# 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*[1]

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)*[2]

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*[3]

## *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 broad definition of health implied by the right to health encompasses both the curative and preventive aspects of health. It has been said that this dual focus corresponds with the distinctive perspectives of clinical medicine and public health, both of which have influenced how the right to health has been defined and evolved. Whereas clinical medicine has traditionally focused on the health status of individuals, public health has focused on the need to promote and protect the health of populations and to ensure conditions under which people can be healthy and remain so.*

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*[4]

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*[6]

*'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*[5]

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:

> 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)[7]

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*

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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 fulfiled. 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 pre-empt, 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.[8]

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.'*

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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*[10]

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 fulfiling 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*[11]

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.[12]

## 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 fulfiled 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.

*'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.*[13]

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.)

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.[14] 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.[15]

### *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*[16]

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 in formation. 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.