



The Right to Health:  
*A Resource Manual for NGOs*

Written by: Judith Asher

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## List of Abbreviations

CAT	Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment or Committee against Torture
CEDAW	Committee on the Elimination of All Forms of Discrimination against Women
CERD	Committee on the Elimination of Racial Discrimination
CP	civil and political (rights)
CRC	Convention on the Rights of the Child or Committee on the Rights of the Child
CESCR	Committee on Economic, Social and Cultural Rights
ESC	economic, social and cultural (rights)
FGM/C	Female Genital Mutilation/Cutting
FWCW	Fourth World Conference on Women (Beijing, 1995)
HRC	Human Rights Committee (Committee that monitors the ICCPR)
ICCPR	International Covenant on Civil and Political Rights
ICERD	International Convention on the Elimination of All Forms of Racial Discrimination
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICPD	International Conference on Population and Development (Cairo, 1994)
IFIs	International Financial Institutions
IGOs	Inter-governmental organizations
ILO	International Labour Organization
GATS	General Agreement on Trade in Services
GNP	Gross National Product
MDGs	Millennium Development Goals
MSM	Men who have sex with men
MWC	International Convention on the Protection of the Rights of All Migrant Workers and Their Families
NGO	Non-Governmental Organization
NHRIs	National Human Rights Institutions
NMA	National Medical Association
NNA	National Nurses Association
OHCHR	Office of the United Nations High Commissioner for Human Rights
PFA	Platform for Action (Beijing, 1995)
PLWHA	People Living with HIV / AIDS
PoA	Programme of Action (Cairo, 1994)
PRSPs	Poverty Reduction Strategy Papers
SAPs	Structural Adjustment Programmes
STIs	Sexually transmitted infections
SWAps	Sector Wide Approaches
UDHR	Universal Declaration of Human Rights
UN	United Nations
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner on Refugees
WCHR	World Conference on Human Rights (Vienna, 1999)
WHO	World Health Organization

## Acknowledgements

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From the start, the author of the various drafts of the text has been Judith Asher who has been able to call on the advice of several most distinguished experts in drawing together in a masterful manner the two very different disciplines of health and human rights, which are at last beginning to show signs of understanding each other.

The whole project has been directed by Marianne Haslegrave, Director of Commat, whose extensive experience and knowledge of issues affecting international health and human rights, especially within the United Nations System, has been invaluable. Two other members of the Commat team should be mentioned especially as their most valuable work keeps them in the background for most of the time. They are Richard Huggard, Commat's desktop publisher and Webmaster, for whom the impossible is never impossible, and Sally Johnson, our maid of all work, who has always been prepared to meet our unreasonable demands. The team was joined for the purpose of research on the manual by two part-time assistants, Camilla Nygren and Lucy Young, whose efforts were much appreciated.

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Paul Hunt, who became the first UN Special Rapporteur on the Right to Health gave us much encouragement on what at first seemed to be a daunting task, and we were particularly grateful to him for providing the preface to the Manual. His assistant Judith Bueno de Mesquita was also most helpful to us.

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John Havard  
Chairperson, Commat



# Foreword

by Paul Hunt

*UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*

The alarmingly low health status of millions of people in many developing countries is now recognised as a major obstacle to the process of development. In response, increasing numbers of non-governmental organizations are championing the right to health of the disadvantaged, vulnerable and those living in poverty. They are using the right to health in their struggle for access to quality health services, as well as the underlying determinants of health, such as safe drinking water and adequate sanitation. In other words, the right to health — and other fundamental human rights — are seen as a way of promoting development.

In many rich countries there are also rural and urban areas where people live in appalling conditions: pockets of poverty amid wealth. Here, too, there is an increasing recognition that the right to health and other human rights have a crucial role to play in the reduction — and elimination — of poverty.

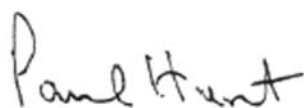
Today, there are more opportunities than ever before to promote and protect the right to health at the national, regional and international levels.

Health professionals — doctors, nurses, pharmacists, technicians, administrators and so on — and their professional associations have an indispensable role to play in the vindication of the right to health. Provided they are equipped with suitable training, they occupy a pivotal position to promote the right to health and identify alleged violations. Too often, however, their training encompasses ethics but not human rights. While ethics are vital, human rights are both vital and binding.

Since the World Conference on Human Rights in Vienna during 1993, the Commonwealth Medical Trust has published a series of reports dealing with the obligations of health professionals and health institutions in relation to the right to health. This Resource Manual on the Right to Health, which has been prepared in collaboration with the American Association for the Advancement of Science and Human Rights, both leaders in the field of human rights, is the culmination of many years of experience working on the right to health.

In a clear style and accessible format, the Manual shows health professionals, their associations and other interested non-governmental organizations, some of the practical ways in which they can promote, protect and monitor the right to health in their communities and countries. It considers the obligations of states in relation to individuals within their borders, as well as the human rights responsibilities of states beyond their borders. As befits a human rights Manual, it has a particular preoccupation with the right to health of the vulnerable, marginalized and otherwise disadvantaged groups and those living in poverty.

As Special Rapporteur, I warmly recommend this unique, practical, timely Resource Manual on the Right to Health.



## Why should health professional and health-concerned non-governmental organizations (NGOs) monitor the right to health? Let's start by looking at some examples ...

The National Medical Association (NMA) and National Nurses' Association (NNA) in developing country X are concerned about the effects of cut-backs to hospital care in rural areas. In recent years, physicians and nurses have not only been reporting increased overtime hours and inadequate numbers of qualified staff in public institutions, but also shortages of essential medicines and emergency facilities. The response from the health authorities has repeatedly been that their hands have been tied because of the conditions attached to the country's development loans from an international financial institution (IFI). The NMA and NNA have worked with health economists at the university to review health budgets (national, sub-national, and institutional) since the imposition of structural adjustment programmes (SAPs) and other health sector reforms that have placed obstacles on access to health services. The study reveals that primary health care spending has diminished dramatically and provides evidence of increasing disparities between the standard of health services offered in the private and public sectors.



A grassroots HIV/AIDS advocacy group has heard informal reports of patients infected with HIV being turned down for surgery in certain hospitals, although national health laws and policies provide for equal access to health services and therefore prohibit discrimination. The group conducts a small-scale community-based study among HIV-positive patients and their careers which reveals that infected patients are indeed routinely turned down for elective surgery as well as for other healthcare services in public hospitals within a particular medical district. It also provides evidence that the official non-discrimination policy is being neither implemented nor monitored adequately.



A NMA is concerned about the health effects of a cyanide spill in one of the rural areas in the country. A number of villages have been hit by a spillage of thousands of cubic meters of mine waste-water contaminated with cyanide and heavy metals. A local river was contaminated when a dam ruptured at a mine operation owned by a multinational mining company. The NMA contacts a local environmental NGO in order to monitor the situation together with it. The NMA collects clinical data from physicians working at the local hospitals. The NGO provides toxicologists to collect water samples for testing and investigates what measures are in place to protect the public from such accidents, and how these are being implemented (for example, how often public regulatory authorities have visited the company).



A few years ago, a national coalition of women's health groups worked together with an international association of women lawyers to launch a test case on female genital mutilation/cutting (FGM/C) in the national courts. The case was successful, and, as a result, the laws concerning FGM/C were changed. Despite this, a number of women's groups wonder if their success has been limited, as they have reason to suspect that the change in the law has driven the practice underground. The NGO coalition undertakes a follow-up study, which does indeed reveal that the government has neglected to enforce the new laws. Not only has FGM/C continued to take place virtually unabated in the intervening years, but there have not been any prosecutions of offenders and both the public and local authorities are ill informed about the changes in legislation.

## Objectives of the Resource Manual

This Resource Manual has been prepared for health-concerned NGOs, including medical and other health professional associations. Its main aims and objectives are to:

- **raise their awareness** of human rights perspectives on health, including the right to health;
- **emphasize the important role they can play** by promoting and protecting the right to health at local, national and international levels;
- **demonstrate the benefits they can derive** from invoking the right to health in the course of their work;
- **show how they can hold governments accountable** for their obligations arising from the right to health; and
- **provide them with a resource guide** that will help them to promote fulfilment of the right to health and to prevent its violation.

Its more specific goals and objectives are to provide:

- **practical advice** on how to undertake the advocacy work and monitoring strategies that are involved in adopting a human rights approach to health;
- **strategies and tools** that can be employed to promote and protect the right to health; to evaluate its implementation; and to monitor its violation;
- **case studies** demonstrating how human rights have been invoked successfully in a wide variety of ways to promote and protect health at local, national and international levels; and
- **information and guidance** on national and international procedures that are now available to monitor and enforce implementation of the right to health.

# Introduction Understanding a health and human rights approach

## 0.1 Who will find this Resource Manual useful?

The range of organizations whose activities involve promoting and protecting the health and well-being of individuals and communities is very wide. Accordingly, this Resource Manual has been designed to provide information to a broad group of organizations around the world working with health and health-related issues at local, national and international levels.

Because of their considerable (though largely unexploited) potential to advocate and promote the right to health, the Resource Manual makes special reference to medical and other health professional associations. These organizations have an especially important role to play in developing countries.

One main reason for the delay in promoting health through a human rights framework is ignorance about the health-related components of internationally recognized and legally enforceable human rights instruments, as well as relevant national legislation. This is made worse by the difficulties experienced by many of those working in both the human rights and in the health fields to understand each other's language, priorities and concerns.

This Resource Manual will be of particular help to NGOs providing health care information and services to poor, vulnerable, or otherwise disadvantaged groups and to those suffering from particular illnesses or disabilities. They should find it useful whether or not they already have some experience of invoking human rights in the course of their work.

A wide variety of single-interest and multiple-interest organizations may be expected to find this Resource Manual useful, including:

### **(1) those that focus exclusively on preventive health, health care and related issues. These groups include:**

- health professional associations, including national medical associations;
- those providing healthcare;
- those involved in service delivery;
- health professional licensing bodies;
- health authorities;
- health promotion groups, including NGOs providing health-related education;
- NGOs working in sexual and reproductive health;
- NGOs concerned with specific illnesses and disabilities, including HIV/AIDS organizations;
- community health care groups;
- advocates for patients' rights;
- NGOs concerned with mental health; and
- anti-smoking NGOs.

### **(2) those that advocate on behalf of poor, vulnerable, or otherwise disadvantaged groups, such as:**

- women;
- children;
- adolescents;
- older persons;
- refugees;
- asylum seekers;
- minority groups suffering discrimination;
- indigenous peoples; and
- persons with disabilities.

**(3) those concerned with health-related issues as only one aspect of their overall work. These organizations include those working on:**

- human rights;
- humanitarian assistance;
- sustainable development;
- domestic violence;
- education; and
- the environment.

Other examples include:

- trade unions;
- civic associations;
- consumer organizations; and
- religious groups.

For the sake of simplicity, the Resource Manual refers to both health professional associations and civil society organizations collectively as ‘non-governmental organizations’ or as NGOs. Of course this list of examples is not exhaustive. There are many others, such as private businesses operating in the health sector or in health-related areas, which might equally find valuable information in the following chapters.

## **0.2 Why would an NGO choose to use a human rights framework to promote health?**

### **(1) Because it is relevant to much NGO work**

To some people, working within a human rights framework implies that it is limited to specialists, human rights lawyers, and the United Nations system. But the right to health, like other human rights, does not represent a remote set of international principles or abstract idealistic values. Human rights are grounded in real lives and real problems experienced at the community level. They have to do with combating elementary forms of injustice and serve to protect and realize human dignity. Human rights begin with individuals and groups who have entitlements, and with governments which have corresponding obligations. States that ratify human rights treaties freely agree to assume responsibility for guaranteeing that people can enjoy the benefits of the right to health. It is the job of NGOs to hold them to this responsibility. The right to health is relevant to the everyday lives of ordinary people and is therefore relevant to NGOs, because it is often their work that promotes and protects the health of individuals, local communities, and poor, vulnerable, or otherwise disadvantaged groups.

An important consequence of placing health in a human rights framework is that it broadens health issues beyond the domain of clinical medicine and puts the individual at the centre. In a human rights framework, health is placed in the context of social justice and linked with principles of equity and non-discrimination. Recognizing health as a human right dramatically re-frames health issues. When health is not described simply in terms of *needs* but also in terms of *rights*, governments find it far more difficult to justify the withholding of basic provisions and services on account of alleged financial constraints or because of discriminatory priorities.

In this way, the right to health offers an empowering strategy for NGOs. Empowerment and participation, central to much NGO work, are key elements of a right to health approach. Assisting individuals and groups to claim their right to health emphasizes empowerment as both a means and an end. And, as this Resource Manual explains, empowerment and participation come into play in how NGOs can work with the right to health. It is up to each NGO to define the aspects of the right that are important to its work; to identify possible violations it might be aware of; to set its own priorities; and to choose the best strategies to achieve its goals.

**(2) Because it is based on already established government commitments, international standards and legal obligations, as well as national legislation, it can provide NGOs with a powerful tool to move a wide variety of issues forward**

Since human rights are grounded in international and national law, using them as a framework can add legitimacy and strength to NGO strategies and activities. The right to health has been recognized and reaffirmed in numerous international treaties and documents. As the Resource Manual will explain, states that ratify human rights treaties are required to fulfil certain commitments. Understanding these commitments can provide NGOs with a powerful tool to promote a wide variety of issues. Invoking the right to health can add *authority* and *weight* to NGO goals and strategies by providing a framework of internationally agreed standards and relevant national legislation, and by placing emphasis on holding governments accountable for their obligations.

*Legal responsibility* is closely linked to the *notion of entitlement*. The legal recognition of the right to health is important because it allows the right to be *claimed* by individuals and groups. NGOs working to promote the health of individuals and groups can benefit from using a human rights approach because it stipulates legally sanctioned guidelines *on what* individuals and groups are entitled to receive, or to be protected from, in order to achieve the highest attainable standard of health, and on who is the responsibility placed for providing the necessary services and conditions. For the right to health to be experienced and enjoyed, and for it to become a lived reality, the entitlements of individuals and groups must be reflected in the actions of others such as those of the state, and also of various civil society actors including NGOs and health professionals.

**(3) Because many of the strategies that NGOs use to promote and protect the health of individuals and groups will be enhanced by this approach**

A right to health approach complements many of the strategies that are already being employed by NGOs. In many cases, the work being done by NGOs already contributes to implementing human rights standards affecting health. Making this link explicit will help reinforce their work. In other cases, a right to health approach may add new dimensions to an NGO's work and perhaps help to sharpen the focus of its strategies by clarifying the relationship between *rights-holders* (the public) and *duty-bearers* (public authorities).

In many important respects, there is overlap between strategies and goals employed in public health and 'right to health' advocacy and monitoring. Although they use different terminologies, the two perspectives share many common concerns including providing populations with the preventive and treatment services that are essential to health promotion and protection, such as clean water, sanitation, adequate nutrition, primary health care, and health information and education.

A human rights framework can enhance policies by helping to shape more comprehensive, effective and equitable responses to diverse public health problems. It can also help strengthen NGO advocacy by enabling the evaluation of existing public health policies and programmes in light of concrete government obligations.

A right to health approach may be integrated in a wide array of advocacy procedures and strategies that can be undertaken at local, national and international levels. Activities that involve promoting the right to health include:

- monitoring implementation of government obligations arising from the right to health;
- co-operating with governments in using human rights standards as criteria for the design and implementation of health-related policies and programmes;
- participating in community education, awareness-raising and mobilizing public opinion;
- acting as a watchdog of governments by exercising vigilance in identifying actual and potential violations of the right to health, and documenting and exposing them;
- making full use of existing laws and procedures to address violations of the right to health; and
- participating fully in national, regional and international human rights reporting procedures, where relevant to an NGO's own country.

**(4) Because it can help amplify its voice in the public arena, expose the local reality of what is happening 'on the ground' and bring violations of the right to health to the attention of a wider audience**

Health-concerned NGOs and health professionals are often privy to important information about what is *actually happening at the community level*. They are in a position to understand the most pressing health-related problems being faced by particular groups and the reality of local conditions. Moreover, they are able to ascertain whether government health-related policies benefiting those most in need are being fully implemented. They are therefore often in a favourable position to observe actual or potential violations of the right to health.

Documenting violations of the right to health, and using this information both for advocacy and for seeking remedies can alert the public to the reality of local conditions and what changes need to be made. Working with the media, NGOs can bring urgent problems to the attention of a wider public and can mobilize national and even international public pressure to bring about change.

The right to health cannot be invoked effectively if individuals and groups do not know what it means. It is only through knowledge and awareness that individuals can exercise their rights and demand that they be enforced and protected. Community education and awareness-raising are often central to work done by NGOs. Since the right to health entails entitlements, NGOs can enhance their effectiveness by making individuals and communities aware of their rights.

***Are NGOs able to use a right to health approach only in relation to governments that are parties to particular international treaties?***

The answer to this is a *qualified 'no'*. Because the right to health has been recognized and reaffirmed in a body of internationally accepted norms, standards and principles, these can serve as a reference and an authoritative framework for NGOs in all countries. Also, the right to health is recognized in a number of different international instruments. This means that any given country in the world is party to at least one treaty containing provisions that affect health directly or indirectly. Approximately 75 percent of countries have ratified the International Covenant on Economic, Social and Cultural Rights (ICESCR), which has comprehensive provisions on the right to health.

Moreover, the right to health is recognized in a variety of ways in national legislation. For example, in most countries legislation exists to a greater or lesser extent to protect health either directly or indirectly as a result of the recognition of a general right to equality or freedom from discrimination.

The World Conference on Human Rights (WCHR) held in Vienna, Austria in 1993, emphasized that it is the duty of *all states*, regardless of their political, economic and cultural systems, to promote and protect all human rights and fundamental freedoms. NGOs should, therefore, be aware that although a state may not have ratified any particular one of the international and *legally* binding human rights treaties nor has relevant national legislation, this does not mean that it is not expected to promote and protect the right to health. It means only that it is not legally bound to comply with specific obligations as set out in international and national law. NGOs are therefore justified in directing their advocacy at such states.

The private sector and international institutions also have the potential to influence the enjoyment of the right to health in both positive and negative ways. Examples of the latter include, on the one hand, multinational corporations that have exposed their workers and local communities to environmental hazards and, on the other hand, international financial institutions (IFIs) that have reduced the availability of free health services by the imposition of user fees through structural adjustment programmes (SAPs) and other health sector reforms. Monitoring in accordance with the standards of a right to health approach can help reveal the consequences to health of such activities by the private and non-governmental sectors. It follows that although ultimate legal responsibility for implementing the right to health lies with states that are party to relevant human rights treaties and that have relevant national legislation, there is much that NGOs can do through advocacy to call attention to violations perpetrated by the private and non-governmental sectors. (See chapters 6 and 10.)

**0.3 How should the Resource Manual be used?**

NGOs should choose strategies based on their own areas of expertise and that promote goals that they have set for themselves. This Resource Manual has been designed in a flexible manner to serve as a hands-on

manual, an educational tool and a reference guide. It is intended, first and foremost, that NGOs should be able to find ideas and inspiration in it, which they can then adapt to their own needs and interests. Since the Resource Manual aims to cover a wide range of information, it does not attempt to be comprehensive in any particular area.

Working with the right to health will come as a new experience for many NGOs that pick up this Resource Manual, and they may find it necessary to do more targeted research when it comes to designing concrete strategies and advocacy plans. For the most part, NGOs working on health and health-related issues have only recently started to work within a human rights framework. The Manual therefore aims to supply the most basic information and to describe basic monitoring strategies that will help NGOs to get started. It should, therefore, be used by such NGOs as a starting point, as a resource guide, and above all, as a flexible tool.

The Resource Manual may be used, for example:

- as an introduction to the right to health;
- as an overview of where the right to health has been endorsed and where it is recognized in law;
- to find ideas and suggestions about how NGOs can promote implementation of the right to health;
- to learn how NGOs can monitor their government's compliance with its obligations;
- as a guide for identifying violations of the right to health;
- to learn about national enforcement procedures and mechanisms, such as courts of law, ombudsman offices, and National Human Rights Institutions (NHRIs), through which NGOs can address, and often seek remedies for, violations of the right to health;
- to understand how NGOs can participate in international and regional human rights monitoring and enforcement mechanisms;
- to help health service providers find out about the particular issues and strategies relevant to their work; and
- as a source of inspiration, in showing how other NGOs have been successful in monitoring, promoting and protecting the right to health in their work.

### *Read it for yourself!*

Human rights instruments do not exist only for governments, human rights lawyers and UN officials. They are there for anyone who is interested in understanding, promoting and protecting the rights of individuals and communities. Human rights instruments are the products of international agreements about how our fundamental rights should be reflected and protected in government legislation, policies, and practices.

Among other things, this Resource Manual provides an overview of the standards, principles and norms for implementing the right to health that appear in international human rights instruments. However, you are strongly advised to read each instrument for yourself, and to read all of it. The right to health exists within a body of other rights, and of corresponding state obligations, many of which are overlapping.

The internationally-accepted standards and norms set out in these instruments should be used by NGOs, in conjunction with existing national laws, as a framework for monitoring the right to health; for promoting the right by helping to turn legal standards into health-related policies and programmes at the national-level; and for guiding their own health-related work.

## **0.4 Organization of the Resource Manual**

The Resource Manual is organized so as to allow readers to find and to use the information that they require for their own work. It is meant to be a reference book as well as a handbook. This means that it does *not* have to be read from beginning to end. Chapters can be read in any order, as required, and for this reason, there is some unavoidable repetition in the text. Certain pertinent pieces of information appear a number of times precisely because we must assume that some readers will 'flip through' some chapters, and that others will read them more carefully, or will review particular chapters more closely, as the need arises.

The Manual is organized in three parts that describe *how to progress from knowledge to action* in working with a human rights approach to health. The overall subject-matter of each part will be outlined here, and a more



detailed chapter division will be provided in the introductions to Parts 2 and 3. There are case studies and examples throughout the Manual to illustrate ways in which NGOs have been successful in monitoring and promoting the right to health.

## **Part 1**                    *Gaining knowledge: Understanding the legal framework*

Part 1 is introductory and gives basic information about the legal framework of human rights, human rights monitoring systems and the right to health. These chapters are meant to be treated as a reference source. As such, they provide a comprehensive overview of basic human rights concepts and how the right to health fits within the context of human rights instruments and monitoring systems, as well as within national laws and enforcement mechanisms. Working with a human rights approach to health means turning the legal language of human rights instruments into policies and programmes that can address national-level health issues. That is why it is important that NGOs have a basic understanding of the legal framework of human rights.

## **Part 2**                    *Moving towards action: Focussing on obligations arising from the right to health*

Part 2 provides a detailed examination of the meaning and scope of government obligations arising from the right to health. This section of the Manual explains the nature both of *state obligations* and of violations of the right to health. It provides a detailed account of the *state of the art* on internationally-accepted standards, norms and principles of the right to health. These standards will serve as a framework for monitoring by NGOs. Part 2 explains, from the perspective of health professionals and health-concerned NGOs, the meaning and implications of the health-related provisions contained in relevant international human rights instruments.

## **Part 3**                    *Taking action: Working with the right to health*

Part 3 contains *hands-on* information about how to work with the right to health. It presents strategies for monitoring and advocacy, and provides guidance on how to work with *monitoring tools* such as invoking legal obligations; identifying violations; and using statistics, indicators and benchmarks. Part 3 also presents information on a variety of practical ways in which NGOs can monitor and promote the right to health at local, national and international levels. A separate chapter in this Part is devoted to clarifying the special role and function of medical ethics and of national medical and other health professional associations.

# Part I **Gaining knowledge: Understanding the legal framework**

## Chapter 1 **What are human rights? The legal framework**

### *Keys to Chapter 1*

#### *key information:*

- Human rights are an important part of international law;
- They are also enshrined in regional legal instruments and often in national laws;
- They have a special language and a conceptual framework;
- They serve as guiding principles for domestic policies and international relations;
- They are supported by monitoring and enforcement mechanisms at the global, regional and national levels;
- They are a powerful tool for advocacy.

### **1.1 Concept of human rights**

Human rights, as part of international law, are rights that every human being possesses, irrespective of race, religious or political beliefs, legal status, economic status, language, colour, national origin, gender, ethnicity, etc. In other words, human rights are accorded to every human being. They apply to all individuals and groups on the basis of equality and non-discrimination. Even if they are not always honoured in fact (*de facto*), everyone is entitled by international law (*de jure*) to enjoy benefits of human rights.

*All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.*

*Universal Declaration of Human Rights, art 1'*

A fundamental aspect of human rights is that they protect human dignity and integrity. They are based on generally accepted principles of equality and justice and, in this way, protect individuals and groups from elementary forms of injustice. Human rights belong to all and must never be regarded as a favour, gift, or privilege conferred by the state or by any organization or individual.

Another basic feature of human rights is that they regulate relationships between the state and individuals or groups. Human rights are *claim rights*. This means that the rights of one party impose a corresponding duty on another party (or parties) to protect those rights. Human rights therefore create *obligations*, usually on governments. These obligations correspond with the entitlements to rights of individuals and groups. Human rights require *minimum standards* of legal and administrative practice that must be followed and enforced by governments if individuals are to enjoy their fundamental rights.

There is, furthermore, a duty on the part of governments not to obstruct any person's ability to claim his or her rights. *Obstructing* can mean either action or inaction — in other words, by actively preventing someone from exercising a right or by failing to take the necessary action to ensure that the right can be exercised.

Human rights place a particular emphasis on the protection of individuals and groups that are vulnerable or otherwise disadvantaged, as they are most likely to suffer from discrimination and deprivation. Examples include most women, and particularly adolescent girls, in developing countries; indigenous peoples; refugees; asylum seekers; minorities; migrant workers; and children.

Human rights are stated as being interrelated, interdependent, and indivisible. *What does this mean?* It means that each right depends on, and connects with, others and each human right gives added meaning to the others. The right to life, for example, cannot be conceived without rights to food, shelter, clean water, freedom from torture, etc. This 'interconnectedness' reflects the complex variety of overlapping needs and situations that people all over the world face throughout their lives. *All* human rights are essential to preserving the dignity, security and survival of individuals, and to ensuring that every person is treated with decency and basic elements of respect.

*Human rights can and should be claimed.* Sometimes, the relevance of human rights is questioned because the necessary national legislation and/or enforcement procedures are not in place everywhere to allow all human rights to be protected and enforced by courts of law. But this does not mean that human rights are irrelevant. It simply underlines the importance of demanding and working for their recognition and enforcement.

The relevance of human rights is reflected in the fact that the international community has agreed upon and accepted them. As a result, it has included them in a body of international law that affirms their legitimacy and defines them as legal entitlements which every individual possesses. In practice, the universal recognition and implementation of human rights requires a long, ongoing process to which many parties must contribute. *Human rights in practice* means the creation of conditions where human rights can be claimed and enjoyed, and where violations of them exposed, condemned and rectified.

## 1.2 International human rights laws and norms

The international community has developed a number of human rights instruments setting out the various principles and norms which constitute the fundamental rights that individuals everywhere should be entitled to enjoy. *What is the nature of their legal status?*

Those that are referred to as *declarations, principles, guidelines, standard rules and recommendations* have no binding legal effect. They are the result of an international consensus or agreement and provide practical guidance for states on their conduct. Their value lies in their recognition and acceptance by a large number of states and, even without binding legal effect, they can be seen as declarations of broadly accepted principles within the international community.

They must be distinguished from those international treaties that are referred to as *covenants, protocols or conventions*, all of which are legally binding on states that ratify or accede to them. Treaties adopted within the United Nations system are open for signature and ratification by all UN member states, while those adopted within the framework of regional organizations depend for their acceptance on membership in the organization concerned.

The first international codification of human rights took place in the aftermath of World War II, with the adoption by the United Nations' General Assembly of the Universal Declaration of Human Rights (UDHR) on 10 December, 1948. This document was intended to set a *common standard of achievement* for all nations. The rights and freedoms contained in the UDHR establish guidelines to which all UN member states should aspire and adhere, and which people everywhere should strive to achieve. The UN has continued ever since to emphasise the importance of the UDHR as a source for human rights among its member nations. Although declarations are not legally binding documents under international law, the UDHR is seen to be exceptional because of its universal acceptance. It therefore remains a valid standard and is widely regarded as carrying the status and authority of *international customary law*.

In 1966 the UN General Assembly adopted two treaties to strengthen the UDHR by converting the principles it contains into legal obligations for the states that ratify them, namely the International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR). These covenants and the UDHR are referred to collectively as the *International Bill of Rights*, from which has evolved most of the basic principles contained in the body of international human rights law today. The International Bill of Rights contains a broad definition of human rights together with an affirmation that its provisions apply universally. For these reasons, it is generally considered to be the most important set of instruments dealing with international human rights law.

### 1.2.1 *Civil and political rights as compared to economic, social and cultural rights: understanding their relationship*

There has been much confusion and debate about the difference between civil and political (CP) rights, on the one hand, and economic, social and cultural (ESC) rights, on the other hand. This debate still continues. *What purpose, if any, is served by categorising human rights in this way?*

It has been claimed that the two categories reflect different sets of priorities that arise in societies that are organized around different political systems, such as liberal democracies and socialist societies; or societies that are at different socio-economic levels, for example, the relatively affluent societies in the Northern hemisphere and the less well developed societies in the Southern hemisphere. Another frequent comment is that CP rights are associated with ensuring people's liberties whereas ESC rights are concerned with ensuring their basic needs in accordance with social justice. The right to health, for example, is generally considered to

be a part of ESC rights. While it can certainly be understood as a right to protect individuals from suffering socio-economic deprivations and injustices, it is also closely related to, and dependent on, several well-established CP rights, such as the rights to life; to privacy; to freedom of information and to various other important freedoms such as freedom from torture.

Because of the overlapping nature of human rights, it is reasonable to question the purpose for such categorization. The UDHR, as the primary source of human rights law, does not make any distinction between CP rights and ESC rights. In practice, it is impossible to have one without the other. Accordingly, the ICCPR and ICESCR have equal legal status. The fact that the two Covenants are categorised in this way should be regarded as a (regrettable) consequence of the particular historical and political circumstances at the time when they were drafted. But this is no excuse for giving priority to the one set of rights over the other.

One unfortunate outcome has been the tendency to regard CP rights as *real* or *fully-fledged* human rights, and ESC rights as *goals* or *second-class* rights, compliance with which is regarded as little more than optional for governments. Although this interpretation has been rejected by the UN, it persists in a variety of practical ways. Hence, monitoring and enforcement mechanisms for CP rights are far more developed than those for ESC rights. The widespread though undeserved reputation of ESC rights as secondary rights has resulted in their receiving less attention and being less well understood, than CP rights. Their implementation is also given lower priority and there are fewer legal precedents for their enforcement.

However, there are many signs that this situation is changing. Such a categorization of legally binding international human rights is now widely criticized for being artificial and counter-productive. Meanwhile it is significant that the statement that human rights are universal, indivisible, interdependent and interrelated was reaffirmed by representatives from 171 UN member states in 1993 at the conclusion of the World Conference on Human Rights (WCHR) in Vienna, Austria. Of equal importance is the fact that ESC rights are increasingly becoming invoked and better understood. As the following chapters in this Resource Manual will demonstrate, the right to health is a case in point.

### 1.2.2 *Legally binding human rights instruments*

Since the International Bill of Rights came into effect, there have been numerous international human rights instruments that clarify and refine the specifics of human rights norms in particular subject areas. When a state ratifies or accedes to a human rights convention, it becomes known as a *State party* to the convention and is thereafter legally bound (subject to any reservations it has entered) to the obligations imposed by the convention. *State party obligations* describe what a state must do, and must not do, in order to ensure that the population of the country is able to enjoy the rights set out in the convention.

States parties are expected to adopt or to modify domestic legislation and policies so that they conform to the human rights standards set out in the covenants, conventions or protocols.

States parties may submit *reservations* to treaties that they ratify. These refer to specific paragraphs or sections of the treaty with which a state does not agree to be legally bound to comply in ratifying the treaty. Many such reservations concern women and the girl child and involve health-related issues. States often invoke religious or cultural obstacles as reasons for submitting reservations to human rights treaties.

Besides the obligation to apply treaty provisions, ratification of a treaty requires States parties to accept international supervision of their compliance with its terms. This is why they are required to submit regular reports on the measures they are taking to fulfil their obligations under the treaty concerned. Included in each UN human rights treaty are monitoring mechanisms in the form of monitoring committees to which States parties are required to report regularly. They are composed of independent experts elected in their own right and are not representatives of their government nor of any organization.

The task of *treaty monitoring committees* (also referred to as a *treaty monitoring bodies*) is to assess the extent to which States parties are complying with the obligations they accepted on ratification of the treaty. This

*‘When we speak of human rights, we must never forget that we are labouring to save the individual man, woman or child from violence, abuse and injustice... Freedom from want and freedom from fear go hand in hand.’*

*Kofi Annan, UN Secretary General, on human rights being indivisible<sup>2</sup>*

*‘[All human rights] must be upheld with equal determination in every country — and that means looking beyond cultural differences — to recognize, for example, that the rights of women on one continent are the rights of women on every continent.’*

*Kofi Annan, UN Secretary General, on human rights being universal<sup>3</sup>*

includes the examination of any actual or potential violations. The committees evaluate the information given by governments and relevant interested parties, such as NGOs, and make suggestions and recommendations for future follow-up of the implementation of the treaty within the country concerned. Each committee follows its own set of procedures. There are a number of avenues through which NGOs can participate in the work of treaty monitoring bodies, such as by providing supplementary information about the extent to which their government is complying with its treaty obligations.

#### *What do human rights treaties offer? <sup>4</sup>*

- They guarantee specific rights to individuals;
- They establish state obligations corresponding with those rights; and
- They create mechanisms to monitor states' compliance with their obligations and allow individuals to seek redress for violations of their rights.

In addition to the ICCPR and ICESCR, there are five other principal international treaties that enshrine and safeguard human rights. These core treaties deal with particular groups of people or types of violations:

- International Convention on the Elimination of All Forms of Racial Discrimination (ICERD), adopted in 1965;
- Convention on the Elimination of All Forms of Discrimination Against Women (Women's Convention), adopted in 1979;
- Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Torture Convention, or CAT), adopted in 1984;
- Convention on the Rights of the Child (CRC), adopted in 1989; and
- International Convention on the Protection of the Rights of All Migrant Workers and Their Families (MWC), adopted in 1990.

All seven treaties are concerned to a greater or lesser extent with health issues and each has a treaty monitoring committee. Chapter 11 includes a detailed discussion of international human rights reporting mechanisms and explains how the various monitoring bodies work, the procedures they follow, and the ways in which health-concerned NGOs can participate in the monitoring process.

The seven principal international human rights treaties are monitored by the following committees:

- ICCPR is monitored by the Human Rights Committee;
- ICESCR is monitored by the Committee on Economic, Social and Cultural Rights;
- ICERD is monitored by the Committee on the Elimination of Racial Discrimination;
- Women's Convention is monitored by the Committee on the Elimination of Discrimination against Women;
- CAT is monitored by the Committee against Torture;
- CRC is monitored by the Committee on the Rights of the Child; and
- MWC is monitored by the Committee on the Protection of the Rights of All Migrant Workers and Their Families.

### **1.2.3** *What is the significance of legally non-binding international human rights instruments and why are they considered to be important?*

The value of legally binding treaties and of non-binding commitments and recommendations is that cumulatively they create a framework within which a variety of actors, including NGOs and human rights activists, can work in different ways to promote and protect human rights. In addition to being legally binding, international legal instruments provide a reference point that adds specificity to abstract human rights. Documents that are not legally binding provide greater interpretation on specific *components of these rights*.

Legally non-binding human rights instruments and other documents, such as the outcomes of UN world conferences that have been reached by consensus, are important because they provide standards and authoritative guidance on the meaning and content of international human rights. In addition, they provide

guidance on some of the policy implications of compliance with particular rights and thus have a significant influence on policy-making at national, regional and international levels.

The primary purpose of *treaties* being legally binding is to establish basic human rights norms and set minimum standards for the conduct of governments. In keeping with this, their provisions are often worded in broad and general terms. A notable exception to this is the CRC, which refers to the right to health care facilities; adequate food; drinking water; environmental health; access to information; and the prohibition of harmful traditional practices.

In contrast, many *non-binding documents* tend to provide a more detailed interpretation of the meaning of certain rights and of standards set for their implementation, for example, on state obligations, on particular vulnerable groups, or on the role of health personnel. Moreover, many of those emanating from UN world conferences include commitments on action to be taken by governments as well as targets and timetables.

As with legally binding human rights treaties, states may submit *reservations* to a non-binding document before committing themselves to it. In the case of non-binding documents there also tend to be a high number of reservations concerning women and the girl child and involving health-related issues, many of which are justified by invoking religious or cultural reasons.

#### *For example...*

In 1994 the International Conference on Population and Development (ICPD), held in Cairo, approved by consensus a Programme of Action (PoA)<sup>5</sup> to guide governments and international co-operation in the field of population and development over the next twenty years. The PoA was the outcome of negotiations in preparatory committee meetings leading up to, and culminating in the Conference itself. It was adopted by consensus by the representatives of the governments of 179 UN member states participating in the Conference, with a small number of reservations on specific paragraphs. By doing so Governments committed themselves to pursue actively its agenda and the goals that it set out.

The PoA provides the following comprehensive definition of reproductive health and reproductive health rights:

‘Reproductive health means that women and men have the freedom to decide if and when to reproduce and the right to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice as well as the right of access to appropriate health-care services that will, for example, enable women to go safely through pregnancy and childbirth.’ (Chapter VII, para 7.)

‘Everyone has the right to the enjoyment of the highest attainable standard of physical and mental health. States should take all appropriate measures to ensure, on a basis of equality of men and women, universal access to health-care services, including those related to reproductive health care, which includes family planning and sexual health. Reproductive health-care programmes should provide the widest range of services without any form of coercion. All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education, and means to do so’. (Chapter II, Principle 8.)

This definition has since provided authoritative standards for implementing the right to reproductive health at all levels — internationally, regionally, nationally, and locally — and is used as a framework for legislative and policy change worldwide. The PoA was endorsed by the UN General Assembly (in Resolution 49/128) and was later re-enforced by the *Key Actions for the Further Implementation of the Programme of Action of the International Conference on Population and Development*, adopted by the 21st Special Session of General Assembly in 1999.

International human rights law is based on the minimum extent to which consensus can be reached among UN member states, and not on what the maximum number of people ideally would like.

#### **1.2.4** *Human rights standards constitute a body of ‘living law’*

In addition to an emerging body of national and regional case law, two examples of this are the consensus documents emanating from UN world conferences and the documents issued by treaty monitoring committees that provide more specific interpretation of particular rights that are included in their respective

treaties. The latter documents are called, depending on the committee that issues them, *general comments* or *general recommendations* (two different ways of referring to what is, in many respects, the same thing). Committees issue such documents on an as-needed basis to clarify treaty provisions and help governments fulfil their obligations. The Committee on Economic, Social and Cultural Rights (CESCR) has adopted General Comment 14 on the *right to the highest attainable standard of health* (2000) which expands upon Article 12 of the ICESCR. This General Comment 14 is the most comprehensive interpretation of the international right to health, and corresponding state obligations, to date. As such, it should be consulted by NGOs for internationally-accepted standards, principles and norms applicable to the right to health and used as a framework for monitoring and advocacy. (See introduction to Part 2.)

The Committee on the Elimination of Discrimination against Women (CEDAW) has adopted General Recommendation 19 on Article 12: Women and health. In addition, the Committee on the Rights of the Child (CRC) has adopted General Comment 4 on Adolescent health and development in the context of the Convention on the Rights of the Child (CRC) and General Comment 3 on HIV/AIDS and the rights of the child.<sup>6</sup>

Meanwhile the world is continually changing. New challenges to the integrity and dignity of individuals and groups are continuously surfacing, often exposing the need for new forms of protection. Examples include recent advances in genetic sciences and information technology. At the same time there is a continual process of naming and gaining acceptance of previously unnamed rights; interpreting established rights in further detail; and ensuring that established rights are enforced at the national level, such as by developing a body of case law. Human rights claims, including the right to health, are increasingly being argued in courts of law.

### 1.3 What is the relationship between international human rights law and international humanitarian law?

Human rights standards define the minimum requirements for an inherently legitimate rule of law. International humanitarian law, by contrast, defines minimum standards of protection in emergency situations where the rule of law has generally collapsed. This can be seen to represent a compromise between humanitarian considerations and military necessity or other security considerations arising in situations of armed conflict or natural disasters. Certain human rights provisions, however, are explicitly identified as *non-derogable* which means that they must be respected even in a time of crisis.

The important point is that all actors, regardless of their status, that are involved in such 'emergency' situations are subject to international humanitarian law. The Geneva Conventions are the paramount example. They are among the most widely ratified of multilateral treaties, and they enjoy virtually universal ratification. Within the context of armed conflict, humanitarian law aims to ensure that the wounded should be collected and cared for, and to protect individuals and groups against certain gross human rights violations, such as arbitrary killings, rape, sexual violence and enforced prostitution.

#### *Basic characteristics of human rights<sup>7</sup>*

Human rights:

- focus on the dignity and integrity of the human being;
- are guaranteed by international standards;
- are legally protected and define legal obligations;
- protect individuals and groups;
- apply to all individuals on the basis of equality and non-discrimination;
- place obligations on states and state actors;
- specify individual entitlements;
- cannot be arbitrarily waived or taken away;
- are universal, interdependent, indivisible and interrelated; and
- can and should be claimed.

## 1.4 Human rights and state obligations

International human rights law sets a minimum standard for national legislation and policies and establishes a framework within which legislative and administrative choices can be made at the national level. Human rights refer mainly to the relationship between the state and the individual or group, and are concerned with entitlements which imply *accountability* and *government responsibility*. Wherever there is a recipient of rights, there is a corresponding body, primarily the state, whose duty is to ensure the existence of conditions under which rights can be claimed and enjoyed.

*In what way are obligations imposed on governments by human rights conventions?* Because they confer both freedoms and entitlements to individuals and groups, human rights place both positive and negative duties on the state. The state can fail to carry out its obligations by either *commission* or *omission*. Positive obligations require government to take certain actions, while negative ones require it to refrain from other actions such as obstructing enjoyment of the right to health.

### *Human rights framework<sup>a</sup>*

*Individuals are the holders of civil, political, economic, social and cultural rights, and governments have corresponding obligations to respect, promote, protect and fulfil these rights. The legal and normative standards for these rights and the governmental obligations associated with them are based on the relevant human rights instruments and national constitutional provisions concerned.*

### *Human rights impose three different types of obligations or duties on the state, its organs and agents*

In current human rights language, the precise nature of a state's positive and negative duties is often distinguished respectively as obligations to *respect*; to *protect*; and to *fulfil*. (See chapter 3.) The obligation to respect is generally a negative duty, ensuring that governments refrain from acting in a way that impedes any attempts to claim rights. The other two obligations impose many positive duties on states as well.

#### *The three types of governmental obligations*

##### *To respect human rights*

duty of the state not to violate rights by its actions. *How?*

- By refraining from interfering directly or indirectly with the enjoyment of human rights.

##### *To protect human rights*

duty of the state to prevent human rights violations by others. *How?*

- By preventing third parties from interfering with or violating human rights. This means taking the necessary measures to prevent individuals or groups from violating the rights of others.

##### *To fulfil human rights*

duty of the state to act in order to ensure that rights can be enjoyed. *How?*

- By adopting appropriate legislative, administrative, budgetary, judicial, promotional and other measures to facilitate the full realization of human rights. This means taking the necessary measures to ensure that each person has the opportunity to satisfy their entitlements, as guaranteed in human rights instruments. The *obligation to fulfil* is often broken down to include the *obligations to facilitate; to provide; and to promote*.



## 1.5 Human rights monitoring and enforcement mechanisms of the UN system

The UN human rights system works through three different types of mechanisms.

- *Treaty based mechanisms* These are administered by the treaty monitoring committees of the various legally-binding human rights instruments. The committees meet regularly to monitor States parties' compliance with their treaty obligations. They do this by reviewing State party reports in a procedure that includes 'a constructive dialogue' on each report with representatives of the governments concerned. Certain treaties provide complaint mechanisms (called optional protocols) that allow individuals or groups to submit complaints of violations to the monitoring committee for investigation. (See chapter 11.)
- *Non-treaty-based mechanisms* These are also referred to as 'extra-conventional' mechanisms and are administered by the UN Commission on Human Rights. The Commission appoints independent experts known as Special Rapporteurs to investigate particular countries or particular themes, such as harmful traditional practices, disability, violence against women, and torture, and to report on the human rights implications involved. A Special Rapporteur on the right to health was appointed in 2002. (See chapter 11.)
- *Specialised agencies of the UN* are sometimes charged with monitoring specific rights and with drafting guidance on their implementation. Specialised agencies of the UN include: the International Labour Organization (ILO), which monitors labour standards; the World Health Organization (WHO), which monitors health and the implementation of the WHO Framework Convention on Tobacco Control; the UN Children's Fund (UNICEF), which monitors children's rights; the UN Population Fund (UNFPA), which monitors reproductive rights; and the UN High Commissioner for Refugees (UNHCR), which monitors the rights of refugees.

The Office of the UN High Commissioner for Human Rights (OHCHR) is a key entity within the UN human rights system. The OHCHR has a mandate to protect and promote human rights for all and the High Commissioner for Human Rights is the official with principal responsibility for UN human rights activities.

NGOs can participate in the various UN monitoring mechanisms in many different ways, depending on what they want to achieve. The most effective ways for them to participate in the UN monitoring system on issues concerning the right to health are discussed in detail in chapter 11.

## 1.6 Human rights monitoring and enforcement mechanisms of regional systems

Regional human rights monitoring mechanisms are in place in Europe, the Americas and Africa and are directly linked with corresponding regional human rights treaties. (See Annex 1.) These mechanisms are administered, respectively, by the Council of Europe; the Inter-American Commission on Human Rights (under the Organization of American States); and the African Commission on Human and Peoples' Rights (under the African Union).

The respective bodies have various mechanisms to hear complaints of violations from individuals and groups, including regional Courts of Human Rights which can rule on complaints of specific violations of regional treaties. The first two have their own regional Courts of Human Rights which can rule on complaints of specific violations of regional treaties, namely the Inter-American Convention on Human Rights and the European Convention for the Protection of Human Rights and Fundamental Freedoms and its protocols. These courts provide victims of violations of human rights with the opportunity for litigation and compensation as well as develop case law on particular rights. Before a regional or international court will accept jurisdiction, it is usually necessary to have exhausted all national level remedies. The Human Rights Courts issue legal judgements that apply to all countries within their jurisdictions and not just to the country against which the case has been brought.

In addition the Council of Europe (to be distinguished from the European Union) has a limited complaints procedure for the rights contained in the European Social Charter, which includes the right to the protection of health. This procedure allows NGOs to submit collective complaints that allege violations of a right in a member county. Similar non-judicial mechanisms exist in the inter-American and African human rights protection systems.

Generally speaking, the main disadvantage of international and regional human rights mechanisms is not what they can do, but what they cannot do. While the UN and other bodies can monitor human rights, condemn violations, and make recommendations on how to rectify them, they have limited ability to enforce them. International and regional human rights mechanisms do not have the power to force states to comply.

Instead, they must rely on the good faith of States parties and on the states' susceptibility to having their human rights practices and violations subjected to internal and/or international criticism. The authority of UN and regional human rights mechanisms is now highly respected and escalating globalization is exposing states responsible for human rights violations to increasing condemnation and unwanted publicity, together with unwelcome political, trade and diplomatic consequences.

## 1.7 Human rights in domestic law

While the international protection of human rights is crucial, it is their national protection that makes them viable and effective in the local setting. National-level legislation, policies and enforcement mechanisms are the key factors in rights being claimed and granted in the everyday lives of individuals and groups. Not only do national laws offer variable degrees of protection against human rights violations, but national bodies are often also able to hear complaints of violations and enforce the human rights norms that can be found in international and regional human rights law.

Human rights may be protected through a constitutional *bill of rights* or by other laws of the country. Constitutional bills of rights set out rights that cannot be changed, by law, without certain fixed procedures being followed. This would usually require a repeal of the constitution. Furthermore, a government cannot introduce laws which conflict with the country's bill of rights.

Many countries base their national bill of rights on the UDHR's underlying principles of dignity, equality and justice. Countries that have drafted their constitutions recently, such as South Africa, have often adopted the principles, and even the language, of international and regional human rights norms. States that are party to legally binding human rights treaties are expected to make them locally applicable and enforceable. After ratification, states must ensure that national laws take account of, and do not conflict with, treaty provisions. The laws of some states require them to pass legislation to incorporate their treaty obligations into national law, while others automatically consider treaties to be part of their domestic laws.<sup>9</sup>

Under international human rights law, states have an obligation to provide individuals and groups with legal recourse to human rights violations and effective judicial, quasi-judicial, or other appropriate remedies.

Any person or group victim of a violation of the right to health should have access to effective judicial or other appropriate remedies at both national and international levels. All victims of such violations should be entitled to adequate reparation, which may take the form of restitution, compensation, satisfaction or guarantees of non-repetition. National ombudsmen, human rights commissions, consumer forums, patients' rights associations or similar institutions should address violations of the right to health.

The incorporation in the domestic legal order of international instruments recognizing the right to health can significantly enhance the scope and effectiveness of remedial measures...Incorporation enables courts to adjudicate violations of the right to health ...

*CESCR General Comment 14, paras 59 & 60<sup>10</sup>*

National enforcement of human rights usually involves the courts and other state organs that serve as investigative, judicial or quasi-judicial bodies. These include national human rights institutions (NHRIs), human rights commissions and ombudsmen. The general purpose of NHRIs is to promote and protect human rights. Their precise structure, authority and function, however, differ between countries. Depending on its mandate, a NHRI might be empowered to investigate alleged violations of human rights; to conduct public enquiries (often regarding systemic violations of rights among vulnerable groups); to provide advice and assistance to governments; and/or to provide human rights education<sup>11</sup>. Ombudsman offices may exist at national and/or sub-national levels. Ombudsmen can act as advisors and are often mandated to consider and investigate complaints by individuals or groups (for example, about human rights violations that arise through administrative practices of government departments or other public bodies). Ombudsman offices might include: health ombudsmen; mental health ombudsmen; environmental health ombudsmen; parliamentary ombudsmen; hospital ombudsmen; and patient ombudsmen.

A country may have constitutional and/or domestic courts that have jurisdiction to hear claims of violations of human rights based on either domestic or international law. There are encouraging examples in some

countries where either the international or constitutional right to health has been argued before the domestic courts. (See chapter 10.) Alternately, a country might have an effective national human rights commission.

There is much that NGOs can do to monitor and challenge their country's implementation of the right to health, such as to pursue administrative and/or legal remedies for violations. This might involve, for example, invoking national mechanisms that may exist to enforce human rights through the courts. NGOs can also be extremely effective by employing their recognized expertise in advocacy. (See chapter 10 for examples.)

## Notes

- 1 Universal Declaration of Human Rights, UN General Assembly Resolution 217 A (III). A/810 at 71 (1948).
- 2 Kofi Annan, Secretary-General United Nations, address to the UN Commission on Human Rights, April 24, 2003.
- 3 Kofi Annan. *Ibid.*
- 4 Women, Law and Development International (WLDI); Human Rights Watch (HRW), Women's Rights Division. *Women's human rights step by step: a practical guide to using international human rights law and mechanisms to defend women's human rights.* Washington, D.C.: WLDI and HRW. 1997:11.
- 5 Programme of Action of the International Conference on Population and Development; Cairo, 1994. A/CONF.171/13.
- 6 There are many other general comments and general recommendations issued by the various treaty monitoring committees which are relevant to the right to health. See [www.unhchr.ch](http://www.unhchr.ch).
- 7 Adapted from: The United Nations system and human rights: Guidelines and information for the resident coordinator system. Approved on behalf of the Administrative Committee on Coordination (ACC) by the Consultative Committee on Programme and Operational Questions (CCPOQ) at its 16th Session, Geneva, March 2000. As quoted in: Hunt P. *Neglected diseases, Social Justice and human rights: some preliminary observations.* International workshop on intensified control of neglected diseases: Berlin. Dec. 10-12. 2003.
- 8 International Human Rights Internship Programme (IHRIP). *Ripple in still water: reflections by activists on local and national-level work on economic, social and cultural rights.* Washington D.C.: IHRIP. 1997:11.
- 9 Center for Reproductive Rights, *An Advocate's Guide to the Work of the UN treaty Monitoring Bodies on Reproductive and Sexual Rights.* Available from <http://www.reproductiverights.org>.
- 10 Committee on Economic, Social and Cultural Rights. General Comment 14, The right to the highest attainable standard of health. E/C.12/2000/4.
- 11 Adapted from *The United Nations Human Rights — Droits de l'homme*, Geneva: The United Nations and National Human Rights Institutions; 1998:21-6.

# Part I **Gaining knowledge: Understanding the legal framework**

## Chapter 2 **What is meant by the right to health?**

### *Keys to Chapter 2*

#### *key information:*

- The right to health is a fundamental human right;
- It is enshrined in the UDHR and the ICESCR and recognized in numerous other international and regional human rights instruments as well as in domestic legislation in many countries;
- It is based on a broad definition of health that encompasses medical and public health perspectives;
- It accords priority to the needs of the poor and otherwise vulnerable and disadvantaged groups;
- It entails specific government obligations regarding health care and the underlying determinants of health, as well as obligations to ensure non-discrimination and people's right to participate in relevant decision-making processes.

### **2.1 Health as a human right**

The right to health should not be seen as a right to be *healthy*. The state cannot be expected to provide people with protection against every possible cause of ill health or disability such as the adverse consequences of genetic diseases, individual susceptibility and the exercise of free will by individuals who voluntarily take unnecessary risks, including the adoption of unhealthy lifestyles. Nor should the right to health be seen as a limitless right to receive medical care for any and every illness or disability that may be contracted. Instead, the right to health should be understood as a right to the enjoyment of a variety of facilities and conditions which the state is responsible for providing as being necessary for the attainment and maintenance of good health.

It is helpful to view the right to health as having two basic components: *a right to health care* and *a right to healthy conditions*. It is not easy to compile a comprehensive list of the necessary conditions as their relevance will depend on a number of variable social and economic factors, such as the extent of avoidable and unavoidable exposure to health hazards in different situations. However, as will be seen later, decisions have recently been taken, and advice has been issued, by UN treaty monitoring committees as to what the right to health means in practical terms. This process of clarification is likely to continue with the result that the scope of the right to health will become still clearer in the future, for example through the development of regional and national case law.

The World Health Organization (WHO) articulated the first specific international health and human rights provisions in the preamble to its Constitution (written in 1946). It declares that:

... the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic, or social condition.

*WHO Constitution Preamble<sup>1</sup>*

The phrase the *highest attainable standard of health*, which is commonly referred to by the short-hand term the *right to health*, has since been endorsed by a wide array of international and regional human rights instruments. Soon after the WHO Constitution was formulated, the right to health was affirmed by the Universal Declaration of Human Rights (UDHR) which states that:

Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

*UDHR art 25(1)<sup>2</sup>*

The International Covenant on Economic, Social and Cultural Rights (ICESCR) was the first human rights treaty to require states to recognize and realize progressively the right to health, and it provides key provisions for the protection of the right to health in international law:

- 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 achieve the full realization of this right shall include those necessary for:
  - (a) The provision for the reduction of the still birth 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 services and medical attention in the event of sickness.

*ICESCR art 12<sup>3</sup>*

### *A broad concept of health*

From its earliest codification, it can be seen that the right to health was conceived in broad terms that included a right to a standard of living adequate for basic health. This corresponds with the public health principle that health status is influenced by a number of socio-economic factors that are generally accepted as falling outside the confines of clinical curative medicine.

The right to the highest attainable standard of health, in other words, takes account of the holistic approach to health that regards both health care and social conditions as being important determinants of health status. These include the provision of safe drinking water, adequate sanitation, and health-related education and information, as well as others such as equitable health-related resource distribution, gender differences, and social well-being. They also include socially-related events that are damaging to health, such as violence and armed conflict.

The General Comment on the right to health adopted by the Committee on Economic Social and Cultural Rights (CESCR) elaborates in detail on the content of ICESCR Article 12, and emphasizes that:

... the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health.

... [It is] an inclusive right extending to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health. A further important aspect is the participation of the population in all health-related decision-making at the community, national and international levels.

*CESCR General Comment 14, paras 9 and 11<sup>4</sup>*

The right to health, therefore, contains both freedoms and entitlements. The freedoms include the right to have control over one's own health and body as well as the right to be free from non-consensual medical treatment and experimentation. The entitlements, on the other hand, include the right of access to an equitable system of health protection.

Moreover, the right to health is interrelated with other human rights, such as those to food, housing, education, and safe working conditions which illustrate how human rights are interrelated, as well as being indivisible and interdependent. Because health status reflects a wide range of socio-economic factors, the right to health is clearly linked to other basic rights — including civil and political rights as well as economic, social and cultural rights — and it cannot be conceived of as separate from them. Conversely, the right to health is essential to the exercise of other rights.

### *Key health-related human rights*

**Freedom from:** discrimination; torture; inhuman or degrading treatment and harmful traditional practices; and freedom of association, assembly and movement.

**Rights to:** life; education; food and nutrition; privacy; participation; individual autonomy and physical integrity; to benefit from scientific progress (and its application); and to receive and to impart information.

*From the public health perspective,  
the right to the highest attainable standard of health also includes the rights to:*

- comprehensive primary health care;
- adequate, accessible, acceptable, affordable, appropriate and equitable health care services;
- basic immunizations;
- adequate nutrition;
- adequate housing;
- freedom from violence;
- sexual and reproductive health information and services, including family planning;
- underlying preconditions to health, for example the right to safe water and adequate sanitation; and, in general, the right to a clean and safe environment; and
- information about health.

*Protection against discrimination and the right to participation are especially important components of the right to health. Non-discrimination is a well-established and integral component of nearly all human rights and is essential for protecting the health status of the poor and otherwise vulnerable and disadvantaged groups who bear a high proportion of health problems in any given society. Poverty is now recognised as a major adverse risk factor for health status worldwide. Discrimination, which can manifest itself in a complex variety of ways, is often directly or indirectly at the root of what makes individuals and groups vulnerable to poverty and ill-health. (See chapter 5.) Hence the ICESCR emphasises that States parties must:*

*... undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.*

*ICESCR art 2.2<sup>6</sup>*

The right to participate in decision-making is also a guiding principle of all human rights and an important component of working within a human rights framework. Individuals and groups have the right to participate in decision-making processes that might affect their health and development. The International Covenant on Civil and Political Rights (ICCPR) states that:

*'The right to health does not mean the right to be healthy, nor does it mean that poor governments must put in place expensive health services for which they have no resources. But it does require governments and public authorities to put in place policies and action plans which will lead to available and accessible health care for all in the shortest possible time. To ensure it happens is the challenge facing the human rights community and public health professionals.'*

*Mary Robinson, former UN High Commissioner for Human Rights<sup>5</sup>*

Every citizen shall have the right and the opportunity, without ... [discrimination] ... and without unreasonable restriction: ... to take part in the conduct of public affairs, directly or through freely chosen representatives

ICCPR art 25(a)<sup>7</sup>

A human rights approach to health emphasises that the effective and sustainable provision of health-related services can only be achieved if people participate in the design of policies, programmes and strategies that are meant for their protection and benefit. The involvement of communities in setting priorities, and in designing, implementing and evaluating government programmes, policies, budgets, legislation and other activities relevant to the right to health is not only a human right, but has been shown to increase the likelihood that the needs of the community will be met more effectively. Community action and involvement is the key to the empowerment that is essential to understanding and claiming human rights, including the right to health. Effective community action also contributes to achieving better health.

This illustrates the *overlap between the goals of both a public health and a human rights approach to health*. Although public health and human rights are expressed in different languages, there is, in a number of important respects, a convergence of interest between the goals and priorities of both of them.

### *Overlap between public health advocacy and working with the right to health*

*Contribution by Ann Sommerville  
British Medical Association (BMA)*

All organizations with a health remit, including those representing health professionals, have a role to play in safeguarding the health of society. Most recognise a duty to influence positively public policies affecting health and a duty to act as advocates for vulnerable groups. Any concern with public health must include disease prevention and the maximisation of people's ability to function effectively in society. It obviously involves promoting social inclusion and the health of society as a whole. Thus, while using a different terminology, public health overlaps with society's obligations to ensure that the human rights of all are recognised, respected, protected and fulfilled. Precisely because it is concerned with populations, public health must deal with concepts of equity, justice and the indivisibility of rights which are also central to the notion of a right to health.

Rights, by their nature, are the possession of everyone in society, without discrimination. Similarly, public health strategies can only succeed when they are inclusive, comprehensive and designed to prevent, as well as treat, disease and disability. For example, restricting the access of vulnerable groups, such as the poor, the homeless, asylum seekers or undocumented immigrants, defeats the whole point of public health measures as well and violates the right to health.

There should be a natural convergence of interest between all those involved in public health and those monitoring and promoting the right to health. Nor is this common interest limited to questions about who should benefit from preventive and treatment services. It has long been recognised that many of the fundamental causes of ill health are rooted in social factors and that the greatest single determinant of health in any community is socio-economic status. Protection of health frequently depends less on the provision of health care services than on the practical availability of other essentials, such as clean water, adequate nutrition, transport, education, and security from violence and poverty.

Only by taking into consideration a full range of rights and needs can public health planning succeed. In the past, public health agencies and professional bodies have sometimes been criticised for failing to develop coherent conceptual frameworks for dealing with such societal factors. Increasingly, however, international human rights agencies that translate theories of entitlement into practical and standards which can be implemented provide the basis for precisely such frameworks. Nevertheless, there is a continuing and urgent need for a closer alliance between agencies setting benchmarks for measuring compliance with human rights and those trying to improve community health.

### *How does a human rights approach to health relate to empowerment?*

Participation and empowerment go hand in hand. The human rights system identifies individuals and groups as claim-holders and States parties, which are governments, as duty-bearers. (See introduction, 0.2, and chapter 1.) In this scheme, individuals and groups who might otherwise be vulnerable, marginalized or disadvantaged within the population are provided with the tools to:

- adopt a legitimate voice in the public realm;
- participate in decision-making; and
- raise legitimate demands based on claiming their rights.

This is the quintessential definition of empowerment. No longer are they powerless beneficiaries of government benevolence (or, more often, victims of government neglect), as even the most vulnerable segments of the population have a right to ‘come to the table’ through participatory processes that should be inclusive and transparent.

### *Basic components of government obligations*

As outlined in CESCR General Comment 14, the **basic components of government obligations** arising from the right to health can be reduced to:

- *obligations regarding health care*, including health facilities, and those goods and services that are necessary for the treatment of illness and rehabilitation. This means ensuring timely and appropriate health care together with essential elements such as hospitals; clinics and other health-related facilities; and essential medicines. (See chapter 3.)
- *obligations regarding the underlying determinants of health*, including safe and potable water; adequate sanitation; an adequate supply of safe food; adequate nutrition; adequate housing; healthy occupational and environmental conditions; and education and information about health, including sexual and reproductive health. (See chapter 3.)

The **two key principles** that underline all health-related rights involve:

- *obligations to ensure non-discrimination* in access to health care and to the underlying determinants of health, as well as to the means and entitlements for their procurement; and
- *obligations to ensure participation in decision making* — ensuring that people can participate in decision-making processes, including the design and implementation of policies that affect their health, at community, national and international levels.

## 2.2 What does a shift to a human rights approach to health involve?

### *Human rights approach*

A rights approach uses international human rights treaties and norms to hold governments accountable for their obligations under the treaties. A rights approach can be integrated into any number of advocacy strategies and tools, including monitoring; community education and mobilization; litigation; and policy formulation.<sup>8</sup>

The main effect of a human rights approach to health is that it re-frames basic health needs as health rights. In other words, becoming healthy and remaining so is regarded not merely as a medical, technical or economic problem, but as a question of social justice and of concrete government obligations. Furthermore, a human rights approach recognises that every human being is endowed with human rights.

The potential consequences of this are enormous. Take, as an example, child immunization. Within a human rights framework, immunization is not simply a necessary medical requirement for children and a responsible public health measure; it is a right of all children, with corresponding government obligations. A government’s immunisation programme cannot, within this framework, be bargained away because of financial constraints or of other priorities as to how money should be spent in the health sector. The bearer of rights,

*‘A human rights approach mandates that any public health strategy ... be informed by evidence and openly debated. This approach protects against unproved and potentially counterproductive strategies, even those motivated by genuine despair in the face of overwhelming public health challenges. ... There is no ‘one-size-fits-all’ approach. Rights issues and the appropriateness of [public health] policies and programmes might be of concern in one setting and one population but not in another. Central to all settings, however, are the principles of non-discrimination, equality, and, to the extent possible, the genuine participation of affected communities: these principles will not undermine but further advance public health.’*

*Sofia Gruskin, Francois-Xavier Center for Health and Human Rights, Harvard University, USA; and Bebe Loff, Dept of Epidemiology and Preventive Medicine, Monash University, Australia<sup>9</sup>*



in this case the child, is the focus. The protection to which the child is entitled through immunization cannot be regarded as a 'charity' and, therefore, be dependent upon the goodwill of government.

Another important consequence of a human rights approach to health is the effect it has on setting priorities. Human rights need to be considered whenever health programmes and policies are being developed. In other words, they help answer the question '*how should scarce resources be allocated?*'. A human rights approach ensures that the necessary resources are allocated to those who have the greatest needs. It exposes situations such as those where public funds are being used to build yet more hospitals in a capital city, or where expensive equipment is being purchased for elective procedures that benefit only the wealthy while, at the same time, rural populations or vulnerable groups are denied even the minimum standards of health care.

*'It is my aspiration that health will finally be seen, not as a blessing to be wished for; but as a human right to be fought for.'*

*Kofi Annan, UN Secretary General<sup>10</sup>*

A human rights approach to health establishes priorities for the allocation of resources even when resources are not particularly scarce. A developed country, for example, which generally provides good standards of health care and whose population enjoys an overall high health status, can still be in violation of its non-discriminatory obligations. This could happen when a particular group, for example indigenous people, has no access to either health care or the underlying determinants of health (such as safe water and sanitation).

### ***Holding states accountable and claiming the right to health***

By ratifying international human rights treaties that affirm the right to health, a state agrees to be accountable to the international community, as well as to the people living within its jurisdiction, for the fulfilment of its obligations. A central advocacy principle for NGOs using a human rights approach to health is that governments are accountable for their obligations under international law, regional law, and within the framework of national constitutions and legislation. (See section 2.5.)

Indeed, the legal recognition of the right to health is important precisely because it allows the right to be claimed by individuals and groups. (See introduction, 0.2.) In view of this, States parties to an international human rights treaty are required specifically to adopt *legislative measures* and to employ all *appropriate means* to ensure that the population can enjoy the rights conferred by the treaty. This entails ensuring that international treaty provisions are incorporated into domestic legislation and that individuals and communities have access to effective judicial or other appropriate remedies in the face of violations of their rights. (See chapter 1.)

## **2.3 How do *universal* obligations apply to *all* states, despite their social and economic differences?**

How can states comply with their *universal* obligations towards the right to health when there are stark differences between economic, social, cultural and political conditions, as well as disparities between health status and health care, in different countries? The phrase 'the highest attainable standard of health' acknowledges that there are differences between countries in their state of development, financial resources, health status and social conditions. These are taken into account within a human rights framework by the requirement that certain obligations apply uniformly to all states and require *immediate* compliance, whereas others can be realized *gradually*, or *progressively*, depending on conditions in the country concerned.

This is why the principle of *progressive realization* is adopted for the right to health. This principle is particularly important for those countries where the full realization of the right to health is a difficult and complicated process requiring both resources and time. The principle of progressive realization is essential to the practical *implementation* of the right to health, particularly in developing countries where resources are scarce. Progressive

*It is important to note that while many countries have legislation that provide for various elements of the right to health, including constitutional provisions on non-discrimination, many of them have failed to introduce the procedures or mechanisms required for enforcing such laws. In addition, the tendency to regard economic, social and cultural rights, including the right to health, as second-class rights that are more akin to policy goals than justiciable (legally enforceable rights) rights has resulted in there being comparatively few legal precedents for their enforcement (See chapter 1.) This situation, however, is changing. There is an increasing number of examples of court cases, as well as other laws and decisions at the international, regional and national level that confirm the justiciability of the right to health. (See chapter 10.)*

realization allows for a degree of variation in how states fulfil their duties. However, governments must not regard this flexibility as an excuse for not fulfilling their international human rights obligations: they must move as expeditiously and effectively as possible towards the full realization of the right to health and other human rights. (See chapter 3.)

The principle of progressive realization is articulated in certain human rights treaties, such as ICESCR and CRC, in relation to some of the obligations contained in them. States parties to these treaties are bound by such obligations. According to the ICESCR, a State party has the obligation 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 recognised in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.

*ICESCR, art 2<sup>11</sup>*

While international treaties exert binding obligations on States parties to them, many other actors, including NGOs and the international community, also have important roles to play in the progressive realization of the right to health.

#### *What do the critics say?*

Critics point to the fact that the obligation of progressive realization creates a loophole to allow states not to comply fully with their obligations: indeed on account of progressive realization, some states have argued that economic, social and cultural rights are non-justiciable and are only aspirational goals. (See chapter 1.) However, as General Comment 3 of CESCR points out, progressive realization must be understood as an obligation on States parties to move as expeditiously and effectively as possible towards the full realization of the right in question.<sup>12</sup>

## **2.4 Are there obligations that are of immediate effect to all states?**

Certain state obligations apply irrespective of adverse conditions such as severe shortage of economic resources. These are obligations of immediate effect, and are therefore known as *immediate* state obligations. Included in a state's immediate obligations are the duties to ensure freedom from discrimination in all health-related matters, especially those affecting the poor and other vulnerable and disadvantaged groups; to ensure that people can participate in decision-making processes that affect their health and well-being; and to take deliberate, concrete and targeted steps towards the full realization of the right to health.

Also included in a state's immediate obligations is the duty to ensure that people can enjoy the *minimum essential level* of the right to health, such as by ensuring essential primary health care. These components of immediate obligations are known as *minimum core obligations*. In the case of the right to health, minimum core obligations include the provision of minimum essential standards of health care and of the underlying determinants of health. (See chapter 4.)

The fact that economic conditions may make it impossible for a government to fulfil its core obligations immediately does not mean that it is entitled to do nothing about them. The state still has the obligation to take immediate, deliberate, concrete and targeted steps towards fully realizing the right to health, and must start immediately (and in a systematic manner) to create the conditions necessary to fulfil its core obligations. Where necessary, this may be undertaken within the framework of international assistance and co-operation, for example with technical assistance or aid from international organizations or bilateral and multilateral donors. (See chapter 6.)

Another immediate obligation is that the state must refrain from interfering, directly or indirectly, with the enjoyment of the right to health. This element of immediate obligations is known as the obligation to *respect* the right to health, and it applies mainly to associated government laws and policies. Examples include the duty of states to refrain from marketing unsafe medicines; and to refrain from censoring, withholding or intentionally misrepresenting health-related information, including sex education and information related to maintaining sexual and reproductive health.

Another related violation would be for a government to take *retrogressive measures* (*take-backs*) as part of its health-related laws or policies. This is not allowed under international law, except in emergency situations, and then only where the measures taken are both justifiable and temporary.

For a state to take progressive steps forward, on the other hand, involves adopting all appropriate measures to ensure that the right to health can be fully claimed, for example by passing laws, introducing the necessary administrative, financial, educational, and social measures, and ensuring access to redress for violations. This is why there is a core obligation for States parties to adopt and implement a *national public health strategy and action plan* that requires them to realize progressively their full obligations by setting goals for themselves, and to continue to move forward towards achieving them. This process includes the establishment of clearly defined targets, termed *national benchmarks*, and the development of tools, known as *indicators*, to measure progress towards these targets. (See chapter 8.)

### ***What actions must a government take to comply with the right to health?***

Governments must take action *immediately* to:

- ✓ comply with *core* obligations;
- ✓ ensure that individuals and groups are *not discriminated* against;
- ✓ *refrain from* undertaking any measures that *infringe*, directly or indirectly, upon enjoyment of the right to health;
- ✓ *refrain from* taking *retrogressive steps* ('take-backs');
- ✓ ensure adequate *participation*;
- ✓ take concrete steps towards *realizing progressively* obligations that are not immediate; and
- ✓ commit resources and make genuine and convincing efforts to *realizing progressively* all other obligations.

Many governments make the excuse that fulfilment of the right to health is costly. But to a large extent it involves no more than the redistribution of available resources in a more equitable manner and ensuring that people do not suffer adverse health effects from discrimination. Even on a small health budget, for example, countries can design health systems to improve access to services for poor, vulnerable, or otherwise disadvantaged groups. Indeed, many state obligations are of a legal and policy nature and can often be fulfilled at minimal cost. What is required is the political will to take obligations seriously and to redistribute available resources accordingly.

In some cases obligations may require additional expenditure that is beyond the scope of available resources, and the need will arise for the international community to assume some responsibility, for example, by contributing to development aid. Where a state is unable to give effect to core obligations, such aid should be directly linked to the fulfilment of these obligations, as a matter of priority for the state in question.

### ***Basic consequences of a human rights approach to health***

- Increased accountability of governments for health;
- Increased attention to the health needs of the poor and otherwise vulnerable and disadvantaged groups, and to the correction of unacceptable imbalances between the health status of different population groups. (Governments are required to prevent, avoid and halt discrimination);
- More participatory approaches to the provision of health services and the determinants of health;
- Governments cease imposing retrogressive measures (take-backs) in health-related legislation and budgetary and administrative practices;
- Governments honour concrete obligations to provide immediately for the minimum standards that are essential to enjoyment of the right to health; and
- Governments must accept that they have obligations to take progressive steps towards realizing fully the right to health and must immediately take steps to set the stage for progress. This includes the setting of goals and targets that will demonstrate progress.

## 2.5

## Where has the right to health been affirmed and codified?

### *Human rights instruments and other documents that recognise and provide standards for the right to health (international, regional, national)*

Since it was first proclaimed in the UDHR, the right to health, including the associated obligations placed on States parties, has been progressively clarified. There currently exists a wide range of authoritative documents that recognize and provide standards for the right to health at the international and national levels.

It is now clear that the right to health refers to a set of rights concerning health that have been expressed in various documents in a number of ways, such as the 'highest attainable standard of physical and mental health' (ICESCR); the 'highest attainable standard of health' (CRC); and the right to be free from discrimination 'in the field of health care' (Women's Convention). There is some overlap between the documents that recognise the right, and human rights instruments emphasise and provide standards for different aspects of it. Two treaties, the ICESCR and the CRC, provide detailed provisions on the right to health. (See Annex 1 for selected excerpts and references.)

*'Bringing health and human rights together in public health ... allows the progress, success, or failure of a policy or programme to be assessed against public health and human rights benchmarks [or targets]. Ultimately, much of the work to bring human rights into public health involves looking at trade-offs and working within a framework of transparency and accountability towards achieving the highest attainable standard of health.'*<sup>13</sup>

At the international level, the right to health is firmly embedded in a number of legally enforceable human rights instruments. (See chapter 1.) Their provisions can interpret *health* fairly broadly, for example by including the right to *health care* and the right to *underlying determinants* of health. Others have a narrower scope and refer to only one or two aspects, such as the right to health care or non-discrimination in health care. Still others have been designed to protect the health of specific vulnerable, marginalized or otherwise disadvantaged groups such as women, children, indigenous peoples, and migrant workers. (See chapter 5 for a list of groups whose rights are provided for in specific human rights instruments.)

At the regional level, the right to health is included in all three regional human rights treaties, and is currently legally enforceable through regional human rights courts in two of them (the European and Inter-American human rights systems). (See chapter 1.)

At the national level, the right to health as such is rarely mentioned specifically in the constitution or other legislation, and then usually only as the right to health care or to a healthy environment. However, in most countries legislation exists to a greater or lesser extent to protect health either directly or indirectly as a result of the recognition of a general right to equality, freedom from discrimination, etc.

Moreover, most countries have introduced enforceable public health regulations dealing with issues such as food safety, the control of infectious diseases, and accident prevention.<sup>14</sup> A few countries have introduced detailed provisions requiring governments to provide various kinds of health services. Examples include a national health service that guarantees either comprehensive or limited health care for the whole population, or for certain aspects of health such as maternity, mental health, emergencies, and occupational health.

It is, of course, necessary that NGOs know which international and regional human rights instruments their government has ratified, as well as the consensus documents, including from UN world conferences, to which it is committed. They should also be aware whether or not the government has entered any health-related reservations to any of the above. NGOs should, as well, know how, if at all, their national constitutions and other national legislation deal with the right to health. (See chapter 1.)

### *Documents setting standards for the right to health*

#### *Legally binding instruments:*

- International and regional human rights treaties, conventions, and covenants and protocols;
- International humanitarian law; and
- National constitutions and other legislations dealing with health-related obligations.

#### *Non-binding instruments:*

- Interpretative statements on particular health-related standards adopted by UN treaty-monitoring bodies, including General Comments and General Recommendations;

- UN world conference outcome documents (consensus documents on global policies and commitments);
- International declarations, guidelines, principles and recommendations;
- \*Codes of conduct; and
- \*Ethical, professional and technical standards, principles and guidelines, such as those issued by recognized international medical and other health professional associations and bodies.

\*These types of documents can serve as authoritative sources for standards for the right to health, even though they do not necessarily address human rights issues per se.

### *Looking beyond the word ‘health’ in standard-setting documents on human rights*

It is important that NGOs seeking to invoke a particular human rights instrument carefully read all of its articles. In many cases, articles that do not specifically mention ‘health’ will contain provisions that are relevant to health issues. This is particularly likely to occur when the health issue concerned is one of discrimination.

For example, an article in a treaty or national constitution that does not mention ‘health’ but which guarantees non-discrimination in education can be used by NGOs to campaign for the introduction of family life / sexual and reproductive health education programmes or for advocating the provision of educational programmes on maternal health in minority languages for marginalized communities that have high rates of maternal morbidity and mortality. Functional illiteracy is a major determinant of the reproductive health status of women in developing countries, in many of which half of the women cannot read. A discussion of the Women’s Convention in the box below illustrates this point.

Other articles in human rights instruments that are indirectly related to health include those dealing with rights to receive and impart information; privacy; individual autonomy; physical integrity; equal rights in marriage and divorce; and freedom of association. Moreover, many of these rights overlap in the context of the right to health.

For example, there is a relationship between the rights to information and freedom of association in societies where particular population groups, such as sex workers, cannot meet to discuss health issues. In such cases, it has been difficult to establish effective HIV/AIDS prevention programmes that are suitable for their particular needs and in the local context — and this can have an adverse effect on their enjoyment of the right to health.<sup>15</sup>

#### *How to ‘read’ human rights instruments beyond the health-specific article: Drawing on other provisions in the Women’s Convention to invoke the right to health<sup>16</sup>*

The Women’s Convention provides a good example of how to ‘read’ a human rights treaty in order to invoke health-related articles that do not mention health *specifically*. The wording of Article 12, which deals with women’s health is relatively narrow. (See Annex 1.) It focuses on the provision of services and equal access to health care facilities for women. It does not include a basic right to health, nor does it address the underlying causes of women’s poor health nor provide an explicit right to access to the highest attainable quality of health care, information and services throughout a woman’s life-cycle. Nutrition, for example, is mentioned only in the context of pregnancy and lactation, thereby ignoring the serious consequences of malnutrition throughout a woman’s life.

It is essential to read Article 12 in connection with the General Recommendation 19 on the Article issued by the Convention’s treaty monitoring committee (CEDAW). The purpose of this document is to guide States parties on the Committee’s interpretation of the obligations that the Women’s Convention places on them in the context of health. (See chapter 1.)

Moreover, many of the health concerns of women are linked to other provisions in the Convention including: the right to non-discrimination on the basis of gender; the right to education; the right to receive and impart information; the right to equality within the family; and the right to marry and found a family. This illustrates how the right to health is interdependent with other rights.

In the absence of a broader concept of health in Article 12, other articles in the Convention can be invoked with regard to women’s right to health. For example:

- Article 1 calls for non-discrimination 'irrespective of marital status'. This can be used to campaign against policies which deny equal access to services such as contraceptives for unmarried women.
- Article 2 requires States parties to 'repeal all national penal provisions which constitute discrimination against women'. This could be invoked to encourage governments to repeal restrictive abortion legislation and policies insofar as they amount to discrimination in situations where women with financial means or social connections are able to access services that poor women (particularly adolescents) cannot.
- Article 5 recognises that 'culture' is often offered as an excuse for denying women equal rights. Practices based on the supposed superiority of one sex and the inferiority of the other should be eliminated. From a health perspective, this article is useful for campaigning against a wide range of gender-based discriminatory practices such as pre-natal sex selection; infanticide; unfair allocation of resources such as food, clothing and education; female genital mutilation/cutting (FGM/C) and other harmful practices, including early and forced marriage.
- Article 10, on the right to education, can be invoked to advocate for women's right of access to educational information to help ensure the health and well-being of their families, including information and advice on family planning.
- Article 11, on the right to employment, can be invoked to protect women's health by ensuring their safe working conditions and accident prevention.
- Article 14 affirms the right of rural women to enjoy "access to adequate health care facilities, including information, counselling and services in family planning".
- Article 16 promises freedom from discrimination for women in all matters relating to marriage and the family. There is clearly a violation of this article in countries where married women can obtain contraceptives only with their husband's approval. This Article also prohibits child marriage and requires governments to set a minimum legal age of marriage. Both provisions recognize indirectly the detrimental impact of early pregnancy and childbirth on women's health.

## Notes

- 1 Constitution of the World Health Organization, adopted by the International Health Conference, 22 July 1946.
- 2 Universal Declaration of Human Rights, UN General Assembly Resolution 217 A (III). A/810 at 71 (1948).
- 3 International Covenant on Economic, Social and Cultural Rights, UN General Assembly Resolution 2200A(XXI). A/6316 (1966).
- 4 Committee on Economic, Social and Cultural Rights. General Comment 14, The right to the highest attainable standard of health. E/C.12/2000/4.
- 5 As quoted in: Nygren-Krug H. 25 Questions and answers on health and human rights. World Health Organization health and human rights publication series No 1. Geneva: WHO. 2002:11.
- 6 International Covenant on Economic, Social and Cultural Rights, UN General Assembly Resolution 2200A(XXI). A/6316 (1966).
- 7 International Covenant on Civil and Political Rights, UN General Assembly Resolution 2200A(XXI). A/6316 (1966).
- 8 Based on International Human Rights Internship Programme (IHRIP). Ripple in still water: reflections by activists on local- and national-level work on economic, social and cultural rights. Washington D.C.: IHRIP. 1997:11.
- 9 Gruskin S, Loff B. Do human rights have a role in public health work? *The Lancet* 2002; 360:1880.
- 10 As quoted in: Nygren-Krug H. *Ibid*:4.
- 11 International Covenant on Economic, Social and Cultural Rights, UN General Assembly Resolution 2200A(XXI). A/6316 (1966).
- 12 Committee on Economic, Social and Cultural Rights. General Comment 3, The nature of States parties obligations. 14 December 1990.
- 13 Gruskin S, Loff B. *Ibid*:1880.

- 14 Pan American Health Organization (PAHO). The right to health in the Americas: a comparative constitutional study. Washington, D.C.: PAHO. 1989.
- 15 Freedman LP. The right to know: human rights and access to reproductive health information. Philadelphia: University of Pennsylvania Press. 1995.
- 16 Adapted from: Commonwealth Medical Trust. Report of a consultation on medical ethics and women's health, including sexual and reproductive health, as a human right; 23-26 January 1997; New York, USA. London, UK: Commonwealth Medical Trust.

## Introduction to Part 2

### ***Moving towards action: Focussing on obligations arising from the right to health***

The right to health is a universal entitlement, based on the dignity and integrity of all individuals. In adopting a human rights approach to health it is important that health professional associations and other concerned NGOs should understand that individuals and groups have well-defined non-negotiable health-related entitlements, and that governments are legally responsible for ensuring that those entitlements can be enjoyed effectively.

In order to monitor the right to health, NGOs must know exactly *what* they should be monitoring. Until recently there was considerable lack of clarity within the international human rights community as to the specific obligations that the right to health places on governments. As has already been seen in Part 1 of the Resource Manual, the right to health has been formulated in different ways by the various international human rights treaties (notably Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR)). Moreover, the wording of the treaties usually does not spell out in enough detail the obligations it places on governments.

This situation has now changed significantly with the adoption by the Committee on Economic, Social and Cultural Rights (CESCR) of its *General Comment 14 on the right to the highest attainable standard of health*. This provides the most detailed interpretation to date of state obligations and internationally accepted standards and principles arising from the right to health. (See chapter 1.) It is an authoritative document that sets out clearly for states that have ratified the ICESCR their obligations in the context of the right to health. Furthermore it serves as a point of reference that NGOs can use for internationally accepted standards, principles and norms.

At the same time it is important to understand that the right to health is a universal entitlement, to be enjoyed by people everywhere, whether or not their country has ratified any of the relevant human rights treaties. NGOs in all countries should invoke and adopt the standards, principles and norms set out in CESCR General Comment 14 as a means to assess critically the policies and practices of their country that adversely affect health. This is especially important for NGOs working in developing countries, where difficult choices and *trade-offs* are often made by governments when facing resource constraints, including conditions imposed by international financial institutions (IFIs). CESCR General Comment 14 provides guidance on which health-related priorities require immediate action and which can be included in a co-ordinated and comprehensive longer-term plan for health development.<sup>1</sup>

Because of their familiarity with the local health situation, national medical and other health professional associations are ideally placed to monitor and promote the right to health. As with other NGOs, what they need in order to do this effectively is a clear understanding of their government's obligations concerning this fundamental right. Closely linked to the issue of state responsibility is knowledge of the ways in which the right to health can be violated by governments. An effective monitoring strategy should also take account of situations involving potential violations, and for this reason it is also important to understand why such violations may occur.

### **Outline of Part 2**

Part 2 describes key aspects of CESCR General Comment 14 that have important implications for monitoring the right to health. It also draws on other sources that add meaning and content to specific aspects of the international right to health. These include health-related provisions of the Children's Convention (CRC) as well as relevant General Comments and Recommendations adopted by the monitoring committees of the Women's Convention and the CRC, which add an extra dimension of detail concerning the health rights of children, adolescents and women. Part 2 describes what government obligations arising from the right to health consist of and what constitutes their violation. It also reviews the role that NGOs have to play in monitoring.

Chapter 3, which forms the bulk of Part 2, explains the nature and logical structure of state obligations and introduces certain key conceptual distinctions between their different aspects, particularly the distinction between *immediate* and *progressive* obligations and that between the obligations to *respect, protect and fulfil* the right to health. It describes in more detail what government obligations consist of, and what constitutes their



*violation*. It also provides an overview of the four standards, or criteria, for the evaluation and implementation of those obligations — namely *accessibility, availability, acceptability, and quality*.

Chapters 4 and 5 provide details of universal aspects of the right to health that are particularly important for monitoring, and these will therefore be revisited in Part 3 of the Resource Manual. Chapter 4 identifies *minimum core obligations* and explains their importance for monitoring the right to health in developing countries. Chapter 5 discusses the obligations owed to the poor and otherwise *vulnerable and disadvantaged groups*, which is a critical factor in monitoring the right to health in both low-income and high-income countries. Underpinning the responsibility and accountability of public health systems to such groups is the need to pay special attention to the principle of *non-discrimination*.

Chapter 7 provides a brief overview of how the standards and norms set by CESCR General Comment 14 affect the responsibilities of *non-governmental enterprises and agencies*, including multinational corporations and IFIs. This chapter is included in the manual in order to call attention to the impact that globalization is having on the right to health.

## Note

- 1 Committee on Economic, Social and Cultural Rights. General Comment 14, The right to the highest attainable standard of health. E/C.12/2000/4. Available at [www.unhcr.ch](http://www.unhcr.ch).

## Part II *Moving towards action: Focussing on obligations arising from the right to health*

### Chapter 3 The nature of state obligations

#### *Keys to Chapter 3*

##### *key information:*

- States have concrete positive and negative obligations arising from the right to health;
- These obligations broadly fall into three categories: to respect, to protect and to fulfil the right to health;
- Some obligations are immediate, while others are to be realized progressively and over time, taking into account the country's economic and developmental context;
- State obligations provide standards against which existing health laws, policies, programmes and practices can be evaluated and violations identified;
- NGOs that want to monitor the right to health need to understand the nature of state obligations in order to evaluate their government's compliance with them.

##### *key questions:*

- To what extent is the government making adequate progress in meeting its legal obligations to respect, protect and fulfil the right to health?
- To what extent is the government meeting its legal obligations while avoiding discrimination and ensuring true participation?
- In complying with its obligations, is the government ensuring that progress is made on each of the following requirements: accessibility, availability, acceptability, and quality?

### 3.1 Basic components of government obligations

#### *What must governments do?*

NGOs need to understand, first and foremost, the nature of government obligations that arise from the right to health. While the core meaning of the right has remained relatively constant since it was stated in the Universal Declaration of Human Rights (UDHR) in 1948, its interpretation has expanded dramatically during the intervening decades. General Comment 14 on the right to the highest attainable standard of health issued by the Committee on Economic, Social and Cultural Rights (CESCR) in July 2000 summarizes earlier developments in clarifying the meaning of the right to health and also breaks new ground in several important respects. The current understanding of the right to health was presented in broad outline in chapter 2. In this chapter it will be further elaborated in the light of the observations contained in CESCR General Comment 14 and with a special view to clarifying state obligations.

CESCR General Comment 14 states that government obligations include ensuring the availability of timely and appropriate health care, as well as the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, healthy occupational and environmental conditions, together with access to health-related education and information. (See box overleaf.) It also requires states to provide health-related services to the whole population equally and without discrimination, and to pay particular attention to vulnerable and otherwise disadvantaged groups. In complying with these obligations states must always ensure that there is no discrimination and full participation in all decision-taking. (See chapters 2 and 5.)

## *Quick guide to the scope of government obligations regarding health care and the underlying determinants of health*

Governments have obligations in two main areas: health care and the underlying determinants of health. *To which specific duties do these two areas refer?* The following breakdown provides an interpretation of their main elements, based on CESCR General Comment 14. NGOs in any country can use this breakdown as a framework to promote the right to health, to evaluate their government's performance and to monitor the right to health.

States have obligations concerning:

- maternal, child and reproductive health;
- healthy natural and workplace environments;
- prevention, treatment and control of diseases; and
- health facilities, goods and services.

*In these areas, states must take measures to:*

### *1 Maternal, child and reproductive health*

- improve child and maternal health; and
- provide the population with sexual and reproductive health services, including access to family planning, pre- and post-natal care, emergency obstetric services, as well as access to the necessary information and the resources needed to act on that information.

### *2 Healthy natural and workplace environments*

- prevent occupational accidents and diseases;
- ensure an adequate supply of safe and potable water and basic sanitation;
- prevent and reduce the population's exposure to harmful substances such as radiation and harmful chemicals or other detrimental environmental conditions that directly or indirectly affect health adversely;
- minimise, as far as is reasonably practicable, the causes of health hazards that are inherent in the working environment (industrial hygiene);
- ensure adequate housing and safe and hygienic working conditions;
- ensure an adequate supply of food and proper nutrition; and
- discourage the abuse of alcohol and the use of tobacco, narcotics and other harmful substances.

### *3 Prevention, treatment and control of diseases*

- establish prevention and education programmes for behaviour-related health conditions such as sexually transmitted infections, (STIs), in particular HIV/AIDS, and other conditions that adversely affect sexual and reproductive health;
- promote social determinants of good health, such as environmental safety, functional literacy, education, economic development and gender equity;
- create a system of emergency medical care for the management of accidents, epidemics and similar health hazards;
- provide disaster relief and humanitarian assistance in emergency situations;
- make available the benefits of relevant technologies;
- introduce and/or improve epidemiological surveillance and data collection on a disaggregated basis; and
- introduce or enhance immunization programmes and other relevant strategies for the control of infectious diseases.

#### 4 Health facilities, goods and services

- ensure equal and timely access to basic preventive, curative, and rehabilitative health services and health education;
- provide hospitals, clinics and other health-related facilities for the treatment of illness and rehabilitation of health;
- ensure the provision of appropriate regular screening programmes;
- ensure that prevalent diseases, illnesses, injuries and disabilities receive appropriate treatment, preferably at the community level;
- ensure that there is an adequate establishment of trained medical and other health professional personnel and that they receive domestically competitive terms and conditions of service;
- provide essential medicines, as defined by WHO;
- ensure appropriate mental health services; and
- improve and expand the level of participation by the population in the provision of preventive and curative health services, including the organization of the health sector and health insurance systems, and that political decisions affecting the right to health are taken at both community and national levels.

#### *When must governments fulfil their obligations?*

[The ICESCR] ... clearly imposes a duty on each State to take whatever steps are necessary to ensure that everyone has access to health facilities, goods and services so that they can enjoy, as soon as possible, the highest attainable standard of physical and mental health.

*CESCR General Comment 14, para 53<sup>1</sup>*

CESCR General Comment 14 includes a wide range of state obligations. These establish a framework within which legislative, policy and administrative choices must be made at national level to realize the right to health. It also stipulates that some obligations are universal and immediate (applicable uniformly to all states) while others can be brought about progressively, over a period of time. (See also chapter 2.)

Given the vast differences in health, developmental, political, economic, social, and cultural conditions between countries, the process of fully realizing the right to health will need variable amounts of time and resources. In addition, the most appropriate measures to implement the right to health will vary significantly from one state to another. Although the General Comment 14 sets out the various state obligations, it is intended that each government should determine for itself which measures are the most suitable for complying with these obligations in a way that meets its own specific circumstances.

#### *What is the minimum that all governments must immediately do?*

##### **3.1.1 Universal immediate obligations**

Certain obligations arising from the right to health require immediate compliance in every country, regardless of its level of development. Universal immediate obligations highlight the fact that, even in countries with severe financial constraints, governments must observe human rights and meet specific and legally binding obligations in order to do so. No matter what else, states must respect the dignity of all their people by ensuring that they have humane living conditions and basic health care without discrimination. Universal immediate obligations define the *bottom line* of what governments can do, cannot do, and must do. (See chapter 2.)

CESCR General Comment 14 identifies States parties' immediate obligations as:

- ✓ ensuring the satisfaction of minimum essential standards of the right to health by complying with *core obligations* (see chapters 4 and 9);
- ✓ preventing, avoiding or halting *discrimination* (see chapters 5 and 9);
- ✓ *refraining from taking any measures that infringe upon* (or interfere with), directly or indirectly, the enjoyment of the right to health;
- ✓ *refraining from taking retrogressive measures* (take-backs) that are incompatible with the enjoyment of the right to health;

- ✓ taking deliberate, concrete, positive and targeted *steps towards the progressive realization* of the right to health; and
- ✓ ensuring that people can *participate* in decision-making processes which may affect their health and development.

In addition, every country that ratifies a human rights treaty is obliged to report regularly on its implementation to the relevant treaty monitoring committee.

While the International Covenant on Economic, Social and Cultural Rights (ICESCR) acknowledges that constraints may exist owing to the limits of available resources, it also imposes certain obligations which are of *immediate effect*. These include the immediate obligations to guarantee that the right to health will be exercised without discrimination of any kind and that States will take deliberate, concrete and targeted steps towards the full realization of the right to health.

*based on CESCR General Comment 14, para 30<sup>2</sup>*

This Resource Manual focuses mainly on monitoring core obligations and obligations related to non-discrimination, especially those affecting vulnerable and otherwise disadvantaged groups, as these are areas where violations of the right to health are likely to occur. Because they are universal and immediate obligations, they are *absolutely fundamental* to realizing the right to health. As such, they provide globally accepted principles and norms for the right to health, and essential standards against which national health laws, policies, programmes and practices can be evaluated. They also indicate certain areas of government responsibility that should be treated as important priorities for monitoring and advocacy by NGOs.

### *Which obligations must governments comply with progressively?*

#### **3.1.2**            *Progressive obligations*

There is no justification for any state, at any level of development, to fail to comply with obligations to *respect* the right to health (see sections 3.2 and 3.5), as this implies only *negative* duties. (See chapter 1) Negative duties are those actions that a *government must not do*. This includes refraining from introducing laws, policies, or actions that are likely to result in bodily harm or other kinds of avoidable morbidity and mortality. For example, the requirement that a married woman obtain the authorization of her spouse in order to be able to receive reproductive health services violates her right to health, and it is within the power of any government to prevent such adverse consequences to health by immediately abolishing what is clearly an unjustified gender-discriminatory policy.

Compliance with *positive* duties is often more complicated. A government will generally require time and resources to protect and fulfil the right to health, particularly in a developing country with a weak public health infrastructure. Although it costs relatively little to change legislation and policies, the process of implementing the changes in practice may often be complex and expensive, requiring investment; strengthened capacity; extended services; changes in public institutions; public education; and extra training for public authorities and health personnel.<sup>3</sup>

According to international human rights law, states are required to take steps ‘to achieve progressively the full realization’ of the right to health ‘to the maximum of their available resources’. What this means is that governments must do their utmost, as a matter of the highest priority, to realize fully and progressively their obligations by all appropriate means, including the adoption of necessary legislative and policy measures that can be implemented and enforced.<sup>4</sup>

Different countries have different levels of resources available to secure the right to health. For example, whereas a budgeted level of spending for information campaigns on HIV/AIDS, sexual and reproductive health, or the use of harmful substances such as tobacco and narcotics might represent a very substantial commitment of resources for a low-income country, it would be regarded as a clear lack of commitment for a high-income country.

Although the right to health is universal and establishes common minimum obligations for all governments, many state obligations should be considered in the light of the country’s level of development and its available resources. Clearly, there is no simple and universal formula for the design and implementation of policies to realize the right to health progressively, although international law does prescribe certain criteria which must be factored into this such as non-discrimination and participation. In complying with their obligations, it is the task of governments to create the policies and social conditions that are necessary to ensure that the right to health is being fulfilled within the circumstance prevailing in their own countries. The

extent to which these circumstances can, or cannot, be taken into account is a regular feature of country reports to treaty monitoring committees. (See chapter 11.)

The progressive realization of the right to health over a period of time should not be interpreted as depriving State parties' obligations of all meaningful content. Rather, progressive realization means that States parties have a specific and continuing obligation to move as expeditiously and effectively as possible towards the full realization of the right to health.

*CESCR General Comment 14, para 31*

Evaluating the extent to which a government is complying with its progressive obligations can be complicated for NGOs because it calls for a close focus on context. It requires not only specific types of data and indicators, but also a variety of performance standards. (See chapter 8.)

A government's obligations to realize the right to health progressively are not static nor are they uniform. Rather, they are a variable set of national measures that are dynamic and will change over time. Targets (benchmarks) for specific health outcomes and facilitating conditions should be set nationally to reflect the available resources, health issues and the feasible aspirations of each country. Whenever certain targets are met by a state, authorities are meant to re-define new benchmarks to realize the right to health more fully.

## 3.2 Obligations to respect, protect and fulfil the right to health

### *Does the state respect, protect and fulfil the right to health?*

Government obligations broadly fall into three *categories* — to *respect*, to *protect* and to *fulfil* the right to health. (See chapter 1.) This distinction is important for NGOs if they are to assess the full extent of their government's compliance with its obligations — including those that are immediate and progressive, as well as those that are negative and positive. Evaluating how a state is respecting, protecting and fulfilling the right to health requires NGOs to use various types of evaluation tools and methods. (See Part 3.) The definitions included in this section are all based on CESCR General Comment 14.

**Respecting** the right to health applies mainly to government laws and policies and requires that states refrain from undertaking actions that inhibit or interfere (directly or indirectly) with people's ability to enjoy the right to health, such as by introducing actions, programmes, policies or laws that are likely to result in bodily harm, unnecessary morbidity, and preventable mortality. It also requires states to refrain from taking retrogressive measures (*take-backs*) as part of its health-related laws and policies.

In exceptional circumstances of urgent public health concerns such as the need to contain outbreaks or epidemics of serious infectious diseases, the state's obligation to respect can be superseded. An example would be the necessity to quarantine an individual with open pulmonary tuberculosis who refuses treatment, so as to prevent the spread of infection and secure public health. However such measures by government must be temporary and fully justifiable. All such exceptions must conform to the *Siracusa principles*.<sup>5</sup>

#### *Examples of how a state must respect the right to health:*

- When introducing medical fees, governments must ensure that they do not make health care unaffordable for the poorest sections of the population.
- The state must refrain from imposing laws or regulations that require a married woman to have the authorization of her spouse before she can receive reproductive health information and services.

**Protecting** the right to health applies mainly to obligations of governments to make efforts to minimise risks to health and to take all necessary measures to safeguard the population from infringements of the right to health by third parties. States are *not responsible* for the acts or omissions of non-governmental enterprises such as the private sector (for example, multinational corporations, including pharmaceutical companies, health insurance companies, biomedical research institutions, private care providers, and health management organizations); but they *are responsible* for taking measures aimed at ensuring that such bodies refrain from violating the rights of individuals and communities.

In practice, this means that states *are responsible for regulating the conduct* of individuals and groups who are working in the non-governmental sector (also referred to as *non-state actors*) and for protecting people's right to health through legislative and other measures. This includes ensuring, even when the private sector and other non-governmental actors provide health-related services, that there is no discrimination in access to health facilities, goods and services, or health technologies, and that they provide reliable and safe information about health.

***Examples of how a state must protect the right to health:***

- The government must ensure that private employers comply with labour standards that protect the right to health of their employees.
- The government must ensure that private enterprises, including corporations, refrain from polluting the environment and causing harm to the health of the community. For example, it should establish standards and laws to regulate the practices of corporations and enforce them through regular inspections, with penalties for infringements.

**Fulfilling** the right to health applies to positive measures that governments are required to take, such as by providing relevant services, to enable individuals and communities to enjoy the right to health in practice. It requires that all necessary steps be taken to ensure that the benefits covered by the right to health are provided and that appropriate legislative, administrative, budgetary, judicial, promotional and other relevant measures are adopted to ensure its full realization. It also requires that special measures be taken to prioritise the health needs of the poor and otherwise vulnerable and disadvantaged groups in society.

***Examples of how a state must fulfil the right to health:***

- The government must focus on rectifying existing imbalances in the provision of health facilities, goods and services. For example, it should allocate sufficient public resources to the most deprived regions in the country, in particular to the poor and otherwise vulnerable and disadvantaged groups in the population, including women, children, persons with disabilities, and those living with HIV/AIDS. It should also ensure that information about sexual and reproductive health, including protection against the transmission of STIs and HIV/AIDS, is made available to groups at higher risk of infection, such as adolescents, sex workers and men who have sex with men (MSM).
- The state must give sufficient recognition to the right to health in national political and legal systems, preferably through legislation, and must adopt a national health policy with a detailed plan for realizing the right to health.

The obligation to *fulfil* the right to health is commonly divided into the associated obligations to *facilitate*, *provide* and *promote* the right to health. This reflects the different types of responsibility that governments incur to take positive measures to implement the right to health.

- *Facilitating the right to health* requires states to take positive measures that enable and assist individuals and communities to enjoy the right to health.
- *Providing the right to health* requires states to intervene when individuals or groups are unable, for reasons beyond their control, to realize the right to health themselves through the means at their disposal.
- *Promoting the right to health* requires states to undertake actions that create, maintain and restore the health of the population. Health promotion is an important component of the measures necessary to fulfil the right to health. It points to the close link between good health and information and education — a link that is intrinsic to public health. In order to enjoy the right to health, individuals and communities must have adequate and appropriate health-related information.

*Examples of state actions aimed at facilitating, providing and promoting the right to health include:*

- The state must foster recognition of activities that can benefit good health, including research into the causes of ill health and making the resulting information available;
- The state must ensure that health information and services are culturally appropriate and that health care staff are trained to recognise and respond to the specific needs of the poor and otherwise vulnerable or disadvantaged groups;
- The government must ensure the dissemination of appropriate information relating to healthy lifestyles and nutrition, harmful traditional practices, and the availability of services; and
- The government must support people in making informed choices about their health.

Section 3.5 of the Resource Manual contains a catalogue of examples of state obligations to respect, protect and fulfil the right to health, based primarily on CESCR General Comment 14.

### **3.3 Availability, accessibility, acceptability and quality: the four essential standards for evaluating the implementation of state obligations**

*How must a government comply with its obligations to respect, protect and fulfil the right to health?*

#### *Fictional case study*

Over the last three years, the government of developing country 'X' has allocated funds to build a number of clinics in a rural area where primary health services (including reproductive health services and maternity care) have been severely lacking for the surrounding communities. Although the buildings themselves were completed more than a year ago, with the assistance of funding from a bilateral donor, there is still no running water and there has been a continuous shortage of basic medical equipment, essential medicines and trained medical personnel. The local authorities have not taken any steps to rectify this situation and have told the affected communities that it is the fault of the regional authorities which, although they had promised to provide the necessary funding and had written it into their budgets for two consecutive years, have not in fact provided it.

This case illustrates a government's *non compliance with its core obligations*. What might be dismissed as a failed development initiative becomes, when viewed through the lens of health and human rights, a failure by the state to comply with its legally binding obligations. A human rights approach to health emphasises that people have fundamental entitlements, and that states must comply with their corresponding duties. Clearly, it is neither meaningful nor sufficient to build health care facilities if they are not functional. Building a health facility does not, by itself, ensure that the right to health will be realized, nor does it comply adequately with state obligations. In this case, the state is not complying with its minimum core obligations to fulfil the right to health by ensuring primary health care, reproductive and maternal health care, and by providing essential drugs. (See chapters 5 and 9.)

In order to clarify the implications of adopting a health and human rights approach, the CESCR has stated that there are four underlying standards, or criteria, with which states must comply in order to make the right to health meaningful. They are: *availability, accessibility, acceptability, and quality*. To realize fully the right to health, it is essential for progress to be made on all four of them.<sup>6</sup>

In terms of being standards for evaluation, these four criteria reflect how monitoring within a health and human rights framework requires a shift in focus in comparison with 'traditional' public health and development perspectives. For example, a 'traditional' development approach to monitoring maternal health in a given community would be expected to look at maternal mortality ratios and the number of maternal health facilities available, whereas adopting a human rights approach would evaluate indicators such as the availability and accessibility of prenatal health services, their quality and the proportion of births attended by trained personnel.



Introducing a human rights framework into public health work is not about the imposition of any preordained result, but about *processes* and their application towards maximum public health gains. A focus on health systems, therefore, requires attention to their *availability, acceptability, accessibility, quality* and their outcomes among different populations.<sup>7</sup>

Therefore, when monitoring the right to health, NGOs should use all four criteria as a framework for assessing how well a government is performing. The purpose of these criteria is to serve as a standard by which attainment of the right to health can be evaluated and, for this reason, they provide a good focus for monitoring a government's compliance with its obligations.

If, in the fictional case given above, the responsible authorities point to the clinics and claim that 100 percent of the rural population in question is provided with adequate primary health care, NGOs can use the four criteria to document how this misrepresents the real situation. With this information, NGOs can then advocate for the changes that are needed to make the clinics functional and of practical use to the local community.

The following questions, adapted from CESCR General Comment 14, illustrate how the four standards can be used as a framework for evaluating health services. The term *health services* in this context refers to health care services and services related to the underlying determinants of health. If monitoring reveals that the answer to any of these questions is 'no', the presumption is that the government is not complying adequately with its obligations and NGOs should advocate for appropriate changes to the relevant government policies and practices. (See chapters 7 and 10 for monitoring strategies.)

### ***Monitoring availability***

- Are the numbers, quality, and distribution of functional public health and health care facilities in the country adequate, taking into account its developmental and economic condition?

### ***Monitoring accessibility***

Accessibility has four dimensions: *non-discrimination, physical accessibility, economic accessibility* (affordability), and *accessibility to information*. When monitoring accessibility, attention needs to be paid to the following points:

#### ***Monitoring non-discrimination:***

- Are health facilities, goods and services accessible, both in law and in fact, to everyone, including the poorest and most vulnerable or otherwise disadvantaged groups in the population? (See chapter 5.)

#### ***Monitoring physical accessibility:***

- Are health facilities, goods and services within safe physical reach of all sections of the population, including rural communities, ethnic minorities, indigenous populations, women, children, adolescents, older persons, persons with disabilities, and persons living with HIV/AIDS?

#### ***Monitoring economic accessibility (affordability):***

- Are health facilities, goods and services affordable to everyone?
- If it is required that people pay for health care services, or for any other services concerned with the underlying determinants of health, such as sanitation and drinking water, is payment based on the principle of equity?

*Equity* refers to the obligation of the government to ensure that such services, whether they are publicly or privately provided, are affordable to everyone and that poorer households are not burdened disproportionately with health expenses as compared with richer households.

#### ***Monitoring accessibility to information:***

- Is everyone able to seek freely, and to receive and to impart health-related information and ideas? For example, do young people have access to sexual and reproductive health education and information that is presented to them in an unbiased manner?

### ***Monitoring acceptability***

- Are all health facilities, goods and services provided in conformity with human rights and medical ethics? Is the dignity of patients or clients respected? Are they culturally appropriate?

*Culturally appropriate* means that: they are respectful of the culture of individuals, minorities, peoples and communities; they are sensitive to gender and life-cycle requirements; they protect confidentiality; and they are adequate to improve the health status of those concerned.

### ***Monitoring quality***

- Are all health facilities, goods and services scientifically and medically appropriate and of the highest possible quality? This requires, for example, adequate provision of skilled medical and nursing personnel; scientifically approved drugs and equipment; safe, potable water; and sanitation.

## **3.4 What constitutes violations? A quick guide to violations of the right to health**

### ***What must governments not do?***

A human rights approach to health establishes minimum requirements and provides standards to combat inequities and basic forms of injustice. The fact that governments are accountable for complying with their obligations arising from the right to health is a central aspect of this approach. Accordingly, NGOs need to understand not only the nature of state obligations, but also to understand and to be able to recognize both violations and potential violations.

Monitoring whether violations are taking place offers NGOs a way to focus their work on potential problem areas and to assess the extent to which their government is taking seriously, and treating as a matter of priority, fulfilment of its duty to implement the right to health effectively.<sup>8</sup> The identification of common violations should therefore help direct monitoring. (See chapter 9.) This section of the Resource Manual provides a reference guide and general outline of how governments can violate their obligations. It is based on CESCR General Comment 14.

### ***Violations by ‘acts of commission’ and by ‘acts of omission’***

Just as states have positive and negative duties, they can violate their obligations by what they do, and by what they fail to do.

Violations of the right to health can occur through the direct action by the state or of others who are not sufficiently regulated by the state. In addition, any retrogressive measures adopted by a state that are incompatible with its core obligations violate the right to health. Violations through acts of commission include:

- formal repeal or suspension of legislation that is necessary for the continued enjoyment of the right to health; and
- adoption of legislation or policies which are manifestly incompatible with pre-existing domestic or international legal obligations affecting the right to health.

Violations of the right can also occur through omission or failure by states to take necessary actions or measures arising from their legal obligations.

### ***Violations through acts of omission include failure to:***

- take appropriate and deliberate steps towards the full realization of everyone’s right to the enjoyment of the highest attainable standard of physical and mental health;
- have a national policy on occupational safety, health, and occupational health services; and to enforce relevant legislation; and
- introduce and enforce adequately laws that regulate the conduct of companies. Examples include failure to: comply with national food and product safety standards; respect the right to health of employees; or to protect the environment adequately.

### *Violations of obligations to respect, protect and fulfil the right to health*

Just as states have duties to respect, protect and fulfil the right to health, they can also violate their obligations to all three of them. What follows is a general description of these three categories of violations.

#### *Violations of the obligation to respect*

Violations of the obligation to respect apply to those state actions, policies or laws that contravene the standards of the right to health and are likely to result in bodily harm, unnecessary morbidity and preventable mortality. Violations also include a state taking retrogressive measures (take-backs) in its health-related policies, programmes or practices.

Examples of such violations include:

- denial of access to health facilities, goods and services to particular individuals or groups as a result of discrimination of any kind;
- deliberate withholding or misrepresentation of information that is vital to the protection of health or to the provision of effective treatment;
- repeal or suspension of legislation, or adoption of laws or policies that interfere with the enjoyment of any of the components of the right to health; and
- failure by the state to take into account its legal obligations under the right to health when entering into bilateral or multilateral agreements with other states, international organizations such as international financial institutions (IFIs) and other bodies, including multinational corporations.

(See section below, 'Violations of universal immediate obligations', for detailed examples concerning the obligation to respect.)

#### *Violations of the obligation to protect*

Violations of the obligation to protect are caused by a state's failure to take all necessary measures to safeguard persons within its jurisdiction from infringements of the right to health by third parties.

Examples of such omissions include a state's failure to:

- regulate the activities of individuals, groups, or corporations so as to prevent them from violating the right to health of others;
- protect consumers and workers from practices detrimental to health, such as by employers and manufacturers of medicines or food;
- discourage the production, marketing, and abusive consumption of tobacco, narcotics, and other harmful substances;
- protect women against violence and prosecute those who attack them;
- discourage the continuation of harmful traditional or cultural practices; and
- enact or enforce laws to prevent the pollution of water, air and soil by extractive and manufacturing industries.

#### *Violations of the obligation to fulfil*

Violations of the obligation to fulfil occur as a result of failure by states to take all necessary steps to ensure the realization of the right to health.

Examples of such violations include the failure to:

- monitor the realization of the right to health, such as by identifying national indicators and benchmarks for the right to health;
- take measures to reduce the inequitable distribution of health facilities, goods and services;
- adopt a gender-sensitive approach to health;
- reduce infant and maternal mortality rates; and
- provide expenditure and allocate resources sufficient to ensure the enjoyment of the right to health by individuals or groups, particularly those who are poor or otherwise vulnerable and disadvantaged. This includes the correction of any under-funding or misallocation of public resources that prevents or interferes with the enjoyment of the right.

### *Violations of universal immediate obligations*

Some obligations are legally binding on all states, even in situations of severe resource limitations. (See chapter 2 and section 3.1.) States must comply with their immediate obligations, and any failure to do so constitutes a violation of the right to health.<sup>9</sup>

See chapter 9 for detailed examples of such violations, which are particularly important for monitoring the right to health in developing countries. Certain aspects of core obligations, however, are often violated in developed countries as well.

States can violate their immediate obligations by:

- *failing to comply with minimum core obligations* (ensuring the satisfaction of minimum essential standards of the right to health).
  - The state fails to recognize and/or implement the right to health or to health care, for example by not providing constitutional or legal recognition of it.
  - The state fails to adopt a national health policy, including a detailed plan for realizing the core obligations of the right to health.
- *failing to prevent, avoid or halt discrimination*.
  - Laws or policies restrict access to adequate health services for certain segments of society, such as prisoners, illegal immigrants, refugees, women, or adolescents.
  - The state maintains discriminatory laws, policies, or practices that have an adverse effect on women's health status, for example by allowing forced medical interventions, such as caesarean sections and blood transfusions, without consent, or by restricting their opportunities to train as health care workers in communities where women can only be treated by female doctors and nurses.
- *undertaking any measures that directly or indirectly infringe upon the right to health. This includes taking retrogressive measures ('take backs') that are incompatible with its obligations*.
  - In order to comply with structural adjustment programmes (SAPs) and health sector reforms, a government cuts back drastically on social spending. As a result, the government allows its health care services to become weaker (for example, by closing hospital emergency wards in sparsely populated areas), to an extent that is incompatible with its right to health obligations.
  - A state deliberately withholds life-saving information about a community's exposure to toxic substances or misrepresents the existence of disease.
  - A state-owned mining company wants to engage in extensive preliminary drilling that would make the source of drinking water undrinkable. The state formally repeals or suspends existing legislation that controls such types of drilling so as to allow it to take place.
- *failing to take positive and effective steps towards the progressive realization of the right to health*.
  - The state's vital registration system fails to provide adequate statistical information on the health status of the rural population. Despite having adequate resources to rectify the problem, the government ignores the issue and instead increases funds for tertiary care institutions in the capital city.

- Public authorities neglect to formulate targeted policies to establish priorities for addressing a widespread lack of adequate nutritious food among the population.
- The state fails to set and meet targets that demonstrate how the right to health is being progressively realized, to the maximum of the state's available resources.

#### *How do violations occur in relation to the progressive realization of the right to health?*

In determining what constitutes a violation of the right to health, it is important to distinguish the *inability* from the *unwillingness* of a state to comply with its obligations. States must, in their realization of the right to the *highest attainable standard of health*, take the necessary steps to the maximum of their available resources. A state that is *unwilling* to use the maximum that is needed of its available resources for this purpose is in violation of its obligations.

If, on the other hand, resource constraints render it impossible for a government to comply fully with its obligations, it has the burden of justifying that every effort has been made to use all available resources at its disposal. If it deliberately takes any retrogressive measures, it must be able to prove that they were introduced after the most careful consideration of all the alternatives and that its non-compliance is justified in the light of the maximum resources available. Questions of this nature arise frequently when states appear in support of their country's report before monitoring committees that enforce treaty obligations subject to progressive realization (eg CESCR and CRC). (See chapter 2 and section 3.1.)

For NGOs, it is not a simple task to evaluate financially whether their government is progressively fulfilling its obligations *to the maximum extent possible*. (See section 3.1.) However evaluating government budgets and plans is a useful means of finding out how a state is prioritising its expenditures.

The main point about obligations that are subject to *progressive realization* is that governments are required to assign them priority in order to comply with them. Authorities must demonstrate a continual and meaningful commitment of resources and effort to make progress in realizing the right to health. They must do so by all appropriate means, including the adoption of legislative and policy measures, and the establishment of mechanisms for implementation.

Violations should always be suspected whenever governments take any deliberately retrogressive measures affecting their progressive obligations and/or if they neglect to put in place laws, policies and the implementation mechanisms that demonstrate a commitment to realizing their obligations fully.

- The Ministry of Health closes down several mental health treatment facilities that service rural areas, including clinics that offer counselling to victims of domestic violence. No alternative facilities are provided for the local communities, and the government blames severe budget constraints for the closures. At the same time, the country's main teaching hospital in the capital city invests in 'high-tech' diagnostic equipment and hires a number of new 'super-specialists'.
- Authorities bow to pressure from a small, but politically influential, lobby group and remove sexual and reproductive health education programmes, including on STIs and HIV/AIDS prevention and on contraception, from its schools.

### **3.5 Catalogue of examples of state obligations to respect, protect and fulfil the right to health**

The wide range of government obligations that arise from the right to health reflect the socio-economic factors that, along with health care, promote conditions whereby people can lead a healthy life, including enjoyment from the benefits of the underlying determinants of health. The tables in this section present an overview of examples of government's legally binding obligations to respect, protect and fulfil the right to health. They are meant to provide health professional organizations and other health advocates with a *catalogue of examples* of state obligations in order to assist them in understanding the range of obligations, and to clarify how obligations to respect, protect and fulfil the right to health correspond with and complement each other.

The tables are based primarily on CESCR General Comment 14<sup>10</sup>, but are also supported by several other international human rights instruments. Where appropriate, elements from the CRC, the Women's Convention and interpretative documents adopted by their respective monitoring committees are incorporated and referenced as such.

The examples are illustrative and grouped together in thematic categories. They refer to government obligations concerning:

- *formal recognition of the right to health and a formal plan to implement it;*
- *maternal, child and reproductive health;*
- *healthy natural and workplace environments;*
- *prevention, treatment and control of diseases, including obligations concerning health-related information and education; and*
- *health facilities, goods and services;*

Specific categories have not been included for obligations regarding non-discrimination and participation as they are key principles of a human rights approach to health. They characterise and cross-cut all aspects of government obligations. As such, they appear throughout the tables, interwoven with other obligations.

### 3.5.1 State obligations regarding the formal recognition of the right to health and a formal plan to implement it include:

States have obligations to:	<ul style="list-style-type: none"> <li>• give sufficient recognition to the right to health in national political and legal systems, wherever possible by way of legislative implementation; and</li> <li>• adopt a national public health strategy and plan of action for the realization of the right to health.</li> </ul>
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### 3.5.2 State obligations regarding maternal, child and reproductive health<sup>11</sup>

States have <i>respect-bound obligations</i> to take measures to:	<ul style="list-style-type: none"> <li>• refrain from limiting access to contraceptives and other means of maintaining sexual and reproductive health; and</li> <li>• abstain from imposing discriminatory laws or policies relating to women’s health status and needs.</li> </ul>
States have <i>protection-bound obligations</i> to take measures to	<ul style="list-style-type: none"> <li>• ensure that harmful social or traditional practices do not interfere with access to pre- and post-natal care and family-planning;</li> <li>• prevent third parties from coercing women (including children and adolescents) to undergo harmful traditional practices, including female genital mutilation/cutting (FGM/C) and child marriage;<sup>12</sup></li> <li>• take measures to prevent coercion of women with respect to fertility control and reproduction;<sup>13</sup> and</li> <li>• take measures to protect all vulnerable or otherwise disadvantaged groups of society, in particular women, children, adolescents and older persons, from gender-based violence.<sup>14</sup></li> </ul>

<p>States have <i>fulfilment-bound obligations</i> to take measures to:</p>	<ul style="list-style-type: none"> <li>• ensure, particularly in rural areas, the provision of sexual and reproductive health services and information, including access to family planning, pre- and post-natal and safe motherhood care, emergency obstetric services, access to information, together with the resources needed to act on the information;</li> <li>• ensure that protective measures are in place for the security and physical and mental health for women who are victims of violence or at risk of violence;<sup>15</sup> and</li> <li>• ensure the provision of adequate health services for women in especially difficult circumstances, such as women trapped in situations of armed conflict or who are refugees.<sup>16</sup></li> </ul>
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### 3.5.3 State obligations regarding healthy natural and workplace environments

<p>States have <i>respect-bound obligations</i> to take measures to:</p>	<ul style="list-style-type: none"> <li>• refrain from using or testing nuclear, biological or chemical weapons in situations where such testing results in the release of substances harmful to health; and</li> <li>• refrain from unlawfully polluting air, water and soil, for example through industrial waste from state-owned facilities. They must not permit the environment to be poisoned or destroyed by harmful practices in mineral or oil production and exploration, manufacturing, forestry, fishing or farming.</li> </ul>
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<p>States have <i>protection-bound obligations</i> to take measures to:</p>	<ul style="list-style-type: none"> <li>• enact or enforce laws to prevent the pollution of water, air and soil by private corporations, such as extractive and manufacturing industries;</li> <li>• discourage production, marketing, and the abuse of alcohol and the use of cigarettes, narcotics and other harmful substances;<sup>17</sup></li> <li>• regulate the activities of individuals, groups, organizations and corporations so as to prevent them from violating the right to health of others;</li> <li>• protect consumers and workers from practices detrimental to health;<sup>18</sup> and</li> <li>• ensure that third parties do not limit people's access to health-related information (eg, employers, manufacturers of medicines and food). This involves taking regulatory measures in order to minimize, so far as is reasonably practical, the causes of health hazards inherent in the working environment.</li> </ul>
<p>States have <i>fulfilment-bound obligations</i> to take measures to:</p>	<ul style="list-style-type: none"> <li>• ensure equal access for all to the underlying determinants of health, such as nutritionally safe food and potable drinking water, basic sanitation and adequate housing and living conditions;</li> <li>• adopt measures against environmental and occupational health hazards and against any other threat as demonstrated by epidemiological data. For this purpose, formulate and implement national policies aimed at reducing and eliminating pollution of air, water and soil, including pollution by heavy metals such as lead in gasoline;</li> <li>• formulate, implement and periodically review a coherent national policy to minimise the risk of occupational accidents and diseases; and</li> <li>• provide a coherent national policy on occupational safety and health services.<sup>19</sup></li> </ul>



3.5.4

**State obligations regarding the prevention, treatment and control of diseases (including health-related information and education)**

<p>States have <i>respect-bound obligations</i> to take measures to:</p>	<ul style="list-style-type: none"> <li>• refrain from censoring, withholding or intentionally misrepresenting accurate health-related information, including sexual health education and information.</li> </ul>
<p>States have <i>protection-bound obligations</i> to take measures to:</p>	<ul style="list-style-type: none"> <li>• ensure that third parties do not limit people’s access to health-related information and services, including those involving behaviour-related health concerns such as STIs, HIV/AIDS, and others that adversely affect sexual and reproductive health.</li> </ul>
<p>States have <i>fulfilment-bound obligations</i> to take measures to:</p>	<ul style="list-style-type: none"> <li>• prevent, treat and control epidemic and endemic diseases;</li> <li>• ensure provision of essential medicines, as defined by WHO’s Action Programme on Essential Medicines;</li> <li>• provide education and access to information about the main health problems in the community, including methods of prevention and control;</li> <li>• foster recognition of, and promote, factors favouring positive health results, for example, through the promotion of medical research, the provision of health-related information and health education;</li> <li>• ensure the dissemination of appropriate information relating to healthy lifestyles and nutrition, and the availability of health services;<sup>20</sup></li> <li>• establish and promote prevention and education/information campaigns for behaviour-related health concerns such as STIs and HIV/AIDS;</li> <li>• ensure that adolescents have access to the information that is essential for their health and development and the opportunities to participate in decisions affecting their health, to acquire life skills, to obtain adequate and age-appropriate information, and to make appropriate health behaviour choices;<sup>21</sup></li> <li>• promote information campaigns, for example on sexual and reproductive health,<sup>22</sup> harmful traditional practices, domestic violence, the abuse of alcohol and the use of cigarettes, narcotics and other harmful substances; and</li> <li>• ensure provision of immunization programmes against the major infectious diseases.</li> </ul>

### 3.5.5

## State obligations regarding health facilities, goods and services

<p>States have <i>respect-bound obligations</i> to take measures to:</p>	<ul style="list-style-type: none"> <li>• refrain from denying or limiting equal access for all persons, including prisoners, detainees, minorities, asylum seekers and illegal immigrants, to preventive, curative and palliative health services;</li> <li>• refrain from prohibiting or impeding safe traditional care, healing practices and medicines;</li> <li>• refrain from marketing unsafe drugs;</li> <li>• refrain from limiting access to health services as a punitive measure, for example during armed conflicts in violation of international humanitarian law; and</li> <li>• refrain from applying coercive medical treatments, unless on an exceptional basis for the treatment of mental illness or the prevention and control of communicable diseases.<sup>23</sup></li> </ul>
<p>States have <i>protection-bound obligations</i> to take measures to:</p>	<ul style="list-style-type: none"> <li>• adopt legislation or take other measures to ensure equal access to health care and health-related services provided by third parties<sup>24</sup>;</li> <li>• introduce and enforce appropriate controls for the marketing of medical equipment and medicines by third parties;</li> <li>• ensure that medical practitioners and other health professionals meet appropriate recognized standards of education, skill and ethical codes of conduct; and</li> <li>• discourage the continued practice of harmful traditional or cultural practices.</li> </ul>

<p>States have <i>fulfilment-bound obligations</i> to take measures to:</p>	<ul style="list-style-type: none"> <li>• provide essential primary health care;</li> <li>• ensure the provision of a sufficient number of hospitals, clinics and other health-related facilities;</li> <li>• ensure the promotion, support and equitable establishment of institutions providing counselling and mental health services;</li> <li>• ensure that doctors and other health care professionals are trained appropriately;<sup>25</sup></li> <li>• provide a public, private or mixed health insurance system which is affordable for all;</li> <li>• ensure that health services are culturally appropriate and that health care professionals are trained to recognise and respond to the specific needs of the poor and other vulnerable or disadvantaged groups in the population;<sup>26</sup></li> <li>• provide sufficient expenditure and proportionate investment of public resources in the health sector to ensure that a large proportion of the population will benefit and that existing inequities and imbalances in the provision of health facilities, goods and services will be rectified; and</li> <li>• focus expenditure on rectifying existing imbalances in the provision of health facilities, goods and services</li> </ul>
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## Notes

- 1 Committee on Economic, Social and Cultural Rights (CESCR). General Comment 14, The right to the highest attainable standard of health. E/C.12/2000/4.
- 2 Ibid.
- 3 United Nations Development Programme (UNDP). Human Development Report 2000. Geneva: UNDP; 2000.
- 4 This is a legally binding obligation for States parties to those treaties that stipulate progressive realization, including ICESCR and CRC. See chapter 2.
- 5 United Nations, Economic and Social Council, U.N. Sub-Commission on Prevention of Discrimination and Protection of Minorities. Siracusa Principles on the Limitation and Derogation of Provisions in the International Covenant on Civil and Political Rights. E/CN.4/1985/4 (1985).
- 6 CESCR. Ibid:para 12.
- 7 Gruskin S, Loff B, Do human rights have a role in public health work? The Lancet 2002; 360:1880.
- 8 Chapman AR. Conceptualizing the right to health: A violations approach. Tennessee Law Review. Winter 1998; 65:389-418.
- 9 Sources for examples of violations in this section include: Chapman AR. Approaches to monitoring the internationally defined right to health. (Unpublished paper); CESCR. General Comment 14, The right to the highest attainable standard of health. E/C.12/2000/4; McChesney A. Promoting and defending economic, social and cultural rights. A handbook. Washington, D.C.: AAAS; 2000; Mann J, Gruskin S, Grodin M, Annas G. editors. Health and human rights: a reader. New York: Routledge; 1999; Toebes BCA. The right to health as a human right in international law. Antwerp, Belgium: Intersentia Publishers; 1999.

- 10 CESCR. Ibid.
- 11 See table 3.5.4 for examples of obligations regarding the right to information about sexual and reproductive health.
- 12 CRC specifies that States parties have an obligation to “protect adolescents from all harmful traditional practices, such as early marriages, honour killings and female genital mutilation.” CRC General Comment 4, Adolescent health and development in the context of the Convention on the Rights of the Child. CRC/GC/2003/4: para para 39 (g).
- 13 CEDAW General Recommendation 19, Violence against women. A/47/38: para 24(m).
- 14 With regard to gender-based violence, CEDAW provides explicit guidance for States parties to ensure: the enactment and effective enforcement of laws and the formulation of policies, including health-care protocols and hospital procedures to address violence against women and sexual abuse of girl children and the provision of appropriate health services; fair and protective procedures for hearing complaints and imposing appropriate sanctions on healthcare professionals guilty of sexual abuse of women patients. CEDAW General Recommendation 24, Women and health. 02/02/1999: paras 12 and 15.
- 15 CEDAW enumerates that such protective measures include refuges, counselling, rehabilitation and support services and that states must ensure that services for victims of violence are accessible to rural women and that where necessary special services are provided to isolated communities. CEDAW General Recommendation 19. Ibid:para 24.
- 16 CEDAW General Recommendation 24. Ibid:para 16.
- 17 CRC specifies that “States parties are ... urged to regulate or prohibit information on and marketing of substances such as alcohol and tobacco, particularly when it targets children and adolescents.” CRC General Comment 4. Ibid:para 25.
- 18 See also ILO Convention 155, Occupational safety and health convention: 1981: art 4.2.
- 19 Ibid and ILO Convention 161, Occupational health services convention. 1985.
- 20 The CRC enumerates the obligation to ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breast-feeding, hygiene & environmental sanitation & the prevention of accidents. Convention on the Rights of the Child, UN General Assembly Resolution 44/25 (1989): art 24.
- 21 CRC General Comment 4. Ibid:para 39 (b).
- 22 CEDAW provides further guidance, elaborating that States parties should ensure, without prejudice or discrimination: the right to sexual health information, education and services for all women and girls, including those who have been trafficked, even if they are not legally resident in the country; the rights of female and male adolescents to sexual and reproductive health education by properly trained personnel in specially designed programmes that respect their right to privacy and confidentiality. CEDAW General Recommendation 24. Ibid:para 18.
- 23 Such exceptional cases should be subject to specific and restrictive conditions, respecting best practices and applicable international standards, including the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, UN General Assembly Resolution 46/119 (1991).
- 24 This includes ensuring that privatization of the health sector does not constitute a threat to the availability, accessibility, acceptability and quality of health facilities, goods and services and that private providers of health services and facilities comply with the principle of non-discrimination, particularly in relation to vulnerable groups.
- 25 CEDAW expands on the notion of appropriate training with regard to women’s right to health and in the context of gender-based violence. ‘Appropriate training’ includes gender-sensitive training of health workers, judicial and law enforcement officers and other public officials to detect and manage the health consequences of gender-based violence. CEDAW General Recommendations 19. Ibid:para 24(b) and CEDAW General Recommendation 24. Ibid:para 15(b).
- 26 CRC General Comment 4 specifies in particular that States Parties must ensure “that health facilities, goods and services, including counselling and health services for mental and sexual and reproductive health, of appropriate quality and sensitive to adolescents’ concerns are available to all adolescents” (para 39 (c)). Moreover, the General Comment specifies that “Adolescents have the right to access adequate information essential for their health and development and for their ability to participate meaningfully in society. It is the obligation of States parties to ensure that all adolescent girls and boys, both in and out of school, are provided with, and not denied, accurate and appropriate information on how to protect their health and development and practise healthy behaviours. This should include information on the use and abuse, of tobacco, alcohol and other substances, safe and respectful social and sexual behaviours, diet and physical activity”. CRC General Comment 4. Ibid:para 24.

## Part II *Moving towards action: Focussing on obligations arising from the right to health*

### Chapter 4 Focus on Core Obligations

#### *Keys to Chapter 4*

##### *key information:*

- Core obligations define a minimum standard of essential health-related services and conditions that states are responsible for ensuring to all sectors of the population;
- All states, irrespective of their economic resources, have an immediate duty to comply with core obligations.

##### *key questions:*

- To what extent is the government meeting its core obligations arising from the right to health?
- To what extent does the government accord priority to implementing its core obligations?
- In the case of developing countries, to what extent does health-related international development aid prioritise the implementation of core obligations?

#### **This is the very least that governments must do immediately**

CESCR General Comment 14 asserts that all states have immediate obligations, including *minimum core obligations*. Core obligations are intended to ensure that people are provided with, at the very least, the minimum conditions under which they can live in dignity; enjoy the basic living conditions needed to support their health; and be free from avoidable mortality. They serve, in other words, as a *minimum* or *bottom line* for responsibilities of states. They require governments to take the basic measures that are needed to enable people to achieve minimum standards of health, including the provision of essential primary health care. They also take into account the fact that health problems associated with poverty and inequity pose the main obstacles to attaining minimal standards of health and well-being for most of the world's population. (See chapter 2.)

Minimum core obligations cannot be subjected to progressive realization. All states, regardless of their level of development, are required to take immediate action to implement them. This can include legislation; the regulation, design and enforcement of policies; and mobilization of the necessary resources.

CESCR General Comment 14 identifies the core obligations that arise from the right to health as including at least the following obligations.<sup>1</sup>

In the case of *health care*, governments must provide:

- immunization against the major infectious diseases;
- measures to prevent, treat and control epidemic and endemic diseases;
- essential medicines, as defined by WHO's Action Programme on Essential Medicines;
- reproductive, maternal (pre-natal and post-natal) and child health care;
- essential primary health care;
- right of access to health facilities without discrimination, especially for the poor, and otherwise vulnerable and disadvantaged groups;
- equitable distribution of all health facilities, goods and services; and

In the case of *underlying determinants of health*, governments must provide:

- access to the minimum amount of food that is sufficient, nutritionally adequate and safe, to

ensure their freedom from starvation and malnutrition; and

- access to basic shelter, housing and sanitation, together with an adequate supply of safe and potable water.

In the case of *health education and information*, governments must provide:

- education and access to information about the main health problems in the community, including methods of prevention and control; and
- appropriate training for medical and other health professionals, including education in health and human rights.

When formulating a *national health policy*, governments must:

- adopt and implement a national public health strategy and plan of action, which is based on epidemiological evidence, and which takes into account the health concerns of the whole population. The strategy and plan of action must be developed through a participatory and transparent process and subject to regular review. Specific objectives and a cost-effective strategy must be adopted for using available resources, as well as methods such as right to health indicators and benchmarks, by which progress can be closely monitored. The process by which the strategy and plan of action are formulated, as well as their content, shall pay particular attention to all the vulnerable or marginalized groups in the population.

## Core obligations: a framework for monitoring the right to health in developing countries

Monitoring core obligations is particularly important in developing countries, where basic resources and infrastructures (upon which realization of the right to health depends) are often inadequate and sometimes do not even exist. Moreover, many governments in developing countries make inappropriate decisions on investment in health despite resource constraints.

Minimum core obligations require governments to assign priority to public health measures, comprehensive primary health care, and preventive services, and expect them to invest their available resources in an equitable manner. They also require governments to give priority to correcting existing inequities and imbalances in the distribution of health sector resources in order to improve services for the poor and otherwise vulnerable and disadvantaged groups in the community. Many developing countries need to take incremental steps (over a period of time) towards implementing the comprehensive health policies that core obligations stipulate, and for this purpose they are required to design a systematic plan, which must include the adoption of goals and a timeframe.

In keeping with this, a human rights approach entails that health-related development aid should be directly linked to the fulfilment of core obligations, as a matter of priority. CESCR General Comment 14 stipulates that it is incumbent on States parties and other actors in a position to assist, to provide international assistance and cooperation, particularly economic and technical, which enable developing countries to fulfil their core obligations.<sup>2</sup> (See Chapter 6.)

Minimum core obligations provide concrete standards for adoption of the public health measures needed to improve the health status of the population, including primary health care and health education. They also provide a formula for a legal framework, a public policy agenda, and effective government action that can promote the enhancement of health as an integral part of development.

Core obligations acknowledge that the poor, vulnerable, or otherwise disadvantaged groups in the community carry the greatest burden of disease in the world. (See chapter 5.) In developing countries, where resources are limited, many governments make policy choices and allocate public funds in ways that are both unwise and unjust. Many of them misallocate their scarce resources, in particular by funding tertiary health care facilities and higher specialist training when investment in primary and preventive health measures would benefit a far greater proportion of the population. Another common example is when enormous public resources, often many times higher than that expended on basic health care services, are spent by poor countries on their armed forces (and are usually presented as being needed for purposes of defence).

*'... good health and economic prosperity tend to support each other. Healthy people can more easily earn an income, and people with a higher income can more easily seek medical care, have better nutrition, and have the freedom to live healthier lives.'*

*Amartya Sen<sup>3</sup>*

Even when economic conditions are bad, governments can still achieve major health improvements by using their available resources more wisely. They can do so by investing in programmes that benefit the greatest number of people living within their jurisdiction, and in particular, the needy. The issue here is one of policy and allocation of resources rather than level of spending. The reason why some rich countries, such as the USA, do not implement some of their core obligations is because they allocate spending on health inequitably, and without due regard to areas such as public health and primary health care.

Many of the core obligations included in CESCR General Comment 14 were derived from the minimum standards of a 'basic needs strategy' that was agreed upon by experts in the international health and development community. This strategy was designed to ensure that populations could share in the economic development of their countries. The *Declaration of Alma Ata* on Health for All by the Year 2000 emphasized the importance of providing comprehensive primary care as part of that strategy. In this way, core obligations can promote the basic features necessary for improved health and sustainable development. Moreover, they carry the added authority of being legally binding, as they are based on internationally accepted standards and principles of human rights, and are derived from people's human rights entitlements.

This reflects the fundamental difference between a 'classic' needs-based approach to health and development, on the one hand, and a human rights approach to health, on the other. Unlike the development perspective, core obligations are not about benevolence or charity, and cannot be argued away for reasons of financial constraint, or more pressing state priorities. A human rights approach is based on the inherent dignity of all individuals, on people's entitlements, and on corresponding state obligations. States that have freely agreed to take on obligations (by ratifying human rights instruments) can, therefore, be held accountable for not doing so.

Core obligations provide an important framework for NGOs in all countries to monitor the right to health as they identify a *bottom line* for the minimum essential services and conditions that are necessary to be healthy and to continue to be so. The fact that they do so from a human rights perspective means that they focus as much on the process as the outcome, and they deal with inequities in health status between social groups and between men and women. They set out what should be a government's highest priorities in making policy, programme, and budgetary choices on health issues.

From the NGO perspective, they provide legally enforceable and internationally recognised standards against which existing health-related laws, policies, budgets, programmes, and administrative practices can be evaluated. Furthermore, CESCR General Comment 14 makes it clear that a state's failure to implement core obligations constitutes a violation of the right to health. There are simply no circumstances that can justify a government's failing to take immediate action to implement its core obligations.

Chapter 7 contains a checklist of questions to guide health-concerned NGOs in evaluating the extent to which their government is complying with its core obligations. This checklist should be read in conjunction with chapter 9, which gives detailed examples of some of the most common ways in which governments violate core obligations.

## Notes

- 1 Committee on Economic, Social and Cultural Rights. General Comment 14, The right to the highest attainable standard of health. E/C.12/2000/4: paras 43-44.
- 2 Ibid:para 45.
- 3 Amartya Sen. Keynote address to World Health Assembly, May 1999.

## Part II *Moving towards action: Focussing on obligations arising from the right to health*

### Chapter 5 Focus on non-discrimination and vulnerable and otherwise disadvantaged groups

#### *Keys to Chapter 5*

##### *key information:*

- A focus on vulnerable groups is fundamental to a human rights approach to health;
- States have an immediate obligation to prevent any discrimination, overt or implicit, in access to health care and underlying determinants of health;
- In order to overcome existing inequalities in the health status in different groups in society, states furthermore have positive obligations to take special measures to meet the health needs of the poor, vulnerable, or otherwise disadvantaged groups, and to rectify the cumulative adverse effects on health of past systematic discrimination.

##### *key questions:*

- Can any overt or implicit violations of the principle of non-discrimination be attributed to the government or to other relevant parties? To what extent is the government taking effective measures to remedy this?
- Which vulnerable and disadvantaged groups in society disproportionately suffer adverse health effects? What steps is the government taking to rectify these imbalances?
- Is the government taking adequate legal and other measures in order to eliminate any discrimination against women and ensure their equal opportunity to enjoy the highest attainable standard of health?

## 5.1 Ensuring non-discrimination

### *This is the very least that governments must do immediately*

Freedom from discrimination is the *key principle* in international human rights law. As such, it is central to a human rights approach to health. CESCR General Comment 14 spells out that all states have an immediate obligation to ensure non-discrimination and that this duty is *not* subject to progressive realization. Regardless of their level of development, all states are required to take immediate action to ensure non-discrimination in order to reduce existing health inequities within and between populations. This *immediate* and universal obligation prohibits:

any discrimination in access to health care and underlying determinants of health, as well as to the means and entitlements for their procurement, on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation, civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health.

*CESCR General Comment 14, para 18<sup>i</sup>*

In practice, ensuring non-discrimination requires governments immediately to:

- abolish without delay any discriminatory laws, regulations or policies adversely affecting the right to health;
- refrain from discriminatory practices in implementing laws, regulations, policies, or programmes;
- ensure that laws and policies embody the principle of non-discrimination and prioritize the health needs of the poor, vulnerable, or otherwise disadvantaged groups; and
- where necessary, implement temporary special measures aimed at counter-balancing the cumulative effects of discrimination on particular groups (often called *affirmative action*).



There are countless ways in which discrimination can occur. Many examples of violations of the right to health that appear in this Resource Manual involve discrimination in one way or another. Here are a few examples of how discrimination can occur:

- state-funded health research often fails to include research into health problems that are heavily over-represented in, or uniquely relevant to, certain population groups such as breast cancer, ovarian cancer, or sickle cell disease;<sup>2</sup>
- a relatively minor health issue that mainly affects a dominant group in the community can systematically be given higher priority in research, resource allocation, policies and programme development than other more serious and widespread health problems;<sup>3</sup>
- restrictive laws and policies deliberately focus on particular population groups without adequate data (both epidemiological and otherwise) to support their approach. One example is where controversial laws and policies have been condoned by the state on grounds that they are necessary to safeguard the health of the individuals concerned, such as the compulsory sterilisation of women from certain population groups (for example women with a severe mental disability). Such grounds are spurious and often mask the real reason for them which, in this case, might be that such women are notoriously vulnerable to violence, including sexual assaults and resulting pregnancies. Another example is the justification offered for criminalising homosexual practice as being necessary to prevent the spread of HIV/AIDS.<sup>4</sup>
- public health campaigns can effectively exclude large segments of the population, for example, when campaigns on HIV/AIDS protection are conducted only in the dominant-language of the country, and/or only on television;
- public education campaigns can ignore the limited ability of vulnerable groups to respond to risk. For example, warnings about lead poisoning in children can be given without taking into account that low-income population groups may not have the financial means to ensure their children's safety;
- authorities can fail to make, or to enforce laws effectively, that are designed primarily or exclusively to protect one group, such as laws against female genital mutilation/cutting (FGM/C), domestic violence, or child marriage; and
- laws, policies and/or practices exist that are detrimental to the health of particular groups, for example, those which criminalize induced abortion, or which require spousal or parental consent for contraception or sterilization.

(For other examples of violations, see chapters 3 and 9.)

The obligation to ensure non-discrimination is closely linked to the principle of equity, which implies that states must pay attention to *all* sectors of the population. This does not mean that everyone should be treated in exactly the same way, but rather that health systems must recognise, and provide for, the differences and specific needs of groups within the population who experience a disproportionate level of mortality, morbidity and disability.<sup>5</sup>

Thus, the obligation to ensure non-discrimination calls for specific health standards to be applied to particular population groups, such as women, persons with disabilities, and children particularly in developing countries. The reason is because generic and other standard approaches to health issues can perpetuate and reinforce existing inequalities between the health status of vulnerable groups and the general population. In keeping with this, CESCR General Comment 14 emphasises that governments are required to take *affirmative action* to rectify the cumulative adverse effects on health of past systematic discrimination and to eliminate the conditions that contributed to them.

Accordingly, a focus on vulnerable groups is fundamental to a human rights approach to health. CESCR General Comment 14 stresses the need to pay special attention to such groups, not only as an immediate obligation *in and of itself*, but also as a cross-cutting factor that characterises and runs through all aspects of government obligations. The principle of non-discrimination applies to all state obligations, which means that immediate measures must be undertaken to eradicate discrimination, even where it is concerned with obligations that do not have to be met fully and immediately.

Hence, although states are required to meet only progressively the obligation to ensure the provision of a sufficient number of hospitals, clinics and other health-related facilities, they must undertake *immediate*

measures to ensure the right of access to existing health facilities on a non-discriminatory basis. They should also prioritize the needs of the poor, vulnerable, or otherwise disadvantaged groups in the course of providing *new* facilities progressively.

The obligation to ensure non-discrimination requires governments to take any special measures that may be needed to ensure equal treatment and to meet the needs of vulnerable groups such as:

<ul style="list-style-type: none"> <li>• children, including specifically: <ul style="list-style-type: none"> <li>• the girl child</li> <li>• children involved in armed conflicts</li> <li>• children involved in child labour</li> <li>• adolescents</li> </ul> </li> <li>• women (with particular emphasis on women living in rural areas)</li> <li>• older persons</li> <li>• ethnic, religious, linguistic and national minorities</li> </ul>	<ul style="list-style-type: none"> <li>• indigenous and tribal populations</li> <li>• migrants and displaced populations</li> <li>• migrant workers</li> <li>• immigrants</li> <li>• persons living with HIV/AIDS</li> <li>• prisoners and detainees</li> <li>• persons with mental and physical disabilities</li> <li>• refugees and internally displaced persons</li> </ul>
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There are various UN human rights instruments that aim to provide the above-mentioned groups with increased protection. Such instruments set internationally accepted standards and norms for state duties and outline the special measures that are needed to comply with the related obligations. NGOs working with any of these groups should consult the relevant instruments for health-related provisions. (See Annex 1 for examples of such human rights instruments.)

CESCR General Comment 14 emphasises that there is no justifiable excuse for not protecting vulnerable members of society from health-related discrimination. Both overt and implicit discrimination violate a fundamental principle of human rights. The obligation to ensure non-discrimination is binding on states even in times of severe resource constraints.

... many measures, such as most strategies and programmes designed to eliminate health-related discrimination, can be pursued with minimum resource implications through the adoption, modification or abrogation of legislation or the dissemination of information. ... even in times of severe resource constraints, the vulnerable members of society must be protected by the adoption of relatively low-cost targeted programmes.

*CESCR General Comment 14, para 18* <sup>6</sup>

Non-discrimination demands the equitable allocation and distribution of resources in the provision of health care and other health services. This is part of the underlying goals of equity and distributive justice that characterise a human rights approach to health.

With respect to the right to health, equality of access to health care and health services has to be emphasized. States have a special obligation to provide those who do not have sufficient means with the necessary health insurance and health care facilities, and to prevent any discrimination on internationally prohibited grounds in the provision of health care and health services.

*CESCR General Comment 14, para 19* <sup>7</sup>

Furthermore states are obliged to regulate, facilitate and ensure that the groups concerned receive health-related services even when the state is not itself the provider of these services. (See chapter 3 on obligations to protect the right to health).

[States must] ensure that not only the public health sector but also private providers of health services and facilities comply with the principle of non-discrimination, particularly in relation to vulnerable groups ... [States are obliged to] ensure that privatization of the health sector does not constitute a threat to the availability, accessibility, acceptability and quality of health facilities, goods and services.

*CESCR General Comment 14, paras 26 & 35* <sup>8</sup>

CESCR General Comment 14 warns that the inappropriate allocation of health resources can result in discrimination. It stipulates that this implicit, though common, form of discrimination is also prohibited.

For example, investments should not disproportionately favour expensive curative health services

which are often accessible only to a small, privileged fraction of the population, rather than primary and preventive health care benefiting a far larger part of the population.

*CESCR General Comment 14, para 19*<sup>9</sup>

## 5.2 How does discrimination against vulnerable groups occur?

Inequity and discrimination often lie at the root of low health status among the poor and otherwise vulnerable and disadvantaged groups. But discrimination is not always straightforward. It can occur in a complex and wide variety of ways. Generally speaking, discrimination results from legislation, policies and practices, which create, maintain or aggravate the disadvantages suffered by a given group in any given society.<sup>10</sup> Discrimination can be *direct* (or overt), as with policies that explicitly privilege some groups at the expense of others. It can also be *indirect*, or implicit, occurring as an unintended result of policies or of their implementation processes.

A budget, for example, might indicate that resources in the health sector are equitably distributed, but discrimination can still occur if the actual expenditures that result are different from those planned *on paper*. Indirect discrimination may also result from neglect, such as when certain groups are given inadequate consideration in targeted policies, programmes, or access to services. Well-intentioned public health programmes may inadvertently discriminate if they are not based on the principle of non-discrimination that is fundamental to a human rights approach.

A common obstacle to rectifying health-related inequities within countries has been the absence of an institutional and political environment that actively supports and promotes a human rights based policy. Even when governments have chosen freely to ratify human rights instruments and have accepted the associated obligations, including the formal enactment of domestic non-discrimination laws, a lack of political will can often result in neglect in putting the policies, programmes and resources in place to ensure that non-discrimination is both implemented and enforced.

A lack of political will by governments is often accompanied by the excuse that making the necessary changes costs too much money. This excuse, however, obscures the fact that a government's *priorities* in its health-related spending are often to blame. Ensuring the equitable distribution of public resources and making appropriate choices about resource allocation is an important means of dealing with systematic discrimination. Even on a limited health budget, low-income countries can design health systems to improve access to services for the poor, vulnerable, or otherwise disadvantaged groups, for example in Sri Lanka and the State of Kerala in India.

In order to ensure non-discrimination, states must recognise and deal with health problems that disproportionately affect certain population groups as well as those, which affect the population as a whole, and especially those who are poor, vulnerable, or otherwise disadvantaged. Vulnerability, as a result of discrimination, is a key factor in determining the health status of individuals and groups throughout the world. In any given country, these groups carry the greatest burden of disease and ill health. In turn, most differences, both in health issues and in the consequences of disease, that affect these groups can be explained by patterns of systematic discrimination. Indeed, if discrimination were to be eradicated in any given country, many potential violations of the right to health would be avoided.

A human rights approach to health is based on the fundamental entitlements of people, and on the recognition that multiple and complex forms of discrimination severely limit the ability of people to enjoy their health-related entitlements. It poses the question: 'what can and should be done programmatically to address these issues?'<sup>11</sup> Authorities are responsible and accountable for prioritising the health needs of the poor, vulnerable, or otherwise disadvantaged groups in multi-sectoral policies and programmes, with the aim of rectifying existing inequities.

A broader implication of the obligation to ensure non-discrimination and equity is that states should address the socio-economic and political conditions that contribute to systematic discrimination. This is characterized throughout the world by a vicious cycle that entails poverty.



‘...ill health is both a cause and a consequence of poverty: sick people are more likely to become poor and the poor are more vulnerable to disease and disability. Good health is central to creating and sustaining the capabilities that poor people need to escape poverty. A key asset of the poor, good health contributes to their greater economic security. Good health is not just an outcome of development: it is a way of achieving development.’

Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health <sup>12</sup>

Moreover, states have an obligation to provide vulnerable groups with opportunities and tools to participate in decision-making on issues that affect their health and well-being. This means enabling such groups to contribute to shaping the special measures needed to address their specific needs.

### ***Discrimination, vulnerable groups and HIV/AIDS***

Evidence has shown that 'respect for human rights in the context of HIV/AIDS, mental illness, and physical disability leads to markedly better prevention and treatment. Respect for the dignity and privacy of individuals can facilitate more sensitive and humane care. Stigmatization and discrimination thwart medical and public health efforts to heal people with disease or disability.'<sup>13</sup>

(For example, it has been demonstrated that) 'discrimination toward HIV-infected people and people with AIDS is counterproductive. Specifically, when people found to be infected were deprived of employment, education, or the ability to marry and travel, participation in prevention programmes diminished.'<sup>14</sup>

The case of HIV/AIDS illustrates the close link between vulnerable groups and discrimination in relation to the right to health. In the course of the epidemic, in countries throughout the world, vulnerability to infection and to receiving inadequate AIDS care is largely felt by population groups who are already marginalized and discriminated against within each society — with women being the most notable group. They now carry the burden of the epidemic worldwide. Other such groups include: adolescents, racial and ethnic minority populations, rural communities, inner-city poor and slum-dwellers, men who have sex with men (MSM), prisoners, intravenous drug users, migrant workers, refugees, and sex workers (especially women in these various communities).

Not only is discrimination prohibited in the context of the right to health, but it has been demonstrated that ensuring the right to health in laws, policies, programmes and practices (including respecting the dignity and privacy of individuals) leads to better prevention and treatment and that, conversely, stigmatising and discriminating against people undermines medical and public health efforts aimed at prevention and treatment by driving the epidemic underground.

Monitoring health-related discrimination against poor, vulnerable, or otherwise disadvantaged groups is thus *essential* for NGOs in both developing and developed countries. Attention has to be paid to the extent to which factors such as gender stereotypes, racism and homophobia are reflected in population groups with excessive morbidity and mortality and what steps are being taken to deal with the problem. It is also necessary to assess how authorities are responding to the special needs of these groups, and the extent to which the policies and practices of public organizations challenge or reinforce inequalities between different groups in society.

Monitoring non-discrimination involves making comparisons between groups and evaluating the differences between those who are vulnerable and mainstream or privileged groups within society. Examples would include assessing public budgeting and government expenditure for different groups, or evaluating risk factors such as exposure to illness, frequency and severity of diseases within the groups concerned. In addition, it involves monitoring the extent to which existing inequalities are recognised and rectified. This usually requires inequalities to be identified, and then documented and analysed. (See chapter 8.)

CESCR General Comment 14 sets out health-related standards that apply to particular groups, namely women, children and adolescents, older persons, persons with disabilities, and indigenous peoples. General Comments and Recommendations adopted by other UN treaty monitoring committees elaborate further on standards for certain vulnerable groups, including women, children and adolescents.<sup>15</sup> These standards help NGOs to monitor how the state is taking the special measures that are required to ensure that there is no discrimination against vulnerable and disadvantaged groups as far as their health is concerned.

## 5.3 Obligations and special measures for ensuring that women are able to enjoy the right to health

### 5.3.1 Integrating a gender perspective

Gender-based discrimination, which is usually against women, is a worldwide cause of ill-health and a widespread cause of violations of the right to health. Patterns of gender discrimination vary widely between countries, societies and cultures, but there is a universal tendency for gender discrimination cumulatively to disadvantage the health status of women and girls. In applying a human rights framework to health-related policies and programmes governments must create the enabling conditions essential for the effective realization of the right to health — and this includes ensuring non-discrimination and an equitable distribution of power, not only between different social groups, but also between women and men.

CESCR General Comment 14 specifically recognizes gender-based discrimination by emphasising the need for both a gender perspective and a comprehensive national strategy for the elimination of discrimination against women. It recommends that states:

... integrate a gender perspective in their health-related policies, planning, programmes and research in order to promote better health for both women and men. A gender-based approach recognizes that biological and socio-cultural factors play a significant role in influencing the health of men and women.

*CESCR General Comment 14, para 20*<sup>16</sup>

The obligation to adopt a gender perspective is meant to eliminate the barriers that systematically limit women's enjoyment of the right to health. To comply with this obligation, states must take into account the adverse effect of societal factors (not just biological differences) that influence women's health, including any unequal power relationship of men over women. Such factors include:

- women's lower socio-economic status resulting, for example, in their higher incidence of disease, as well as a lower quality, or relative lack, of health care services that cater for their needs;
- adverse cultural and religious factors, such as female genital mutilation/cutting (FGM/C), son preference, wife inheritance, and the much higher priority that is given in many societies to feeding boys;
- environmental factors, including unsafe working conditions, to which affect women disproportionately;
- unequal access to education, which is an important determinant of women's health; and
- violence against women.

The adoption of a gender-sensitive approach to health is an *obligation to fulfil* for states. (See chapter 3.) Failure to review laws and policies so as to eliminate barriers to women's access to health services, or to deal with the social and cultural factors that adversely affect women's health and well-being, can be considered *violations* of the right to health. A gender-sensitive approach to health also often requires governments to take affirmative action to redress the barriers that systematically limit women's enjoyment of the right to health.

An essential step in identifying and remedying gender-based inequalities in health is to break down (disaggregate) population statistics in order to reveal health-related discrimination. Collecting disaggregated health and socio-economic data according to sex is crucial for any government in applying a gender perspective and for monitoring its own compliance with the right to health.

### 5.3.2 Women and the right to health

Obligations concerning non-discrimination are fundamental to safeguarding women's right to health. Health problems associated with poverty and inequity are the main obstacles to most of the world's population attaining minimal levels of well-being, and 70 percent of the poorest people in the world are women. Women

comprise the largest vulnerable group in the population and they suffer multiple and compounding forms of health-related discrimination throughout the course of their lives, especially disabled women, women from ethnic or linguistic minorities, indigenous women, and women living in rural communities.

In addition to the social disadvantages associated with adverse gender roles and relationships, there are also significant biological factors that contribute to the different and disproportionate effects of disease on women. Women's health differs from men's in a number of ways, the most obvious being that the female reproductive system can result in diseases or conditions that affect only women. There are also other conditions that affect women either uniquely or differently from men (including STIs, diabetes, hypertension, and diseases resulting from malnutrition), as well as conditions that are more prevalent or have different risk factors in women (such as breast cancer, depressive disorders, and anaemia).

Ensuring non-discrimination and equal treatment for women therefore means that governments must take account of, and provide for, women's unique experience of disease. Not only must they be provided with the same health services as men, but where their health needs differ from men they must be given access to comparable services to meet those needs, including preventive, diagnostic, treatment and follow-up services, as well as access to appropriate, accurate and reliable health-related information and education.

*The Convention on the Elimination of All Forms of Discrimination against Women defines discrimination against women as: any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms.*

*Women's Convention, art 1*<sup>17</sup>

Measures to eliminate discrimination against women are considered to be inappropriate if a health-care system lacks services to prevent, detect and treat illnesses specific to women. It is discriminatory for a State party to refuse to provide legally for the performance of certain reproductive health services for women. For instance, if health service providers refuse to perform such services based on conscientious objection, measures should be introduced to ensure that women are referred to alternative health providers.

*CEDAW, General Recommendation 24, para 11*<sup>18</sup>

CESCR General Comment 14 sets standards for special legal and other measures that states must take in order to eliminate discrimination against women. The following questions refer to these special measures and can be used by NGOs in monitoring. NGOs should assess to what extent is the government taking measures to<sup>19</sup>:

- develop and implement a comprehensive national strategy for promoting women's right to health throughout their life span? (Such a strategy should include interventions aimed at the prevention and treatment of diseases affecting women, as well as policies to provide access to a full range of high quality and affordable health care services, including those for sexual and reproductive health. A major goal should be to reduce risks to women's health, in particular by lowering rates of maternal mortality and protecting women from domestic violence).
- remove all barriers that interfere with women's access to health services, education and information, including those involving sexual and reproductive health.
- undertake preventive, promotional and remedial action to shield women from the impact of all harmful traditional cultural practices and norms that deny them their full reproductive rights.

### 5.3.3 Discrimination and gender-based violence

Discrimination manifests itself in a variety of ways that can directly or indirectly affect health. A human rights approach to health recognises that gender-based violence, or 'violence that is directed against a woman because she is a woman or that affects women disproportionately'<sup>20</sup>, is a public health issue and, more specifically, a form of discrimination against women.

[Violence against women is recognised as] a manifestation of historically unequal power relations between men and women, which have led to domination over and discrimination against women by men and to the prevention of the full advancement of women, and that violence against women is one of the crucial social mechanisms by which women are forced into a subordinate position compared with men ... some groups of women, migrant women, women living in rural or remote communities, destitute women, women in institutions or detention, female children, women with disabilities, elderly women and women in situations of armed conflict, are especially vulnerable to violence.

*UN Declaration on the Elimination of Violence Against Women, preamble*<sup>21</sup>

Gender-based violence is not only a serious form of discrimination but also a widespread cause of ill-health among women and a violation of women's right to health. Governments have an obligation to protect women against violence by third parties, including domestic violence and abuse, sexual assault, and sexual harassment in the workplace.

CESCR General Comment 14 stipulates that a state's failure to protect women against violence by failing to investigate and prosecute those who attack them, including men who commit domestic violence, is a violation of its obligation to protect the right to health. (See section 3.5.) However, although governments are obliged to regulate conduct in the private sector so as to protect the right to health, violence against women continues to be tolerated, disregarded and remains unpunished throughout the world. Despite the existence of laws prohibiting violence, including battery or rape, these laws are generally not enforced. The issue of violence against women is generally not regarded by law enforcement and other public authorities as a matter of priority and certainly not as a matter of human rights.

A human rights framework provides NGOs monitoring and promoting women's health with a powerful tool for advocacy. By treating violence against women as an abuse of fundamental human rights, of universal entitlements, and of state accountability, NGOs are placed in a strong position to demand changes in laws, policies, and their enforcement by invoking legally binding state obligations and internationally accepted standards for state conduct.

As with other vulnerable groups, international standards stipulate that states are obliged to take special legal and other measures (preventive, punitive, and remedial) to protect women from gender-based violence. These measures, examples of which are set out below, illustrate the complex linkages that exist between gender-based discrimination and a range of state obligations that ensure equality and that protect and fulfil women's right to health. They also provide important standards for NGOs monitoring discrimination against women.

The following points in Section 5.3 refer to the special measures that governments are required to take in order to comply fully with the above obligations.<sup>22</sup> They relate both to protection-bound and fulfilment-bound obligations.

NGOs should ascertain to what extent the government is taking measures to:

- protect the poor and vulnerable or otherwise disadvantaged groups in the community, in particular women, children, adolescents and older persons, against gender-based expressions of violence;
- offer adequate protective measures to ensure the security and physical and mental health of women who are victims of violence or at risk of violence, including counselling, rehabilitation and support services;
- ensure that services for victims of violence are accessible to rural women and that, where necessary, special services are provided to those living in isolated communities;
- ensure the enactment and effective enforcement of laws, and the formulation of policies, including health care protocols and hospital procedures, to address violence against women and the sexual abuse of the girl child and to provide the victims with appropriate health services;
- ensure fair and protective procedures for hearing complaints, and impose appropriate sanctions, in cases where health care professionals are accused and found guilty of sexual abuse of women patients; and
- ensure that health workers, judicial and law enforcement officers, and other relevant public officials have received the appropriate training (including gender-sensitive training) for them to detect and manage the health consequences of gender-based violence.

## **5.4 Special measures to ensure non-discrimination for other vulnerable groups**

CESCR General Comment 14 elaborates, and provides international standards for, special measures that states are required to take in order to enable certain vulnerable groups to enjoy the right to health effectively. Documents issued by other UN treaty monitoring committees expand upon some of these standards. For example, the CRC has issued General Comments that provide detailed interpretation of certain aspects of the right to health.<sup>23</sup>

In complying with their immediate obligation to ensure non-discrimination, governments must take adequate steps to ensure equitable treatment for such groups and to rectify existing imbalances. The following questions are based primarily on CESCR General Comment 14 and refer to examples of the special measures

that governments are required to take in order to comply fully with their obligations to children, adolescents, older persons, disabled persons, and indigenous peoples.

## Children and adolescents

The *best interests of the child* must be the guiding principle for all laws, policies and programmes aimed at ensuring that children can enjoy the right to health. This principle comes from the CRC, along with the stipulation that 'children' are defined as those under 18 years of age. NGOs need to ascertain to what extent the government is taking measures to:

- reduce infant and child mortality;
- promote the healthy development of infants and children;
- ensure access to essential health services for the child and his/her family, including pre- and post-natal care for mothers, and, in particular, the provision of primary health care;
- ensure access to information about preventive and health-promoting behaviour, including child nutrition, breast-feeding, hygiene, environmental sanitation, and accident prevention, as well as the provision of support for families and communities to adopt these practices;
- ensure that girls, as well as boys, have equal access to adequate nutrition, safe environments and physical as well as mental health services;
- abolish harmful traditional practices affecting the health of children, particularly of girls, including early marriage, FGM/C and preferential feeding for boys; and
- ensure that children with disabilities are given the opportunity to enjoy a fulfilling and dignified life and to participate within their communities.

## Adolescents

In the case of adolescents NGOs should ascertain to what extent the government is taking special measures to provide them with a safe and supportive environment and the opportunity to:

- participate in decisions affecting their health;
- develop life-skills;
- acquire the appropriate information that they need about health;
- receive counselling; and
- negotiate the choices they make about adopting behaviour affecting their health.

In the case of adolescent health care, NGOs should assess to what extent the government is taking measures to provide youth-friendly health services, which include sexual and reproductive health and guarantee confidentiality and privacy.

The CRC General Comment 4 on adolescent health and development identifies detailed standards for special legal and other measures necessary to ensure that adolescents are able to enjoy the right to health. It specifies that governments are responsible for ensuring an environment fostering adolescent development and protection from neglect, abuse and exploitation.<sup>24</sup> This includes ensuring access to adequate and age-appropriate information as well as the promotion of healthy behaviours.

The document also identifies groups in need of special protection or support. These include adolescents: with disabilities; living with HIV/AIDS; living in poverty; in early marriage; and exposed to trafficking and/or sexual exploitation.

## Health care for older persons

NGOs should ascertain to what extent the government is taking measures to ensure:

- an integrated approach to the health care of older persons that combines preventive, curative and rehabilitative elements;
- regular medical check-ups for persons of both sexes;
- physical and psychological rehabilitation to maintain their function and autonomy; and
- attention and palliative care, including pain relief and death with dignity.



## Health care for persons with disabilities

NGOs should ascertain to what extent the government is taking measures to ensure that persons with disabilities:

- receive as adequate a standard of physical and mental health care as is provided for the population as a whole;
- can benefit from those medical and social services (including orthopaedic devices) that will help them to remain independent; prevent them from becoming more dependent; avoid further disablement and support their social integration;
- have access to rehabilitation services that can help them to achieve the maximum possible degree of independence and functioning while, at the same time, preserving their rights and dignity; and
- are given the same protection from discrimination by providers of health care services in the private sector as they do in the public sector.

## Health care for indigenous peoples

NGOs should ascertain to what extent the government is taking measures to ensure that indigenous peoples:

- receive culturally appropriate health services that take into account traditional methods of prevention, healing practices and medical care;
- are involved in the design, delivery and control of such services;
- are given protection for their vital medicinal plants, animals and minerals; and
- are protected from displacement against their will from their traditional territories and environment and from the damage that this can cause to their health by denying them their traditional sources of nutrition and by destroying the unique relationship they enjoy with their land.

## Notes

- 1 CESCR General Comment 14, The right to the highest attainable standard of health. E/C.12/2000/4: para 18.
- 2 Mann J. The Hastings Center Report. 1997 May-June;27(3):9. Other examples in the following are similarly based on the work of Jonathan Mann.
- 3 Based on input by Virginia Leary.
- 4 Gruskin S, Tarantola D. Health and human rights. In: Detels R, Beaglehole R, McEwen J, Tanaka H, editors. Oxford textbook of public health. Fourth edition. Oxford: Oxford University Press; 2004.
- 5 Based on input by Virginia Leary.
- 6 CESCR. Ibid:para 18.
- 7 Ibid:para 19.
- 8 Ibid:paras 26 and 35.
- 9 Ibid:para 19.
- 10 Based on input by Virginia Leary.
- 11 Jacobson J. Transforming Family Planning Programmes. Reproductive Health Matters. 2000;8(15).
- 12 Hunt P. Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. E/CN.4/2003/58: paras 43 and 44.
- 13 Mann J, Gruskin S, Grodin M, Annas G. editors. Health and human rights: a reader. New York: Routledge; 1999:445.
- 14 Ibid.
- 15 Including CEDAW General Recommendation 19, Violence against women. A/47/38; CEDAW General Recommendation 24, Women and health. 02/02/99; CRC General Comment 3, HIV/AIDS and the rights of the child. CRC/GC/2003/1; and CRC General Comment 4, Adolescent health and development in the context of the Convention on the Rights of the Child. CRC/GC/2003/4.
- 16 CESCR. Ibid:para 20.
- 17 Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). A/RES/34/180: art 1.

- 18 CEDAW General Recommendation 24. Ibid:para 11.
- 19 CESC. Ibid:para 21.
- 20 UN Declaration on the Elimination of Violence Against Women. A/RES/48/104: preamble.
- 21 Ibid.
- 22 Based on CESC. Ibid.; CEDAW General Recommendation 19. Ibid.; CEDAW General Recommendation 24. Ibid.; CRC General Comment 3. Ibid.; and CRC General Comment 4. Ibid.
- 23 CRC General Comment 3. Ibid.; and CRC General Comment 4. Ibid. See moreover: CEDAW General Recommendation 19. Ibid.; CEDAW General Recommendation 24. Ibid.
- 24 CRC General Comment 4. Ibid.

## Part II *Moving towards action: Focussing on obligations arising from the right to health*

### Chapter 6 Globalization, obligations of non-state actors, and international obligations arising from the right to health

#### *Keys to Chapter 6*

##### *key information:*

- Although governments have a primary legal obligation to respect, protect, and fulfil the right to health, other actors including NGOs, international financial institutions (IFIs), and the private sector and are also expected to comply with the right to health as far as their own activities are concerned.
- Internationally accepted norms and principles contained in CESCR General Comment 14 provide guidance for the private sector and civil society on what is required in order to conform with the right to health.
- They also provide NGOs monitoring the right to health with standards against which the policies and activities of international corporate institutions (such as multinational corporations) and IFIs, such as the World Bank and International Monetary Fund (IMF), can be evaluated.

##### *key questions:*

- To what extent are international trade agreements and policies of IFIs consistent with internationally-agreed standards and norms of the right to health? What evidence might serve to illustrate the shortcomings and adverse effects of existing agreements and policies on enjoyment of the right to health?
- To what extent does health-related development assistance (provided by or received by your government) enhance enjoyment of the right to health and conform to its standards and norms? Is such assistance tied to the fulfilment of core obligations as a matter of priority?
- Is the government adequately regulating private sector actors, including multinational corporations and companies responsible for health-related services that have been privatized, to ensure that their activities do not violate enjoyment of the right to health?

#### 6.1 Some notes on globalization and the right to health

“Globalization, which is a consequence of increased mobility, enhanced communications, greatly increased trade and capital flows, and technological developments, opens new opportunities for sustained economic growth and development of the world economy, particularly in developing countries. Globalization also permits countries to share experiences and to learn from one another’s achievements and difficulties, and promotes a cross-fertilization of ideals, cultural values and aspirations. At the same time, the rapid processes of change and adjustment have been accompanied by intensified poverty, unemployment and social disintegration.”

*Copenhagen Declaration and Programme of Action, para 14,  
adopted at World Summit for Social Development, Copenhagen 1995<sup>1</sup>*

When human rights treaties such as the International Covenant on Economic, Social and Cultural Rights (ICESCR) were first drafted, public health was recognized as primarily the responsibility of governments. States parties are, in other words, the primary duty holders of human rights obligations. (See chapter 1.) However, one of the consequences of economic globalization has been that the role and power of the state has changed dramatically. In the era of globalization, governmental functions in many countries have shifted to include an increased reliance on non-state actors (profit and non-profit) for the management and delivery of health systems. Moreover, health-related policy decisions in many developing countries have been increasingly subject to the influence of international trade regimes, loans and development assistance.

In relation to human rights, the phenomenon of globalization has been characterised by both positive and negative effects. The present chapter focuses on one particular aspect of this broad and complex picture, namely how the diminished power and influence of the state is significant for NGOs engaged in practical work to promote and protect the right to health. It begins with a general and non-exhaustive overview of some of the more *problematic effects of globalization on the realization of the right to health*, many of which pose the greatest burden on developing countries. The chapter goes on to present discussions of obligations of *non-state actors* as well as the nature of *international obligations* arising from the right, both of which are of particular significance to NGO advocacy.

### 6.1.1 Problematic impacts of globalization on the realization of the right to health

It is often argued that privatization and the rapidly increasing activities of multinational corporations, as well as the growing influence of the Bretton Woods Institutions (the International Monetary Fund (IMF) and World Bank) and other aid agencies on health policies and service delivery, have resulted in the under-funding of public services and a marked diminution in the role of the state.<sup>2</sup> As a consequence there has been a significant reduction in the health status of the poor and other vulnerable and disadvantaged groups in some developing countries.

One of the results of globalization has been increasing delegation by states of their responsibilities in health matters to non-governmental agencies including private health care providers, health insurance companies, health management organizations, biomedical research institutions, and the pharmaceutical industry. States have privatised many of their traditional functions, such as the provision of health care and safe water<sup>3</sup>, which has often resulted in the imposition of user fees. These developments have led to reductions in attendances at, for example, family planning clinics which were previously free of charge. The health of the poor and other vulnerable groups has suffered most from these changes. Meanwhile increasing numbers of health professionals have migrated into private practice, with adverse consequences for the health of vulnerable populations, particularly of women, children and adolescents, in developing countries.

#### Influence of transnational corporations and international trade rules and policies

Globalization has also resulted in the enormous growth and influence of transnational corporations (TNCs), many of which have larger incomes than those of some of the smaller developing countries. This shift, together with the development of international trade agreements (including Trade-Related Aspects of International Property Rights (TRIPS) and General Agreement on Trade in Services (GATS)), has still further eroded the power of the governments in the countries concerned and has compromised their ability to provide public health services. Not only do drug patents held by multinational pharmaceutical companies often restrict governments in low-income countries from distributing affordable generic drugs, but the activities of some TNCs have undermined the practical realization of the right to health.

Negative impacts of globalization on the right to health, expressed at the International Conference on Financing for Development (the Monterrey Conference)<sup>4</sup>:

- while overseas development assistance (ODA) 'filled in some financing gaps for the poorest countries, nothing could compensate for international trade and investment regimes that worked against them'; and
- 'deep concern expressed over an international trade regime that allows developed countries to selectively protect certain sectors while not allowing developing countries to do the same'.

*Monterrey: Building Momentum for Financing Development, NGLS Roundup 91.*<sup>5</sup>

These issues, however, must be seen in a wider context. Medical research and the processes of discovery, development, testing and licensing of new drugs by biomedical research institutions and pharmaceutical companies have become extremely expensive. The requirement, imposed by the global market in which the pharmaceutical companies operate, to recover costs, to make a profit during patent lifetime and to invest in new research has meant that the so-called 'unprofitable developing world' diseases, such as malaria and several other mainly tropical diseases, have been relatively neglected.<sup>6</sup> For diseases which have long been treatable and for which there are effective remedies off-patent, governments have been able to meet many of their 'essential medicines' needs through the availability of generic products at competitive prices. However, there have been recent moves under the World Trade Organization (WTO) to extend patent lifetimes, and

recent years have also witnessed the increasing emergence of new or more resistant diseases requiring new drugs. The expense of these new, patented products has made it much more difficult for governments in developing countries to provide adequate supplies of essential medicines in accordance with their human rights obligations.

It is important to note that such challenges have not gone unnoticed. The negative impact of international trade rules and policies on key elements of the right to health, such as access to essential medicines in developing countries and in the context of pandemics like HIV/AIDS, is the subject of much international attention, debate, and NGO advocacy. The result has been the clarification of how and when exceptions can be made to certain trade rules in favour of human rights protection. While TRIPS, for example, generally protects international patents in favour of TNCs, it also contains provisions for the bypassing of patent restrictions in situations of public emergency. This aspect of TRIPS became a central point of focus in the highly publicized case between 39 multinational pharmaceutical companies and the Republic of South Africa. (See chapter 10, case study 10.4.1.)

A significant step was taken with the formal clarification that *public health emergencies* could be invoked to bypass certain patent restrictions under TRIPS with the adoption in 2001 of the Declaration on the TRIPS Agreement and Public Health at the Fourth Ministerial Conference in Doha (the *Doha Declaration*, see section 6.3.)<sup>7</sup> The Doha Declaration recognizes that patents can impede access to affordable medicines and affirms that governments are free to take all necessary measures to protect public health in medical emergencies.

Another important initiative regarding international trade rules and access to medicines in developing countries is the WTO agreement on TRIPS and health of 30 August 2003 that allows WTO member countries that produce generic copies of patented drugs to export the drugs to countries with little or no drug manufacturing capacity.<sup>8</sup> The potential impact of this agreement is illustrated by the Canadian government's passing of legislation in May 2004 to amend the Patent Act and the Food and Drugs Act in a way which makes it possible for Canadian generic pharmaceutical producers to obtain licenses to supply lower cost copies of patented medicines to developing countries.<sup>9</sup> The adoption of principles such as the Doha Declaration and the WTO agreement that interpret international trade law in light of public health priorities marks one of the most important accomplishments in recent years of NGOs engaging in advocacy for the right to health.

### **Influence of international financial institutions (IFIs)**

A critical problem for developing countries is that economic policies imposed by IFIs leave many of their governments little scope for exercising free choice in allocating resources, with resulting under-funding of their public health services.<sup>10</sup> The conditions attached to structural adjustment programmes and other health sector reforms imposed by the IMF and World Bank are known to have reduced significantly the extent to which the right to health can be enjoyed in many developing countries, especially by the poor and other vulnerable and disadvantaged groups, particularly through the forced imposition of user fees for accessing health care services. For example, a joint consensus statement by the Indigenous Caucus on the activities of the UN system relating to indigenous people states that: 'We know that the structural adjustment policies of the World Bank and the IMF did not only push for cutting back the government budgets for health ... but also pushed for further liberalization, deregulation and privatization of basic social services. We also know that many of the WTO Agreements like TRIPS, the Agreement on Agriculture and GATS, among others, have brought more negative than positive impacts to indigenous peoples'.<sup>11</sup>

### **Need for global responses to global health challenges**

A different facet of challenges related to globalization and the diminished power and influence of the state concerns the increased importance for international cooperation in addressing contemporary health issues. In a globalized world, many health problems 'cross borders'. For example, issues related to HIV/AIDS, the environment, the drug trade and most recently SARS call for measures that go beyond traditional forms of state control. They call for global action that requires international cooperation in designing and implementing appropriate responses.

In general terms, it can be argued that a shift has taken place. The phenomenon of globalization has greatly increased the influence of powerful non-governmental bodies and corporations around the world; diminished the influence of governments; and has created an unprecedented interdependence between states and the non-governmental sector. Globalization has also led to widening inequality of income among and within countries, and it is the poor, vulnerable and marginalized groups of the world that have suffered most as a result. The negative impacts of globalization on the right to health is particularly noticeable in developing countries, many of which have seen their economic situation worsen and their public services deteriorate. In this sense, globalization can be seen to illustrate how intimately economic policies, socioeconomic inequities, and health outcomes are linked.

## Role of NGO advocacy in face of the challenges posed by globalization

While the macro-economic forces of globalization have had an undeniably negative impact on enjoyment of the right to health in many developing countries, it is important also to make note of the *opportunities* afforded to human rights monitoring and advocacy by other aspects of globalization. Most significantly, advances in technology, such as email and the internet, have allowed for greater participation and organization of civil society within countries and across borders. By taking advantage of the opportunities presented by communications technology, NGOs have formed national, regional and international networks and have mobilized public opinion and activism on human rights issues to an unprecedented degree. For example, the speed with which information can be exchanged electronically allows for the 'open' scrutiny of many states' conduct; the organization of international pressure for holding powerful actors accountable (including states, IFIs, and the private sector); and the mounting of global advocacy campaigns to promote and protect human rights.

## 6.2 Obligations of non-state actors

One of the main challenges that NGOs have to face as a result of globalization is the lack of accountability for the right to health. While governmental roles and responsibilities are being delegated increasingly to the private and non-governmental sector, very little has been heard about the practical ways in which actors other than States parties can, or should, be held accountable for realization of the right to health.

Although the legally binding obligations arising from the right to health fall upon each State party, which in effect includes all those in its direct employment within the public sector, the responsibility to advance the right to health also applies outside the public sector. Within a human rights framework, the private sector and non-governmental bodies are expected to carry out their activities with full regard for the fundamental health rights of individuals and groups. Although not in a direct sense legally bound by the relevant obligations, they are expected to comply with the accepted health and human rights standards and norms by giving due attention to protecting, promoting, and realizing the right to health, both in the work that they carry out (for example, advocacy or service delivery) and in the conduct of their internal processes and administration.<sup>13</sup>

In other words, rights and responsibilities go hand in hand. The full realization of human rights, including the right to health, depends on all members of society recognising that they have a responsibility to respect them.

*"... decision-makers in governments, international financial institutions and even multinational corporations must come to view health and health care as non-negotiable entitlements, not as matters of governmental largesse or productivity."*

*A. Yamin, Harvard School of Public Health<sup>14</sup>*

With regard to obligations of actors other than States parties, CESCR General Comment 14 stipulates that:

*While only States are parties to the Covenant and thus ultimately accountable for compliance with it, all members of society — individuals, including health professionals, families, local communities, intergovernmental and non-governmental organizations, civil society organizations, as well as the private business sector — have responsibilities regarding the realization of the right to health.*

*States parties should therefore provide an environment which facilitates the discharge of these responsibilities.*

*CESCR General Comment 14, para 42<sup>15</sup>*

Moreover, CESCR General Comment 14 emphasizes the importance of international cooperation and coordinated efforts between and among States parties, intergovernmental and non-governmental actors, including the various components of civil society, in realizing the right to health. These include UN bodies and specialized agencies such as WHO and UNICEF as well as IFIs.

*Since approved by the Executive Boards of the World Bank and IMF in 1999, Poverty Reduction Strategy Papers (PRSPs) have become important policy instruments that affect both development assistance and national development policy. A survey was conducted for the United Nations Population Fund on the extent of coverage of seven thematic population and development issues, including human rights, by PRSPs carried out in 44 developing countries up to the end of 2001.<sup>12</sup> The survey revealed that human rights issues linked explicitly to international treaties were the least well covered of the themes in PRSPs in all 44 countries surveyed, and that most countries did not mention human rights at all. This survey highlights the need for NGOs in developing countries to press their governments to adopt a human rights based approach to health, including reproductive health, in their national development policy. It also highlights the need for NGOs in donor countries to advocate that greater attention in donor funding be paid to prioritizing the fulfilment of immediate and core obligations arising from the right to health. (See chapter 2.)*

In particular, the international financial institutions, notably the World Bank and IMF, should pay greater attention to the protection of the right to health in their lending policies, credit agreements, and structural adjustment programmes.

*CESCR General Comment 14, para 64<sup>16</sup>*

Thus the right to health must always be given the fullest attention whenever bilateral or multilateral agreements are made between states and international organizations (including multinational corporations). Care must be taken to ensure that such agreements do not have any adverse affect on the right to health nor inhibit the states involved from complying with their obligations, for example by imposing conditions that undermine a state's ability to fulfil its legally binding commitments and in particular its core obligations.

### **6.3 International obligations arising from the right to health<sup>17</sup>**

#### **How can NGOs invoke a human rights framework to health when confronting the challenging aspects and effects of globalization?**

One approach is to understand and invoke relevant international obligations that arise from the right to health. In many cases, the precise content and legal nature of international obligations arising from human rights have not yet been given as much attention or clarification as domestic obligations placed on States parties and thus remain ambiguous. This is however an area of international law which is rapidly evolving, as it serves to address many pressing contemporary issues related to the practical realization of human rights. It is thus useful for NGOs to review the international obligations upon which they can rely in their health and human rights advocacy.

Several aspects of the international obligations arising from the right to health, including the promotion of international assistance and cooperation, have been sufficiently clarified to be invoked by NGOs working to promote and protect the right. Using such obligations as a reference point for advocacy can offer NGOs a powerful means of addressing problems related to the influence of international trade regimes, loans and development assistance on health-related policy decisions in many developing countries.

The issue of international obligations arising from human rights dates back to the UDHR, which includes provisions on international cooperation as an entitlement:

Everyone ... is entitled to realization, through national effort and international co-operation and in accordance with the organization and resources of each State, of the economic, social and cultural rights indispensable for his dignity ...

Everyone is entitled to a social and international order in which the rights and freedoms set forth in this Declaration can be fully realized.

*UDHR, excerpts from articles 22 & 28<sup>18</sup>*

The ICESCR recognises international assistance and cooperation as an obligation arising from economic, social and cultural rights:

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 right recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.

*ICESCR, art 2(1)<sup>19</sup>*

Other international human rights treaties, such as the Convention on the Rights of the Child (CRC)<sup>20</sup>, contain provisions on international obligations. Moreover, a number of documents, including UN world conference outcome documents, address the issue of human rights and international assistance and cooperation and include concrete commitments to international assistance.<sup>21</sup>

CESCR General Comment 14 provides interpretation of various dimensions of international obligations arising from the right to health. For example, it stresses that States parties should recognise the essential role of international co-operation and continue to comply with their commitments by taking part in joint and separate activities aimed at achieving full realization of the right to health,<sup>22</sup> including through international assistance and cooperation.

NGOs wishing to invoke international obligations in their advocacy should draw upon the following key issues which have been clarified in CESCR General Comment 14:

- international dimensions of obligations to respect, protect and fulfil the right to health;
- the importance of prioritising core obligations in the provision of international assistance and cooperation;
- obligations related to international medical and financial aid, humanitarian assistance, and embargoes

Key provisions related to these issues are presented below.

The CESCR General Comment 14 provides an interpretation of how States parties are not only legally bound by international human rights law *to respect, protect and fulfil the right to health* by complying with domestic obligations (see chapter 3), but also by complying with international obligations. These obligations relate, for example, to the role of States parties as members of international organizations, including IFIs, and to the role of State parties as providers of international aid.

### ***International dimensions of the obligations to respect, protect and fulfil the right to health***

- *international dimensions of the obligation to respect the right to health*

States parties have to respect the enjoyment of the right to health in other countries.

- *international dimensions of the obligation to protect the right to health*

States parties have to ... prevent third parties from violating the right in other countries, if they are able to influence these third parties by way of legal or political means, in accordance with the Charter of the United Nations and applicable international law. ... States parties have an obligation to ensure that their actions as members of international organizations take due account of the right to health. Accordingly, States parties which are members of international financial institutions, notably the International Monetary Fund, the World Bank, and regional development banks, should pay greater attention to the protection of the right to health in influencing the lending policies, credit arrangements and international measures of these institutions.

- *international dimensions of the obligation to fulfil the right to health*

Depending on the availability of resources, States should facilitate access to essential health facilities, goods and services in other countries, wherever possible and provide the necessary aid when required.

*CESCR General Comment 14, para 39<sup>23</sup>*

Along with CESCR General Comment 14, the Doha Declaration provides NGOs with a strong advocacy tool to promote the interpretation and implementation of international trade agreements in light of public health protection and the right to health. Doha Declaration recognizes:

... the gravity of the public health problems afflicting many developing and least-developed countries, especially those resulting from HIV/AIDS, tuberculosis, malaria and other epidemics.

*Doha Declaration, paras 1& 4<sup>24</sup>*

Furthermore, it states that TRIPS can and should be interpreted and implemented in a manner supportive of WTO members' right to protect public health and, in particular, to promote access to medicines for all.

### **Giving priority to core obligations**

In relation to the provision of international assistance and cooperation, CESCR General Comment 14 explicitly states that the fulfilment of core obligations must be prioritised.

... it is particularly incumbent on State parties and other actors in a position to assist, to provide 'international assistance and cooperation, especially economic and technical' which enable developing countries to fulfil their core [obligations].

*CESCR General Comment 14, para 45<sup>25</sup>*

### **International medical and financial aid, humanitarian assistance, and embargoes**

CESCR General Comment 14 highlights the importance of international cooperation in relation to international obligations that concern medical and financial aid, and humanitarian assistance. With regard to medical and financial aid and financial assistance it stipulates that:



States parties have a joint and individual responsibility ... to cooperate in providing disaster relief and humanitarian assistance in times of emergency, including assistance to refugees and internally displaced persons. ... Priority in the provision of international medical aid, distribution and management of resources, such as safe and potable water, food and medical supplies, and financial aid should be given to the most vulnerable or marginalized groups of the population.

*CESCR General Comment 14, para 40<sup>26</sup>*

#### **With regard to embargoes, it stipulates that:**

States parties should refrain at all times from imposing embargoes or similar measures restricting the supply of another State with adequate medicines and medical equipment. Restrictions on such goods should never be used as an instrument of political and economic pressure.

*CESCR General Comment 14, para 41<sup>27</sup>*

## **6.4 NGO advocacy related to non-state actors and international obligations**

According to CESCR General Comment 14, the whole of society has responsibilities arising out of the right to health. While not all those responsibilities may be legally enforceable in a particular country, NGOs can invoke obligations arising from the right to health as part of their advocacy against international policies such as structural adjustment programmes (SAPs) and other health sector reforms, international trade agreements, and embargoes,<sup>28</sup> whenever they can be shown to have adverse effects on health, including by limiting states' ability to comply with their core obligations arising from the right to health. A good example is the need to advocate for adequate relief for developing countries from servicing the huge debt load that many of them have been allowed to accumulate, and which is crippling their capacity to raise the health status of their populations to acceptable levels.

### ***Case study 6.1***

Since the broader economic and social context deeply affects the possibility of realizing human rights, it is natural for health professional associations and NGOs working with the right to health to campaign for government commitments in areas such as development assistance, international trade, and international debt relief.

The *British Medical Association* (BMA) has a long history of involvement in international health issues. Many of the Association's members have first-hand experience of working in countries where poverty devastates health care and have seen the suffering of the poorest and most vulnerable in these countries. The BMA has close links with medical associations in developing countries through the *World Medical Association* (WMA) and the *Commonwealth Medical Trust* (Commat). These interests regularly find expression in BMA resolutions, as the following excerpts illustrate:

"That the BMA should actively seek to end global inequalities in health by campaigning for an increase in the proportion of the GDP spent on overseas aid, and by seeking assurances that aid will be spent on projects which will benefit the recipient rather than the donor."<sup>29</sup>

"That this Conference notes that many of the poorest countries in the world face a complete inability to care adequately for the health of their populations; and that the repayment of foreign debt exceeds spending on health and education in several of these; and therefore calls on Council to ask the British Government to work with other members of the Group of Eight industrial nations to cancel the unpayable debt of the poorest countries by the year 2000; and to support calls by the UN for more investment in health care by governments and aid donors."<sup>30</sup>

"That this Meeting wants the UK government to take a lead and influence other governments, in order to ease the burden of Third World countries' loans and aid at least the Commonwealth countries to develop better health care."<sup>31</sup>

*For further information see [www.bma.org](http://www.bma.org)*

Many NGOs have already taken up advocacy efforts that promote the adoption of human rights principles as a framework for policy-making by, and monitoring of, IFIs and the private sector. The Doha Declaration can be seen as one result of such pressure being exerted by NGOs. Regarding the private sector, invoking the right to health can be an effective way for NGOs to advocate that more attention be given by multinational corporations to removing hazards to health arising from their activities, particularly in developing countries, where legal restrictions on their activities may be few and enforcement may be lax. By working with the media to expose abuses of the right to health, NGOs can appeal to the powerful court of public opinion and to key corporate stakeholders (including board members and shareholders) as a way to pressure corporations to acknowledge and change inappropriate policies and practices related, for example, to employee health and safety, the use of child labour, and environmental hazards related to corporate activities. Such media campaigns can be coupled effectively with public mobilization campaigns, including letter writing, petitions, and public demonstrations.

Despite the relative absence of legal enforcement mechanisms, there are some encouraging recent examples of NGOs using domestic legal systems to address private sector policies which have a detrimental effect on the enjoyment of the right to health. For example, in 2002 the Treatment Action Campaign (TAC) and other NGOs filed a complaint with the Competition Commission in South Africa against two multinational pharmaceutical companies, GlaxoSmithKline (GSK) and Boehringer Ingelheim (BI). The complaint concerned the companies' pricing of its antiretroviral drugs for the treatment of HIV and their practices related to patents for such drugs. In 2003, the Competition Commission found GSK and BI in breach of the South African Competition Act for excessive pricing of its antiretrovirals and for abusing their patents with the effect of restricting access to these life-extending medicines.<sup>32</sup> Other pharmaceutical companies have adopted policies conducive to the right to health. On the same day as the above mentioned finding by the South African Competition Commission, GSK in fact reduced the not-for-profit price of an important HIV / AIDS treatment regimen, Combivir.<sup>33</sup>

The trend among many multinational companies to put in place voluntary codes of conduct can also be seen as a response to mounting NGO and public pressure. There are, however, sceptics who point to the fact that voluntary codes of conduct are self-regulatory and can end up serving public relations more than influencing substantial change. A problem with multinational corporations is that, while they have plenty of rights under international law (for example, investment treaties ensuring investment protection, allowing them to hold a state accountable for violating an investment treaty), they have almost no legally binding duties under international law (except regarding bribery and corruption). As of yet, there are no treaties or conventions that impose duties on companies, so there are limited legal mechanisms to hold companies accountable. Nonetheless, some multinational corporations have included human rights standards in their codes of conduct and/or 'social responsibility' policies and there are examples of broad-based initiatives to place human rights higher on the business agenda, such as the UN Global Compact. There are also encouraging developments both at the national and international level that stem from cooperation between NGOs and corporate actors. One long-term advocacy goal for NGOs could be to promote the concept that compliance with the codes of conduct of private enterprises should be supervised by independent bodies.

### *Case study 6.2*

*Médecins Sans Frontières (MSF) began an international campaign to increase access to essential medicines in 1999. The Campaign for Access to Essential Medicines arose from a growing recognition that the basic ability to deliver medical assistance in developing countries was being frustrated by the global rules surrounding pharmaceutical drug production. On the one hand, the patent system was making drugs unaffordable for many people throughout the developing world; on the other hand, it was doing little, if anything to promote the research and development of drugs for diseases that only affect the poor. The campaign is firmly rooted in and guided by the experience of MSF medical professionals working throughout the developing world. It is the injustices seen at the local level among some of the most marginalized groups in the world who die because they cannot access basic medicines that drives advocacy at the international level. This requires engagement in complex medical, pharmaceutical, legal and political issues with different actors in society, including NGOs, private industry, international organizations, and government representatives.*

For further information see [www.accessmed-msf.org](http://www.accessmed-msf.org)

In certain areas there is a clear need for governments and private corporations to cooperate in order to ensure important aspects of the right to health. The cost-intensive development of new pharmaceuticals, which can

be of vital importance when it comes to ensuring access to essential medicines, is a case in point. The emergence of 'public-private partnerships' (PPPs) in this regard illustrates a constructive effort to address diseases of the poor which tend otherwise to be neglected. NGOs can function as a catalyser of the development of such partnerships.

### ***Case study 6.3***

The *Human Rights and Business Project*, jointly started in 1999 by the Danish Institute for Human Rights, the Confederation of Danish Industries, and the Danish Industrialization Fund for Developing Countries, is an example of constructive cooperation between business and civil society. The Human Rights and Business Project is a non-profit organization which aims to develop concrete human rights standards for companies and to help companies to live up to these standards in practice through training and advisory services. One of the project's achievements has been the development of a 'human rights compliance assessment' tool that can be used by companies in monitoring their own operations.

*For more information see [www.humanrightsbusiness.org](http://www.humanrightsbusiness.org).*

### ***Pointers for NGO advocacy***

NGOs can effectively undertake advocacy activities in relation to obligations of international assistance and cooperation as well as to the conduct of powerful non-state actors, both by acting *in cooperation with governments* and *as watchdogs of governments*. (See chapter 10, section 10.8, for further examples.)

#### ***With regard to obligations of international assistance and cooperation,***

##### ***NGOs in developed and developing countries can:***

- advocate against any policies of IFIs that are not consistent with internationally-agreed human rights standards, principles and norms and promote the use of a human rights framework for health-related international assistance and cooperation policies;
- provide evidence that illustrates the shortcomings and adverse effects of international trade agreements on enjoyment of the right to health; and
- exploit the human rights friendly provisions contained in such agreements, for example by promoting the implementation of the Doha Declaration, and liaising when relevant with the Special Rapporteur on the right to health in this regard.<sup>34</sup>

##### ***NGOs in donor countries can advocate that government:***

- give development assistance that will enhance enjoyment of the right to health, and that assistance be tied to the fulfilment of core obligations as a matter of priority; and
- use their influence as members of multilateral and intergovernmental organizations to promote conformity with human rights standards in trade and lending policies.

##### ***NGOs in recipient countries can:***

- support their governments by providing evidence for, and advocating against, harmful policies and practices of powerful bodies such as IFIs and multinational corporations; and
- advocate that government seek international assistance which will enhance enjoyment of the right to health, with priority being given to the fulfillment of core obligations.

#### ***With regard to the conduct of health-related private sector actors, such as multinational corporations, NGOs can:***

- promote the positive potential of the private sector in the realization of the right to health, for example by voicing the interests and concerns of 'community stakeholders' when relevant;
- promote that codes of conduct, enforced by independent bodies, conform to internationally

accepted standards and principles of the right to health;

- pressure government to regulate private sector actors effectively; and
- make use of existing procedures to ensure accountability of powerful private sector actors, such as by addressing violations in courts of law.

### 6.4.1 A note about health professionals

It has long been recognized that health professionals have a crucial role to play as witnesses to human rights abuses and advocates of human rights protection. Health professionals in many countries around the world have taken a leading role in this regard, sometimes as courageous individuals and sometimes as members of large international NGOs such as Amnesty International and Médecins Sans Frontières (MSF). In some (but not many) countries, health professional associations have similarly taken a leading role in the promotion and protection of human rights. Some of the main human rights issues traditionally advocated by health professionals include torture prevention, campaigns against the death penalty, and illegal organ transplantation. Other issues of primary concern include the complex role of health professionals operating in repressive regimes, as well as their role in providing forensic evidence to courts of law. Moreover, there are increasing examples of health professionals engaging in advocacy that explicitly refers to the right to health, both broadly and with respect to particular aspects of it. One example of this is MSF's global campaign for access to essential medicines in developing countries.

Generally speaking, it is of equal importance that health professionals should comply with ethical and human rights requirements at individual and institutional levels. These include respecting the dignity and confidence of patients; non-discrimination; obtaining fully informed consent; and ensuring that health care and information is available, accessible, acceptable, and of adequate quality, particularly in the case of those who are poor or otherwise vulnerable and disadvantaged. Furthermore, health professionals and their representative associations should be vigilant in ensuring that none of the health practices, policies, procedures or programmes in which they, or their members, participate involve violations of the right to health.

It is particularly important that the codes of conduct and guidance issued by national and international health professional associations should conform to the international standards and principles that govern the right to health. Yet this is by no means always the case. The right to health should, therefore, be incorporated into the curriculum for basic (undergraduate), higher (specialist), and continuing health professional education. Adhering to the norms and standards of a human rights approach to health coincides with, and supports, the standards of 'good practice'. (See chapter 12.) In this way the conduct of health professionals can be regulated so as to conform far more closely with accepted ethical and human rights standards than it does at present. Successive UN world conferences, beginning with the World Conference on Human Rights (Vienna Declaration and Programme of Action<sup>35</sup>) in 1993 have called attention to this, but little notice appears to have been taken of it.

## Notes

- 1 Copenhagen Declaration and Programme of Action of the World Summit for Social Development; Copenhagen, 1995. A/CONF.166/9: para 14.
- 2 The Committee on Economic, Social and Cultural Rights (CESCR) 'has noted that increasingly States parties have claimed in their progress reports that key domestic legislative and policy decisions are now conditioned by the advice of IFIs and requirements that they conform to the rules of the international trading regime'. United Nations Non-Governmental Liaison Service. Globalization, human rights approaches to sustainable development. Roundup 90.
- 3 This is often done without adequately strengthening the regulation by public authorities of private providers. It is a situation which typically only comes to light after public health problems have arisen, such as when numerous deaths were caused by tainted water in Walkerton, Ontario, Canada in 2000.
- 4 Several thousand NGO representatives met for three days prior to the 2002 Monterrey Conference at the 'Global Forum on Financing the Right to Sustainable Development' and rejected the Monterrey consensus as an insufficient basis for combating poverty or for advancing economic, social and cultural rights. See also Monterrey Consensus of the International Conference on Financing for Development. A/Conf.198/11.
- 5 United Nations Non-Governmental Liaison Service (NGLS). NGLS Roundup 91. Geneva: United Nations; May 2002.
- 6 According to WHO, neglected diseases are those that 'affect almost exclusively poor and powerless people living in rural parts of low-income countries'. Neglected diseases result from several problems, including the so-called 10/90 gap. This refers to the phenomenon whereby only 10 percent of the worldwide expenditure on health research and development is devoted to health conditions that represent 90 percent of the global burden of ill-health. WHO. Global defence against the infectious disease threat. Geneva:WHO; 2002:96.

- 7 WTO Ministerial Declaration. WT/MIN(01)/DEC/1.
- 8 World Trade Organization (WTO). Implementation of paragraph 6 of the Doha Declaration on the TRIPS Agreement and public health. Decision of the General Council of 30 August 2003. WT/L/540.
- 9 Canadian HIV/AIDS Legal Network. Access to Treatment: Canadian Bill C-9 and the Compulsory Licensing of Pharmaceuticals for Export to Countries in Need; July 2004. Available at <http://www.aidslaw.ca/new.htm>
- 10 The UN Human Rights Sub-Commission has examined the question of whether IFIs are accountable to human rights prerogatives and has appointed two Special Rapporteurs on Globalization and its impact on the full enjoyment of all human rights.
- 11 United Nations Non-Governmental Liaison Service (NGLS). NGLS Roundup 93. Geneva: United Nations; May 2002.
- 12 UNFPA. Coverage of Population and Development Themes in Poverty Reduction. Strategy Papers (PRSPs). Challenges and Opportunities for UNFPA. New York: UNFPA, Population and Development Branch, Technical Support Division; 2002.
- 13 Included among relevant non-governmental and civil society actors whose activities can have a decisive impact on the extent to which the right to health is either realized or violated are: health professionals not working in the public sector, their associations and national licensing bodies; international and national NGOs; trade unions, faith-based groups; academics and universities; the UN and its bodies and specialized agencies; IFIs; health insurance companies; biomedical research institutions; pharmaceutical companies; and other private corporations that work in health-related fields.
- 14 Yamin A. Protecting and Promoting the Right to Health in Latin America. *Health and Human Rights*. 2000 5(1); 134.
- 15 CESCR General Comment 14, The right to the highest attainable standard of health. E/C.12/2000/4: para 42.
- 16 *Ibid*:para 64.
- 17 Section 6.3 is, in part, inspired and adapted from Bueno de Mesquita J, *International Covenant on Economic, Social and Cultural Rights: Obligations of international assistance and cooperation*, an unpublished summary paper for members and secretariat of CESCR.
- 18 Universal Declaration of Human Rights, UN General Assembly Resolution 217 A (III). A/810 at 71 (1948).
- 19 International Covenant on Economic, Social and Cultural Rights, UN General Assembly Resolution 2200A(XXI). A/6316 (1966).
- 20 See Convention on the Rights of the Child. A/RES/44/25, art 4.
- 21 These include World Conference on Human Rights: The Vienna Declaration and Programme of Action. A/CONF.157/23; the Millennium Declaration. A/RES/55/2; and Monterrey Consensus of the International Conference on Financing for Development. A/Conf.198/11.
- 22 See CESCR General Comment 14. para 38.
- 23 *Ibid*:para 39.
- 24 WTO Ministerial Declaration. WT/MIN(01)/DEC/1.
- 25 CESCR General Comment 14. para 45.
- 26 *Ibid*:para 40.
- 27 *Ibid*:para 41.
- 28 Including UN-approved embargoes, country-specific embargoes, eg USA-Cuba, and internal embargoes, eg Iraq-Kurds, Sri Lanka-Tamils.
- 29 1997 resolution from the BMA Junior Doctors Committee; approved by BMA Council 1998. As cited in: British Medical Association (BMA). *The Medical profession and human rights. Handbook for a changing agenda*. London: Zed Books. 2001: 345, n71.
- 30 Resolution passed at the BMA annual conference of public health medicine and community health, 1998. As cited in: *Ibid*:345, n73.
- 31 Resolution passed at BMA 1998 Annual Representative Meeting. As cited in: *Ibid*: n74.
- 32 Information source: [http://www.tac.org.za/newsletter/2003/ns16\\_10\\_2003.htm](http://www.tac.org.za/newsletter/2003/ns16_10_2003.htm)
- 33 *Ibid*.
- 34 NGOs should note that the Special Rapporteur on the right to health has chosen in his mandate to focus on relevant WTO agreements from the perspective of the right to health. (See chapter 11.)
- 35 Vienna Declaration and Programme of Action of the World Conference on Human Rights; Vienna, 1993. A/CONF.157/23.

## Introduction to Part 3

### **Taking action: Working with the right to health**

Internationally recognised and legally binding human rights instruments impose many obligations affecting the right to health on governments that have ratified them. CESCR General Comment 14, which was considered in Part 2 of this Resource Manual, is the most convenient point of reference for NGOs wishing to locate the internationally accepted standards and norms that shape the right to health. The following chapters explain how NGOs can *use these standards as a framework* for reviewing and critically assessing health-related laws, policies and practices in their country from a human rights perspective.

The focus in Part 3 of the Manual is on the key standards for monitoring the right to health: the universal standards of immediate, including minimum core, obligations; the equitable distribution of resources; and the importance of non-discrimination with special regard to the position of poor, vulnerable, or otherwise disadvantaged groups in the community, whose health is at greatest risk.

#### ***Role of NGOs in working with the right to health: narrowing the gap between rhetoric and reality***

Part 1 of the Manual showed how the right to health has been affirmed by several international human rights and other instruments as well as national instruments and is, in some respect, recognized in most countries. However, in many instances there remains a gap between rhetoric and reality. Human rights treaties and domestic laws that codify the right to health are not enough by themselves to ensure that governments will adopt the necessary policy and programme changes for its implementation. There is often very little follow-up at the national level to implement fully human rights obligations and commitments. Lack of political will may often result in failure to adjust health-related budgetary allocations, policies and administrative practices so that they conform fully with human rights standards and related laws.

Therefore it is necessary for NGOs and other health concerned organizations in civil society to come together to ensure that the right to health is fully implemented and enjoyed by both individuals and the community — so as to ensure that *legal rights* are more than *paper rights*. For real changes to take place, there frequently needs to be political pressure from below to counteract the lack of political will from above. A government is far more likely to take serious steps to comply with its obligations when it is challenged by public opinion that has been sensitised to what its rights are; that fully understands them; and is aware of those rights that have been formally recognized by the government but which are not yet being fully implemented. Changes in perceptions, policies and practices mutually reinforce each other.

#### ***Monitoring is essential to advancing the right to health***

Monitoring is essential for making the right to health a reality in the everyday lives of individuals and communities. It enables NGOs to evaluate the extent of their government's compliance with its obligations and to identify any obstacles to implementing the right to health more fully. At the same time, the information obtained from monitoring can be used by NGOs to advocate for, and to contribute to, the design, implementation and evaluation of health-related policies and programmes that respond to the health needs of their community and, in particular, to ensure that they conform with human rights principles and standards. The information so obtained can also be used to identify whether certain health institutional structures and mechanisms (national and/or sub-national) need to be changed, or new ones introduced, in order that policies and programmes can be implemented more effectively.

In Part 3 of the Manual, certain tools and activities that NGOs can employ to promote the right to health and to monitor its implementation will be described in some detail. NGOs will, of course, need to think creatively and strategically as to how they can best be employed in light of the situation in their own country.

### **Outline of Part 3**

Chapters 7, 8, and 9 describe different aspects of monitoring. Chapter 7 contains an overview of what is involved in monitoring the right to health, and discusses the important political and methodological considerations that should be kept in mind. It explains the distinction between monitoring the *obligations of conduct* and *obligations of result* that are imposed on governments and their agents by the right to health, and the basic steps by which NGOs can design and plan advocacy and monitoring strategies.

Chapters 8 and 9 describe the tools that are available for monitoring. Chapter 8 describes how to use indicators, statistical data and benchmarks for monitoring the right to health. Chapter 9 explains why the

identification of violations is an essential aspect of monitoring and it includes a list of some of the most common ways in which governments have been found to violate their immediate obligations to respect, protect and fulfil the right to health.

Chapters 10, 11, and 12 examine how NGOs can use the information that they have obtained from monitoring to advocate a fuller implementation of the right to health by undertaking certain activities. Chapter 10 focuses on advocacy to promote and protect the right to health. It consists mostly of case studies to illustrate how NGOs have worked successfully to monitor, promote and protect the right to health in their own countries and internationally. Chapter 11 explains how health professional associations and other health-concerned NGOs can participate in UN procedures for monitoring compliance by their governments. Chapter 12 is directed specifically at medical and other health professionals and their national associations. It discusses the role of medical ethics in promoting and protecting health. Chapter 12 also provides examples of activities that health professional associations may undertake to promote and protect the right to health.

### Chapter 7 Monitoring the right to health

#### *Keys to Chapter 7*

##### *key information:*

- NGOs have an important role to play in monitoring government compliance with their obligations arising from the right to health;
- Monitoring is essential to the realization of the right to health — the identification of inadequacies in laws, policies and practices marks the first step towards changing them;
- In selecting a monitoring strategy, NGOs should choose their focus in light of community needs, available data and enforcement mechanisms, as well as their own strengths, priorities, and advocacy goals;
- Important areas for monitoring include compliance with core obligations and obligations concerning non-discrimination and vulnerable groups, as this is where violations often occur;
- The results from monitoring can be used broadly in targeted advocacy campaigns and to strengthen pre-existing NGO activities.

##### *key questions:*

- What legally-binding obligations has the government assumed in relation to the right to health?
- To what extent can health-related problems in the community, and particularly among vulnerable groups, be linked with gaps or shortcomings in the government's compliance with these obligations and/or international standards of the right to health?
- What are the central advocacy goals of your NGO?
- What kind of health and human rights monitoring strategy(ies) would be most effective for your NGO to address the above inadequacies and achieve its defined objectives?

##### *key action points:*

- Identify concrete monitoring objectives;
- Collect appropriate data;
- Assess government compliance with specific obligations;
- Identify barriers to the implementation of relevant laws, obligations and commitments;
- Undertake advocacy to facilitate change.

## 7.1 A basic introduction

### 7.1.1 What is meant by monitoring?

Monitoring is the process by which NGOs and other parties can systematically keep track of actions (or inaction) by governmental bodies, institutions and other relevant authorities in order to identify:

- the extent to which the right to health is being implemented;
- barriers and obstacles that exist to its implementation; and
- actual or potential violations.

*Information is key to monitoring.* Monitoring involves systematically collecting information about an existing situation and evaluating it against the standards that have been set for the right to health. In other words, monitoring involves assessment of how well governments meet their obligations to respect, protect and fulfil



the right to health, as set out in international standards, constitutional safeguards or other national laws that have been introduced to protect health status and to prevent discrimination that is adverse to health.

Effective monitoring requires accurate and systematic fact-finding and analysis of information. Finding reliable data, understanding how to recognise information that is relevant to the right to health, and linking it to specific government obligations are all important elements of monitoring.

Systematic monitoring involves three basic processes:

- 1 identifying which kind of data is relevant and how to find it;
- 2 collecting such reliable and valid data; and
- 3 analysing and interpreting the data (for example, to determine patterns and trends).

After completing these processes, NGOs can take action based on the results. Monitoring is, therefore, an essential part of human rights advocacy.

### *NGOs as partners with government as well as watchdogs of government*

Monitoring is an essential part of the work of NGOs because it can ensure:

- successful and sustainable implementation of the right to health by contributing to the design and implementation of government policies; and
- the identification, documentation, reporting and remedy of violations of the right to health.

Monitoring typically involves using a combination of both approaches.

The effectiveness of any particular approach to monitoring the right to health will depend upon the domestic political, social, and economic environment. Wherever possible, it is often preferable, particularly in developing countries, to adopt an approach in working with government that is co-operative, rather than adversarial and confrontational. A cooperative approach will often achieve results more quickly. An approach that focuses monitoring on 'naming and shaming' could, in certain cases, even lead to action being taken by the authorities against the NGO concerned. Invoking a government's own health and development goals in the course of advocacy need not, of course, imply any threat or challenge to its authority and can serve to bring about changes towards a better implementation of the right to health.

The political climate in some countries might lead NGOs to choose not to use the language of human rights at all in their advocacy work. Fortunately, the promotion and protection of the right to health can be articulated effectively in terms of good development practice or as an urgent public health requirement. If, for political reasons, an NGO chooses to state its goals in terms of promoting the improved health of a particular population group, it can still design its internal strategy within a right to health framework and justify its advocacy priorities on the basis of specific violations that it has identified.

Health professional associations and health-concerned NGOs can play an important role in promoting the progressive realization of the right to health by cooperating with public authorities and contributing to the design and implementation of public policies. They can help to shape priorities for public spending by promoting and supporting the establishment of policies that reflect the most pressing health concerns of the population, especially those of poor, vulnerable, or otherwise disadvantaged groups.

Such groups also have an important role to play in assisting governments to fulfil their core obligations arising from the right to health. (See chapter 4.) This includes, for example, contributing to the design of a national public health strategy and plan of action including methods, such as right to health indicators and benchmarks, by which progress can be monitored.

## **7.1.2**                    *Why is it important to monitor the right to health?*

Monitoring the right to health is important because it enables the community, health professional associations, and other health-concerned NGOs to evaluate their country's progress in attaining an effective realization of this important right. In today's world, governments, while freely accepting international standards of compliance with human rights, often fail to translate them into practice. This may be due to an absence of

political will or to a lack of resources or the necessary capacity. Whatever the reason, it is crucial that NGOs contribute constructively to the realization of the right to health — both as cooperative partners of government and as critical watchdogs.

The purpose of monitoring is to identify and evaluate the strengths and weaknesses in a government's compliance with its obligations. *Identifying inadequacies* in national laws and policies as well as in enforcement and implementation practices (including the policies and practices of public institutions) *is the first step towards changing them*. Without effective monitoring, governments cannot be held accountable for implementing the right to health, nor can they be made liable for violating it. The fact that governments *are accountable* is a key element of a human rights approach to health.

The importance of monitoring health-related administrative practices in addition to health-related laws and national policies lies in the fact that many abuses of the right to health such as discrimination occur at the level of administration or at 'unofficial' state-level, and are often the result of institutional policies.

### *The challenge to health-concerned NGOs in developing countries*

The greatest burden of disease in the world is shouldered by those living in poverty. Health advocates in developing countries face particularly difficult challenges as a result of extreme poverty and the inequitable distribution of scarce resources. Recent decades have seen a decrease in public spending on health and related social services partly, it has to be admitted, as a result of reforms imposed by international financial institutions (IFIs) as a condition of providing economic aid, such as poverty reduction strategy papers (PRSPs) and other measures that are adversely affecting the health sector. (See chapter 6.)

In many developing countries, information about health, including vital registration systems, are weak (or non-existent). This poses a significant obstacle to the government's ability to identify priority areas and to monitor progress in implementing the right to health. At the institutional level, the poor terms and conditions of service of medical practitioners and other health professionals employed by the state often undermine their capacity to deliver adequate services. Therefore NGOs have had to provide much of the health care in developing countries. At the same time, NGOs have made significant contributions to promoting the right to health, particularly in the case of women's health and HIV/AIDS.

### *Understanding the overlap and differences between monitoring public health and the right to health*

National medical and other health professional associations with experience in public health monitoring will find many familiar elements in the techniques used to monitor the right to health, in particular with the use of epidemiological methods of collecting and analyzing biomedical data. However there are important differences between the two perspectives in the focus and objectives of monitoring.

In brief, monitoring within a framework of the right to health focuses on *equity, accountability* and on the objective of assessing the extent to which health-related *state responsibilities* and *international standards* are being implemented. From a public health perspective the main purpose of monitoring is to identify the need for interventions to remedy health problems in the population and to evaluate the extent to which they have been successful.

*Key points on monitoring equity and accountability:*

- Because monitoring the right to health calls for special attention to be paid to vulnerable groups, *disaggregated data is essential*. This means that health-related data should be collected and analyzed along such lines as gender and race to reflect the conditions of specifically disadvantaged groups, including poor women, minorities, and indigenous peoples.

- Because its objective is to identify evidence of the extent to which government is complying with its responsibilities, monitoring the right to health should be *carried out with concrete state obligations and international standards in mind*.

There is an important overlap between the ultimate goals of both approaches: to use the results of monitoring towards maintaining and improving people's health and well-being. By focusing on equity and accountability, the integration of a human rights framework can serve to complement and support public health monitoring and objectives.

### 7.1.3 What should be monitored?

The factors which will influence an NGO's choice of monitoring activities include its organizational goals, the context within which it works, and its internal capacity and resources. *NGOs should always focus on monitoring issues that are consistent with their own expertise and strengths*, especially in the following key areas, which are linked with *universal and immediate* state obligations:

- *compliance with core obligations*: whether the government is meeting minimum essential levels of health rights in complying with its core obligations to *respect, protect and fulfil* the right to health; (See chapter 4.)
- *treatment of the poor, vulnerable, or otherwise disadvantaged groups*: whether patterns of ill-health among certain population groups are associated with systematic discrimination. (See chapter 5.)

The obligations to ensure the elimination of discrimination and equitable treatment of vulnerable groups are included in a state's immediate obligations. However NGOs may find it helpful to deal with them separately. They are of special importance in developing countries and are areas in which violations of the right to health are most likely to occur. As such, they are important priorities for NGOs to take into account when monitoring and will help them to focus on potential problem areas. NGOs should use the following tools to monitor the above obligations effectively:

- *legal obligations* arising from existing human rights standards (for which purpose an understanding of what constitutes *violations* of these obligations is required); and
- *vital statistics and health indicators*, including targets and benchmarks.

These are described in chapters 3, 8 and 9.

#### *Obligations of conduct and of result*

Obligations of conduct refer to the *content* of government policies affecting health, while obligations of result refer to the *outcomes (results)* of such policies. As far as NGOs are concerned, the distinction is helpful because it describes two different ways of assessing a government's compliance with its obligations.

Monitoring obligations of conduct requires an evaluation of what the government is doing to ensure that the right to health can be enjoyed. It involves a review of health-related legislation, public policies and implementation mechanisms. Monitoring obligations of result, on the other hand, requires the measurement of outcomes and progress in meeting pre-determined targets by means of health indicators and benchmarks. This often poses a challenge in developing countries, where the quality of data on health can be weak or unreliable. (See chapter 8.)

#### *Monitoring a state's obligations to realize the right to health progressively*

This requires assessment of any relevant advances, setbacks, or stagnation in ensuring enjoyment of the right to health, including the extent to which the state is fulfilling this *obligation to the maximum of its available resources*. Statistical data, health-related budgets, health indicators and benchmarks are essential for this purpose. (See chapter 8.)

## 7.2 Developing a strategy

Different NGOs will inevitably have differing objectives in mind for monitoring, but monitoring must always be regarded as a *means to an end*. The process is important because it enables health professional associations and other NGOs to *identify inadequacies* in the realization of the right to health *in order to work towards improving them*. Monitoring any given health-related situation or issue is always the first step in carrying out advocacy

work, which will often be aimed at policy reform. Before undertaking any kind of monitoring it is important for an organization to clarify its purpose, strategies and objectives.

### *Clarification of objectives within a right to health framework<sup>1</sup>*

It is essential for a health-concerned NGO to be clear about its objectives and the specific types of change that it hopes to help bring about. It must decide what aspect of the right to health it will monitor and how it will go about it, such as whether its activities are to be aimed at government policies, health budgets, or legislation. Results from monitoring can often be used for a variety of advocacy activities. The following checklist gives examples of the kinds of questions that an NGO can use to clarify its objectives when working with the right to health.

- 1 Do you want the government to:
  - ratify a particular human rights treaty that guarantees the right to health?
  - withdraw health-related reservations that it made when ratifying the treaty?
  - introduce laws (including a right to health act) that will bring existing legislation into conformity with international human rights standards on the right to health?
  - amend specific laws or policies, and/or improve their enforcement or implementation?
  - introduce or strengthen mechanisms to monitor and enforce the right to health, such as a health or patient ombudsman?
  - discontinue a particular policy or practice that is damaging to health?
  - take specific steps to comply more effectively with certain human rights standards?
  - regulate more effectively acts or omissions by the private sector that have an adverse effect on enjoyment of the right to health, such as environmental pollution by multinational corporations?
  - take action on, or discontinue, specific violations of the right to health that have been identified?
  - redistribute available resources in a more equitable manner? For example, by increasing budgetary allocations to sectors that are important for fulfilling obligations concerned with determinants of the right to health, including public health services, environmental and urban planning?
  - increase opportunities for public participation in decision making processes that affect health?
- 2 Do you plan to provide evidence of violations to a national human rights complaints or enforcement mechanism? This might include submitting evidence to a national human rights institution (NHRI), human rights commission, or ombudsman's office. Do you plan to seek remedies for violations by bringing a case for litigation before a domestic court or tribunal?
- 3 Do you plan to provide evidence of violations to a regional human rights enforcement mechanism, such as a regional commission or court of human rights?
- 4 Do you plan to submit evidence to a treaty monitoring committee that might challenge what your government has said in its own country (State party) report to the committee? Do you plan to submit evidence to the UN Special Rapporteur on the right to health? (See chapter 11.)
- 5 Are you taking steps through educational campaigns and media work to raise awareness about the right to health and to mobilize public opinion and affected communities?
- 6 Are you aiming to point out important gaps in the collection of official data and statistics about health status in order to encourage those responsible to improve them?

### *Selection of a strategy*

A strategic decision-making process can help clarify how best to move a particular issue forward within the framework of the right to health. This flow-chart illustrates some general steps involved in this process:

*Situate* the issue with which you want to work in the framework of the right to health. Identify priorities with reference to relevant international and national human rights standards and laws;



*Define* a specific goal or desired outcomes for your strategy. Consider the short-term, medium-term and/or long-term aspects of your goals;



*Get the facts!* Know how the right to health is provided for in the laws of your country, including in the constitution and other national laws. Ascertain which of these laws are relevant to your advocacy issue;



*Get more facts!* Know which international and regional human rights instruments your country has ratified; whether it entered any health-related reservations on ratification; and if it did what was its reason. Check the extent to which your country's national laws guarantee that the international obligations and commitments undertaken by your government relevant to the right to health are being, or will be, met. Check also whether the relevant national laws do not conflict with international obligations. Read the country reports your government has submitted to relevant treaty monitoring committees, and note carefully any health-related comments or observations that the committee has made on them. Make sure that you are aware of any relevant commitments adopted by consensus at UN world conferences, and whether your country entered any reservations to them at the time;



*Decide* which of the above obligations and commitments are relevant to your advocacy issue and to what extent your government is already committed to them;



*Identify* barriers to the implementation of relevant laws, obligations and commitments. These could include lack of political will; weak infrastructure or mechanisms for the effective administration of policies and programmes; harmful traditional practices; cultural norms; or policies imposed by IFIs or as a result of adverse reforms of the health sector (which, in certain cases could include sector wide approaches (SWAps) and may still include SAPs) to funding health services;



*Decide* how you want to monitor the situation, for example by evaluating the implementation of relevant laws; by conducting a community-based study or qualitative interviews; by undertaking a budget analysis; or by collecting primary or secondary data on specific indicators. (See chapter 8.)



*Identify* any actual or potential violations of the right to health;



*Seek* any necessary technical or expert input for your monitoring activities. (For example, to get more information about the health issue concerned; to analyze statistical data; to draft reports of violations in the form required by law courts or treaty monitoring committees; or to locate national or regional legal precedents);



*Strategize* around available mechanisms. Ascertain which sub-national, national, regional and international human rights or other bodies might be prepared to investigate, or adjudicate on, violations that you have identified. These might include courts of law, ombudsman's offices, and NHRIs. Bring any complaints of violations to the attention of the relevant authority;



*Consider* forming strategic alliances with other organizations and partners. Think broadly: for example, involve local community leaders and groups; the media; politicians with an interest in the issue; other NGOs, including health professional associations and human rights organizations. Bear in mind that even those with very different mandates from your own may share your concerns about issues such as environmental health or about the adverse effects of indebtedness to foreign countries on health resources. Consider enlisting the aid of organizations working at different levels from your own, for example at community, national, regional or international levels;



*Educate and mobilize* the public about the issue; engage in lobbying activities.

### *To bear in mind about advocacy and monitoring activities*

Effective advocacy strategies can range from the simple to the highly complex. If the resources of your NGO (staff, financial, or otherwise) are already stretched to the limit, be prepared to be creative and willing to *think small* and *think local*. Working to monitor and promote the right to health can involve taking very simple measures at the local level, within the context of an NGO's everyday activities. This could include advocating changes at a rather basic level. Examples might include advocating changes at individual local health facilities where spousal consent is required for women to attend family planning clinics, or where rights to privacy or confidentiality are not observed, particularly in the case of adolescents and those who are HIV-positive.

### *A human rights approach to health is a 'way of doing'*

Rights and responsibilities go hand in hand. Make sure you follow human rights principles in your own work and in the activities that your organization undertakes. Always bear in mind the importance of confidentiality and informed consent. For example, be careful not to reveal sources of information that may wish to remain anonymous, nor disclose sensitive health-related information about particular individuals or groups without their full, free and informed consent. Otherwise the rights of others may be violated inadvertently in the course of your monitoring and advocacy activities.

NGOs providing health services must be particularly careful to respect the dignity and integrity of individuals, especially of women and adolescents. Participation is an integral part of the human rights approach to health. NGOs should set an example and follow this principle themselves by inviting appropriate community participation in their decision-making before they begin to determine their priorities.

### *Fictional case study*

A women's health NGO is working with a refugee community where there is an alarmingly high rate of death and disability among young women. Preliminary investigations, including interviews with affected individuals and health care workers in the refugee community, reveal a variety of barriers limiting the access of unmarried women to contraceptive services, including lack of information and education about contraception and reproductive health. The NGO also finds that there are no safe abortion services available to these women, although induced abortion is not illegal in the country. The NGO therefore decides to carry out various monitoring activities to ascertain whether the situation has resulted from the government's failure to comply with its legally binding human rights obligations. These activities might include finding out:

- which reproductive health services are available;
- how many unmarried women use them;
- whether any cases of avoidable premature death, disability or other morbidity have resulted; and
- what services the community is entitled to receive under national laws, human rights treaties ratified by the government, or commitments entered into by the government through consensus agreements from UN world conferences (including ICPD and FWCW).

Monitoring will involve finding out what, if any, action the public authorities (local and national) have taken to remedy the situation, and assessing the results of their efforts. It will also involve comparing the community's entitlements, as rights-bearers, with the government's corresponding obligations, and identifying where they do not coincide. Once this has been done, the NGO is in a position to decide whether there is a violation of the right to health and can attempt to hold the government accountable and seek a remedy for the women concerned.

## **7.3 Key questions for monitoring the right to health**

### *How well is your government complying with its immediate obligations?*

The following questionnaire outlines specific issues that are important for monitoring. They concern primarily the areas identified above: core obligations; and the treatment of poor, vulnerable, or otherwise disadvantaged groups. (See section 7.1 in this chapter.) NGOs will need to assess legislation, government policies and their implementation in order to answer the questions. Many require only a *yes* or *no* answer; some demand quantitative answers (such as percentages); and others need basic descriptive or qualitative responses if the extent of a state's compliance with its human rights obligations is to be assessed effectively.

## Questions and issues for monitoring how a state is complying with its obligations<sup>2</sup>

Monitoring how a state is complying with (a) its immediate obligations to ensure non-discrimination and equality, and (b) with its immediate minimum core obligations:

- Does your country's constitution include explicit recognition of a right to health, of health protection, or of health care? Does it provide a legally or administratively enforceable entitlement to health protection and/or access to health services for all?
- Does your government have a national health policy with a detailed plan that includes goals and a timetable for achieving each of its components, and particularly for realizing the minimum core obligations of the right to health?
- Does the national health policy recognize a commitment to rectify existing imbalances in access to health and health-related services? If so, in what ways does it do so?
- Is the government actively and effectively monitoring the provision of health services, including any barriers or other obstacles to access so as to be able to respond appropriately to problems and imbalances?
- Does the government's policy on providing health services take full account of health needs in age groups that are at increased risk, such as children, adolescents and the elderly?
- What percentage of communities (and/or households) has access to an adequate supply of safe and potable water and adequate sanitation? Does the government have a plan which includes a timetable and an investment strategy that will ensure access for the entire population?
- What percentage of the population (and/or communities) has access to primary health care within an hour's walk or easy travel? Does primary health care include the essential services required to provide preventive, curative, and reproductive health care delivered at low cost?
- Is primary health care affordable, particularly for the poor? If not, are there ways the poor can obtain adequate subsidies or other effective support to obtain it?
- Does the government have a comprehensive and gender-sensitive strategy that takes account of inequalities in women's access to health facilities and benefits? Is the government eliminating barriers and restrictions on women's access to health services? Are women or adolescents required to have the permission of husbands, partners, families, or health authorities in order to obtain access to any treatment or services that they need?
- What measures are taken by health authorities to identify, monitor, control, and prevent the transmission of HIV/AIDS, tuberculosis and malaria?
- What percentage of children are currently inoculated against major infectious diseases, including diphtheria, tetanus, whooping cough, measles, poliomyelitis, and tuberculosis? Are there sufficient up-to-date stocks and facilities readily available to ensure that children will continue to receive effective immunisation?
- What reproductive health information and services, including sexual health and family planning, are readily available? Is the government effectively disseminating information about these services? Do they fully meet the needs of individuals and couples? Is induced abortion criminalized and, if so, how is the law enforced?
- What percentage of the gross national product (GNP) is invested in the health sector? What is the policy for allocating funds from national and regional budgets for health services? How is this money being invested? What proportion of funds is allocated to primary and hospital (including tertiary) care, respectively? Are the funds and health care services allocated equitably to regions and between urban and rural areas?
- Does the government have a programme to ensure that basic and essential medicines are available at the lowest possible cost? Are they available at all times, in adequate amounts, in appropriate dosage forms, and at affordable prices at most primary health care facilities? If they are not what is the reason?

A recent study suggests that: "In general, violations of the right to health cannot be effectively monitored in the same manner as classic civil rights violations, such as torture or other atrocities. For example, simply counting children under the age of five who have died reveals little of the true magnitude, distribution, or causes of child mortality. As compelling as individual narratives can be in human rights advocacy, in most cases they will have to be coupled with information that demonstrates their representativeness of systematic patterns or policies, which in turn may reveal the state's failure to respect, protect or fulfil the right to health."<sup>3</sup>

- Are there adequate opportunities for public input into major discussions on health issues and for consultations on health service policies?

*Monitoring other aspects of a government's obligations:*

- To what extent does the government recognise and respect the clinical independence of the medical profession?
- Has the government ever refused or withdrawn access to health services as a punitive measure?
- Has the government ever knowingly withheld from the public information about exposure to toxic substances or to infectious agents?
- Do government policies or religious bodies obstruct women's access to reproductive health services, such as contraception, sterilisation or induced abortion?
- Does the government impose coercive policies to control the size of the population?
- What kinds of discrimination, economic or otherwise, obstruct access to health services?
- Are the health status and needs of women considered primarily in the context of their reproductive role?
- Do diseases and other conditions of ill health that affect women solely or predominantly receive adequate attention?
- Is the government training sufficient numbers of female health care workers at all levels?
- Does the government have a policy that actively discourages the production, marketing, and consumption of cigarettes, alcohol, and other drugs, particularly to children and adolescents?
- Does the government take adequate steps to prevent violence against women?

Negative (and in some cases positive) answers to these questions can suggest issues that can be taken up by NGOs. Once the critical activities have been identified through monitoring, broader advocacy strategies can be developed. But, first of all, an effective strategy for monitoring has to be put in place.

## Notes

- 1 Based on: Women, Law and Development International (WLDI); Human Rights Watch (HRW), Women's Rights Division. Women's human rights step by step: a practical guide to using international human rights law and mechanisms to defend women's human rights. Washington, D.C.: WLDI and HRW. 1997:156-161.
- 2 Adapted from a questionnaire written by Chapman AR, AAAS, as part of a discussion document for a November 1999 Commat meeting in London.
- 3 Yamin A. Protecting and promoting the right to health in Latin America. Health and Human Rights. 2000; 5 (1): 135.



## Part III *Taking action: Working with the right to health*

### Chapter 8 Tools for monitoring I: Working with indicators, benchmarks and statistical data

#### *Keys to Chapter 8*

##### *key information:*

- Indicators and benchmarks are powerful tools for monitoring state obligations subject to *progressive realization*;
- Different methods are required for monitoring *obligations of conduct* and *obligations of result*, namely *policy measurements* and *progress measurements* respectively;
- While different indicators can help monitor different aspects of the right to health, all *progress measurement* indicators require disaggregation by categories such as gender and race, to reflect the situation of vulnerable and minority groups within the population; and
- When working with indicators and benchmarks it is important to be aware of the limitations of the available data.

##### *key questions:*

- Does your government have a national health strategy and plan of action to progressively fulfil its obligations arising from the right to health that defines national indicators and sets realistic yet challenging benchmarks?

*In light of the issue(s) of focus for your NGO's advocacy activities:*

- What are the key indicators that would enable an evaluation of the extent to which the government is complying with its related obligations?
- Which benchmarks might be useful to measure whether the government is making adequate progress in doing so?
- Can budget analysis be helpful to assess the government's priorities in health-related expenditures? Can it serve to evaluate the extent to which the government is fulfilling its obligations to address inequities in resource distribution and focus attention on the needs of vulnerable groups to the *maximum available resources*?

##### *key action points:*

- Link your advocacy issue(s) with specific government obligations and/or international standards;
- Identify and define relevant indicators and benchmarks;
- Analyze available data and assess the extent to which the government is complying with its obligations and its self-set goals;
- Undertake advocacy and suggest/carry out concrete action to promote the necessary changes.

## 8.1 Measurements of policy and progress

A central aspect of a human rights approach to health is that governments are accountable for their obligations, which are based on international law, constitutional guarantees and other forms of national legislation. Monitoring the right to health involves assessing the laws, policies, actions and/or omissions of a government (including those of its institutions, organizations, bodies or agents), and determining the extent to which the highest attainable standard of health can be enjoyed by both individuals and communities.

Human rights monitoring makes a distinction between *obligations of conduct* and *obligations of result*. Obligations of *conduct* refer to state duties that focus on public policy priorities (which governments can control immediately and directly). Obligations of *result* refer to state duties that focus on guaranteeing measurable outcomes, which may be influenced by many different factors, such as the level of economic development, and may therefore take some time to achieve.

The two types of obligations require different monitoring approaches. *Policy measurements* are used to monitor obligations of *conduct*, whereas *progress measurements* (which are quantifiable) are used to monitor obligations of *result*.

The right to health includes both obligations of *conduct* and of *result*. Therefore, when measuring implementation of a government's obligations regarding the right to health, obligations of both *conduct* and of *result* should be monitored, as it is important to measure both process and outcome.

The obligations to respect, protect and fulfil each right contain elements of obligations of both conduct and result. The obligation of conduct requires action to be taken that can reasonably be expected to result in enjoyment of a particular right. In the case of the right to health, for example, the obligation of conduct could involve the adoption and implementation of a plan of action that can reasonably be expected to reduce maternal mortality. The obligation of result, on the other hand, requires states to achieve specific targets to satisfy a detailed substantive standard, such as the reduction of maternal mortality to the levels originally agreed at the International Conference on Population and Development (ICPD) in Cairo in 1994 and at the Fourth World Conference on Women (FWCW) in Beijing in 1995.

*Adapted from the Maastricht Guidelines on Violations of Economic, Social and Cultural Rights, para 7.<sup>1</sup>*

The methods used and the information needed to monitor policies are different from those needed to measure their outcomes.

Monitoring obligations of *conduct* requires assessment of a government's policy objectives and commitments, as well as their implementation. Examples of such monitoring would include answering the following questions:

- Is there a national policy for the provision of affordable contraceptives to all sections of the population?
- Is there a national strategy or operational plan in place for reducing maternal mortality and morbidity and if so, is it being implemented?
- Does the government have a programme for making essential medicines available at the lowest cost possible?
- Is primary health care affordable, particularly for the poor? If not, are there ways in which the poor can obtain health care free of charge or at an affordable price?

Monitoring obligations of *result* involves assessing specific measurable outcomes or targets. Examples include assessing:

- infant mortality rate and whether it is below 50 per 1000 live births;
- maternal mortality rate and whether it will be reduced by three quarters of the comparable figure in 1990 by 2015.

### *Challenges in using progress measurements in developing countries*

For obvious reasons, the use of measurements of progress tends to depend more heavily on the availability of reliable statistical data. Monitoring obligations of result poses a fundamental problem to many NGOs in developing countries, as there is often very little reliable, accurate and current health-related statistical data available at the national and sub-national levels.

In countries in which health information and vital registration systems are weak or non-existent, it can be very difficult for NGOs to find accurate data on which they can base their assessments. The difficulty is further compounded in those countries which distort, under-estimate or misrepresent *official* data in order to conceal sensitive information that might carry a stigma or lead to unwelcome repercussions. Examples might include the incidence of unsafe induced abortions, HIV/AIDS, female genital mutilation/cutting (FGM/C), domestic violence, or substance abuse among particular groups.

### *Problems associated with monitoring maternal mortality<sup>2</sup>*

There is a highly disproportionate incidence of maternal mortality in developing countries, where it is the main cause of premature death and disability among women of reproductive age. Unfortunately, there are a number of serious obstacles to monitoring the extent to which governments are succeeding in reducing maternal mortality, which is a most important obligation of result, as the official data is often unreliable.

The countries which have the greatest need to reduce maternal mortality usually lack vital registrations collecting accurate data on which to base statistical assessments. Official data are often unreliable and rarely available in a sufficiently disaggregated form to identify the subgroups who are most affected. (See section 8.2.4 and 8.3.)

The stigma and public shame attached to pregnancy in unmarried mothers and to deaths from induced abortion (where it is unlawful and therefore likely to be unsafe) contribute to the under-reporting of maternal mortality. Official reports on women's deaths often do not indicate, either for purposes of concealment or because the information was not available, whether they were pregnant.

Measurements of progress are, nevertheless, essential to monitoring certain aspects of the right to health, for example, to assess its progressive realization and expose discrimination. In countries in which the availability of reliable data is poor, it is all the more important that NGOs should collect as much evidence as possible from both official (such as reports from the government) and unofficial (such as reports from NGOs) sources and document the given problem for purposes of providing a 'snapshot' of what they believe to be the current situation. Such information, however modest, can serve many purposes. For example, it can be:

- used in support of litigation or submissions to national human rights bodies; (See chapter 10.)
- analysed by NGOs to initiate changes in their own service delivery; (See chapter 10.)
- included in advocacy to mobilize public opinion; (See chapter 10.) and/or
- submitted to treaty monitoring bodies as a supplementary source of information to the government's official report. (See chapter 11.)

## **8.2 Working with indicators, benchmarks and statistical data**

There are many possible ways to monitor the right to health by using indicators and statistical data, but monitoring must always be carried out systematically. Monitoring involves a three-step process:

- identifying which types of data are relevant and how to obtain them;
- collecting the data; and
- analysing the data.

Although the use of indicators, benchmarks and statistical data must remain the principal means of monitoring progressive implementation of the right to health, NGOs have great flexibility in what they monitor and how they choose to do so. While they may feel intimidated at the prospect of measuring implementation with quantitative data, they should bear in mind that their main strength lies in the fact that they have access to important information about what is going on *at the community level*. Such information is essential for monitoring how a government is actually fulfilling its obligations. It can be used to confirm or rebut claims made by governments, for example, to the public or in reports to treaty monitoring committees. (See chapter 11.)

Health professional associations with access to epidemiological, clinical and public health expertise have critical skills for monitoring, establishing indicators and selecting benchmarks to assess their government's compliance with obligations arising from the right to health. Many other health-concerned NGOs have access to important information at community level but not all of them have the expertise to convert that information into a form that is appropriate for monitoring. Whenever this is the case, an NGO should not hesitate to call in outside help.

According to the standards set out in international human rights instruments states are required, as one of their minimum core obligations arising from the right to health, to adopt a national health strategy and plan of action. (See chapter 4.) Such strategies and action plans must involve the use of national indicators and benchmarks. These are intended to assist governments to monitor the progressive realization of their health-related human rights obligations and to identify any obstacles to it. Related to this obligation is an implicit

commitment of government to provide the data necessary for monitoring, and to strengthen its health information systems when this is not immediately feasible.

Few developing countries have the capacity needed to generate the current and accurate data that is necessary to monitor the progressive realization of the right to health adequately. Unfortunately, many of them assign little or no priority to strengthening their information systems, and this greatly weakens their ability to implement and monitor their right to health obligations effectively. In such cases, NGOs have an important role to play in exposing and publicizing gaps and weaknesses in national data and in the ways in which it is collected. Through such action NGOs can encourage steps to be taken to improve the collection of reliable data, with ultimate benefit to both national and international monitoring mechanisms. When appropriate, it is equally important for NGOs to work together with government to establish relevant indicators and benchmarks and to design ways to strengthen data collection.

## 8.2.1 What are indicators and benchmarks?

### *Indicators*

Indicators are *signals* that make it possible to determine the extent to which a particular obligation or standard has been, or is being, attained. They are tools that can be used to indicate the *present* situation. They can show trends; serve as signs; reveal symptoms; and mark progress towards targets. They are substitutes for capturing elements of the right to health that are otherwise difficult to measure directly.<sup>3</sup>

**Example:** An example of an indicator of child mortality is under-5 child mortality rates (expressed as the number of deaths per 1,000 live births and of children below age 5 years); or the infant mortality rate (also expressed as the number of deaths per 1,000 live births).

### *Benchmarks*

Benchmarks are self-set *goals or targets* to be reached at some *future* date. National and international benchmarks set the framework for measuring progress in implementing the right to health and are used normally for assessing the effectiveness of policies.

**Example:** Reduce infant and under-5 child mortality rates by two-thirds by 2015.

Both benchmarks and comparative indicators can be used to monitor equity, namely the elimination of discrimination, which is an immediate state obligation. (See chapter 5.) Indicators and benchmarks can be in the form of absolute numbers, proportions, averages, rates or ratios. States must formulate explicit, quantifiable and time-limited objectives for the purpose of meeting their obligations and must identify appropriate indicators and benchmarks with which they intend to measure progressive realization. The combined application of indicators and benchmarks enables results to be measured against targets.

## 8.2.2 Working with indicators

Indicators can provide many different types of information, which can be adapted for communicating the impact (or result) of programmes as well as the process (or methods) used to carry them out. They can be quantitative or qualitative, and can be used to describe a particular situation, as well as to measure changes in a given situation over a specified period of time.

Indicators can be used to measure and monitor:

- overall status of a particular situation;
- changes or trends over a period of time;
- achievements towards targets (benchmarks);
- differences between particular groups in the population; and
- differences between geographic regions within a country.

What sort of indicators can be used?

*Policy measurements* (ie *process* or *policy indicators*) are used to monitor a government's compliance with its obligations of *conduct*. Sources of information for such measurements include national legislation, government policy documents and budgets. In contrast, *progress measurements* (ie *outcome* or *impact indicators*) are used to refer to the degree of a government's compliance with its obligations of *result*, and thus the extent to which its laws, policies and programmes are achieving an outcome consistent with enjoyment of the right

to health. Sources of data for progress measurements include statistics based on disease-specific or population-specific indicators.

In other words, *policy indicators* focus on states and their behaviour (their commitment to, and compliance with, human rights obligations), whereas *impact indicators* focus on individuals and groups.<sup>4</sup> The following table illustrates the two types of indicators in relation to a specific government obligation and benchmark. The column headed *data* contains examples of the type of information that needs to be collected.

Government Obligation	Benchmark (Target)	Process/policy indicator	Outcome/ impact indicator	Data
To provide immunization against the major infectious diseases (a core obligation — see chapter 4).	100 percent of children (by 2015) must be immunized against diphtheria, tetanus, whooping cough, measles, poliomyelitis and tuberculosis.	A comprehensive public health strategy is in place to provide full immunization coverage to the entire eligible population.	Rate of infant mortality due to preventable diseases (disaggregated by categories such as region, urban/rural, ethnic/linguistic group and gender).	Number of infant and under-5 child deaths from preventable diseases; and the number of one-year-olds immunized.

### *How to select and use indicators and benchmarks*

The choice of indicators and benchmarks, together with the ways in which they will be used, depends on a number of factors, including:

- particular aspect of the right to health that is being monitored;
- aims of the NGO concerned;
- resources and expertise that are available to assist in the exercise;
- whether national-level indicators and benchmarks have been established; and
- availability of accurate and reliable data.

Wherever feasible, NGOs should work with national indicators and benchmarks. A good starting point is to read the sections relating to health in the country reports submitted by the government to the treaty monitoring bodies, together with any comments on the reports made by the committees concerned. (See chapter 11.) Other ways to locate them include contacting the relevant government department, for example at the national Ministry of Health or national statistical office, as well as contacting relevant UN agencies or bodies (such as UNICEF, UNDP, WHO and UNFPA) and/or referring to their annual reports.

NGOs will also find many of the international databases of health indicators helpful, as well as the global benchmarks and targets that have been recommended in the Millennium Development Goals (MDGs), in the outcomes of UN World Conferences and their follow up meetings, such as ICPD, ICPD+5, the FWCW and FWCW+5, and of UN specialised agencies or bodies, particularly WHO and UNFPA. (See Annex 2.)

A further option is to consult indicators developed by other NGOs that monitor specific aspects of the right to health, such as reproductive health rights. (See box below.) In consulting these various lists NGOs should select as few indicators as possible and adapt them for their own purposes. Alternatively, they can decide on their own indicators and benchmarks to reflect the dimensions of the right to health they are interested in monitoring and thus the type of data they are interested in collecting. (See section 8.3.)

### *For example ...*

The range from which NGOs can choose indicators of health care is wide. Depending on the context, this could include the availability of surgical rubber gloves and disinfectant at the one end of the indicator scale and advanced technical equipment at the other end.

Many indicators have been developed to measure the health of populations as well as the socio-economic conditions that affect health within countries. Such health and development indicators, however, do not

necessarily measure implementation of the right to health. *Right to health indicators must have a rights aspect.* In other words, they must serve to evaluate the extent to which a government is complying with its concrete obligations arising from the right to health.

In addition, *indicators must be able to be disaggregated.* (See section 8.2.4.) In order to reveal information relevant to health and human rights, health data must be collected and analyzed with adequate specificity to reveal information about, and differences between, population groups, with particular sensitivity to vulnerable groups. Accordingly, indicators need to generate statistical data that can be disaggregated by relevant categories such as gender and ethnicity.

NGOs should use as few indicators as possible. They should be:

- helpful;
- simple and specific;
- measurable;
- able to be disaggregated (by categories such as gender, age, rural/urban, ethnic/linguistic minority, etc); and
- appropriate for measuring implementation of the right to health, (in other words, linked with specific government obligations).

The importance of selecting and developing indicators to monitor the right health has been highlighted by several UN human rights bodies, including the CESCR, and organizational efforts to do so are currently underway in varying degrees and scope. At the global level, WHO is in the process of developing indicators to support the monitoring of the right to health as part of its work on health and human rights. The American Association for the Advancement of Science (AAAS) is also working on the development of indicators for monitoring two specific aspects of the right to health, namely core obligations and the environmental dimensions of the right to health. (See section 8.3.) Moreover, there are examples of NGOs and NGO coalitions working on developing indicators for monitoring specific elements of the right to health, such as reproductive health rights. (See box below.)

#### *An example of NGOs working together to develop indicators<sup>5</sup>*

Some of the most impressive work to have been done by NGOs in developing indicators to monitor the right to health has been in the field of sexual and reproductive health rights. For example, the *Latin American and Caribbean Women's Health Network* (LACWHN - *Red de Salud de las Mujeres Latinoamericanas y del Caribe*, or RSMLAC) developed an indicator matrix entitled *Athena* to monitor implementation of the ICPD Programme of Action in seven countries in the region, as part of its activities in preparation for the ICPD ten year review.

LACWHN sought to define indicators that would enable civil society, including women's organizations, to have clearer parameters with which to evaluate compliance by government with its human rights commitments, and to confirm well-founded claims about gaps in its accountability. *Athena* was developed for the purpose of:

- achieving visibility of both the positive and negative effects of applying legislation and norms to issues of compliance;
- generating public policy with a gender perspective;
- clarifying political will on the issue of resource allocation;
- showing how better use could be made of both official and unofficial statistics; and
- where it can be shown to be justified, demanding more transparency in the information provided by government.

Both quantitative and qualitative indicators were identified and focused on a number of priority issues affecting the implementation by governments of their obligations. The indicators were categorized in three groups: political will; process and capacity building; and indicators of outcome or impact. The limitations associated with indicators of outcomes were taken into account. Specific mention was made of lack of accountability, adding to the heterogeneity of registries in the various countries of the region, as well as the insufficiency of data, in particular, the lack of disaggregated data by gender.

*Athena includes 181 indicators related to seven cross-cutting themes, with data from the period 1994-2002*

(each year having its own data). The cross-cutting themes are:

- 1 Sexual violence against girls;
- 2 Male responsibility in sexuality and reproduction;
- 3 Participation by women's organizations in decision-making bodies;
- 4 Adolescent access to sexual and reproductive health information and services;
- 5 Quality of care in sexual and reproductive health services;
- 6 Humane treatment of unsafe abortions; and
- 7 Comprehensive services for the prevention of HIV/AIDS and the care of those affected.

**Examples of Athena indicators on adolescent access to sexual and reproductive health information and services:**

<i>Political will indicators</i>		
Re International commitments	Re Juridical framework	Re Public budgets (health, reproductive health, etc)
<ul style="list-style-type: none"> <li>• Ratification of Convention on the Rights of the Child</li> <li>• Ratification of Convention on the Elimination of All Forms of Discrimination against Women, and its optional protocol</li> <li>• Ratification of Belem do Pará Convention</li> </ul>	<ul style="list-style-type: none"> <li>• Norms for promotion of the rights of adolescents to SRH services</li> <li>• Conditions for access of adolescents to SRH services</li> <li>• Laws regulating minimum age for marriage</li> </ul>	<ul style="list-style-type: none"> <li>• Per capita funds designated for adolescent sex education programmes</li> </ul>

<i>Process / Capacity building indicators</i>			
Re Education & Sector Services	Re Communication	Re Specific Normative	Re Citizen participation
<ul style="list-style-type: none"> <li>• Gender perspective in public upper secondary school curricula</li> <li>• Government strategy for distributing condoms</li> <li>• Health services include counselling for adolescents</li> <li>• Relative participation between sexes in the use of safe contraceptives</li> </ul>	<ul style="list-style-type: none"> <li>• Campaigns and/or public actions promoting adolescent SR rights</li> </ul>	<ul style="list-style-type: none"> <li>• Norms regulating adolescents' right to sexual education</li> <li>• Norms guarantee right of pregnant adolescents to continue education</li> <li>• Norms and protocols for quality of care for adolescents</li> </ul>	<ul style="list-style-type: none"> <li>• Adolescent participation in SRH and SR rights bodies and mechanisms</li> </ul>

## ***Outcome / Impact Indicators***

### **Re Looking for Gender Democracy**

- Maternal deaths in women under 20 years of age
- Maternal mortality in teenagers, categorized by cause and geographic location
- Fertility rate in female adolescents, categorized by geographic location
- Percentage of adolescents who use condom in relation to the total percentage who use some method

The indicators as well as other relevant data from various countries in the region have been entered into a database in such a way that they can be easily accessible to NGOs across Latin America and the Caribbean for the purpose of monitoring in their own countries as well as for making comparisons between countries. *To access the database and for further information, see [www.reddesalud.web.cl](http://www.reddesalud.web.cl).*

### **8.2.3 Working with benchmarks**

In keeping with the commitment to progressive realization of the highest attainable standard of health, government should establish national-level benchmarks (self-set goals or targets). By definition, benchmarks are dynamic and will shift over time. They are the means by which changes, both progressive and regressive, can be monitored.

Therefore, benchmarks will usually be supplemented, when further aims are set nationally to reflect changes in available resources, health issues and feasible aspirations. Whenever certain targets/goals are reached, new goals are likely to be defined and new targets introduced, to realize more fully the right to health. As with indicators, it is important when developing new benchmarks to take into account the realities in the country and the particular aspect of the right to health that is to be monitored. Any benchmarks that are set should be realistic but challenging.

#### ***What sort of benchmarks can be used for monitoring by NGOs?***

- national benchmarks established by your government;
- benchmarks established by both intergovernmental and non-governmental organizations;
- goals and international targets set by MDGs and consensus agreements of UN world conferences (and their subsequent follow-up reviews); and
- global benchmarks established by UN agencies (eg WHO, UNICEF, UNFPA, UNDP)

Many global benchmarks will be of only limited use in the national context. Wherever feasible, NGOs should work with national benchmarks.

### **8.2.4 Working with statistics**

#### ***The importance and limitations of working with statistical data***

Statistical evidence plays an essential role in measuring implementation of the right to health. This includes monitoring actual violations and the use of warning indicators to identify potential violations. In many developing countries improvement in the quality of vital statistics should be recognized as a priority for government. A human rights approach to health places particular focus on, and prioritizes, the needs of the most disadvantaged and vulnerable individuals and communities in a society. It is therefore *essential that data used for monitoring the right to health be disaggregated* so as to enable monitoring the status of, and changes within, these vulnerable groups.

Among other things, disaggregated data can highlight the differential treatment of population groups in risk factors, exposures, manifestations, frequency and severity of disease, as well as government responses to these. Disaggregated health data can help determine which groups require, or are likely to require, additional attention; which groups are suffering from discrimination in access to health-related services or facilities; which practices and behaviours need to be promoted, supported, induced or changed; which service provisions need to be enhanced and in what ways; and what financial mechanisms are needed to ensure that those who need more attention and/or services actually receive more.<sup>6</sup>

However statistical data cannot always be taken at face value. There is a risk that the statistical data made available may conceal inequities or discrimination. Governments are often reluctant to report or share data



that might raise questions about inequalities among groups or geographic regions in access to health-related services or facilities. To avoid doing so, some governments are selective in what kinds of data they report on a disaggregated basis or the types of disaggregation they provide. Others go even further and intentionally decide not to collect data that might portray them in an unfavourable light. During the apartheid period, for example, the South African government stopped collecting data disaggregated by race on key areas of health, such as the incidence of malnutrition, so as to avoid criticism. Other countries fail to take into account administrative practices that are not on the books in reporting outcomes. Therefore, it is important for NGOs to be aware of the limitations involved in working with statistical data and to learn how to ensure that the necessary safeguards are built in.

### ***Sources of information: What statistical data is readily available to NGOs?***

Statistical data relevant to the right to health includes:

- standard-based data, such as maternal mortality rates;
- data based on services provided, such as percentage of births attended by qualified staff; and
- health specifics, such as incidence vs. prevalence; case fatality rates; relative risk as opposed to absolute risk.

### ***Data: Using primary and secondary sources of information***

NGOs should give priority to monitoring available data and make maximum use of existing sources of information. Because many NGOs do not have enough time and resources to collect primary data it is important that they try to get the most out of secondary sources of information. Secondary sources can be used to collect the quantitative data needed to monitor vulnerable groups, for example, to compare the comparative incidence of certain diseases among national or sub-national population groups.

### ***Secondary sources of information include:<sup>7</sup>***

- national statistics and vital registration information published by governments, including institutional records, the census, surveys, and reports;
- international or national statistics published by UN specialized agencies and international organizations, including *World Health Statistics* (published by WHO), UNFPA population health statistics, demographic and health surveys, and US State Department country reports;
- information, including population-based surveys, collected by other NGOs, such as Amnesty International; Human Rights Watch; and the International Planned Parenthood Federation;
- country reports submitted by States parties to human rights treaty monitoring committees;
- shadow reports submitted by NGOs to treaty monitoring committees;
- research by academic institutions, including faculties of public health, environmental studies, medicine, and law;
- routine health services data; health centre registers, and information made available by public or private health facilities, including anonymised statistics based on clients attending family planning clinics;
- clinical records, but only when strictest confidentiality is observed in their use; and
- information provided by the media, including press cuttings from national and local newspapers.

If secondary sources of information are unavailable, contradictory, insufficient or unreliable, steps can sometimes be taken to collect primary sources of information and obtain the data needed by:

- conducting in-depth interviews;
- carrying out community, health service, or population-based surveys using tools such as simple questionnaires and focus group discussions;
- conducting general interviews and focus group discussions as part of a community-based study; and
- direct observation.

### ***Fictional case study on the use of primary sources of information:***

At an international meeting of health professionals, the national medical association (NMA) from developing country 'X' refuted its government's claim to have provided the population with 100 percent immunization coverage. General practitioners in rural areas had informed the NMA that they

had been attending an increasing number of polio patients. Although the NMA had considered approaching the Ministry of Health with this information, it was fearful that the report would be dismissed as a series of isolated incidents. The government had previously announced a highly successful donor-funded campaign to eradicate polio and the NMA was well aware that there were political interests in maintaining the official statistics, unless compelling outside evidence proved otherwise. Accordingly, the NMA took the initiative and circulated a questionnaire to its members. Detailed analysis of the replies revealed that most of the new cases were appearing in isolated regions of the country in which a particular ethnic minority lived, and where the functional literacy rate was below 10 per cent.

## **8.3 Important considerations to inform the selection and development of indicators for monitoring the right to health<sup>8</sup>**

*Section 8.3 is contributed by Sage Russell, AAAS*

The Science and Human Rights Program of the American Association for the Advancement of Science (AAAS) is working on two complementary efforts to develop indicators for monitoring the right to health. Both initiatives are in their relatively early stages as of this writing and the actual indicators and resource materials are not yet available. The emphasis in the following descriptions is on the kinds of considerations that inform the selection and development of indicators for human rights monitoring purposes.

### **8.3.1 Indicators for monitoring core obligations of the right to health**

One effort builds on the Program's longstanding focus on economic, social and cultural rights. Its goal is to develop or select indicators to measure states' compliance with the minimum core content of their health-related obligations, as set forth in CESCR General Comment 14. (See chapter 4.)

Evaluating the core obligations with respect to health as a human right requires a different analysis than simply measuring the availability of primary health care services, for example, although clearly there is overlap between the two. Evaluating health from a human rights perspective requires a determination of whether a state is fulfilling its obligations to respect, protect and fulfill the right to health. (See chapter 3.) It is important to be able to connect statistical information to the normative framework of the right to health in a way that enables human rights advocates to tell a persuasive and meaningful story. A human rights approach also encompasses a special focus on vulnerable groups, determining whether and to what extent traditionally disadvantaged population groups such as women, children, ethnic and racial minorities, and the poor are benefiting, or not, from health services. (See chapter 5.) To do this requires analyzing data that is appropriately disaggregated along such lines as gender and race, which in turn presents a considerable challenge in settings in which good data of any kind are often difficult to obtain.

The indicators should be based upon the criteria in CESCR General Comment 14 and address what the CESCR terms 'special topics of broad application': for example, non-discrimination and equal treatment; women and the right to health; gender perspective; children and adolescents; older persons; persons with disabilities; and indigenous peoples. (See chapter 5.) Health-related provisions in other human rights treaties and interpretive documents, such as CEDAW General Recommendation 24 and the CRC, will also be consulted in selecting or developing indicators.

General principles of international human rights law are relevant in developing indicators, as are the CESCR's reporting guidelines for States parties. For example, in addition to non-discrimination, the following criteria drawn from international human rights law are also critical to a human rights approach to monitoring health: non-regression and adequate progress; social participation (within communities as well as organized civil society groups); accountability/legal framework/remedies; and multi-sectoral strategies.

The CESCR has called on States parties to include the following information in their country reports to the Committee: the population's general state of physical and mental health; existence of a national health policy; percentage of GNP directed toward health; measures adopted to prevent rising health costs; access to care for the elderly; measures taken to promote community participation; measures to promote health education; and the role of international assistance, which is important to consider in evaluating the responsibilities of actors other than the state.

Because indicators are used for a variety of purposes, they may be organized in a variety of ways. For example, the broad range of indicators that might be used to measure general progressive realization of the normative content of the right, as set forth in Article 12, paragraphs a - d of the ICESCR necessarily differs

from a 'core' set of indicators developed to measure the minimum core content of the right. (See chapters 2 and 3.) Advocates for reproductive health, mental health, children's rights and labor rights, for example, will each want to focus on the particular indicators that are most relevant to their work. Litigation based on violations of minimum core content will naturally be very different from educational campaigns about the full range of norms entailed in progressive realization of the right.

The first step in this process will be an examination of NGOs' experiences in using indicators to monitor health for human rights purposes, to identify lessons about the applicability, feasibility and comparability of different indicators. Then, specific sets of indicators will be developed. A practical, reader-friendly manual will be produced, which will present the indicators, explain how to collect and interpret the data, and offer guidance on how to use the data collected.

### **8.3.2 Indicators for monitoring environmental dimensions of the right to health**

The second effort is geared specifically to developing indicators to monitor the environmental dimensions of the right to health. Data on environmental indicators and benchmarks have been collected from a number of multilateral agencies, national governments and international non-governmental organizations.<sup>9</sup> The next step involved developing a set of screening criteria to select indicators and benchmarks that are most relevant to monitoring the environmental dimensions of health from a human rights perspective, as follows:

- 1 Does the indicator measure the indirect or direct impact on the health of the general population? (ie, is the health effect of the environmental condition apparent?)
- 2 Does it measure or highlight the impacts on children and other vulnerable groups?
- 3 Can the source of problem/issue be identified? (ie, lead in gasoline (petrol), unsanitary drinking water etc.)
- 4 Can the indicator be applied (addressed/enforced/monitored) by regulatory agencies or other institutions? (ie, can it be used cost effectively for follow-up purposes on a regular or as-needed basis?)
- 5 Does the indicator signal a gap in achieving already established national regulatory and/or international guidelines?

By employing the above screening criteria, a smaller set has been selected from an initial group of about 500 indicators and benchmarks. In general, environmental indicators were divided into two broad categories:

- (a) preventive indicators, which serve to identify the source of the problem; and
- (b) remedial indicators, which measure the problem's severity.

Preventive indicators are 'warning' signs that point to avoidable adverse impacts, while remedial indicators show the relative degree of degradation of an environment that needs to be restored. In other words, preventive indicators are those that identify the source(s) of the problem, while remedial indicators highlight its symptoms or manifestations. For example, in the area of water and sanitation, an indicator measuring 'population with access to adequate sewerage services' is a preventive indicator, while 'annual incidence of diarrhea morbidity in children' is remedial. States have an obligation to address the causes of environmental impacts on health and to find ways to ameliorate the symptoms. Thus, both preventive and remedial indicators are necessary. While focusing resources on providing clean water and sanitation services and preventing cases of childhood diarrhoea morbidity and mortality in the long run, the plight of children currently suffering from diarrhoea must also be addressed.

Responsibility for ensuring that environmental health concerns are addressed rests primarily on the state. Indices are used to verify whether a government is reaching minimum thresholds. An index is a device that can be used to compare current raw environmental health data against accepted international standards. An air quality index for a particular country, for example, might measure the raw data concerning emissions of selected air pollutants on an annual basis, compared to WHO's international guidelines.

Indicators and indices can serve a variety of human rights purposes. One important human rights application concerns identifying the actor(s) responsible for the harmful effects and holding them accountable for their actions.

For environmental policies to have long-term positive impacts, formal accountability must be written into relevant legislation and regulation. Human rights-based environmental indicators and benchmarks can

provide channels for building accountability and important venues for information gathering, which can enhance the public's ability to assess their options in times of economic, social and cultural loss and instability. Indicators alone are not capable of solving such complex societal issues, but they can raise awareness concerning critical environmental problems and be used, as tools to enable policymakers to target problems where priority action is needed the most.

### 8.3.3 Key elements of indicators

Several key principles and factors must be incorporated within the indicators used to monitor human rights:

- *Policy relevant*

Indicators should measure issues that have the potential to be affected directly or indirectly by policy action.

- *Reliable*

The indicators should be easily accessible to all segments of society, and different people should obtain consistent results when they use them.

- *Accessible*

Data must be formulated in such a way that all readers can understand it.

- *Consistently measurable over time*

This is necessary to ensure that goals are being established and achieved and to evaluate whether progress is being made.

- *Disaggregation of data*

Disaggregating data means separating out data pertaining to particular subsets within the general population, enabling individual assessments to be made concerning identified minority populations and other vulnerable groups. Monitoring disaggregated data helps to identify the presence and effects of discrimination, which can then be addressed. For example, if a study shows that 50 percent of the children in a particular region are attending school, this tells only half the story. If the information is further disaggregated by gender, the data might reveal that of the 50 percent attending school, only two percent are female. This paints a clearer and more complete picture of the situation and indicates the presence of discrimination on the basis of gender.

- *Impartiality*

Enabling non-state actors, including NGOs, to participate in monitoring is important to prevent conflicts of interest that may arise when a party must monitor its own performance. Transparency and reliability of monitors are crucial, in light of the fact that assessing human rights performance is a task that is often controversial.

## 8.4 Undertaking budget analysis

*Section 8.4 is based on a contribution by Audrey R Chapman, AAAS*

*Using budget analysis to evaluate government compliance with the standards of the right to health*

Human rights commitments invariably have financial implications, particularly those related to the fulfilment of human rights obligations. Assessments of national budgets therefore can offer a useful tool to evaluate implementation of the right to health. Analysis of expenditures can enable NGOs to determine whether budgetary allocations match the requirements of a government's obligations arising from the right to health. It can also be helpful to analyze the relative priority given by government to various key components of the right to health.

Because ICESCR specifically mandates that all States parties *take steps to the maximum of available resources*, with a view to *achieving progressively* the full realization of the right to health, the analysis and documentation of a state's failure to do so can serve to identify violations. As such, it could potentially be the basis for various forms of advocacy, as well as litigation.<sup>10</sup> (See chapter 10.)

*Many poor countries devote considerably less than the five percent target; some even less than one percent of their budget, because of disproportionate expenditures on the defence sector or the burden of debt repayment. Government expenditures on health as a percentage of total expenditure are also quite low in some middle income countries.*

NGOs undertaking budget analysis to monitor the right to health should bear in mind four important levels of analysis. These are listed below, along with examples of relevant questions and issues to be investigated in each area.

1 *Analysis of the sufficiency of the resources devoted to health prevention and services*

- Do the funds devoted to health meet the WHO global targets of minimums for health expenditures?
- How does the investment in health compare with other commitments?

2 *Analysis of the manner in which the funds available for health related purposes are allocated*

- Is the money being well spent, with priority given to core obligations? (See chapter 4.)
- Is the government making targeted investments in programmes to assist the poor and disadvantaged?
- What is the relative proportion of resources invested in primary and tertiary care institutions?
- What is the relative balance between per capita investments for urban and rural residents?
- Are sufficient funds being invested in maternal and child health?
- Are sufficient funds being invested for immunizations and infectious diseases?

3 *Comparison of public allocations against expenditures*

Such an analysis should assess whether:

- the programmes and projects relevant to a right to health are actually implemented;
- the target beneficiaries actually benefit from the programmes that are implemented; and
- these projects and programmes contribute to the progressive realization of the right to health.

4 *Comparison of budgets over several years to conduct a time-series evaluation of trends.*

This type of analysis may indicate trends and changes in the state's policies and priorities.

Such an analysis should address questions such as:

- Do these trends generally support progressive implementation of the right to health or regression?
- Is the state allocating more or less money to critical health needs?
- Are the funds available being used more or less equitably over time?
- Have any significant rights related projects been cancelled?<sup>12</sup>

*Many states, including poor countries, choose to invest scarce resources in tertiary facilities and specialist training and interventions at the expense of funding primary and preventive care that could benefit a far larger number of people. To be consistent with a right to health approach, health expenditures should be invested to bring about the greatest health benefit for the population. Moreover, governments should accord priority to efforts to rectify existing inequities and imbalances in the distribution of resources in the health sector with targeted investments in programmes aimed at the poorest populations and for other currently underserved and disadvantaged population groups.*

*NGOs should be aware that access to data, such as official audits of state budgets, may be difficult to obtain and also have a considerable time lag.<sup>11</sup> These data problems particularly affect efforts to assess spending patterns for specific sectors of health. One strategy for dealing with these problems is to analyze, at least initially, approved budgets rather than the more accurate and sometimes revealing audited records of expenditure. Another is to compare total health spending against other areas of spending so as to evaluate the prioritization of resources.*

### ***What is the cost of implementing core obligations in low and middle-income countries?***

A right to health approach calls for priority to be given to the implementation of core obligations. (See chapter 4.) Because many governments in low and middle-income countries argue that budgetary constraints limit their ability to comply with their positive obligations arising from the right to health, it is important to clarify how such an approach can be translated into effective policies that improve health status in a cost-efficient manner.

As one indication that initiatives to improve health status can be cost-efficient, a WHO study identifies a minimum package of cost-effective public health and clinical interventions appropriate for low and middle-income countries. The minimum essential package of health services includes many

interventions identified as core obligations arising from the right to health. These include an expanded programme of immunizations; tobacco and alcohol control; AIDS prevention; prenatal and delivery care; family planning; as well as other clinical services<sup>13</sup>. Properly delivered, it is estimated that this package would eliminate 21 percent to 38 percent of the burden of premature mortality and disability in children under 15 years and 10 percent to 18 percent of the disease burden in adults. The package outlined for low-income countries would have a per capita cost of \$12 per year. The version for middle-income countries would entail about \$22 per capita.

## Notes

- 1 The Maastricht Guidelines on Violations of Economic, Social and Cultural Rights. As printed in *Human Rights Quarterly* 1998: (20)69.
- 2 Adapted from: Chapman AR. Core Obligations Related to the Right to Health. In Chapman AR, Russell S, editors. *Core obligations: Building a framework for economic, social and cultural rights*. Antwerp: Intersentia; 2002: 202-3.
- 3 Sano H-O. *Human rights indicators 2000: Country data and methodology*. Copenhagen: Danish Centre for Human Rights; 2000.
- 4 Ibid.
- 5 Text contributed by Herrerías, Gloria Sayavedra. Monitoring Coordinator, Latin American and Caribbean Women's Health Network (LACWHN).
- 6 A helpful list of secondary sources of national and international health-related data can be found in: International Human Rights Internship Programme (IHRIP) and Asian Forum for Human Rights. *Circle of rights. Economic, social and cultural rights: a training resource*. Washington D.C.: IHRIP. 2000.
- 7 Helpful examples of how to use disaggregated data for monitoring human rights can be found in: United Nations Development Programme (UNDP). *Human Development Report 2000*. New York: UNDP. 2000.
- 8 AAAS wishes to acknowledge the substantial contribution of Alicia Yamin of the Harvard School of Public Health and Karim Ahmed of the Global Children's Health and Environment Fund to drafting this section of the Manual, as well as to the work of developing right to health indicators that it describes.
- 9 These included the United Nations; WHO; Pan American Health Organization (PAHO); World Bank; UNICEF; UNFPA; United Nations Food and Agriculture Organization; Organization for Economic Cooperation and Development (OECD); United States Environmental Protection Agency; World Resources Institute; Worldwatch Institute; and the International Institute for Sustainable Development.
- 10 There are two precedents, *Soobramoney v Minister of Health, KwaZulu-Natal* (1997) in South Africa and *Eldridge v British Columbia (Attorney General)* (1997) in Canada. For an analysis of these cases and their implications for budget analysis see Liebenberg A, *Socio-economic rights*. In Chaskalson M, Kentridge J, Klaaren J, Marcus G, Spitz D, Woolman S. *Constitutional law of South Africa*, 3rd rev. Cape Town: Juta & Co; 1999.
- 11 Dioknow MSI. *A rights-based approach towards budget analysis*. Paper distributed by the International Human Rights Internship Program. Washington, DC; April 2000.
- 12 Ibid:29.
- 13 Bobadilla JL, Cowley P, Musgrove P, Saxenian H. Design, content and financing of an essential national package of health services. In: Murray CJL, Lopez AD, editors. *Global Comparative Assessments in the Health Sector: Disease Burden, Expenditures and Intervention Packages*. Geneva: World Health Organization; 1994: 171-180.

## Part III *Taking action: Working with the right to health*

### Chapter 9 Tools for monitoring II: Identifying violations

#### *Keys to Chapter 9*

##### *key information:*

- Identifying violations of the right to health provides the work of NGOs with focus and critical definition and can help direct their monitoring activities;
- Identifying and documenting violations can help to raise awareness on specific aspects of the right, mobilize public opinion, highlight the responsibility and accountability of government, and be used as the basis for many different advocacy activities;
- Identifying violations can form part of a strategy to work as watchdogs of governments as well as partners with governments;
- Governments can violate their obligations arising from the right to health by direct actions (*acts of commission*) and inactions (*acts of omission*);
- The most common ways that governments violate their immediate obligations to respect, protect and fulfil the right to health result from: direct government action, failure to fulfil minimum core obligations, and patterns of discrimination.

##### *key questions:*

- Can your NGO identify areas in which the government may be guilty of violations, and in particular of its immediate obligations? These include core obligations and obligations related to non-discrimination.
- If your NGO has identified a situation of health-related injustice or inequity as the point of departure for its monitoring and advocacy activities, can it be linked to the government's failure to comply with specific obligations arising from the right to health?
- Will your NGO's advocacy activities be strengthened by framing the main issue(s) in terms of *violations of the right to health*?

##### *key action points:*

- Become familiar with the nature of state obligations arising from the right to health and with common ways that governments violate them;
- Identify possible violations of the right to health that relate to the focus of your advocacy activities and/or to pressing health-related needs in the community.
- Document any identified violations and use these as the basis for monitoring and advocacy activities.

## Why is it important to identify violations of the right to health?

### 9.1 Introduction

Violations of the right to health are not as immediately obvious as the more traditional abuses of human rights such as torture and suppression of free speech. In such cases, NGOs have usually worked to identify and campaign against specific violations. But with economic, social and cultural rights, including the right to health, the tendency has been to concentrate more on monitoring their progressive realization than on identifying and exposing specific violations.

However, the position has been changing in recent years. Rights-based advocacy of health issues is effective precisely because it invokes the language of *legal rights* and *legally-binding state obligations*, and *violations*, all of

which are concerned with the relationship between individuals and the community as *rights-holders* and the state, or other responsible authorities, as *duty-bearers*.

The very fact that governments are accountable for complying with concrete obligations means that the identification of violations that correspond with those obligations, plays a vital part in working with a human rights approach to health. Monitoring whether violations are taking place helps NGOs to focus their work on potential problem areas and to assess the extent to which their government is taking seriously, *as a matter of priority*, the fulfilment of its duties to implement the right to health.<sup>1</sup> For this reason, the identification of common violations is helpful to direct monitoring.

Nevertheless, the reason for NGOs to identify violations of the right to health should not be regarded as necessarily confrontational, for example to *name and shame* governments. A guiding principle of this Resource Manual is that health professional associations and other NGOs working with a human rights approach to health have an important role to play, *both as partners* of governments, by constructively contributing to the promotion and progressive implementation of the right to health, *and as watchdogs* of governments, by monitoring their performance. In adopting a human rights approach to health NGOs should exert pressure from below by identifying violations at the individual and community levels and by educating people about their health-related entitlements. At the same time they should assist governments to meet their obligations in a sustainable manner. (See chapter 7.)

The immediate identification and documentation of specific violations serves several important purposes. It draws attention to urgent problem areas; provides the work of NGOs with focus and critical definition; and can help direct their monitoring activities. Furthermore, a focus on violations emphasizes both the responsibility and accountability of government. When described in the language of *rights* and *violations*, a lack of access to clean water or to primary health care that has been dismissed by the government as a regrettable and inevitable social problem, becomes a case of the government's failure to meet its human rights obligations and, as such, is taken much more seriously.

Bringing individual violations to the attention of the public can help change perceptions about entitlements to rights and mobilize public opinion to influence the government to change its policies and redefine its priorities. However it may still be necessary to rectify rights-based social problems by legal means, which will require identification and documentation of the alleged violation and of the failure by the government to meet the corresponding concrete obligation. The results, for example in the form of high profile court cases, have often had a significance far beyond the outcome for the plaintiffs. Equally important, the pursuit of legal remedies can generate awareness among the population that people do indeed have rights. Once this has happened, individuals and communities will be more likely to notice violations of their rights and demand change. (See chapter 10.) Thus, the monitoring of violations by NGOs can increase both public awareness and government accountability — thereby leading to a better and fuller implementation of the right to health.

In this chapter examples will be given of violations of the obligations to respect, to protect and to fulfil the right to health.

## 9.2 Different types of violations

Violations of human rights occur when a government fails to comply with its legal duties under international, regional and/or national law. *Violations are always linked to specific obligations.* When properly identified and documented as such, they are evidence that specific obligations have not been fulfilled. (See chapter 3 - *a quick guide to violations of the right to health.*)

In general terms, violations of the right to health can be caused by what a government:

- *does itself*, for example acting in defiance of its obligations;
- *fails to prevent others from doing*, for example by inadequate regulation of third parties such as the private sector, including corporations and private health service providers. Governments often use the actions of third parties as an excuse for what has actually been caused by their own neglect to regulate the private and nongovernmental sectors;
- *does not do*, for example failure to comply with its human rights obligations.

The right to health covers a very broad and diverse range of issues, including health care, nutrition, sanitation, and a healthy environment. It is for this reason that international law imposes a similarly broad and diverse range of obligations on states that correspond with the right to health. Because violations result from a government's failure to comply with its obligations, it is essential that NGOs have a basic knowledge of the *types* of obligations that can be violated. State obligations can be summarized as follows:



- The most important distinction is between a government's obligations to *respect*, to *protect* and to *fulfil* the right to health, each of which is subject to obligations of *conduct* and obligations of *result*. Areas in particular need of monitoring are: a government's obligation to comply with its *core* obligations; its budgeting practices; and its willingness and efforts to protect the rights of the poor and otherwise vulnerable and disadvantaged groups. (See chapters 3 and 7.)

The following section deals with the above obligations and gives examples of some of the most common ways in which governments violate them. It also indicates where the need to promote and to facilitate change is most urgent. In keeping with CESCR General Comment 14, the examples are classified as violations of a government's *immediate* obligations to *respect*, to *protect* and to *fulfil* the right to health, including minimum core obligations.

## 9.3 Examples of the most common ways that governments violate their immediate obligations to respect, to protect and to fulfil the right to health

*Section 9.3 based on a contribution by Audrey R Chapman, AAAS<sup>2</sup>*

These violations of the right to health will be classified as follows:

- those resulting from *direct* government action;
- those related to a government's *failure* to fulfil its minimum core obligations; and
- those related to patterns of *discrimination*.

### 9.3.1 In what ways do governments violate their immediate obligations to respect the right to health?

*Governments may violate their immediate obligation to respect the right to health by:*

#### 1 Deliberately withholding or intentionally misrepresenting, information essential for the prevention or treatment of illness or disability

When a government deliberately withholds life-saving information about exposure to toxic substances or intentionally misrepresents the existence of disease, it condemns citizens to unnecessary illness and sometimes even to death.

- President Mikhail Gorbachev's handling of the Chernobyl disaster in 1986 is a notable example. It took twelve hours for the accident to be acknowledged by the authorities. Clean-up personnel sent to the site were not warned about the potential effects of the radiation exposure. Nineteen days passed before a statement was issued giving information about the seriousness of the event. As a result, tens of thousands of citizens were needlessly exposed to radiation and illness and many to a painful death. Estimates of the number of related deaths worldwide range from 40,000 to more than one million.<sup>3</sup>
- In the initial years of the HIV/AIDS pandemic, many governments refused to acknowledge the rapidly increasing prevalence for fear that it would discourage tourism. By so doing, critical time was lost in monitoring the spread of the disease and in taking the necessary preventive measures.
- The failure by the Chinese Government in 2003 to disclose the full extent of the spread of the severe acute respiratory syndrome (SARS) for several weeks after cases of the disease had occurred in other countries is another example.

#### 2 Imposing discriminatory practices affecting women's health status and needs

In many countries women's health status and needs are considered solely or primarily in terms of their reproductive function. As a result, a woman's needs are often subordinated to those of her foetus. The following are examples of consequences to health of gender-based discrimination:

- Some countries condone the prohibition of fertile women (but not of men) from working in occupations that can be hazardous to their health. Others justify forced medical interventions, such as caesarean sections and sterilization, on women without their consent.
- An extreme example was the Taliban's restriction of women's access to health care in Afghanistan. In 1997 a policy segregating men and women into separate hospitals was enforced. Women were denied access to hospitals in the capital, Kabul, other than for emergencies, and

were limited to using a single facility for female patients, which had inadequate services and equipment.

### **3 Adopting laws and policies that interfere with reproductive rights**

Despite recognition of women's reproductive rights by the ICPD and by CESCR General Comment 14, many countries have continued to maintain laws and policies that interfere with, or obstruct, women's reproductive health rights. Examples include:

- imposition of criminal penalties on women who have undergone induced abortion;
- so-called 'right to life' policies that prohibit or severely restrict the availability of reproductive health information and services for women, including contraception;
- the requirement that married women must have the permission of their husbands or partners before they can receive certain reproductive health information and services; and
- the conditions placed on women's eligibility for voluntary sterilization, for example those based on the number of living children, the age of the woman, or the number of caesarean sections she has undergone.<sup>4</sup>

### **4 Promoting harmful substances**

Examples include:

- policies that promote the growth of tobacco crops and encourage tobacco consumption, such as the provision by some states in USA of crop subsidies for the cultivation of tobacco; and
- the reluctance of governments in countries with state-owned tobacco companies, like China, to adopt pricing measures and restrictive advertising policies that effectively discourage the use of tobacco products because of the potential decrease in their revenues.

### **5 Inappropriate health resource allocation**

- The disproportionate investment by some governments in expensive diagnostic and curative health services and equipment that are then accessible only to a small, privileged group of the population, to the detriment of investment in primary and preventive health services that can benefit the health of the population as a whole.<sup>5</sup> This policy is particularly damaging to the health of the poor, vulnerable, or otherwise disadvantaged groups in developing countries, especially those living in rural areas, and must be recognized as indirect discrimination, which is what it is.

## **9.3.2 How do governments violate their core obligations to protect the right to health?**

**Governments violate their minimum core obligations to protect the right to health by:**

### **1 Failure to block or discourage medical or cultural practices that endanger health**

- According to WHO estimates, 130 million women and girls are subjected each year to female genital mutilation/cutting (FGM/C). Very few governments take active steps to discourage this practice, and even when there are laws prohibiting or restricting FGM/C, they are rarely enforced effectively, if at all. In countries where state policies require the operation to be performed by medically qualified practitioners in hospitals, it has been found that this requirement often makes matters worse by appearing to sanction the practice. Ministries of Health rarely take steps to counter religious or medical claims that the operation is mandatory for health, religious, and moral reasons.<sup>6</sup>

### **2 Failure to discourage the production, marketing, and consumption of cigarettes, and the misuse of alcohol**

- Tobacco was estimated to account for over 3 million annual deaths in 1990 and rose to around 4.9 million in 2002. WHO estimates that tobacco-related deaths will increase to 8.4 million in 2020 and 10 million in 2030.<sup>7</sup> Despite the very clear evidence of the causal relationship between the use of tobacco and increased mortality and morbidity, political pressures from the producers of tobacco and others with financial interests in its marketing and distribution often discourage governments from prohibiting, restricting, and/or discouraging smoking and alcohol abuse.

### **3 Failure to protect women against violence**

- Few if any governments undertake effective measures to deal with domestic violence. The abuse is often systematic and sufficiently serious to require women to seek hospital treatment for the

resulting injuries. In the USA domestic violence is the leading cause of injury among women of reproductive age. Battered women can have serious health problems. They may have a higher risk of miscarriage; of giving birth to underweight babies; are more likely to require psychiatric treatment; and are more prone to alcohol abuse, drug dependence, chronic pain, and depression. Rape and sexual abuse are also widespread in all regions, classes, and cultures. They cause physical injury; psychological trauma; unwanted pregnancies and exposure to high risk of STIs and HIV/AIDS.

#### **4 Failure to control activities of transnational corporations that have adverse effects on health and the environment**

- Faced with pressures resulting from globalization and restrictions imposed by weak regulatory infrastructures, many governments have failed to control activities of transnational corporations that have adverse effects on health and the environment.
- Despite evidence that exposure to crude oil and its constituents is harmful to human health, a study of the health effects of oil exploration and extraction in the Ecuadorian Amazon region has revealed that the government of Ecuador permitted a Texaco-Gulf consortium to proceed with unregulated oil development. As a result, billions of gallons of untreated toxic wastes and oil were released directly into the water supply. The effects on health of exposure to oil contamination include increased risk of cancer and adverse effects on the reproductive and immune systems. The government of Ecuador failed to respond to claims by indigenous and environmental groups that contamination had caused widespread damage to both health and the environment. It also refused to provide necessary information or to offer any remedy. (See chapter 10, section 10.4.)<sup>8</sup>

### **9.3.3 How do governments violate their core obligations to fulfil the right to health?**

*Governments violate their minimum core obligations to fulfil the right to health by:*

#### **1 Failure to recognise and/or meaningfully implement the right to health**

- Each State party to the ICESCR incurs a core obligation to recognise explicitly the right to health for all its people by introducing some form of legally or administratively enforceable entitlement to health protection and/or health services. It must also adopt and enforce laws and policies that recognize the importance of health as a priority and a social good; review and repeal legislation that impairs the exercise of the right to health, and refrain from undertaking actions and adopting policies that violate the right. Although more than 130 countries have ratified the Covenant, few of them provide constitutional or legal recognition of the right to health, to health care, or to health protection, and few of them have made explicit commitments to formulating a public policy plan based on the right to health. It is, therefore, unusual for citizens to have legal or administrative grounds for challenging violations based on non-fulfilment.

#### **2 Failure to adopt a detailed plan for realizing the core minimum requirements of the right to health in the national health policy**

- States parties to the ICESCR must legislate, regulate, mobilize resources, and take other appropriate actions to implement their minimum core obligations. The development and implementation of comprehensive health policies consistent with minimum core obligations are likely to require an incremental approach in many countries. States parties should, therefore, develop a systematic plan setting forth goals and a timetable to achieve each component of the relevant obligations. The achievement of greater equity, appropriate allocation of resources, and cost-effective investments is central to policy development.
- Implementing minimum core obligations requires governments to collect the necessary data on health status and outcomes; evaluate progress; and utilize the data to revise and refine their policies. Just as improving the status of the most vulnerable, neglected, and disadvantaged groups (as well as regions) is central to the health planning process, the associated monitoring protocols must be adequate to evaluate the extent to which the government is achieving this goal.<sup>9</sup> Despite these requirements, very few governments have developed a clear and detailed strategy that contains a specific time limit for achieving the minimum core obligations of the right to health. Few governments monitor and evaluate their progress systematically.

- 3 Insufficient expenditure on health, including disproportionate investment of public resources in ways which benefit the health of only a narrow section of the population**
- WHO has set a global minimum target of 5 percent of Gross National Product (GNP) for health expenditure. This includes funding for hospitals, maternity and dental centres; clinics with a major medical component; national health and medical insurance schemes; preventive care; and family planning.<sup>10</sup> A human rights approach requires that this proportion of the GNP be allocated so as to achieve the greatest benefit for the health of the population. Priority should therefore be given to investment in public health measures, primary health care, and preventive services, in preference to expensive tertiary care facilities. Priority should also be given to rectifying existing inequities and imbalances in the distribution of resources in the health sector, so as to bring funding for health services for currently underserved and disadvantaged groups up to the required levels.
  - Most low income countries devote considerably less than 5 percent of their GNP to expenditures on health, and many of them have actually been cutting back on investment in the health sector. In most low income countries with annual per capita incomes of less than US \$1000, only 1 to 3 percent of gross domestic product (GDP) is generally spent on health, translating into health spending per capita of between US \$2 and US \$5.<sup>11</sup> Public health expenditure in the 35 countries ranked as being in the lowest category on the United Nations Development Programme's human development scale ranged from a high of 3.6 percent of GDP to less than 1 percent. More than half of these countries invested less than 2 percent. When both public and private expenditure were taken into account only six of the 35 countries were above the 5 percent recommended minimum.<sup>12</sup>
  - Many countries, including the poorest countries, misallocate scarce resources by investing in tertiary facilities, high technology medicine, and training for specialists, at the expense of primary and preventive health care that could benefit a far larger number of people. It is not uncommon for resources from the public sector in such countries to be invested in interventions that have low cost-benefit, such as organ transplants, while critical and highly cost-benefit interventions, such as services for the diagnosis and treatment of tuberculosis (TB) and STIs remain seriously under-funded.
- 4 Failure of governments to rectify existing imbalances in providing health services**
- In many countries in the world, the poor continue to be deprived of adequate access to basic health care, or receive low quality care, while government spending for health is allocated disproportionately to the more affluent sections of the population in the form of subsidized care to sophisticated public tertiary care hospitals (which are relatively expensive, usually requiring specialty-trained health professionals and high tech equipment) or to private and public health insurance schemes. The consequences to health are often concealed by the failure of the governments concerned to collect and publish adequately disaggregated data (particularly by gender) on access to health services. A single teaching hospital can absorb 20 percent or more of the budget of the Ministry of Health.
  - Preferential funding for urban residents is not uncommon. A study of the Mexican national health budget conducted by FUNDAR, a Mexican NGO, documented enormous inequities between the benefits offered by the country's premium public health program, which covered people in the wealthier urban areas, and those left to fend under other public health services, primarily the indigenous residents of poorer rural health areas. On a per capita basis, rural Mexicans received less than half of the health care resources of the urban residents.<sup>13</sup>
- 5 Failure of governments to provide adequate public health measures against infectious diseases**
- Infectious diseases in 2001 caused 14.7 million deaths, accounting for 26 percent of the total global mortality.<sup>14</sup> They also cause chronic and debilitating illnesses for many millions of people. The resurgence of some infectious diseases in developing countries, such as TB and malaria, is due mainly to deterioration in their public health services rather than to a lack of knowledge concerning their transmission or treatment.<sup>15</sup> Although this is occurring disproportionately in tropical countries, longstanding decay in the infrastructure of public health services, compounded by negligence by governments in monitoring water supplies, has led to a resurgence of infectious diseases in some countries in transition.<sup>16</sup>
  - The enormous increase in the global prevalence of HIV / AIDS infection is particularly disturbing. An estimated 40 million adults and children are currently living with HIV / AIDS, of whom 25 —

28.2 million are in sub-Saharan Africa. The UNAIDS programme estimates that 3 million people died of AIDS and that some 5 million new infections occurred in 2003.<sup>17</sup> In countries such as Senegal and Uganda, governments have taken vigorous national prevention campaigns to contain the infection, with successful results. But few countries are undertaking such measures to contain the pandemic.

#### **6 Failure to cover the eligible population with a package of childhood immunizations**

- The Expanded Programme on Immunization (EPI) claims to cover about 80 percent of children in developing countries against six major diseases. Children in poor households make up a disproportionately large number of those not yet inoculated.<sup>18</sup> This is the case even in some developed countries, such as the USA, where coverage of eligible children for basic inoculations is even less comprehensive than in some developing countries. The lack of infrastructure for vaccine manufacturing, storage, and distribution in many developing countries may make it difficult to maintain their reported rates of coverage.

#### **7 Failure to provide adequate obstetric and family planning services**

- WHO estimates that more than 50 percent of women in the world's poorest regions deliver their babies without the help of a skilled birth attendant. Furthermore, more than 120 million couples have an unmet need for safe and effective contraception.<sup>19</sup> Few countries have met the investment targets agreed by the ICPD and by 2000 the investments from both developing countries and the donor community had fallen short of their original commitments.

#### **8 Failure to provide adequate primary health care, basic health service, or public health infrastructures**

- The provision of primary health care has been a core policy for the international community since the adoption of the Declaration of Alma-Ata in 1978. Many in the global health community consider a primary health care orientation to be essential for equitable progress in health. Primary health care refers both to a discrete level of care and an overall approach to responsive and equitable health service provision. Enormous obstacles exist to the provision of primary health care, particularly in the poorest countries. Many factors account for the lack of progress: insufficient resources and failure to invest available resources in primary care; limitations in the number and distribution of health workers; and lack of a commitment to universal health access among them.<sup>20</sup>

## **Notes**

- 1 Chapman AR. Conceptualizing the right to health: A violations approach. *Tennessee Law Review*. Winter 1998; 65:389-418.
- 2 Most examples in this section are adapted from Chapman AR. Approaches to monitoring the internationally defined right to health. (Unpublished paper) and Chapman AR. Conceptualizing the right to health: A violations approach. *Tennessee Law Review*. Winter 1998; 65:389-418.
- 3 Cuomo K K. Human rights and the environment: Common ground. *The Yale Journal of International Law* 1993;(18): 228.
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- 5 Committee on Economic, Social and Cultural Rights. General Comment 14, The right to the highest attainable standard of health. E/C.12/2000/4: para 19.
- 6 Merton V. Review Essay: Women and health research. *Journal of Law, Medicine, and Ethics* 1994; (22): 274-277.
- 7 Data from WHO, [http://www.who.int/tobacco/health\\_impact/en/](http://www.who.int/tobacco/health_impact/en/).
- 8 Center for Economic and Social Rights. Rights violations in the Ecuadorian Amazon: The human consequences of oil development. *Health and Human Rights* 1994; (1): 82-101.
- 9 On these points see: Office of the United Nations High Commissioner for Human Rights. Report of the Seminar on appropriate indicators to measure achievements in the progressive realization of economic, social and cultural rights. Geneva: 1993 Jan 25-29. A/CONF.157/PC/73: paras 205 and 206.
- 10 World Bank. *World Development Report 1993*. Washington, D.C: World Bank; 1993: 312.
- 11 World Health Organization (WHO). *World Health Report 2003: Shaping the Future*. Geneva: WHO; 2003: 120.

- 12 United Nations Development Programme (UNDP). Human Development Report 2001. New York: Oxford University Press for the UNDP; 2001: 161.
- 13 The results of the study are cited in: Shultz J. Promises to keep: Using public budgets as a tool to advance economic, social and cultural rights. Conference report; 2002 Jan; Cuernavaca, Mexico. Mexico City: Ford Foundation and FUNDAR-Center for Analysis and Research; 2002: 39.
- 14 World Health Organization. Global defence against the infectious disease threat. Communicable diseases 2002. Geneva: WHO; 2003. WHO/CDS/2003.15: 6.
- 15 Platt A. Infecting Ourselves: How Environmental and Social Disruptions Trigger Disease. Washington, D.C: Worldwatch Institute; 1996. Worldwatch Paper #129: 10.
- 16 Examples include the Russian Republic and some former East Bloc countries. See Platt A. Ibid:48-9.
- 17 UNAIDS, WHO. AIDS Epidemic Update. Geneva 2003: 3-5.
- 18 World Bank. World Bank Development Report 1993. Washington, D.C: World Bank; 1993: 8.
- 19 WHO. Reproductive health—Draft Strategy to accelerate progress towards the attainment of international development goals and targets. Geneva. EB113/15 Add 1; 2003: 6.
- 20 World Health Organization (WHO). World Health Report 2003. Ibid:107-110.

## Part III: *Taking action: Working with the right to health*

### Chapter 10 Promoting the right to health: Activities to promote and protect the right to health at community, national and international levels

#### *Keys to Chapter 10*

##### *key information:*

- *Political and legal advocacy complement each other and are mutually reinforcing in promoting and protecting the right to health;*
- *It is important to promote cooperation among NGOs and government in the development and implementation of human rights based health policies and programmes; and*
- *It is equally important that NGOs pursue all available judicial and quasi-judicial mechanisms and procedures at sub-national, national and regional levels in order to seek remedies for violations and hold governments accountable.*

##### *key questions:*

- *How might your NGO effectively use the results from its monitoring activities in multiple and complementary advocacy activities?*
- *Given the priorities, objectives and strengths of your NGO, with which parties could you form strategic partnerships? Examples include government, health professional organizations, and other NGOs including human rights groups and NGOs advocating on behalf of the poor, vulnerable, or otherwise disadvantaged groups.*

##### *key action points:*

Activities by which NGOs can promote and protect the right to health include:

- *engaging in research and documentation;*
- *increasing public awareness of the right to health and engaging in community education and mobilization;*
- *promoting capacity-building among health professionals and conformity with the right to health in service delivery;*
- *building coalitions and forming networks;*
- *promoting sexual and reproductive health rights;*
- *advocacy efforts related to international obligations arising from the right to health; and*
- *working with national and regional enforcement procedures to ensure state accountability.*

## 10.1 Introduction

Health professional associations and other NGOs that advocate for health have a key role to play in monitoring, promoting and protecting the right to health at the community, national, and international levels. As previous chapters in the Resource Manual have discussed, monitoring can involve many different types of NGO activities and objectives. The emphasis in this chapter is on describing a wide variety of practical strategies that NGOs can successfully use to promote and protect the right to health.

In any form it takes, NGO monitoring is usually closely linked with other, mutually-reinforcing, activities. Both *legal and political advocacy strategies* are effective and complementary tools to promote and protect the right to health. Strategies can complement and reinforce each other, such as those that involve political advocacy, including lobbying government to use human rights standards as a framework for health-related

policies and programmes; those that involve engaging in community education and mobilization; and those that pursue judicial or other appropriate remedies for violations. They also can address some of the most typical obstacles to the realization of the right to health including a lack of public awareness about the right and its associated obligations among policy makers and health professionals; a lack of political will; and insufficient legal and other precedents and mechanisms for enforcing the right and ensuring accountability.<sup>1</sup>

In addition, many health professional associations and health-related NGOs are involved, both as policy advisers and service providers, in the organization, management and delivery of health services. For this reason another important element of promoting and protecting the right to health is for NGOs to *work in cooperation with government authorities* to develop and implement human rights based policies and programmes. (See section 10.2 and chapter 7.)

But NGOs must be independent of government in order to remain free to challenge any denial by the responsible authorities of actual or potential violations of the right to health. A key challenge for many NGOs working to promote and protect the right to health involves balancing these two approaches - independence from, and collaboration with, governments.<sup>3</sup>

The bulk of this chapter presents case studies that illustrate NGOs using a human rights approach to health to good effect. It highlights examples of advocacy projects and campaigns that promote and protect the right to health through:

- engaging in research and documentation;
- increasing public awareness of the right to health and engaging in community education and mobilization;
- promoting capacity-building among health professionals and conformity with the right to health in service delivery;
- building coalitions and forming networks;
- promoting sexual and reproductive health rights;
- advocacy efforts related to international obligations arising from the right to health; and
- working with national and regional enforcement procedures to ensure state accountability

The case studies present a sample of the strategies and activities available to NGOs in working within a health and human rights framework. They are intended to highlight how NGOs are promoting and protecting the right to health *in practice* and in the context of their own organizational goals and strengths. Many of the cases also illustrate the successful integration of overlapping and mutually-reinforcing advocacy strategies. For example, NGOs that undertake research and documentation of violations can use their results for community education and mobilization about the situation as well as for seeking a judicial remedy for victims by bringing a case to a domestic or regional court.

The following cases are examples of NGOs using diverse and complementary strategies to advance the right to health:

### **Case study 10.1.1**

The *Centre for Enquiry into Health and Allied Themes* (CEHAT) is a research and advocacy group working at both regional and national levels in India. Its objective is to bring about the right to health, including the right to health care, through a health care system that is universally accessible to all, equitable and socially just. It aims to achieve this by undertaking research and advocacy to challenge existing health care systems. The underlying basis of its work is to develop strategies and to collaborate with other interested bodies for changes that are based on a human rights approach, as opposed to the traditional welfare-orientated based approach to health sector reforms.

Its activities fall into the following programme areas: health services and financing; health legislation; ethics and patients' rights; women and health; and health and human rights. CEHAT has undertaken research on the above thematic areas and has engaged in wide-ranging advocacy to strengthen and improve public health services, including experiments in service provision. In addition, it has

*'Human rights advocacy is hardly ever purely legal or purely political. The most effective strategies combine political action with legal action. ...Ultimately, legal and political actions are mutually reinforcing and work together to shape more equitable policies, standards and attitudes and assure that governments and citizens comply with international human rights law.'*

Women's Human Rights Step by Step<sup>2</sup>



accumulated extensive documentation on health legislation at the national level and has developed a national and regional health services and financing database. CEHAT has also investigated and documented violations of health-related human rights and has attracted public interest by engaging in litigation in support of the right to health.

*For further information, see [www.cehat.org](http://www.cehat.org)*

### **Case study 10.1.2**

The *Canadian HIV/AIDS Legal Network* is an NGO that was founded in 1992 and now has more than 250 members in Canada and around the world. The Legal Network promotes the human rights of people living with and vulnerable to HIV/AIDS, in Canada and internationally, through research, legal and policy analysis, education, advocacy, and community mobilization. Among other things, the Network promotes responses to HIV/AIDS that: implement the International Guidelines on HIV/AIDS and human rights; respect the rights of people with HIV/AIDS and those affected by the disease; facilitate care, treatment and support of people with HIV/AIDS and those affected by the disease; facilitate HIV prevention efforts; and address the social and economic factors that increase vulnerability to HIV/AIDS and to human rights abuses. One example of the Network's extensive legal and policy assessment work is its discussion paper, *Human Rights for People Living with HIV/AIDS* (2004), available along with other similar material at the NGO's website.

*For further information see [www.aidslaw.ca](http://www.aidslaw.ca)*

## **10.2 The importance of promoting cooperation among NGOs and government in the development and implementation of human rights based health policies and programmes**

Implementation of the right to health at the national level is *the key factor* to the enjoyment of the right by people during their everyday lives. In view of this, it is important that NGOs work constructively with government agencies, policy makers, and public officials in the design, promotion, implementation and monitoring of policies and programmes (including associated budgets) that conform to the right to health. Such cooperation between government and civil society can be carried out effectively at institutional, community, and national levels and is a critical element for the implementation of sustainable and relevant programmes. (See chapter 7.)

Working with the right to health at the national level involves engaging with a range of government departments, including those that are not specifically dedicated to health but whose responsibilities may have a direct bearing on it. These include, for example, departments responsible for justice, human rights, social affairs, housing and infrastructure, urban affairs, rural development, education, women's affairs, children's affairs and indigenous peoples' affairs.

There are a variety of ways in which health professional associations and other NGOs that advocate for health can collaborate with public authorities to promote the use of human rights standards as criteria for designing health-related policies and programmes. For example, such organizations can contribute to:

- designing, implementing, managing and monitoring health policies and programmes that focus on remedying inequalities and promoting dignity, and that emphasize an integrated and multi-sectoral approach to health system development;
- identifying barriers to implementing the right to health, particularly those affecting poor, vulnerable, or otherwise disadvantaged groups who need special assistance from the state if they are to enjoy the right to health. These groups include rural women, adolescents, people living with HIV/AIDS, children, people living in poverty, indigenous peoples, and persons with disabilities;
- identifying ways to improve the participation of communities in decision-making processes that affect their health and well-being; and
- building health and human rights standards into the country's programme for development.

Health professional associations and other NGOs also have an important role to play in contributing to a national public health strategy and plan of action that states have a *core obligation* to adopt and put in place. (See chapter 4.) CESCR General Comment 14 stresses that authorities should collaborate with *civil society, including health experts*, in designing the national strategy and in adopting a framework law that can give effect to it. Even in times of resource constraint, governments are required to monitor the extent to which the right to health is realized or not realized, and to devise strategies and programmes for its promotion.

NGOs can contribute to the process of designing and implementing a national public health strategy and plan of action by, for example:

- helping to establish priorities for the national strategy. This might include contributing baseline studies, community-based studies or position papers, or by submitting their conclusions to relevant authorities or for publication in the appropriate professional journals or in the media;
- ensuring that the plan of action takes account of existing gaps in the government's compliance with its obligations arising from the right to health;
- identifying reasonable steps to close these gaps;
- identifying the resources available to meet government obligations, with a priority on core obligations, and the most cost-effective way of allocating those resources;
- helping to identify appropriate country-level right to health indicators;
- helping to establish the national targets (benchmarks) to be achieved in relation to each indicator and the time-frame for their achievement;
- participating in monitoring progress in realizing these targets;
- contributing to the design of appropriate policies by which the targets can be achieved; and
- identifying the most cost-effective way of using the resources available to attain defined objectives in the strategy and plan of action.

### 10.3 Engaging in research and documentation

The research and documentation of violations of health-related human rights is an essential part of promoting and protecting the right to health. Reports and results from investigations constitute important advocacy tools that can be used in other campaigns, both legal and political, including:

- public education and awareness-raising campaigns on the right to health;
- mobilizing public opinion in support of holding government accountable for complying with their obligations. This might involve promoting civil action related to the documented violations, including letter writing/email campaigns, petitions, and public demonstrations;
- lobbying public officials who are responsible for the adoption and implementation of legislation and policies, such as parliamentarians, and national and local government officials, to address and remedy the documented violations as well as to address broader changes necessary to improve enjoyment of the right to health. These might include: incorporating international standards and obligations of the right to health into domestic legislation and policies; initiating law reform if existing laws are inadequate; passing relevant new laws; and improving the enforcement of laws and policies;
- furthering legal action and seeking remedies for the victims of violations;
- seeking quasi-judicial remedies through a domestic administrative human rights body, such as an ombudsman office; and
- preparing a shadow report to an international or regional treaty monitoring body.

#### Case study 10.3.1

*Human Rights Watch (HRW) established the Children's Rights Division in 1994 to monitor human rights abuses against children around the world and to campaign to end them. HRW seeks to encourage governments and civil society to take stronger action to implement the provisions of the Convention on the Rights of the Child (CRC) and to strengthen protections for children. Its HRW Children's Rights Division sends fact-finding missions to countries where abuses are occurring in which interviews are carried out with child victims; parents; human rights activists; lawyers; child care workers; and*

government officials. It also works closely with local human rights groups to identify specific abuses and strategies for change.

After one such fact-finding mission to Zambia, HRW published a report entitled *Suffering in Silence: The Links between Human Rights Abuses and HIV Transmission to Girls in Zambia* (2002). The report documents the widespread sexual abuse of girls in Zambia and shows how such abuse exposes them to HIV infection. The report also analyzes how these abuses violate the rights of children under the CRC. In April 2003, HRW received a letter from the office of the President of Zambia, Levy Mwanawasa, stating that, following his review of its report he had ordered the establishment of an inter-ministerial programme on the sexual abuse of girls in his country.

*For further information, see [www.hrw.org](http://www.hrw.org)*

### **Case study 10.3.2**

*Amnesty International* has been documenting and campaigning for disability rights in Bulgaria. The results of investigative research visits to mental health institutions by experts representing Amnesty and the Bulgarian Helsinki Committee together with Mental Disability Rights International (MDRI) were published in an Amnesty International report entitled *Bulgaria: Far from the Eyes of Society. Systematic Discrimination against People with Mental Disabilities* (2002). The report focuses on persons with mental disabilities who are held involuntarily in psychiatric institutions or in social care homes for adults or children. It concludes that they are victims of systematic discrimination as a result of their mental disabilities and that they suffer a broad range of other human rights violations. The report claims that such violations arise from inadequate legislation and that they are subject to procedures that fail to conform with international standards, as well as from widespread unacceptable practices, including inadequate medical treatment and rehabilitation, inappropriate use of restraint and seclusion, and refusal to take action on complaints of ill-treatment.

The report concludes that these violations should be dealt with through enforcement of international human rights standards and by appropriate reforms of the mental health care services. Meanwhile Amnesty has conducted workshops for staff in two of the institutions that it visited and has initiated a letter-writing campaign, calling for appeals to be sent to the relevant Bulgarian authorities asking them to take immediate remedial action. Amnesty continues to monitor the situation in social care homes including actions that have been taken by the Bulgarian authorities to implement the report's recommendations.

*For further information, see [www.amnesty.org](http://www.amnesty.org)*

### **Case study 10.3.3**

*Physicians for Human Rights – Israel* (PHR-Israel), as part of a project run jointly with another local NGO, The Regional Council for Unrecognized Negev Villages (RCUV), has successfully brought a legal action to address violations of the right to health of communities living in 'unrecognized' Bedouin villages in the south of Israel. Some 75,000 people live in these villages and their 'unrecognized' status excludes them from access to basic services, including medical facilities. The villages do not appear on official maps- hence, a simple task, such as ordering an ambulance into the village, becomes impossible and the arrival time of an ambulance to a designated meeting point can take up to 45 minutes.

In 2000, PHR-Israel submitted a High Court petition demanding that primary health care clinics be erected in three unrecognized villages, based on the premise that all citizens of Israel, irrespective of place of domicile, have the right to primary health care under the National Health Insurance Law. Following this petition, the Health Ministry and the appropriate Health Management Organizations were obliged themselves to establish eight primary health care clinics in unrecognized villages.

PHR-Israel and RCUV worked together on this project for over a year. The work included field work, documentation of individual cases, advocacy and dissemination of information. The NGOs issued a comprehensive joint report on health in the 'unrecognized' villages of the Negev, *No-Man's Land* (2003).

In addition to its activities in documenting violations and enforcing legal remedies, PHR-Israel has been raising public awareness of the right to health and has engaged in advocacy to promote policy changes to end systematic abuses of human rights and of the right to health. It has given priority to

marginalized groups, including migrant workers, disadvantaged citizens and residents of Israel, residents of the Occupied Territories, and prisoners and detainees. PHR-Israel also operates an Open Clinic in Tel Aviv, available to all who do not have health insurance, and it conducts a Mobile Clinic every Saturday in the West Bank.

*For further information, see [www.phr.org.il](http://www.phr.org.il)*

### **Case study 10.3.4**

*Mental Disability Rights International* (MDRI), a USA-based advocacy organization, conducts research on and documents the situation of people with mental disabilities around the world. Based on their field research, MDRI also advises governments and NGOs how to promote and enforce the human rights of people with mental disabilities in the most efficient way.

In a recent report, *Not on the Agenda: Human Rights of People with Mental Disabilities in Kosovo* (2002), MDRI documented a large number of violations of the right to health of people suffering from mental disability. For example MDRI estimated that at least 40,000 Kosovars with severe mental disabilities have no access to appropriate services; that many existing institutions provide no treatment whatsoever and have inadequately trained staff; and that physical and sexual abuse in the institutions often goes unchecked. MDRI found that detention in particular facilities, the Shtime psychiatric facilities, is itself a violation of the right to health, because of the failure to treat patients and the absence of protection for them against physical abuse or sexual violence.

In follow-up to this report, MDRI has opened an office in Kosovo to work on a new project, *Initiative for Inclusion: Kosovo*. This initiative aims to provide technical assistance to policy makers and NGOs, to protect the rights and improve treatment of people with mental disabilities. Based on their research in Kosovo, MDRI has defined specific urgent needs as the focus of their initiative in Kosovo:

- Training of staff in mental health institutions to prevent self-abuse of patients;
- Advocacy for the creation of an oversight system with an independent board to investigate allegations of human rights abuses against patients; and
- Advocacy for the closing of one particular institution, the Shtime Institute, and for reintegrating people with mental disabilities into safe community services and support systems.

*For further information see [www.mdri.org](http://www.mdri.org)*

### **Case study 10.3.5**

*Physicians for Human Rights* (PHR USA) promotes health by protecting human rights. As a founding member of the International Campaign to Ban Landmines, PHR (USA) shared the 1997 Nobel Peace Prize. PHR (USA) mobilizes the health professions to protect human rights, including the right to health, and has built a campaign by health professionals on HIV/AIDS and the right to health. Among its varied activities, PHR (USA) conducts research and investigations on the public health effects of violations of human rights and humanitarian law in internal and international conflicts.

In 2001, PHR (USA) released a report, *Endless Brutality: Ongoing Abuses in Chechnya*, the result of an extensive population-based survey of health and human rights abuses of Chechens by Russian forces. The PHR investigation was designed to document human rights violations in the last five months of 2000. It involved interviewing a random sample of over 1100 people displaced by the war who were able to provide information on human rights violations. The report's findings include documentation of torture; the killing of civilians; landmines, booby-traps, and other explosives; and violations of medical neutrality. The report outlines the health consequences of such violations of human rights and humanitarian law and provides detailed recommendations to the Russian Federation; the fighters on the Chechen side; the international community, including the United Nations, the Council of Europe and the Organization for Security and Cooperation in Europe; and the United States Government. In follow-up to the report, PHR (USA) researchers provided expert testimony abuses in Chechnya before the US Senate in an effort to promote a commission of inquiry into war crimes committed by Russian forces and rebel forces, a necessary precursor to establishing an international tribunal to prosecute those responsible.

*For further information see [www.phrusa.org](http://www.phrusa.org)*

## 10.4 Increasing public awareness of the right to health and engaging in community education and mobilization

Many countries have legislation that provides for various elements of the right to health. National laws can offer varying degrees of protection against human rights violations, including constitutional provisions on non-discrimination. Unfortunately, many such laws are not adequately enforced. Even in countries where key obligations of the right to health are incorporated into laws and policies, there is often, in addition to weak enforcement, very little public awareness of them. This is often the case especially in rural or geographically isolated areas. NGOs can help raise public awareness of international standards, government obligations and national legislation that protect the right to health. They can also help raise awareness of the implications of current domestic laws and policies, particularly for those in need of health care, and how to benefit from them. Identifying and publicising violations helps to mobilize public opinion in support of holding governments accountable for complying with their obligations.

*'lack of consciousness of health as a right remains a fundamental challenge — if not the challenge — for human rights NGOs engaged in promoting the right to health. ... [I]n order for the right to health to be meaningful, it must become part of the understanding that people at the community level have of themselves, their well-being, and their relationship to the state. [Otherwise] violations of the right to health — whether caused by poverty-related conditions or by lack of access to health care — continue to be invisible, [and] accepted as part of the natural order of things.'*

A. Yamin<sup>4</sup>

For example, a women's advocacy group might invoke the anniversary of its state's ratification of the Women's Convention to:

- hold a press conference about the health-related obligations its government has agreed to, comparing these to current national laws and policies;
- highlight illustrative examples of problems that still exist, emphasising the consequences for vulnerable groups of women;
- focus on specific cases of violations, such as those that expose systematic discrimination in access to medicines, for example HIV/AIDS drugs, or to reproductive health services, for particular groups such as women living in poverty, in rural communities, and adolescents;
- lobby public officials who are responsible for the adoption and implementation of legislation, including parliamentarians, and national and local government officials, in order to integrate international standards and obligations of the right to health into national legislation;
- advocate the use of human rights standards as a framework for national and sub-national health-related policies and programmes that predominantly affect women and girls such as those related to reproductive health;
- carry out communication campaigns including: radio, television, or newspaper campaigns; poster campaigns; and public meetings, which are especially important where populations are functionally illiterate; and
- mobilize the public by promoting civil action, including letter writing/email campaigns, petitions, and public demonstrations. Such civil action might be directed at, for example, the remedying of specific violations or the introduction of mechanisms to protect and enforce the right to health such as a patient or health ombudsman.

The following two examples illustrate ways in which an NGO might successfully integrate complementary political and legal advocacy strategies. In each case, an NGO participates in judicial proceedings and, in conjunction with this, successfully uses the legal suit to raise public awareness about the right to health.

### Case study 10.4.1

In response to the South African government's *Medicines and Related Substances Control Amendment Act* (Medicines Act), 39 pharmaceutical firms brought an action through the Pharmaceutical Manufacturers' Association (PMA) in 2001 to try and force the government to withdraw the measure. The purpose of the Act was to make drugs more affordable by allowing proprietary medicines, mainly those prescribed for the treatment of HIV/AIDS, to be substituted by far less expensive generic equivalents or by cheaper drugs imported from abroad, as well as to improve the efficiency of the

Medicines Control Council by introducing a pricing committee that could force pharmaceutical firms to justify their prices. PMA claimed that the measure was tantamount to allowing the government to expropriate or confiscate the property of pharmaceutical firms.<sup>5</sup>

The *Treatment Action Campaign* (TAC) applied to, and was accepted by, the Court to be admitted as *amicus curiae* (friend of the court, or interested party participation) during the hearing. As a result TAC was able to submit evidence to the court on behalf of people living with HIV/AIDS (PLWHA). The petition highlighted the right to health along with a number of other health-related human rights. TAC was also instrumental in attracting massive national and international publicity to the case and called attention to the right of access of people in developing countries to essential medicines and affordable drugs. The PMA eventually withdrew application against the South African government unconditionally, largely as a result of the negative publicity attracted by the case. (See section 10.9 for a related case about TAC)

*For further information, see [www.tac.org.za](http://www.tac.org.za)*

### **Case study 10.4.2**

In 1996, an action was brought in the United States against the oil company Texaco by independent lawyers using information collected by the *Centre for Economic and Social Rights* (CESCR) and a number of other NGOs, on behalf of Ecuadorian plaintiffs, as part of a campaign to protect the health of indigenous peoples living in the Ecuadorian Amazon from the adverse effects of exploitative oil development.<sup>6</sup> An interdisciplinary team, including physicians, had worked together before the court hearing in order to gather the necessary evidence and to launch an advocacy campaign. CESCR and its partners used the lawsuit to raise awareness about the right to health and mobilize public activities concerning the negative impact of oil development on human rights, including the right to health. They held workshops that initiated the formation of a coalition, called the *Amazon Defence Front*, to support the Texaco lawsuit and to advocate against the oil companies' practice of irresponsible dumping. In the words of the director of the CESCR Ecuador office, "The US-based lawsuit against Texaco has probably done more than anything else to raise the profile of the oil problem and to change the terms of the debate from one of government needs and environmental problems to one of rights and violations. ... [T]he suit has reinforced the idea among the Ecuadorian public that 'rights' are at stake and that the industry has been acting with irresponsible double standards".<sup>7</sup>

*For further information, see [www.cesr.org](http://www.cesr.org)*

### **Case study 10.4.3**

In 2001, over two thousand health care providers, patients, and social justice activists gathered in a hospital run by *Partners in Health* in the village of Cange, in rural Haiti, to discuss the right of the poor to survive. For this occasion, a group of about 60 people living with HIV prepared a declaration regarding the right of poor people with AIDS to modern, effective therapy. The *Cange Declaration* was presented at the conference and has since been invoked as a model of a rights-based approach to AIDS treatment as articulated by patients living in poverty. The following are excerpts from the *Cange Declaration*:

'When we the sick, who are living with AIDS, speak on the subject of *Health and Human Rights*, we are aware of two rights that ought to be indivisible, inalienable. Those who are sick should have the right to health care. We who are already infected believe in prevention too. But prevention will not cure those who are already sick. We need treatment when we are sick, but for the poor there are no clinics, no doctors, no nurses, no health care. Furthermore, the medications that are available are too expensive...

The right to health is the right to life. Everyone has a right to live. That means if we were not living in misery but in poverty, we would not be in this predicament today. Having no resources is a great problem for poor people, especially for women and those with small children. ...

We pledge to remain steadfast in this fight and never to tire of fighting for the right of everyone to have necessary medications and adequate treatment'.

*For more information see [www.pih.org](http://www.pih.org)*

## 10.5 Promoting capacity-building among health professionals and conformity with the right to health in service delivery

National and international medical organizations and associations of health professionals play a highly important role in the realization of the right to health. This can happen in many ways, for example through curriculum development, training and awareness raising; through witnessing and reporting of abuses; through lobbying and influencing of policies and budgetary priorities; by helping to define and monitor compliance with national indicators and benchmarks; and in the implementation of service delivery. Through research and publication, medical professionals also make a valuable contribution to clarifying the content and meaning of the right to health.

As a noteworthy example, the *British Medical Association* (BMA) has published a highly-acclaimed book, *The Medical Profession and Human Rights: Handbook for a Changing Agenda* (2001) which explores the interface between medical practitioners and possible abuses of human rights, as well as the promotion of human rights. It contains comprehensive information on a wide range of human rights issues that health practitioners are likely to encounter including refugees; asylum seekers; organ transplantation; torture; ethics; forensic science; and the promotion and protection of the right to health. The publication examines the ethical problems that health professionals can encounter in their professional practice and provides guidance on how to deal with them. It also includes specific recommendations with each chapter.

Health professional organizations and other NGOs concerned with the delivery of health services should decide how their own work in areas such as service delivery and managing health institutions can complement steps taken by government to promote the right to health. These groups complement steps taken by government to promote the right to health. These groups should also ensure that clinical services satisfy the obligations and standards of the right to health of individuals and communities. Health services that comply with international standards of the right to health must:

- be comprehensive and accessible, both financially and geographically;
- be private, confidential, and respectful of the dignity and integrity of the patient;
- be of the highest possible quality and culturally acceptable; and
- provide individuals with information they can use to make their own choices.

Community-based NGOs might consider focusing advocacy activities on the promotion and protection of the right to health at the institutional level, including those that deliver health care services to local populations. Such activities include:

- targeting specific institutions to change their policies or practices, focusing particularly on discrimination against the poor, vulnerable, and otherwise disadvantaged groups. Discrimination often occurs at the institutional level, in administrative practices and in the 'unofficial' ways that policies are carried out;
- lobbying for greater transparency in budgeting practices;
- promoting services that are culturally appropriate to local populations, as well as appropriate for vulnerable groups such as adolescents; and
- promoting improved training for medical and other professionals, including education in health and human rights.

The case studies in the following illustrate the range of possible activities that can be undertaken by health professional organizations and NGOs involved with service delivery.

### Case study 10.5.1

A regional health and human rights conference for health science students, including medical and public health students, was organized in Peru in 2001. The conference was organized by an interdisciplinary student group, named *Civil Association for Health and Human Rights Education* (*Asociación Civil para la Educación en Derechos Humanos con Aplicación en Salud*, or EDHUCASalud). A statement issued as a result of the conference called for increased attention to be given to the right to health by the State; highlighted the role of civil society in promoting the right to health; called attention to the need to provide health science education within a human rights framework; and underlined the importance of participation by health professionals in the identification and reporting of violations of human rights, including the right to health.

During the follow-up to the conference, the group carried out a study of the curricula of all medical and nursing schools in Peru in order to evaluate their human rights content. The results will form a base line for lobbying to promote greater inclusion of human rights in the curricula for medical and nursing training.

*For further information, see [www.edhucasalud.org](http://www.edhucasalud.org)*

### **Case study 10.5.2**

The *International Council of Nurses (ICN)* is a federation of national nurses' associations (NNAs) from more than 120 countries. The ICN Code of Ethics for Nurses incorporates the central notions of health as a fundamental human right and that respect for human rights is inherent in nursing practice. Many ICN activities focus on promoting a human rights approach to health, including a series of fact sheets and policy statements that explain the human rights framework and set out strategies to promote the right to health. The following is an excerpt from an ICN Fact Sheet on health and human rights:

“National nurses' association (NNAs), individual nurses and other health care providers must play a leading role in strengthening the vital link between health and human rights and thereby contribute to prevention of disease and enhance equitable access to health care. More specifically NNAs, nurses and other health care providers need to:

- develop understanding of the human rights declarations and instruments;
- create awareness about the vital link between human rights and health and the harmful impact of human rights violations on health;
- work with the media, human rights groups, lawyers' associations, women's associations and policy-makers to heighten awareness about the rights approach;
- use specific examples of human rights violations such as gender discrimination, FGM/C and other forms of violence to demonstrate their harmful consequences on health;
- mainstream human rights and ethics education into all levels of nursing curricula;
- lobby for equity and universal access to comprehensive, cost-effective and affordable health care for all people;
- monitor impact of health reform mechanisms such as user fees and cost sharing on access to health care and other social services.”

*For further information, see [www.icn.ch](http://www.icn.ch)*

### **Case study 10.5.3**

The American-based *International Anti-Poverty Law Center (IAPLC)* and the Netherlands-based *Johannes Wier Foundation for Health and Human Rights* have drafted a set of preliminary guidelines to assist health professionals in monitoring, promoting and protecting the right to health. The *Guidelines for Health Professionals on the Right to Health* are based on CESCR General Comment 14 on the right to health and propose formal systems for incorporating human rights monitoring into the work of health providers.

In May 2002, the Guidelines were presented and discussed during a meeting of the International Federation of Health and Human Rights Organizations (IFFHRO), a network in which the Johannes Wier Foundation participates, at which it was decided to forward the guidelines to component members of the network.

*For further information, see [www.iaplc.org](http://www.iaplc.org)*

### **Case study 10.5.4**

The *Commonwealth Medical Trust's (Commat)* main objective is to promote an ethical and rights-based approach to the sexual and reproductive health of the poor and otherwise vulnerable and disadvantaged groups in developing countries. Its mission is to align medical ethics with human rights



and in 1999 it published a *Training Manual on Ethical and Human Rights Standards for Health Care Professionals* which contains more than 40 case studies based on violations or potential violations that have actually occurred in developing countries and which have been used successfully in national and regional working groups for training medical and other health professionals in a rights-based approach to health.

Commat works closely with WHO, UNFPA, treaty monitoring committees and concerned NGOs such as national medical and other health professional associations. In New York in 1999 it held a *Consultation on Medical Ethics & Women's Health, including Sexual & Reproductive Health, as a Human Right*, at which a Declaration on the topic was unanimously agreed by the distinguished participants who attended. The following are two extracts from the Declaration:

“The health status, including sexual and reproductive health, of women (including the girl child) is adversely affected by a wide range of human rights violations. Health professionals are well placed to detect many such violations. Accordingly the bodies responsible for producing and enforcing ethical guidelines for health professionals should take account of provisions concerned with women's health and rights, including sexual and reproductive health and rights, in the six major international legally binding human rights treaties”.

“Health professionals who become aware of human rights violations adversely affecting women's health have an ethical obligation to report them through their health professional association, organization or authority, as appropriate. The participation of health professionals in any practices and procedures that are harmful to women or violate their rights, such as FGC, cannot be justified on grounds that their involvement would make the procedures less dangerous or more reliable, because it will serve to make them more respectable and acceptable.”

*For further information, see [www.commat.org](http://www.commat.org)*

### **Case study 10.5.5**

As part of its ongoing work in advocating human rights education for doctors, *Physicians for Human Rights – UK* (PHR-UK) has launched a global campaign to integrate health and human rights in undergraduate and postgraduate medical training. The campaign has included the presentation of a parallel (shadow) report to the CESCR in 2002 which cites evidence of discrimination, including disparities in treatment, by UK doctors against particular groups of patients. (See chapter 11.) The PHR-UK campaign advocates for the adoption of an ethical code in hospitals, medical schools and general practice based on key human rights instruments that are relevant for medical practice. One proposal is that such a code could affirm a commitment to support the sections of the UDHR and CESCR General Comment 14 “that define patients' health rights and provide inspirational and practical advice for everyday medical care.”<sup>8</sup> PHR-UK has also developed an internet-based course, *Medicine and Human Rights*. The entire education module, including lecture notes, student handouts and case studies, is available for free and has been used in UK medical schools. Included in its other activities aimed at educating doctors in health and human rights are: study days on *Medicine and Human Rights*; a *Health and Human Rights* course (approved as ‘continuing medical education’ by the Royal College of Physicians); and the provision of training on the right to health for the staff of international human rights and international health NGOs.

*For further information see [www.phruk.net](http://www.phruk.net)*

### **Case Study 10.5.6**

The NGO *Partners in Health* (USA) works extensively with community-based organizations to incorporate a human rights framework into health service delivery and programmatic implementation, with a focus on remedying inequalities in access to health care services. One example of their work concerns a multi-faceted campaign by Partners in Health and its sister organization in Peru, *Socios en Salud*, to improve access of the poor to treatment for multi-drug-resistant tuberculosis (MDR-TB) in slum areas of Lima, Peru. In the course of its work, *Socios en Salud* provided direct medical services to those being denied it and engaged in political advocacy at the national and international levels to bring about policy changes needed for a sustainable and long-term solution to the problem. Not only did the NGO provide comprehensive MDR-TB treatment for the poor in slum communities, but it influenced

the Peruvian government to change its public health policy regarding such treatment and also played a significant role in persuading the WHO to modify its policy guidelines in favour of providing MDR-TB treatment for poor people. Rather than using cost-effectiveness arguments to plead its case in favour of policy change (with calculations to prove that not treating MDR-TB patients would ultimately cost more), the NGO based its advocacy on an explicit human rights perspective. They did so by insisting that the benefits of scientific progress, including access to the highest attainable standard of care, should be available to all on a non-discriminatory basis without regard to their economic status or ability to pay for such treatment.<sup>9</sup>

*For more information see [www.pih.org](http://www.pih.org)*

## 10.6 Building coalitions and forming networks

The political and institutional sustainability of human rights based health policies and programmes requires that there be a constructive and cooperative relationship at national and sub-national levels between state authorities, health professional associations and health advocates. (See section 10.2.)

It is also important for NGOs to network independent of government authorities, in order to form political coalitions and lobby in support of the reform of policies and the remedy of violations. For this purpose, interdisciplinary alliances involving health professional associations; other NGOs working on health-related issues; grassroots health groups; health service delivery organizations; and human rights groups should be encouraged to promote the advancement of health rights within and across national borders.

### *Case study 10.6.1*

In 2001, the NGO *Physicians for Human Rights – USA* and the *Francois-Xavier Bagnoud Centre for Health and Human Rights* at Harvard University organized a network of physicians, nurses, health practitioners, health administrators, relief workers, human rights professionals, ethicists, scholars, and activists from all over the world to draft a consensus document, entitled the *Declaration on Human Rights and Health Practice*.

The purpose of the Declaration is to clarify the relationship between health and human rights and the responsibilities of health practitioners to protect and to promote human rights. The first draft of the Declaration was prepared by more than 75 experts in health and human rights from 40 different countries. The drafting process calls for continued expansion of regional representation and consensus building, and for the endorsement of the final document by international health and human rights organizations such as the United Nations, the World Health Organization, the World Medical Association, and by health professional associations.

*For further information, see [www.hsph.harvard.edu/fxbcenter/](http://www.hsph.harvard.edu/fxbcenter/)*

### *Case study 10.6.2*

In Peru, the *Association for Human Rights (Asociación pro Derechos Humanos, or APRODEH)* is working to improve broad-based community participation in health policy and programming.<sup>10</sup> APRODEH focuses on building coalitions and providing opportunities for dialogue between civil society and government about health priorities and possibilities for rights-based strategies. This departs from the adversarial role toward government traditionally adopted by the human rights movement in Peru. One of APRODEH's activities has been to organize workshops in urban and jungle regions of the country. These have brought together national and regional government health sector officials; representatives of the Human Rights Ombudsman; international donors and agencies; NGOs offering health services; health and rural development NGOs; local health providers; activists from different fields; community health workers; representatives of patient organizations; and human rights activists. Workshops have allowed stakeholders from civil society both to articulate what they seek from the government in terms of recognition, support and relationships, and to discuss ways to improve community participation in decision making. One important conclusion that has emerged is that incorporating a human rights perspective in health programmes requires changes both in the working conditions of many health workers and in health education.<sup>11</sup> The workshops also focus on eliciting from multiple perspectives

“the priorities and needs of the different areas of the country, with respect to the four dimensions of the right to health, as set out in ICESCR”.<sup>12</sup>

For further information, see [www.aprodeh.org.pe](http://www.aprodeh.org.pe)

## 10.7 Promoting sexual and reproductive health rights

*How have NGOs contributed to clarifying the meaning and content of the international right to health with regard to sexual and reproductive health rights?*

Some of the most successful work by NGOs using a human rights approach to health has been on women’s health rights, sexual and reproductive rights, and the health of the girl child. The fact that these particular aspects of the right to health have now been worked out in some detail can be attributed largely to the effective advocacy strategies adopted by women’s NGOs concerned with health. Recognizing and capitalizing on the benefits of placing health issues firmly within a human rights framework, women’s groups from around the world played a very active role in the ICPD and FWCW and their follow-up reviews by the UN General Assembly. They made a major contribution to the development of the concept of reproductive health rights, highlighting the importance of particular issues, such as the reproductive health rights of adolescents.

Women’s groups across Latin America, for example, organized themselves into networks and played a major role by drafting and proposing texts and by pressuring their governments both before and during these important conferences. Women’s NGOs have also capitalized on the benefits of working on health issues within a human rights framework by publicizing and monitoring the commitments made by their governments and by promoting their enforcement.

### *Case study 10.7.1*

The *International Planned Parenthood Federation (IPPF) Charter on Sexual and Reproductive Rights* was published in 1996. It provides an ethical framework within which IPPF carries out its mission, and clarifies the basic human rights of individuals within the sphere of their sexual and reproductive lives.

The Charter is based on twelve rights, which are grounded in core international human rights instruments, together with additional rights that IPPF believes are implied by them, and it represents IPPF’s response to the challenge of applying internationally agreed human rights language to sexual and reproductive health and rights issues. By drawing on relevant extracts from international human rights treaties, the Charter demonstrates the legitimacy of sexual and reproductive rights as key human rights issues. The Charter has been designed as a tool to help NGOs to hold governments accountable for promises they have made to uphold human rights in general, and sexual and reproductive rights in particular.

The Charter has three key objectives:

- To raise awareness of the extent to which sexual and reproductive rights have now been recognized as human rights by the international community in internationally adopted UN and other declarations and commitments;
- To clarify the connection between human rights language and key programme issues relevant to sexual and reproductive rights; and
- To increase the capacity of NGOs to make use of human rights processes.

The Charter demonstrates, for example, that the basic human right to information and education can be used to campaign for the right of adolescents to sex information and education services. In terms of making the connection clear between human rights and sexual and reproductive health and rights issues, for example, it links the human right to privacy, with the right of all sexual and reproductive health care clients to services that respect their confidentiality.

The Charter is also intended to help NGOs to use international human rights processes to advance sexual and reproductive health and rights. The Charter is now available in more than 25 languages. IPPF has subsequently published *Guidelines* for the use of the Charter, which explain how the document can be used to campaign for improved sexual and reproductive health and rights. Both the Charter and the Guidelines now form part of the *IPPF Rights* pack. The latter also includes a booklet of facts with

statistical information a programme examples for each of the 12 Charter Rights; and three posters featuring the Rights of Young People, the Rights of the Client, and the 12 Charter Rights

*For further information, see [www.ippf.org](http://www.ippf.org)*

### **Case study 10.7.2**

In 1998, the *Latin American and Caribbean Committee for the Defense of Women's Rights (Comité de América Latina y el Caribe para la Defensa de los Derechos de la Mujer, or CLADEM)*, a regional network of women's rights groups, initiated a process of producing an *Inter-American Convention on Sexual and Reproductive Rights*, which includes provisions on the right to health. CLADEM's intention is that the Convention should fill "a vacuum regarding sexual and reproductive rights within the Inter-American human rights system, in which virtually none of the new gendered understandings of human rights [advanced by the world conferences] have been incorporated. The CLADEM project also seeks to strengthen regional mechanisms and set out or clarify regional standards because national legislation relating to reproductive rights in Latin America tends to be weak and subject<sup>137</sup> to shifts based on political whim. The project began with regional consultations; the initiation of an alliance with other NGOs and networks in Latin America and the Caribbean; the preparation of an Ethical Framework and a Manifesto on sexual rights and reproductive rights; and the development of a webpage.

*For further information, see [www.cladem.org](http://www.cladem.org) and [www.convencion.org.uy](http://www.convencion.org.uy)*

### **Case Study 10.7.3**

The *Women's Global Network for Reproductive Rights (WGNRR)* launched its *Women's Access to Health Campaign (WAHC)* in May 2003. The campaign is based on two major documents: the Alma Ata Declaration, adopted in 1978, with its emphasis on primary healthcare and the People's Charter for Health (see case 10.6.4), as a framework to claim the right to health as a basic human right. The campaign focuses on women's enjoyment of their sexual and reproductive rights and on the responsibility of government for women's health. The main objective of the campaign is to provide tools and information to help groups to raise awareness on the issue and to lobby their governments at all levels.

The theme of the 2003 campaign was '*Governments, take responsibility to ensure women's access to health*'. Throughout the campaign, WGNRR collaborated with grassroots groups and NGOs in Africa and the other regions of the world, each group being free to organize its own activities within a broad framework. Examples of NGO activities within the Women's Access to Health Campaign include:

- popularizing the Alma Ata declaration on Health for All and bringing women's perspectives to bear within it;
- using the People's Charter for Health to mobilize and educate community members, policy makers, and government representatives about the right to health, and as an advocacy tool at the local, national and international levels;
- advocating for government representatives at village, district or national levels to improve primary health care provisions within the Alma Ata Declaration, keeping women's health needs a priority;
- demanding that governments ratify and abide by the Women's Convention;
- joining up with other groups working on health issues and raising the demands listed above with them at all levels; and
- documenting how primary health care is being implemented in diverse communities, regions and countries, and how reproductive and sexual health rights are (or are not) being integrated into such services.

*For further information, see [www.wgnrr.org](http://www.wgnrr.org)*

*The Peoples Charter for Health is available at [www.phmovement.org](http://www.phmovement.org)*

### Case study 10.7.4

The *International Programme on Reproductive and Sexual Health Law* at the University of Toronto Faculty of Law and *Action Canada for Population and Development* (ACPD) have jointly developed a publication entitled *The Application of Human Rights to Reproductive and Sexual Health: A Compilation of the Work of International Human Rights Treaty Bodies*. It includes relevant updated selections related to reproductive and sexual health from the concluding observations and general comments (or general recommendations) issued by UN human rights treaty bodies. The publication is designed to assist both governments and NGOs in compiling reports on compliance with, and violations of, the right to sexual and reproductive health; and to assist with the preparation of related advocacy manuals, training programmes, and research protocols.

To view the compilation, see [www.acpd.ca/compilations](http://www.acpd.ca/compilations).  
To order a CD-Rom version, email [info@acpd.ca](mailto:info@acpd.ca).

## 10.8 Advocacy efforts related to international obligations arising from the right to health

NGOs can undertake a number of activities in relation to obligations of international assistance and cooperation. (See chapter 6.) These include:

- advocating against any international assistance and cooperation policies, including bilateral development aid and the lending policies of international financial institutions (IFIs), that have the adverse effect of inhibiting a recipient state from complying with its core obligations arising from the right to health;
- working to ensure that greater attention in donor and lending policies is paid to the conditions that have an adverse effect on the provision of health services for the poor, vulnerable, or otherwise disadvantaged groups, such as the introduction of user fees;
- advocating that priority in the provision of international medical aid, financial aid, and distribution and management of resources, including potable water, food and medical supplies, should be given to the most vulnerable groups of the population;
- campaigning against embargoes or similar measures restricting the supply of adequate medicines and medical equipment to;
- highlighting and campaigning against international trade agreements that have an adverse effect on the enjoyment of the right to health, particularly for developing countries and the poor, vulnerable, or otherwise disadvantaged groups in such countries; and
- promoting implementation of the Doha Declaration.

*'Legal victories relating to the right to health attain a greater significance when they are accompanied by other actions aimed at raising public awareness, and when civil society assimilates those victories into their understanding of their own entitlements. ... The more people receive remedies for violations, the more they perceive the right as real; the more people perceive the right as real, the more they clamor for remedies.'*<sup>14</sup>

### Case study 10.8.1

The *Women's Rights Watch* project of the *Humanist Committee on Human Rights* (*Humanistisch Overleg Mensenrechten*, or HOM), an NGO based in the Netherlands, is developing a gender and human rights impact assessment. HOM use the Convention on the Elimination of All Forms of Discrimination Against Women as its basis and has chosen health as the theme for its pilot project. The aim of the impact assessment is to assist policy makers assess the possible impact of new or changed development policies that impact upon women's right to health.

HOM will also use the Convention as a framework to list and prioritize issues that affect women's right to health that should be included in development policies. HOM co-operates with women's NGOs from Asia, Africa and Latin America, to ensure that the results of its project and strategy can be made use of in both the South and the North.

For further information, see [www.hom.nl](http://www.hom.nl)

### Case study 10.8.2

The *International Day of Action for Women's Health* for 2002 (May 28) focused attention on the effects of international trade agreements on women's rights to health. KULU -*Women and Development*, an NGO based in Denmark, supported the campaign with activities aimed at raising public awareness of the issue. KULU emphasized two messages: first, that women are almost invisible in international trade agreements, and secondly that such agreements and associated liberalization policies have enormous adverse consequences for the right to health of poor women in developing countries, as essential services such as medical care and clean water are increasingly becoming a market-governed privilege.

Included among KULU's activities were a public meeting to discuss the implications of the General Agreement on Trade in Services (GATS) for women's rights to health care services and a postcard campaign that publicized the following messages:

- HIV infection from mother to child could be avoided if pregnant and breastfeeding mothers receive HIV treatment;
- Women and the poor in developing countries must have access to HIV/AIDS treatment and essential drugs; and
- Trade agreements must respect the right to health and life.

*For further information, see [www.kulu.dk](http://www.kulu.dk)*

## 10.9 Working with national and regional enforcement procedures to ensure state accountability

A human rights approach to health must emphasize that states are accountable for complying with their international, regional and national obligations arising from the right to health. (See chapters 1 and 2.) Working to establish legal and other appropriate remedies for violations of the right to health is therefore critical to its promotion and protection. Accountability mechanisms which may be available to hold states accountable for failing to give effect to their human rights obligations include tribunals, parliamentary processes and relevant ombudsmen offices such as a health ombudsman.

It is important that NGOs take every opportunity to bring cases of actual or potential violations of the right to health to national and/or regional courts and other available complaints and enforcement mechanisms, either by invoking the right to health directly or indirectly, or another health-related human right that is protected in national and/or regional legislation (including guarantees of non-discrimination). Successful legal suits can establish judicial precedents and can be coupled with media campaigns that educate the public about the right to health and government obligations. (See chapter 6.)

There are increasing and encouraging examples of NGOs successfully arguing cases in national courts that concern violations of the right to health. Although many NGOs will not have the resources (staff, financial or otherwise) to pursue legal remedies on their own accord, it is important to know that there can be opportunities to contribute to cases brought by others. For example, if a relevant court proceeding is taking place, health professional associations and NGOs can sometimes provide courts with *amicus curiae* (friend of the court) briefs that present (outside) expert information to the court. (See case study 10.4.1.)

*'States have an obligation to take steps, individually and through international assistance and cooperation, towards the full realization of the right to health. For example, States are obliged to respect the enjoyment of the right to health in other jurisdictions, to ensure that no international agreement or policy adversely impacts upon the right to health, and that their representatives in international organizations take due account of the right to health, as well as the obligation of international assistance and cooperation, in all policy-making matters.'*

*Special Rapporteur on the right to health<sup>15</sup>*

### Case study 10.9.1

In Argentina, a domestic legal suit (*amparo*<sup>16</sup>) was successfully brought in 1998 by the *Argentine Centre for Legal and Social Studies* (*Centro de Estudios Legales y Sociales*, or CELS) on behalf of 3.5 million people to force the government to manufacture and distribute a vaccine against a disease that exists only in Argentina and is often fatal (Argentine Hemorrhagic Fever). "CELS argued that, given that rapid diagnosis of the disease is difficult and it affects a population that does not have easy access to medical services, the most effective means of combating the disease is the administration of a vaccine. In a

historic ruling, the Court found that the state had an obligation to manufacture the vaccine and, as requested by the plaintiffs, prescribed that this obligation had to be met by the end of 1999".<sup>17</sup> In its ruling, the Court directly applied international treaty norms regarding the right to health, and based their findings of this obligation on the American Declaration and the Universal Declaration of Human Rights. They also based it on Article 12 of the Argentine Constitution, which incorporates these international human rights documents into domestic law.<sup>18</sup>

*For further information, see [www.cels.org.ar](http://www.cels.org.ar)*

### **Case study 10.9.2**

In a highly successful effort to use litigation in the domestic courts to enforce the constitutional right to health, the *Treatment Action Campaign* (TAC) together with the *Children's Rights Centre* and a group of paediatricians brought an action against the Minister of Health and the South African government on the issue of mother-to-child-transmission of HIV (MTCT). In December 2001, a High Court Judge found that "a countrywide MTCT prevention programme is an ineluctable obligation of the State,"<sup>19</sup> and, in a historic ruling, declared that the government policy of "prohibiting the use of Nevirapine outside the pilot sites in the public health sector is not reasonable and that it is an unjustifiable barrier to the progressive realization of the right to health care."<sup>20</sup>

The judge ordered the government "to make Nevirapine available to HIV positive women who give birth in the public sector, and to their babies, in public health facilities."<sup>21</sup> The judge also found that the government had violated section 27 of the State's Constitution, which guarantees access to health care services, including the right to reproductive health care, in that it had not taken reasonable measures within its available resources to provide women with access to MTCT prevention programmes.

The South African Government appealed against the judge's ruling to the constitutional court, which turned down the appeal in July 2002 in a ruling which went even further in favour of TAC. In this ruling, the Constitutional Court declared that the government is required to "devise and implement within its available resources a comprehensive and co-ordinated programme to realize the rights of pregnant women and their newborn children to have access to health services to combat mother-to-child transmission of HIV. The programme to be realized progressively within available resources must include reasonable measures for counselling and testing pregnant women for HIV, counselling HIV-positive pregnant women on the options open to them to reduce the risk of mother-to-child transmission of HIV, and making appropriate treatment available to them for such purposes." It should also be noted that two South African NGOs, the *Community Law Centre* (CLC) and the *Institute for Democracy in South Africa* (IDASA), intervened in the constitutional case as amici curiae (friends of the court).

*For further information, see [www.tac.org.za](http://www.tac.org.za)*

### **Case study 10.9.3**

In Venezuela, *Provea* (*Programa Venezolano de Educación Acción en Derechos Humanos*) successfully sought domestic legal recourse for violations of the right to health on behalf of a group of approximately 600 children with congenital cardiac disease. In 2001, Provea presented a legal action at the Venezuelan court (children's division) against the metropolitan mayoralty, which is the responsible organ of the hospital that was attending to the children. Provea argued that this group of children were receiving inadequate care and suffering violations of their right to health<sup>22</sup> on the following grounds: that the waiting list for surgery was too long, with almost 800 children waiting at the time of the complaint; that the average waiting time for surgery was too long, between two and three years; and that the hospital demanded payment of 1 million bolivares (equivalent to approximately US\$ 1500) from the children's relatives for medical supplies, despite a provision in the Venezuelan Constitution that establishes free medical care in the public system. The court found in Provea's favour and ordered that medical supplies and equipment be provided for the hospital's surgical unit and be designated for the purpose of cardiac surgery, and that the Venezuelan Ombudsman must coordinate negotiations (*mesa de diálogo*) to find concrete solutions to the problems.

The subsequent negotiations achieved a number of agreements, including the following: agreement to increase the number of surgeries per week; to hire nurses for the cardiac operating room; to remodel

and supply new equipment to the cardiology unit in the hospital; and to eliminate the practice of charging for the medical care of this group of children. Provea reports that while most of these agreements were realized, they have requested that the judge demand a forced execution of the judgment in relation to those which were not complied with.

*For further information, see <http://www.derechos.org.ve>*

### **Case study 10.9.4**

A notable example of NGOs using a regional human rights mechanism to address violations of the right to health involves a case concerning the Ogoni people in Nigeria.<sup>23</sup> The state-owned Nigerian National Petroleum Company (NNPC) formed a consortium with the Shell Petroleum Company to develop oil in the Delta region of Nigeria with the NNPC as the majority shareholder. The case concerned the allegation that a combination of neglect, irresponsible operations and faulty infrastructure had led to the disposal of toxic waste into the environment and local waterways, with heavy contamination of water, soil and air that resulted in massive health, environmental and social problems among the local Ogoni people, including contamination of plants and fish.

Moreover, the case alleged the following against the Nigerian military government: that it had withheld from Ogoni communities information on the dangers created by oil activities; failed to involve them in the decisions regarding the development of Ogoniland; failed to regulate or monitor the oil production; and failed to enforce safety measures that are standard procedures within the oil industry. Instead the military government had condoned and facilitated the activities of the oil companies by placing the legal and military powers of the state at their disposal. When faced with complaints from local communities, the military regime had responded with repression, violence, and executions of Ogoni leaders. After months of imprisonment, torture and denial of legal counsel, Ken-Saro-Wiwa, the leader of the Movement for the Survival of the Ogoni People (MOSOP) had been tried and convicted on false charges, and had been executed along with eight other Ogoni activists.

An application was made in 1996 on behalf of the Ogoni people to the African Commission for Human and Peoples' Rights by two NGOs, the Nigerian-based *Social and Economic Rights Action Center (SERAC)* and the USA-based *Center for Economic and Social Rights (CESR)*. It submitted that the military government had violated the human rights of the Ogoni people, including their right to health and to a clean environment as recognized under Articles 16 and 24 of the African Charter. In 2002, the African Commission handed down a historic decision that concurred with the application by SERAC and CESR. The Commission found the Federal Republic of Nigeria in violation of a number of Articles of the African Charter on Human and Peoples' Rights, including the right to enjoy the best attainable standard of physical and mental health.<sup>24</sup>

*For further information on SERAC and CESR v Nigeria, including the full texts of the NGO communication and the Commission's decision, see [www.cesr.org/ESCR/africancommission.htm](http://www.cesr.org/ESCR/africancommission.htm)*

## **Notes**

- 1 Yamin A. Protecting and promoting the right to health in Latin America. *Health and Human Rights*. 2000;5(1).
- 2 Women, Law and Development International (WLDI); Human Rights Watch (HRW), Women's Rights Division. *Women's human rights step by step: a practical guide to using international human rights law and mechanisms to defend women's human rights*. Washington, D.C.: WLDI; HRW, Women's Rights Division; 1997.
- 3 Yamin A. Challenges and possibilities for innovative praxis in health and human rights: Reflections from Peru. *Health and Human Rights*. 2002;6(1):44.
- 4 Yamin A. 2000. *Ibid*:133.
- 5 An important recent development relating specifically to the issue of access to medicines is the World Trade Organization's (WTO) Doha Declaration which addresses the WTO international trade agreement on patents and countries' freedom to take measures to improve access to essential medicines. In August 2003 the WTO passed a rule that allows WTO member countries that produce generic copies of patented drugs to export the drugs to countries with little or no drug manufacturing capacity. New developments regarding the issue of access to medicines also include an increasing recognition of the role and responsibility of the private sector in this regard. The UN Global Compact is an example of an important international initiative in this area. (See chapter 6).



- 6 Yamin A. 2000. Ibid:132-135.
- 7 As quoted in Yamin A. 2000. Ibid:132-133.
- 8 Hall P. Doctors urgently need education in human rights. *The Lancet*. 2002 Dec 7, (360): 1879.
- 9 Case study description based on Yamin A. 2002. Ibid:43-44.
- 10 Case study description based on Yamin A. 2002. Ibid:45-49.
- 11 Yamin A. 2002. Ibid:48.
- 12 Yamin A. 2002. Ibid:47.
- 13 Yamin A. 2000. Ibid:120-121.
- 14 Yamin A. 2000. Ibid:128.
- 15 Hunt P. Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health . E/CN.4/2003/58: para 28.
- 16 This legal mechanism, called an acción de amparo is the primary means of protecting an individual's constitutional rights in many Latin American countries. It is important to note that there are wide variations in the use of the amparo, such as in the scope of protections offered and the procedures for obtaining it. However, it is being used by NGOs in many countries in the region as an effective legal tool. In most countries in Latin America, suits that use the amparo recourse are limited to establishing or remedying the situation of the individual plaintiffs before the court, as opposed to representative actions which grant general, positive relief. (Adapted from Yamin A. 2000. Ibid:124-125.)
- 17 Case study description based on Yamin A. 2000. Ibid:125.
- 18 Causa No. 31, Viveconte, Mariela Cecilia c/Estado Nacional — Ministerio de Salud y Acción Social, s/Amparo Ley 16. 986. Cámara Nacional en lo Contencioso-Administrativo Federal, Sala IX Jun. 2, 1998. As cited in Yamin A. 2000. Ibid:n34 and n36.
- 19 Minister of Health v Treatment Action Campaign. High Court of South Africa, Transvaal Provincial Division. Case No: 21182/2001.
- 20 Ibid.
- 21 Ibid.
- 22 Provea invoked right to health provisions in the Venezuelan Constitution, the Venezuelan Organic Law of the Protection of the Child and the Adolescent, ICESCR, and CRC.
- 23 Case study description based on excerpt from Submission to the African Commission on Human Rights as reproduced in: International Human Rights Internship Programme. Ripple in still water: Reflections by activists on local- and national-level work on economic, social and cultural rights. Washington, DC: International Human Rights Internship Programme;1997: 107-113.
- 24 Communication 155/96, SERAC and CESR v Nigeria, Fifteenth Annual Activity Report of ACHPR, 2001-2002, Annex V.

## Part III *Taking Action: Working with the right to health*

### Chapter 11 Reporting: Participation by NGOs in UN procedures for monitoring compliance by their governments

#### *Keys to Chapter 11*

##### *key information:*

- Due to their first-hand information about what goes on *at community level*, NGOs have an important role to play in contributing to UN procedures for monitoring the right to health;
- NGOs can work as *partners with government* by participating in the preparation of health-related sections of country reports to treaty monitoring committees;
- They can also act as *government watchdogs* by providing credible and reliable independent information in parallel (*shadow*) reports to treaty monitoring committees;
- NGOs have a key role to play in follow-up at the national level. This includes disseminating information about their country's report and the treaty monitoring committee's concluding observations and recommendations on it to the public, other NGOs and opinion leaders as well as monitoring their government's compliance with committee recommendations; and
- With the establishment of a Special Rapporteur on the right to health, NGOs have the possibility of contributing to, and benefiting from, his mandate to promote and monitor the right to health.

##### *key questions:*

- When is the next review for your country scheduled to be carried out by a treaty monitoring committee?
- Have your NGO's monitoring activities resulted in evidence of violations of the right to health, including systematic health-related discrimination?
- Can this information be used in a shadow report to supplement insufficient or misleading information, or highlight gaps or inaccuracies in data, in the government's report?
- Based on its ongoing advocacy activities, does your NGO have access to information about gaps in, or obstacles to, the government's compliance with its obligations arising from the right to health? Can this information be used in a shadow report, or be included in a joint shadow report with other NGOs?

##### *key action points:*

- Make efforts to contribute to the preparation of your government's country report;
- Consider submitting a shadow report to a treaty monitoring committee;
- Identify how information gathered in the course of your NGO's activities to monitor the right to health might be relevant for a shadow report to a treaty monitoring committee;
- Consider cooperating with other NGOs, including health professional associations, to form a national coalition and submit a single joint report;
- Use the recommendations issued by a treaty monitoring committee at national and community levels to raise public awareness of the right to health; strengthen advocacy activities; and monitor government compliance.

#### 11.1 Getting involved: NGOs should know the real picture

Health professional associations and other NGOs working with health-related issues have great potential to contribute to the procedures for monitoring their government's compliance with the right to health. Because

they work 'on the ground' they can provide credible and reliable information, based on experience of what is actually happening, including:

- most pressing health-related problems of the poor and other vulnerable and disadvantaged groups;
- actual results of their government's efforts to implement the right to health through policy reforms;
- extent to which those policies are being implemented; and
- identification of avoidable obstacles to the implementation of those policies.

Their influence and first-hand knowledge of the situation enables them to assess the extent to which their government is complying with its treaty obligations.

This chapter provides basic information on how the UN reporting and monitoring process functions, including practical, step-by-step guidance on how NGOs can contribute to it. It deals mainly with the work of three treaty monitoring committees, particularly concerned with the right to health, namely: the *Committee on Economic, Social and Cultural Rights (CESCR)*, the *Committee on the Elimination of Discrimination against Women (CEDAW)* and the *Committee on the Rights of the Child (CRC)*.

The treaties monitored by these three committees provide the most substantial guarantees for the various components of the right to health. Moreover, these committees have given attention to interpreting and monitoring the obligations imposed on States parties that arise from the right to health. They also have all become more receptive to the views of NGOs and have encouraged NGO participation by providing opportunities for them to do so.

The chapter also provides information about the *Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health* and how NGOs can contribute to, and benefit from, his mandate. (See Chapter 1.) The Special Rapporteur is an independent expert appointed by the UN Commission on Human Rights to, among other things, report on the status of the right to health throughout the world and make recommendations on appropriate measures to promote and protect the right to health.

It is important to note that there are also various other international and regional monitoring bodies to which NGOs can submit evidence on the extent to which governments are implementing and/or violating their right to health obligations. They include the monitoring committees of the other international legally enforceable human rights treaties, UN charter-based mechanisms (such as other Special Rapporteurs), regional treaty monitoring bodies and human rights tribunals. Furthermore, optional protocols to human rights treaties as well as regional human rights courts in Europe and within the Inter-American system provide various opportunities for individual complaints to be addressed, and these can act as powerful tools for NGOs seeking remedies for violations of the right to health. Optional protocols are mechanisms for individual complaints to be heard against a State party for violating its human rights obligations. Generally, treaty monitoring committees will only hear individual complaints after the individual or group alleging a violation has gone through the national court system and exhausted available domestic remedies. (See chapter 1 and box in section 11.2.1.)

## 11.2 Overview of the reporting process

Ratification of a human rights treaty obliges governments to take the necessary steps for its implementation. Unlike the outcomes of world conferences, whose recommendations and commitments are reached by consensus (therefore allowing each government to decide whether and how they should be implemented), a state that becomes a party to a human rights treaty has made a legally binding commitment to work towards its progressive realization. The government has also undertaken to co-operate with that treaty's monitoring committee in a number of ways. These include submitting country reports at regular intervals to the committee on the progress it is making towards implementing the rights contained in the treaty concerned; sending representatives to discuss its report with the committee; and acting on the committee's concluding observations and final recommendations on its reports once the review has been completed. (See chapter 1.)

### 11.2.1 Treaty monitoring committees

Treaty monitoring committees are composed of independent experts from all regions of the world. They are elected by States parties but serve as individuals in their own right and not as representatives of their

governments. The committees usually meet two or three times a year and each is serviced by a permanent secretariat which, in the case of CESCR and the CRC is at the UN Office of the High Commissioner for Human Rights in Geneva, and in the case of CEDAW is in the UN Department of Economic and Social Affairs in New York. While there are similarities among the committees, there are differences in the ways in which they function. It is important that NGOs contributing to the reporting process are aware of these.

*Important information on each treaty, treaty monitoring committee, as well as opportunities provided for NGO participation in the reporting process is available on the worldwide web. See section 11.4 for website addresses.*

The main responsibility of the committees is to monitor progress made by States parties towards implementing their treaty obligations. The committees do this by examining the country reports that have been submitted to them, in which States parties report on the steps they have taken to implement all the rights contained in the treaty, including the right to health.

In addition to examining country reports, the committees publish detailed interpretations of particular aspects of treaties. These are known as *general comments* or *general recommendations*. (See chapter 1.) *Days of discussion* are also held during which committee members discuss with NGOs and other experts in the field particular themes related to treaty obligations. The CESCR, for example, held a day of discussion about the right to health before adopting General Comment 14 on the right to health.

Some committees also review complaints from individuals or groups against a State party for violating its human rights obligations. Individual complaints can only be considered by a committee if the State party has explicitly agreed to recognize the committee's authority to do so by ratifying an *optional protocol* to the relevant treaty. (See chapter 1.) The Convention on the Elimination of All Forms of Discrimination against Women (Women's Convention) and the International Covenant on Civil and Political Rights (ICCPR) have optional protocols which establish such individual complaints mechanisms.<sup>1</sup> (See box below.)

*There have been exceptional cases where committees have used other means of collecting information. The CESCR, for example, has sought ad hoc reports from specific countries and has conducted fact-finding exercises in particular countries, with the approval of the government concerned. There have also been unusual instances where the CESCR has acted to prevent a violation from taking place. For example, in response to information submitted by a Philippine NGO about a government proposal to evict a large number of people forcibly from their homes, the CESCR (at the end of its 1995 review) called upon the Philippine government to draft an appropriate resettlement plan in order to remain within compliance with its obligations under the Covenant. In other cases a country's NGOs have invited the member appointed by the committee as 'rapporteur' for that country's report to visit the country prior to the session at which the committee was due to review the report. This happened in the case of Hong Kong and the CESCR (in relation to Hong Kong's 2001 report).*

Efforts are underway to adopt an optional protocol to the ICESCR, which, like the others, would permit individual petitions. Progress in adopting such optional protocols has been very slow, and governments of countries that have been responsible for major violations of the relevant treaties are the least likely to ratify them.

Furthermore, certain committees can initiate and conduct investigations into situations of possible mass violations of human rights (for example the Committee against Torture (CAT). Other committees can do so only in countries where the State party has explicitly recognized the committee's authority to do so, for example by ratifying an optional protocol to the treaty (for example CEDAW).

### ***Optional Protocol to the Women's Convention***

The Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women allows individuals and groups from countries that have ratified it to submit a complaint (called a communication) about a violation of the Women's Convention to CEDAW. These communications need to be in writing and cannot be anonymous. The Optional Protocol also allows CEDAW to carry out inquiries into allegations of very serious or systematic violations of the Convention (although governments that ratify the Optional Protocol can opt out of this clause).

Before a complaint can be filed under the Optional Protocol, the complainant must have exhausted all legal remedies in their own country. This means that: the victim(s) (or NGO acting on their behalf) have appealed to the highest domestic court (or human rights commission, ombudsman office, etc) and have received a negative answer; local laws do not permit making such claims or appeals; victims had been denied access to legal remedies; or there had been extensive stalling or inaction in reaching a verdict.

NGOs can assist individuals or groups to bring complaints of a violation against their government (provided it has ratified the Optional Protocol) to CEDAW. One important way to assist is to help the victim(s) gather and document evidence of the alleged violation. NGOs may submit complaints on behalf of individuals or groups, as long as they have their consent (in extreme cases, NGOs may submit complaints on behalf of others without their consent, but this must be justified to the Committee). The Optional Protocol requires governments to ensure that complainants are not subjected to intimidation or ill treatment in their country as a result of having filed a complaint with CEDAW.

The complaints procedure follows these general steps:

- 1 Complaint is submitted to CEDAW.
- 2 CEDAW informs the accused government of the complaint and requests written explanations or statements to hear its side.
- 3 CEDAW examines the documents from both sides (victim and accused government) and determines whether or not a violation has occurred. If there has been a violation, the Committee makes recommendations for a remedy and informs both sides.
- 4 Within six months, the government must inform CEDAW of the action it has taken in response to the Committee's views and recommendations.

See [www.unhchr.ch/html/hchr/contact.htm](http://www.unhchr.ch/html/hchr/contact.htm) and [www.bayesfsy.com](http://www.bayesfsy.com) for detailed information on submitting complaints of human rights violations to a treaty monitoring body.

### 11.2.2 States parties' initial country reports

One year after ratification, (in the case of the *Women's Convention*), and two years after ratification (in the case of CRC and ICESCR), States parties are required to submit an initial report to the relevant treaty monitoring committee. The report should provide a comprehensive overview of the country's situation and the measures the government has taken to ensure that people can enjoy the rights conferred by the treaty. These *initial reports* act as a 'baseline' or starting point from which future policies can be developed and against which progress in implementation can be measured.

### 11.2.3 States parties' periodic country reports

Subsequently governments are required to submit *periodic* country reports at stated intervals (depending on the treaty concerned) which are expected to show what progress has been made since the previous report was presented. In the case of CEDAW these reports must be submitted every four years and in the case of CRC and ICESCR, every five years. It is not uncommon for countries to delay or combine their periodic reports, often due to resource constraints or lack of capacity to prepare the reports.

It is expected that periodic reports should include legislative, judicial, administrative and other measures that the government has taken to ensure that the rights contained in the treaties concerned can be enjoyed. Governments are asked to identify key trends; to explain any factors and obstacles that are preventing them from fully complying with their obligations; and to demonstrate how they have followed up the recommendations made by the committee at the previous review. Treaty monitoring committees may also request additional information during the periods between reviews.

Treaty monitoring committees intend that NGOs should participate in the preparation of country reports (but in reality this does not often happen). It is important, therefore, that NGOs (including medical and other health professional associations) should remind their governments that they expect to be involved and request that they are notified in advanced of the date when the drafting will start.

### 11.2.4 Guidelines for States parties' reports

If NGOs are to participate effectively in drafting country reports, they will need to study the guidelines issued by the various monitoring committees. They include the setting out of specific information about health-related obligations, and, for this purpose the use of *WHO indicators* is usually required. For example, ICESCR requests information on health statistics; actions to reduce infant mortality rates; life expectancy; measures taken to improve the health of vulnerable and disadvantaged groups; the proportion of the national budget expended on health; and what (if any) policy on health has been adopted.

Copies of the country's recent reports to WHO may be requested, together with relevant legislation, judicial decisions, statistical information, national indicators, benchmarks, and details of any recent relevant research. The government is expected to make the country report available publicly once it has been completed. NGOs should apply to the responsible Ministry if the report has not been published within a reasonable period of time.

### 11.2.5 The review process — pre-sessional working groups

CESCR, CRC and CEDAW hold *pre-sessional working group* meetings before the scheduled review of a country report. In the case of CESCR this is done two sessions before the report is due to be considered and, in the case of the other two, one session in advance. During the pre-sessional working group meetings, selected committee members undertake a preliminary review of the report; discuss any supplementary information including inputs from NGOs; and usually develop a *list of issues and questions*. This list is sent to the government of the country concerned in advance of the session and it forms the basis for the discussion of the country report at the formal review. The *rapporteur* appointed by the committee for each country report is responsible for drafting the list of issues and questions, and, after the report has been examined, for writing the committee's *concluding observations or comments*.

#### *How do the committees monitor the right to health?*

##### *Examples of the type of questions posed to States parties after meetings of pre-sessional working groups*

- "Please provide updated information on trends in health-care expenditure over the last five years."
- "Paragraph x of the report provides information about changed morbidity and mortality rates of the most vulnerable population categories. Please indicate the changes that have occurred since the report was submitted."
- "Please provide information about the results of the health-care programmes mentioned in paragraph x of the report."
- "Please provide updated information on any changes affecting health care in the social insurance scheme."
- "Please indicate whether any measures have been taken to address the problems arising from teenage pregnancy and [induced or unsafe] abortion."
- "Please provide updated information about maternal [and child] mortality rates."
- "Please provide information on the effective measures being taken to protect the environment from oil spills and the degradation of the country's forested areas."

*based on CESCR Lists of Issues*

### 11.2.6 The review process — dialogue between committees and States parties

At the formal review session, the committee examines the report in the presence of the government representative and observers. The government representative usually starts by making a statement updating the written report. Members of the committee can then ask questions and raise issues with the country representative, which are frequently based on the pre-sessional meeting and the *list of issues and questions*. Such questions may make it necessary for the government representative to provide further clarification, and the committee often gives the government one or two days to prepare its answers following which it will usually reply question by question.

The procedure is rarely adversarial, as the intention is that the committee should conduct its review in the form of a 'constructive dialogue' with the government representatives. However, committee members often ask pointed questions and may request supplementary information about serious health problems or health-related discrimination.

The opportunities for NGO participation in formal sessions differ, depending on the committee in question. Some committees, including CEDAW and CESCR, set aside one afternoon at the beginning of each session for

NGO presentations. While NGOs do not have a formal opportunity to speak during any committee review of State party reports, they may attend as observers and can meet informally with committee members between sessions.

### 11.2.7 The review process — concluding observations or comments of the committee

At the end of the formal review the committee prepares its concluding observations (in the case of the CESCR and CRC) or comments (in the case of CEDAW) on the progress made by the government in implementing its treaty obligations. These will reflect the main discussion points, highlight major problem areas in current implementation, and recommend action for further and improved implementation. Specific matters of concern that require follow-up action by the government may be mentioned and recommendations made for urgent action to remedy serious violations of the right to health, particularly failures to comply with core obligations. (See chapters 4 and 9.)

In the spirit of a constructive dialogue, treaty monitoring committees tend not to use the *language of violations* in their concluding observations or comments. Instead they are more likely to point out the government's shortcomings, indicating *subjects of concern*, and suggest how the government might change laws, regulations, policies and practices (including administrative) in order to make them conform more closely to the provisions of the treaty.

#### *How do the committees monitor a State party's compliance with its obligations to respect, protect and fulfil the right to health?*

##### *Examples of comments and recommendations by committees:*

"In particular the Committee is concerned over the alarming trend that child immunization is on the decrease."<sup>2</sup>

- » **Note:** There is a core fulfilment-bound obligation<sup>3</sup> to provide immunization against the major infectious diseases affecting the community.

"The Committee wishes to express concern at the information brought to its attention which indicates that disparities exist between regions and between rural and urban areas with regard to the provision of health care to children..."<sup>4</sup>

- » **Note:** There are core obligations to ensure equitable distribution of health facilities, goods and services; and to ensure access on a non-discriminatory basis, especially for vulnerable and disadvantaged groups.

"With a view to contributing to the most effective use of scarce resources, the Committee recommends that the State party accord greater attention and consideration on the development of a strong primary health care system. Such a system would have the benefits of according due attention to developing a culture of nutrition, hygiene and sanitation education, transmitting health skills to parents, and enhancing participatory approaches to the distribution and use of resources throughout the health care system."<sup>5</sup>

- » **Note:** There is a core fulfilment-bound obligation to provide essential primary health care.

"The Committee views the trend of rising child mortality rates as a matter of deep concern..."<sup>6</sup>

- » **Note:** There is a core obligation to ensure reproductive, maternal and child health care.

"The Committee expresses great concern at the high level of easily preventable maternal mortality - one of the highest in the region - and of extremely unsafe abortions, especially among very young girls, as well as the high fertility rate and limited access to basic health and family planning services. It stresses that this situation was particularly serious among rural women, most of whom did not benefit from the right to health guaranteed by the Convention."<sup>7</sup>

- » **Note:** There is a *core obligation* to ensure reproductive, maternal and child health care.

"...the Committee wishes to encourage the Government...to consult with non-governmental organizations when preparing its next report and to obtain their assistance in achieving the Convention's objective of improving the status of women in its country."<sup>8</sup>

### 11.2.8 Follow-up at country-level

The purpose of the review procedure is to monitor how a government is complying with its obligations; to identify urgent matters in need of immediate action; and to assess the areas where a State party needs to ensure longer-term changes. It is intended that governments should take the necessary steps as soon as the review process is over. This means that on-going follow-up activities carried out by the government concerned in-between its periodic reviews is an expected outcome of the review process. The committee also intends that its comments and recommendations should be publicized in the country concerned; acted upon by its government; and used as guidance for effecting better implementation in that country of the right to health.

### 11.3 Realities of the reporting process

The reporting process is an essential part of the process of monitoring implementation by governments of the right to health. However, NGOs should be aware of the following limitations:

- States that ratify human rights treaties agree to be monitored and to submit reports on a regular and pre-determined basis, but many of them have problems fulfilling their human rights treaty commitments. The number of overdue reports, listed on the UN website for the OHCHR ([www.unhchr.ch](http://www.unhchr.ch)), suggests that many of them do not take their human rights treaty commitments seriously. It is also not uncommon for incomplete reports to be submitted that fail to conform with the treaty monitoring committees' reports, or which contain vague, inaccurate or misleading information that may conceal actual or potential violations of the right to health. It is in such cases that the committees often welcome supplemental information from NGOs.
- The UN under-funds the work of the treaty monitoring committees, with the result that they have a continuing backlog of reports to review. By the time some of the reports are reviewed the information they contain is very much out of date. Committee members serve part-time; meet only for a few weeks each year, and are faced with an enormous workload. During the sessions, they are overburdened with information to read and to analyze, as a result of which they have inadequate time to form a comprehensive view of the situation in any one country. Despite these demands and their limited resources, committee members have remained highly committed to their work and have made an essential contribution to the development of the right to health.
- Contributions from civil society groups help to offset weaknesses in the system. NGOs are encouraged and respected by CESCR, CEDAW and CRC members, as they have proven to be a reliable source of alternative information on the extent of compliance by governments with the obligations imposed by the right to health. They often provide treaty committees with the only outside factual evidence of pressing health-related problems in a given country, including actual and potential violations of the right to health, and they make practical suggestions as to how governments can improve the situation.

*For your information...*

*The Convention on the Rights of the Child is the only international human rights treaty that explicitly allows NGOs a role in monitoring its implementation. Article 45(a) states that the Committee may invite specialized agencies and "other competent bodies" (including NGOs) to provide expert advice on the implementation of the Convention.*

### 11.4 Why should NGOs participate in the reporting process?

- A human rights approach to health holds governments *accountable* for their obligations. By ratifying human rights treaties governments have freely agreed to be monitored by an independent body. NGOs can help to make this process more meaningful and effective;
- NGOs can point out gaps between *rhetoric and reality* by providing credible and reliable independent information in a *shadow report* (see section 11.5) — even a modest one. By participating in preparing their government's report, NGOs can ensure that it gives a realistic picture of the population's pressing health issues. In both cases, civil society groups participating in the treaty monitoring process can improve its relevance and impact on the lives of people whose health is adversely affected by the denial of their rights;
- NGOs can use the information that they have gathered *from their own monitoring activities*, in which case their participation need not involve them in much extra work. Such information can also be used for other purposes, for example to petition their government directly to make necessary legal or policy changes.



- Experience shows that *treaty monitoring committees pay considerable attention to input by NGOs*. CESCR, CRC and CEDAW all enable civil society groups to have direct input to the reporting process and often use the issues and questions raised by NGOs in the questions they put to government representatives and in their concluding observations and comments;
- The comments, observations and recommendations by treaty monitoring committees can be used by NGOs *to strengthen their advocacy* in the country concerned by stimulating public discussion; raising public consciousness of the right to health and the government's related duties; and publicising how a government has failed to meet its obligations. The committee's comments can also provide a focus for NGO activities to change legislation, policies and practices;
- *Participation improves the credibility of NGOs*. Bringing the realities of local conditions, particularly those affecting the poor and otherwise vulnerable and disadvantaged groups, into the international arena is a powerful way to voice concerns about a government in an impartial setting. It gains credibility for the views of NGOs in their own country, and helps to empower the disaffected population groups concerned.

***Before starting it is crucial that NGOs should know:***

- which human rights treaties their own government has ratified and when they did so;
- whether or not the government has entered any health-related reservations to them, or reservations that could have an adverse impact on health status;
- when the next formal reviews for their country are scheduled to be carried out by CESCR, CRC and CEDAW;
- the dates by which their own country's should submit its next reports to the above committees, or to any other relevant committees such as the Human Rights Committee (HRC) which monitors the International Covenant on Civil and Political Rights (ICCPR); and
- if a report has already been submitted, what it says about current health issues in their own country.

It is also **very helpful for NGOs to have read:**

- the health-related sections of previous country reports submitted by their governments;
- previous lists of health-related issues and concluding observations or comments issued by the relevant treaty monitoring committees;
- summary records from previous reviews of their own country's reports; and
- any relevant general comment or recommendation issued by treaty monitoring committees on health-related articles in human rights treaties.

**Do the basic groundwork!** NGOs should urge their governments to ratify all international legally binding conventions and covenants, and to withdraw any health-related reservations that they made on ratifying them. In the case of the *Women's Convention*, for example, while over 170 countries have ratified, a substantial number have submitted reservations which are incompatible with the basic purpose of the Convention and can have seriously adverse effects on its health-related obligations. NGOs should therefore urge their governments to remove such reservations as quickly as possible.

***Finding useful information on the Web!***

**www.unhchr.ch** — There is a wide array of important information on the website of the UN Office of the High Commissioner for Human Rights (OHCHR). The website includes: names of the committee members and contact details for the committees; general comments and recommendations issued by each committee; information on individual complaints mechanisms; information on the status of country ratifications and accessions to treaties and Optional Protocols; information on the reporting status of States parties (including status of late reports); calendar of scheduled committee sessions and scheduled reviews of country reports; information on committee sessions; information on and calendar of scheduled pre-sessional working groups; committee guidelines for government reports; State party country reports; lists of issues and questions together with replies by governments; concluding

observations and comments; summary records of review sessions; guidelines for NGO shadow reports; and examples of NGO shadow reports.

[www.un.org/womenwatch/daw/cedaw](http://www.un.org/womenwatch/daw/cedaw) — Information (such as listed above) concerning the Women's Convention and CEDAW can be found at this website.

[www.crin.org](http://www.crin.org) — The *NGO Group for the Convention on the Rights of the Child* serves as a liaison between CRC and NGOs. The NGO Group provides support to NGOs and has prepared a comprehensive guide to NGO participation in CRC activities. Their website includes the guide as well as other information about CRC and examples of NGO shadow reports.

## 11.5 Flowchart of the reporting cycle<sup>9</sup> and suggestions for NGO participation

steps where NGOs can participate are marked in **bold** and with (\*)

**Step 1(\*)** The **government's county report is prepared** and made available to the public (carried out in the country).



**Step 2** The government submits its report to the relevant treaty monitoring committee.



**Step 3** The committee (usually) appoints one of its members as *rapporteur* for the country concerned.



**Step 4(\*)** **Pre-sessional working group:** NGOs and members of UN specialised agencies (eg, WHO, UNAIDS, ILO, UNICEF) can participate by making written and/or oral submissions to the pre-sessional working group. NGOs should inform the Secretariat in advance if they wish to be present.



**Step 5(\*)** **Formal session: Oral submissions to the committee by interested parties.** In the case of some committees, NGOs can submit commentaries (oral presentations, written briefs, even videos) about the official government report, usually at a set time at the beginning of the session. NGOs wishing to do so or otherwise to attend the review of a State party's report as observers should inform the relevant Secretariat in advance. (CESCR holds NGO hearings on the first afternoon of each formal session, and CEDAW holds an informal open session during the first week of each formal session).



**Step 6(\*)** **Formal session: Dialogue between State party and the committee.** NGOs can be present at the formal session, but only as silent observers.



**Step 7** Concluding observations or comments by the committee on the review. These are sent to the government of the country concerned and are published on the UN website.



**Step 8(\*)** **Follow-up at the national level,** which includes publicising the committee's comments and recommendations and acting upon them.

... and the cycle continues...

### **Step 1: Contributing to the preparation of the government's country report**

As already pointed out NGOs, especially national medical and other health professional associations, should seek to become involved in the drafting of health-related sections of country reports by their own government, for example by checking their accuracy and conformity with what is actually happening in practice.

The first step is to find out the dates when the government is due to prepare, and to submit, reports to the relevant treaty monitoring committees. The government department responsible for the overall preparation

of the reports (usually Foreign Affairs) should know when reports are being prepared and the dates for submission can be obtained from the OHCHR website.

It is usual for the first drafts of separate sections of the report to be prepared by the government departments concerned such as Health, Women's Affairs, Environment, Social Security, and Public Works. The appropriate department should, therefore, be approached with an offer to assist in drafting relevant sections or to make comments on the draft before it is finalised.

NGOs can also help their governments in selecting indicators for assessing the progress that is being made in realizing the right to health and in identifying appropriate national benchmarks for each indicator. This is a *core obligation* for governments. (See chapters 4 and 8.) National benchmarks help both governments and treaty monitoring committees to monitor implementation of the right to health, and to set or to revise national goals or targets to be achieved before the next periodic reporting exercise.

Although the above activities can take place at any time they are often neglected. The knowledge that a periodic report is due to be submitted on a fixed date can be a timely reminder of the work that needs to be done.

In developing countries where the conditions attached to economic policies imposed by international financial institutions (IFIs) such as the World Bank may be undermining the government's ability to comply with its obligations arising from the right to health (particularly core obligations), health professional associations can contribute evidence of the adverse health consequences suffered by the poor and otherwise vulnerable and disadvantaged groups.

#### **Step 4: Sending evidence to the committee**

The next step is to obtain a copy of the final country report and to send comments on it to the appropriate committee. Even if it is not possible for an NGO to obtain a copy of the government's report, it can also send a 'shadow report' (prepared specifically for that purpose) or other forms of evidence, directly to the committee. Committee members prefer references to be made to the country report wherever possible.

##### **(a) Shadow (or parallel) reports**

The submission by a NGO of a *shadow report* (also called a *parallel report*) to a treaty monitoring committee is an effective way for NGOs to draw the attention of the relevant committee to information that may have been omitted or inaccurately presented in the government's country report. The more specific the information that an NGO can collect and submit to the committee, the more likely it is that it will be used to question the government on its report and to incorporate the issues concerned into the concluding observations and comments (which will usually be specific and targeted towards particular changes).

NGOs are free to choose the nature and extent of the evidence that they submit to treaty committees. Shadow reports do not need to be comprehensive. They can be as simple as one or two pages that focus on a particular complaint, ongoing problem or article of the treaty concerned. They can also be longer, more detailed reports that outline a pattern of violations and follow the government report article by article of the treaty concerned. They can be submitted by one NGO or by a group of NGOs.

Government reports tend to concentrate on legislation and policies that they have introduced in order to comply with their obligations. They generally use data in the form of statistical trends, such as averages, means and percentiles. NGO reports, on the other hand, tend to look at the *implementation of laws and policies*. They reflect the experiences of individuals and groups in exercising the right to health; highlight the situations of particular vulnerable or disadvantaged groups; and/or point out specific violations. Even in cases where the government has failed to submit a report, NGOs can submit shadow reports, and in these situations that their reports are especially effective.

#### ***What can NGOs do if government neglects to submit its reports to a committee?***

*Faced with a state that was 15 years late in submitting a report to the Committee on Economic, Social and Cultural Rights (CESCR), a large group of NGOs in Brazil (over 1000!) combined to produce a 300-page alternative report that was presented to the CESCR. This prompted the government to produce its country report which was submitted to the CESCR in 2002.*

#### ***Shadow reports can provide:***

- qualifying information that supplements insufficient or misleading information in the government's report, or that points out gaps and inaccuracies in the data;
- specific information on discriminatory acts, laws or policies, or examples of systematic discrimination affecting health;

- qualitative and/or quantitative information on the implementation of health-related laws and policies, and the circumstances in which weak implementation is occurring; (For example this could be information about any adverse consequences to health from privatization of health services or health sector reforms.)
- evidence of violations of the right to health and of failure by the government to respond appropriately to them;
- examples of cases involving the right to health that have been brought before the country's courts and/or human rights tribunals.

#### *Tips for compiling a shadow report*

- consider cooperating with other NGOs, especially health professional associations, to form a national coalition and submit a single joint report;
- find out which NGOs, including international groups, participated in previous reviews of your country and seek advice from them;
- examine previous government reports and the committee's comments on them in order to assess whether the government acted on them and/or whether it took any retrogressive measures in periods between reviews. Shadow reports might address how the state has followed up on the last set of committee recommendations;
- be clear and concise in stating the issue you are raising and its relevance to the government's right to health obligations. Highlight the priorities being addressed in the report. Identify concrete areas of concern (including possible violations);
- provide reliable supporting evidence and use as many different sources of information as possible;
- provide specific questions that the committee can ask the government;
- suggest concrete recommendations for appropriate changes to laws, policies or practices that your government might enact;
- try to anticipate the government's response to the issues you raise. Provide relevant evidence to demonstrate why such a response would be inadequate;
- use clear headings to organize the report (remember, committee members are swamped with information!);
- at the end of the report, provide a concise summary of the key issues and suggested questions. List these in order of priority.
- send your reports to the committee rapporteur and secretariat well in advance (and make sure that they arrive in time for the pre-session meeting);
- whenever possible, invoke other relevant health-related international or regional standards and commitments that your government has endorsed (eg outcomes from ICPD, ICPD+5, FWCW, FWCW+5; MDGs);
- if possible, submit documents on a computer diskette.

Many of the committees have specific guidelines for NGO submissions. The guidelines include information on how and when to prepare and submit shadow reports and on opportunities for NGO participation during the review process.

#### **(b) Other written submissions**

Other written submissions, however modest, can provide helpful information for treaty monitoring committees. These include: an informative letter about a particular concern; relevant newspaper clippings; NGO newsletters, reports, or press releases. NGOs can also send the committee a list of suggested issues and/or questions to ask the government. These should be organized with headings that categorize the issues, with specific questions under each heading, and with suggestions about actions that the government might take.

If the political context makes it difficult for NGOs, including health professional associations, to criticize the government publicly, other groups can discreetly feed information (particularly about patterns of health-related violations) to international NGOs which can include them in their own shadow reports.

### ***Making oral presentations at pre-sessional working groups***

Oral presentations by NGOs, including health professional associations, at pre-sessional working groups can provide the committee with a full and realistic picture of the country's health situation and help to ensure that serious problems are included by the rapporteur in the *list of issues and questions*. The formation of coalitions of national NGOs is helpful, as their resources can be pooled to create a joint report and/or to send a representative to meetings of the working group in Geneva or New York.

### ***Step 6: Attending the formal session at which the government's report is examined***

Attending the review session provides NGOs with an opportunity for informal lobbying, or 'corridor advocacy'. NGO delegates can speak with committee members during breaks and hand them suggested written questions to put to the government. If a government representative provides inaccurate or misleading answers to questions, NGOs can discreetly point this out during a break. Some committees also allow NGOs to schedule lunchtime briefings with its members. For this type of lobbying NGO delegates should pay particular attention to the country rapporteur and to committee members who show specific interest in health-related issues.

NGOs can also send updates on the review process to their organization and to the media in their own countries, to set the stage for follow-up activities when the committee's findings are published.

*The role of NGOs in providing written information, making statements to the committee and by being present to highlight specific issues in informal discussions with committee members, is extremely important. NGOs, armed with the appropriate background information and evidence, are often able to call attention to issues that the government may have ignored or glossed over.*

### ***Step 8: Undertaking follow-up activities at home***

When the committee's formal review cycle has been completed, follow-up 'back home' concerning information obtained during the review and the committee's observations and comments on it. The monitoring cycle is not just a formality to enable states to claim that they support the right to health. It is an effective procedure for regularly calling attention to hazards to health that should be rectified and for affording relief to the poor, vulnerable, or otherwise disadvantaged groups that bear a highly disproportionate share of the ill health in the community.

There are many ways in which NGOs, especially medical and other health professional associations (whether or not they participated in the review process) can make use of their government's review for the purpose of undertaking follow-up activities. These include:

- ✓ raising awareness about the right to health by publicizing the government report, health-related NGO shadow reports, and the committee's comments and recommendations;
- ✓ promoting the right to health by working with the media; issuing press releases; and arranging workshops, conferences and publications about specific aspects of the report, for example those affecting the health related policies and activities of the country's NGOs;
- ✓ using the occasion to bring attention to particularly pressing health problems within a health and human rights perspective and mobilizing individuals and organizations to demand that the government comply with its related obligations;
- ✓ using the committee's comments to urge the government to deal with the concerns expressed and act on its recommendations;
- ✓ monitoring the extent to which the government is responding to the committee's comments and concluding observations and publicizing any failure to take the recommended actions;
- ✓ using the occasion to network with other health-concerned groups (building on old partnerships and developing new ones) in order to promote the right to health and call attention to issues of common concern; and
- ✓ lobbying for the nomination and election of candidates with health expertise to serve on treaty monitoring committees.

Health professional organizations (whether or not they participated in the reporting process) should take careful note of the committees' concluding comments and recommendations, and work constructively with the government and other health professional groups in implementing them, for example by contributing positively to the development of a national health plan; by identifying institutional policies or practices that

effectively discriminate against the poor and otherwise vulnerable and disadvantaged groups; and by determining how these policies and practices can be remedied.

### *Making the most from your efforts!*

There is some overlap between the health provisions of the ICESCR, *Women's Convention* and the CRC. NGOs should bear in mind the following points:

- States parties are rarely required to report to more than one of the committees at the same time but NGOs might be able to use some of the information they have gathered in shadow reports to more than one committee;
- Different treaty monitoring committees monitor the right to health from different perspectives, for example CEDAW focuses on women, CRC focuses on children, and CESCRC deals with virtually all the main issues concerned with the right to health.
- There is also some overlap between the three treaties in the health issues that are addressed, such as those affecting the girl child and adolescents are covered by all three of them.

It follows that it is a good strategy for NGOs to submit relevant information on violations of the right to health to more than one treaty monitoring committee (whenever this is possible).

### *Flowchart of an NGO intervention*

#### *PHR-UK submits a parallel (shadow) report to CESCRC*

In 2002, *Physicians for Human Rights–UK* (PHR-UK) submitted a shadow report to CESCRC in response to the United Kingdom government's fourth report under the ICESCR.<sup>10</sup> The PHR-UK shadow report focused on the UK's implementation of ICESCR Article 12 on the right to health. Based on research from secondary sources, it highlighted several issues, including discrimination in access to healthcare services towards prisoners, people with learning disabilities, people with HIV, women and elderly people. It also provided evidence of discrimination in the selection for training as, and employment of, doctors from certain minority groups. The impact of the parallel report is reflected in the fact that more than 90 minutes of discussion was devoted to health issues during the Committee's review of the country report. In its response to the report, the CESCRC "expressed concern at 'de facto discrimination in relation to some marginalized and vulnerable groups' and urged the UK government to ensure that human rights education curricula and training programmes give adequate attention to the right to highest attainable standard of health".<sup>11</sup>



#### *PHR-UK issues press release on committee's concluding observations*

After the conclusion of the CESCRC session, PHR-UK issued a press release entitled *UN Committee recommends UK strengthen its human rights obligations within healthcare*.

An excerpt from the press release reads: "PHR-UK had presented alarming evidence to the Committee that decisions about access to investigations and treatment are sometimes based upon whom patients are, rather than their health care needs. Research indicates that doctors discriminate against elderly people, people with learning disabilities, and women in terms of life saving primary and secondary care of coronary heart disease."



#### *Newspaper story published in UK press*

Soon after the PHR-UK press release was issued, a widely-circulated British newspaper published an article, *UN experts attack Britain's record on social issues*.<sup>12</sup> The first sentence of the article states that: "Britain's record on social issues ranging from discrimination to poverty has been strongly criticised by a United Nations committee."

*For more information on PHR-UK see, [www.phruk.net](http://www.phruk.net).*

## 11.6 Contributing to the mandate of the Special Rapporteur on the right to health<sup>13</sup>

In 2002, the UN Commission on Human Rights adopted resolution 2002/31 in which it decided to appoint, for a period of three years, a Special Rapporteur with a mandate focusing on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. (See chapter 1 on non-treaty mechanisms to monitor human rights.) The subsequent appointment of Professor Paul Hunt, New Zealand, as the Special Rapporteur created a new opportunity for all those concerned with monitoring, promoting and protecting the right to health, including NGOs.<sup>14</sup> Not only does the appointment of Special Rapporteur help to draw international attention to the right to health, but Professor Hunt has emphasized a commitment to dialogue and cooperate with civil society organizations in the course of his work.

In order to contribute effectively to the work of the Special Rapporteur, it is important that NGOs are familiar with the Special Rapporteur's mandate (see box below). They should also be familiar with Professor Hunt's approach, including his principle objectives and thematic concerns. These are outlined in his preliminary report to the Commission on Human Rights, along with six illustrative examples of issues he would like to address through the prism of the right to health over the course of his mandate.<sup>15</sup>

The Special Rapporteur is concentrating on *three primary objectives*:

- 1 promoting — and encouraging others to promote — the right to health as a fundamental human right;
- 2 clarifying the contours and content of the right to health; and
- 3 identifying good practices for the operationalisation of the right to health at the community, national and international levels.

These are being explored by way of *two main inter-related themes*:

- poverty and the right to health; and
- discrimination and stigma and the right to health.

The issues that the Special Rapporteur is examining, from the perspective of the right to health, include:

- poverty reduction strategies;
- 'neglected diseases';
- impact assessments;
- relevant WTO Agreements;
- sexual and reproductive health
- mental health; and
- the role of health professionals.

There are a variety of ways in which NGOs can contribute to, and benefit from, the work of the Special Rapporteur. These include by:

- ⇒ providing essential information and analysis on obstacles impeding the enjoyment of the right to health at the national or international levels, especially related to the above themes and issues, and which might be used in his reports or in dialogue with other actors including governments and international organizations;
- ⇒ providing examples of good practices, as well as recommendations for the improvement of policies and practices, for the operationalisation of the right to health at the community, national and international levels;
- ⇒ disseminating information on the work and mandate of the Special Rapporteur to local constituencies;
- ⇒ notifying the Special Rapporteur of cases of gross, systematic violations of the right to health. This may be done by sending a communication to his office; and
- ⇒ requesting that the Special Rapporteur make a country visit to investigate situations of particular concern, and interacting with the Special Rapporteur and engaging in other advocacy in relation to a visit, prior to, during and after its occurrence. While country visits tend to generate much political and media attention, it is important to note that the Special Rapporteur has the mandate to make only two country visits per year, which limits the extent to which these requests may be met.

### *Commission on Human Rights resolution 2002/31 and 2003/28 on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*

Terms of reference for the mandate of the Special Rapporteur are set out in Commission on Human Rights resolution 2002/31, which created the post of Special Rapporteur. Commission resolution 2003/28 includes further requests to the Special Rapporteur in fulfilling his mandate (future resolutions on the right to health may also contain further requests or other information).

Resolution 2002/31 requests the Special Rapporteur to, among others:

- gather, request, receive and exchange information from all relevant sources, including NGOs;
- develop a dialogue and discuss areas of cooperation with governments, UN bodies and specialized agencies, NGOs and international financial institutions;
- report on the status of the right to health throughout the world; and
- make recommendations on appropriate measures to promote and protect the right to health.

It also requests him to apply a gender perspective to his work, pay attention to the needs of children and take into account relevant provisions of the Durban Declaration and Programme of Action<sup>16</sup> and other international conference outcome documents.

Resolution 2003/28 requests the Rapporteur to pay particular attention to the links between poverty reduction strategies and the right to health; the impact of stigma and discrimination on the enjoyment of the right to health; and the identification of good practices for the realization of the right to health. It also requests him to pursue his analysis of neglected diseases and right to health impact assessments.

For more information on the Special Rapporteur and NGO participation, see [www.unhchr.ch](http://www.unhchr.ch)

## Notes

- 1 The Optional Protocol to the ICCPR can be used to argue violations of the right to health in terms of other rights provided for in the ICCPR including the right to life; right to liberty and security of the person; and the right to privacy. International Covenant on Civil and Political Rights, including Optional Protocol. Concluded: 16 December 1966, entered into force: 23 March 1976. 999 UNTS 171.
- 2 Committee on the Rights of the Child. Concluding Observations, Madagascar, Seventh session. CRC/C/15/Add.26.
- 3 For a description of core obligations, see chapter 4 and CESCR General Comment 14. E/C.12/2000/4.
- 4 Committee on the Rights of the Child. Concluding Observations, Federal Republic of Yugoslavia, Eleventh session. CRC/C/15/Add.49.
- 5 Ibid.
- 6 Committee on the Rights of the Child. Concluding Observations, Nigeria, Thirteenth session. CRC/C/15/Add.49.
- 7 Committee on the Elimination of Discrimination Against Women (CEDAW), Concluding Comments, Paraguay, Fifteenth session. A/51/38.
- 8 CEDAW, Concluding Comments, Barbados, Thirteenth session. A/49/38.
- 9 Adapted from CRC flowchart presented by Dr Nafsiah Mboi to Commat Expert Consultation on Adolescent Sexual and Reproductive Health and Rights, Biel, Switzerland, 1999.
- 10 PHR-UK. Response to the UK government's fourth report under the International Covenant on Economic, Social and Cultural Rights. London: PHR-UK; 2002.
- 11 Hall P. Doctors urgently need education in human rights. *The Lancet* 2002 Dec 7; (360):1879.
- 12 Rozenberg J. UN experts attack Britain's record on social issues. *The Daily Telegraph* 2002 May 21.
- 13 Special thanks to Judith Bueno de Mesquita for contributing to this section.
- 14 In the course of their work to monitor and promote the right to health, NGOs should consider using all appropriate mechanisms at all levels. At the UN level, this might include contacting and working with other Special Rapporteurs, many of whom have health-related mandates that might overlap with advocacy work undertaken by an NGO.
- 15 Hunt P. Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. E/CN.4/2003/58.
- 16 Durban Declaration and Programme of Action of the World Conference against Racism, Racial Discrimination, Xenophobia and Related Intolerance. Durban, 2001. A/CONF.189/12.



## Part III *Taking action: Working with the right to health*

### Chapter 12 Medical and other health professionals: working with the right to health

Written by John Havard, Commat

#### *Keys to Chapter 12*

##### *key information:*

- Identifying obligations of health professionals to protect the health rights of their patients;
- Identifying the responsibilities of health professionals in relation to other health practitioners.

##### *key questions:*

- What is meant by a 'health professional'?
- What are the most important principles of medical ethics?
- What can be done to enforce principles of medical ethics?

##### *key action points:*

- Review existing relevant legislation, policies and practices;
- Network with other health professional associations and CSOs in promoting and monitoring the right to health;
- Participate in treaty monitoring process.

## 12.1 Introduction

The previous chapters in this Resource Manual have described how the right to health is promoted and monitored, including by the operation of international human rights treaties that impose obligations on those member states that have ratified them. Those obligations are concerned mainly with the responsibilities of governments to ensure that individuals and groups are able, and continue to be able, to enjoy the highest attainable state of health.

This chapter looks at the role of health professionals, and particularly of medical practitioners, in promoting the right to health through the arrangements that have been made for determining their competence to practice, and for regulating their conduct towards their patients and others with whom they come into contact in the course of their professional work.

It has long been recognised that sick and disabled persons are vulnerable to exploitation in their anxiety to obtain relief from pain and suffering, and that they need to be protected from unscrupulous or incompetent healers. The earliest attempts to deal with this problem came about as the result of the development, a long time ago, of the principles of medical ethics. The term 'ethics' connotes relationships and the purpose of those principles is to regulate the relationship between the healer, who is in a position of power and privilege, and the patient, who is in a position of trust and dependence on the healer.

It is by following the principles of medical ethics in their professional practise that health professionals should be able to feel confident that they are protecting the rights of their patients. But this is by no means always the case today. It is, therefore important to understand the differences between ethical obligations on the one hand and human rights obligations on the other.

Human rights obligations are directed primarily at governments in respect of rights to which their citizens are entitled, (and therefore own), whereas ethical obligations are directed primarily at the conduct of medical and other health professionals during their professional practice towards those with whom they come into contact in a professional relationship, mainly their patients, but also their colleagues and other members of the

community. Other important differences, including the ways in which the two different kinds of obligation ie ethics and human rights are enforced, will be considered later in this chapter.

## 12.2 What is a health professional?

For the purpose of this Resource Manual it is important to define what is meant by a 'health professional'. A health professional is a health worker who has agreed to comply with recognized standards of conduct, training and competence, for which he or she has undertaken to remain accountable to an independent licensing body that is empowered to set those standards and to enforce them.

The main distinction between health professionals and other health workers, therefore, is one of accountability. All health workers should strive to attain the highest ethical standards of conduct in providing health services, but only health professionals are accountable to an independent regulatory body, whose requirements, in terms of ethical obligations concerning their professional conduct and competence to practice must always take priority over any other directives to which they may be subjected, for example those of an employer or of a trade union that is involved in industrial action affecting health workers.

The only exception is in cases where the ethical principle concerned conflicts with the laws of their country, and even then physicians have often been known to risk, and to suffer, imprisonment for insisting on acting in accordance with ethical principles.

The overall standard of competence of non-professional health workers is continually improving as the training they receive becomes more concentrated and comprehensive. But only health professionals are required to have satisfied an independent examining body and to maintain the standards of competence and ethical conduct that is required of them.

These considerations apply irrespective of the contractual circumstances governing the conditions of employment of health professionals eg whether they are employed under contracts of services, (ie on a master and servant basis); or indirectly under contracts for services (ie as independent contractors); or whether the contract concerned is expressed or implied (eg attending a private patient); or part-time or whole time. Nor should the considerations be affected by the nature of the service provided eg those for the Armed Forces, Prison Medical Service or government.

## 12.3 What are the main ethical principles and how do they contribute towards promoting and protecting the right to health?

From the point of view of the right to health the following is a summary of important ethical principles with which medical practitioners and other health professionals are expected to comply. Insofar as they are concerned with professional relationships it will be immediately obvious that they usually correspond closely, but by no means always, with human rights obligations associated with the right to health.

### 12.3.1 Relationships with patients

#### *Respect for persons*

This is widely regarded as the most important principle of medical ethics, namely, that health professionals should show respect at all times and in all circumstances to persons they are attending. It reinforces the basic human rights principles of autonomy and non-discrimination that play such an important role in a human rights based approach to the provision of health information and services. (See chapter 5.)

This principle applies irrespective of the race, colour, age, sexual orientation, religion, or political affinities of the persons they are attending, as well as their status, for example whether they are indigenous, refugees, schoolchildren, prisoners or visitors and of the diseases or disabilities from which they may be suffering. Special care needs to be taken to avoid discrimination against persons suffering from STIs, especially HIV / AIDS infection, and against those whose lifestyle a health professional may personally disapprove such as unmarried mothers, commercial sex workers, drug abusers, homosexuals or lesbians. <sup>1</sup>

Respect does not, of course, imply that health professionals must seek to gratify the every wish of those whom they treat.

Patients should be seen as members of both their families and of the broader community. Their autonomy and rights should be viewed in the context of their environment, especially where resources are limited. In some cases this may give rise to conflicts of interest, as when certain kinds of expensive treatments are given preferentially to those who are expected to derive lasting benefit from them, as against those who can derive only transitory benefits for example coronary by-pass operations for intractable chain smokers or very expensive treatments for patients suffering from terminal clinical AIDS. <sup>2</sup>

Respect for the dignity and integrity of patients and other persons who may consult, or be examined or treated by health professionals, especially by medical practitioners, is particularly important and has been the subject of much criticism recently.

'The correct technique for carrying out breast or pelvic examinations is taught in order to ensure that important abnormalities are not missed, but the technique for carrying them out painlessly and with dignity is usually omitted. This is one of the reasons why so many women postpone attending doctors in cases where such examinations are urgently needed.'<sup>3</sup>

### ***Health care of the poor and otherwise vulnerable and disadvantaged groups***

The vulnerability of immature, senile, sick and disabled persons must constantly be borne in mind by health professionals. Repeated violence to children is rarely, if ever, accidental and the sexual abuse of children may be concealed for long periods of time. It follows that health professionals must always remain vigilant. They should keep in mind that women attending them for injuries that were, in fact, inflicted by husbands or partners, will often claim that the injuries occurred as the result of an accident.

Health professionals should be aware, and take account of, those persons who are deprived of adequate access to health care or who have difficulty in making their requirements known. They should bear in mind that such groups are exposed to risk of exploitation, violence and abuse. They should also take account of their special health needs as well as ascertaining the causes of their ill health. <sup>4</sup>

When attending adolescents, health professionals should be mindful of the fact that it may take some time before an adolescent will come to the point in the course of a consultation, particularly if it concerns a sexual or reproductive health problem. They should, therefore, be patient, and refrain from adopting a critical and judgemental attitude towards them.

### ***Right to information***

Patients have a right to demand that information about their medical condition such as the results of diagnostic tests, their treatment, or their prognosis should be given it, unless there are *bona fide* medical reasons why it should be withheld. For example it could be that it would be seriously detrimental to the patient's health to be told. In any event information should be withheld only on a temporary basis. Refusal to impart information diminishes the trust that is fundamental to the ethical relationship of the doctor with the patient, who in any case has a right to know.

Certain information must always be given to patients, whether or not it is requested from the attending doctor. Examples include expected adverse consequences of treatment such as the adverse main or side effects of prescribed medicines, whether or not expected, and the need to avoid unwanted interactions with other drugs (including alcohol) on skills requiring divided attention such as driving motor vehicles or operating dangerous machinery. (In developed countries physicians should assume that their patients will be driving until proved otherwise.) Patients should always be informed of any significant mishaps that may have occurred during their treatment.

Patients who demand information about all the possible adverse effects of proposed medical interventions are entitled to be told about them. They should always be warned about the possibility of any significant personal financial or social consequences that could result from investigations or treatment such as HIV tests, removal of ovaries etc. Patients should always be informed of any significant errors or mishaps that might have occurred in the course of medical procedures.<sup>5</sup>

### *Consent to medical interventions*

Patients have a right to be allowed to refuse proposed medical interventions, for example invasive procedures and other forms of treatment. Consent should always be 'full, free and informed' for which purpose the patient must be given the information needed to exercise choice, including all relevant risks of treatment; or diagnostic procedures, as well as the expected benefits. Any change of mind by the patient during treatment should be respected. Coercion must always be avoided, particularly where employed for purposes of population control, whether general or selective.

Where patients are regarded, for whatever reason, as incapable of making a decision for themselves, the test must always be whether they have the capacity to understand the nature of the proposed treatment and its likely consequences. It follows that, subject to laws relating to the age of consent, the wishes of minors who have that capacity, should be respected regardless of any other factors that might be considered as affecting their ability to consent, such as the need to obtain parental consent.

Conflict situations based on cultural, religious or moralistic objections are common in such cases and the issue has given rise to considerable controversy. However one thing is clear beyond doubt, namely that when attending children the interests of the health of the child must always be a primary consideration. This is reiterated in the Convention on the Rights of the Child (CRC).<sup>6</sup>

Wherever possible health professionals should try and persuade a reluctant adolescent to agree to a parent or guardian being involved. However, subject to the laws of the country concerned, adolescents who are capable of understanding the required treatment and its consequences, but who refuse to allow their parents to be involved, should be given the necessary advice or treatment including contraception, or even termination of pregnancy, if it is clearly in the best interests of their health to do so. If the child is considered to be incapable of understanding the nature and consequences of the proposed intervention, no further action should be taken, but the confidentiality of the consultation should be respected.<sup>7</sup>

In the case of adults who do not have the capacity to consent health professionals must be particularly careful to avoid being unduly influenced by others, including members of the family, who may have financial or other interests in the management of the case. Where the proposed treatment infringes human rights including reproductive rights, application should be made to a court of law. This may arise when it is proposed to sterilize a woman suffering from severe mental disability as being the only practicable means of preventing her becoming pregnant as a result of sexual assault, to which such women are, unfortunately, highly susceptible.

### *Confidentiality*

Patients must feel that their rights to privacy and confidentiality will not be violated and feel able to trust health professionals not to disclose to anyone else, without their consent, information obtained about them during consultations or medical procedures. While this is a fundamental right for the patient, the health professional must also be aware that, unless this is strictly observed, patients will be reluctant to disclose those aspects of their medical history of which account must be taken in order to provide safe and effective health care. Adverse consequences of failure by patients to disclose conditions such as abortions, extra-marital pregnancies, sexually transmitted infections (STIs), or drug abuse include incorrect diagnoses, adverse drug reactions and dangerous drug interactions, allergic reactions and inappropriate treatment. Uncertainty about the confidentiality of the medical consultation is one of the main reasons given by adolescents for their reluctance to seek medical advice about sexual and reproductive health problems.

'.....a young woman's right to privacy, confidentiality, respect and informed consent is often not considered.'<sup>8</sup>

The ethical obligation of medical confidentiality is particularly important in 'common law' countries, such as England, where it is given little if any protection by law, as compared with 'civil' law countries where breach of the *medical secret* is a criminal offence that is severely punished under the *droit penale*.

The danger of breach of confidentiality through unauthorised disclosure is probably greatest when third parties request medical information in support of applications for employment, insurance policies or evidence in support of litigation etc. Health professionals, in such cases, must be careful to ensure that only such information as is necessary for the stated purpose is disclosed, and then only with the informed consent of the person to whom it refers (who should be made aware of any possible adverse consequences of consenting to disclosure). If, for any reason, confidentiality cannot be assured the patient concerned should be warned in advance of the information being disclosed, to whom it is being disclosed and for what purpose.

An Indian couple, engaged to be married, consult their priest about their wedding plans. He tells them they will have to undergo medical tests in order to prove their fitness for marriage and gives them forms for the necessary tests which must be signed by the doctor concerned and returned to him. Blood samples are carried out at a clinic after pre-test counselling and they return to the clinic two days later for the results and any post-test counselling that might be necessary. They are devastated to be told that the prospective bridegroom is HIV positive, and when they take the results back to the priest he refuses to marry them. The wedding was due to take place in four weeks' time and the local community, which has been eagerly expecting the event, is surprised and anxious to know why it has had to be postponed.<sup>9</sup>

### ***Medical emergencies***

The right to life and the right to the enjoyment of health are very important human rights. Health professionals must acknowledge that their primary obligation is to save life and to relieve pain and suffering. *Conscientious objection* to procedures such as induced abortion and sterilization does not absolve them from taking immediate steps in an emergency, either to give the necessary life-saving treatment or to ensure that it is given by a colleague without delay and before any permanent damage results. Even where there is no immediate need for medical attention, there is an ethical obligation to ensure that the patient concerned is informed where to go in order to find a colleague who has no conscientious objection to providing the necessary treatment.

Health professionals should be alert to situations where pressure may be brought on them to withhold treatment that a patient urgently needs, for example by other health workers during industrial action, or the inability of the patient to pay for it, and should take all necessary steps to ensure that the provision of emergency care will be continued until it is safe for the patient to be moved elsewhere.

### ***Medical attendance on persons held in detention***

Steps taken by health professionals to treat persons held in detention should always be in the best interests of their rights including the right to health. Full account should be taken of the adverse effects to health of inadequate nutrition, bad sanitation, prolonged detention, abuses of various kinds, and other adverse conditions to which detainees may be subjected during their enforced stay in a dehumanising environment, nearly all of which are abuses of their human rights.

The attention of the authorities should be called to any actual or potential violations of the human rights of the detainee, whose personal dignity and integrity must be respected whenever they are being attended by a medical practitioner. Medical examinations should be conducted in private and any signs of physical violence should be carefully recorded and reported to the prison authorities. Drugs should be given only for *bona fide* medical reasons.

There are a number of other important ethical issues concerning the role of health professionals when attending detainees including the conduct of intimate body searches, the management of hunger strikes, and participation in judicial amputations and executions, which may often be in violation of the victim's right to health.

A part-time prison medical officer is asked during his daily prison visit to certify a prisoner fit to be punished by caning. Having recently been to a workshop on medical ethics and human rights he is aware that it is both unethical and a violation of human rights to acquiesce in caning which is a brutal, degrading and inhuman punishment. He is also aware that his predecessor in his post was summarily sacked for having protested against the refusal of prison warders to contact him about a woman with ante-partum haemorrhage (who died as a result). His contract as a part-time prison medical officer provides one third of his income and his refusal to examine the prisoner for the stated purpose would almost certainly lead to his dismissal.<sup>10</sup>

The issues involved with the medical care of prisoners are dealt with in a number of human rights instruments notably the Convention on Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (*Torture Convention*) which does not entirely conform with the ethical guidance issued on the subject to the medical profession. The number of UN member states that have ratified the Torture Convention is significantly smaller than for most of the other legally binding international human rights treaties.

### ***Competence to practice***

Health professionals should take steps to ensure that they remain competent to provide their patients with the best possible medical treatment and to give them reliable advice on the measures they should take to promote good health. Patients must not be subjected to risk of avoidable harm from unnecessary or outdated medical procedures, nor should they be placed at risk as a result of a health professional's own ill health, such as that resulting from the abuse of alcohol or other drugs, or infections such as hepatitis, or mental illness.

Every hospital or health care facility should have in place effective procedures for the prompt investigation of medical or surgical accidents and of any unusually high incidence of complications or mistakes, and should institute risk management procedures to deal with them. The health professionals involved should be ready and willing to co-operate fully in such procedures.<sup>11</sup>

## **12.3.2 Relationships with other health practitioners**

### ***Relationships with health professional colleagues***

Delegation of clinical care to other professional colleagues must be exercised responsibly. Patients should not be left in the charge of less experienced colleagues unless they themselves or a suitably qualified colleague is available to provide effective cover, including emergency care. Shared health care has become increasingly common and depends for its effectiveness on full co-operation within the team concerned.

Unfair criticism of a colleague is detrimental to the care of patients and should therefore be avoided. On the other hand where it is apparent that patients are at risk from the illness of a colleague who is caring for them, for example as a result of drug abuse or mental illness, the appropriate authorities should be informed immediately.

A junior hospital doctor examined a woman who had been admitted in labour with her fourth pregnancy, and had been in labour for more than sixteen hours. Suspecting disproportion and obstructed labour, he called the duty obstetrician, who had just returned home after an alcoholic party. Upon arrival at the hospital the duty obstetrician, who smelt strongly of alcohol, examined the woman and found that she was fully dilated with a large baby in an occipito-posterior position. Disregarding the warning of the senior midwife he prescribed oxytocin for the woman and went home, saying that he would see the woman again in the morning when he did his round. On arrival the next morning he was told that the woman had died an hour after he had left without having delivered the baby. He was transferred to the Ministry of Health and given an office job, where he is still working.<sup>12</sup>

### ***Relationships with other (non-professional) health workers***

Health professionals should acknowledge the expertise of non-professional health workers and reinforce the contribution they make to health care by always giving them clear and explicit directions as to the procedures

they want followed in the management of patients under their active clinical care, whilst retaining full responsibility for the management of such case.

### ***Relationships with traditional healers***

In many developing countries a substantial proportion of the population will rely partly or wholly on traditional healers for their health care, often attending practitioners of western conventional medicine at the same time. A distinction should be made between traditional healers who have undertaken a structured system of training such as qualified practitioners of Traditional Chinese Medicine (TCM) and those claiming to cure diseases by the exercise of supernatural powers.

Traditional healers should not be ostracised by health professionals, who should encourage them to adopt safe procedures, in particular infection control.

A three month old child suffering from sporadic fever and diarrhoea was taken to a dental clinic by her mother who claimed that the cause was 'nylon teeth'. The dentist told her that there was no such condition as 'nylon teeth' and advised her to seek medical treatment for the child. However the child's grandmother insisted that the cause was 'nylon teeth' and that the child should be taken to a traditional healer, who confirmed the grandmother's belief, and proceeded to excavate the germinating deciduous tooth buds of the child's canine teeth. This resulted in such heavy bleeding that the local doctor could not control it. On arrival at the local hospital the child was found to be dead from cardiac failure caused by the blood loss.<sup>13</sup>

### **12.3.3 Responsibility to the community**

#### ***Recognition of unsuspected hazards to health***

By virtue of their training and experience health professionals are in a favourable position to call attention to hazards that they encounter to the health of the community that have not already been noticed by the relevant authorities, especially in developing countries where adequate environmental health preventive measures may not be in place. The hazards most likely to be encountered will be industrial, domestic or therapeutic.

Examples include water pollution, bad sanitation, toxic emissions, use of asbestos as lagging; improper disposal of toxic waste and dumping of time expired drugs by multi-national pharmaceutical or other industrial firms. It is generally regarded as an ethical obligation for health professionals to call attention to such unrecognised hazards especially in developing countries where they are most likely to remain unrecognized for the longest period of time.

#### ***Health promotion***

Health professionals should promote healthy lifestyles among their patients and help to educate them, and other members of the community, to remain healthy by avoiding cigarette smoking, the abuse of alcohol and other drugs, unprotected sexual promiscuity, teenage pregnancy, and unhealthy lifestyles, wherever possible setting a personal example.

A public health doctor working in the Ministry of Health was asked by the Minister to devise a simple health promotion training module on adolescent health for use in teacher training colleges, focusing on reproductive health, smoking and alcohol abuse. He is aware that many youngsters see smoking as 'cool' and a badge of adulthood, and that hundreds of people make a living from illegally selling single cigarettes to children. He is also aware that the long-term consequences are likely to include huge demands upon the health services of a country that is hard pressed to provide its people with even the most basic services. Upon submitting his training module to the Ministry he is told that there has been 'a change of heart' and that he must delete all references to smoking as it will be dealt with 'at a later stage'.

The doctor is strongly committed to the programme he has submitted, but he is also politically ambitious and has hopes of establishing himself in the eyes of the ruling party as a future Minister of Health. He is aware that the change of heart by the government has resulted from heavy pressure being exerted by the tobacco growers who have an important economic role in the country and wield considerable political power.<sup>14</sup>

### 12.3.4 Responsibility in the use of modern technology

The most publicised aspects of medical ethics in recent times have been those concerned with the acceptability of procedures using modern technology such as artificial conception; cloning; telemetric medicine; artificial prolongation of life etc. As yet they have been mainly confined to developed countries. However, there are certain procedures that are causing increasing concern in developing countries, including:

#### *Transplantation*

Health professionals involved in organ transplantation have an ethical obligation to safeguard the interests of potential donors and recipients by observing internationally accepted rules and procedures such as the WHO *Guiding Principles on Human Organ Transplantation*. They should ensure that the health risks involved are fully explained to potential donors and satisfy themselves that the decision to donate has been entirely voluntary and not influenced by coercion.

The selection of recipients for available organs should be made on the basis of their medical suitability for the procedure. Health professionals should not get involved in arrangements for commercial donor transplantation, and on no account should they acquiesce in situations where donors from developing countries are induced by financial consideration to travel to a developed country in order to donate organs. In developing countries the donor is often a close relative of the recipient, which usually obviates the need for financial inducements and lessens the risk of organ rejection.

The safest course is to have two entirely independent clinical teams, one of which is responsible for the clinical management of the terminal state of the donor and the other for the care of the recipient. There are ethical objections to using organs from the bodies of executed prisoners (cadaveric transplantation) because of the risk of judicial decisions affecting the timing of executions being influenced by the optimal time for the operation to take place.

Adam, the young son of a successful entrepreneur suffers from nephrotic syndrome with incipient renal failure. Renal dialysis is not a long-term option and as there is no transplantation service available in the country it will be necessary to have the operation abroad. However no matching cadaveric kidneys were found to be available on his extended visits to Europe. Tissue typing of his relatives has revealed that his 14-year-old sister would be a compatible donor. She is terrified at the prospect, and believes that she is merely being used to enable the adored and only son to inherit the family business. She has nightmares about the operation and has become increasingly anorexic. But she is too frightened to tell her parents the reason. The whole family is about to travel to Spain for the transplant to be carried out when it was decided to consult the family doctor about the risks of the operation in view of Elena's loss of weight.<sup>15</sup>

#### *Medical research*

Health professionals should not participate in medical research that does not conform with internationally accepted guidelines such as the World Medical Association's *Declaration of Helsinki*, which insist that full, free and informed consent must be given by research subjects, and that those who are unable, for whatever reason, to give valid consent to participation should not be included in the project unless it has been endorsed by a properly constituted ethical review committee. However research subjects may be at risk where research is carried out in developing countries that do not enforce the guidelines.

Dr Kelly, who is interested in the socio-demographic impact of HIV/AIDS in developing countries, visits a drop-in centre in a South-East Asian country for commercial sex workers run by a charity that also provides a personal development programme for the women concerned. He finds that the women are participating reluctantly in a research programme run by an international pharmaceutical firm which includes the taking of monthly blood samples from them in order to test the efficacy of anti-HIV drugs. They are given no information about the purpose of the research and are not told the results of their blood tests. They have asked to see details of the research protocol, but their request has been ignored. They dare not raise the matter with the Ministry of Health as most of them are illegal immigrants and officially do not exist. As a result the charity workers, who know that the women's human rights are being violated, are maintaining a low profile.<sup>16</sup>



There is currently much controversy over the ethical acceptability of withholding very highly expensive treatments, mainly certain drugs from control groups. The preferred view is that control groups should be given the most effective treatment that is generally available for the condition concerned eg the most effective treatment for the condition should not be withheld from the control group *if it would otherwise be available to them*.

## 12.4 Enforcement of the principles of medical ethics

### 12.4.1 National licensing bodies

The primary purpose of licensing bodies is to ensure that practitioners claiming to be health professionals are, in fact, fully qualified to practice, and that the public can recognise them as such. Licensing bodies also ensure that they are fit to exercise the privileges associated with holding a licence to practice, such as issuing death certificates, prescribing scheduled drugs etc.

Licensing bodies usually issue instructions to health professional training schools stating what they require to be included in the curriculum before they will recognise the relevant degrees or diploma for purposes of granting a licence to practice. In many cases certain recognized medical titles can lawfully be used only by licensed or registered practitioners and this provides the public with further protection against unqualified health professionals.

Licensing bodies investigate allegations and complaints of *serious professional misconduct*, against licensed or registered health practitioners and in most cases these involve *de facto* violations of the human rights of the patients concerned. They can exercise statutory powers of suspension or revocation of the licence to practice. They tend to investigate only the more serious breaches of medical ethics, such as sexual assaults on patients, negligence and gross breaches of medical confidentiality.

Such investigations are particularly effective where the conduct concerned is covered inadequately by national laws. For example, no damages can be awarded for breaches of medical confidentiality, however serious, in the English courts other than for consequential pecuniary damage (which is unusual) whereas in the French courts and other civil law systems unauthorised disclosure of the medical secret is a serious criminal offence punishable under the *droite penale*. (See section 12.3.1.)

There is much variation in the composition and procedures of national licensing bodies. Ideally they should be independent of government, but this is by no means always the case. In some of the smaller countries their responsibilities are exercised by the national health professional association, usually the national medical association.

### 12.4.2 National medical associations

Most national medical associations (NMAs) have ethical committees that issue guidance to their members on medical ethics. In some cases they will investigate complaints of unethical conduct made by one of their members against another member. The complaints investigated will usually be of a less serious nature, in terms of the consequences to the health of the patients involved, as the more serious cases are dealt with by the courts or the licensing body. In a few countries all medical practitioners who are licensed to practice are required by law to be members of the national medical association.

The activities of NMAs in calling attention to unethical practices, which can cause damage to health by governments or by non-governmental enterprises such as private health services, pharmaceutical firms, tobacco manufacturers, and advertisers are often highly effective.

NMAs have a responsibility to increase the awareness of their members of both the medical ethical and the health components of human rights. It is important that health professionals should adopt an approach to health care that is consistent with both their ethical obligations and the human rights of those with whom they come into contact in a professional relationship. Failure to do this will undermine the trust between health professionals and their patients that is so essential to providing effective diagnosis and treatment.

### 12.4.3 Institutional bodies

Many hospitals, professional bodies, and research establishments have appointed ethical committees for purposes of approving specific research projects involving human subjects. They are concerned particularly with issues such as whether sufficient information is given to the subjects to enable them to exercise choice

about their inclusion in the project; whether the risks involved can be justified; and (where very expensive drugs are involved) whether there is unjustifiable discrimination against the controls who, by definition are not treated by the drug under trial. (See section 12.3.4) Again, it is important that the institutional bodies concerned are fully aware of both the human rights and ethical implications for health professionals of the work they require them to carry out.

## **12.5 Obstacles to a co-operative approach by health professionals to the right to health**

In this Resource Manual the contribution of health professionals to the right to health has been considered in the light of existing laws, human rights treaties and ethical principles. The inter-relationship between them is not as well understood as it should be. Indeed it is sometimes apparent that human rights lawyers and health professionals can experience difficulty in understanding each other's point of view, not least because of the different terminologies involved.

The situation is reflected in the inadequate coverage given to the right to health in medical schools and in medical text books where human rights issues are often dealt with solely as a problem for medical ethics or not dealt with at all. Both the right to health and the corresponding ethical principles are continuously evolving in response to changing attitudes, for example, those concerning health related discrimination, and the dilemmas created by modern medical technology.

The fact that ethical principles governing the conduct of health professionals can continue to be developed without taking account of legally binding obligations imposed on their governments through ratification of the relevant human rights treaties, or by the guidance on the right to health issued by treaty monitoring bodies is both confusing and unsatisfactory. It is to be hoped that this Resource Manual will encourage those concerned to effect a reconciliation sooner rather than later.

Meanwhile it is now more than ten years since the World Conference on Human Rights identified the health professions as one of the special groups (along with the military forces, law enforcement personnel and the police) in need of special education concerning the standards contained in human rights instruments and in humanitarian law.<sup>17</sup>

## **12.6 How can health professionals and their national professional associations promote, protect and monitor the right to health?**

The following are examples of activities that national medical and other health professional associations can carry out in three areas concerned with the right to health:

- Reviewing existing relevant legislation, policies and practices;
- Promoting and monitoring the right to health; and
- Participating in the treaty monitoring process.

Few such associations in developing countries will have the resources to carry out all of the above activities without the aid of outside organizations. This is why networking with human rights and other NGOs working on health-related issues is so important.

The examples below are not prescriptive. They are provided only as suggestions to guide and inspire health professional associations in selecting activities that are feasible and appropriate for their organizational interests, goals and resources.

### **12.6.1 Reviewing existing relevant legislation, policies and practices**

#### **12.6.1.1 Check the legislation, practices and policies of the government that affect the right to health, and determine the extent to which they conform with its human rights treaty obligations, relevant international commitments, constitutional guarantees and other domestic legislation**

- Identify the health-related obligations and commitments that the government has acquired through ratification of legally binding human rights treaties or consensus agreement reached at UN World Conferences;

- Assess the extent to which those obligations and commitments have been implemented;
- Review national constitutional measures, laws and policies that affect the right to health, especially those that prohibit discrimination in the provision of health information and services or of health determinants;
- Assess the extent to which the government is implementing such laws and policies and identify any obstacles to their enforcement;
- Make use of research studies and findings that show the need for changes in laws and policies; publicise them, and advocate for the necessary changes to be introduced by the government;
- Determine whether the health priorities adopted by the government conform with the position as disclosed in national health statistics, such as maternal mortality and teenage pregnancy rates, and assess whether they are consistent with the most pressing health concerns and needs of the population; and
- Identify and assess any adverse effects that existing laws and policies of the government (including their implementation) may be having on the right to health.

#### **12.6.1.2 Check whether the accepted national ethical code or guidance for health professionals is consistent with a human rights approach to the provision of health information and services**

- Review national codes and guidelines on medical ethics and ascertain whether they conform with a human rights approach to health care, for example by offering the poor, vulnerable, or otherwise disadvantaged groups a free choice of services, and by taking fully into account relevant social and cultural values.

#### **12.6.1.3 Check whether quality health information and services are accessible to the poor, vulnerable, or otherwise disadvantaged groups in the community**

- Review the health information and services that are available to protect the health, especially the sexual and reproductive health of the poor, vulnerable, or otherwise disadvantaged groups, including their quality, accessibility, affordability and acceptability;
- Identify any unmet health needs, particularly those resulting from adverse discrimination, and network with other NGOs, especially those working with the above groups, to examine and assess the special health care needs of those who are most adversely affected by ill health; and
- Assess the relevance of public health messages and determine whether they are accessible and meaningful, for example directives in HIV / AIDS campaigns with a central message such as ‘Stay faithful to your wife’ have little impact on adolescents in most societies.

#### **12.6.1.4 Investigate the extent to which instruction in an ethical and human rights approach to health care has been included in the training of medical and other health professionals at all levels<sup>18</sup>**

- Examine the curricula of medical and other health professional training schools, together with the educational requirements of licensing bodies for granting a licence to practice, in order to ascertain whether they include adequate and appropriate instruction in medical ethics and the health-related components of human rights;
- Advocate that evidence of satisfactory completion of such instruction should be made a condition of the award of a licence to practice and be also included in the continuing professional development requirements for the periodical renewal of the licence;
- Advocate, in co-operation with medical and other health professional associations and licensing bodies, the adoption of an ethical and human rights approach to health care in the training of medical and other health professionals at all levels.

## **12.6.2 Promoting and monitoring the right to health**

### **12.6.2.1 Networking and forming coalitions with other health professional associations and civil society organizations**

- Form coalitions with other NGOs that are working on health-related human rights issues, especially those working with the poor, vulnerable, or otherwise disadvantaged groups, in order to monitor, promote and protect the right to health;
- Advocate that action be taken at the national level on key issues, including the improved implementation of a government's immediate obligations and the promotion of the research needed to support the necessary changes in policy or legislation;
- Mobilize support for the above activities within professional groups, health care institutions, and NGOs; and, where necessary consider submitting a 'shadow' report to relevant treaty monitoring committees; and
- Keep the media informed about the above activities, including the results of research, and such other evidence as may be needed to promote the right to health, for example by issuing position statements and press releases.

### **12.6.2.2 Contributing to national policies on health**

- Seek to become involved in the formulation by the government of national health-related legislation and policies and emphasise the need for health priorities set by government to reflect fully the most pressing health concerns of the population. Also focus on the equitable distribution of health resources including the needs of the poor, vulnerable, or otherwise disadvantaged groups. For example establish a national consortium for this purpose or contribute to one that has already been set up;
- Collaborate with the government's health and development programmes and lobby in support of the adoption of a human rights approach to the provision of health information and services;
- Advocate for the provision of integrated, cost effective and comprehensive health services that can address key health problems in the community, such as those affecting the poor, vulnerable, or otherwise disadvantaged groups; and
- Advocate for government regulation of the activities of multinational corporations whose activities are suspected of having an adverse effect on health, including pharmaceutical companies and for-profit health insurance enterprises, in order to prevent and/or alleviate any adverse consequences to the enjoyment of the right to health, as by:
  - calling attention to any adverse effects on the right to health that may result from the imposition of GATS and TRIPS agreements;
  - advocating that health sector reforms guarantee free access of the poor, vulnerable, or otherwise disadvantaged groups to the health information and services that they need;
- Mobilize support for countering obstacles to the free access of such groups to health information and services, for example those resulting from the removal of subsidies for attending clinics or from the introduction of user fees as a consequence of the imposition of SAPs and of other reforms of the health sector; and
- Contribute to the establishment of national indicators and benchmarks to monitor progressive realization of the right to health and, in particular, the extent to which the governments is complying with its health-related human rights obligations.

### **12.6.2.3 Promoting training in advocacy skills**

- Instruct interested members of medical and other health professional associations in advocacy skills, including techniques for dealing with the media, with a view to educating the public and policy makers about right to health issues.

### **12.6.2.4 Initiating compliance with ethical standards**

- Ensure that full account is taken of relevant health-related human rights principles in the national code or guidance on medical ethics and that priority is given to the respectful treatment of poor, vulnerable, or otherwise disadvantaged groups including:

- ensuring preservation of their dignity;
- providing them with the health information and services they need;
- allowing them free choice of treatment;
- obtaining their full, free and informed consent to medical interventions; and
- observing strict confidentiality.

#### **12.6.2.5 Engaging in research and documentation**

- Identify key health issues, particularly those affecting the health of the poor, vulnerable, or otherwise disadvantaged groups (concerning which data is often unreliable) and advocate for the necessary research to be carried out, including:
  - keeping records of cases where there is reason to believe that violations of human rights or ethical abuses may have occurred, with a view to their use as case studies for training purposes as well as for advocacy;
  - noting vital health statistical trends that have been caused by persistent violations of human rights; and
  - advocating the necessary disaggregation of data, such as those applicable to adolescent health and development, and the use of indicators relevant to the right to health such as the Ten Year Census and other surveys of demographic and health status.

#### **12.6.2.6 Promoting an ethical and rights-based approach to health**

- Appoint a small advisory group to recommend ways in which medical and other health professionals can be sensitised and helped to adopt an ethical and human rights approach to health care, for example by organizing training programmes and supplying them with examples of good practice and promotional materials;
- Contact civil society representatives including opinion leaders; parliamentarians; faith and community leaders; women's groups; and youth organizations. Discuss with them the adoption of an ethical and human rights approach to issues affecting key health and developmental issues in the community, especially those affecting the poor, vulnerable, or otherwise disadvantaged groups;
- Seek representation on the National Human Rights Institution (NHRI), or equivalent institution, and advocate its introduction in countries where it does not exist;
- Ensure that steps are taken independently of government, and wherever possible in collaboration with human rights NGOs, to monitor both actual and suspected ethical abuses and human rights violations in the health sector, and report them to the responsible government department or authority (such as an ombudsman).

### **12.6.3 Participating in the treaty monitoring process**

#### **12.6.3.1 Participating in the preparation of country reports to treaty monitoring bodies**

- Try to get involved in drafting the health-related sections of country reports to treaty-monitoring bodies, for example, by establishing relationships with the responsible government departments to ensure that progress in meeting treaty obligations relating to health is adequately addressed in the reports. Raise with the relevant government department any inadequacies in that report such as failure to implement core obligations or the inclusion of inaccurate data; and
- Pay particular attention to the need to ensure that obligations concerned with the elimination of discriminatory practices in providing health care are being dealt with. (When governments are willing to cooperate in this regard, it is important to check the final version of such reports before they are submitted to treaty monitoring bodies).

#### **12.6.3.2 Contributing shadow reports**

- Consider preparing and submitting a 'shadow', or parallel, report. This can be done through a comprehensive joint report submitted by a national NGO consortium, by a group of NGOs that are focusing on the right to health, or by a single health professional association. Shadow reports should be supported by the results of research studies, wherever possible.

### 12.6.3.3 Participating in the work of treaty monitoring bodies

- Consider participating in pre-sessional working groups of relevant committees, in collaboration with any national NGO coalition that has been set up for the purpose;
- Consider attending plenary sessions of the relevant treaty monitoring committees and lobbying its members to ensure that important health issues that are contained in, or left out of, country reports, are adequately addressed;
- Note carefully any concluding comments or observations by treaty monitoring bodies on the country report and monitor the extent to which the government responds to them. Any failure by the government to take the recommended action should be publicised; and
- Call attention to the need for treaty monitoring committees to include at least one member with expertise in health issues and suggest the names of suitable candidates to the government for nomination. (This may require devising strategies to facilitate such nominations, and taking account of the election time-tables of the committees concerned).

## Notes

- 1 Commonwealth Medical Trust (Commat). Training manual on ethical and human rights standards health care professionals. London: British Medical Association; 1999: Part 2: Training module One - 1. Note: References to this manual in future boxes in this chapter will be abbreviated to '*Commat Training Manual*'. The extracts from the Manual in the boxes are all based on authenticated cases that have actually occurred in developing countries.
- 2 Commat. Ibid:Part 2: Training module One - 1.
- 3 United Nations Economic and Social Affairs, Women and Health. Report of the expert group meeting 28 September - 2 October Mainstreaming the Gender Perspective in the Health Sector. Tunis; 1998: 13.
- 4 Commat. Ibid:Part 2: Training module one - 2.
- 5 Commat. Ibid:Part 2: Training module two - 7.
- 6 Article 3.1 of CRC states 'In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration' Article 6 states that 'States parties recognize that every child has the inherent right to life' (6.1) and 'shall ensure to the maximum extent possible the survival and development of the child' (6.2). Article 24 (1) recognises the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation shall strive to ensure that no child is deprived of his or her right of access to such services' and (24.2) shall pursue full implementation of this right ...
- 7 Commat. Ibid:Part 2: Training module two - 8. Note also para 107(e) of the Platform for Action of the Fourth World Conference on Women. Beijing, United Nations; 1995
- 8 Platform for Action of the Fourth World Conference on Women. Beijing, United Nations; 1995: para 83.
- 9 Commat. Ibid:Part 3: Case studies: Module one - 7.
- 10 Commat. Ibid:Part 3: Case studies: Module two - 15.
- 11 Commat. Ibid:Part 2: Training module three - 13.
- 12 Commat. Ibid:Part 3: Case studies: Module three - 19.
- 13 Commat. Ibid:Part 3: Case studies: Module three - 25.
- 14 Commat. Ibid:Part 3: Case studies: Module four - 31.
- 15 Commat. Ibid:Part 3: Case studies: Module four - 32.
- 16 Commat. Ibid:Part 3: Case studies: Module four - 33.
- 17 Vienna Declaration and Programme of Action of the World Conference on Human Rights, Vienna 14-25 June, 1993: para 82.
- 18 Commat. Sexual and reproductive health in the medical curriculum. London: Commonwealth Medical Trust; 2001.

## **Annex 1            Examples of international, regional, and national instruments relevant to the right to health <sup>1</sup>**

- I      Selected excerpts from international human rights treaties**
- II     Regional human rights instruments**
- III    Selected excerpts from constitutional provisions and national legislation that confirm the right to health**
- IV    International instruments relating to specific groups**
- V     International instruments relating to specific contexts**
- VI    Selected international conference outcomes, and their follow ups, that relate to the right to health**
- VII   Other international documents that provide standards for the right to health**

### **I                      Selected excerpts from international human rights treaties**

#### **Universal Declaration of Human Rights (UDHR)**

##### *Article 25*

1. Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.
2. Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

#### **International Covenant on Civil and Political Rights (ICCPR)**

##### *Article 6*

1. Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life.

##### *Article 7*

No one shall be subjected to torture or to cruel, inhumane or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation.

#### **International Covenant on Economic, Social and Cultural Rights (ICESCR)**

##### *Article 12*

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 still-birth 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 services and medical attention in the event of sickness.

Note: CESCR General Comment 14 on the right to the highest attainable standard of health (2000) provides the most detailed interpretation to date of state obligations and internationally accepted standards and principles arising from the right to health.

## **International Convention on the Elimination of All Forms of Racial Discrimination (ICERD)**

### *Article 5*

- (e) ...State Parties undertake to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, notably in the enjoyment of the following rights:
- (iv) The right to public health, medical care, social security and social services

## **Convention on the Elimination of All Forms of Discrimination against Women (Women's Convention)**

### *Article 11*

1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of employment in order to ensure, on a basis of equality of men and women, the same rights, in particular:
- (f) The right to protection of health and to safety in working conditions, including the safeguarding of the function of reproduction.

### *Article 12*

1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.
2. ...States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

### *Article 14*

2. States Parties shall take all appropriate measures to eliminate discrimination against women in rural areas in order to ensure, on a basis of equality of men and women, that they participate in and benefit from rural development and, in particular, shall ensure to such women the right:
- (b) To have access to adequate health care facilities, including information, counselling and services in family planning;
- (h) To enjoy adequate living conditions, particularly in relation to housing, sanitation, electricity and water supply, transport and communications.

Note: Important CEDAW documents that expand upon the right to health include: CEDAW General Recommendation 14 on female circumcision (1990); CEDAW General Recommendation 19 on violence against women (1992); and CEDAW General Recommendation 24 on women and health (1999).

## **Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Torture Convention, or CAT) <sup>2</sup>**

### *Article 1*

[Article 1 provides that ...the term 'torture' includes] any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions.



## Convention on the Rights of the Child (Children's Convention, or CRC)

### Article 24

1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such care services.
2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:
  - (a) To diminish infant and child mortality;
  - (b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;
  - (c) To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;
  - (d) To ensure appropriate prenatal and postnatal health care for mothers;
  - (e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breast-feeding, hygiene and environmental sanitation and the prevention of accidents;
  - (f) To develop preventive health care guidance for parents, and family planning education and services.
3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.
4. States Parties undertake to promote and encourage international cooperation with a view to achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries.

**Note:** Important CRC documents that expand upon the right to health include: CRC General Comment 4 on adolescent health and development in the context of the Convention on the Rights of the Child (2003); and CRC General Comment 3 on HIV / AIDS and the rights of the child (2003).

## II Regional human rights instruments

### Inter-American System

- American Declaration of the Rights and Duties of Man (1948), Article 11;
- American Convention on Human Rights (1969);
- Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights — 'Protocol of San Salvador' (1988), Article 10 (and Article 11, the right to a healthy environment); and
- Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women — 'Convention of Belém Do Pará.

### African System

- African Charter on Human and Peoples' Rights (1981), Article 16;
- African Charter on the Rights and Welfare of the Child (1990), Article 14;

## European System

### *Council of Europe (CoE):*

- European Social Charter (1961), and the Revised Charter, (1996), Article 11;
- European Convention for the Protection of Human Rights and Fundamental Freedoms (1950) and its Twelve Protocols (1952-2000) [as amended by Protocol No.11];
- European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment; and
- European Convention on Human Rights and Biomedicine and its Protocols (1997).

### *European Union (EU):*

- Charter of Fundamental Rights of the European Union (2000)

Note: There is no regional human rights system in place in Asia.

## III Selected excerpts from constitutional provisions and national legislation that confirm the right to health

There are over 60 constitutional provisions which include the right to health or the right to health care, and over 40 constitutional provisions which include health-related rights, including the right to reproductive health care, the right of disabled persons to material assistance, and the right to a healthy environment.<sup>3</sup>

The following examples of national constitutional provisions and legislation illustrate how different health-related provisions are used to achieve different results.

### Constitution of the Republic of South Africa

27(1) Everyone has the right to have access to -

- a health care services, including reproductive health care;
- b sufficient food and water; and
- c social security, including, if they are unable to support themselves and their dependants, appropriate social assistance.

(2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of each of these rights.

(3) No one may be refused emergency medical treatment.

24(a) Everyone has the right -to an environment that is not harmful to their health or well-being

### Constitution of India

47. "Duty of the State to raise the level of nutrition and the standard of living and to improve public health.

The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties and, in particular, the State shall endeavour to bring about prohibition of the consumption except for medicinal purposes of intoxicating drinks and of drugs which are injurious to health."

*from Part IV of Indian Constitution, Directive Principles of State Policy*

### Canada Health Act

The 1984 Canada Health Act establishes national health services and sets out the basic principles for achieving the goal of universal health care coverage. In order for the country's provincial health systems to be eligible for federal funding, five preconditions must be met: comprehensive benefits, universality, accessibility, portability, and public administration. The Act sets out the following requirements to be met in order for these conditions to be satisfied:

- **Comprehensiveness:** ‘Medically necessary’ health care services are to be provided, including the services of general practitioners and specialists as well as in-patient and out-patient services. In-patient services of hospitals are to be equipped and staffed to provide care at a standard level;
- **Universality:** 100 percent of the population (ie eligible residents) has to be covered in order to qualify as a ‘universal plan’;
- **Accessibility:** Payment for the cost of insured services must be on uniform terms and conditions that neither impede nor preclude reasonable access by insured persons, including those with the lowest incomes;
- **Portability:** Available benefits will continue to be honoured when residents visit or move permanently to another province; and
- **Public administration:** Medical plans must be administered and operated on a non-profit basis by an independent, non-political agency that is accountable to the provincial/territorial minister of health and government.

## **IV International instruments relating to specific groups <sup>4</sup>**

### **Racial and ethnic groups**

- International Covenant on the Elimination of All Forms of Racial Discrimination (1965); ILO Convention No 169 (concerning Indigenous and Tribal Peoples in Independent Countries, 1989); and
- Declaration on the Rights of Persons Belonging to National or Ethnic, Religious and Linguistic Minorities (1992).

### **Women**

- Convention on the Elimination of All Forms of Discrimination against Women (1979);
- Declaration on the Elimination of Violence against Women (1993);
- General Recommendation 14 of the Committee on the Elimination of Discrimination against Women (CEDAW) on female circumcision (1990);
- General Recommendation 19 of CEDAW on violence against women (1992); and
- General Recommendation 24 of CEDAW on women and health (1999).

### **Children**

- Convention on the Rights of the Child (1989);
- ILO Convention No 138 (concerning Minimum Age for Admission to Employment, 1973);
- ILO Convention No 182 (the Worst Forms of Child Labour Convention, 1999);
- United Nations Standard Minimum Rules for the Administration of Juvenile Justice (1985);
- United Nations Rules for the Protection of Juveniles Deprived of Their Liberty (1990);
- Declaration on the Rights of the Child (1959);
- General Comment 4 on adolescent health and development in the context of the Convention on the Rights of the Child (2003); and
- General Comment 3 on HIV/AIDS and the rights of the child (2003).

### **Migrant workers**

- International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (1990).

## **People with disabilities including mental disabilities**

- Declaration on the Rights of Disabled Persons (1975);
- Standard Rules on the Equalization of Opportunities for Persons with Disabilities (1993);
- Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Healthcare (1991);
- CESCR General Comment 5 on persons with disabilities (1994); and
- Human Rights Committee General Comment 21 (1992).

## **Older people**

- United Nations Principles for Older Persons (1991); and
- CESCR General Comment 6 on the economic, social and cultural rights of older persons (1995).

## **Refugees**

- Convention relating to the Status of Refugees (1951).

# **V International instruments relating to specific contexts<sup>5</sup>**

## **Armed conflict**

- The Geneva Convention for the Amelioration of the Condition of Wounded and Sick in Armed Forces in the Field (1949);
- The Geneva Convention for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of the Armed Forces at Sea (1949);
- The Geneva Convention relative to the Treatment of Prisoners of War (1949);
- The Geneva Convention relative to the Protection of Civilian Persons in Times of War (1949);
- Additional Protocol 1 to the Geneva Conventions relating to the Protection of Victims in International Armed Conflict (1977);
- Additional Protocol II to the Geneva Conventions relating to the Protection of Victims of Non-International Armed Conflicts (1977);
- Declaration on the Protection of Women and Children in Emergency and Armed Conflict (1974); and
- Protocol on Prohibitions or Restrictions on the Use of Mines (1980).

## **Occupational health and safety**

- ILO Convention No. 155 (Occupational Health and Safety Convention, 1981);
- ILO Convention No. 148 (Working Environment Convention, 1977); and
- several other ILO Conventions (eg Conventions Nos. 130, 152, 161, 164, 167, 170, 171, 176, 177 and 184).

## **Environmental health**

- Basel Convention on the Control of Transboundary Movements of Hazardous Wastes and Their Disposal (1989);
- Code of Practice on the International Transboundary Movement of Radioactive Waste (1990); and
- Convention on Nuclear Safety (1994).

## Administration of Justice

- International Covenant on Civil and Political Rights (ICCPR, 1966);
- Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT, 1984);
- Standard Minimum Rules for the Treatment of Prisoners (1955);
- Body of Principles for the Protection of All Persons under any Form of Detention or Imprisonment (1988);
- Code of Conduct for Law Enforcement Officials (1979); and
- Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (1982).

## Development

Declaration on the Right to Development (1986).

## Research, experimentation and genetics

- Nürnberg Code (1947);
- ICCPR;
- Universal Declaration on the Human Genome and Human Rights (1997);
- Declaration on the Use of Scientific and Technical Progress in the Interests of Peace and for the Benefits of Mankind (1975); and
- General Comment 20 of the Human Rights Committee (1992).

## Data Protection

- Guidelines for the Regulation of Computerized Personal Data Files (1990); and
- General Comment 16 of the Human Rights Committee (1988).

## Nutritional Health

- Universal Declaration on the Eradication of Hunger and Malnutrition (1974).

## VI Selected international conference outcomes, and their follow ups, that relate to the right to health <sup>6</sup>

- Johannesburg Declaration and Plan of Implementation of the World Summit for Sustainable Development (2002);
- Monterrey Consensus of the International Conference on Financing for Development (2002);
- Political Declaration and Madrid International Plan of Action on Ageing of the Second World Assembly on Ageing (2002);
- “A World Fit for Children” adopted by the United Nations General Assembly Special Session on Children (2002); Declaration and Plan of Action of the World Summit for Children (1990);
- Declaration of Commitment on HIV/AIDS, “Global Crisis-Global Action”, adopted by the United Nations General Assembly Special Session on HIV/AIDS (2001);
- Durban Declaration and Programme of Action of the World Conference against Racism, Racial Discrimination, Xenophobia and Related Intolerance (2001);
- United Nations Millennium Declaration, adopted by the United Nations General Assembly “Millennium Assembly of the United Nations” (2000);

- Beijing Declaration and Platform for Action of the Fourth World Conference on Women (1995) and its follow-up, Beijing Plus 5 (2000)
- Programme of Action of the International Conference on Population and Development (1994) and its follow-up, ICPD+5 (1999)
- Rome Declaration on World Food Security and World Food Summit Plan of Action of the World Food Summit (1996) and its follow-up, Declaration of the World Food Summit: Five Years Later, International Alliance Against Hunger (2002);
- Istanbul Declaration and the Habitat Agenda of the Second United Nations Conference on Human Settlements (Habitat II) (1996), and the Declaration on Cities and Other Human Settlements in the New Millennium of the Special Session of the General Assembly for an overall review and appraisal of the implementation of the Habitat Agenda (2001);
- Copenhagen Declaration on Social Development and Programme of Action of the World Summit for Social Development (1995) and its follow-up, Copenhagen Plus 5 (2000);
- Vienna Declaration and Programme of Action adopted by the World Conference on Human Rights (1993);
- Rio Declaration on Environment and Development and Agenda 21 of the United Nations Conference on Environment and Development (1992); and
- Stockholm Declaration of the United Nations Conference on the Human Environment (1972).

## VII Other international documents that provide standards for the right to health

The following are examples of legally non-binding documents that elaborate detailed and targeted standards, principles and norms on the right to health. As such, they are complementary to legal instruments by adding meaning and substantive content to specific aspects of the right to health.

- Declaration of Alma Alta from the International Conference on Primary Health Care (1978);
- World Health Organization Action Programme on Essential Drugs;
- World Medical Association Declaration of Helsinki (1964);
- Commonwealth Medical Association Guiding Principles on Medical Ethics and Human Rights;
- Framework Convention on Tobacco Control (2003);
- Principles relating to the status of national institutions ('Paris Principles' 1992); and
- International Guidelines on HIV/AIDS and Human Rights (1997).

## Notes

- 1 Annex 1 does not provide a comprehensive list of instruments that are relevant to the right to health. For further standards, see references: WHO. 25 Questions and answers on health and human rights. Health and Human Rights Publications Series Issue 1. Geneva: 2002; Alfredsson G, Tomasevski K (eds.). A Thematic guide to documents on health and human rights: Global and regional standards adopted by intergovernmental organizations, international non-governmental organizations, and professional associations. Dordrecht, The Netherlands: Nijhoff; 1998.
- 2 It should be noted that the so-called 'United Nations Code of Medical Ethics', ie Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and other Cruel, Inhumane or Degrading Treatment or Punishment (1962), is equivocal on the ethical position of health professionals participating in the carrying out of sentences of capital or corporal punishment by properly constituted courts of law, including judicial amputations (see chapter 12 and Administration of Justice above).
- 3 According to preliminary findings from a study commissioned by the WHO from the International Commission of Jurists. ICJ, Right to Health Database, Preliminary Proposal, 2002, as cited in: Hunt P. Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. E/CN.4/2003/58. p 8.
- 4 Reproduced, with minor adaptation, from: Hunt P. Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. E/CN.4/2003/58. Annex I, Section B, p 28.
- 5 Reproduced, with minor adaptation, from: Hunt P. Ibid:Annex I, Section C, p 29.
- 6 Reproduced, with minor adaptation, from: Hunt P. Ibid:Annex I, Section D, p 30-31.

## **Annex 2            Examples of global goals, targets and indicators relevant to health**

Annex 1 highlights three examples of global goals, targets and indicators that can be relevant for monitoring implementation of the right to health. The examples include:

- I      Millennium Development goals (MDGs), targets and indicators;**
- II     World Health Organization (WHO) reproductive health indicators for global monitoring;**
- III    International Conference on Population and Development (ICPD) Programme of Action (PoA) 20-year goals; and Key Actions for the Further Implementation of the Programme of Action of the ICPD (ICPD+5).**

### **I                    Millennium Development goals, targets and indicators <sup>1</sup>**

#### **Goal 1            Eradicate extreme poverty and hunger**

##### **Target 1**

Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day

##### **Indicators**

- 1      Proportion of population below \$1 (PPP) per day (World Bank) <sup>2</sup>
- 2      Poverty gap ratio [incidence x depth of poverty] (World Bank)
- 3      Share of poorest quintile in national consumption (World Bank)

##### **Target 2**

Halve, between 1990 and 2015, the proportion of people who suffer from hunger

##### **Indicators**

- 4      Prevalence of underweight children under five years of age (UNICEF-WHO)
- 5      Proportion of population below minimum level of dietary energy consumption (FAO)

#### **Goal 2            Achieve universal primary education**

##### **Target 3**

Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling

##### **Indicators**

- 6      Net enrolment ratio in primary education (UNESCO)
- 7      Proportion of pupils starting grade 1 who reach grade 5 (UNESCO) <sup>3</sup>
- 8      Literacy rate of 15-24 year-olds (UNESCO)

#### **Goal 3            Promote gender equality and empower women**

##### **Target 4**

Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015

### **Indicators**

- 9 Ratio of girls to boys in primary, secondary and tertiary education (UNESCO)
- 10 Ratio of literate women to men, 15-24 years old (UNESCO)
- 11 Share of women in wage employment in the non-agricultural sector (ILO)
- 12 Proportion of seats held by women in national parliament (IPU)

## **Goal 4 Reduce child mortality**

### **Target 5**

Reduce by two thirds, between 1990 and 2015, the under-five mortality rate

### **Indicators**

- 13 Under-five mortality rate (UNICEF-WHO)
- 14 Infant mortality rate (UNICEF-WHO)
- 15 Proportion of 1 year-old children immunized against measles (UNICEF-WHO)

## **Goal 5 Improve maternal health**

### **Target 6**

Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio

### **Indicators**

- 16 Maternal mortality ratio (UNICEF-WHO)
- 17 Proportion of births attended by skilled health personnel (UNICEF-WHO)

## **Goal 6 Combat HIV/AIDS, malaria and other diseases**

### **Target 7**

Have halted by 2015 and begun to reverse the spread of HIV/AIDS

### **Indicators**

- 18 HIV prevalence among pregnant women aged 15-24 years (UNAIDS-WHO-UNICEF)
- 19 Condom use rate of the contraceptive prevalence rate (UN Population Division) <sup>4</sup>
- 19a Condom use at last high-risk sex (UNICEF-WHO)
- 19b Percentage of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS (UNICEF-WHO) <sup>5</sup>
- 19c Contraceptive prevalence rate (UN Population Division)
- 20 Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years (UNICEF-UNAIDS-WHO)

### **Target 8**

Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases

### **Indicators**

- 21 Prevalence and death rates associated with malaria (WHO)
- 22 Proportion of population in malaria-risk areas using effective malaria prevention and treatment measures (UNICEF-WHO) <sup>6</sup>
- 23 Prevalence and death rates associated with tuberculosis (WHO)



- 24 Proportion of tuberculosis cases detected and cured under DOTS (internationally recommended TB control strategy) (WHO)

## **Goal 7 Ensure environmental sustainability**

### **Target 9**

Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources

#### **Indicators**

- 25 Proportion of land area covered by forest (FAO)
- 26 Ratio of area protected to maintain biological diversity to surface area (UNEP-WCMC)
- 27 Energy use (kg oil equivalent) per \$1 GDP (PPP) (IEA, World Bank)
- 28 Carbon dioxide emissions per capita (UNFCCC, UNSD) and consumption of ozone-depleting CFCs (ODP tons) (UNEP-Ozone Secretariat)
- 29 Proportion of population using solid fuels (WHO)

### **Target 10**

Halve, by 2015, the proportion of people without sustainable access to safe drinking water and sanitation

#### **Indicators**

- 30 Proportion of population with sustainable access to an improved water source, urban and rural (UNICEF-WHO)
- 31 Proportion of population with access to improved sanitation, urban and rural (UNICEF-WHO)

### **Target 11**

By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers

#### **Indicators**

- 32 Proportion of households with access to secure tenure (UN-HABITAT)

## **Goal 8 Develop a global partnership for development**

Indicators for targets 12-15 are given below in a combined list.

### **Target 12**

Develop further an open, rule-based, predictable, non-discriminatory trading and financial system.

Includes a commitment to good governance, development and poverty reduction - both nationally and internationally

### **Target 13**

Address the special needs of the least developed countries.

Includes: tariff and quota-free access for least developed countries' exports; enhanced programme of debt relief for heavily indebted poor countries (HIPC) and cancellation of official bilateral debt; and more generous ODA for countries committed to poverty reduction

### **Target 14**

Address the special needs of landlocked developing countries and small island developing States (through the Programme of Action for the Sustainable Development of Small Island Developing States and the outcome of the twenty-second special session of the General Assembly)

## Target 15

Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term

Some of the indicators listed below are monitored separately for the least developed countries (LDCs), Africa, landlocked developing countries (LLDCs) and small island developing States (SIDS)

### *Indicators*

#### *Official development assistance (ODA)*

- 33 Net ODA, total and to LDCs, as percentage of OECD/Development Assistance Committee (DAC) donors' gross national income (GNI)(OECD)
- 34 Proportion of total bilateral, sector-allocable ODA of OECD/DAC donors to basic social services (basic education, primary health care, nutrition, safe water and sanitation) (OECD)
- 35 Proportion of bilateral ODA of OECD/DAC donors that is untied (OECD)
- 36 ODA received in landlocked developing countries as a proportion of their GNIs (OECD)
- 37 ODA received in small island developing States as proportion of their GNIs (OECD)

#### *Market access*

- 38 Proportion of total developed country imports (by value and excluding arms) from developing countries and from LDCs, admitted free of duty (UNCTAD, WTO, WB)
- 39 Average tariffs imposed by developed countries on agricultural products and textiles and clothing from developing countries (UNCTAD, WTO, WB)
- 40 Agricultural support estimate for OECD countries as percentage of their GDP (OECD)
- 41 Proportion of ODA provided to help build trade capacity (OECD, WTO)

#### *Debt sustainability*

- 42 Total number of countries that have reached their Heavily Indebted Poor Countries Initiative (HIPC) decision points and number that have reached their HIPC completion points (cumulative) (IMF - World Bank)
- 43 Debt relief committed under HIPC initiative (IMF-World Bank)
- 44 Debt service as a percentage of exports of goods and services (IMF-World Bank)

## Target 16

In cooperation with developing countries, develop and implement strategies for decent and productive work for youth

### *Indicators*

- 45 Unemployment rate of young people aged 15-24 years, each sex and total (ILO)<sup>7</sup>

## Target 17

In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries

### *Indicators*

- 46 Proportion of population with access to affordable essential drugs on a sustainable basis (WHO)

## Target 18

In cooperation with the private sector, make available the benefits of new technologies, especially information and communications

### *Indicators*

- 47 Telephone lines and cellular subscribers per 100 population (ITU)
- 48 Personal computers in use per 100 population and Internet users per 100 population (ITU)

## II WHO reproductive health indicators for global monitoring

ICPD and ICPD+5 reproductive health goals and the 17 indicators <sup>8</sup>

**Table: ICPD and ICPD+5 benchmarks and the relevant reproductive health indicator from the interagency's short list which can be used (some as a proxy) to measure progress towards the global target**

<i>Global Indicator</i>	<i>ICPD goal</i>
1. Total fertility rate	While the Programme of Action does not quantify goals for population growth, structure and distribution, it reflects the view that an early stabilisation of world population would make a crucial contribution to realizing the overarching objective of sustainable development <i>ICPD+5 ,21st Special Session, Agenda item 8, §7</i>
2. Contraceptive prevalence	Assist couples and individuals to achieve their reproductive goals and give them the full opportunity to exercise the right to have children by choice <i>ICPD Principle 8, 7.12, 7.14(c), 7.16</i>  Provide universal access to a full range of safe and effective family planning methods, as part of comprehensive sexual and reproductive health care <i>ICPD 7.2, 7.4, 7.6, 7.14 (a)</i>  By 2005, 60 percent of primary health care and family planning facilities should offer the widest achievable range of safe and effective family planning methods <i>ICPD+5 ,21st Special Session, Agenda item 8, §53</i>
3. Maternal Mortality Ratio	Countries should strive to effect significant reductions in maternal morbidity and mortality by the year 2015: a reduction in maternal mortality by one half of the 1990 levels by the year 2000 and a further one half by 2015. Disparities in maternal mortality within and between countries, socio-economic and ethnic groups should be narrowed <i>ICPD 8.21</i>
4. Antenatal care coverage	Expand the provision of maternal health services in the context of primary health care. These services should offer prenatal care and counselling, with special emphasis on detecting and managing high-risk pregnancies <i>ICPD 8.17, 8.22</i>
5. Births attended by skilled health personnel	All births should be attended by trained persons <i>ICPD 8.22</i>  All countries should continue their efforts so that globally, by 2005 at least 80 percent of all births should be assisted by skilled attendants, by 2010, 85 percent, and by 2015, 90 percent <i>ICPD+5 ,21st Special Session, Agenda item 8, §64</i>
6. Availability of basic essential obstetric care	Expand the provision of maternal health services in the context of primary health care. These services should offer adequate delivery assistance and provision for obstetric emergencies <i>ICPD 8.22</i>

7. Availability of comprehensive essential obstetric care  
By 2005, 60 percent of primary health care and family planning facilities should offer, directly or through referral, essential obstetric care  
*ICPD+5 ,21st Special Session, Agenda item 8, §53*
8. Perinatal mortality rate  
Within the framework of primary health care, extend integrated reproductive health care and child health services, including safe motherhood, child survival programmes and family planing services, particularly to the most vulnerable and under-served groups  
*ICPD 8.17*
- 9 Low birth weight prevalence  
To improve the health and nutritional status of women, especially of pregnant women, and of infants and children  
  
Interventions to reduce low birth-weight should include the promotion of maternal nutrition and the promotion of longer intervals between births  
*ICPD 8.15(b), 8.17, 8.20 (b)*
- 10 Positive syphilis serology prevalence in pregnant women  
Prevent and reduce the incidence of, and provide treatment for, sexually transmitted diseases, including HIV / AIDS  
*ICPD 7.29*  
  
By 2005, 60 percent of primary health care and family planning facilities should offer prevention and management of reproductive tract infections, including STDs and barrier methods to prevent infection  
*ICPD+5 ,21st Special Session, Agenda item 8, §53*
- 11 Prevalence of anaemia in women  
Countries should implement special programmes on the nutritional needs of women of childbearing age, and give particular attention to the prevention and management of nutritional anaemia  
*ICPD 8.24*
- 12 Percentage of obstetric and gynaecological admissions owing to abortion  
Women should have access to quality services for the management of complications arising from abortions  
*ICPD 8.25*
- 13 Reported prevalence of women with FGM  
Countries should take steps to eliminate violence against women  
  
Governments should prohibit female genital mutilation/cutting wherever it exists and give vigorous support to efforts among non-governmental organizations and religious institutions to eliminate such practices  
*ICPD 4.4(e), 4.22*
- 14 Prevalence of infertility in women  
Prevent and reduce the incidence of, and provide treatment for, sexually transmitted diseases, including HIV / AIDS, and the complications of sexually transmitted diseases such as infertility, with special attention to girls and women  
*ICPD 7.29*  
  
By 2005, 60 percent of primary health care and family planning facilities should offer prevention and management of reproductive tract infections, including STDs and barrier methods to prevent infection  
*ICPD+5 ,21st Special Session, Agenda item 8, §53*

15 Reported incidence of urethritis in men	Prevent and reduce the incidence of, and provide treatment for, sexually transmitted diseases, including HIV/AIDS <i>ICPD 7.29</i>
	By 2005, 60 percent of primary health care and family planning facilities should offer prevention and management of reproductive tract infections, including STDs and barrier methods to prevent infection <i>ICPD+5 ,21st Special Session, Agenda item 8, §53</i>
16 HIV prevalence in pregnant women	HIV infection rates in persons 15-24 years of age should be reduced by 25 percent in the most affected countries by 2005 and by 25 percent globally by 2010 <i>ICPD+5 ,21st Special Session, Agenda item 8, §70</i>
17 Knowledge of HIV-related prevention practices	By 2005 at least 90 percent of young men and women, aged 15-24, should have access to the information, education and services necessary to develop the life skills required to reduce their vulnerability to HIV infection <i>ICPD+5 ,21st Special Session, Agenda item 8, §70</i>

## Definitions

### 1 *Total fertility rate*

Total number of children a woman would have by the end of her reproductive period if she experienced the currently prevailing age-specific fertility rates throughout her childbearing life.

### 2 *Contraceptive prevalence (any method)*

Percentage of women of reproductive age\* who are using (or whose partner is using) a contraceptive method\*\* at a particular point in time.

\* Women of reproductive age in this indicator refers to all women aged 15–49, who are at risk of pregnancy, i.e. sexually active women who are not infecund, pregnant or amenorrhoeic.

\*\* Contraceptive method includes female and male sterilisation, injectable and oral hormones, intrauterine devices, diaphragms, spermicides and condoms, natural family planning and lactational amenorrhoea where cited as a method.

### 3 *Maternal mortality ratio*

The number of maternal deaths per 100 000 live births.

### 4 *Antenatal care coverage*

Percentage of *women* attended, at least once during pregnancy, by skilled health personnel\* (excluding trained or untrained traditional birth attendants) for reasons relating to pregnancy.

\* Skilled health personnel refers to doctor (specialist or non-specialist), and/or persons with midwifery skills who can manage normal deliveries and diagnose or refer obstetric complications. Both trained and untrained traditional birth attendants are excluded.

### 5 *Births attended by skilled health personnel*

Percentage of *births* attended by skilled health personnel\* (excluding trained or untrained traditional birth attendants).

\* Skilled health personnel refers to doctor (specialist or non-specialist), and/or persons with midwifery skills who can manage normal deliveries and diagnose or refer obstetric complications. Both trained and untrained traditional birth attendants are excluded.

### 6 *Availability of basic essential obstetric care*

Number of facilities with functioning basic essential obstetric care\* per 500 000 population.

\* Basic essential obstetric care should include parenteral antibiotics, oxytocics and sedatives for eclampsia and the manual removal of placenta and retained products.

## **7 Availability of comprehensive essential obstetric care**

Number of facilities with functioning comprehensive essential obstetric care\* per 500 000 population.

\* Comprehensive essential obstetric care should include basic essential obstetric care plus surgery, anaesthesia and blood transfusion.

## **8 Perinatal mortality rate**

Number of perinatal deaths\* per 1000 total births.

\* Deaths occurring during late pregnancy (at 22 completed weeks gestation and over), during childbirth and up to seven completed days of life.

## **9 Low birth weight prevalence**

Percentage of live births that weigh less than 2500 g.

## **10 Positive syphilis serology prevalence in pregnant women**

Percentage of pregnant women (15–24) attending antenatal clinics, whose blood has been screened for syphilis, with positive serology for syphilis.

## **11 Prevalence of anaemia in women**

Percentage of women of reproductive age (15–49) screened for haemoglobin levels with levels below 110 g/l for pregnant women and below 120 g/l for non-pregnant women.

## **12 Percentage of obstetric and gynaecological admissions owing to abortion**

Percentage of all cases admitted to service delivery points providing in-patient obstetric and gynaecological services, which are due to abortion (spontaneous and induced, but excluding planned termination of pregnancy).

## **13 Reported prevalence of women with FGM**

Percentage of women interviewed in a community survey, reporting to have undergone FGM.

## **14 Prevalence of infertility in women**

Percentage of women of reproductive age (15–49) at risk of pregnancy (not pregnant, sexually active, non-contracepting and non-lactating) who report trying for a pregnancy for two years or more.

## **15 Reported incidence of urethritis in men**

Percentage of men (15–49) interviewed in a community survey, reporting at least one episode of urethritis in the last 12 months.

## **16 HIV prevalence in pregnant women**

Percentage of pregnant women (15–24) attending antenatal clinics, whose blood has been screened for HIV, who are sero-positive for HIV.

## **17 Knowledge of HIV-related prevention practices**

The percentage of all respondents who correctly identify all three major ways of preventing the sexual transmission of HIV and who reject three major misconceptions about HIV transmission or prevention.

# **III International Conference on Population and Development (ICPD) Programme of Action (PoA) 20-year goals <sup>9</sup>**

## **1 Universal Education**

"Beyond the achievement of the goal of universal primary education in all countries before the year 2015, all countries are urged to ensure the widest and earliest possible access by girls and women to secondary and higher levels of education, as well as to vocational education and technical training, bearing in mind the need to improve the quality and relevance of that education." [para. 4.18]

## 2 Reduction of Infant and Child Mortality

"... Countries should strive to reduce their infant and under-five mortality rates by one third, or to 50 and 70 per 1,000 live births, respectively, whichever is less, by the year 2000, with appropriate adaptation to the particular situation of each country. By 2005, countries with intermediate mortality levels should aim to achieve an infant mortality rate below 50 deaths per 1,000 live births and an under-five mortality rate below 60 deaths per 1,000 live births. By 2015, all countries should aim to achieve an infant mortality rate below 35 per 1,000 live births and an under-five mortality rate below 45 per 1,000. Countries that achieve these levels earlier should strive to lower them further." [para. 8.16]

## 3 Reduction of Maternal Mortality

"Countries should strive to effect significant reductions in maternal mortality by the year 2015: a reduction in maternal mortality by one half of the 1990 levels by the year 2000 and a further one half by 2015. The realization of these goals will have different implications for countries with different 1990 levels of maternal mortality. Countries with intermediate levels of mortality should aim to achieve by the year 2005 a maternal mortality rate below 100 per 100,000 live births and by the year 2015 a maternal mortality rate below 60 per 100,000 live births. Countries with the highest levels of maternal mortality should aim to achieve by 2005 a maternal mortality rate below 125 per 100,000 live births and by 2015 a maternal mortality rate below 75 per 100,000 live births. However, all countries should reduce maternal morbidity and mortality to levels where they no longer constitute a public health problem. Disparities in maternal mortality within countries and between geographical regions, socio-economic and ethnic groups should be narrowed." [para. 8.21]

## 4 Access to Reproductive and Sexual Health Services Including Family Planning

"All countries should strive to make accessible through the primary health-care system, reproductive health to all individuals of appropriate ages as soon as possible and no later than the year 2015. Reproductive health care in the context of primary health care should, inter alia, include: family-planning counselling, information, education, communication and services; education and services for pre-natal care, safe delivery and post-natal care; prevention and appropriate treatment of infertility; abortion as specified in paragraph 8.25, including prevention of abortion and the management of the consequences of abortion; treatment of reproductive tract infections; sexually transmitted diseases and other reproductive health conditions; and information, education and counselling, as appropriate, on human sexuality, reproductive health and responsible parenthood. Referral for family-planning services and further diagnosis and treatment for complications of pregnancy, delivery and abortion, infertility, reproductive tract infections, breast cancer and cancers of the reproductive system, sexually transmitted diseases, including HIV/AIDS should always be available, as required. Active discouragement of harmful practices, such as female genital mutilation, should also be an integral component of primary health care, including reproductive health-care programmes." [para. 7.6]

The United Nations Population Fund (UNFPA) and WHO are both committed to the achievement of the ICPD goal that "All countries should strive to make accessible through the primary health care system, reproductive health to all individuals of appropriate ages as soon as possible and no later than the year 2015". At a WHO/UNFPA technical consultation, held in December 2003 it was agreed that the following indicators be used to achieve this goal: <sup>10</sup>

- percentage of births attended by skilled health personnel;
- contraceptive prevalence;
- knowledge of HIV-related prevention practices; and
- percentage of men aged 15-49 reporting receipt of treatment for urethral discharge.

## Key Actions for the Further Implementation of the Programme of Action of the ICPD — ICPD+5 <sup>11</sup>

In 1999, the UN General Assembly convened a special session to review progress towards meeting the ICPD goals. After reviewing the topics highlighted in the ICPD PoA, the special session (known as ICPD+5) agreed on a new set of benchmarks in four areas:

## 1 Education and literacy

"Governments and civil society, with the assistance of the international community, should, as quickly as possible, and in any case before 2015, meet the Conference's goal of achieving universal access to primary education; eliminate the gender gap in primary and secondary education by 2005; and strive to ensure that by 2010 the net primary school enrolment ratio for children of both sexes will be at least 90 per cent, compared with an estimated 85 per cent in 2000." [para. 34]

"Governments, in particular of developing countries, with the assistance of the international community, should: ... Reduce the rate of illiteracy of women and men, at least halving it for women and girls by 2005, compared with the rate in 1990." [para. 35 (c)]

## 2 Reproductive health care and unmet need for contraception

"... Governments should strive to ensure that by 2015 all primary healthcare and family planning facilities are able to provide, directly or through referral, the widest achievable range of safe and effective family planning and contraceptive methods; essential obstetric care; prevention and management of reproductive tract infections, including sexually transmitted diseases, and barrier methods (such as male and female condoms and microbicides if available) to prevent infection. By 2005, 60 per cent of such facilities should be able to offer this range of services, and by 2010, 80 per cent of them should be able to offer such services." [para. 53]

"Where there is a gap between contraceptive use and the proportion of individuals expressing a desire to space or limit their families, countries should attempt to close this gap by at least 50 per cent by 2005, 75 per cent by 2010 and 100 per cent by 2050. In attempting to reach this benchmark, demographic goals, while legitimately the subject of government development strategies, should not be imposed on family planning providers in the form of targets or quotas for the recruitment of clients." [para. 58]

## 3 Maternal mortality reduction

"By 2005, where the maternal mortality rate is very high, at least 40 per cent of all births should be assisted by skilled attendants; by 2010 this figure should be at least 50 per cent and by 2015, at least 60 per cent. All countries should continue their efforts so that globally, by 2005, 80 per cent of all births should be assisted by skilled attendants, by 2010, 85 per cent, and by 2015, 90 per cent." [para. 64]

## 4 HIV/AIDS

"Governments, with assistance from UNAIDS and donors, should, by 2005, ensure that at least 90 per cent, and by 2010 at least 95 per cent, of young men and women aged 15 to 24 have access to the information, education and services necessary to develop the life skills required to reduce their vulnerability to HIV infection. Services should include access to preventive methods such as female and male condoms, voluntary testing, counselling and follow-up. Governments should use, as a benchmark indicator, HIV infection rates in persons 15 to 24 years of age, with the goal of ensuring that by 2005 prevalence in this age group is reduced globally, and by 25 per cent in the most affected countries, and that by 2010 prevalence in this age group is reduced globally by 25 per cent." [para. 70]

## Notes

- 1 United Nations Millennium Development Goals (MDGs). Available at <http://www.un.org/millenniumgoals/>.
- 2 For monitoring country poverty trends, indicators based on national poverty lines should be used, where available.
- 3 An alternative indicator under development is "primary completion rate".
- 4 Among contraceptive methods, only condoms are effective in preventing HIV transmission. Since the condom use rate is only measured amongst women in union, it is supplemented by an indicator on condom use in high-risk situations (indicator 19a) and an indicator on HIV/AIDS knowledge (indicator 19b). Indicator 19c (contraceptive prevalence rate) is also useful in tracking progress in other health, gender and poverty goals.
- 5 This indicator is defined as the percentage of population aged 15-24 who correctly identify the two major ways of preventing the sexual transmission of HIV (using condoms and limiting sex to one faithful, uninfected partner), who reject the two most common local misconceptions about HIV transmission, and who know that a healthy-looking person can transmit HIV. However, since there are currently not a sufficient number of surveys to be able to calculate the indicator as defined above, UNICEF, in collaboration with UNAIDS and WHO, produced two proxy indicators that represent two components of the actual indicator. They are the following: (a) percentage of women and men 15-24 who know that a person can protect herself from HIV infection by "consistent use of condom"; (b) percentage of women and men 15-24 who know a healthy-looking person can transmit HIV.



- 6 Prevention to be measured by the percentage of children under 5 sleeping under insecticide-treated bednets; treatment to be measured by percentage of children under 5 who are appropriately treated.
- 7 An improved measure of the target for future years is under development by the International Labour Organization (ILO).
- 8 World Health Organization. Reproductive health indicators for global monitoring. Report of the second interagency meeting. Geneva: 2001. WHO/RHR/0.1.19. Available at [http://www.who.int/reproductive-health/pages\\_resources/listing\\_global\\_mtg.en.html](http://www.who.int/reproductive-health/pages_resources/listing_global_mtg.en.html).
- 9 Programme of Action of the International Conference on Population and Development; Cairo, 1994. A/CONF.171/13. Available at <http://www.unfpa.org/icpd/docs/>.
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- 11 United Nations General Assembly. ICPD+5: Key Actions for the Further Implementation of the ICPD Programme of Action. New York: 1999. A/RES/S-21/2. Available at <http://www.unfpa.org/icpd/docs/>.

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