad consensuses about different practices and behaviors. Thus, everyone, through their discussions and actions, has a role to play in helping develop our understanding of what these rights mean. When, fifty years ago, people claimed they had been tortured, there was no clear international agreement on what did or did not constitute torture. Over the years, as situations were brought to public attention and complaints filed with police or in the courts, as people discussed one case, then another, more and more lines were drawn and conclusions reached as to what constituted torture, what did not. While the lines are not yet totally clear, the "profile" of torture is much clearer now than it was fifty years ago.

The "content"/meaning of the various ESC rights is being developed each day through consideration of cases, whether these are addressed in public discussions, handled administratively or through law reform or litigation, whether this occurs at the local, national, regional or international level.

An important role in our developing understanding of the "content" or meaning of various ESC rights is played by the Committee on Economic, Social and Cultural Rights (CESCR). The Committee is a group of individuals from countries that have ratified the ICESCR. Governments that have ratified the Covenant have a responsibility to report to the CESCR on a regular basis with regard to their implementation of the Covenant. The CESCR reviews and comments on their reports. Similar "treaty bodies" have been established to monitor other treaties, such as CEDAW or the CRC.

As part of its work, the Committee occasionally issues "General Comments" that elaborate on the meaning of different rights. These General Comments have, to date, addressed the rights to housing, education, food and health, among other topics. They reflect and help further the development of our understanding on these various rights.

(You will see in the case study in Section 5 how the General Comment (GC) on the right to health (GC 14) can be helpful in guiding budget analysis).[17]

Bringing it all together—the right to health

As was mentioned above, it is important, in considering the rights issues in a particular case, to look first to the national constitution and national laws of a country for provisions that might protect the right that is of concern. Regional and international human rights law can also be usefully employed where relevant national provisions either do not exist or where they are weak, vague or insufficiently detailed.

In approaching the situation of health care for the "open population" in Mexico, Fundar chose to rely particularly on the Mexican Constitution and national laws and on the relevant provisions of the ICESCR, to which Mexico acceded in 1981.

After identifying the Mexican laws and the relevant provisions in the ICESCR, and before analyzing the extent to which these provisions were guaranteed in practice through the budget, Fundar compared the Mexican provisions to its international obligations under ICESCR—to determine, first of all, if Mexican law was in keeping with these obligations. The ICESCR also provided useful additional "content" or meaning—it helped "fill in" the outline provided by the Mexican law.

When you get to the case study in Section 5, you will see reference to various of the domestic and international law provisions discussed in the following paragraphs.

Mexican law: Article 4 of the Mexican Constitution stipulates that "every person has the right to health protection." According to the General Health Bill, which is the national legal framework that details actions the Mexican government should adopt related to health, the right to health protection is to be understood primarily as *the enjoyment of health services and assistance that satisfy the needs of the population* (art. 2).

The General Health Bill considers, as "basic health services," medical care, including preventive, curative and prophylactic measures as well as emergency care (art. 27). As part of medical care, the law (art. 29) stipulates that the Ministry of Health (SSA) must guarantee that certain medicines are readily available in a public stock to primary health facilities, and provides a list of drugs that must be available for the purposes of secondary and tertiary care (art. 28).

[17] The full text of General Comment 14 can be found at: http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En?OpenDocument

The Bill establishes clear provisions with respect to *progressiveness*. It provides that public services to the general population must be granted to those who need them, guaranteeing "qualitative and quantitative extension of services, with preference given to the most vulnerable groups." (art. 25) In addition, these services must be available to all, and must be provided on a cost-free basis depending upon the person's socio-economic situation (art. 35).

With respect to *reproductive, maternal and child health care* (detailed in art. 12 of the ICESCR; see below), Title III of the General Health Bill, "The Provision of Health Services," dedicates its Chapter V to maternal and infant care, to which it gives highest priority. This implies that prenatal, perinatal, and postpartum care for women as well as care for children during their growth and development, are essentials. Chapter VI deals with family planning services, which are also given high priority, and this, in turn, implies sex orientation and education for adolescents as well as information about contraceptive methods for partners.

With regard to the *prevention, treatment and control of diseases* (ICESCR, art. 12), the Bill stipulates that the prevention and control of high priority, transmittable diseases and the most frequent non-transmittable diseases, should be considered to be part of "basic health services." Title VIII, "Prevention and Control of Diseases," stipulates that the Ministry of Health (SSA) should implement programs and activities necessary for the prevention and control of disease. With respect to treatment, Title II on the "Provision of Health Services" stipulates that medical care can be preventive, curative or rehabilitative.

Concerning what is referred to in article 12 of the ICESCR as the *creation of conditions that assure to all medical services and medical care in the event of illness* (see below), it is important to refer to the Bill's provisions with respect to health facilities, goods and services. These were already discussed in Section 1, above, which explained that the national health system is divided into services through the Ministry of Health and the states for the "open population," and social security services as well as private services for those who qualify within public institutions (Title III, Chapter III, on "Service Providers"). Consequently, treatment of diseases depends on the socio-economic condition of the individual, since access to the health facilities and goods corresponds to this division.

As you will soon see yourself, it appears that these Mexican Constitution and laws related to health are quite consistent with Mexico's international obligations under the ICESCR. What are those obligations?

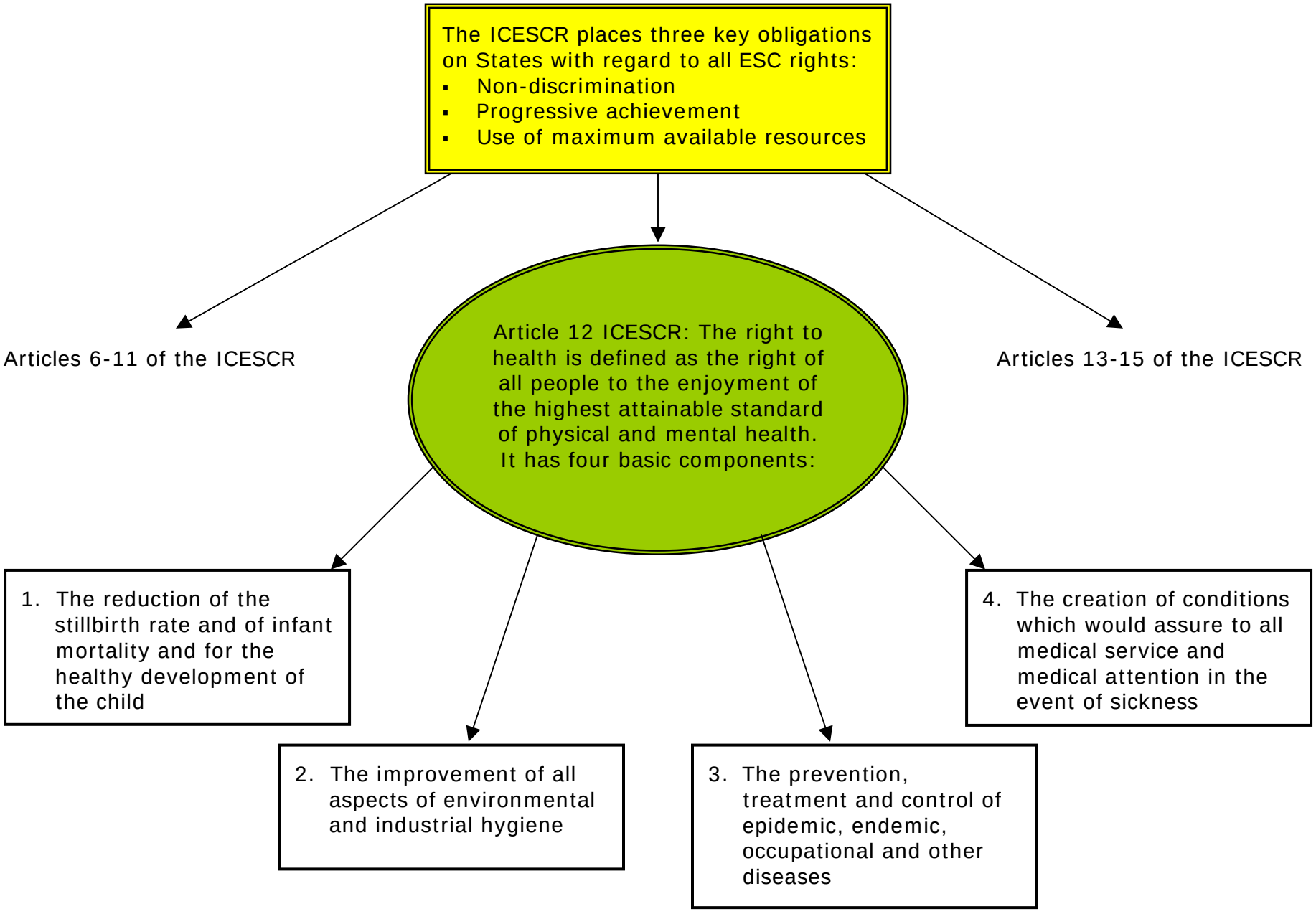
International guarantees relating to the right to health: The central ICESCR provisions related to the right to health are found in article 12. Article 12 states:

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
   (a) The provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child;
   (b) The improvement of all aspects of environmental and industrial hygiene;
   (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
   (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

Other international treaties, declarations and resolutions related to the right to health further our understanding of this right.[18] Much of this understanding has been pulled together and summarized in General Comment 14 on the right to health issued by the CESCR.

The charts on the next pages pull together information about governments' general obligations under the ICESCR and the specific provisions in article 12 with regard to the right to health. They relate these obligations and provisions with details in General Comment 14. You can see from the previous discussion and the following charts that the broad guarantee in article 12 of the Covenant of the right to the "highest attainable standard of physical and mental health" turns out to be not quite as vague as those words would lead one to believe!

[18] See pp. 267-285 of *Circle of Rights* for a more detailed discussion of international standards related to the right to health. (See Appendix 3 for more details on *Circle of Rights*.)


The ICESCR places three key obligations on States with regard to all ESC rights:
▪ Non-discrimination
▪ Progressive achievement
▪ Use of maximum available resources
Articles 6-11 of the ICESCR
Article 12 ICESCR: The right to health is defined as the right of all people to the enjoyment of the highest attainable standard of physical and mental health. It has four basic components:
Articles 13-15 of the ICESCR
1. The reduction of the stillbirth rate and of infant mortality and for the healthy development of the child
2. The improvement of all aspects of environmental and industrial hygiene
3. The prevention, treatment and control of epidemic, endemic, occupational and other diseases
4. The creation of conditions which would assure to all medical service and medical attention in the event of sickness

Elaborating upon these four broad areas mentioned in article 12, the CESCR has provided greater detail on how a government should work to respect, protect and fulfill the right to health. In its General Comment 14 the CESCR says they should:

Guarantee

- The *availability* of health care as well as the availability of the resources, goods and services important to health, such as clean water, education about health. It provides further detail on what else should be available.
- The *accessibility* of health care; of the resources, goods and services, etc., important to health on the basis of non-discrimination. "Accessibility" includes both physical accessibility and economic accessibility (that is, affordability). It also guarantees people access to information about their health and about the resources, goods and services important to health; etc.
- The *acceptability* of health care; of resources, goods and services important to health, etc. This means, for example, that health care must be culturally acceptable to those seeking it.
- *The quality* of health care; the quality of the resources, goods and services important to health, etc.

- Ensure the right of access to health facilities, goods and services;
- Ensure access to the minimum essential food
- Ensure access to basic shelter, housing and sanitation, and potable water;
- Provide essential drugs;
- Ensure equitable distribution of all health facilities, goods and services;
- Adopt a national public health strategy and plan of action that gives particular attention to all vulnerable groups;
- Ensure reproductive, maternal and child health care;
- Provide immunization against the major infectious diseases;
- Take measures to prevent, treat and control epidemic and endemic diseases;
- Provide education and access to information concerning the main health problems;
- Provide appropriate training for health personnel, including education on health and human rights

- Issues of availability, accessibility and quality, mentioned in the left-hand column, arise in the case study (Section 5) as do certain of the eleven specific provisions mentioned in the right-hand column.

SECTION 3

Budget analysis — an overview

Introduction

A budget is the most important economic policy instrument any government produces. Writing a budget requires concrete decisions about how money should be raised and how it will be spent. Thus the budget reflects a government's true social and economic policy priorities, often supporting, but sometimes contrasting with, the goals, commitments, slogans, and policies articulated by political leaders. Understanding what governments are *actually* doing—as opposed to what they may say they want to do or hope to do—requires understanding what is in the budget.

The government's budget affects the lives of every one of its citizens. The money it raises comes from taxpayers, and the way it is spent on education, health care, public safety, transportation, and infrastructure—among many other priorities—affects the economy and social system in many, many ways. Everyone has a stake in the budget process. But while budgets affect everyone, certain groups such as the elderly, children, the poor, the disabled, rural residents and minorities, are often particularly vulnerable to the decisions governments make in raising and spending money. Because they often live on the edge, small changes in how governments allocate resources can have a big effect on their quality of life.

Despite the importance of funding for recognizing the economic rights of marginalized people, programs that benefit the poor are often among the first to face cuts in times of budget deficits. There are many reasons for this. Other items such as interest on the debt, the public-sector wage bill, and military expenditures are more likely to have first claim on scarce funds. Other groups such as business leaders or urban elites often have more effective and experienced lobbyists. Too often vulnerable people are comparatively “invisible” to government elites who may socialize with and circulate among the well-to-do. And even when funds have been allocated to anti-poverty programs or other services benefiting vulnerable communities, weak expenditure and program management and the lack of political power among the poor can mean that the money never reaches the intended beneficiaries.

In a wide range of countries around the world, pro-poor groups have discovered that developing the capacity to analyze, understand, and influence the budget can be a powerful tool for advancing their issues. This applied budget work can include the national budget, the budgets of states or provinces, and even budgets of local communities. An ability to

engage in the budget process can help human rights organizations in several ways, including:

- Measuring government's commitment to specific policy areas, and contrasting that commitment to other lower-priority areas;
- Determining the trends in spending on program areas, to ensure that programs aimed at meeting human rights commitments receive a growing share of the budget over time.
- Costing out the implications of policy proposals;
- Analyzing the impact of budgetary choices on people;
- Assessing the adequacy of budgets relative to international or local conventions and commitments; and
- Identifying sources of new funding for proposed policies.

In any country, no matter how rich or poor, there are insufficient resources available to meet all existing needs; this is a central assumption of budget analysis. By digging into the details of the budget, by making the raw numbers tell a story about government priorities, budget analysis helps lay bare the choices confronting a government and its people. But while budget work can assist in identifying what government officials are doing or have done over time and what the true priorities of the government are, budget analysis cannot by itself identify what the true priorities ought to be. A human rights framework can help fill this gap.

Budgets can be intimidating documents. They are big, full of numbers, and often riddled with technical language. Too often budgets provide few useful summary tables, little in the way of historic context, and no handy directions for the casual reader. As a result, most people feel intimidated by the idea of trying to delve into the budget, assuming that it is highly sophisticated, technical, and detached work.

That's where a well-placed budget analyst working in a civil society organization comes in handy. While the degrees of sophistication in budget analysis can vary—as they do in human rights work—the bottom line is usually simple. Budget analysis can be reasonably simple and straightforward. Using the tools of arithmetic—adding and subtracting, multiplying and dividing—human rights advocates can learn to talk about budgets and the priorities they embody in powerful ways. After all, while it is easy to argue whether or not the government should spend more on health care, it may be a lot harder to argue whether spending on health care has dropped, if that's what the data show. By sustaining this effort to unravel and understand the budget, human rights advocates can learn to tell a story about the budget and the use of public resources, translating the dry data of a budget into a compelling case for improved and expanded programs for the poor and other vulnerable people.

Access to information

One of the most widespread problems facing anyone trying to analyze a government's budget—particularly in developing countries and emerging democracies—is the lack of accurate budget data and socio-economic statistics. Less than 10 years ago, for instance, the federal budget of Mexico was one of the country's best-guarded secrets. In many countries, some important data are simply non-existent, while problems of timeliness, accuracy, and accessibility also hinder the analyst. Civil society groups seeking to address human rights abuses by undertaking budget analysis will likely encounter sizeable obstacles to securing the information they need.

The absence of solid data, however, is rarely a good reason to just walk away from the budget. As discussed above, the budget is simply too important—for programs that would help poor people, for the economic future of the country, and indeed for the development of democracy itself—to ignore. While a budget analyst would always prefer more and better data, it is often possible to at least start unraveling the mysteries of a government's budget and tax system with whatever information is available.

Moreover, beyond the immediate need to understand and analyze the budget, civil society organizations have a strong interest in promoting reforms to the budget system, since it is typically the poor and powerless who are most adversely affected by a weak or corrupt budget system. A sound budget system, one that is transparent and accountable, is far more likely to yield results that reflect the will of *all* the people, rather than that of an elite minority.

Thus, at the same time that an organization may be trying to come to conclusions about spending priorities based on limited data—and challenging the government to provide better data if officials believe the conclusions are inaccurate—an organization may also begin a campaign to improve transparency and accountability in budgeting.[19] Not only can such a campaign eventually yield powerful and important data, but it can also bring a human rights group new and useful allies. After all, business groups, parliamentarians, journalists, researchers, and others often share an interest in improved budget conditions.

Health care in Mexico

The case study summarized in Section 1 provides an opportunity to explore in some detail just how budget analysis can help answer key

[19] Access to information regarding public matters is a right under international human rights law, and a campaign can be based on the State's international human rights obligations.

questions about a government's commitment to economic, social, and cultural rights. Does the budget of Mexico reflect an effort toward "progressive achievement" of the right to health? Does the government of Mexico use "maximum available resources" in efforts to improve health? What can budget data tell us about Mexico's commitment to maternal and child health, preventive health care, and access to health care facilities? A careful analysis of the national budget, informed by health care experts and other demographic data, provides a strong indication that Mexico is *not* meeting its obligations under international human rights standards. *These results don't just reaffirm the notion that lower-income Mexicans get inadequate care; they also provide important support for the conclusion that Mexican officials could and should be doing more to ensure the right to health care.*

How does the analysis in Section 5 translate the dry numbers contained in the budget into a powerful indictment of the government's actions? The key is its marshaling of the data in a convincing way, while remaining scrupulous about the integrity of the data. In that sense, one of the key attributes of Section 5 is the way it explains carefully all the analysis that goes into the case being made. It models the very transparency we ask government officials to exhibit.

Early in the report, Fundar makes three key observations that will help the reader understand how the data are being used.

- First, even though health-related programs can be found in many places in the budget, this report focuses on the part of the budget that deals directly with health care. While that creates a modest limitation on the conclusions drawn from the analysis, it substantially reduces the complexity of the analysis. And because the authors are entirely transparent about this limitation, they cannot be faulted for trying to hide this caveat or manipulate the analysis.

- Second, the analysis explains why the data used are from 1998 to 2002. Because significant accounting changes took place in 1998, it is all but impossible to compare data from before and after the change; in addition, 2002 data are the most current available for actual as opposed to projected or planned spending.

- Finally, the text makes clear that all the budget data in the case study are adjusted to account for inflation. The difference between inflation-adjusted data (what economists call "real" money) and unadjusted (or "nominal" data) is a crucial distinction to make. Over time, inflation erodes the value of money, making any analysis using nominal data suspect.

Probably the first step in any budget analysis is simply to determine how the government spends its money. This requires a certain amount of

familiarity with the budget, and is rarely as simple as it seems. For example, the question "How much does the government spend each year?" can yield several different answers:

Adjusting for inflation

One of the most important calculations done in budget analysis is to adjust spending and other economic data for inflation. The failure to adjust these data for inflation gives a misleading impression of changes over time or levels of spending. This is particularly true in countries with relatively high inflation rates, but is even true when inflation is more modest.

In order to adjust for inflation, an analyst first needs to find the government's consumer price index. This is the measure used to compare the buying power of the local currency from one year to the next. The consumer price index shows the relative value of each year and typically looks something like this:

1998	88.4
1999	91.6
2000	97.8
2001	101.4
2002	106.2
2003	112.7

Imagine education spending in 1998 was 37.4 billion pesos (or whatever the local currency is). By 2003, if spending had stayed flat at 37.4 billion pesos, it clearly would not buy as much—you couldn't hire as many teachers, buy as many books, and so on. What level of 2003 spending would equal that earlier amount?

To figure that out, you would multiply the spending in 1998 times the consumer price index for 2003, and then divide it by the index from 1998. The equation would look like this:

(37.4 billion pesos x 112.7) ÷ 88.4 = 47.7 billion pesos

Eventually, this calculation becomes second nature to a budget analyst, but it is always useful to keep in mind this rule of thumb: Unless the economy is suffering from deflation—a highly unusual scenario, inflating past data to current levels should always make the earlier figure grow. If it shrinks, you have done the calculation incorrectly.

- While the legislature typically approves a budget that may include some total figure, the government may spend more or less than that amount in practice. In some countries, the difference between the budget as it is enacted and as it is implemented can be significant.

- While there may be some information about changes to the budget as it is being implemented, in most cases the total amount spent, as well as the amounts spent in various categories or departments, may not be known definitively for many months after the end of the year.

- Beyond tracking the differences between projected spending and actual spending, many governments use several different budgets for different purposes. It is not unusual, for instance, for a government to use an "operating budget" for ordinary government programs and a "capital budget" to account for long-term infrastructure spending. Beyond that, governments often use a variety of what are called "off-budget" gimmicks to keep some programs outside of the normal budget process; old-age pension programs and spending from oil resources in oil-rich countries are common examples.

Thus it becomes clear that even the most simple budget analysis can be complicated and challenging; that is the fundamental reason budget analysis cannot be merely an occasional interest for an organization. Understanding and interpreting the budget, making the data in the budget tell a story about the recognition of human rights—or failure to recognize human rights—requires an ongoing commitment of time and resources. But the payoff, as the analysis in Section 5 shows, can be considerable.

Progressive achievement of the right to health

As human rights activists know, human rights conventions do not require governments to immediately ensure access to health care, housing, nutrition, and other ESC rights. Instead, governments have a more modest requirement: they are obligated to move toward full achievement of those rights, what is known as progressive achievement. The Government of Mexico may not yet be able to provide health care for all its citizens, but it should be able to show progress in that direction. The budget analysis in this case study suggests that they are failing even according to this relatively modest standard.

The first piece of analysis in Section 5 shows how inflation-adjusted spending on health care in Mexico has changed over time. By simply totaling health care spending for each of the years covered, Graph 1 (p. 48) shows that inflation-adjusted health care spending rose in two years, fell

A simple graph showing inflation-adjusted spending over time is often a useful first look.

slightly in one, and fell sharply in the last year. This sort of analysis over time is nearly always a useful first look at spending trends. While the graph shows there is some initial indication of progressive achievement, that progress essentially evaporates by the end of 2002.

As is probably true in any field, from budget analysis to human rights to geophysics, the answer to one question always leads to more questions. In this case, since the drop in spending in 2002 is the most striking aspect of health care spending, the report examines just why spending fell so sharply. To do this, the analysis looks at the same question—how did health care spending change between 1998 and 2002?—but this time looks at each of the four major components of health care spending in Mexico—the Ministry of Health (SSA), decentralized health funds (FASSA) and health care spending in the two main social security institutions (IMSS and ISSSTE). The result of this exercise is striking. It is clear that the drop in spending in 2002 is *entirely* the result of a drop in spending in one of these areas, IMSS.

The next step in the unraveling story demonstrates the importance of marrying budget analysis with knowledge about the health care system in Mexico. Graph 3 in the analysis (p. 50) shows that while the population in Mexico is split nearly equally between those known as "right-holders" in the social security system—those who have a claim to social security health benefits as a result of their employment in the formal economy—and the "open population"—those outside the formal economy who receive health care through a different funding stream—health care spending on "right-holders" is nearly double spending on the "open population." *By dividing the total spending on each group by the number of individuals covered by each program, Graph 4 (p. 51) shows that the spending per person on "right-holders," known as "per capita spending",* is nearly double the spending on the "open population."

Showing spending levels on a "per capita" basis (also known as "per person") can yield important insights.

Full use of maximum available resources

Under the ICESCR, the government should be able to document that it is using the maximum resources available to guarantee the right to health. In budget terms, as the analysis in Section 5 states, "this means that the government … should prioritize the allocation of resources to necessary services." Again, as with progressive achievement, this is a standard that can be measured using available budget data.

The limits of budget analysis

While budget analysis is a powerful tool for understanding government's priorities, there is a wide range of questions budget analysis cannot answer. Most important, while an analysis of the budget can identify what has been spent or is being spent, it cannot ultimately determine what should be spent; that is a political or philosophical question. It is also a human rights question, because human rights obligations constrain or direct the State in several ways, obliging them to allocate resources to the fulfillment of rights.

Additionally, while analyzing both proposed and actual spending is useful, just looking at the budget does not tell you how effectively or efficiently the money is being spent, or whether the resources allocated are reaching their intended purpose. Looking at the budget can give indications of what populations are being served, but an objective analysis of the budget cannot duplicate the critical information provided by observation in the field of how programs actually operate and who is actually served.

In addition, budget analysis needs to be supplemented by detailed information about the economy, the population, regional issues, and specific programs. Budget analysts typically know a great deal about the overall budget, but may not have such detailed information about any particular area of the budget, such as health, education, community development, and so on. For this, budget analysts need to rely on partnerships with others who are able to specialize in particular areas. It is this sort of partnership or coalition that can provide a dynamic resource to challenge—or support—government spending patterns.

One way to determine the priority of the claim health care spending has on available resources is to compare health care spending to *the size of the total national economy, a figure known as gross domestic product or GDP.* Because this is a standard economic measure, every country has an estimated GDP. By dividing the amount spent by the government of Mexico on health care by the GDP, we find that Mexico spends a little over two percent of GDP on health care. Looking at this over time, however, as in Graph 5 (p. 52), we see that the amount spent on health care has fallen from about 2.4 percent of GDP to just 2.15 percent. In other words, health care spending appears to be falling as a priority, at least when measured against all the resources available to the country.

Spending on a program can be compared to the economy (GDP) or to total spending to get a sense of the level of priority it is given.

A second useful way to measure the priority given to health care is to compare health care spending to total government spending. This question goes directly to decisions of policy makers: whatever the level of government spending, how does health care stack up against other demands for public spending?

As with spending as a share of GDP, this is a pretty straightforward question. So long as there is an estimate of total government spending, we can divide health care spending by total spending and, over time, get a sense of the priority officials give to health care spending. Graph 6 (p. 52) shows that health care spending in Mexico has fallen from over 11 percent of total government spending in 1998 to less than nine percent in 2002. Thus health care spending, whether measured as a share of the economy or as a share of total spending, appears to be a falling priority for government officials. They are spending available resources somewhere else.

It makes sense, then, to look at just where else the government *is* spending money. There are a number of ways to do this. For instance, if the data are available, one could look at different categories of spending over time—education, transportation, defense, economic development, and so on—and look at which have grown relative to total spending (or GDP) and which have fallen. This, however, can require a great deal of information about the budget, and in particular how various programs may have moved from one department to another over time. Thus while this can be a useful exercise in determining changing priorities, it is not always necessary. Instead, as the Fundar analysis does, one can analyze how the government chooses to allocate resources in practice during the course of a year.

Always keep in mind the difference between budgeted spending and actual spending.

One of the most important distinctions budget analysts can make is to differentiate between *budgeted* spending (what government officials say they intend to spend when they enact the budget) and actual spending (the amounts that actually go out the door during the course of the year). While it is often easier to analyze *budgeted* spending, what really matters is *actual* spending.

The analysis in the Fundar case shows, for instance, that the Ministries of Finance, Tourism, and Foreign Affairs each spent more during the course of the year than was allocated in the budget (pp. 53-55). In other words,

when extra resources became available, they were not allocated to health programs. Moreover, when looking at capital spending—longer-term investments in infrastructure like buildings or major pieces of equipment—the Navy Department spent nearly 25 percent more than was budgeted, while the Defense Department spent 17 percent more than what was in the original budget. In sharp contrast, the Ministry of Health spent less than half the amount budgeted to it for capital investments.

Finally, this same part of the Fundar analysis provides one more example of how budget analysis can tell a story about government priorities. Too often, budget analyses can become dry stacks of numbers, one statistic piled on top of another, with little context to engage the reader. This analysis, in contrast, shows how various health care programs compare with other programs throughout the budget. It demonstrates, for instance, that the additional spending in the Ministries of Finance, Tourism, and Foreign Affairs, above and beyond the amount originally

Budget work and human rights groups

Not every human rights group is going to expand its "portfolio" to include budget analysis. Keeping on top of all the changes and debates in the budget process is a challenging task, typically requiring the full-time attention of at least one staff person. Most groups find that this is not something they can just dip into and walk away from whenever they need some information.

Besides developing your own budget capacity, another model that may work well is to partner with a good budget group in your country. In many cases, budget groups emphasize the role of the budget in alleviating poverty, even if they do not approach their work within an explicitly human rights framework. A list of budget groups around the world can be found at the International Budget Project's website, www.internationalbudget.org.

If you are able to locate a good budget group in your country and can develop a good working relationship with them, it often makes sense to leave most of the budget analysis to that group, rather than duplicating their capacity. In order to take full advantage of the skills these budget groups can offer, though, human rights groups need to understand enough about budget work to ask the right questions and guide the budget group towards the kind of information that would be most useful. That's why learning at least a little about budget work is useful even for groups that may not be doing a significant amount of budget analysis on their own.

allocated in the budget, was 2.3 times the total budget of a health care program aimed at 10 million Mexicans in extreme poverty. Similarly, the analysis shows that the 2002 *increase* in the Ministry of Finance budget was 22 times the budget for health care infrastructure for fiscal years 2000 to 2002 *combined*. This sort of comparison can be a powerful tool to demonstrate misguided priorities.

Using creative comparisons of budget levels helps the reader put the analysis in context.

Analysis of three components of article 12

While the initial parts of the Fundar analysis focus on two general human rights obligations—progressive achievement and maximum available resources—the remainder of the analysis looks at specific obligations under article 12 of the ICESCR. An important consideration for this more detailed look at the government's obligations and performance regarding health care is that such an analysis requires more background on both health care programs and underlying demographics than did the earlier analyses. This is a good example of how the best analyses combine the expertise of both budget analysts and other analysts in specific fields, in this case, health care analysts.

For instance, the data show (p. 56) that the budget for the General Office of Reproductive Health grew modestly between 1998 and 2001, but then grew substantially in 2002 and 2003. Even though actual spending lagged behind budgeted spending in each of those years—suggesting, as discussed above, that the government is not using maximum available resources—the substantial increases in 2002 and 2003 certainly indicate that the government is taking this issue seriously.

However, a careful analysis of health care programs shows that not all programs that have an impact on reproductive health fall under the General Office of Reproductive Health. The Program for the Extension of Coverage (PAC) targets the poorest communities in Mexico with the highest levels of “marginalization,” and includes care for women during and after pregnancy. Yet Graph 9 (p. 57) shows that PAC spending was highest on a per capita basis in relatively higher-income states and lowest in lower-income states.

This is a complicated point, and deserves some explanation. The National Population Council has developed a methodology to estimate the level of marginalization for each of Mexico's 31 states and the Federal District, and ranks each state as very high, high, medium, low, or very low; a state with very high marginalization is quite poor, while a state with very low marginalization is relatively affluent (see Appendix 2). To create Graph 9, the analysts needed to know PAC spending in each state as well

as the total population in each state that was eligible for PAC spending. From these data they could calculate per capita PAC spending in each state. Then, by grouping states according to their level of marginalization, they could calculate the overall per capita PAC spending for each group.

It may be obvious that spending twice as much per person in higher-income states compared to lower-income states, as shown in Graph 9, is not a good use of limited resources and, moreover, suggests a degree of discrimination in access to health care. To make that more obvious, however, and to give further examples of misplaced priorities, the analysis (pp. 57-58) shows that PAC spending in high-income Michoacán is seven times as high as in low-income Veracruz. Finally, there were five states where per capita spending was more than three times the level of the poorest six states. This is a clear indication of *de facto* discrimination in the provision of health care.

In considering the role of government spending in disease prevention, the report makes an important point. Graph 10 (p. 60) shows the combined budgets for the General Office of Health Promotion and the National Center for Epidemiological Monitoring. After adjusting for inflation, spending has gone down significantly since 1999. Yet, the report notes,

> It is entirely possible that several programs and offices within the Ministry of Health contemplate additional resources for prevention and treatment of diseases. However, this is the picture that can be put together with the best information publicly available. If there is a better way of identifying resources allocated to prevention, the government should be accounting for it in a transparent way.

That is to say, it is often useful to acknowledge that additional evidence, not currently available or accessible to the public, may exist. However, using the best data available, budget analysts can provide a transparent case to make up part of the public discussion in a democratic process.

Finally, the Fundar analysis considers the obligation of the State to create conditions that assure medical services and care (pp. 61-68). A quick look at spending for people who lack social security (FASSA spending) shows a steady increase since 1998 (p. 62). Without looking any deeper, that would suggest that the government is doing well. However, using the methodology described above of measuring spending based on the degree of marginalization, we come to quite a different conclusion.

Finding ways to group states or regions can help the reader who may not have detailed information about each state.

Graph 14 (p. 63) shows that per capita FASSA spending is significantly higher in states with lower poverty levels than in states with higher poverty levels, notwithstanding the greater need in lower-income states. Similarly, additional data suggest that there are more doctors per capita and significantly more hospital beds in higher-income states (that is, states with lower levels of marginalization) (Graphs 15, and 16, pp. 64-65). Finally, although the data are less stark, there are more doctors' offices per capita in higher-income states (Graph 17, p. 66).

Taken together, the data and analysis in the Fundar case study provide a compelling argument that, from a variety of perspectives, the Mexican government appears not to be meeting its obligations regarding the right to health. The analysis looks at health care spending over time, health care spending compared to other priorities, and health care spending in poor versus wealthier states, and each of these approaches suggests the same conclusion: Mexicans—particularly low-income Mexicans—are not getting the health care that should be available to them.

Budget analysis and the courts

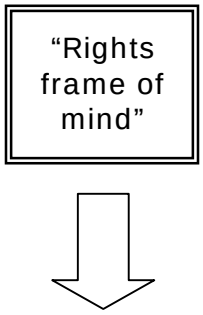
Argentine hemorrhagic fever threatens the lives of 3.5 million people who live in the endemic area, which includes the moist pampa of Argentina. A vaccine has been found to be 95% effective in treating the fever. When the Argentine Government failed to carry out a massive vaccination campaign, a judicial writ of *amparo* was filed in court to protect the right to health of the persons living in the affected areas. In 1998 a court ruled favorably on the writ and established the State's obligation to manufacture and administer the vaccine. It also set a binding deadline—the end of 1999—for the obligation to be met.

The *Centro de Estudios Legales y Sociales* (CELS) in Argentina verified that, as of July 2000, the government had not fulfilled its obligation, claiming lack of raw materials and technical staff. CELS filed a new petition in the court, asking the judge to fix a new deadline. In support of its petition, CELS provided budget figures and other information demonstrating that enough resources had been allocated for manufacturing the vaccine, but these had not been used. This information was persuasive, since it showed the court that the problem was not one of resources, but of neglect. The judge fixed a new deadline for the Ministries of Health and of the Economy to comply. When this deadline was also not met, the judge ordered budget funds allocated for the vaccine to be frozen to stop the government from spending them on other activities.

SECTION 4

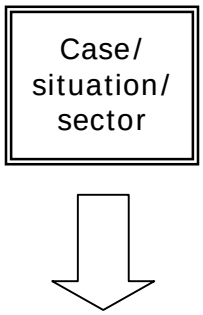
Putting it all together—some further thoughts on process

The next section, Section 5, weaves together much of the information provided in Sections 1, 2 and 3. Because those sections covered a lot of ground, it seems wise, before plunging ahead, to review the relationships among these sections through returning to the suggested steps in the Introduction on "how to" use budget analysis to assess a government's compliance with its ESC rights obligations. A review should also help make the case study easier to understand.

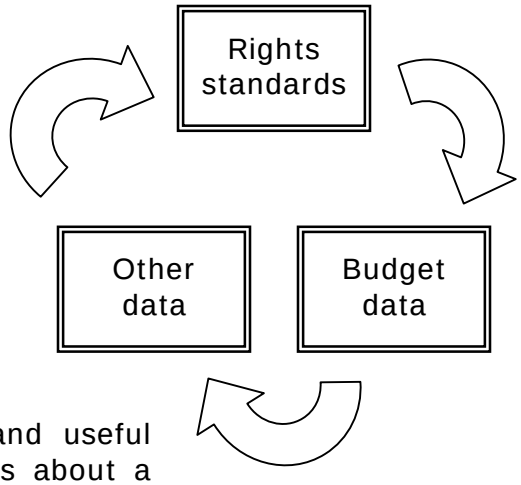


Starting with a "rights frame of mind": You have probably heard the expression, "The answers you get depend upon the questions you ask." In a similar way, what you see in a situation depends a lot of what you are looking for. Where there are hungry children, you may see the signs of malnourishment, you may observe a need for emergency food provision, you may notice the drought-plagued fields and think about the need for irrigation ditches—and you may also wonder whether what you are seeing is a violation of the right to food.

Thinking about the right to food in a situation like this is what we mean by seeing a situation in a "rights frame of mind." Whether you are working at the "macro" level (for example, on national or international policies related to a particular sector, like education or labor), or at the "micro" level (for example, with the parents of those hungry children who have come to you for help), bringing a "rights frame of mind" to your work is essential.



Identifying the case or situation of particular concern: The situation that Fundar identified dealt with the availability of and access to health care of the "open population" in Mexico. However, as was already alluded to, you can start at any point along the "macro" to "micro" spectrum when deciding to use budget analysis. You may be concerned about the situation of that individual or your work may focus on national policies that affect millions of people. In these cases and in cases that fit somewhere between, looking at the human rights implications of budgets means that ultimately your concern is about the welfare of a person or persons.



Following the "iterative" process of looking at rights, doing budget analysis and gathering additional information: Three things should be said here:

- The dictionary says that "iterative" relates to a "computational process in which replication of a cycle of operations produces results which approximate the desired result more and more closely."

  In order to arrive at an accurate and useful understanding of what a budget says about a government's compliance with its rights obligations, a repeating cycle of looking at the relevant rights standards, doing some budget analysis and gathering additional information about the situation, then going back and thinking again about the rights standards, gathering additional information, doing further budget analysis, and so on, will be necessary.

  In addition to knowing the relevant provisions in your national constitution and laws, you need to determine which regional and international treaties your government has ratified—and to which, thus, it is legally bound. Looking at the national, regional and international rights standards will guide you to the human rights dimensions of specific issues (for example, maternal mortality as a focus in the health arena, mentioned in article 12 of the ICESCR). This focus will, in turn, help shape your budget analysis—you will be looking for areas of the budget or line items in the budget that relate, for example, to health care for pregnant women.

  You will likely also find that you do not have enough other information about the situation to draw a conclusion about a potential rights violation or to make the most sense of the budget information. If your concern is about the right to health of pregnant women, you will likely want to know, for example, how many pregnant women in the country die each year from complications related to pregnancy or child birth. This information seems important in order to make sense of the amounts allocated in the budget to care for pregnant women. Is that amount a lot or is it, in reality, very small, given the number of pregnant women? Other questions will likely arise: Is maternal mortality higher in certain areas of the country? Why is that? And so on. Many possible questions will arise, depending upon your focus of concern and the human rights standards involved.

  As your iterative research process continues, you might be able to determine, for instance, that more women die due to pregnancy or

birth in poor and rural areas, just because they cannot be taken care of in case of emergency. Thus, you will learn that it is not sufficient to look at the budget components that deal with health care for pregnant women, but that there are other factors related to the general availability of medical attention that can play a crucial role in preventing maternal death. Such factors can range from the existence of functioning ambulances to the capacity of emergency attention to "stabilize" a woman whose condition is deteriorating. To fully understand the situation of pregnant women, what their rights and the government's obligations entail, you need this type of information.

As you gather your information, you may find you need to go back and look in more detail at what the national constitution or laws say about programs related not only to pregnant women or maternal mortality, but also, for example, to emergency services in marginalized communities. You may want to explore more fully the international human rights standards related to maternal mortality—or, in your case, whatever is developing into your particular focus of concern. These standards may, in turn, help you identify where in the budget you need to look more closely and what more you need to find out about allocations and expenditures.

- As is probably obvious by now, using budget analysis to assess a government's compliance with its rights obligations requires a substantial amount and different types of information, and also requires a lot of analysis. More important than simply "crunching the numbers" in the budget is relating policy analysis and even field information to the way in which the money is being allocated.

  While one organization may be able to do a lot of work, it rarely has all of the expertise needed "in house." This hard reality can, in fact, be grasped as a great opportunity to network with other organizations and activists, and to develop in-depth dialogues as well as strategic alliances with them.

  In developing the case study in Section 5, Fundar, which works on national-level policies, was in direct contact with and relied upon research by organizations working in the areas of Mexico most affected by the unequal impact of health expenditures. Information from organizations such as these can serve as an impetus for an organization that does budget analysis to start focusing on a particular problem. It can also add meaning to the work by illustrating what is actually happening "on the ground," thus bringing the needed human face into the analysis. At the same time, working in cooperation with others can help when it comes time to assess impact (the "obligation of result"). If changes are made in budget allocations with the goal of improving a situation, it is often those "on the ground" who can assess

the impact of the changes and draw conclusions as to whether the changes rendered the expected results.

Similarly, while the information produced by budget analysts can be used very effectively at the national policy level, it can sometimes have an even greater impact when used by communities to hold their local government officials accountable. Strategic alliances between national and local-level organizations can thus enhance the usefulness of any information produced.

- Access to information can be a problem. In some countries, the national budget is publicly available, and even, as in Mexico, can be downloaded from the web. In such countries, other government statistics may also be relatively easy to access.

  In many countries, however, governments do not make the budget available to the public, and the struggle to get a copy, even if ultimately successful, can be very time-consuming. While this can be a very discouraging situation, we should, at least, take heart from some situations where, after a prolonged struggle to get access to a government budget in one year, organizations have found it relatively easy to get copies in subsequent years. In other situations, as in Mexico, with the passage in 2002 of a law guaranteeing freedom of information, large amounts of government information, including the budget, have become increasingly available to the public.

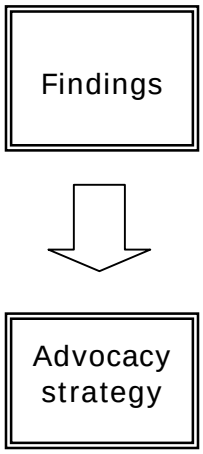
  Another difficulty organizations may face is that government data that is important to make sense of budget figures—statistics, for example, on maternal mortality, on school attendance by boys and girls, on per capita income—may not be available. This may be because the government will not make it accessible, because it does not collect the relevant data, or because the data it produces is inaccurate or inappropriate to the organization's needs. While these situations can create real problems, there are sometimes ways to get around them.

  It may be, for example, that even if the government's figures are not very accurate, they can be used, because the government will not challenge its own figures. In other situations, data from independent institutes, university-based research or international bodies, such as the World Bank or World Health Organization, can be useful for your purposes. In the case of maternal mortality, for example, inadequate registration of deaths related to pregnancy, birth and postpartum complications has been a common problem. Working with the government's registration estimates is relevant, but it may also be important to add another perspective on what is *not* being registered. In the case of Mexico, through ethnographic information not related to the budget, researchers working at the local level have, for example, calculated the number of maternal deaths that are not being

considered by the national government. This kind of information adds depth and perspective to what the overall information has to say.

Writing up your findings

After gathering your information and doing your analysis, the next step is to write up your findings. This is what you will see in the next section, Section 5, which details Fundar's process as well as its findings from using budget analysis to assess the Mexican Government's compliance with its right to health obligations.



Developing an advocacy strategy

Your findings will be of little practical significance, however, if you don't have a strategy to ensure their use and impact. The final section, Section 6, talks a bit more about using budget analysis in strategies designed to protect and promote ESC rights.

Protecting child rights through budget work

The South African Government has ratified the Convention on the Rights of the Child (CRC) as well as the African Charter on the Rights and Well-being of the African Child. In addition, the South African Constitution has within it strong human rights provisions.

The Children's Budget Unit (CBU) of IDASA in South Africa aims to contribute to child rights realization and child poverty alleviation by conducting research, training and information dissemination on budget allocations and service delivery in relation to the government's rights obligations. It uses the CRC and ICESCR as frameworks for its analyses. The CBU has analyzed specific government programs to determine whether the budget expenditures associated with the program are adequate and appropriate to meet the government's obligations. It also produces an annual analysis of the government's budgets to assess how well it is designed to protect child rights.

IDASA has produced a guide for NGOs on monitoring government budgets to advance child rights. (See Resources).

SECTION 5

The right to health in Mexico: from "right-holders" to "nothing-holders"— an analysis

The following analysis focuses on the case study briefly summarized in Section 1. The analysis looks at certain of the Mexican Government's right to health obligations with respect the "open population." In particular, it considers its obligations with respect to

- progressive achievement of the right to health,
- use of maximum available resources to achieve fulfillment, and
- specific guarantees in article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR).

The analysis is not exhaustive, but you will notice as you read that even looking only at certain aspects of the situation can provide some very important insights—insights with respect to the government's compliance that would have been impossible to document as convincingly without looking at the budget. We provide at the end of this section a summary of the conclusions reached.

In doing the analysis, Fundar focused only on the health sector of the budget, despite the fact that health-related expenditures can be found in many places, such as in expenditures related to sanitation, education and even the labor department. The focus was limited in this way, because three out of the four components of article 12 of the Covenant are directly related to expenditures in the health sector (reproductive, maternal and infant health; prevention, control and treatment of diseases; and health care and services), and thus very useful information can be derived using this focus.

Most of the data used in this study are from the years 1998 to 2002. Major modifications in the arrangement and classification of budget information took place in 1998, making it difficult to draw comparisons with previous years. In addition, 2002 is the latest data available for *actual* spending. Actual spending can vary significantly from the approved budget.

For the purpose of doing comparisons, all the figures are adjusted for inflation—that is, the effect of inflation has been calculated so that the 2002 money has the same value as that of 1998. Thus, the resources allocated to the health sector are expressed in "real terms."

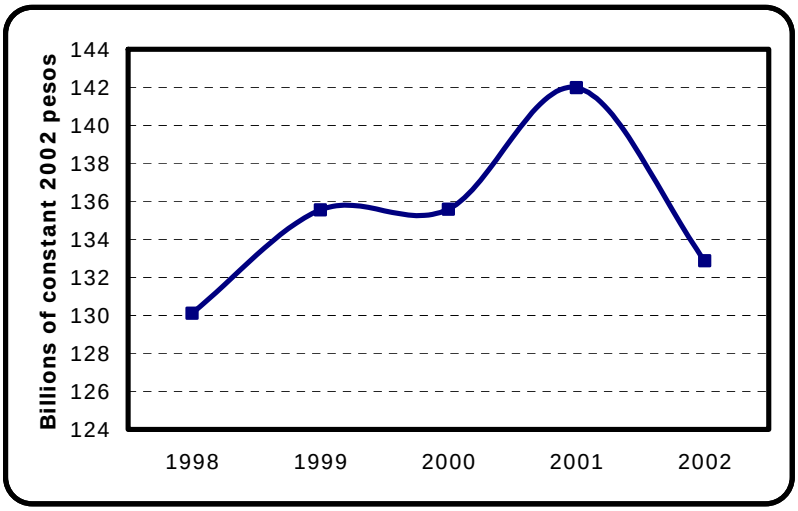
a) "Progressive achievement" with respect to the fulfillment of the right to health

In line with article 2 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), it is an explicit duty of the State to take deliberate steps toward the realization of ESC rights, which means that the State must not regress from levels of fulfillment previously achieved.

"Progressive achievement" involves government action over the course of years. The intention of a State to comply with the principle of progressiveness can thus be analyzed by comparing the resources it has allocated to specific public services over several years.

Total health spending on the part of the federal government can be seen in Graph 1. Though there is some indication of progressiveness, the trend is rather inconsistent. Overall, there is a tendency towards increasing federal resources allocated to health. From 1998 to 2001, the health budget increased from 130 billion to 142 billion pesos. Nevertheless, 1999 to 2000 registered a small decrease, while 2002 falls almost to the level of spending established in 1998.

Graph 1: Health expenditure of main health institutions



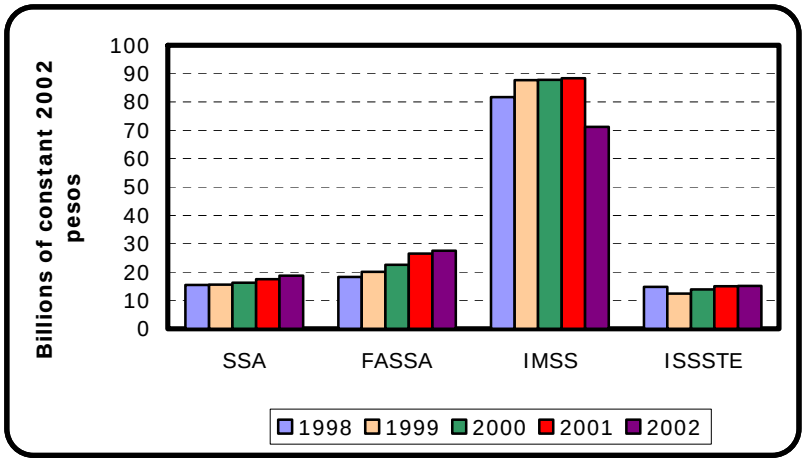
Source: Created with data from the Public Account 1998 to 2002.

This graph was created by combining the budgets dedicated to health expenditures in different institutions—the Ministry of Health (SSA), decentralized health funds (FASSA) and the two main social security institutions (IMSS and ISSSTE)—in order to derive an overall health budget. In the case of IMSS and ISSSTE, expenditures directed toward health services had to be specifically identified, since substantial parts of their budgets go into retirement benefits.

Since the total health spending reflected in Graph 1 is comprised of diverse public institutions, each of which has a different relationship with specific groups of the population, it is important to disaggregate the components of this total budget. Only in this way can we know how much has been set aside for different institutions and thus for different groups of the population—especially for those benefiting from more complete structures of protection and those that lack them.

Graph 2 shows the federal resources used for health services by the different institutions, between 1998 and 2002.

Graph 2: Health expenditures by institution, 1998-2002



Source: Created with data from the Public Account 1998 to 2002.

This graph allows us to make some initial observations that are important for the evaluation we are doing:

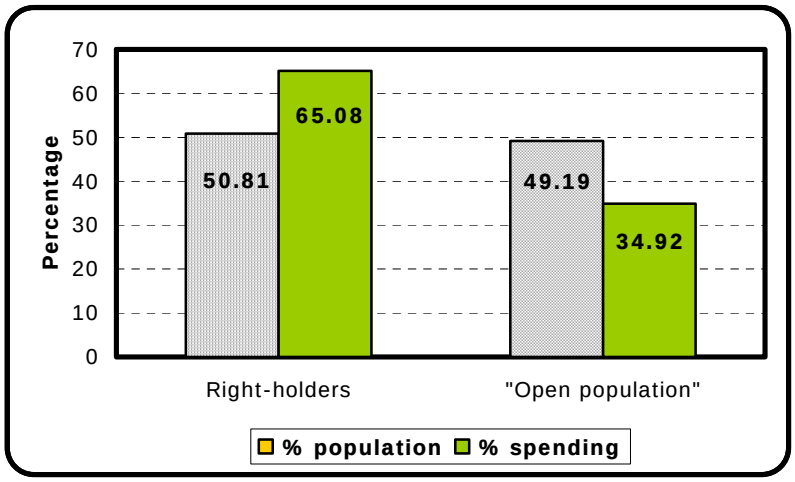
- First, the decrease in the total health budget in 2002 can be attributed to the fact that fewer resources were available to IMSS. SSA, FASSA and ISSSTE increase their budgets in 2002, but due to the relative size of the resources allocated to IMSS, the decrease there has a decisive impact on the total figure.

- Secondly, both the resources of SSA and FASSA—which is the decentralized Health Services Fund—have shown a growth trend. FASSA, for example, moved from 20 billion to almost 30 billion real pesos in a period of 5 years. It is thus safe to say that each year more and more resources for health care have been set aside for the populations these programs or institutes serve. *This points to an effort at progressiveness*.

- However, as Graph 3 vividly illustrates, the difference between the resources set aside for the formally employed population, and the

informally employed or unemployed population is striking. Mexicans under the protection of the social security network get almost twice the resources that the "open population" does. In 2002, for example, 65 percent of total health spending was allocated for those qualifying for the social security system; the remaining 35 percent went to the rest of the population, even though both groups represented approximately 50 percent of Mexico's population.

Graph 3: Population covered and share of the total health spending, 2002

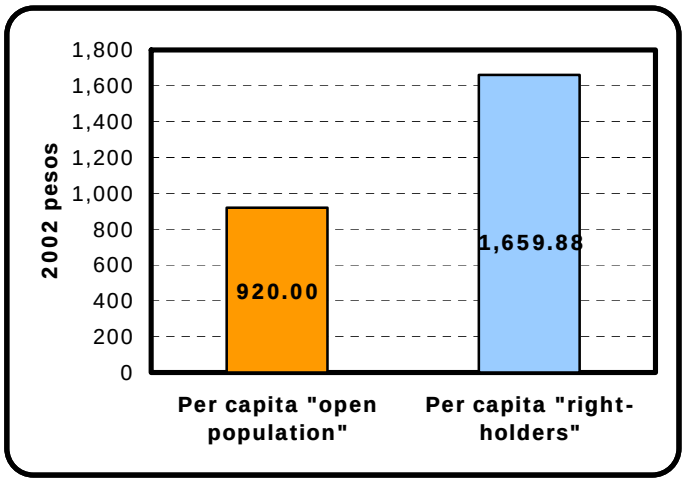


Source: Created with data from the Public Account 2002 and the Ministry of Health General Data Office

– This disparity highlights the importance of paying special attention to the population that receives care through the SSA and state health services. This population obviously finds itself in a doubly precarious position: *They are in a fragile situation because they lack formal employment and social security plans. On top of that, considerably fewer resources are set aside for their needs, despite the government's commitment to ensure "the qualitative and quantitative extension of [health] services, with preference given to the most vulnerable groups."*[20] As seen in Graph 4, 920 pesos are put aside yearly for each person in the "open population," while "right-holders" can count on 1,660 pesos.

[20] Article 25 of the National Bill of Health.

Graph 4: Per capita spending between sectors, 2002



Source: Created with the data from the Public Account 2002 and the Ministry of Health, General Data Office

b) Full use of maximum available resources

Another important governmental obligation is “use of maximum available resources”: The government has to demonstrate that it is using the maximum of available resources in order to fulfill the right to health. *In budget terms this means that the government, in distributing resources, should prioritize the allocation of resources to necessary services in order to guarantee the economic and social rights of the population.*

It is not easy to determine what to do with this contention. First of all, it is a fact that many governments confront an almost permanent situation of inadequate budgets, with the result that it is difficult to reach fully satisfactory levels of spending in all areas. This means that it is very likely that a government will not be able to increase spending adequately in various priority areas at the same time. In addition, a key difficulty stems from the fact that “maximum available resources” is, in itself, a vague term.

In the following paragraphs, we are going to present *two possible options* for dealing with this necessary prioritization of resources.

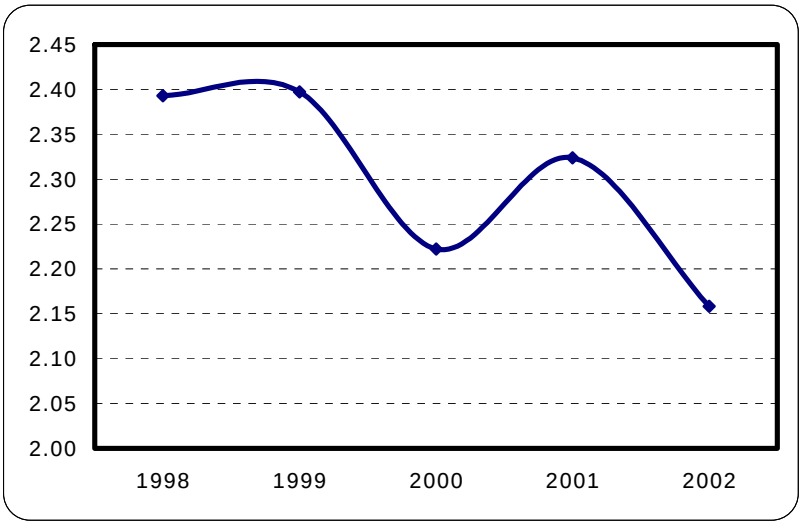
1. Comparison with the Gross Domestic Product

One way to evaluate the prioritization of resources towards the fulfillment of the right to health is to contrast the amount of total health spending with macroeconomic statistics, specifically the Gross Domestic Product (GDP) and total government spending. The GDP is the total amount that the internal economy of a country generates in one year. Total government spending, which in the case of Mexico is called *Presupuesto de Egresos de la Federación* (PEF), includes all the resources that the

national government allocates to its operations and the provision of services. These pieces of information (GDP and PEF), taken together, put into perspective the total resources set aside for health.

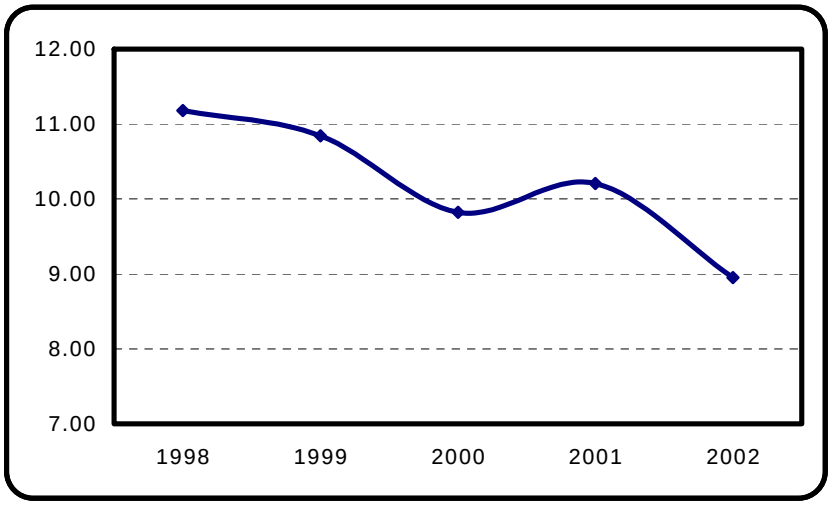
Graph 5 shows the percentage of health spending relative to GDP, from 1998 to 2002. Graph 6 depicts the percentage of health spending relative to PEF, during the same time frame. These graphs allow us to have an initial perspective on the use of maximum available resources for health, highlighting two important things:

Graph 5: Percentage of spending on health relative to GDP



Source: Created with data from Public Account 1998 to 2002 and *Encadenamiento de Series Históricas del PIB*, Chamber of Deputies, Centre for Public Finance Studies, 2001.

Graph 6: Percentage of spending on health relative to PEF



Source: Created with data from Public Account 1998 to 2002.

- On the one hand, there is no sustained increase in health spending with respect to the GDP. In fact, the data seems to show a downward trend over these five years. After following an erratic path, in 2002 health spending does not reach even the 1998 percentage levels of spending. In 2000, 2001, and 2002 fewer resources were allocated to the provision of health services in proportion to GDP than in 1998.

- In comparing Graph 5 and Graph 6, it also becomes evident that the decrease in health spending as a proportion of GDP during 2000, 2001 and 2002 did not necessarily correspond to a general decrease in public resources, since health expenditures *also decreased as part of the PEF.* If the total budget of the national government had been reduced consistently in all areas, the same percentage of health spending would have been maintained all three years—if all parts are reduced in the same proportion, their relationship to the whole remains unchanged. In reality, however, because the proportion of health expenditures as part of total expenditures decreased, it appears that resources that could have been available for allocation to health were, in fact, allocated somewhere else.

2. Comparison with other areas of spending

Another way to evaluate the prioritization of resources—especially when the results of such an initial analysis raise questions about the government's compliance with its ESC rights obligations—is to compare health spending with spending in other program areas.

In this instance, we are not going to compare health spending over the course of different years, but instead compare health spending with other types of non-ESC rights spending—particularly in those years where other areas seemed to have been given higher priority (2000, 2001 and 2002, according to Graphs 5 and 6).

If we compare the variations between what is approved and what is spent by programs for different sectors, the assessment of the government's compliance with its obligation to expend "maximum available resources" towards the right to health does not look good. It is evident that certain government priorities are not in keeping with its social and economic rights obligations. Some examples that point to this conclusion are:

- The 2001 Public Account reveals that the Ministries of Finance, Foreign Affairs and Tourism all spent more than was originally allocated to them. In other words, there was extra funding available that could have been directed to areas of priority as defined by the government's rights obligations.

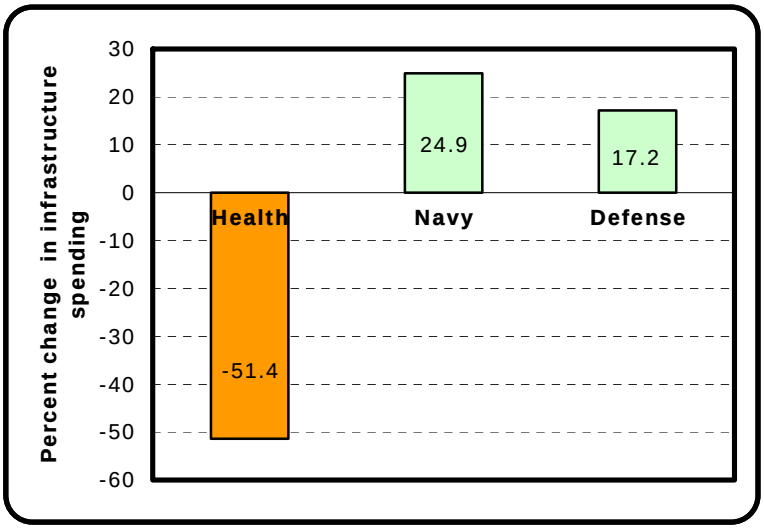
  The additional resources spent by these three ministries above and beyond what was originally allocated to them in the budget equaled

2.3 times the *approved budget* for the Extension of Coverage Program (PAC) in 2002. This program offers basic health services to almost 10 million Mexicans in extreme poverty, with funding that only allows mobile care schemes.

- The Navy Department and the Defense Department increased their spending in infrastructure by 24.9% and 17.2%, respectively, compared to their original budget (see Graph 7).

  The Ministry of Health, in contrast, failed to use 51.4% of its money for the development of needed infrastructure.

Graph 7: Budget spent on infrastructure, in relation to approved budget, 2001



Source: Created with data from Public Account 2001.

- In 2002, the Ministry of Finance increased its spending by 47 billion pesos—an increase of 217 percent.

  – This increase is equivalent to 61 percent of the budget allocated to all programs and activities aimed at the eradication of poverty.
  – It equals 23 times the *actual budget* for the Extension of Coverage Program in 2002.
  – It is equivalent to 22 times the federal government's budget for the health infrastructure in 2000, 2001 and 2002 combined.

Conclusion with respect to "maximum available resources"

- This assessment points to the fact that the Mexican Government, even if it has increased allocations of resources for health year by year, has not allocated the maximum available resources for this purpose.
- During the fiscal year when adjustments are made and reprioritizing takes place in accordance with the actual available resources, the health budget does not increase, despite possibilities for doing so.

c) Analysis of three components of Article 12

The analysis above, by itself, does not enable us to draw very full conclusions, and thus it is necessary to turn to more specific issues. This will also allow us to analyze trends among regions and among different groups of the population. The latter is an essential element when evaluating questions of non-discrimination.

i) Maternal and child health

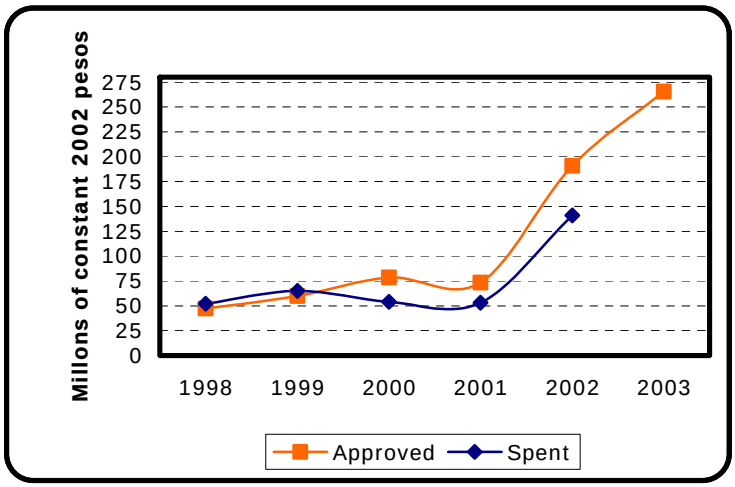
> *The steps to be taken by the States Parties to the present Covenant to achieve the full realization of [the right to health] shall include those necessary for:*
>
> > *The provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child…*
>
> *(article 12 (a))*

According to official information, in 2001 close to 5 women died every day in Mexico due to pregnancy, birth or postpartum complications. Of the total number of women that died nationally, 65% were not protected by the social security network. Additionally, 67.3% of these pregnant women were located in the southern and southeastern states of the country, where a significant number of inhabitants are indigenous and live in rural areas in conditions of extreme poverty.

Subsection a) of article 12 makes reference to maternal and child health. General Comment 14 expands on this, by specifying that an important component of the right to health is reproductive, maternal (pre- and postpartum) and infant health care. The responsibility for coordinating programs for maternal and infant care at the national level rests with the General Office of Reproductive Health, which is part of SSA.

Graph 8 shows the budget of the General Office of Reproductive Health for 1998 to 2003. It illustrates a more or less steady level of resources between 1998 and 2001. Beginning in 2002, a substantial increase becomes evident, which can be explained by the inclusion of new programs in the General Office.

Graph 8: Budget of the General Office of Reproductive Health



Source: Created with data from the Public Account 1998 to 2002 and PEF 2003.

There are two relevant trends that are reflected in Graph 8. On one hand, an important increase in resources was registered in 2002, and there is thus an undeniable effort to allocate more money to reproductive health. On the other hand, in virtually every year there is a tendency to spend less than was approved in the budget.

At the same time that there is a consistent pattern of under-spending, especially in social programs and areas, as illustrated in the previous section significant overspending happens in other areas. In order for a government to be moving toward compliance with "use of the maximum available resources," social spending should be prioritized within available budgetary resources. The consistent pattern of under-spending would seem to indicate that, for the moment, this is not happening with respect to reproductive, maternal and infant care. Furthermore, the approved budget for the General Office illustrates that the latter was given higher priority in budget allocations than during the budget execution. It is the duty of the government to explain exactly why it is under-spending in areas that are crucial to social goals and for the realization of the right to health.

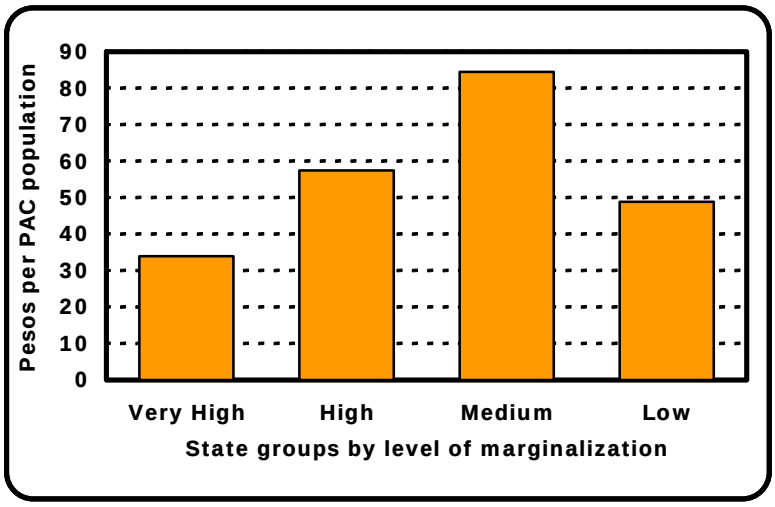
The picture would not be complete without the inclusion of other programs in the Ministry of Health that have reproductive and infant health components—like the Program for the Extension of Coverage (PAC), the Opportunities Program, and the Health Program for Indigenous Groups. It is not possible to identify the total resources allocated to maternal and infant health within these programs, but some inferences can nonetheless be drawn.

PAC is composed of 13 basic components, one of which refers specifically to care for women during pregnancy, birth and the postpartum period. The program targets the poorest communities of the states with the highest levels of marginalization, and these health services are aimed at contributing to the prevention of the maternal mortality of women that live in conditions of extreme poverty. As pointed out at the beginning of this section, it is exactly in areas of greatest marginalization that maternal mortality is the highest.

Between 1996 and 2002, the total allocation of resources to PAC experienced real growth of 13.27%; in other words, the resources increased constantly even after adjusting for inflation. During the same time period, the program had as a goal to offer its services to more people every year. As a result, several trends developed.

The Government of Mexico spent much more of its PAC funding for people who lived in better-off states than it did on those in poorer states. Most striking, the government spent on average just 33.9 pesos per person for those eligible for the PAC program in the states labeled as having very high levels of marginalization[21], while spending more than twice as much–84.5 pesos per person–in states with medium levels of marginalization (see Graph 9)[22].

Graph 9: PAC per capita spending, 2001



Source: Based on data from Ministry of Health, General Office of Equity and Development in Health; Public Account 2001 and *Municipal Marginalization Index*, National Population Council (CONAPO), 2000.

[21] According to the Municipal Marginalization Index 2000 from the National Population Council (CONAPO), each of the 32 states is classified in one of five categories. In Appendix 2 there is a full list of the states and their respective levels of marginalization.

[22] These estimates stem from the number of patients the government claims to have served and offered services to through the PAC program.

- The lowest per capita spending occurred in Veracruz, where spending for those eligible for the PAC program amounted to just 18.1 pesos per person (less than 2 US$). In contrast, the highest per capita spending occurred in Michoacán, where per capita spending amounted to 137.2 pesos, or more than seven times that in Veracruz.

- Altogether, there were six states where per capita PAC spending amounted to less than 40 pesos per person: Chiapas, Guerrero, Mexico, Puebla, Veracruz, and Yucatán. On the other hand, there were five states where per capita spending was more than 120 pesos per person, or three times the level of the poorer states: Chihuahua, Durango, Guanajuato, Jalisco, and Michoacán.

These disparities point to a pattern of *de facto* discrimination, under which the most vulnerable states, with the highest levels of marginalization, get the least money per capita. This would go against the provisions established in the Mexican Bill of Health regarding the protection of the most vulnerable population, and against the general obligation of non-discrimination in the ICESCR.

Furthermore, if we take into consideration other information and expert opinions relevant to the issue of maternal health itself, we can add new layers to our analysis.

The World Health Organization and other bodies concerned with sexual and reproductive health have identified the following as necessary for effective prevention of maternal deaths: ongoing medical monitoring, timely transfer to secondary levels of care, access to emergency services and availability of blood transfusions, and trained personnel.

- Although it is impossible to find out how much of PAC's budget has been concretely allocated for maternal and infant health care, it is clear that the available resources are insufficient to fully satisfy any of the above-mentioned requirements. We can infer with a high degree of confidence that less than 20 pesos (US$2) spent per person per year is not sufficient.

- The scarce resources PAC has to address the needs of the marginalized population have a direct impact on the physical accessibility and quality of the services offered.

  - The program depends, in large part, on volunteer personnel who have very little training in decision-making in case of emergencies.
  - The more highly trained medical staff work within a framework of scheduled care, arriving in each community only once a month. Consequently, this staff is rarely present in emergencies.
  - The program does not incorporate follow-up mechanisms for high-risk cases.

- It also fails to ensure mechanisms for transporting patients to secondary level hospitals in case of emergency.

Knowing these features makes it easy to understand why the program cannot adequately address the main cause of maternal death in rural areas—obstetric emergencies. There is too small an amount of resources allocated for attention to the most vulnerable population.

ii) Prevention and treatment of diseases

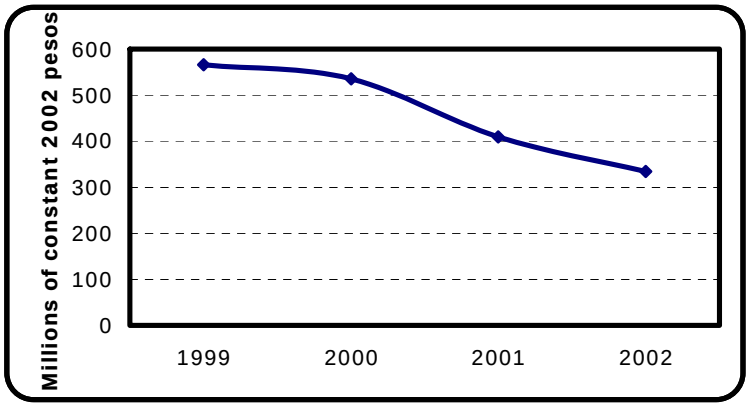
> *The steps to be taken by the States Parties to the present Covenant to achieve the full realization of [the right to health] shall include those necessary for:*
>
> *The prevention, treatment and control of epidemic, endemic, occupational and other diseases…*
>
> *(article 12 (c))*

General Comment 14 says that a core obligation related to the right to health is to provide immunization against the main infectious diseases of a community, as well as to adopt measures for the prevention, treatment and control of epidemic and endemic diseases. These obligations carry with them measures for disease control and prevention. The resources of the General Office for the Promotion of Health and of the National Center for Epidemiological Monitoring, which have precisely this responsibility, are located in the SSA budget.

The promotion of health in the SSA consists of planning, coordinating and assessing the actions of the states in relation to control and prevention of diseases. It has programs for family health, adolescent health, municipal health and health education. The National Center for Epidemiological Monitoring is dedicated to "improving the health condition of the Mexican population through the fostering and coordination of monitoring, prevention and control of the most frequent, recurring and new ailments that affect society in different population groups."

The combined budgets of these institutions can be seen in Graph 10. The figures show a declining trend in resources allocated for the control and prevention of diseases. This trend is in contrast to information the Center for Epidemiological Monitoring has collected about the different diseases that should be considered priorities. In 1999, infectious-contagious diseases constituted 88% to 96% of all cases of illness throughout the country. Thus, most ailments are still due to infectious-contagious diseases, which in turn require federal and state resources for prevention and control. This persistently high percentage of infectious-contagious diseases does not seem to be consistent with a reduction in the budget for the prevention and control of such diseases.

Graph 10: Budgets of the General Office for Health Promotion and the National Center for Epidemiological Monitoring, 1999-2003

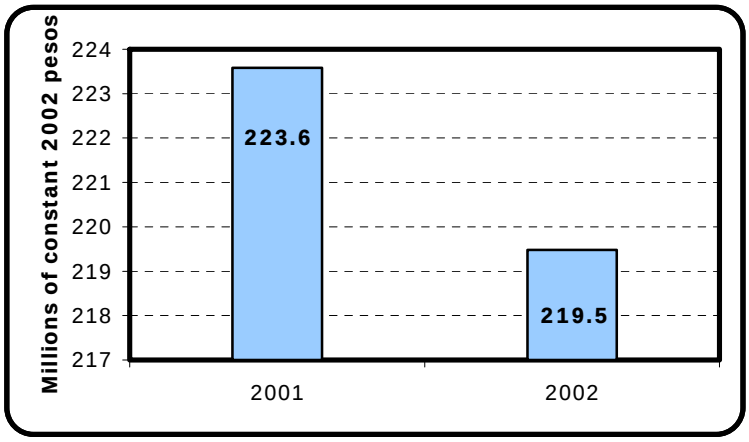


Source: Created with data from the Public Account 1999 to 2002.

It is entirely possible that several programs and offices within the Ministry of Health contemplate additional resources for prevention and treatment of diseases. However, this is the picture that can be put together with the best information publicly available. If there is a better way of identifying resources allocated to prevention, the government should be accounting for it in a transparent way.

Another useful piece of information related to disease prevention is vaccination. Since 2001 responsibility at the national level for immunization of children under one year of age falls on the National Center for Infant and Adolescent Health. The two-years' allocation for vaccination programs can be seen in Graph 11.

Graph 11: Budget of the National Center for Infant and Adolescent Health on vaccination programs



Source: Created with data from the Public Account 2001 and 2002.

For 2003, the number of infants in this age range was 1,901,562, of whom the program aimed to cover 94.5%. It should be mentioned that the vaccination program has been an outstanding success. Achieving immunization of 95% of the children that should be reached is probably as close as you can get to universal coverage. However, guard should not be let down, and resources should not be diminished. The achievement is far too important to allow for any discontinuity.

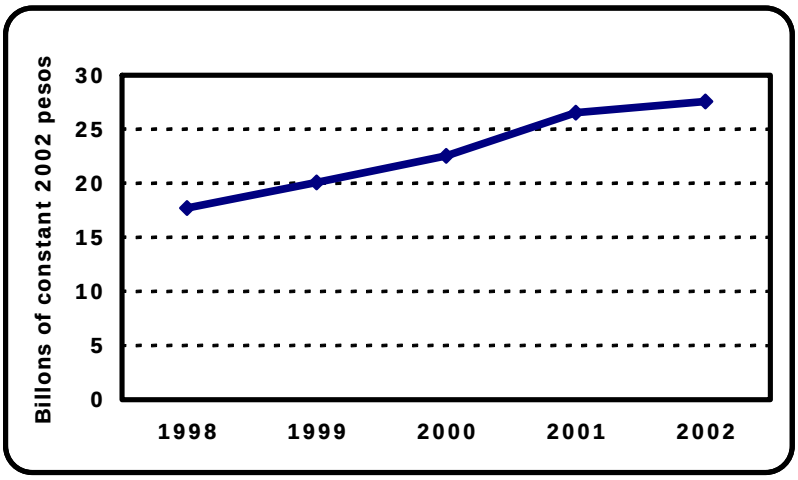
iii) Creation of conditions that assure medical service and care

> *The steps to be taken by the States Parties to the present Covenant to achieve the full realization of [the right to health] shall include those necessary for:*
>
> > *The creation of conditions which would assure to all medical service and medical attention in the event of sickness.*
> >
> > *(article 12 (d))*

The last of the three points that we examine is the creation of conditions that assure medical care and services in the event of sickness. This is the fourth and final component mentioned in article 12 of the ICESCR. *It directly relates to the equitable distribution of services and trained health professionals*. To analyze compliance with obligations related to this guarantee, we will look at three specific elements: budgetary resources, infrastructure and human resources. Each brings us back to the issue of health services' accessibility and availability.

Budgetary resources: In the case of Mexico, the federal government distributes budgetary resources for health care among states by means of established formulas approved by Congress. The largest part of the budget spent by each state directed to the "open population" comes from FASSA, which is the decentralization fund for health services. Since 1998 the trend regarding allocations to FASSA has been one of constant and sustained increase (Graph 12), 40 percent in real terms for some states. This is a clear effort towards progressiveness and the availability of more resources, year after year, related to the provision of health services.

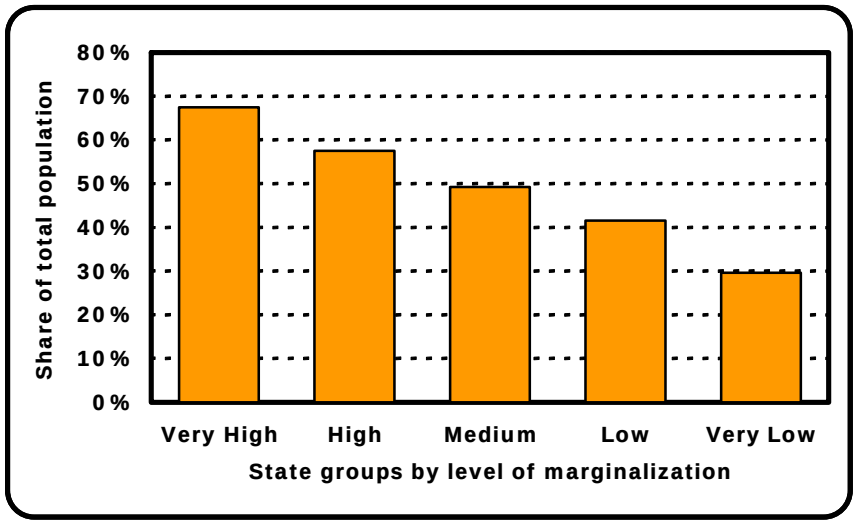
Graph 12: FASSA spending, 1998 to 2002



Source: Created with data from the Public Account 1998 to 2002.

While it is important to acknowledge that year by year there has been this increase in resources allocated to health services at the state level, it is even more important to determine if this trend is consistent with existing needs. As mentioned earlier, FASSA focuses on the health needs of the population that lacks social security. It is necessary to relate the distribution of FASSA resources to the population it seeks to serve. Graph 13 matches the levels of "open population" with the level of marginalization. Not surprisingly, it becomes immediately evident that there is a direct relation between degree of marginalization and percentage of "open population." The poorest states also have the largest proportion of unemployed and underemployed population.

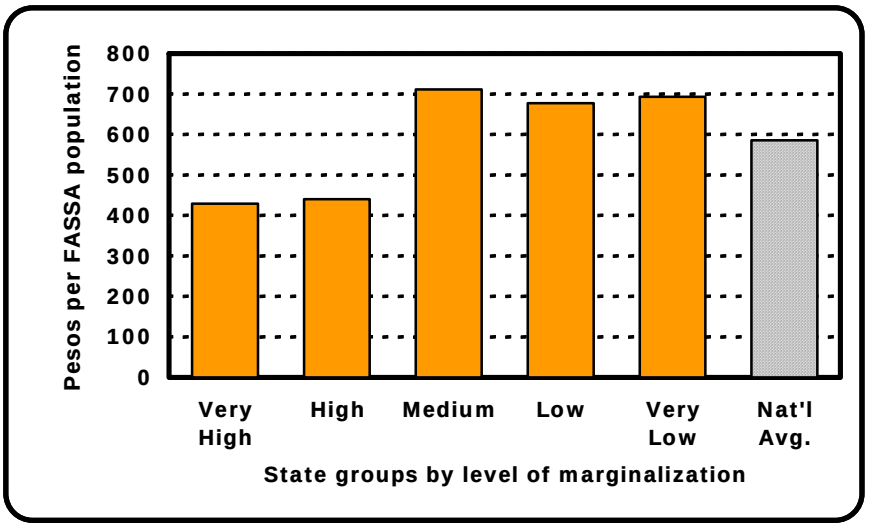
Graph 13: Unprotected population, 2002



Source: Created with data from Ministry of Health, General Data Office and *Municipal Marginalization Index*, National Population Council (CONAPO), 2000.

Given that FASSA has the mandate of bolstering state-based health departments that offer medical care and services to the "open population," it would make sense to expect, at a minimum, that a similar level of resources would be allocated across states for each person in the "open population." However, there is actually a negative correlation between resources spent per capita between states with high and low levels of marginalization, as can be seen in Graph 14.

Graph 14: FASSA Per Capita Spending, 2002



Source: Created with data from the Public Account 2002 and *Municipal Marginalization Index*, National Population Council (CONAPO), 2000.

- The amount spent on each person in the "open population" in states with very high and high levels of marginalization is roughly 420 pesos per year (42 US$). In states with medium, low and very low levels of marginalization, the amount spent rises up to 700 pesos (70 US$). The severity of poverty, which has a direct impact on health-related issues such as sanitation, nutrition and others, is not consistently taken into account through a more equitable distribution of health resources among states.

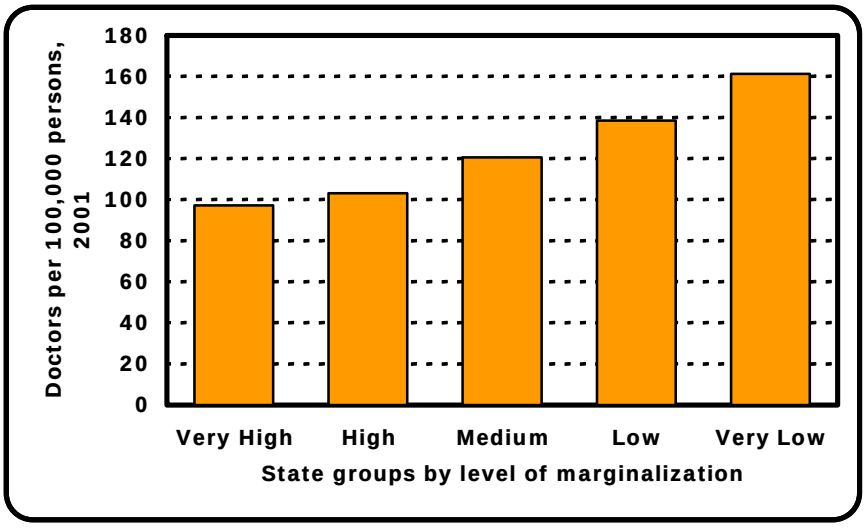
- Furthermore, states with very high and high levels of marginalization have a per capita FASSA allocation far below the national average.

This does not mean that the federal government should redistribute these same resources differently, in order to have a more equal allocation among different states, since that would involve deliberate steps backwards in some cases. It means, however, that concrete efforts have to be made to bring the states with higher levels of marginalization up to an acceptable level of per capita health spending.

Infrastructure and human resources: The allocation of resources at the state level also has a direct impact on the availability of a functioning health system with adequate facilities, programs, staff and medicine. The information in the next four graphs relates to *access to health care*, and points to a situation in which it seems that access may be significantly easier in states with lower levels of marginalization than in those with higher levels. This suggests that the government may not be ensuring equal access to health care and, in particular, may not be giving preference "to the most vulnerable groups."

One clear measure of access to health care is the availability of doctors in any state or area. Graph 15 shows the number of doctors per 100,000 population; the graph again separates states into categories based on the degree of marginalization as measured for 2000 by CONAPO. As is clear from the graph, the five states with the highest level of marginalization have, on average, fewer than 100 doctors available for every 100,000 people in these states.[23] In contrast, there are two-thirds more doctors, relative to population levels, in the more advantaged states.

Graph 15: Doctors per 100,000 persons, 2001

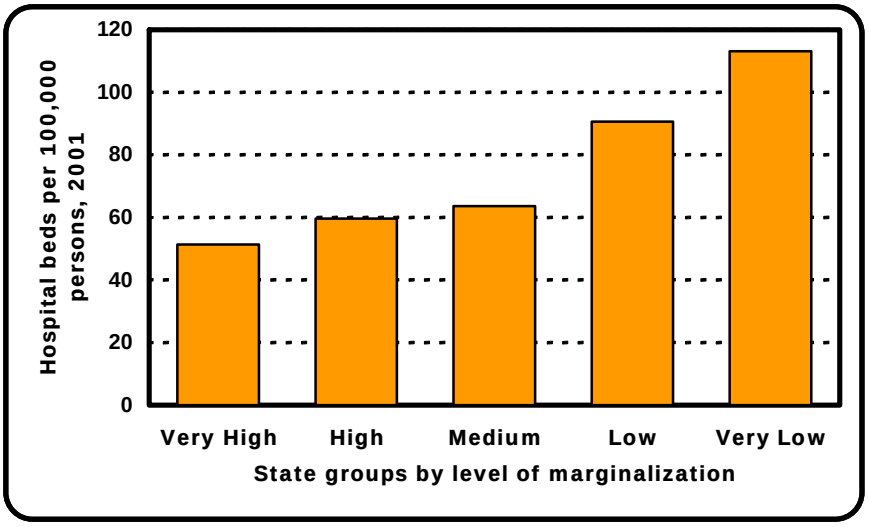


Source: Created with data from *Statistical Information Bulletin No* 21, Ministry of Health, 2002; and *Municipal Marginalization Index*, National Population Council (CONAPO), 2000.

[23] Unlike earlier graphs, the averages used in Graphs 15-18 reflect an "unweighted" average for the states, calculated by simply adding the doctor-to-population ratio (or other variable depending on the graph) for each state and dividing by the number of states in each category. A "weighted" average takes population differences into account and thus gives more weight to states with larger populations; a state with twice the population would be given twice the weight. As a result, a weighted average shows more accurately how many doctors there are per 100,000 people for the entire population of these states. The less accurate unweighted average are used here due to the lack of detail in the data provided by the Ministry of Health.

Graph 16 shows a similar pattern for the number of hospital beds. The poorest states have just over 50 beds for every 100,000 persons or, put another way, roughly one bed for every 2,000 people. People living in higher-income states have more than twice the access to hospital beds, with over 110 beds per 100,000 people, or roughly one bed for every 900 people. This is strong evidence that those living in poorer states have much less access to secondary and tertiary health care than others in the nation.

Graph 16: Hospital beds per 100,000 persons, 2001

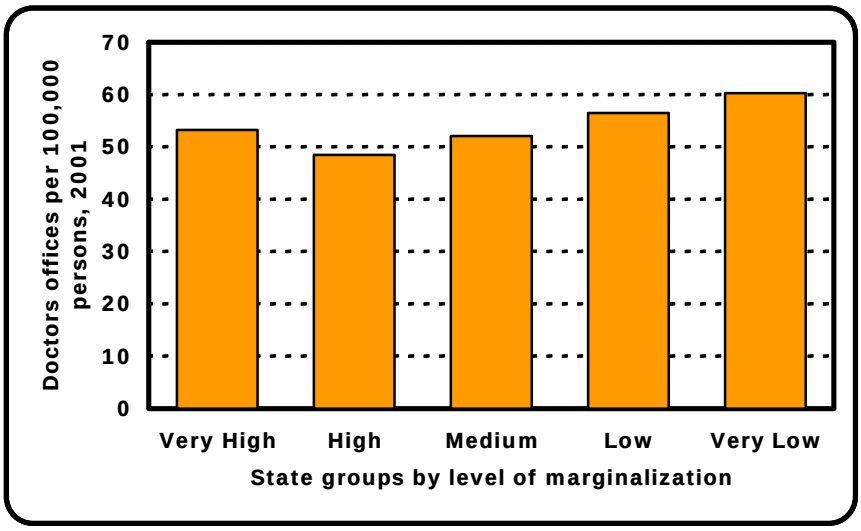


Source: Created with data from *Statistical Information Bulletin No* 21, Ministry of Health, 2002; and *Municipal Marginalization Index*, National Population Council (CONAPO), 2000.

Two additional pieces of evidence suggest, however, that with respect to primary health care, lower-income Mexicans are not faced with the same differences. It appears that people living in poor states may have *access* to basic health care services.

- Graph 17 indicates the number of doctor's offices in the various states. This measure is a useful indicator of the likely proximity of services; people who live in states with fewer doctor's offices are more likely to face obstacles in getting to any doctor. As is shown in the graph, there are 53 doctor's offices for each 100,000 people in the poorest states, more than in either high- or medium-marginalization states. Still, it is important to note that states with either low or very low levels of marginalization have more doctor's offices than the poorer states. In particular, there are nearly one-quarter more doctor's offices, relative to the size of the population, in the highest income states than there are states with high levels of marginalization.

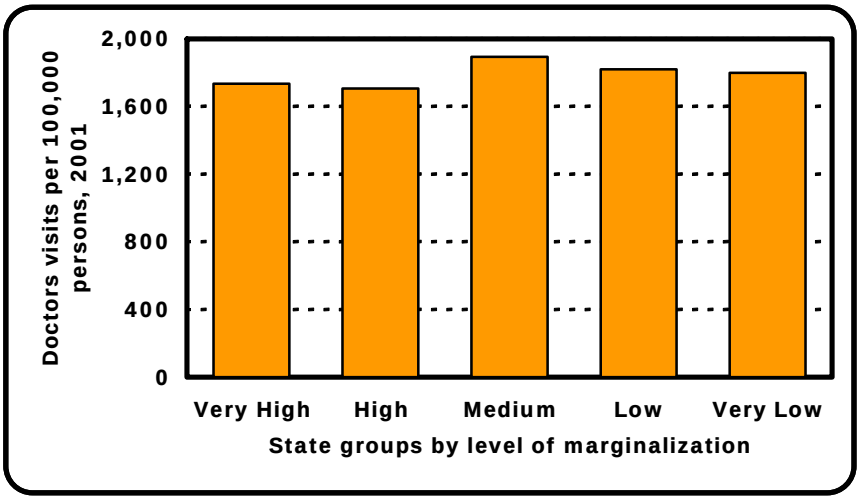
Graph 17: Doctor's offices per 100,000 persons, 2001



Source: Created with data from *Statistical Information Bulletin No* 21, Ministry of Health, 2002; and *Municipal Marginalization Index*, National Population Council (CONAPO), 2000.

- Finally, Graph 18 shows no consistent pattern at all regarding the number of doctor visits relative to population. All else being equal, this is good news—it suggests a relatively equal degree of access to at least primary health care. However, the lack of both doctors and hospital beds, described above, indicates a remaining degree of inequality in access to health care. While people from less-advantaged states may go to the doctor as often as others, it is unlikely they receive a similar quality of care if there are far fewer doctors and far fewer hospital beds, should they need greater levels of care.

Graph 18: Doctor visits per 100,000 persons, 2001



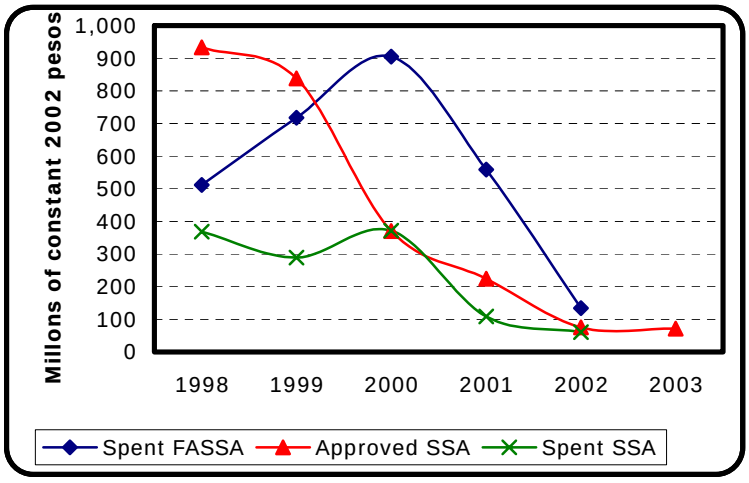
Source: Created with data from *Statistical Information Bulletin No* 21, Ministry of Health, 2002; and *Municipal Marginalization Index*, National Population Council (CONAPO), 2000.

This situation of inequality regarding human resources and infrastructure is caused by an inequitable starting point among states. Poor and rural states, generally located in the southern part of the country, have long suffered a significant gap in terms of infrastructure. The Mexican Government has made consistent efforts to extend basic health care throughout these regions, but has not been able to build up all levels of attention in a similar fashion.

Furthermore, the mechanism currently used to decentralize the health budget reinforces existing patterns. The formula that determines the distribution of FASSA funds takes into account already existing infrastructure, operating and investment expenses and the staff of each state. In order to move towards a more equitable situation, states with budgetary deficits in relation to the "minimum acceptable spending for health services" also benefit from a small fund that seeks to compensate for their underdevelopment. Evidently, however, this amount is too small to reverse longstanding inequalities among states.

Given that the poorest states are also those with the largest percentages of "open population," it is crucial that additional resources be allocated for the development of non-existent capacities. More resources should be directed towards investment, in order to rectify the current insufficiency of health facilities for the poorest population. However, resources allocated to infrastructure have followed a clearly regressive trend, as can be seen in Graph 19.

Graph 19: Spending on basic infrastructure by FASSA and SSA



Source: Created with data from the Public Account 1998 to 2002, as well as PEF 2003.

The absence of resources allocated to the expansion and maintenance of infrastructure is alarming:

- 11 states have had no money for this type of expenditure during 2002 and 2003.
- Furthermore, for 1998 and 1999 the approved budget for health infrastructure surpassed 800 million pesos. Despite this, less than 400 million pesos were actually spent. A similar situation happened again in 2001, when SSA spent approximately half of the resources that had been allocated for infrastructure.

d) *Results of analysis*

There are several results that stem from this budget analysis. Specific shortcomings in the Mexican Government's compliance with its obligations related to the right to health of the "open population" of the country have been identified. In some cases the analysis has even pointed to suggestions about what the government needs to do to remedy the situation. While the insights and conclusions have all been mentioned at various points in the analysis above, it is useful to pull them together in one place:

1. While the government has increased resources to SSA and FASSA in recent years, it continues to allocate a significantly disproportionate share of the budget to those employed in the formal sector. Thus, within a situation where it looks like progressive achievement has been realized, in reality a situation of discrimination against the informally employed and unemployed exists. *A specific recommendation to the government could be to adjust the relative allocation of health resources so that SSA and FASSA get a greater share.*

2. Over the past few years the government has not been directing an increased share of budget resources to the health sector at the same time that overall government spending has increased. Other ministries and agencies are increasing their spending by significant percentages, equivalent to amounts that would make a significant contribution to the health budget. *At a minimum, the government should be asked to explain this discrepancy, which appears to violate its obligation to direct the "maximum of available resources" to the protection of health.*

   Furthermore, it appears that the problem is not just in the government's allocations to different areas. At least part of the fault appears to lie with the Ministry of Health, which most years does not use all the funding allocated to it. *This is not consistent with the obligation to use the "maximum of available resources" in order to fulfill the right to health, and thus could amount to a violation of the*

government's obligations. In any case, the responsibility lies on the State to adequately justify the gap and also to quickly find ways to redress the situation. A remedy would seem to be to have the SSA fully expend the resources allocated to it and to explain its past failure to do so.

3. *A breach of the obligation to allocate "maximum available resources" appears to have also occurred with regard to maternal and infant health, where the General Office of Reproductive Health seems consistently to under-spend its budget*.

4. With regard to the provisions related to maternal mortality under the right to health, marginalized women ostensibly covered by programs directed to pregnant women have disproportionately suffered from the lack of physically accessible services. While resources to the program in question (PAC) increased markedly over the years in question, there appears to be a *discriminatory pattern in the allocation of these resources*, with those areas of the country with the greater marginalized populations receiving fewer *per capita* resources. *This would suggest that the government should be asked to equalize resources available on a per capita basis under PAC.*

5. With regard to guarantees to provide immunization against the principal infectious diseases, it appears that the government has actually decreased the resources available for immunization, despite the fact that not all children have yet been immunized. *This would appear to violate their responsibility of "progressive achievement." A remedy would appear to be for the government to enhance the resources available in this area.*

6. With regard to access to basic health facilities and the services of doctors, again it appears that those areas of the country having the largest shares of marginalized population suffer from fewer per capita resources. At the same time, in its budget the government is directing insufficient funds to build and maintain the infrastructure at primary, secondary and tertiary care levels that would start closing the gap. Meanwhile, the SSA is significantly under-spending the funds allocated to it for infrastructure development. *Thus, the Ministry of Health appears to have failed to comply with its obligation to devote the "maximum of available resources" to correcting the situation, which is dramatically affecting the rights of the marginalized with regard to access to health facilities. Again, a specific remedy is suggested: the government should redo the formula it uses to allocate these funds and, in addition, the SSA should be required to fully expend its infrastructure funds in a given year*

SECTION 6

Using your findings in advocacy

Woven together, human rights and budget analysis can provide compelling evidence of a government's compliance or non-compliance with its ESC rights obligations. Once we have such evidence, the next step is to develop an effective advocacy strategy that will help ensure that the information you have produced will have a beneficial impact on the enjoyment of ESC rights. Any strategy that is effective in protecting and promoting human rights can likely be made that much more effective through the appropriate integration of findings derived from budget analysis.

Before outlining a few of those strategies, some words about approach: Some people who do not typically work on human rights issues, including those who work on budget issues, may have an image of human rights work as necessarily confrontational. They themselves may not feel comfortable with such an approach and may, in fact, believe that it would be counter-productive to their efforts, including efforts to protect ESC rights. It is important to stress that a confrontational approach is not, in fact, a necessary part of a human rights framework. It is an approach that has been used by human rights organizations in a large number of countries where they have found the governments otherwise unresponsive to their concerns. However, it is not the most effective approach in all circumstances. The best approach to use will depend upon the context. As you develop your strategy, the key question will be: Which approach will have the most positive results for human rights protection?

Some examples of strategies where the results of budget analysis can be used include:

- *Fact-finding and documentation:* Getting the facts straight is fundamental to addressing any human rights issue. A situation may appear to be discriminatory or otherwise problematical, but it is important not to draw conclusions prior to gathering as much relevant information as possible and analyzing it carefully. In a large number of situations, what a government has spent or not spent to address a problem can be a pivotal factor. In such situations, budget figures can be a valuable component of the facts gathered and budget analysis can tell us a lot about what those figures mean.

- *Community education:* Many groups are involved in working with communities to ensure that they are familiar with their rights and know how to claim them. A community that is struggling to secure adequate education for its children or health clinics to serve all its members may become energized to demand accountability from local

government officials when they are provided with specific information about expenditures the local government is supposed to make to hire more teachers or to build a health clinic closer to the community. For example of one such community approach, see box on p. 3.

- *Policy or law reform:* Policies or laws may be inadequate to protect the rights of specific groups, such as indigenous communities, or sectors of a society, such as women or children, and may, in some cases, actually harm them. Human rights work often involves bringing evidence to the government to demonstrate the detrimental impact of a policy or law, with the goal of reforming one or both. A budget, which should be an embodiment of a government's policies and laws, can reveal whether the latter do, in fact, protect and promote human rights—and, if they do not, what needs to be changed. For an example of an organization using budget analysis for this purpose, see the box on p. 46.

- *Working with the legislature:* On many occasions it is necessary to shed light on situations that could involve human rights violations, in order to draw attention to them and bolster the role that legislative bodies—such as a Congress or Parliament—can play. This can be particularly true with regard to budget work, since legislatures are the natural counterweight of the executive branch of a government. Many groups have channeled relevant budget analyses to health committees, gender and equity committees as well as budget committees in their Congress or Parliament, in order to bring them into the discussion and move them to exert pressure on the government. See the box on the next page for an example of this type of work.

- *Litigation*: When a government fails to follow through on its rights obligations, it is, on occasion, necessary to initiate litigation to put pressure on it. The stronger the evidence of a wrong and the more clearly the source of that wrong can be demonstrated, the easier it is for courts to rule in favor of those whose rights have been violated. Courts that have been presented with evidence based on budget analysis seem to have been quite persuaded by it. An example of such a case is on p. 41.

- *Filing complaints or "shadow reports" with intergovernmental bodies*: At times domestic pressure to move a government to comply with its rights obligations has little effect and it becomes necessary to go to regional or international bodies that are charged with overseeing a government's compliance with its rights obligations, in the hope that pressure from the regional or international community will move a government where domestic pressure alone has been inadequate. See the case described in the box on p. 18.

As was mentioned earlier, governments that have ratified the ICESCR are required to submit reports on a regular basis to the Committee on Economic, Social and Cultural Rights. NGOs are given opportunities there to submit "counter-evidence" if they have it. One way they have done so is through developing "shadow reports" and submitting them to the Committee when the government is scheduled to submit its report. Such "shadow reports" typically point up inaccuracies in the government report or provide information on issues not addressed in it. The evidence Fundar has produced in its case study (Section 5) will be integrated into a "shadow report" being developed by it and a number of other groups in Mexico for submission to the CESCR.

Working with the legislature
Maternal mortality and the Mexican Congress

During 2002, Fundar engaged in a project to evaluate the extent to which public resources were being allocated to the reduction of maternal mortality. The Mexican Government had committed itself at the international level to this goal, which was listed as one of its main health objectives for 2000-2006. This case illustrates, among other things, the importance of building strategic alliances. As a result of their longstanding commitment to and work on safe motherhood, other groups had greater leverage on this issue than Fundar, which lacked the same expertise. Fundar cooperated with these groups to develop a shared understanding of what was needed to shed light on the issue of maternal mortality and prioritize resources towards it.

The research document that came out of the project provided more than 100 pages of data, analysis and arguments. An executive summary—responding to the interests of the groups that were going to engage in the political debate regarding maternal mortality—was designed and meetings with both Chambers of Congress were arranged. One meeting, broadcast on the Congress channel, was a public forum dedicated exclusively to the issue of maternal mortality. The right actors were convened—including federal health officials—and the information was disseminated in a meaningful and keenly strategic way during the discussion of the budget, informing some of the decisions that were being made.

The results were significant: The federal government earmarked a substantial amount of decentralized health resources to programs specifically targeting maternal health. The arguments of Congress-people working on gender, equity and health were bolstered. The agenda of long-committed groups was reinforced with new information, and articulated in terms that allowed the government no possibility of denying the validity of their points.

APPENDIX 1

Glossary of human rights terms

Accession	The act by which one nation becomes party to an agreement already in force between other powers (e.g., accession to a human rights treaty).
Adoption	Formal acceptance and putting into effect (e.g., adoption of a human rights treaty).
African Charter on Human and Peoples' Rights	The principal regional human rights treaty for Africa. Adopted by the Organization of African Unity in 1981; went into force in 1986.
African Commission on Human and Peoples' Rights	The supervisory organ established under the African Charter.
Civil rights	Rights an individual has in his/her role as a citizen or in his/her relation to the State.
Committee on Economic, Social and Cultural Rights (CESCR)	Body charged with supervising implementation of the ICESCR (see below).
Committee on the Elimination of all Forms of Discrimination against Women (CEDAW)	Body charged with supervising implementation of the Women's Convention (CEDAW) (see below).
Convention	Treaty; agreement between states related to matters affecting all of them.
Content (of a right) / Core Content / Minimum Core Content	The meaning of the right; what it guarantees Controversial concepts adopted by the CESCR to assist it in monitoring the implementation of the ICESCR. The core content of a right refers to the entitlements that make up the right. Minimum core content has been described as the nonnegotiable foundation of a right to which all individuals, in all contexts and under all circumstances, are entitled.

Covenant	Formal, written agreement between parties, usually requiring the performance of some action. In the human rights context, "covenant" usually refers to either the International Covenant on Economic, Social and Cultural Rights or the International Covenant on Civil and Political Rights (see below).
Cultural rights	Rights that protect a person's enjoyment of his/her own culture.
Declaration	A statement by governments that is not legally binding on them.
Discrimination	In the human rights context, the act or practice of discriminating against someone on the basis of their membership in a category (e.g., race, ethnicity, gender). Discrimination is normally a violation of human rights.
ESC rights	Shorthand for economic, social and cultural rights.
European Commission on Human Rights	Body charged with supervising implementation of the European Convention (see next entry).
European Convention on Human Rights	Principal regional human rights treaty for Europe. Adopted in 1950; went into force in 1953. Addresses a broad range of human rights.
European Social Charter	Adopted in 1961; entered into force in 1965. Addresses economic and social rights in more detail than does the European Convention. Effective primarily since the 1990s, when a supervisory system was established.
General Comments	Produced by the CESCR, to clarify and provide detail on procedures related to its work and, primarily, about the content of specific ESC rights.
General Recommendations	Produced by CEDAW. Similar in purpose to General Comments.
Inalienable	Incapable of being alienated, surrendered or transferred. Human rights are inalienable, which means that no one can take away a person's rights.

Indivisibility	See interdependence (below).
Inter-American Commission on Human Rights	Body charged with supervising implementation of the American Convention.
Interdependence / Indivisibility	Guiding principles of human rights work, meaning that civil and political rights and ESC rights are interdependent; one set of rights does not take precedence over the other and neither set can be fully guaranteed without guaranteeing the other.
International Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)	Adopted by the General Assembly in 1979; came into force in 1981. Principal international treaty related to women's rights.
International Convention on the Rights of the Child (CRC)	Adopted by the UN General Assembly in 1989; details civil and political as well as ESC rights of children; most widely ratified international human rights treaty.
International Covenant on Civil and Political Rights (ICCPR)	Adopted by the UN General Assembly in 1966; came into force in 1976.
International Covenant on Economic, Social and Cultural Rights (ICESCR)	Adopted by the UN General Assembly in 1966; came into force in 1976. Principal international human rights treaty focused on ESC rights.
International human rights	Generally referring to the rights contained in the international legal documents and treaties related to human rights that have their roots primarily in the United Nations system.
Legally-binding	Having the force of law.
Maximum available resources	Key provision of article 2 of the ICESCR related to governments' obligations with respect to ESC rights. Governments must use the *maximum of available resources* to meet their ESC rights obligations.

Non-discrimination	Fundamental human rights principle, meaning that all rights are guaranteed to all without discrimination.
Norms (human rights)	Requirements in human rights treaties or declarations. A standard against which a government's actions are measured. Same as standards.
Obligations to respect, protect, fulfill	Governments' obligations with respect to ESC rights. *Respect*: the government must not act counter to the human rights standard in question. *Protect*: the government must act to stop others from violating the human rights standard *Fulfill*: the government has an affirmative duty to take appropriate measures to ensure that the human rights standard is attained.
Political rights	Rights related to government or the conduct of government (e.g., the right to vote and to participate in governmental decision-making)
Progressive realization / Progressive achievement	Key provision of article 2 of the ICESCR related to a government's obligations with respect to ESC rights. ESC rights must be achieved progressively; no backward steps may be taken.
Protocol	Document or treaty related to an existing treaty.
Provision	An article or clause in a treaty or other legal document.
Ratification	Formal approval, in this case of a treaty. Has greater legal force than a signature.
Social rights	Rights relating to the person in society, such as the right to education, social security, health.
Standards (human rights)	Requirements in human rights treaties or declarations. Used to assess/measure how well a government's policies and practices comply with human rights.
Treaty	Written contract between States. Legally-binding on States that ratify it.

Treaty body	Group established to oversee compliance with a treaty.
Universal Declaration of Human Rights	Adopted by the UN General Assembly on December 10, 1948; generally considered the primary international human rights document. Although not a treaty, it is generally considered binding on all members of the United Nations.
Universal	Applying to all human beings (as in “human rights are universal”).
Universality	Essential quality of human rights meaning that human rights apply to all human beings by the fact of their being human.
Violation of human rights	Failure of a State with regard to one of its obligations under human rights norms.

APPENDIX 2

Additional information relevant to Sections 1 and 5

Appendix 2 contains

1. a glossary of acronyms and terms used in Sections 1 and 5, and
2. a CONAPO chart grouping states in Mexico by levels of marginalization (see p. 57, Section 5)

1. Glossary of acronyms and terms

CONAPO
The *Consejo Nacional de Población (CONAPO)* is the National Population Council, the government agency in charge of statistical information on population trends.

FASSA
The *Fondo de Aportaciones para la Salud (FASSA)* is the fund through which money earmarked for health purposes is disseminated to the states. The money is allocated according to a formula that considers population, infrastructure and local health expenditure. It includes most of the decentralized health funds allocated in a fiscal year.

IMSS
The *Instituto Mexicano del Seguro Social (IMSS)* is the Mexican Social Security Institute. In contrast to other countries, the IMSS provides its own health services to the entitled salaried workers.

ISSSTE
The *Instituto de Seguridad Social y Servicios para los Trabajadores del Estado (ISSSTE)* is a social security institute for workers in the Federal Government and the government bureaucracy. It also provides its own health services to entitled workers.

Municipal Marginalization Index
This is an index developed by the National Population Council to evaluate the proportion of people that live in poverty and extreme poverty conditions in a municipality (see CONAPO, above).

Opportunities Program
The Opportunities Program or *Programa Oportunidades* in Spanish is the government's poverty reduction program. It includes the sum of actions undertaken by the government to reduce poverty and aid poverty–stricken communities. It has four components: education, health, nutrition and, more recently, housing. It is dispersed through many government agencies.

PAC
The *Programa de Ampliación de Cobertura (PAC)* amounts to an Extension of Coverage Program. It aims to provide minimal health services to population groups that have no health coverage whatsoever, and includes different aspects of health services. It is run by the Ministry of Health.

PEF
The *Presupuesto de Egresos de la Federación* or *PEF* is the budget decree. It includes all expenditure and allocation information for a fiscal year and it adds up to total government spending.

Public Account
The Public Account or *Cuenta Pública* in Spanish, is the government report, presented no more than six months after the end of the fiscal year, that includes information on actual expenditures in a fiscal year. Actual expenditures can vary significantly from budgeted amounts.

SSA or Ministry of Health
SSA is short for *Secretaría de Salud*, the Ministry of Health, in Mexico.

2. Chart grouping states in Mexico by levels of marginality

State	Total population 2002	Unprotected population 2002	Protected population 2002	Percentage of unprotected population 2002	Level of marginality CONAPO 2000
Chiapas	4,176,199	3,228,265	947,934	77.3%	Very High
Guerrero	3,264,735	2,331,066	933,669	71.4%	Very High
Hidalgo	2,376,222	1,499,425	876,797	63.1%	Very High
Oaxaca	3,662,824	2,604,319	1,058,505	71.1%	Very High
Veracruz	7,205,637	4,294,644	2,910,993	59.6%	Very High
Average	**20,685,617**	**13,957,719**	**6,727,898**	**67.5%**	
Campeche	735,862	361,315	374,547	49.1%	High
Guanajuato	5,061,839	2,849,871	2,211,968	56.3%	High
Michoacán	4,357,309	2,884,595	1,472,714	66.2%	High
Nayarit	979,682	511,404	468,278	52.2%	High
Puebla	5,303,248	3,521,426	1,781,822	66.4%	High
San Luis Potosí	2,488,314	911,463	1,576,851	36.6%	High
Tabasco	2,002,775	1,209,700	793,075	60.4%	High
Yucatán	1,724,897	745,170	979,727	43.2%	High
Zacatecas	1,482,372	896,853	585,519	60.5%	High
Average	**24,136,298**	**13,891,796**	**10,244,502**	**57.6%**	

Durango	1,562,050	626,394	935,656	40.1%	Medium
Morelos	1,651,942	915,194	736,748	55.4%	Medium
Querétaro	1,481,730	651,974	829,756	44.0%	Medium
Quintana Roo	864,863	369,304	495,559	42.7%	Medium
Sinaloa	2,524,778	1,323,809	1,200,969	52.4%	Medium
Tlaxcala	1,026,061	604,362	421,699	58.9%	Medium
Average	**9,111,424**	**4,491,036**	**4,620,388**	**49.3%**	
Aguascalientes	1,037,057	352,606	684,451	34.0%	Low
Baja California Sur	416,350	131,569	284,781	31.6%	Low
Chihuahua	3,168,978	1,010,924	2,158,054	31.9%	Low
Colima	568,454	233,639	334,815	41.1%	Low
Jalisco	6,694,217	2,932,124	3,762,093	43.8%	Low
México	13,642,704	6,343,981	7,298,723	46.5%	Low
Sonora	2,307,292	703,738	1,603,554	30.5%	Low
Tamaulipas	2,819,109	1,037,452	1,781,657	36.8%	Low
Average	**30,654,161**	**12,746,034**	**17,908,127**	**41.6%**	
Baja California	2,505,285	831,771	1,673,514	33.2%	Very Low
Coahuila	2,441,879	493,269	1,948,610	20.2%	Very Low
Distro Federal	8,857,833	3,038,296	5,819,537	34.3%	Very Low
Nuevo León	3,985,148	904,646	3,080,502	22.7%	Very Low
Average	**17,790,145**	**5,267,983**	**12,522,162**	**29.6%**	

APPENDIX 3

Some additional resources

Are our Budgetmakers Faithful to the Constitution? A Tour of the Budgets 1947-2001, L.C. Jain, People's Bias, National Centre for Advocacy Studies and Patheya, India, 2000.

Budget Analysis as Social Audit, Tamilnadu Peoples' Forum for Social Development, India, 2002.

Circle of Rights—Economic, Social and Cultural Rights Activism: A Training Resource, International Human Rights Internship Program and Forum-Asia, USA and Thailand, 2000.

Follow the money: Lessons from civil society budget work and how they might be applied to the challenge of monitoring oil and gas revenues, Jim Shultz, Open Society Institute, New York, 2004.

Monitoring government budgets to advance child rights: a guide for NGOs, IDASA, South Africa, 2003.

Promises to Keep: Using public budgets as a tool to advance economic, social and cultural rights, Fundar and Ford Foundation, Mexico, 2002. (Available in English and Spanish).

A Rights-Based Approach towards Budget Analysis, Ma. Socorro Diokno, International Human Rights Internship Program, USA, 1999.

The International Budget Project has a web site, which is generally very informative and which has a page devoted to budget analysis and ESC rights: http://www.internationalbudget.org/themes/ESC/index.htm

APPENDIX 4

Participants at March 2004 workshop

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