Training program

on

Orientation to "Health as a Human Right towards realizing 'Health for All' "

4th and 5th February 2008
Bangalore

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Orientation / Training Program on
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CORE READING MATERIALS

CONTENTS

Note: The articles/written works are derived from various sources. The author's name can be found in individual papers. We acknowledge with thanks the contribution of various authors in disseminating and improving the knowledge on theory and practice of health and human rights.

Session 1 Conceptual Framework of right to health and health care

Community Health Cell, Bangalore

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Right to Health and Health Care Theoretical Perspectives

Ravi Duggal

Introduction

The Indian Constitution provides a framework for a welfare/socialist pattern of development. While civil and political rights are enshrined as Fundamental Rights that are justiciable, social and economic rights like health, education, livelihoods etc. are provided for as Directive Principles for the State and hence not justiciable. The latter comes under the domain of planned development, which the State steers through the Five Year Plans and other development policy initiatives.

Post-independence India adopted a development paradigm that aimed at creating limited entitlements to a wide range of resources for the underserved people. While this was critical to India's economic development it also contributed substantially to the growth of private capital. The State also actively participated in the productive sectors of the economy, especially capital goods industry. This often subsidized inputs for private sector growth. In the social sector the approach was not very different.

The development paradigm adopted by the political leadership and the state had a social dimension, but also supported private sector growth. To take two examples, while private pharmaceutical industry got a lot of subsidy and support for its growth, drug price control helped keep the prices on a leash. Similarly, while production of doctors contributed largely to the development of private markets in the health sector, the government evolved a system of limited entitlements for healthcare through a primary healthcare system in rural areas, and district and town hospitals and dispensaries in urban areas. However, the development approach was never rights-based and hence the limited entitlements that were made under different development programmes, including healthcare, had a limited impact. The contribution of the Five Year Plans to the social sectors has been abysmally poor; less than one-fifth of the Plan resources have been invested in this sector. Health, water supply and education are the three main sub-sectors under social services.

Within the State's development strategy the health sector has always been a weak link. For the political class it had little value because at one level the private health sector, at least for non-catastrophic care, was already well entrenched and was reasonably accessible, and at another for the poor masses non-catastrophic healthcare attention was way below in their priority list, what with the struggle for basic survival. The political class invested in development where they could maximize their political returns; their concern was for vote-banks and hence the focus of development programmes (not rights) was in 'rural development', 'infrastructure development' and development through 'reservations'. Rural development programmes helped direct agricultural growth with the goal of achieving self-sufficiency in basic food production. In reality the middle and the rich peasantry benefited and the small peasantry and landless remained under the illusion that their turn in development was next. Infrastructure development helped create space and conditions for their growth, and the reservation policies appeased the oppressed minorities.

With this kind of a development strategy key social development issues like health, education, and housing got sidelined and never became 'political' issues which would drive the development strategy. Planned development without a rights based approach can only yield limited results and outcomes. For issues to become sustainable political agendas, they must be contextualised in the rights domain. The right to health and healthcare too cannot be realized through the current development agenda. It has to be constituted as an independent right, like the right to life in Article 21 of the Constitution of India and/ or through a legislative mandate with clear resource commitments.

Health Care System

The Constitution has made health care services largely a responsibility of State governments but has left enough manoeuvrability for the Centre since a large number of items are listed in the concurrent list. The Centre has been able to expand its sphere of control over the health sector.[1] Hence the central government has played a far more significant role in the health sector than demanded by the Constitution. The health policy and planning framework has been provided by the central government. In concrete terms, the central government has pushed various national programmes (vertical programmes for leprosy, tuberculosis, blindness, malaria, smallpox, diarrhoea, filaria, goitre and now HIV/AIDS) in which the States have had little say. The States have acquiesced due to the central government's accompanying funding. These programmes are implemented uniformly across the length and breadth of the country. Then there are the Centre's own programmes of family planning and universal immunization which the states have to implement. In sum, central government intervention in the state's domain of health care activities is an important feature that needs to be considered in any analysis of public health care services.

The distribution of health care services is skewed favouring urban areas. Large cities, depending on their population have a few state- run hospitals (including teaching hospitals). At the district level on an average there is a 150 bedded Civil General Hospital in the main district town and a few smaller hospitals and dispensaries spread over the other towns in the district and sometimes in large villages. In the rural areas of the district there are rural hospitals, primary health centres (PHCs) and sub-centres that provide various health services and outreach services.

For the country as a whole presently there are an estimated 22,000 hospitals (30 per cent rural), 23,000 dispensaries (50 per cent rural) and about 1.5 million beds (21per cent rural) (Table A). The rural areas in addition have 23,500 PHCs and 140,000 sub-centres. However, when this data is represented proportionately to its population we see that urban areas have 4.48 hospitals, 6.16 dispensaries and 308 beds per 100,000 urban population in sharp contrast to rural areas which have 0.77 hospitals, 1.37 dispensaries, 3.2 PHCs and 44 beds per 100,000 rural population. The city hospitals and the civil hospitals are basically curative centres providing outpatient and in-patient services for primary, secondary and tertiary care. In contrast the rural institutions provide mainly preventive and promotive services like communicable disease control programmes, family planning services and immunization services. Curative care in the rural health

[1] The Constitutional provisions (Schedule 7 of article 246) are classified into three lists, including a Concurrent list which both centre and states can govern but with the overriding power remaining with the centre. The list here includes original entry numbers **Central List:** 28.Port quarantine, including hospitals connected therewith; seamen's and marine hospitals 55.Regulation of labour and safety in mines and oilfields; **State List:** 6.Public health and sanitation; hospitals and dispensaries 9.Relief of the disabled and unemployable; **Concurrent List:** 16.Lunacy and mental deficiency, including places for the reception or treatment of lunatics and mental deficients 18.Adulteration of foodstuffs and other goods. 19. Drugs and poisons, subject to the provisions of entry 59 of List I with respect to opium 20A.Population control and family planning 23.Social security and social insurance; employment and unemployment. 24.Welfare of labour including conditions of work, provident funds, employers' liability, workmen's compensation, invalidity and old age pensions and maternity benefits 25.Education, including technical education, medical education and universities, subject to the provisions of entries 63, 64, 65 and 66 of List I; vocational and technical training of labour.] 26. Legal, medical and other professions 30.Vital statistics including registration of births and deaths. (http://alfa.nic.in/const/schedule.html)

institutions are the weakest component even though there exists a high demand for such services. This demand is met either by the city hospitals or by private practitioners.

Medical education is imparted largely through state-owned/funded institutions at highly subsidized costs. There are 195 recognized allopathic medical colleges in the country producing over 20,000 medical graduates every year 75 per cent of whom are from public institutions. However, the outturn from these institutions does not benefit the public health services because 80 per cent of the outturn from public medical schools either joins the private sector or migrates abroad.

The private health sector in India is very large. In 2002 an estimated 62 per cent of hospitals, 54 per cent dispensaries and 35 per cent of beds were in the private sector (Table A). An estimated 75 per cent of allopathic doctors are in the private sector and about 80 per cent are individual practitioners. Over 90 per cent of non-allopathic doctors work in the private sector. Private health services, especially the general practitioners, are the single largest category of health care services utilized by the people. There also exist a large number of unqualified practitioners in urban and rural areas in the private sector whose services are well utilized, but their actual numbers are not known. Available data show that in 2004 there were over 660,000 registered allopathic doctors and over 780,000 registered non-allopathic doctors. Of the 1.4 million doctors about 1.2 million are estimated to be in the private sector.

The private health sector, especially the allopathic, constitutes an influential lobby in policy-making circles in India. There is virtually no regulation of this sector. The medical councils of the various systems of medicine perform only the function of registering qualified doctors and issuing them the license to practice. There is no monitoring, continuing education, price regulation, prescription vetting etc., either by the medical councils or the government. It has not been possible to implement progressive policy initiatives, such as the recommendation of the Hathi Committee Report[2] Pharmaceutical formulation production in India is presently worth over Rs. 280 billion and over 98 per cent of this is in the private sector.

How does all this impact on health outcomes, especially among the poor? In Table A we see substantial improvements in health outcomes such as IMR, CBR, CDR and life expectancy over the years. But India's global rank vis-à-vis these indicators has not changed. In fact the latest Human Development Report shows a downward trend in India's global ranking.[3]

This slowing of growth in India's human development score is perhaps linked to the declining investments and expenditures in the public health sector (as also the social sectors as a whole), especially in the 1990s. In the mid- 1980s public health expenditure had peaked because of the large expansion of the rural health infrastructure but after 1986 one witnesses a declining trend in both new investments as well as expenditures as a proportion to the GDP, and as a percent of government's overall expenditures. [Duggal et.al., 1995 and Duggal, 2002]. In sharp contrast out-of-pocket expenses that go largely to the private health sector, have witnessed unprecedented increases. (See Table A)

[2] The Hathi Committee's recommendations pertained to removal of irrational drug combinations, generic naming of essential drugs and development of a National Formulary for prescription practice.

[3] India's human development index rank is down from 115 in 1999 to 124 in 2000 and 127 in 2001, though still better than the 1994 rank of 138. It is on the fringe of medium and low HDI group of countries. India's improvement in the HDI in the last 26 years has been marginal from a score of 0.407 in 1975 to 0.590 in 2001 - working out to an average increase of 1.7 per cent per annum. The slowing down of growth is shown in the table below: [UNDP HDR, various years]

	1975	1980	1985	1990	1995	2000
HDI score	0.407	0.434	0.473	0.511	0.545	0.577
Annual % increase over previous period	—	1.3	1.8	1.6	1.3	1.1

Table A: Health Care Development in India, 1951-2004

			1951	1961	1971	1981	1991	1996	1997	2001-02	Latest**
1	Hospitals*	Total	2694	3054	3862	6805	11174	15170	15188	18436	22000
		Per cent Rural	39	34	32	27		34	34	30	30
		Per cent Private				43	57	68	68	62	75
2	Hospital & dispensary beds*	Total	117000	229634	348655	504538	806409	892738	896767	914543	1500000
		Per cent Rural	23	22	21	17		23	23	21	21
		Per cent Private				28	32	37	37	35	50
3	Dispensaries*		6600	9406	12180	16745	27431	25653	25670	22291	
		Per cent Rural	79	80	78	69		41	40	50	
		Per cent Private				13	60	57	56	54	
4	PHCs		725	2695	5131	5568	22243	21917	22446	22842	23500
5	Sub-centres				27929	51192	131098	134931	136379	137311	140000
6	Doctors	Allopaths	60840	83070	153000	266140	393640	462745	496941	605840	660000
		All Systems	156000	184606	450000	665340	920000		1080173	1297310	1430000
7	Nurses		16550	35584	80620	150399	311235	565700	607376	805827	880000
8	Medical colleges	Allopathy	30	60	98	111	128	165	165	189	195
9	Out turn	Graduates	1600	3400	10400	12170	13934				20000
		Postgrad-uates		397	1396	3833	3139		3656		6000
10	Pharmaceutical production	Rs. in billion	0.2	0.8	3	14.3	38.4	91.3	104.9	220	280
11	Health outcomes	IMR/000	134	146	138	110	80	72	71	66	65
		CBR/000	41.7	41.2	37.2	33.9	29.5	27	27	25	24
		CDR/000	22.8	19	15	12.5	9.8	9	8.9	8.1	8
	Life Expectancy	years	32.08	41.22	45.55	54.4	59.4	62.4	63.5	64.8	65
	Births attended by trained practitioners	Percent				18.5	21.9	28.5			
12	Health Expenditure Rs. Billion	Public	0.22	1.08	3.35	12.86	50.78	101.65	113.13	211	249
		CSO private		2.05	6.18	29.7	82.61	329	373.41	1100	1464
	Health Expenditure as percent of GDP	Public	0.25	0.71	0.84	1.05	0.92	0.91	0.88	0.89	0.91
		Private CSO		1.34	1.56	2.43	1.73	2.95	3	5.32	5.4
	Health Expenditure as % to Govt. Total	Public	2.69	5.13	3.84	3.29	2.88	2.98	2.94	2.72	2.6

*Data on hospitals, dispensaries and beds pertaining to the private sector is grossly under reported and figures for 2001-02 for public facilities also suffers from under-reporting as a number of states do not send up-to-date information. Thus the actual figures should be much higher, and especially so for the private sector
**Latest years – rounded figures are estimates by author and figures pertain to years 2003/2004

Source : 1. Health Statistics / Information of India, CBHI, GOI, various years; 2. Census of India Economic Tables, 1961, 1971, 1981, GOI 3.OPPI Bulletins and Annual reports of Min. of Chemicals and Fertilisers for data on Pharmaceutical Production 4. Finance Accounts of Central and State Governments, various years 5. National Accounts Statistics, CSO, GOI, various years 6. Statistical Abstract of India, GOI, various years 7. Sample Registration System - Statistical Reports, various years 8. NFHS - 2, India Report, IIPS, 2000

Human Right to Health and Healthcare[4]

Constitutional and Legal Dimensions

India joined the UN at the start on October 30th 1945 and on December 12th 1948 when the Universal Declaration of Human Rights (UDHR) was proclaimed, India was a party to this. The formulation of India's Constitution was certainly influenced by the UDHR and this is reflected in the Fundamental Rights and the Directive Principles of State Policy. Most of the civil and political rights are guaranteed under the Indian Constitution as Fundamental Rights. But most of the Economic, Social and Cultural Rights do not have such a guarantee. The Constitution makes a forceful appeal to the State through the Directive Principles to work towards assuring these rights through the process of governance but clearly states that any court cannot enforce them.[5]

The experience of governance in India shows that both Fundamental Rights and Directive Principles have been used as a political tool. While the Fundamental Rights are justiciable, and on a number of occasions citizens and courts have intervened to uphold them, there have also been numerous instances where even the courts have failed either because the ruling government has steamrolled them or the court orders have been ignored. In case of the Directive Principles it is mostly political mileage, which determines which of the principles get addressed through governance. For instance, Article 46[6] has been implemented with a fair amount of seriousness through the policy of reservations for scheduled caste, tribes and other backward castes/classes because it is the most powerful tool for success in India's electoral politics. But Articles 41, 42 and 47, which deal with social security, maternity benefits and health, respectively, have been addressed only marginally.

When we look at right to health and healthcare in the legal and constitutional framework, it is clearly evident that the Constitution and laws of the land do not in any way accord health and healthcare the status of rights. There are instances in case law where, for instance the right to life, Article 21 of

[4] The debate on terminology of 'Right to Health' and 'Right to Healthcare' is endless and we will not get into this here.. Suffice to say that right to health is not independent of right to healthcare and hence they must be seen in tandem. The WHO definition was influenced largely by Sigerist, who argued that state of health is a physical, mental and social condition and "health is, therefore, not simply the absence of disease – it is something positive, a joyful attitude toward life, and a cheerful acceptance of the responsibilities that life puts on the individual" [Sigerist, 1941, p.68]. This broad definition, including social well-being is often criticised for being too broad and as a consequence the concern for access to healthcare is lost. However Sigerist also emphasized that healthcare protection and provision was the right of the citizen and it was the state's duty to respect this. The focus in this paper is on the right to access healthcare and other related rights, and as a consequence, health. Hence, the use of the phrase 'right to health and healthcare'... For a debate on the definitions and further references see Toebes(1998).

[5] Article 37 pertaining to the application of the principles contained in Part IV of the constitution states, "The provisions contained in this Part shall not be enforceable by any court, but the principles therein laid down are nevertheless fundamental in the governance of the country and it shall be the duty of the State to apply these principles in making laws"

[6] Article 46 - Promotion of educational and economic interests of Scheduled Castes, Scheduled Tribes and other weaker sections: The State shall promote with special care the educational and economic interests of the weaker sections of the people, and, in particular, of the Scheduled Castes and the Scheduled Tribes, and shall protect them from social injustice and all forms of exploitation.

the Constitution, or various Directive Principles have been used to demand access to healthcare, especially in emergency situations or references made to the International Covenants.

These are exceptional cases, and even if the Supreme Court or the high courts have upheld some decisions as being a right, for instance getting at least first aid in emergency situations from private clinics or hospitals, or access to public medical care as a right in life threatening situations, or right to healthy and safe working environment and medical care for workers etc., the orders are rarely respected in day to day practice unless one goes back to the courts to reiterate the orders. In fact, this is often the case even with Fundamental Rights, which the State has failed to respect, protect, or fulfil as a routine, and one has to go to the courts to demand them. For a population, which is predominantly at the poverty or subsistence level, expecting people to go to the courts to seek justice for what is constitutionally ordained as a right is unrealistic as well as discriminatory. The mere constitutional provision is not a sufficient condition to guarantee a right, and more so in a situation like health and healthcare wherein provisions in the form of services and commitment of vast resources are necessary to fulfil the right.

Despite the above, it is still important to have health and healthcare instituted as a right within the Constitution and/or established by a specific Act of Parliament guaranteeing the right. Ruth Roemer discussing this issue writes, "The principal function of a constitutional provision for the right to health care is usually symbolic. It sets forth the intention of the government to protect the health of its citizens. A statement of national policy alone is not sufficient to assure entitlement to health care; the right must be developed through specific statutes, programs and services. But setting forth the right to health care in a constitution serves to inform the people that protection of their health is official policy of the government and is reflected in the basic law of the land".

To take an example, government policy vis-à-vis healthcare services has mandated entitlements under the Minimum Needs Programme started with the Fourth Five Year Plan. Each district should have a civil hospital in each district, a primary health centre in rural areas for each 20,000 –30,000 population (depending on population density and difficulty of terrain) and five such units supported by a 30 bedded Community Health Centre (CHC), a sub centre with two health workers for a rural population unit of 2500-5000 population, and similarly a Health Post for 50,000 persons in urban areas. But what is the real situation? No district (except perhaps the very new ones) has a civil hospital (and each district did have a civil hospital even during the colonial period!). The situation regarding PHCs varies a lot across states from 1 per 7000 rural population in Mizoram to 1 per over 100,000 in some districts of the EAG[7] states. The villagers deprived of this entitlement cannot go to the courts demanding the right to a PHC for their area because such a legal backing does not exist. Further, in many states where this ratio is honoured for PHCs or CHCs, adequate staff, medicines, diagnostic facilities, maintenance budgets are often not available to assure that proper provision of services is available to the people accessing these services [MoHFW, 2001]. Further still, if one looks at distribution of healthcare resources across regions, rural and urban areas, one sees vast discrimination – in metropolitan areas public health budgets range from Rs.500-1300 per capita in sharp contrast to PHC areas with only Rs. 40-120 per capita; urban areas across the country have a bed-population ratio of over 300 beds per 100,000 population in contrast to rural areas having around 40 beds per 100,000 persons. This is gross inequity but there is no law presently that can help address this.

Apart from the above a small privileged section of the population, largely what is called the organized sector, that is those working in government, private industry and services have some form of health/social insurance coverage, either through

[7] EAG stands for Empowered Action Group states which include Rajasthan, Madhya Pradesh, Chattisgarh, Uttar Pradesh, Uttaranchal, Bihar, Jharkhand and Orissa

social security legislation like Employee State Insurance Scheme, Central Government Health Scheme, Maternity Benefit Scheme, and various other schemes for mine workers, plantation workers, beedi workers, cinema workers, seamen, armed forces, railway employees etc., or through employer provided health services or reimbursements. This population estimated to be about 12 per cent of the country's population might be said to have right to healthcare, at least during the working life of the main earner in the family. Another 1per cent of the population is covered through private health insurance like Mediclaim [Ellis, Randal et.al, 2000]. In these cases entitlement is based on employment of a certain kind, which provides rights on the basis of protective legislation that is not available to the general population. While this is a positive provision, it becomes discriminatory because the entitlement as a right is selective and not universal. Mere entitlements having basis only in policy or as selective rights does not establish a right and neither can assure equity and non-discrimination.

At the global level the International Covenant on Economic, Social and Cultural Rights (ICESCR) mandates right to health through Article 9 and Article 12 of the covenant:

Article 9
The States Parties to the present Covenant recognize the right of everyone to social security, including social insurance.

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 stillbirth-rate and of infant mortality and for the healthy development of the child;
(b) The improvement of all aspects of environmental and industrial hygiene;
(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
(d) The creation of conditions, which would assure to all medical service and medical attention in the event of sickness.

Also Articles 7 and 11 include health provisions: "The States Parties ... recognize the right of everyone to ... just and favourable conditions of work which ensure ... safe and healthy working conditions; ... the right to ... an adequate standard of living."

India ratified this Covenant on 10th April 1979, and having done that became obligated to take measures to assure health and healthcare (among others) as a right. As per Articles 2 and 3 of this covenant States ratifying this treaty are obligated to:

Article 2
1. Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.
2. The States Parties to the present Covenant 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.
3. Developing countries, with due regard to human rights and their national economy, may determine to what extent they would guarantee the economic rights recognized in the present Covenant to non-nationals.

Article 3
The States Parties to the present Covenant undertake to ensure the equal right of men and women to the enjoyment of all economic, social and cultural rights set forth in the present Covenant.

It is now over 25 years since India committed to this treaty. Post-ratification efforts through the

Sixth Five-year Plan and the first National Health Policy in 1982 were indeed the first steps in honouring this commitment. As we have seen above, the rural public health infrastructure was expanded considerably during the first half of the 'Eighties, more resources were being committed to the health sector etc., but somewhere by the mid- Eighties the commitment seems to have lost ground. In the 1990s with the economic crises the public health sector lost out completely, with the final blow being delivered by the National Health Policy 2001. Interestingly, the last decade of the 20th century also saw the declining commitment to Health For All by the WHO, when in the 1998 World Health Assembly it announced its policy for Health for All in the 21st Century. WHO had started toeing the World Bank line from the 1993 World Development Report (WDR) Investing in Health, which asked poor country/developing country governments to focus on committing public resources to selective care for selected/targeted populations, and to leave the rest to the market. With inter-governmental commitment to assure the right to the highest attainable standard of health waning, it became even more difficult for the Indian State to honour its commitment to ICESCR in an economic environment largely dictated by the World Bank. At another level the Committee of the Economic, Social and Cultural Rights, which is supposed to monitor the implementation of ICESCR, has also failed to get countries like India to take measures to implement the provisions of the ICESCR. India has submitted its combine 2nd, 3rd, 4th & 5th periodic report to UN in October 2006.[8]

Following are other international laws, treaties and declarations, which India is a party to and which have a bearing on the right to health. Provisions in most of these also relate to Fundamental Rights and Directive Principles of the Indian Constitution as well as relate to many policy initiatives taken within the country.[9]

> Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, and political belief, economic or social condition. The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and States. The achievement of any State in the promotion and protection of health is of value to all. Unequal development in different countries in the promotion of health and control of disease, especially communicable disease, is a common danger. Healthy development of the child is of basic importance; the ability to live harmoniously in a changing total environment is essential to such development. The extension to all peoples of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health. Informed opinion and active co-operation on the part of the public are of the utmost importance in the improvement of the health of the people. Governments have a responsibility for the health of their peoples, which can be fulfilled only by the provision of adequate health and social measures. - **WHO Constitution**

> "Everyone has the right to a standard of living adequate for ... health and well-being of himself and his family, including food, clothing, housing, medical care and the right to security in the event of ... sickness, disability.... Motherhood and childhood are

[8] The report is available at http://www.ohchr.org

[9] For instance, the impact of CEDAW, Cairo and Beijing Declarations is closely linked to the formulation of a policy on women and women's empowerment, and setting up of the national and state Commissions on Women, the Rashtriya Mahila Kosh and of formulation of many development programs for women like DWACRA, savings and credit programs etc... Similarly the various human rights treaties like those dealing with racial discrimination, torture, civil and political rights etc.and the UNCHR have been instrumental in India setting up the National and State Human Rights Commissions. The NHRC has presently set up a separate cell to monitor ICESCR as also for right to public health.

entitled to special care and assistance...." - **Universal Declaration of Human Rights, Article 25**

"States Parties shall ... ensure to [women] ... access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning.... States Parties shall ... eliminate discrimination against women in ... health care ... to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning....; ensure ... appropriate services in connection with pregnancy.... States Parties shall ... ensure ... that [women in rural areas] ... have access to adequate health care facilities, including information counselling and services in family planning...." - **Convention on the Elimination of All Forms of Discrimination Against Women, Articles 10, 12, and 14**

"States Parties undertake to ... eliminate racial discrimination ... and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, ... the right to public health, medical care, social security and social services...." -**Convention on the Elimination of All Forms of Racial Discrimination, Article 5**

"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...." - **Convention on the Rights of the Child, Article 24**

In the 1977 World Health Assembly member states pledged a commitment towards a health for all strategy, "... the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life..." (AL Taylor –Making the World Health Organisation Work : A legal framework for universal access to the conditions for Health, American Journal of Law and Medicine, Vol 18 No. 4, 1992, 302). At the International conference which followed in 1978 at Alma Ata this was converted into the famous primary health care declaration whereby Governments would be responsible to the people to assure primary health care for all by the year 2000. Primary health care is "essential health care which is to be universally accessible to individuals and families in the community in ways acceptable to them, through their full participation at a cost the community can afford" (WHO, Primary Health Care, 1978, p. 3) - **Alma Ata Declaration on Health For All by 2000**

"Health and development are intimately interconnected. Both insufficient development leading to poverty and inappropriate development ... can result in severe environmental health problems.... The primary health needs of the world's population ... are integral to the achievement of the goals of sustainable development and primary environmental care.... Major goals ... By the year 2000 ... eliminate guinea worm disease...; eradicate polio... By 1995 ... reduce measles deaths by 95 per cent...; ensure universal access to safe drinking water and ... sanitary measures of excreta disposal...; By the year 2000 [reduce] the number of deaths from childhood diarrhoea ... by 50 to 70 per cent..." - **Agenda 21,Chapter 6, paras. 1 and 12**

"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.... The role of women as primary custodians of family health should be recognized and supported. Access to basic health care, expanded health education, the availability of simple cost-effective remedies ... should be provided...." **- Cairo Programme of Action, Principle 8 and para. 8.6**

"We commit ourselves to promoting and attaining the goals of universal and equitable access to ... the highest attainable standard of physical and mental health, and the access of all to primary health care, making particular efforts to rectify inequalities relating to social conditions and without distinction as to race, national origin, gender, age or disability...." - **Copenhagen Declaration, Commitment 6**

"The explicit recognition ... of the right of all women to control all aspects of their health, in particular their own fertility, is basic to their empowerment.... We are determined to ... ensure equal access to and equal treatment of women and men in ... health care and enhance women's sexual and reproductive health as well as Health." - **Beijing Declaration, paras. 17 and 30**

"Women have the right to the enjoyment of the highest attainable standard of physical and mental health. The enjoyment of this right is vital to their life and well-being and their ability to participate in all areas of public and private life.... Women's health involves their emotional, social and physical well-being and is determined by the social, political and economic context of their lives, as well as by biology.... To attain optimal health ... equality, including the sharing of family responsibilities, development and peace are necessary conditions." - **Beijing Platform for Action, para. 89**

"Strategic objective ... Increase women's access throughout the life cycles to appropriate, affordable and quality health care, information and related services.... Actions to be taken: ... Reaffirm the right to the enjoyment of the highest attainable standards of physical and mental health, protect and promote the attainment of this right for women and girls and incorporate it in national legislation...; Provide more accessible, available and affordable primary health care services of high quality, including sexual and reproductive health care...; Strengthen and reorient health services, particularly primary health care, in order to ensure universal access to health services...; reduce maternal mortality by at least 50 per cent of the 1990 levels by the year 2000 and a further one half by the year 2015;... make reproductive health care accessible ... to all ... no later than ... 2015...; take specific measures for closing the gender gaps in morbidity and mortality where girls are disadvantaged, while achieving ... by the year 2000, the reduction of mortality rates of infants and children under five ... by one third of the 1990 level...; by the year 2015 an infant morality rate below 35 per 1,000 live births.... Ensure the availability of and universal access to safe drinking water and sanitation...." - **Beijing Platform for Action, para. 106**

"Human health and quality of life are at the centre of the effort to develop sustainable human settlements. We ... commit ourselves to ... the goals of universal and equal access to ... the highest attainable standard of physical, mental and environmental health, and the equal access of all to primary health care, making particular efforts to rectify inequalities relating to social and economic conditions ..., without distinction as to race, national origin, gender, age, or disability. Good health throughout the life span of every man and woman, good health for every child ... are fundamental to ensuring that people of all ages are able to ... participate fully in the social, economic and political processes of human settlements.... Sustainable human settlements depend on ... policies ... to provide access to food and nutrition, safe drinking water, sanitation, and universal access to the widest range of primary health-care services...; to eradicate major diseases that take a heavy toll of human lives, particularly childhood diseases; to create safe places to work and live; and to protect the environment.... Measures to prevent ill health and disease are as important as the availability of appropriate medical treatment and care. It is therefore essential to take a holistic approach to health, whereby both prevention and care are placed within the context of environmental policy...." - **Habitat Agenda, paras. 36 and 128**

International law apart, as discussed earlier, provisions within the Indian Constitution itself exist to give the people of India right to healthcare. Articles 41, 42 and 47 of the Directive Principles[10] enshrined in Part IV of the Constitution provide the basis to evolve right to health and healthcare:

Article 41. Right to work, to education and to public assistance in certain cases: The State shall, within the limits of its economic capacity and development, make effective provision for securing the right to work, to education and to public assistance in cases of unemployment, old age, sickness and disablement, and in other cases of undeserved want.

Article 42. Provision for just and humane conditions of work and maternity relief: The State shall make provision for securing just and humane conditions of work and for maternity relief.

Article 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.

Thus social security, social insurance, decent standard of living, and public health coupled with the policy statements over the years, which in a sense constitutes the interpretation of these constitutional provisions, and supported by international legal commitments, form the basis to develop right to health and healthcare in India. The only legal/constitutional principle missing is the principle of justiciability. In the case of education the 93rd amendment to the Constitution has provided limited justiciability. With regard to healthcare there is even a greater need to make such gains because often in the case of health it is a question of life and death. As stated earlier, for a small part of the working population right to healthcare through the social security/social insurance route exists. This means that such security can be made available to the general population too. That a few people enjoy this privilege is also a sign of discrimination and inequity that violates not only the non-discrimination principle of international law, but it also violates Article 14 of the Constitution, Right to Equality, under the chapter of Fundamental Rights.

With regard to the question of justiciability of international law, like Britain, India follows the principle of dualism. This means that for international law to be applicable in India, it needs to be separately legislated. Since none of the international human rights treaties have been incorporated or transformed into domestic laws in India, they have only an evocative significance and may be used by the Courts or petitioners to derive inspiration [Nariman, 1995]. Thus on a number of occasions many of these human right treaties ratified in India, have been used by the Indian Courts in conjunction with Fundamental Rights.[11] International law has its importance in providing many principles but in India's case, there is substantial leeway within our own legal framework on right to health and healthcare. The emphasis needs to shift to critical principles as laid down in the directive principles. This is the only way of bringing right to health and healthcare on the national agenda, even as the support of international treaties will play a role in cementing this demand.

[10] "The courts are much more aware of and attentive towards their obligation to implement socio-economic uplift programmes and to ensure decent welfare for all. The state has a duty to all citizens to adhere to that part of the Constitution, which describes the directive principles as 'fundamental' to the governance of the country. The courts have therefore been using the directives as an instrument to determine the extent of public interest in order to limit the extension of fundamental rights. In doing so they have upheld a number of statutes on the grounds of public interest, which in other circumstances may have been nullified." (De Villiers, 1992).

[11] In a judgment on sexual harassment at the work place, in which the CEDAW and Beijing Declaration was invoked, the Supreme Court outlined this approach as follows – Any international convention not inconsistent with the fundamental rights and in harmony with its spirit must be read into these provisions to enlarge the meaning and content thereof, to promote the object of the constitutional guarantee (Vishaka v/s State of Rajasthan, writ petition number 666-70 of 1992, quoted in Toebes, 1998)

Framework for Right to Health and Healthcare

Health and health care is now being viewed very much within the rights perspective and this is reflected in Article 12 'The right to the highest attainable standard of health' of the International Covenant on Economic, Social and Cultural Rights. According to the General Comment 14 the Committee for Economic, Social and Cultural Rights states that the right to health requires availability, accessibility, acceptability, and quality with regard to both health care and underlying preconditions of health. The Committee interprets the right to health, as defined in Article 12.1, as an inclusive right extending not only 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. This understanding is detailed below:

The right to health in all its forms and at all levels contains the following interrelated and essential elements, the precise application of which will depend on the conditions prevailing in a particular State party:

(a) ***Availability.*** Functioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party. The precise nature of the facilities, goods and services will vary depending on numerous factors, including the State party's developmental level. They will include, however, the underlying determinants of health, such as safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs, as defined by the WHO Action Programme on Essential Drugs.

(b) ***Accessibility.*** Health facilities, goods and services have to be accessible to everyone without discrimination, within the jurisdiction of the State party. Accessibility has four overlapping dimensions:

Non-discrimination:health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds.

Physical accessibility: health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS. Accessibility also implies that medical services and underlying determinants of health, such as safe and potable water and adequate sanitation facilities, are within safe physical reach, including in rural areas. Accessibility further includes adequate access to buildings for persons with disabilities.

Economic accessibility (affordability): health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.

Information accessibility: accessibility includes the right to seek, receive and impart information and ideas concerning health issues. However, accessibility of information should not impair the right to have personal health data treated with confidentiality.

(c) ***Acceptability.*** All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.

(d) ***Quality.*** As well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires, inter alia, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation. (Committee on Economic, Social and Cultural Rights Twenty-second session 25 April-12 May 2000)

Universal access to good quality healthcare equitably is the key element at the core of this understanding of right to health and healthcare. To make this possible the State parties are obligated to respect, protect and fulfill the above in a progressive manner:

The right to health, like all human rights, imposes three types or levels of obligations on States parties: the obligations to respect protect and fulfil. In turn, the obligation to fulfil contains obligations to facilitate, provide and promote. The obligation to respect requires States to refrain from interfering directly or indirectly with the enjoyment of the right to health. The obligation to protect requires States to take measures that prevent third parties from interfering with article 12 guarantees. Finally, the obligation to fulfil requires States to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health. (Ibid)

States parties are referred to the Alma-Ata Declaration, which proclaims that the existing gross inequality in the health status of the people, particularly between developed and developing countries, as well as within countries, is politically, socially and economically unacceptable and is, therefore, of common concern to all countries. States parties have a core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights enunciated in the Covenant, including essential primary health care. Read in conjunction with more contemporary instruments, such as the Programme of Action of the International Conference on Population and Development, the Alma-Ata Declaration provides compelling guidance on the core obligations arising from article 12. Accordingly, in the Committee's view, these core obligations include at least the following obligations:

(a) To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups;
(b) To ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone;
(c) To ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water;
(d) To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs;
(e) To ensure equitable distribution of all health facilities, goods and services;
(f) To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process; they shall include 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 devised, as well as their content, shall give particular attention to all vulnerable or marginalized groups.

The Committee also confirms that the following are obligations of comparable priority:
(a) To ensure reproductive, maternal (pre-natal as well as post-natal) and child health care;
(b) To provide immunization against the major infectious diseases occurring in the community;
(c) To take measures to prevent, treat and control epidemic and endemic diseases;
(d) To provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them;
(e) To provide appropriate training for health personnel, including education on health and human rights. (Ibid)

The above guidelines from General Comment 14 on Article 12 of ICESCR are critical to the development of the framework for right to health

and healthcare. As a reminder it is important to emphasise that in the Bhore Committee report of 1946 we already had these guidelines, though they were not in the 'rights' language. Thus within the country's own policy framework all this has been available as guiding principles for now 60 years.

Where does India stand today vis-à-vis the core principles of availability, accessibility, acceptability and quality in terms of the State's obligation to respect, protect and fulfil?

To sum up from the earlier section, healthcare infrastructure, except perhaps availability of doctors and drugs is grossly inadequate. Then there are the underlying conditions of health and access to factors that determine this, which are equally important in a rights perspective. Given the high level of poverty and even a lower level of public sector participation in most of these factors, the question of the State respecting, protecting and fulfilling them is quite remote.

Besides this environmental health conditions in both rural and urban areas are quite poor, working conditions in most work situations, including many organized sector units, which are governed by various social security provisions, are unhealthy and unsafe. In fact, most of the court cases using Article 21 of the Fundamental Rights and relating it to right to health have been cases dealing with working conditions at the workplace, workers rights to healthcare and environmental health related to pollution these will be dealt with in the following chapters.

Other concerns in access are the question of economic accessibility. It is astounding that large-scale poverty and predominance of private sector in healthcare co-exist. This contradiction reflects the State's failure to respect, protect and fulfil its obligations by letting vast inequities in access to healthcare and vast disparities in health indicators, to continue to persist, and in many situations get worse. Data shows that out of pocket expenses account for over 4 per cent of the GDP as against only 0.9 per cent of GDP expended by state agencies, and the poorer classes contribute a disproportionately higher amount of their incomes to access health care services both in the private sector and public sector [Ellis, et.al, 2000; Duggal, 2000; Peters et.al. 2002]. Further, the better off classes use public hospitals in much larger numbers with their hospitalization rate being six times higher than the poorest classes,[12] and as a consequence consume an estimated over three times more of public hospital resources than the poor [NSS-1996; Peters et.al. 2002].

Related to the above is another concern vis-à-vis international human rights conventions' stance on matters with regard to provision of services. All conventions talk about affordability and never mention free of charge services. In the context of poverty this notion is questionable as far as provisions for social security like health, education and housing go. Access to these factors socially has unequivocal consequences for equity, even in the absence of income equity. Free services are viewed negatively in global debate, especially since we have had a unipolar world, because it is deemed to be disrespect to individual responsibility with regard to their healthcare [Toebes, 1998, p.249]. For instance in India there is great pressure on public health systems to introduce or enhance user fees, in the belief that they will enhance responsibility of the public health system and make it more efficient [Peters, et. al.]. In many states that have adopted such a policy the immediate adverse impacts are seen, the most prominent being decline in utilization of public services by the poorest. It is unfortunate that the Tenth Five Year Plan draft document supports raising more resources by increasing user charges in secondary and tertiary hospitals. India's taxation policy favours the richer classes. Direct tax revenues, like income tax is a very small proportion of total tax revenues. Hence the poor end up paying a larger proportion of their income as tax revenues in the form of sales tax, excise duties etc. on goods and services they consume. Viewed from this perspective the poor have already pre-paid for receiving public goods like health and education from the state free of cost at the point of provision.

[12] The poorer classes have reported such low rates of hospitalization, not because they fall ill less often but because they lack resources to access healthcare, and hence invariably postpone utilization of hospital services until it is absolutely unavoidable.

So their burden of inequity increases substantially if they have to pay for such services when accessing from the public domain.

The above inequity in access gets reflected in health outcomes, which too, reflect strong class gradients. In India there is an additional dimension to this inequity – differences in health outcomes and access by social groups, specifically the scheduled castes and scheduled tribes. Data show that these two groups are worse off than others on all counts. Thus in access to hospital care as per NSS 1996 data the STs had 12 times less access in rural areas and 27 times less in urban areas than others; for SCs the disparity was four and nine times, in rural and urban areas, respectively. They fare worse even in urban areas where overall physical access is reasonably good. Their health outcomes 1.5 times more adverse than others [NFHS 1998].

Another stumbling block in meeting state obligations is information access. While data on public health services, with all its limitations, is available, data on and from the private sector is conspicuous by its absence. For one, the size of the private sector is an under-estimate as occasional studies have shown.[13] Medical councils of all systems of medicine are statutory bodies but they have been unable to regulate medical practice and prevent unqualified and untrained practitioners. The private sector does not meet its obligations to supply data on notifiable, mostly communicable, diseases, which is mandated by law adversely affecting the epidemiological database for those diseases as also public health practice and monitoring drastically.

Finally there are issues pertaining to acceptability and quality. Here the Indian state fails totally. There is a clear rural-urban dichotomy in health policy with urban areas enjoying comprehensive healthcare services through public hospitals and dispensaries and now, preventive inputs and in contrast rural areas with poor curative services. This violates the principle of non-discrimination and equity and hence is a major ethical concern to be addressed.

Medical practice, especially private, suffers from a complete absence of ethics. There has been poor regulation of malpractices in medical practice. There exist no standard protocols for clinical practice making the monitoring of quality difficult. For hospitals the Bureau of Indian Standards has developed guidelines, and often public hospitals do follow these guidelines [Nandraj and Duggal, 1997]. But in the case of private hospitals they are generally ignored. Recently efforts at developing accreditation systems has been started in Mumbai [Nandraj, et.al, 2000],[14] and on the basis of that the Central government is considering measures at the national level on this front so that it can promote quality of care. The pharmaceutical industry plays a major role in encouraging irrational practices.[15]

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[13] A survey in Mumbai in 1994 showed that the official list with the Municipal Corporation accounted for only 64per cent of private hospitals and nursing homes [Nandraj and Duggal, 1997]. Similarly, a much larger study in Andhra Pradesh in 1993 revealed extraordinary missing statistics about the private health sector. For that year official records indicated that AP had 266 private hospitals and 11,103 beds, but the survey revealed that the actual strength of the private sector was over ten times more hospitals with a figure of 2802 private hospitals and nearly four times more hospital beds at 42192 private hospital beds. [Mahapatra, P, 1993].

[14] In Mumbai CEHAT in collaboration with various medical associations and hospital owner associations has set up a non-profit company called Health Care Accreditation Council. It hopes to provide the basis for evolving a much larger initiative on this front.

[15] Data of 80 top selling drugs in 1991 showed that 29per cent of them were irrational and/or hazardous and their value was to the tune of Rs. 2.86 billion. A study of prescription practice in Maharashtra in 1993 revealed that outright irrational drugs constituted 45per cent of all drugs prescribed and rational prescriptions were only 18per cent. The proportion of irrationality was higher in private practice by over one-fifth. (Phadke, 1998)

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Building on the Synergy between Health and Human Rights: A Global Perspective

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1. Introduction

Before human rights, there was altruism and after human rights there is altruism—the unselfish concern for the welfare of others. Altruism has been and remains an integral part of the beliefs, behaviors and practices of public health practitioners. But altruism means different things to different people. What human rights does for public health is to provide an internationally agreed upon framework for setting out the responsibilities of governments under human rights law as these relate to people's health and welfare.

Human rights as they connect to health should be understood, in the first instance, with reference to the description of health set forth in the preamble of the WHO Constitution, and repeated in many subsequent documents and currently adopted by the 191 WHO Member States: Health is a "state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity."[1]

This definition has important conceptual and practical implications, as it illustrates the indivisibility and interdependence of rights as they relate to health. Rights relating to autonomy, information, education, food and nutrition, association, equality, participation and non-discrimination are integral and indivisible parts of the achievement of the highest attainable standard of health, just as the enjoyment of the right to health is inseparable from other rights, whether categorized as civil and political, economic, social or cultural.[2] Thus, the right to the highest attainable standard of health builds on, but is by no means limited to, Article 12 of the International Covenant on Economic, Social and Cultural Rights.[3] It transcends virtually every single other right.

This paper highlights the long evolution that has brought health and human rights together in mutually reinforcing ways. It will summarize key dimensions of public health and of human rights and will suggest a manner in which these dimensions intersect in a framework of analysis and action. It will address these issues against the background of the progress being made by the World Health Organization towards defining its roles and functions from a health and human rights perspective.

2. When Health and Rights Had Not Yet Met

Until only a few years ago, public health and human rights were often considered as two distinct, almost antagonistic sets of principles and practices. Public health was understood to promote the collective physical, mental and social well-being of people—this, even if in order to

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[1] Constitution of the World Health Organization, adopted by the International Health Conference, New York, 19 June–22 July 1946, and signed on 22 July 1946 by the representatives of 61 States.

[2] Leary V, "The Right to Health," *Health and Human Rights*, 1 (1994): 28.

[3] Article 12, International Covenant on Economic, Social and Cultural Rights, adopted and opened for signature, ratification and accession by United Nations General Assembly Resolution 2200 A(XXI), 1966. Entered into force on 3 January 1976 in accordance with article 27.

achieve public health goals, individual freedom to choose, to behave or to act had to be sacrificed to the common good.

This was, and continues to be, exemplified by the principles and practices which have guided the control of such communicable diseases as tuberculosis, typhoid or sexually transmitted infections, where quarantine or other restrictions of rights have too often been imposed on affected individuals without any valid public health justification.

Public health abuses have also been exemplified by the excessive institutionalization of people with physical or mental impairments where alternate care and support approaches have not been considered. And far from uncommon is discrimination in the health care setting on the basis of health status, gender, race, color, language, religion or social origin, or any other attribute that can impact the quality of services provided to individuals by or on behalf of the State.

In contrast, human rights law has tended to bring into focus the relationship between the State—the first-line provider and protector of human rights—and individuals who hold their human rights simply for being human. Even though people hold these rights throughout their lives, they are nonetheless often constrained in their ability to fully realize these rights. Those who are most vulnerable to violations or neglect of their rights are also often those who lack the power to evidence this impact on their wellbeing, including their state of personal health.

From an advocacy perspective, until recently, claims for better fulfillment of civil and political rights have taken precedence over other rights—social, economic and cultural. Human rights advocates recognized the negative health impact of infringements on civil and political rights—best exemplified by torture and other forms of degrading treatment.[4] Yet many feared that broadening the spectrum of rights advocacy to encompass the multifarious dimensions of health and rights violations might dilute the issues and thereby weaken their claims. Thus, for a long time, health ignored rights and rights ignored health.

These two worlds remained apart until the 1980s, when reproductive health issues and, later, HIV/AIDS brought into light the true nature of the relationship between health and rights. This relationship was not antagonistic, but it was not neutral; it was, in fact, mutually reinforcing and synergistic.[5]

The fields of health and rights are illuminated today by their commonalties, no longer by their differences. It is now understood that both represent universal aspirations; both are obligations of governments towards their people; and each supports and requires the fulfillment of the other.

Through their practice and research, public health and human rights practitioners have the responsibility to further establish *how* and *to what extent* the promotion and protection of health and human rights interact. What they do *not* have to do is to show *why* both health and human rights are good for people. In the relentless quest for a world where the attainment of the highest standard of physical, mental and social well being necessitates, and reinforces, the dignity, autonomy and progress of every human being, the broad goals of health and human rights are universal and eternal. They give us direction for our understanding of humanity, and practical tools for use in our daily work.

3. Four Directions for Public Health Action

In May 2000, the World Health Assembly adopted a WHO Corporate Strategy. This strategy sets out a useful typology which can be used as the backbone for a WHO health and human rights strategy. The WHO Corporate Strategy addresses four directions for public health:

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[4] Article 7, International Covenant on Civil and Political Rights, adopted and opened for signature, ratification and accession by United Nations General Assembly Resolution 2000 A(XXI), 1966. Entered into force on 23 March 1976 in accordance with article 49.

[5] Mann JM, Gostin L, Gruskin S, Brennan T, Lazzarini Z, Fineberg H, "Health and Human Rights," *Health and Human Rights* 1(1) (1994).

- **Reduce disease, disability and death** by getting information about who is healthy and who is not, and by applying proven methods of prevention, care and support.
- **Promote healthy lifestyles** where the risks imposed on individuals by the environment or by cultural or social constructs are recognized and acted upon.
- **Build health systems** that equitably improve health, respond to people's expressed needs, and are financially fair.
- **Promote the recognition of health dimensions of social, economic, environmental and development policies** to ensure that such policies and consequent programs contribute to the advancement of health.

The primary goal of the Corporate Strategy is to advance global public health through an enhanced interaction between the Organization and its Member States. It also aims to ensure that the Hippocratic dictum of "first and foremost, cause no harm" is applicable not only to individual but also public health practices.

If we consider each of these directions for public health through the lens of human rights, we discover how the lack of respect for human rights can shape our vulnerability to ill health and how, on the flip side, the promotion and protection of human rights can be as powerful as a vaccine. Take as an example the core human right of *non-discrimination* and the impact that violation or neglect of this right can have on the above-mentioned directions for public health.

Discrimination can impact directly on the ways that **morbidity, mortality and disability**—the burden of disease—are both measured and acted upon. In fact, the burden of disease itself *discriminates*: disease, disability and death are not distributed randomly or equally within populations, nor are their devastating effects within communities. Tuberculosis is exploding in marginalized communities. The AIDS epidemic is finding new vulnerable populations among the poor and those with unequal status in society, women in particular. Discrimination compounds the effects of poverty; it is at the root of disease and of premature death. The burden of disease is dependent on the unequal capacity of individuals to access information, understand the risks to which they have been exposed, and acquire the ability and freedom both to reduce these risks and to access preventive and care services when they are needed.

Ill health finds fertile ground in populations that live in the shadows of our societies and are, therefore, never counted. Acting positively about health and human rights implies recognizing who, in society, is at a disproportionate risk of ill health. Counting, and counting well, counting while protecting people's dignity and privacy, is the beginning of a successful approach towards better health and rights.

The year 2000 issue of the *World Health Report* applied a new set of indicators to help determine the profiles of national health systems around the world.[6] This report posed that health systems have three goals: achieving good health; enhancing responsiveness to the expectations of the population; and assuring fairness of financial contributions. For each of these goals, it proposed a composite indicator to assess the attainment and performance of each nation's health system. Two of the three indicators used in measuring attainment—health status and health system responsiveness—were subdivided so as to reflect overall national level and the disparity within each country. The notion of inequality was built intrinsically into the third indicator—fairness in financing. It is hoped that this new assessment method will stimulate countries to recognize the health differentials that national, aggregate measures can hide. As these indicators are further improved and become more "human rights sensitive," they may produce relevant evidence for a health and human rights analysis of health systems. Such an approach could, for example, seek to link disparities in health and health system performance between and within each nation with progress being achieved in the realization of human rights, for example the right to non-discrimination.

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[6] World Health Organization: *The World Health Report 2000: Health Systems: Improving Performance* (Geneva, Switzerland: WHO, 2000).

Discrimination also affects **lifestyles**. The patterns of smoking in the world show the tobacco industry taking a new focus on those with limited access to information and education and those whose ability to choose and decide on matters related to their own health are limited by economic and social pressure. Around the world, lower income, lower education and lower purchasing power increasingly translate into higher rates of smoking and a higher probability of dying from it. Multinational companies marketing tobacco operate in a relative vacuum of international law. New ways have to be found to hold them accountable and for governments to fulfill the human rights obligations raised by this new challenge, including the rights of children to be protected against the promotion of harmful substance use.

Discrimination in **health systems**, including health centers, hospitals or mental institutions, may further contribute to exacerbating disparities in health. Think of migrant workers receiving poor or no treatment for fear of having to justify their civil status. Think of those who, for reasons of marginalization related to sexual identity or to behaviors considered to be "against social or cultural norms" are denied access to treatment available to other individuals. Think of immunizations or other essential care or procedures that are withheld from children and adults who are thought to be already affected by other illnesses considered incurable. Think of people with hemophilia who are given unsafe blood products on the premises that this adds only a "marginal" risk to their lives, and think of people with physical or mental disabilities receiving sub-standard care and unable to complain because their voices are not heard.

Discrimination in health systems concerns not only diseases that are already stigmatized, such as AIDS, tuberculosis and cancer, but also others, such as diabetes and cardiovascular diseases, which could be alleviated if *equal treatment* within societies and within health care settings became the norm.

Discrimination can also be at the root of unsound **human development policies and programs** that may impact directly or indirectly on health. For example, an infrastructure development project may require the displacement of entire populations and fail to pay sufficient attention to the new environment to which these populations will have to adjust. In the developing world, the impact of large-scale development programs at the local level is often considered from the perspective of the possible further spread of such infectious diseases as malaria and other water-born diseases. The psychological capacity of displaced communities to relocate and rebuild new lives, or the long-term physical and social consequences of such displacement, are seldom factored into the equation.

The impact of discrimination on health, whether perpetrated, condoned or tolerated by the State, is but one—although perhaps the most visible—representation of the health impact of the violation or neglect of human rights. But there are many other ways, far more subtle, in which health and rights interact.

We have known for decades that one of the strongest determinants of child health and survival is the level of educational attainment of the child's mother. Yet inequality remains in the ability of boys and girls to enroll in schools and complete primary education—although most governments in the world have ratified treaties guaranteeing the right of everyone to education.[7] To educate children works towards better health. To protect their health is essential for them to achieve better education and prepare them better for their lives. Health and human rights converge in the present as they do in the future.

Human rights and health act in synergy when dignity and privacy are protected and when people can confide in a health system that listens to them and responds to their needs, without prejudice or arbitrary judgement. The convergence of health and rights is in sight when health policies are informed by, and respectful of human rights and dignity. Central to the responsiveness of health systems to people's needs is the concept of dignity. Respect for dignity is often challenged by overburdened health systems where time for treating disease seems to compete with time for treating patients. Dignity is a hard-to-define concept. However, as the late Jonathan Mann used to remind us,

[7] Article 13, International Covenant on Economic, Social and Cultural Rights.

we may find it difficult to define dignity, but we know immediately what it is once our own dignity has been offended.[8]

4. Three Sets of Governmental Obligations with Respect to Human Rights

Along with the entire United Nations system, the World Health Organization is in the process of integrating human rights into its work. For each of the UN agencies, this means analyzing what they do and do not do in relation to their human rights obligations to respect, protect and fulfill human rights in their policies, programs and practices. For WHO, it means defining its global public health responsibilities and role from a health and human rights perspective and drawing a new action and research agenda. The process of integrating health and human rights, currently underway at WHO, requires the development of a strategy that builds on its existing Corporate Strategy. Its effectiveness is likely to involve conceptual and procedural changes as well capacity building within the Organization itself and among its Member States.

The construct of a WHO health and human rights strategy may arise from the recognition of three sets of human rights obligations, in particular as these apply to States and to the UN system, in this particular instance with regards to health:[9,10]

- Governments have the obligation to **respect** human rights, which requires governments to refrain from interfering directly or indirectly with the enjoyment of human rights. In practice, no health practice, policy, program or legal measure should violate human rights. The provision of health services should be ensured to all population groups on the basis of equality and freedom from discrimination, paying particular attention to vulnerable and marginalized groups.
- Governments have the obligation to **protect** human rights, which requires governments to take measures that prevent non-state actors from interfering with human rights. In practice, Governments should acquire an enhanced capacity to analyze health-related actions or inactions attributable to non-state actors on the national and international levels, and act accordingly. This relates to such important non-state actors as private health care providers, health insurance companies and, more generally, the health-related industry.
- Governments have the obligation to **fulfill** human rights, which requires States to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of human rights. In practice, Governments should be supported in their efforts to develop and apply these measures and monitor their impact, with an immediate focus on vulnerable and marginalized groups.

5. Applying the Right to Health

As this work has been progressing, in May 2000, the Committee on Economic, Social and Cultural Rights adopted a General Comment on Article 12 of the International Covenant on

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[8] "The definition of dignity itself is complex and thus far elusive and unsatisfying. While the Universal Declaration of Human Rights starts by placing dignity first … we do not yet have a vocabulary or taxonomy, let alone an epidemiology of dignity violations. Yet it seems we all know when our dignity is violated or impugned." Cited from Jonathan Mann; "Medicine and Public Health, Ethics and Human Rights," in: Mann JM, Gruskin S, Grodin MA and Annas GJ, eds., *Health and Human Rights: A Reader* (New York: Routledge, 1999), pp. 439–52.

[9] Eide A, "Economic, Social and Cultural Rights as Human Rights," in: Eide A, Krause C, Rosas A, eds., *Economic, Social and Cultural Rights: A Textbook* (Dordrecht: M. Nijhoff, 1995), pp. 21–40.

[10] Toebes B., The Right to Health as a Human Right in International Law, School of Human Rights Research Series, vol. 1, INTERSENTIA-HART, 1999.

Economic, Social and Cultural Rights: the right to the highest attainable standard of health.[11] It is a solid document that will, over time, contribute to the understanding, actions and accountability of States under international human rights law and their health-related obligations.[12] The General Comment lays out directions for the practical application of Article 12 and a monitoring framework. It may be worth commenting briefly here on three selected aspects of the document that have important implications for public health practice: progressive realization; limitations of rights in the interest of public health; and monitoring the application of health and human rights principles by Member States and the United Nations.

Progressive Realization of the Right to Health

In all countries, resource and other constraints can make it impossible for a government to fulfill all rights immediately and completely. The principle of "progressive realization" is fundamental to the achievement of human rights as they apply to health.[13] This is critical for resource-poor countries that are responsible for striving towards human rights goals to the maximum extent possible. It is of equal relevance to wealthier countries in that they are responsible for respecting, protecting and fulfilling human rights not only within their own borders, but also through their engagement in international assistance and cooperation.

The Director-General of WHO, Gro Harlem Brundtland, has cited the need to integrate efforts towards this goal, noting: "Even when governments are well-intentioned, they may have difficulty fulfilling their health and human rights obligations. Governments, the WHO and other intergovernmental agencies should strive to create the conditions favorable to health, even in situations where the base of public finance threatens to collapse."[14]

The 1978 Declaration of Alma-Ata called on nations to ensure the availability of the essentials of primary health care (PHC), including: education concerning health problems and the methods for preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common disease and injuries; and provision of essential drugs.[15] While the current delineation of PHC elements may provide for the initial core obligations of the right to health, progressive realization requires reexamination of governmental obligations as they are fulfilled and health needs and technologies evolve.[16]

The ambitious and constantly advancing objectives of health development must be examined keeping in mind the role of governments in ensuring equal and equitable access to medical care and health promotion while striving, within available resources, to create the underlying conditions necessary for health. Given that the advancement of health necessitates infrastructure and human

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[11] General Comment 14 on the Right to the Highest Attainable Standard of Health; drafted under the leadership of Pr Eibe Riedel, Rapporteur to the UN Committee on Economic, Social and Cultural Rights; Geneva, Switzerland, 20 May 2000.

[12] Analyzing the normative content of the right to the highest attainable standard of health, the draft general comment distinguishes between four essential features of health services: (a) Availability essentially provides that governments have a responsibility to ensure that prevention and care facilities, including infrastructures, skilled human resources, goods and services are in place and appropriately funded; (b) Accessibility brings forward the government obligation to ensure these to all; (c) Acceptability implies that the services provided are designed and delivered in such ways that the intended beneficiaries feel comfortable in using them and that their dignity and privacy are protected and respected; and (d) Quality of services requires that these services are scientifically sound and conform to public health "best practice."

[13] Article 2, International Covenant on Economic, Social and Cultural Rights.

[14] Gro Harlem Brundtland, Director General of the World Health Organization, "Fifty Years of Synergy Between Health and Rights," *Health and Human Rights*, 3(2) (1998): 21–25.

[15] Adopted at the International Conference on Primary Health Care, Alma-Ata, 6-12 September 1978, and endorsed by the Thirty-second World Health Assembly in resolution WHA32.30 (Geneva, May 1979).

[16] This need was reflected in the World Health Declaration adopted by the Fifty-first World Health Assembly, WHA51.5 (Geneva, May 1998) which adapted and extended the initial elements of primary health care to include expanding options for immunization; reproductive health needs; provision of essential technologies for health; health promotion, prevention and control of non-communicable diseases; food safety and provision of selected food supplements.

and financial resources that may not match existing or future needs in any country, the principle of progressive realization takes into account the inability of Governments to meet their obligations overnight. Yet, it creates an obligation on Governments to show how and to what extent they are achieving progress towards health goals they have agreed to in international fora such as the World Health Assembly, and those they have set additionally for themselves.

Human Rights Limitations in the Interest of Public Health

There are situations where it is considered legitimate to limit rights in order to achieve a broader public good. As described in the International Covenant on Civil and Political Rights, the public good can take precedence to: "secure due recognition and respect for the rights and freedoms of others; meet the just requirements of morality, public order, and the general welfare; and in times of emergency, when there are threats to the vital interests of the nation."[17]

Public health is a public good that may justify the limitation of certain rights under certain circumstances. Interference with freedom of movement when instituting quarantine or isolation for a serious communicable disease—for example, Ebola fever, syphilis, typhoid or untreated tuberculosis—is an example of a limitation on rights that may be necessary for the public good and therefore may be considered legitimate under international human rights law. Yet arbitrary restrictive measures taken by public health authorities that fail to consider other valid alternatives may be found to be both abusive of human rights principles and in contradiction with public health "best practice." The public health response to the HIV/AIDS pandemic revealed that the sorts of restrictive measures traditionally applied to epidemic control are generally ineffective or even counter-productive.

If the limitation of certain rights in the interest of public health remains an option under both international human rights law and public health laws, the decision to impose such limitations must be achieved at through a structured process. The limitations under consideration must be in the interest of a legitimate objective of general interest. It must be in accordance with the law and strictly necessary in a democratic society to achieve the objective. There should be no less intrusive and restrictive means available to reach the same objective; and it should not be imposed arbitrarily, i.e., in an unreasonable or otherwise discriminatory manner.[18]

Monitoring Health and Human Rights

Mention has been made earlier of the ongoing development of indicators of health *outcome* (e.g. morbidity, mortality, disability rates) and health system performance which, by providing national and sub-national data, create new opportunities for enhancing governmental ability to assess and report on progress achieved towards realizing human rights in conformity with international human rights law.[19] Yet indicators of disease burden or of performances of health systems may not translate fully a Government's commitment or capacity to promote and protect human rights in relation to health.

Equally relevant to the monitoring of health and human rights are indicators reflecting compliance with health and human rights principles of the *processes* of policy and program development. For example, through appropriately designed indicators and monitoring systems, the State should be able to show evidence that efforts towards collecting and analyzing data do not discriminate against any population groups. It should be able to show that the process of policy development, program design and resource allocation was/is inspired by, and respectful of, human rights principles, including participation, equality and non-discrimination.

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[17] Article 4, International Covenant on Civil and Political Rights.

[18] The Siracusa principles on the limitation and derogation provisions in the International Covenant on Civil and Political Rights, Annex to UN Doc. E/CN.4/1985/4 of 28 September 1984.

[19] Article 16, International Covenant on Civil and Political Rights.

International accountability of the United Nations system and of its Member States on both selected outcome and process indicators would provide a clearer representation of the efforts developed to progress in health and human rights terms, and within the specific context of available structures, environmental constraints and resources.[20] The dual emphasis on outcome and process monitoring is particularly relevant here, as a long interval may separate the time when chosen measures are taken from the time their impacts begin to be felt.

6. The Convergence of Health and Rights: From Concept to Action

By combining the four directions of public health and the three sets of governmental obligations with respect to human rights, an analytical and action-oriented framework begins to emerge.[21] (See Table 1.) This framework builds on each of the four dimensions of public health: disease and impact reduction, promotion of healthy lifestyles, strengthening of health systems and human development policies informed by health. Intersecting with each of these directions are the three human rights obligations: to respect human rights (not to violate rights), to protect human rights (to be attentive to non-state actors) and to fulfill human rights (to take measures to promote human rights and establish redress mechanisms). The issues presented in Table 1 are not meant to be highly detailed, but simply to serve as examples of the points of convergence between health and rights this approach brings to light.

Each of the intersections between the four directions of public health and the three dimensions of human rights obligations are rich in questions and suggestive of specific actions. These actions include the development of adequate monitoring tools reflecting both health and human rights concerns; the application of health and human rights principles to policy development and practices; and the creation of a significant research agenda to advance our collective understanding of the health and human rights relationship.

The framework can be applied to define the roles and responsibilities of WHO in health and human rights, as well as the technical support the Organization needs to extend to its Member States to reinforce their capacity to translate their commitments under international human rights law into effective health policies and actions. Although it is intended primarily to guide the development of a WHO strategy on health and human rights, a similar analytical framework can be applied to recognition of the points of convergence between health and rights in specific public health domains such as the design of an approach to disease control. The analysis can begin by identifying public health options for effective disease control and, using the three sets of governmental obligations with respect to human rights, consider which intervention achieves the highest results in both health and human rights terms.[22]

People engaged in the promotion or protection of human rights may begin their analysis by examining a specific right and seeking how, and to what extent the violation or the lack of realization of this right may impact on health.

These analyses will be most effective if done in partnership between public health practitioners and people with substantive knowledge of human rights. This partnership will foster a clearer understanding of the synergy between health and human rights and provide additional impetus to Governments to undertake policies, programs and actions that best serve public health while contributing to the advancement of human rights.

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[20] Tarantola D: Presentation on behalf of WHO on the General Comment on the Right to the Highest Attainable Standard of Health, before the Committee on Economic, Social and Cultural Rights, United Nations High Commission for Human Rights, Palais Wilson, Geneva, Switzerland, 8 May 2000.

[21] Gruskin S, Tarantola D, "Health and Human Rights," in: *The Oxford Textbook of Public Health* (Oxford University Press, in press).

[22] Gostin L, Mann J: Toward the Development of a Human Rights Impact Assessment for the Formulation and Evaluation of Public Health Policies. In: *Health and Human Rights: A Reader*, Mann J, Gruskin S, Grodin M, Annas G eds; Routledge, (1999), 54-71.

Table 1. A Pathway to Health and Human Rights

Domains of health	Governmental obligations with respect to human rights		
	Respect	**Protect**	**Fulfill**
1. **Reduce morbidity, disability and mortality**	Government not to violate rights of people on the basis of their health status including in information collection and analysis, as well as in the design and provision of health and other services.	Government to prevent non state actors (including private health care structures and insurance providers) from violating the rights of people on the basis of their health status including in the provision of health and other services.	Government to take administrative, legislative, judicial and other measures to promote and protect the rights of people regardless of their health status, including the generation of data concerning health outcomes for use in guiding health policies and the provision of health and other services, as well as providing legal means of redress that people know about and can access.
2. **Promote healthy lifestyles**	Government not to violate rights, in particular those violations which result in, or perpetuate, lifestyles associated with increased morbidity, mortality, disability.	Government to prevent non-state from human rights violations, in particular those which result in, or perpetuate lifestyles associated with increased morbidity, mortality, disability.	Government to take administrative, legislative, judicial and other measures including sufficient resource allocation to ensure that healthy lifestyles are promoted, and provision of legal means of redress as applicable.
3. **Strengthen health systems**	Government not to violate rights directly in the design, implementation and evaluation of national health systems, including ensuring that they are sufficiently accessible, efficient, affordable and of good quality for all members of the population.	Government to prevent non-state actors (including private health care structures and insurance providers) from violating rights in the design, implementation and evaluation of health systems and structures, including ensuring that they are sufficiently accessible, efficient, affordable and of good quality	Government to take administrative, legislative, judicial and other measures including sufficient resource allocation and the building of safety nets, to ensure that health systems are sufficiently accessible, efficient, affordable and of good quality, as well as providing legal means of redress that people know about and can access.

Continued on following page

4. Develop health-sensitive policies and programs	Government not to violate the civil, political, economic, social and cultural rights of people directly, recognizing that neglect or violations of rights impact directly on health.	Government to prevent rights violations by non-state actors, recognizing that neglect or violations of rights impact directly on health.	Government to take all possible administrative, legislative, judicial and other measures, including the promotion of human development mechanisms, towards the promotion and protection of human rights, as well as providing legal means of redress that people know about and can access.

Health and Human Rights

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1. Introduction

Since the creation of the United Nations over fifty years ago, international responsibility for health and for human rights has been increasingly acknowledged. Yet the actual linkages between health and human rights had not been recognized even a decade ago. Generally thought to be fundamentally antagonistic, these two worlds had evolved along parallel but distinctly separate tracks until a number of recent events helped to bring them together.

Conceptually one can point to the HIV/AIDS pandemic; to women's health issues, including violence; and to the blatant violations of human rights which occurred in such places as the Balkans and the Great Lakes region in Africa as having brought attention to the intrinsic connections that exist between health and human rights. Each of these issues helped to illustrate distinct, but linked, pieces of the health and human rights paradigm. While the relationship between health and human rights with respect to these and similar issues may always have made sense intuitively, the development of a "health and human rights" language in the last few years has allowed for the connections between health and human rights to be explicitly named, and therefore for conceptual, analytical, policy and programmatic work to begin to bridge these disparate disciplines and to move forward. In the last few years human rights have increasingly been at the center of analysis and action in regard to health and development issues. The level of institutional and stated political commitment to health and human rights has, in fact, never been higher. This is true within the work of the United Nations system but, even more importantly, can also be seen in the work of governments and non-governmental organizations (NGOs) at both the national and international level.

A. From HIV/AIDS and Human Rights to Health and Human Rights

The importance of the HIV/AIDS pandemic as a catalyst for beginning to define some of the structural connections between health and human rights cannot be overemphasized. The first time that human rights were explicitly named in a public health strategy was only in the late 1980s, when the call for human rights and for compassion and solidarity with people living with HIV/AIDS was embodied in the first WHO global response to AIDS (WHO 1987). This approach was motivated by moral outrage but also, even more importantly, by the recognition that protecting the human rights of people living with HIV/AIDS was a necessary element of the worldwide public health response to the emerging epidemics. The implications of this call were far-reaching. Framing this public health strategy in human rights terms—although initially focused on the rights of people living with HIV/AIDS rather than on the broad array of human rights influencing people's vulnerability to the epidemic—allowed it to become anchored in international law, thereby making governments and intergovernmental organizations publicly accountable for their actions toward people living with HIV/AIDS. The groundbreaking contribution of this era lies in the recognition of the applicability of international law to HIV/AIDS issues and in the attention this approach then generated to the linkages between other health issues and human rights—and therefore to the ultimate responsibility and accountability of the state under international law for issues relating to health and well-being (Mann et al. 1994).

This paper will appear as a chapter in Detels, McEwan, Beaglehole, and Tanaka (eds.), *The Oxford Textbook of Public Health*, 4th edition (Oxford University Press, forthcoming).

B. International Conferences and the United Nations System

The series of international conferences held in the past decade under the auspices of the United Nations system have also been of critical importance in helping to clarify the linkages between health and human rights. While all of these conferences, ranging from the World Summit for Children, held in 1990, to the World Conference on Racism, to be held in 2001, are relevant to health and human rights concerns, the two most crucial in articulating the health and human rights linkage were the 1994 International Conference on Population and Development and the 1995 Fourth World Conference on Women. These conferences brought together policy makers, activists and representatives from local, national and international agencies, as well as government representatives. The negotiated documents resulted in the first concrete linkages of health and human rights in international consensus documents and helped to draw focused attention to the dual obligations of governments regarding both health and human rights.[1] These documents were of use to governments and others in shaping policy and programmatic work which explicitly dealt with these linkages, as well as to activists and NGOs in framing their advocacy for government responsibility for health in the human rights language of responsibility and accountability.

In recent years there has been a substantial increase in attention and resources devoted to implementation of health and human rights within virtually all UN development agencies and programs, due in large part to these international conference processes. All of the organizations and agencies of the United Nations have, albeit to varying degrees, begun to consider the relevance of human rights to their work in the health field (Alston 1997). The 1997 Program for Reform put out by UN Secretary-General Kofi Annan, however, has been most crucial in moving the UN system's conceptual attention to human rights towards implementation and action within their own work. The Program for Reform designates human rights as among the core activities of the United Nations system (UN 1997). The document states that human rights are to be understood to cut across the four substantive fields of the United Nations' work: peace and security, economic and social affairs, development cooperation and humanitarian affairs. Each of the agencies with responsibility for health currently has policy documents at various stages of elaboration which concern health and human rights, and technical staff responsible for the integration or implementation of human rights into at least some aspects of their work, a situation that would have been unimaginable even a few years ago. For example, the United Nations Children's Fund (UNICEF) has restructured its policy and programmatic framework around the Convention on the Rights of the Child (UNICEF 2000); the Joint United Nations Programme on HIV/AIDS (UNAIDS) recognizes human rights as a cross-cutting theme relevant to all aspects of its policy and program work;[2] a Memorandum of Understanding now exists between the United Nations Development Program (UNDP) and the Office of the High Commissioner for Human Rights (UNDP 1999); the UNDP Human Development Report for the year 2000 has an explicit focus on human rights, and the World Health Organization (WHO) is currently preparing its first-ever strategy on health and human rights(WHO 1999b). Likewise, the bodies of the United Nations system with responsibility for human rights are also paying increasing attention to health-related concerns. This is most easily seen in the recent attention to HIV/AIDS and reproductive health by the human rights treaty monitoring bodies (UNHCHR 1996-98). However, this commitment extends to the recent appointment of two health-related focal points in the Office of the High Commissioner for Human Rights: one responsible for integrating HIV/AIDS issues into the work of the human rights bodies and structures, and the other serving as a general liaison for all health and human rights issues.

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[1] See, in particular, Chapters IV through VII of the Report of the International Conference on Population and Development, and chapter IV (C) Women and Health, and (I) Human Rights of Women of the Fourth World Conference on Women.

[2] See UNAIDS Strategic Plan 1996-2000 (Revised December 1995), pp. 5, 6, and 13 where the importance of contextual factors that increase vulnerability to HIV/AIDS is recognized, including existing discrimination against certain groups, and where human rights are cited as core values and guiding principles for UNAIDS' mission.

C. State and Non-State Actors Entering the World of Health and Human Rights

Governments too are increasingly recognizing the relevance of human rights to their health and development work and calling for technical assistance in the field of human rights. This is true in developing and industrialized countries alike. In Nepal, a comprehensive workshop was recently held on tuberculosis and human rights (WHO 1999c). An open debate in South Africa recently focused on the human rights implications of a proposed new regulation concerning AIDS reporting and AIDS-status disclosure to third persons. (South Africa Government Gazette 1999) In Colombia, the Convention on the Elimination of All Forms of Discrimination Against Women is being used as a framework for mobilization around much of the work in family planning (Corporación Casa de la Mujer 1998; Plata, Yanuzova 1993). Within the United States, President Clinton issued an Executive Order in commemoration of Human Rights Day in 1998 that obliges the United States to fully respect and implement its obligations under the international human rights treaties to which it is a party and to "promote respect for international human rights in our relationships with all other countries (Clinton 1998)." As a result, all U.S. federal agencies, including those with health related responsibilities, have been directed to re-examine their policies and strategies from the perspective of international human rights standards.

Non-governmental organizations (NGOs), such as Amnesty International and Human Rights Watch, are also increasingly considering the implications of the health and human rights connection for their own work. NGOs that focus on health or development issues, many of which previously saw human rights as having little relevance to their work, are increasingly using not only the rhetoric of human rights but its method of analysis to help shape their interventions. One prime example is the recent decision of the International Council of AIDS Service Organizations (ICASO) to name the promotion of human rights in the context of HIV/AIDS as one of its fundamental organizing principles (ICASO 1998). In addition, human rights NGOs are expanding their formerly tight focus on civil and political rights to pay increasing attention to economic, social and cultural rights, including the right to health. These developments are helping to shape new forms of advocacy and to put increased pressure on governments to take responsibility for the health of their populations. The current challenge is to ensure that the increased rhetorical attention to rights translates into policies, national legislation and actions that will effectively impact on the underlying conditions necessary for health, as well as the ways in which health policies, programs and services are conceptualized and delivered.

Academics and researchers are also increasingly finding the linkages between health and human rights to be of critical importance in expanding their domains of work (Alfredsson, Tomaševski 1998; Toebes 1999). Academic centers with an explicit focus on the linkages between health and human rights are beginning to appear in a number of places, some with a focus on specific, substantive issues, others concerned with health and human rights more broadly.[3] In the last several years, institutions around the globe have begun to offer courses in health and human rights, international conferences on health and human rights have been held in a number of locations, and professional health journals such as *The Lancet, The Journal of the American Medical Association* and the *American Journal of Public Health* have devoted space within their pages to exploring health and human rights issues (Sonis et al. 1996; Brenner 1996; Leaning 1997;).[4]

Understanding the implications of linking health and human rights is of increasing importance to policy makers, government officials, and activists—indeed, to anyone concerned with health issues, human rights issues or the linkages between the two (Marks 1997). This chapter is intended to demonstrate the basic relationship between health and human rights, and to provide a glimpse of some of the conceptual, analytical and practical approaches to bringing health and human rights together that are currently being explored. It

[3] See, for example, the François-Xavier Bagnoud Center for Health and Human Rights at the Harvard School of Public Health, as well as Macfarlane Burnett Center for Medical Research in Australia, the Program on Gender, Sexuality, Health and Human Rights at the Mailman School of Public Health at Columbia University, Netherlands Institute of Human Rights (SIM), and the Department of Community Health at the University of Cape Town, South Africa.

[4] The first course on health an human rights was offered at the Harvard School of Public Health in 1992. Since that time, courses on health and human rights have been increasingly offered in countries ranging from the United States to France, Sweden, Brazil, South Africa and Zimbabwe. Efforts are currently under way to document existing courses on health and human rights. Results will be available from http://www.hsph.harvard.edu/fxbcenter.

begins by explaining the basic concepts and procedures of human rights, with specific emphasis on their relation to health. It goes on to explore the framework of health as it relates to human rights promotion and protection. The next section considers the reciprocal relationships between health and human rights, with an emphasis on the human rights impact of public health policies and programs and the impact of neglect or violation of human rights on health. Attention is then given to suggested methods for increasing the synergy between health and human rights, both as a method of analysis and as an approach to the design, implementation and evaluation of health policies and programs. It is hoped that this last section will offer a method useful for considering the practical application of health and human rights concepts to policy and programmatic work.

2. What are Human Rights?

While human rights thinking and practice has a long history, the importance of human rights for governmental action and accountability was first widely recognized only after World War II. Agreement between nation-states that all people "are born free and equal in dignity and rights" was reached in 1945 when the promotion of human rights was identified as a principal purpose of the newly created United Nations (UN 1945). The United Nations Charter established general obligations that apply to all its member states, including respect for human rights and dignity. Then, in 1948, the Universal Declaration of Human Rights was adopted as a common standard of achievement for all peoples and all nations (UN 1948). The basic characteristics of human rights are that they are the rights of individuals, which inhere in individuals because they are human; that they apply to people everywhere in the world; and that they are principally concerned with the relationship between the individual and the state. In practical terms, international human rights law is about defining what governments *can* do *to* us, *cannot* do *to* us, and *should* do *for* us. For example, governments obviously should not do things like torture people, imprison them arbitrarily or invade their privacy. Governments should ensure that all people in a society have shelter, food, medical care and basic education.

The Universal Declaration of Human Rights (UDHR) can well be understood to be the cornerstone of the modern human rights movement. The preamble to the UDHR proposes that human rights and dignity are self-evident, the "highest aspiration of the common people," and the "foundation of freedom, justice and peace." "Social progress and better standards of life" including the "prevention of barbarous acts which have outraged the conscience of mankind," and, broadly speaking, individual and collective well-being, are understood to depend upon the "promotion of universal respect for and observance of human rights" (UN 1948). Although the UDHR is not a legally binding document, nations have endowed it with a tremendous legitimacy through their actions, including invoking it legally and politically at the national and international levels. Portions of the UDHR are cited in the majority of national constitutions drafted since it came into being, and governments often cite to the UDHR in their negotiations with other governments, as well as in their accusations against each other of violating human rights.[5]

Under the auspices of the United Nations, more that twenty multilateral human rights treaties have been formulated since the adoption of the UDHR. These treaties create legally binding obligations on the nations that have ratified them, thereby giving them the status and power of international law. Countries that become party to international human rights treaties accept certain procedures and responsibilities, including periodic submission of reports on their compliance with the substantive provisions of the texts to international monitoring bodies. The key international human rights treaties, the International Covenant on Economic, Social and Cultural Rights (ICESCR, 1976) and the International Covenant on Civil and Political Rights (ICCPR, 1976), further elaborate the content of the rights set out in the UDHR and contain legally binding obligations for the governments that ratify them. As of January 2000, 142 countries had ratified the ICESCR and 144 had ratified the ICCPR. Together with the UDHR and the United Nations Charter, these documents are often called the "International Bill of Human Rights (Humphrey 1976)." Building upon these core documents, other international human rights treaties have focused on either specific populations, e.g., the International Convention on the Elimination of All Forms of Racial Discrimination (1965), the Convention

[5] A useful compilation can be found in Hannum, H. (1998). The UDHR in national and international law. *Health and Human Rights*, 3 (2), 145-58.

on the Elimination of All Forms of Discrimination Against Women (1979), and the Convention on the Rights of the Child (1989), or on specific issues, e.g., the Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (1985).

There are also regional human rights treaties, which essentially concern the same sets of rights but are only open for signature by states in the relevant region, such as the African Charter on Human Peoples' Rights (1986), the American Convention on Human Rights (1992), and the European Convention on the Protection of Human Rights (1959). Only the Asian region does not contain such a treaty. Additionally, there are numerous international declarations, resolutions and recommendations which, although not strictly binding in a legal sense, express the political commitment of governments to promote and protect human rights and provide broadly recognized norms and standards relevant to the topic at hand, e.g., the Declaration on the Elimination of All Forms of Intolerance and of Discrimination Based on Religion or Belief (1981).

In the past decade, the series of international conferences held under the auspices of the United Nations have, to a great degree, helped give recognizable content to many of the rights contained in the various human rights treaties. Out of each of these conference processes has come a Declaration and Program of Action reflecting the consensus of the nations of the world. Though technically "non-binding" commitments, these documents demonstrate that there is a consensus of the world community that international human rights treaty norms encompass the relationship between health and human rights, including reproductive rights, and that there are steps that ought to be taken at the local, national and international levels to advance these concerns.

While these conference declarations and programs of action represent nothing more than the political commitments of the governments present at their inception, the fact that they are then adopted at the next session of the UN General Assembly gives them a degree of formal standing. Although the Declarations and Programs of Action from the 1994 International Conference on Population and Development (ICPD 1994)and the 1995 Fourth World Conference on Women (FWCW 1995)have been of particular relevance, the 1993 World Conference on Human Rights (UN 1993b)and the 1995 World Summit for Social Development (UNWSSD 1995) have also helped explicate the relevance of the health and human rights framework to government action. Individually and collectively, these documents have been of critical importance in helping to elaborate provisions relevant to vulnerable groups, to women's human rights, and to broader concepts of health and human rights. Those commitments have helped create new approaches for considering the extent of government accountability for health issues, as well as for determining the content of health issues using a rights framework. In so doing, these conference documents are helping to clarify the evolving meaning of the relationship between health and human rights and the steps needed for implementation (Gruskin 1998).

3. A Human Rights Perspective on Health

The specific rights that form the corpus of human rights law are found in the international human rights documents. While it is possible to identify different categories of rights, it is also critical to rights discourse and action to recognize that all rights are interdependent and interrelated, and that individuals rarely suffer neglect or violation of a particular right in isolation. For historical reasons, the rights described in the human rights documents have been divided into civil and political rights on the one hand and economic, social and cultural rights on the other. Civil and political rights include, among others, the rights to liberty, to security of person, to freedom of movement, to vote, and not to be subjected to cruel, inhuman or degrading treatment or punishment or to arbitrary arrest or detention. Economic, social and cultural rights include, among others, the rights to the highest attainable standard of health, to work, to social security, to adequate food, to clothing and housing, to education, and to enjoy the benefits of scientific progress and its applications. Although the UDHR contains both categories of rights, these rights were artificially split into two treaties due to Cold War politics, with the United States championing civil and political rights, and the former Soviet Union those rights considered to be more economic, social and cultural in nature (Steiner, Alston 1996). Since the end of the Cold War, acknowledgment of the indivisibility and interdependence of rights has, once again, become commonplace (UN 1993b). The Convention on the Rights of the Child, the first human rights treaty to be

opened for signature after the end of the Cold War, is the only one so far to include civil, political and economic and social rights considerations not only within the same treaty but within the same right.[6]

Health and government responsibility for health is codified in these documents in several ways. The right to the highest attainable standard of health appears in one form or another in most every one of them. Even more importantly, nearly every article of every document can be understood to have clear implications for health (Mann et al. 1994). While the rights to information, to education, housing and safe working conditions, and to social security, for example, are particularly relevant to the health and human rights relationship, specific reference must be made to three rights: the right to nondiscrimination, the right to the benefits of scientific progress, and, of course, the right to health.

A. Nondiscrimination

The principle of nondiscrimination is key to human rights thinking and practice. Under international human rights law, all people should be treated equally and given equal opportunity. Within the international human rights framework, discrimination is a breach of a government's human rights obligations (Bilder 1992). Adverse discrimination occurs when a distinction is made against a person that results in their being treated unfairly or unjustly. In general, groups that are discriminated against tend to be those that do not share the characteristics of the dominant groups within a society. Thus, discrimination frequently reinforces social inequalities and denies equal opportunities. Common forms of discrimination include racism, gender-based discrimination and homophobia. Each of the major human rights treaties specifically details the principle of nondiscrimination with respect to race, color, sex, language, religion, political or other opinion, national or social origin, property, birth and, as it is called, "other status." [7] Governmental responsibility for this right includes ensuring equal protection under the law, as well as in relation to such issues as housing, employment and medical care. The prohibition of discrimination does not mean that differences should not be acknowledged, only that different treatment must be based on objective and reasonable criteria. Although the international human rights documents do not explicitly prohibit discrimination on the basis of health status, the United Nations Commission on Human Rights has stated that "all are equal before the law and entitled to equal protection of the law from all discrimination and from all incitement to discrimination relating to their state of health" (UN 1992).

B. Right to Enjoy the Benefits of Scientific Progress

Closely allied to many of the issues relevant to health is the right to "enjoy the benefits of scientific progress and its applications," recognized explicitly in the ICESCR at Article 15. This right includes governmental obligations for the steps necessary to conserve, develop and diffuse science and scientific research, as well as freedom of scientific inquiry. The implications of this right for health issues have been explored recently with respect to access to drugs for the developing world, to name one important example (Lallemant et al. 1994; Reich 2000). In fact, this right is increasingly being cited by activist groups, NGOs and others concerned by the large and growing disparities and inequities between wealthier and poorer populations regarding access to anti-retroviral therapies and other forms of HIV/AIDS care. In addition, the relevance of this right to concerns about the development of vaccines that adequately respond to the specific needs of all populations, both in the north and in the south, has recently been cited (Beloqui et al.1998; Fluss,

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[6] See, in particular Article 6, which in guaranteeing the right to life includes both the more civil and political provision which states that "every child has the inherent right to life" and the more economic and social provision in which, "State Parties shall ensure to the maximum extent possible the survival and development of the child," Convention on the Rights of the Child (CRC), G.A. Res. 44/25, UN GAOR, 44th Sess., Supp. No. 49, at 166, UN Doc. A/44/25 (1989).

[7] See, for example, Article 2 of the Universal Declaration of Human Rights, which states in pertinent part, "Everyone is entitled to all the rights and freedoms set forth in this Declaration without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status."

Little 1999).[8] Unfortunately, while this right has long been recognized as relevant to governmental obligations under the ICESR its implications for health and health-related issues are only just beginning to be recognized.

C. The Right to Health

The human right to health should be understood, in the first instance, with reference to the description of health set forth in the preamble of the WHO Constitution and repeated in many subsequent documents. Health is a "state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity" (WHO 1946). This definition has important conceptual and practical implications, and it illustrates the indivisibility and interdependence of rights as they relate to health (Leary 1994; Tomaševski 1995a; Toebes 1999; Kirby 1999). Rights relating to discrimination, autonomy, information, education and participation are an integral and indivisible part of the achievement of the highest attainable standard of health, just as the enjoyment of health is inseparable from that of other rights, whether categorized as civil and political, economic, social or cultural. While the right to health has been set out in a number of international legal instruments, government obligations under this right are in fact, quite narrowly defined. As first elaborated in the ICESCR, the right is set forth only as "the right to the highest attainable standard of physical and mental health," with obligations understood to encompass both the underlying preconditions necessary for health and the provision of medical care.

It is worth noting here that the apparent tension between the broad definition of health proposed by WHO, which includes the notion of social well-being, and the more restrictive definition set out in the ICESCR reflects the very different purposes of these two documents. The WHO definition projects a vision of the ideal state of health as an eternal and universal goal to constantly strive towards, and has as its main purpose defining directions for the work of the Organization and its member states. The ICESCR definition differentiates the two attributes of health—physical and mental well-being—and is specifically concerned with assigning particular responsibilities to the governmental health sector; it assigns obligations relevant to social well-being to the same governments under other articles of the treaty. The right to health as stated in the ICESCR, reproduced below, is the principal framework for understanding governmental obligations under the right to health:

> **Article 12 of the International Covenant on Economic, Social and cultural rights**
>
> 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 take by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:*
>   a. *The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;*
>   b. *The improvement of all aspects of environmental and industrial hygiene;*
>   c. *The prevention, treatment and control of epidemic, endemic, occupational and other diseases;*
>   d. *The creation of conditions which would assure to all medical service and medical attention in the event of sickness* (ICESCR 1976).

[8] See, for example, Statement from the community AIDS movement in Africa, presented at the meeting on the international partnership against HIV/AIDS in Africa, New York, UN Headquarters, December 6-7, 1999.

4. Governmental Obligations for Health under International Human Rights Law

Governments are responsible not only for not directly violating rights, but also for ensuring the conditions which enable individuals to realize their rights as fully as possible. This is understood as an obligation to respect, protect and fulfill rights, and governments are legally responsible for complying with this range of obligations for every right in every human rights document they have ratified (Eide 1995a, b; Maastricht 1997).

A. Respecting, Protecting and Fulfilling Human Rights

Governmental obligations towards ensuring that every individual enjoys the right to health are summarized below as an illustration of the range of issues relevant to respecting, protecting and fulfilling all human rights:

- **Respecting the right** means a state can not violate the right directly. A government violates its responsibility to respect the right to health when it is immediately responsible for providing medical care to certain populations, such as prisoners or the military, and it arbitrarily decides to withhold that care.

- **Protecting the right** means a state has to prevent violations of rights by non-state actors and offer some sort of redress that people know about and can access, if a violation does occur. This means the state would be responsible for making it illegal to automatically deny insurance or health care to people on the basis of a health condition, and they would be responsible for making sure some system of redress exists that people know about and can access if a violation does occur.

- **Fulfilling the right** means a state has to take all appropriate measures—including but not limited to legislative, administrative, budgetary and judicial—towards fulfillment of the right, including the obligation to promote the right in question. A state could be found to be in violation of the right to health if it failed to incrementally allocate sufficient resources to meet the public health needs of the communities within its borders.

In all countries, resource and other constraints can make it impossible for a government to fulfill all rights immediately and completely. The human rights machinery recognizes this and acknowledges that, in practical terms, a commitment to the right to health is going to require more than just passing a law. It will require financial resources, trained personnel, facilities and, more than anything else, a sustainable infrastructure. Therefore, realization of rights is generally understood to be a matter of progressive realization of making steady progress towards a goal (ICESCR, Art. 2.1; Alston, Quinn 1987). The principle of "progressive realization" is fundamental to the achievement of human rights. This is critical for resource-poor countries that are responsible for striving towards human rights goals to the maximum extent possible. It is also of relevance to wealthier countries in that they are responsible for respecting, protecting and fulfilling human rights not only within their own borders, but through their engagement in international assistance and cooperation (UN 1984).

B. Valid Limitations on Human Rights

In spite of the importance attached to human rights, there are situations where it is considered legitimate to restrict rights in order to achieve a broader public good. As described in the International Covenant on Civil and Political Rights, the public good can take precedence to: "secure due recognition and respect for the rights and freedoms of others; meet the just requirements of morality, public order, and the general welfare; and in times of emergency, when there are threats to the vital interests of the nation" (ICCPR Art. 4). Public

health is one such recognized public good.[9] Traditional public health measures have generally focused on curbing the spread of disease by imposing restrictions on the rights of those already infected or thought to be most vulnerable to becoming infected. In fact, coercion, compulsion and restriction have historically been significant components of public health measures (Smith 1911; Schmidt 1995; M. Cohen 1998). Although the restrictions on rights that have occurred in the context of public health have generally had as their first concern protection of the public's health, it is also true that the measures taken have often been excessive. Interference with freedom of movement when instituting quarantine or isolation for a serious communicable disease—for example, Ebola fever, syphilis, typhoid or untreated tuberculosis—is an example of a restriction on rights that may be necessary for the public good and therefore could be considered legitimate under international human rights law. On the other hand, arbitrary measures taken by public health authorities that fail to consider other valid alternatives may be found to be abusive of both human rights principles and public health "best practice." In recent times, measures taken around the world in response to HIV/AIDS provides examples of this type of abuse(R. Cohen,Wiseberg 1990; UN 1992a; UN 1994; HRI 1998).

Certain rights are absolute, which means that restrictions may never be placed on them, even if justified as necessary for the public good. These include such rights as the right to be free from torture, slavery or servitude; the right to a fair trial; and the right to freedom of thought.[10] Paradoxically, the right to life, which might at first glance appear to be inalienable, is not absolute; what is forbidden is the arbitrary deprivation of life. Interference with most rights can be legitimately justified as necessary under narrowly defined circumstances in many situations relevant to public health.[11] Limitations on rights, however, are considered a serious issue under international human rights law, regardless of the apparent importance of the public good involved. When a government limits the exercise or enjoyment of a right, this action must be taken only as a last resort and will only be considered legitimate if the following criteria are met:

1. The restriction is provided for and carried out in accordance with the law;
2. The restriction is in the interest of a legitimate objective of general interest;
3. The restriction is strictly necessary in a democratic society to achieve the objective;
4. There are no less intrusive and restrictive means available to reach the same goal; and
5. The restriction is not imposed arbitrarily, i.e., in an unreasonable or otherwise discriminatory manner (UNECOSOC 1985).

Whereas this approach, often called the Siracusa Principles, because they were conceptualized at a meeting in Siracusa, Italy, has long been recognized by those concerned with human rights monitoring and implementation as relevant to analyzing a government's actions, it has also recently begun to be considered a useful tool in a number of places by those responsible within government for health-related policies and programs (WHO/UNAIDS 1999). This framework, although still rudimentary, may be helpful in identifying public health actions that are abusive, whether intentionally or unintentionally.

5. Human Rights Monitoring Mechanisms Relevant to Health

The degree of governmental compliance with the obligations to respect, protect and fulfill human rights are of direct relevance to the people affected, but they are also of interest to the international community.

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[9] The specific power of the state to restrict right in the state of public health can be understood to be derived from Article 12 (c),of the ICESCR, which gives governments the right to take the steps they deem necessary for the "prevention, treatment and control of epidemic, endemic, occupational and other diseases."

[10] See, for example, Article 4 of the International Covenant on Civil and Political Rights, which states in pertinent part that "No derogation from articles 6, 7, 8 (paragraphs 1 and 2), 11, 15, 16, 18 may be made under this provision.

[11] See, for example, Article 4 of the ICCPR, which states in pertinent part, "In time of public emergency which threatens the life of the nation and the existence of which is officially proclaimed, the States Parties to the present Covenant may take measures derogating from their obligations under the present Covenant to the extent strictly required by the exigencies of the situation, provided that such measures are not inconsistent with their other obligations under international law and do not involve discrimination solely on the ground of race, colour, sex, language, religion or social origin."

The accountability of governments for their legal commitments is monitored at the international level through the reporting process and, in many places, at the national level by governments themselves through the creation of commissions and ombudspersons, as well as by NGOs.

A. Reporting under the Human Rights Treaties

As mentioned previously, once a government has ratified a human rights treaty, it is obliged to report every several years to the specific body responsible for monitoring government action under that treaty. Governments are responsible for showing the ways they are and are not in compliance with the treaty provisions, and must show constant improvement in their efforts to respect, protect and fulfill the rights in question (UN 1996). Each of the treaty bodies meets several times each year to review a number of the government reports submitted. The process is very formal, with the government under review submitting a copy of their report approximately two months before the meeting. The report is officially presented at the meeting by a high-ranking government official, and the treaty body engages in formal dialogue with the country in question. Health-oriented UN institutions, such as WHO, UNAIDS or UNICEF, are invited to provide the treaty bodies with information on the state of health and the performance of health systems in the country under review. NGOs can also submit informal reports (often termed *shadow reports*) providing additional information, as well as stating their views on the situations and issues at stake. At the conclusion of the session, the treaty body prepares Concluding Comments and Observations, which are made part of the substantive record. These comments address the extent to which the government in question is in compliance with its treaty provisions and provide concrete suggestions for actions to be taken by the country in order for it to be found in compliance at its next review. While this process can be extremely useful, there is, unfortunately, a tremendous backlog, largely because governments are often late in their reports, and none of the treaty bodies meets for a sufficient amount of time each year to cover all of the countries that are responsible for reporting to it.

At this point in time, all of the human rights treaty bodies have expressed a commitment to exploring the implications of health broadly defined, as well as the specific issues raised by both HIV/AIDS and reproductive health concerns, for governmental obligations under the treaties (UNDAW, UNFPA, UNHCHR 1996; Boerefon, Toebes 1998). While several of the treaties contain specific health-related provisions, the added impetus to pay attention to health in the context of monitoring work can largely be attributed to the interest generated from international conferences and the political commitments made there about governmental responsibility for ensuring the human rights of individuals in relation to health.

For each of the human rights treaties, General Guidelines for Reporting provide guidance to governments as to how to present the information about their compliance with their obligations to the treaty bodies (UN 1996). The information requested by the treaty bodies concerning health-related issues relates to what governments are doing with respect to both the underlying preconditions for health and the ways in which health policies, programs and services are designed and implemented. From a health perspective, however, the actual information requested under current requirements is largely insufficient to get at this range of issues. The General Guidelines provided to governments for reporting on the right to health under the International Covenant on Economic, Social and Cultural Rights are included below (Box 1). They provide a concrete example of what the treaty body with primary responsibility for implementation of the right to health considers in determining if and the degree to which a government is in compliance with its obligations for the right to health.

Box 1.
Guidelines for Reporting on Article 12 of the ICESCR

1. *Please supply information on the physical and mental health of your population, both in the aggregate and with respect to different groups within your society. How has the health situation changed over time with regard to these groups? In case your government has recently submitted reports on the health situation in your country to the World Health Organization (WHO) you may wish to refer to the relevant parts of these reports rather than repeat the information here.*

2. *Please indicate whether your country has a national health policy. Please indicate whether a commitment to the WHO primary health care approach has been adopted as part of the health policy of your country. If so, what measures have been taken to implement primary health care?*

3. *Please indicate what percentage of your GNP as well as of your national and/or regional budget(s) is spent on health. What percentage of those resources is allocated to primary health care? How does this compare with 5 years ago and 10 years ago?*

4. *Please provide, where available, indicators as defined by WHO, relating to the following issues:*
   - *(a) Infant mortality rate (in addition to the national value, please provide the rate by sex, urban/rural division, and also, if possible, by socio-economic or ethnic group and geographical area. Please include national definitions of urban/rural and other subdivisions);*
   - *(b) Population access to safe water (please disaggregate urban/rural);*
   - *(c) Population access to adequate excrete disposal facilities (please disaggregate urban/rural);*
   - *(d) Infants immunized against diphtheria, pertussis, tetanus, measles, poliomyelitis and tuberculosis (please disaggregate urban/rural and by sex);*
   - *(e) Life expectancy (please disaggregate urban/rural, by socio-economic group and by sex);*
   - *(f) Proportion of the population having access to trained personnel for the treatment of common diseases and injuries, with regular supply of 20 essential drugs, within one hour's walk or travel;*
   - *(g) Proportion of pregnant women having access to trained personnel during pregnancy and proportion attended by such personnel for delivery. Please provide figures on the maternity mortality rate, both before and after childbirth.*
   - *(h) Proportion of infants having access to trained personnel for care.*

   (Please provide breakdowns by urban/rural and socio-economic groups for indicators (f) to (h)).

5. *Can it be discerned from the breakdown of the indicators employed in paragraph 4, or by other means, that there are any groups in your country whose health situation is significantly worse than that of the majority of the population? Please define these groups as precisely as possible and give specifics. Which geographical areas in your country if any, are worse off with regard to the health of their population?*

   - *(a) During the reporting period, have there been any changes in national policies, laws and practices negatively affecting the health situation of these groups or areas? If so, please describe these changes and their impact?*
   - *(b) Please indicate what measures are considered necessary by your government to improve the physical and mental health situation of such vulnerable and disadvantaged groups in such worse off areas.*
   - *(c) Please explain the policy measures your government has taken, to the maximum of available resources, to realize such improvement. Indicate time-related goals and benchmarks for measuring your achievement in this regard.*
   - *(d) Please describe the effect of these measures on the health of the vulnerable and disadvantaged groups or worse off areas under consideration, and report on the successes, problems and shortcomings of these measures.*
   - *(e) Please describe the measures taken by your government in order to reduce the stillbirth rate and infant mortality and to provide for the healthy development of the child.*
   - *(f) Please list the measures taken by your government to improve all aspects of environmental and industrial hygiene.*

(g) *Please describe the measures taken by your government to prevent, treat and control epidemic, endemic and occupational and other diseases.*

(h) *Please describe the measures taken by your government to assure to all medical service and medical attention in the event of sickness.*

(i) *Please describe the effect of the measures listed in subparagraphs (e) to (h) on the situation of the vulnerable and disadvantaged groups in your society and in any worse-off areas. Report on difficulties and failures as well as on positive results.*

6. *Please indicate the measures taken by your government to ensure that the rising costs of health care for the elderly do not lead to infringements on these persons' right to health.*

7. *Please indicate what measures have been taken in your country to maximize community participation in the planning, organization, operation and control of primary health care.*

8. *Please indicate what measures have been taken in your country to provide education concerning prevailing health problems and the measures of preventing and controlling them.*

9. *Please indicate the role of international assistance in the full realization of the right enshrined in Article 12.*

(UNECOSOC 1991).

The increasing linkages among the work of the treaty bodies, the UN specialized agencies and NGOs are useful to the treaty monitoring process, but they are also beginning to contribute directly and concretely to enhancing implementation of human rights at the country level by governments as well as other actors. The role of the technical and specialized agencies, funds and programs of the UN in the treaty monitoring process is growing, with respect to both provision of information and interactions with the treaty bodies and governments in question. This includes primarily UNICEF, UNAIDS and WHO but also, increasingly, the International Labour Organization (ILO), UNDP and UNFPA. More and more, these agencies and programs have been providing the treaty bodies with statistical information and other data collected as part of their routine work concerning the country in question to assist the treaty bodies in their review of government compliance. They have also been providing treaty bodies with guidelines and other examples of "best practice" they have produced, which can assist the treaty bodies in their analysis of the information provided by the government and in the drafting of their Concluding Comments and Observations. To date, however, the input of these agencies has been somewhat uncoordinated, even within the same institution, often resulting in heavy servicing of some treaty bodies in some specific ways while virtually ignoring others. As a result, a country may be heavily questioned by one treaty body as to some specific aspect of their compliance with their health-related obligations under one treaty but questioned not at all by another treaty body responsible for monitoring similar health-related obligations. In addition, due to lack of resources and the relative newness of their engagement with this process, the UN agencies, funds and programs do not provide even the treaty bodies they do work with equivalent information on all countries reporting at a particular time. Thus, while one country may be heavily questioned by a treaty body as a result of information provided by a particular agency, the next country immediately under review may not even be questioned superficially on comparable issues. UNICEF has been involved in the treaty monitoring process in other ways as well. For example, it has expended considerable resources on helping governments to prepare their reports as well as increasingly framing technical assistance to countries according to the provisions of the Convention on the Rights of the Child (UNICEF 1998). This approach to the work of UN agencies and programs at the country level has increasingly been considered of interest by the other technical agencies of the United Nations, especially UNAIDS and WHO, and may help to frame some of their work in the future.

Non-governmental organizations play a critical role to play in monitoring government compliance with treaty provisions. In countries, NGOs are increasingly using government obligations under the human rights treaties, as well as the Concluding Comments and Observations of the treaty bodies, in their advocacy efforts. The input of NGOs is also crucial at the international level in that they are able to provide treaty monitoring

bodies with much-needed additional outside information on the action (or inaction) of the government in question, which can then be used by the treaty body in their dialogue with that government. Although NGOs are sometimes present during the formal dialogue, this information is most often presented in shadow reports. There is no formal mechanism, however, for ensuring that NGO information gets to the treaty bodies, and, unfortunately, NGOs generally do not coordinate with each other on the information they provide. At times, the same information about a particular situation has been presented to a treaty body from numerous sources, while other potentially critical information of a more general nature is never provided. In addition, many local NGOs are unaware of or lack access to the treaty monitoring process, resulting in a number of problems: only the most publicized cases come to the attention of the monitoring body, and the lack of functioning NGOs in a majority of countries results in both a dearth of information from countries with some of the worst human rights records and a privileging of the information provided by well-established international human rights NGOs such as Amnesty International and Human Rights Watch, which have more contacts and closer relationships with the treaty body members than other organizations do. This last point is of particular concern in relation to health-related human rights issues, as these issues often fall outside the purview of mainstream human rights organizations, and little alternative information on health-related issues therefore reaches the relevant bodies (UNAIDS 1997). As a result, while the utility of the involvement of NGOs to this process is at this point undisputed, mechanisms for ensuring their involvement in a comprehensive way, particularly with respect to health-related information, still remain to be worked out.

B. General Recommendations and General Comments Concerning Health

In the past five years, there have been increasing efforts to draft authoritative interpretations of the right to health in order to ensure state responsibility and accountability with respect to health in a structured way. These authoritative interpretations have taken the form of General Comments or General Recommendations, which are drafted and endorsed by the treaty monitoring body in question and which form the basis of the treaty body's formal understanding of the content of a particular right or issue. These General Comments or General Recommendations then help to serve as a guide for governments concerning the issues they must consider in making their periodic reports under the guidelines, for non-governmental organizations in their monitoring of governmental action and for the treaty bodies themselves in their dialogue and interaction with governments in the context of the monitoring process (UN 1996). While these comments and recommendations are meant only to provide interpretation, their formulation does have concrete implications for whether or not a government is judged to be in compliance with its treaty obligations. For example, the right to health as formulated in international treaties contains no mention of primary health care. In large part, this is because the concept of primary health care had not yet been internationally recognized at the time the ICESCR was drafted. While the guidelines for reporting contain substantive mention of primary health care, the relationship between a primary health care approach and government obligations under the treaty are not spelled out. Thus, in the absence of a general comment or recommendation emphasizing a primary health care approach, it is difficult to judge a country that pays little or no attention to primary health care not to be in compliance with its health related obligations.

Until very recently, no general comments or recommendations had been issued by any of the treaty bodies specifically related to health. In 1999, the CEDAW Committee, which monitors governmental compliance under the Women's Convention, issued a General Recommendation on Health, and in 2000 the Committee on Economic, Social and Cultural Rights, the body responsible for monitoring the ICESCR, issued a General Comment on the Right to Health (CEDAW 1999, CESCR 2000). Nonetheless, a number of the general comments and recommendations issued by the treaty bodies in past years have had clear health-related implications. These include the General Comments on Disability, Housing and Food issued by the Committee on Economic, Social and Cultural Rights and the General Recommendations concerning HIV/AIDS, Female Circumcision and Violence against Women issued by the CEDAW Committee (UNCEDAW 1989; UNCEDAW 1990 a, b; UNCESCR 1994; UNCESCR 1995; UNCESCR 1997).

At the outset of the 21st century, the translation of the right to health into guidelines and other tools useful to national and international monitoring of governmental and inter-governmental obligations is still in its infancy. The CESCR General Comment on the Right to the Highest Attainable Standard of Health, which

was adopted in 2000, may help to provide some useful guidelines. In parallel, as described later in this chapter, WHO is developing a new set of tools and recommendations aimed at redirecting the attention given to monitoring global health indicators from disease-specific morbidity and mortality trends towards others that are more reflective of the degree to which health and human rights principles are respected, protected and fulfilled (WHO 2000b in press). How and to what extent these instruments will actually be put to use and how effective they will be in advancing the health and human rights agenda has yet to be seen, but there are several factors that, even at this early stage, allow for guarded optimism. First, the treaty bodies and international organizations concerned with health are doing this work based on open dialogue and a degree of collaboration that greatly exceeds the level and quality of inter-agency collaboration traditionally observed within the UN machinery. This is exemplified by the sharing of goals and the collective technical cooperation that has prevailed in the current processes of defining obligations and monitoring methods and standards relevant to health and human rights in the process of operationalizing both the international treaties and the recommendations promulgated at the international conferences (UNDAW, UNFPA, UNHCHR 1996; UNDP 1998b, WHO 2000c). Potentially, this work will help not only to monitor what governments are doing, but also to build their capacity to incorporate health and human rights principles into their policies and programs. In several countries, including Brazil, Thailand and South Africa, human rights principles relevant to health recently have found their way into national legislation and new constitutions, thereby ensuring citizens the right to seek fulfillment of their right to care, for example, through national juridical means (Hannum 1998). As the methods and tools for monitoring and accountability of health related issues mature, it is likely that cases of human rights violations related to health will increasingly be heard both within countries and at the regional and international level.[12] A focus on monitoring and redress of violations of the right to health is but one means of ensuring action using the human rights documents. Equally important are the steps being taken to build national and international capacity to develop and reform public policy and laws in line with international human rights norms and standards as they apply to health (UNFPA 1998). This work requires institutional changes, as well as capacity building within both governmental systems and international organizations. The Director-General of WHO has cited the need to integrate efforts towards this goal, noting: "Even when governments are well-intentioned, they may have difficulty fulfilling their health and human rights obligations. Governments, the WHO and other intergovernmental agencies should strive to create the conditions favorable to health, even in situations where the base of public finance threatens to collapse" (Brundtland 1998).

The process of "mainstreaming human rights", currently well underway in the UN system, is specifically aimed toward this goal (UN 1997a). Mainstreaming human rights is "the process of assessing the human rights implications of any planned action, including legislation, policies or programs, in all areas and at all levels. It is a strategy for making human rights an integral dimension of the design, implementation, monitoring and evaluation of policies and programs in political, economic and social spheres (UN 1997a)." Two examples may serve to illustrate how this is done. In the 1990s, UNICEF adopted the Convention on the Rights of the Child (CRC), thereby ensuring that their policy and programmatic work would be guided by the principles and standards established by the CRC, as well as the Convention on the Elimination of All Forms of Discrimination Against Women. The 1996 Mission Statement says explicitly that pursuit of the rights of children and of women is a fundamental purpose of the organization. These efforts have led to a restructuring of UNICEF and a rights-based approach to all programming efforts at all levels of its work (UNICEF 1998). In WHO, a similar process began in 1999 with the aim of defining the goals of human rights mainstreaming for their national and international health work (WHO 1999b). The process was begun following a 1998 World Health Assembly Resolution that set out the need to "promote and support the rights and principles, actions and responsibilities enunciated in the [World Health Declaration] through concerted action, full participation and partnership, calling on all peoples and institutions to share the vision of health for all in the twenty-first century, and to endeavor in common to realize it (WHO 1998c)." In 2000, work began toward a strategy document which would incorporate health and human rights into the policy and

[12] See, for example, Open Door Counselling and Dublin Well Women's Centre v. Ireland, 15 EUR. H.R. Rep. 244 (1992).

program work of WHO. Toward this aim, health and human rights are considered relevant to each of WHO's four strategic directions (WHO 1999b):

1. Reducing excess mortality, morbidity and disability, especially in poor and marginalized populations;
2. Promoting healthy lifestyles and reducing risk factors to human health that arise from environmental, economic, social and behavioral causes;
3. Developing health systems that equitably improve health outcomes, respond to people's legitimate demands and are financially fair;
4. Developing an enabling policy and institutional environment in the health sector and promoting an effective health dimension to social, economic, environmental and development policy (WHO, 1999d).

These strategic directions will be discussed more extensively below with specific reference to their health and human rights implications. To pursue these directions, WHO is proposing to contribute to the building of skills and knowledge within the Organization and in countries; perform an internal review of its policies and programs to verify their conformity with health and human rights principles; further its cooperation with the Office of the High Commissioner for Human Rights and the treaty monitoring bodies; disseminate information; and develop and refine human rights–sensitive monitoring and evaluation processes applicable nationally and internationally.

6. A Health Perspective on Human Rights

As stated above, over fifty years ago, the Constitution of WHO projected a vision of health as a state of complete physical, mental and social well being—a definition of health that is more relevant today than ever (WHO 1946). It recognized that the enjoyment of the highest attainable standard of health was one of the fundamental rights of every human being and that governments have a responsibility for the health of their peoples, which can be fulfilled only through the provision of adequate health and social measures. The 1978 Declaration of Alma-Ata called on nations to ensure the availability of the essentials of primary health care, including: education concerning health problems and the methods for preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common disease and injuries; and provision of essential drugs (WHO/UNICEF 1979). In 1998, the World Health Assembly reaffirmed the commitment of nations to strive towards these goals in a World Health Declaration that stressed the "will to promote health by addressing the basic determinants and prerequisites for health" and the urgent priority "to pay the greatest attention to those most in need, burdened by ill health, receiving inadequate services for health or affected by poverty" (WHO 1998). These ambitious objectives of health development must be examined from the perspective of the role of governments in ensuring equal and equitable access to medical care and health promotion while striving to create the underlying conditions necessary for health.

This section will begin with a discussion of the traditional dichotomy between the roles and functions of medicine and those of public health, which will help begin to frame the content of governmental obligations towards individuals and populations for health under international human rights law. Health will then be placed in the broader context of human development in order to underscore the relevance of a broad array of governmental obligations, well beyond the health sector, that may impact on health. The four strategic directions to health development mentioned earlier will then be presented as an approach relevant to the development of both a health and human rights analysis and monitoring and accountability. Finally, a new grouping of these issues will be proposed as an entry point into their analysis from a human rights perspective, leading to a pathway for action.

A. Medicine, Public Health and Human Rights

Health as it connects to human rights analysis and implementation concerns two related but different disciplines: medicine and public health. Historically the territorial boundaries of medicine and public health

reflected not only professional interest and skill, but also the environments within which these skills were practiced: homes, clinics, hospitals and clinical laboratories on the one hand; institutes, public health laboratories, offices and field projects on the other (Detels et al. 1997). In recent years, the apparent differences between the two professions—the first primarily understood to focus on the health of individuals, the second on the health of populations—have profoundly impacted the ways in which the relationship between health and human rights has been understood by different actors. From a rights perspective, this ancient division resulted in the assumption that, of the two, medicine was more concerned with the health and rights of the individual (for example, in creating conditions enabling a particular individual to access care), while the primary focus of public health was the protection of collective interests, even at the cost of arbitrarily restricting individual rights (Mann 1997). For example, coercion and restrictions of rights had been critical to traditional smallpox eradication efforts (Fenner et al. 1998). Yet as the human rights approach has made increasingly clearer, this stark differentiation between medicine and public health is no longer fully relevant either to human rights or to health. Although they apply different methods of work, both medicine and public health seek to ensure every person's right to achieve the highest attainable standard of health, and both have a strong focus on the individual. Medicine is more concerned with analyzing, diagnosing and treating disease, as well as preventing ill health in individuals through such methods as immunization, appropriate diet or prophylactic therapies. Public health seeks to address health and ill health by focusing on individual and collective determinants, be they behavioral, social, economic or other contextual factors.

Three sets of factors have contributed to blurring traditional boundaries between medicine and public health in past decades. First, the transitions in health status through which many populations have been recently evolving have called for a closer understanding of the links between individual health, public health and the environment (Gubler 1998, Shrader-Frechetter 1991). Contemporary thinking about optimal strategies for disease control have evolved, as efforts to confront the most serious global health threats including cancer, mental disorders, cardiovascular disease and other chronic diseases, injuries, reproductive and sexual health, infectious diseases and individual and collective violence have increasingly emphasized the role of personal behavior within a broad social context (Murray, Lopez 1996). The transition of the global disease burden moving from communicable diseases to non-communicable diseases, which are understood to be heavily dependent on lifestyle, has evoked a medical need to care for patients in the context within which they are born and grow through childhood and adulthood until death. There has been increasing understanding that behaviors and their social, economic and cultural contexts are inextricably interwoven with the biology of health and disease, and are therefore relevant to individual care (Krieger, Sidney 1996).

Second, the tools and technologies of each field have been found to be of increasing utility to the other. For example, new technologies developed through biomedical research in such fields as immunology, molecular biology and genetics are of increasing relevance to public health (Barry, Molyneux 1992; Andrews 1995; Aluwihare 1998). Scientific discoveries in molecular virology have provided tools that are as useful to individual diagnosis and care as they are to epidemiology, vaccine development and public health programs (Hunter 1999). Likewise, traditional public health tools, drawn from epidemiology, ecology and social and behavioral sciences, have demonstrated their usefulness in deciphering powerful determinants of health and of disease outcomes, thus creating stronger bridges between biomedical care and public health interventions (Krieger, Zierler 1997; Terragni 1993).

Third, the human rights framework has shown that the state's human rights responsibilities to respect, protect and fulfill rights relating to health include obligations concerning both medicine and public health. In the context of a health and human rights analysis, a challenge to the now-artificial dichotomy between medicine and public health is not merely rhetorical or of analytical interest; it also brings into play the range of obligations of the state towards every individual. The health and human rights paradigm is relevant to clinical practice, community health, large-scale health program development, implementation and policy. The synergistic health and human rights perspective aims to guarantee that every individual can achieve the highest attainable standard of physical, mental and social well being. Human rights are progressively being understood to offer an approach for considering the broader societal dimensions and contexts of the well-being of individuals and populations, and therefore to be of utility to all those concerned with health.

B. Globalization and Health Development

The definition of health enshrined in the WHO Constitution was an important step in helping to move health thinking beyond a limited biomedical- and pathology-based perspective towards the more positive domain of well being, understood to include recognition of individuals and their need to realize aspirations, to satisfy needs and to change or cope with their environments. The societal dimensions of this effort were emphasized in both the Declaration of Alma-Ata (1978), and the Ottawa Charter for Health Promotion (1986). The Alma-Ata Declaration describes health as a social goal whose realization requires the action of many social and economic sectors in addition to the health sector. The Ottawa Charter proposes that the fundamental conditions and resources for health are peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity.

When WHO was created to improve health 50 years ago, there were hopes that antibiotics and the progress achieved in vaccines and biomedical technology would provide the tools sufficient to enable individuals everywhere in the world to reach the highest attainable standard of physical, mental and social well-being (Tomaševski, 1995b). However, decades later, as reflected in both the Alma-Ata Declaration and the Ottawa Charter, it is now clear that regardless of the effectiveness of technologies, the underlying civil, cultural, economic, political and social conditions at both a global and local level have to be addressed as well. The major determinants of better health are increasingly understood to lie outside the health system and to include better education and information, as well as fulfillment of an array of rights which are relevant to, but not intrinsically connected to, the right to health (Carrin, Politi 1996). Thus health requires attention to the increasingly complex relationship of people to their environment and an understanding of respecting, protecting and fulfilling human rights as a necessary prerequisite for the health of individuals and populations.

Globalization and the direct and indirect impacts of intensifying global flows of money, trade, information, culture and people on health and related aspects of human development, have brought out a new set of human rights issues (Brundtland 2000). These issues need particular attention, as they have largely been ignored up to now. The process of globalization has proceeded at a much faster pace than the development of policies aimed at maximizing its benefits to human development and preventing or mitigating its harmful effects.

Globalization, and the privatization of the means of production and services that inherently accompanies it, can contribute to the advancement of health through the sharing of information, technologies and resources, as well as through the competition it generates to provide more effective, more widely available and higher-quality services. Globalization can create new employment opportunities in some populations or sectors of the economy, but at times may do so to the detriment of others. It can also stimulate the spread of health hazards and disease as a result of intensified population mobility, or through the worldwide marketing of harmful substances, such as tobacco and alcohol. If poorly conceived and monitored, globalization can contribute to the widening of inequalities by increasing the autonomy and well-being of some sectors of the population while producing negative consequences for others without access to safety nets to support the fulfillment of essential needs (Cooper Weil et al. 1990; UN 1995b; WHO 1995; Al-Mazrou et al. 1997; Heggenhougen 1999 Hallack 1999; Brundtland 2000). In the wake of globalization and privatization, increasing attention must be paid to the role of non-state actors because they are now influencing the health and well-being of people to an unprecedented extent, comparable even to the influence of governments (UNHCHR 2000). The role of the state is to ensure that all human beings are guaranteed their basic human rights, including the right to the highest attainable standard of health, whether this obligation is fulfilled directly through government-run services or through private intermediaries. Governmental roles and responsibilities are increasingly being delegated to non-state actors (e.g., biomedical research institutions, health insurance companies, care providers, health management organizations and the pharmaceutical industry) whose accountability for what they do, do not do or should do about people's health is poorly defined and inadequately monitored. There is today a universal need to reinforce the commitment and capacity of governments to ensure that actions taken by the private sector and other actors in civil society relevant to health and other aspects of human development, both within and outside the boundaries of nation-states, are informed by and comply with human rights principles. Current structures are generally insufficient for NGOs or governments to effectively monitor and hold corporations operating on a national

scale accountable. This problem is compounded when these companies are multinational (Hossain 1999; Orford 1999; UNHCHR 2000).

Attention to health reveals that multinationals are more than agents of economic change whose decisions are increasingly effecting the distribution of wealth, the fabric of society and the creation of conditions favorable to advancing health; they are also increasingly the institutions called upon by political and social forces to create and operate alternative mechanisms to extend health and social services and to make available new and affordable vaccines and drugs (Kolodner 1994). Yet because they are multinational, they largely escape the realm of legal accountability within states, and, while they may choose to adopt ethical guidelines and codes of conduct, there is no international human rights law that directly applies to them or to their actions. Today, the fora where world issues are debated have expanded from assemblies of governments—for example, under the UN umbrella—to gatherings and congresses such as the Davos forum that give a prominent role to these non-state actors, demonstrating that the state and non-state actors leading the world economy have become inseparable partners. From a health and human rights perspective, the desirable forms and extent of responsibility for multinational actors within the international legal system have yet to be defined in ways that help to effectively shape international trade agreements and to ensure their accountability. This is the next and most important challenge in the world of human rights, and it will have far-reaching health consequences.

C. Strategic Directions to Better Health

Human rights can help to provide an approach for redefining the ways in which governments and the international community as a whole are accountable for what is done and not done about the health of people (Mann et al. 1994). This requires an understanding of the content of the health issues most relevant to the health and well-being of individual and populations, as well as of those actions which ought to be taken at the national level to move towards health development.

As the approaches set out by WHO are relevant to all its member states, this discussion will be framed around the strategic framework laid out by the WHO in its 1999 corporate strategy (WHO 1999c). From a strategic perspective, the issues relevant to health development can be understood to lie along four converging axes: (1) reducing excess mortality, morbidity and disability; (2) promoting healthy lifestyles and reducing risk factors to human health that arise from environmental, economic, social and behavioral causes; (3) developing health systems that equitably improve health outcomes, respond to people's legitimate demands and are financially fair; and (4) developing an enabling policy and institutional environment in the health sector while promoting an effective health dimension to social, economic, environmental and development policy. Each of these approaches will be briefly discussed below.

1. Reducing excess mortality, morbidity and disability

Recent WHO information reveals that six preventable or curable diseases cause 90 percent of infectious disease deaths worldwide, as well as half of all premature deaths, most of which occur in children and young adults living in developing countries (Murray, Lopez 1996; WHO 1999a). Reduction of excess mortality, morbidity and disability calls for a combination of sound health interventions—some of a clinical nature, such as diagnosis and treatment of communicable and non-communicable diseases, and others building on large scale programs to inform, immunize or apply population-based prophylactic therapies. From a health and human rights perspective, it is worth recognizing that the growing health disparity between the North and the South creates compelling needs both for every country to develop effective disease prevention and control programs targeted to their specific needs *and* for global sharing of technology and resources in order to enable poorer countries to accelerate progress in health development. Therefore, priority must be given both locally and globally to poor and marginalized communities.

2. Promoting healthy lifestyles and reducing risk factors to human health that arise from environmental, economic, social and behavioral causes

Modern public health recognizes the influence of external factors on the ability of individuals to adopt healthy behaviors or to access care when ill health has set in (*note to Editor: would suggest to cross reference to OTPH chapter on Health and Behaviors*). As stated earlier, health promotion is the process of enabling people to increase control over and improve their health. To do so, individuals or groups must be informed and able to identify and realize aspirations, satisfy needs and change or cope with their environment. The concept of interventions aimed at reducing risk is familiar to those working on such health issues as HIV/AIDS and other sexually transmitted diseases, tobacco and other types of substance use or occupational hazards (Mann et al. 1992; Mann, Tarantola1996a, b; WHO 1998d). Risk reduction interventions can also bring attention to the inadequacy of public services to address such issues as reproductive health, access to safe blood transfusion or access to clean water. Some authors have distinguished the notion of risk, defined as a statistical probability of suffering from ill health, from that of "vulnerability," which impacts on risk via societal, program-related or individual factors (Mann, Tarantola 1996a, b; Tarantola 1998). Others have further extended this analysis by defining "susceptibility" as the influence of external or individual factors on risk and "vulnerability" as the degree to which individual, communities or nations are able to effectively cope with the impacts of ill health (Barnett, Whiteside 1999). Still others have grouped these factors among the "underlying preconditions for health," including policy, legal and institutional environments, which have traditionally been dealt with as a separate issue (Mann et al. 1994). All of these paradigms recognize the importance of integrating morbidity, mortality and disability reduction programs with interventions to mitigate or address the factors underlying the occurrence of these events. Reducing susceptibility or vulnerability requires, first, understanding who is affected and how and to what extent these people are exposed to and able to cope with the factors that impact on their health, and then designing interventions that can help enable them to cope effectively. From a health and human rights perspective, this process is linked to the need to create conditions conducive to health through information, education and the development or strengthening of health systems and social support programs that promote healthy behaviors, impact on risk-taking behaviors and increase individual and collective commitment and capacity to engage in these processes.

3. Developing health systems that equitably improve health outcomes, respond to people's legitimate demands and are financially fair

In this context, "health systems" can be understood as the set of public or private structures, services, actions and people whose main aim is to promote health and prevent and treat disease. In order to progress towards these aims, health systems must be sufficiently accessible, efficient, affordable and of good quality (WHO 2000b). The WHO World Health Report 2000 has proposed measures that reflect responsibility and create the grounds for accountability within health systems with regard to three dimensions of health: health outcome, fairness and responsiveness (WHO 2000b). The responsibilities of health systems in relation to health outcomes largely determines the type of services, interventions and technologies they offer. If analyzed on the basis of health outcomes, the accountability demanded of health systems must take into consideration the capacity of these systems to recognize and respond to health issues, as well as such factors as personal behaviors or unforeseen social, economic or environmental situations or events. From an accountability perspective, it is worth recognizing that some of these latter factors may impact on health outcomes but are beyond the responsibilities assigned to health systems. They must be taken into account in other ways—for example, in relation to governmental accountability for education, employment, freedom of movement or association, or in relation to other rights that impact on health.

Underlying this attention to the responsibility and accountability of health systems is the concept of equality, which implies that health systems are capable of defining and recognizing the characteristics and specific needs of populations within a nation who experience a disproportionate level of mortality, morbidity and disability. This, in turn, requires that health data be collected and analyzed with a degree of sensitivity and specificity sufficient to determine who is likely to require additional attention; what behaviors and practices have to be supported, induced or changed; what service provisions have to be enhanced and in what ways; and what financial mechanisms are necessary to provide the safety nets necessary to ensure that those who need more actually receive more. Therefore, it follows that the information used to develop, monitor and

evaluate policies and programs must accurately reflect characteristics that may be associated with discrimination and inequality, including sex, age, rural/urban location and other relevant behavioral, social or economic factors (Barton Smith 1998).

The WHO World Health Report 2000 proposes that "the way health care is financed is perfectly fair when the burden that health spending represents on the household, or its relative health financial contribution is identical for all households, independent of their income, their health status or their use of the health system" (WHO 2000b). Although the principle of fairness is not articulated as such in human rights treaties, it builds on an array of rights, such as nondiscrimination, equality and participation, that, together with obligations directly related to health, can be used to consider the responsibilities of governments for health systems. The financing of health systems must, of course, be considered from the perspective of competing human development priorities within a nation, as well as that of the intrinsic priorities within health systems themselves. No global benchmark can therefore be proposed to establish the minimum national spending for health systems, whether from public or private sources, and the debate must remain open as to the extent to which and the ways in which governments will invest in the health of their populations. Within health systems, the decisions concerning allocation of public funds for specific health initiatives can draw from epidemiological, economic or political considerations and can use a variety of methods and processes, including cost-effectiveness analysis, as well as human rights considerations. The concept of financial fairness implies that these systems should enable all individuals to seek and receive services that are commensurate to their needs and economically affordable.

Finally, the concept of responsiveness imposes on health systems a requirement that they be sensitive to people's aspirations, needs and demands with full respect for human rights, and that they offer support and services. The principles of non-discrimination, protection of confidentiality (privacy) and respect for people's dignity are central to both the design of health systems and to the attitude and practices of health providers. From a health and human rights perspective, each of the components considered necessary for health systems to equitably improve health outcomes raises additional issues to be considered from the perspective of governmental responsibility and accountability.

4. Developing an enabling policy and institutional environment in the health sector while promoting an effective health dimension to social, economic, environmental and development policy

If it is clear that policies and practices within health systems may impact positively or negatively on health, it is also clear that policies and practices concerned with the broad spectrum of human development may also impact significantly on health status and health-seeking behaviors (Cooper Weil et al. 1990). A large-scale industrial project may, for example, create selective migratory movements that may result in accentuated health hazards, whether these are linked to inadequate working conditions, housing or social or cultural uprooting (Shenker 1992; ILO 1996). The association between enhanced vulnerability to HIV/AIDS among migrant laborers and economically motivated mobility in Africa and Asia provides one example (UNAIDS, IOM 1998). Similarly, factors such as the amount of pollution that industries have generated, or the impact that the use of pesticides in agriculture has had on the health of some populations, imply that health impacts must be considered at all stages of human development programs (McMichael 1993). From a health and human rights perspective, this requires attention to health impacts in the design of human development programs; this would include preventing or counterbalancing their potential negative health effects, as well as ensuring that health indicators are built into the monitoring of human development initiatives (WHO 1992; Watson et al. 1998).

The four strategic elements of health as briefly described above provide a useful framework for analyzing the interface between health and rights. Indeed, each of these elements involves governmental obligations that are relevant to policies and programs directly impacting on health, as well as those more broadly concerned with human development.

D. Health Development and Human Rights

While the above categorization of strategic directions for health is useful because it reflects the approach being taken by WHO and is guiding the current global health agenda, a perspective of governmental human rights obligations towards health development emerges more clearly if these strategies are divided into the following three domains:

1. The highest attainable standard of health. This is measured by morbidity, mortality and disability, by positive health measures of growth and development in children and by demographic variables, reproductive health, healthy lifestyles, behaviors and practices in adults. The focus here is on health outcomes affecting individuals and populations.
2. Access to health systems which provide affordable and quality preventive, curative and palliative care services and related social support. The focus here is on health systems.
3. A societal and physical environment conducive to health promotion and protection, including access to education, information and other positive expressions of rights necessary for health as well as protection from violence, environmental and occupational hazards, harmful traditional practices and other factors that may impact directly and negatively on health. The focus here is on the societal and environmental preconditions for health.

The development and application of governmental policies transcends all three of these domains of health development and is equally relevant to governmental responsibilities both to promote and protect health and to respect, protect and fulfill human rights (Roemer et al. 1990; UNDP 1998a). A systematic analysis of the responsibilities of governments for health, considered with respect to their obligations under international human rights law, begins to lead us towards the practice of health and human rights.

7. Recognizing the Reciprocal Impact of Health and Human Rights

There are two approaches to analyzing the relationship between health and human rights that help not only to illustrate their connection, but also to provide a framework for considering the implications of the health and human rights relationship for government responsibility and accountability (Mann et al. 1994). The first focuses consideration on the ways in which health policies, programs and practices can promote or violate rights in the ways they are designed or implemented. By design, neglect or ignorance, health policies, programs and practices in and of themselves can promote and protect or, conversely, restrict and violate human rights. The second approach examines how violations or lack of attention to human rights can have serious health consequences. The promotion, protection, restriction or violation of human rights all can be seen to have direct and indirect impacts on health and well being. Looking at health through a human rights lens means recognizing not only the technical and operational aspects of health interventions but also the civil, political, economic, social and cultural factors that surround them. These factors may include, for example, gender relations, religious beliefs, homophobia or racism, which individually and in synergy influence the extent to which individuals are able to access services or to make and effectuate free and informed decisions about their lives—and, therefore, the extent of their vulnerability to ill health. Thus, health and human rights interact in numerous ways, both direct and indirect (Ibid). Public health and human rights each recognize the ultimate responsibility of governments to create the enabling conditions necessary for people to make and effectuate choices, cope with changing patterns of vulnerability and keep themselves and their families healthy. Using human rights concepts, one can look at the extent to which governments are respecting, protecting and fulfilling their obligations for all rights—civil, political, economic, social and cultural—and how these government actions influence both the patterns of mortality, morbidity and disability within a population and what is done about them.

A. The Impact of Health Policies, Programs and Practices on Human Rights

A human rights framework can help to identify potential burdens on the lives of individuals and populations that are created by health policies, programs and practices. An obvious example, as was recognized in the ICPD Programme of Action, is demographic goal-driven family planning programs, which may by their very nature violate basic human rights (ICPD 1994). More subtle human rights issues may arise from health programs that fail to provide services to certain populations or are not appropriately tailored to meet the needs of marginalized groups (Jackson 1998; Altman 1998; Wodak 1998; Beyrer 1998; Stevens 1998).

Responsibilities for public health are in large measure carried out through policies and programs promulgated, implemented and, at the very least, supported by the state. Therefore, a human rights approach to public health requires analysis of every stage of the design, implementation and evaluation of health policies and programs. This section is intended to tease out some of the issues that a human rights analysis can raise at various stages of policy and program design and implementation. HIV/AIDS, sexual health and reproductive health will serve as primary examples in this section because, in recent years, these issues have been especially important in illuminating the impact that health policies and programs can have on human rights.

Human rights considerations arise at the initial formulation of health policies and programs. Relevant issues would be raised, for example, if a state decides to approach a health issue in a particular way but refuses to disclose the scientific basis of its decisions or permit any debate on its merits, or if a government willfully or neglectfully fails to consult with members of affected communities in reaching its decisions, or in any number of ways refuses to inform or involve the public in policy or program development. Human rights issues may also interact with the development of health policies and programs when prioritization of certain health issues is based less on actual need than on existing discrimination against certain population groups (Gilmore, 1996). This can occur when, for example, minor health issues that predominantly impact the dominant group are systematically given higher priority in research, resource allocation and policy and program development than other more major health problems. Restrictive laws and policies that deliberately focus on certain population groups without sufficient data, epidemiological and otherwise, to support their approach may raise an additional host of human rights concerns. Two examples might be policies concerning the involuntary sterilization of women from certain population groups that are justified as necessary for their health and well-being (Comite Latiamericano para la Defensa de los Derechos de la Mujer 1999; Lombardo 1996), and sodomy statutes criminalizing same-sex sexual behavior that are justified as necessary to prevent the spread of HIV/AIDS (UNHRC 1994).

Human rights also need to be considered when choosing which data are collected to determine the type and extent of health problems affecting a population, as this choice has a direct impact on the policies and programs that are designed and implemented (Zierler et al. 2000).The choice of issues to be assessed and the way in which a population is defined in these assessments are of primary relevance here (Braveman 1998). A state's failure to recognize or acknowledge health problems that particularly impact a marginalized group, or to consider the impacts of particular health issues on all members of a population, may not only violate the right to nondiscrimination, but may also lead to neglect of necessary services, which in turn may adversely affect the realization of other human rights (Cook 1994; Hendriks 1995; Miller et al. 1995). Examples of this would include the almost complete lack of attention and resources devoted to the early detection of cervical cancer by a number of governments, or state-controlled reproductive health programs that exist for some population groups but exclude certain marginalized communities from their consideration and outreach (WHO 1994b). Likewise, the scarcity or absence of HIV-related services in a number of places can well be understood to have resulted in a disproportionate burden of health consequences that could have been prevented or alleviated through simple and affordable prevention messages and methods of early diagnosis and treatment.

Once a decision is made that a particular health problem will be dealt with, human rights issues can come into play in both the articulation and the implementation of the health policy or program. Programs that provide contraception to young boys but deny access to young girls, with the stated rationale that access might prompt girls to be sexually active, illustrate this point (Radhakrishna et al. 1997; Youth Research 1998).

From a human rights perspective, this distinction can be understood to be treating young girls unfairly and unjustly on the basis of their sex. The prohibition of discrimination in the human rights documents does not mean that differences should not be acknowledged, but rather that different treatment must be based on reasonable and objective criteria (Cook 1992; Coliver 1995). Therefore, applying different approaches to girls and boys in policy and programs development must be based on a valid recognition of gender-related differentials in risk and vulnerability with respect to the particular health issue and with an attempt to minimize the influence of prescribed gender roles and cultural norms in making this determination (Holder 1992; Moody 1989).

The severity of the devastating tuberculosis epidemic in developing countries, and in marginalized communities in affluent nations, calls attention to the relevance of a human rights analysis for the implementation of a health policy and program (Raviglione et al. 1995; WHO 1999c). While the directly observed therapy strategy (DOTS) is widely recognized for its efficacy in controlling tuberculosis, the issues raised by the very different ways this strategy is administered in different countries, and to different population groups, demonstrates how discrimination may be relevant to the ways in which health programs are implemented (WHO 2000a). Many health practitioners argue that the speed with which tuberculosis is spreading and the potential impact of individual non-compliance to treatment are likely to aggravate both the spread of the disease and the currently observed prevalence of multiple-drug resistance (WHO 1998b). The DOTS strategy is meant to combat this by enrolling patients diagnosed with active tuberculosis in a program where drugs are administered under the direct observation of a care provider, rather than self-administered by the patient (WHO 1994a). The strategy requires frequent visits by patients to the site where drugs are administered, which can potentially involve work absenteeism and in some cases out-of pocket travel expenses. In small communities, the strategy may also lead to breaches of the right to privacy, as frequent visits to a treatment point may be associated with the stigma commonly attached to the disease. In cases of non-compliance to regular treatment administered in this way, measures up to and including mandatory hospital admission may be taken to motivate defaulting patients to comply. There is ample evidence to suggest, however, that in a number of places the level of coercion exercised by health practitioners in the decision to apply DOTS, as well as in the application of mandatory institutionalization, is directly associated with the levels of discrimination against particular population groups within the society in question (Farmer et al. 1991; Bayer et al. 1993; Schmidt 1994; Efferen 1997; Heymann et al. 1999).

Attention must also be given to whether health and social services take into account logistic, financial and socio-cultural barriers to access and enjoyment, as a failure to do so can result in discrimination in practice, if not in law (Focht-New 1996). This includes attention to the factors that may impact on service utilization, such as hours of service and accessibility via public transportation. Issues are also raised by decisions concerning the location of prevention and treatment services for certain health issues. An extreme example relates to the location of STD diagnosis, prevention and care services, which may be integrated into the reproductive health services generally available to women or else offered only in centers dedicated to STD prevention and treatment. Evidence suggests that individuals, and women in particular, are less likely to take advantage of STD services that operate under this latter designation for fear of stigma and discrimination within the community if they are seen at the facility (d'Cruz-Grote 1996; Weiss, Gupta 1993).

Laws and policies that may seem neutral on their face but neglect to sufficiently detail the steps necessary for their implementation may raise additional human rights issues. Illustrative of such a situation are laws and policies that mandate the reporting of HIV infection but fail to spell out the actors responsible for doing so, or fail to take into account a lack of infrastructure to ensure that privacy can be respected and that mechanisms for redress exist if breaches of confidentiality occur (Gruskin, Tarantola in press). Indeed, collecting personal information from individuals about their health status (e.g., HIV infection, cancer or genetic disorders), or behaviors (e.g., sexual orientation or the use of alcohol or other substances) has the potential for misuse by the state, whether directly or because this information is intentionally or inadvertently made available to others. In recent times the most explicit examples of the impact of misuse or neglect of privacy protections are found in the context of HIV/AIDS . Misuse of personal information related to HIV status has led to restrictions on the right to marry and found a family and the right to work and education, as well as, in extreme cases, limitations on freedom of movement, arbitrary detention or exile and even cruel, inhuman and degrading treatment. The release of information concerning a person's HIV status to others

has, in many places, led to loss of employment and housing, as well as harassment and verbal and physical attacks (R. Cohen, Wiseberg 1990; Gruskin et al. 1996; UNDP1998b).

Decisions on how data are collected have a direct influence on the policies and programs that are put into place. For example, differentials determined by sex or gender roles in relation to HIV/STD infection are generally not systematically considered in the collection and analysis of HIV/STD epidemiological data, nor are they sufficiently studied or built into the design of prevention and care programs. In countries where the HIV/AIDS pandemic has matured, some 15–16 year-old girls attending antenatal clinics for their first pregnancy are already infected with HIV, and no information is available as to the cause of this infection (i.e., whether it involved sex or another mode of transmission) (Tarantola, Gruskin 1998). The degree to which gender factors influence the relative risk of becoming infected through various routes of transmission during childhood, and how they may influence patterns of access to care and the quality of care provided to boys and girls once HIV infection has set in, remains unknown. There has been very little attention to the general failure to differentiate by sex in the collection and analysis of epidemiological information on "children" younger than 15. This raises a host of human rights concerns and may result in neglect of the very real differences between female and male adolescents in the prevention and care programs that do exist.

Violations of the right to information in the context of health policies and programs must be mentioned specifically, as these can have substantial health impacts (Freedman 1999). Examples include decisions by governments to withhold or block access to valid scientific information that would enable people to participate in the improvement of their health, avoid disease or claim and seek better care. Such is the case for young women who become unwillingly pregnant or acquire sexually transmitted diseases because they are denied information considered too sexually explicit for them—even though they became pregnant or infected because they were in fact sexually active (Alan Guttmacher Institute 1998; Dowsett, Aggelton 1999).

The health and human rights approach requires determining whether health policies, programs and practices are valid from both a public health and a human rights perspective. The first step in this analysis will always be to determine the stated justification for the measure—and then to consider the framework set forth in the "Siracusa Principles" mentioned earlier (UNECOSOC 1985). In analyzing health policies and programs, as Jonathan Mann was fond of saying: "Assume all health policies and programs are discriminatory or restrictive of rights until proven otherwise."

B. The Impact of Neglect of Violations of Human Rights on Health

When health is understood to include physical, mental and social well being, it seems reasonable to conclude that the violation or neglect of any human right will impact adversely on health. While this is certainly true with respect to specific rights, such as nondiscrimination or education, the impact of neglect or violation of rights is also compounded by the number of rights brought into question by any particular situation. The health impacts of certain severe human rights violations, such as torture, imprisonment under inhumane conditions, summary executions and disappearances have long been understood. Much work has been done in this field, and efforts in this regard continue to expand. Such efforts include exhumations of mass graves to ascertain how people have died and in what ways, the coding and matching of genetic information to reunite families separated during war and massive political repression, examination of torture victims to bring perpetrators to justice and to assist with asylum claims, and entry into prisons and other state-run institutions, such as detention centers, to assess health conditions and the health status of confined populations. The impacts on health of these human rights violations can be both obvious and subtle. For example, torture is a violation that causes immediate and direct harm to health. Yet only recently has the full impact of torture begun to be recognized, including the lifelong injury to the victim, the effects on the health of families and of entire communities and the transgenerational damage (AI 1983). There is increasing recognition of the need to assess the duration and extent of the health impacts of such human rights violations, including the direct and immediate impact of being subjected to torture oneself, but also its severe and life-long effects on survivors and the trauma associated with being forced to witness summary executions, rape and other forms of torture and trauma perpetrated on others (Dawes 1990).

Health practitioners can—and in most cases do—have a strong positive influence on the promotion and protection of human rights within the populations they serve. Yet violations of human rights perpetrated by

50

health professionals regularly occur. These include not only such egregious examples as physician participation in torture and other severe violations of human rights, but also actions in the provision of treatment and care. For example, when care providers make decisions concerning patient access to available prevention services, children with a chronic fatal disease or disability may be denied immunization against measles and other preventable childhood infections (UN 1998b; Savage 1998; Ward, Myers 1999). In many countries, rich and poor, patients with diabetes, carcinoma, chronic renal syndrome, mental disability, hemophilia or other severe health conditions may receive a lower standard of care than others not only with respect to the health issue in question but in general because their possibility of cure is regarded as limited (UN1992b; Crofts et al. 1997).

A less obvious impact of neglect of human rights on health concerns the many children from poor or marginalized communities, where poor nutrition and ill-health prevail, that have a below-average school enrollment and attendance rate and, as a result, lower-than-average educational attainment (Brundtland 1999). The deprivation of these children from access to basic health services, coupled with the imposition of school fees, leads to a limitation of their ability to exercise their right to education, producing lifelong effects on their health and well-being.

In addition to the impact of egregious violations of rights on health, the more subtle effects of neglect or violations of rights on health can also be considered. These would include exposures to ill health resulting from violations of such rights as work, free movement, association and participation (Daniels et al. 1990; Berlinguer et al. 1996). The impact of neglect or violation of factors considered to form the underlying preconditions for health must also be considered. In addition to medical services, these have been understood to include such factors as adequate housing, education, food, safe drinking water, sanitation, information and protection against discrimination. Understood in human rights terms, neglect of these rights, particularly in combination, can have serious negative consequences on health (Mann et al. 1994). No community is fully protected from neglect or violation of rights and its detrimental consequences to individual and public health (UN 1999a, b; Center for Economic and Social Rights 1999). In particular, gender-based discrimination poses a pervasive threat to health. Girls and women who are denied access to education, information and various forms of economic, social and political participation are particularly vulnerable to the impact of discrimination on their health. This is true when discrimination is recognized, tolerated, acknowledged or even condoned by governments, but also when it remains insidiously hidden or deliberately ignored behind an accepted status quo (Sullivan 1995; Dixon-Mueller 1990).

One example, drawn from the world of reproductive health, dramatically illustrates this point. There is now general acknowledgement that violations of human rights, including systematic gender discrimination, create an environment of increased risk in relation to women's health (Cook 1995; Berer 1999). In this context, it is necessary to consider those factors that are understood to influence directly the reproductive health of women. Access to information, education and quality services is critical, as are services adequately targeted to respond to the needs of women of different ages and from different communities. Underlying all of this is the impact that gender roles and gender discrimination have on both health status and service delivery (Doyal 1995; WHO 1998a). The relevance of human rights to this analysis becomes clear when considering the gaps and inequalities in services and structures in relation to the social roles that construct male and female identity. Equally important is how these factors play out at the policy and program level in terms of reproductive health research, policy, financing and service delivery. Traditional public health focused on the need for information, education, contraception, counseling and access to quality services. These elements of health practice were, and still are, central to improving women's reproductive health. However, even if these services are available, an individual woman has to be able to decide when and how she is going to access these services. This implies that she has to have the ability to control and make decisions about her life.

In the above example, considering the impact that violation or neglect of human rights has on health highlights the societal context that would hinder or empower an individual woman's ability to make and effectuate the free and informed choices necessary for her reproductive health. From a broader policy and program perspective, this insight reveals that linking the human rights framework to health implies recognizing that individual health is largely influenced by one's environment. This means that the integration of human rights in the design, implementation and evaluation of health policies and programs is necessary

not only because of a government's human rights obligations, but also in purely pragmatic public health terms. Thus, attention to the civil, political, economic, social and cultural factors that are relevant to a person's life, such as gender relations, racism or homophobia, and the ways this combination of factors projects itself into who gets ill and what is done about it, is central to sound health and human rights practice.

Because of the multifarious effects on health of human rights neglect or violations, the process of documenting evidence on the health impacts resulting from violations or neglect of human rights must be thorough and thoughtful. The involvement of communities that are disproportionately affected by human right violations in the development, implementation and monitoring of decisions affecting them is crucial to mitigating these impacts. Affected individuals working together in defense or advocacy groups—be they concerned with breast cancer, diabetes, renal syndromes, hemophilia, chronic disabilities or other health issues—have been effective in bringing to light some of the more subtle mechanisms that come into play in linking health status with the human right violations to which people are subjected (Steingraber 1997; UNAIDS 1999).

8. Optimizing Health and Human Rights in Practice

A crucial step in optimizing the relationship between health and human rights is to conduct a systematic review of how and to what extent governmental policies and programs are respectful of human rights and of benefit to public health. Such a review, presented below in Box 2, is proposed as a critical first step in improving new and existing policies and programs through assessment of their validity, applicability and soundness, while addressing their practical implications from both human rights and public health perspectives. The suggested questions can be used by policymakers and public health and other government officials to help in the development, implementation and evaluation of more effective policies and programs, and by non-governmental organizations and other concerned actors as an advocacy tool to hold governments accountable for the ways they are and are not in compliance with their international legal obligations to promote and protect both public health and human rights.

Box 2. Issues to be Addressed in Assessing Policies and Programs

The following questions may serve as a starting point to help guide this analysis:

- *What is the specific intended purpose of the policy or program?*
- *What are the ways and the extent to which the policy or program may impact positively and negatively on health?*
- *Using the relevant international human rights documents, what and whose rights are impacted positively and negatively by the policy or the program?*
- *Does the policy or program necessitate the restriction of human rights?*
- *If so, have the criteria/preconditions to restrict rights been met?*
- *Are the health and other relevant structures and services capable of effectively implementing the policy or program?*
- *What system of monitoring, evaluation, accountability and redress exist to ensure that the policy or program is progressing towards the intended effect and that adverse effects can be acted upon?* (Gruskin, Tarantola, in press)

The importance of the human rights framework to policies and programs is that it can provide a method of analysis and a framework for action, which can then be used to help shape specific interventions aimed at reducing the impact of health conditions on the lives of individuals and populations. This approach requires working with the international human rights documents to determine the specific rights applicable to a given situation, and then considering how and to what extent morbidity, mortality, disability, risk behaviors and vulnerability to ill-health are caused or exacerbated by insufficient realization of human rights. This analysis will be most effective if done in partnership with people with substantive knowledge of human rights.

A second level of analysis can be created by recognizing the convergence of the three health domains described in Section VI (health outcome, health systems and underlying conditions for health) with the three levels of governmental obligations that exist for each right—respect, protect and fulfill. (Figure 1) Health practitioners will find this table most relevant to their work if they use the suggested health domains (first column) as their entry point and then move to the right, seeking to identify how each level of governmental obligation can influence health policies and action within each of the three domains. Ultimately, such an analysis could be extended to examine how those approaches recognized as best health practice in each of the three domains could contribute to the advancement of human rights with respect to each level of governmental obligation. The issues raised in the boxes below are not meant to be highly detailed, but simply to serve as examples of the issues this approach brings to light.

Figure 1. A Pathway to Health and Human Rights[13]

Domains of health	Governmental obligations With respect to human rights		
	Respect	**Protect**	**Fulfill**
1. Health outcome	• Government not to violate rights of people on the basis of their health status including in information collection and analysis, as well as in the design and provision of health and other services.	• Government to prevent non state actors (including private health care structures and insurance providers) from violating the rights of people on the basis of their health status including in the provision of health and other services.	• Government to take administrative, legislative, judicial and other measures to promote and protect the rights of people regardless of their health status, including the generation of data concerning health outcomes for use in guiding health policies and the provision of health and other services, as well as providing legal means of redress that people know about and can access.

[13] Adapted from Tarantola, D., Gruskin, S. (1998). Children confronting HIV/AIDS: charting the confluence of rights and health. *Health and Human Rights*, 3(1), 60-86.

2. Health systems	• Government not to violate rights directly in the design, implementation and evaluation of national health systems, including ensuring that they are sufficiently accessible, efficient, affordable and of good quality for all members of the population.	• Government to prevent non-state actors (including private health care structures and insurance providers) from violating rights in the design, implementation and evaluation of health systems and structures, including ensuring that they are sufficiently accessible, efficient, affordable and of good quality	• Government to take administrative, legislative, judicial and other measures including sufficient resource allocation and the building of safety nets, to ensure that health systems are sufficiently accessible, efficient, affordable and of good quality, as well as providing legal means of redress that people know about and can access.
3. Societal and environmental preconditions	• Government not to violate the civil, political, economic, social and cultural rights of people directly, recognizing that neglect or violations of rights impact directly on health.	• Government to prevent rights violations by non-state actors, recognizing that neglect or violations of rights impact directly on health	• Government to take all possible administrative, legislative, judicial and other measures, including the promotion of human development mechanisms, towards the promotion and protection of human rights, as well as providing legal means of redress that people know about and can access.

The questions proposed in Box 2 may be used to create an agenda for action to help guide the analysis of governmental obligations for health outcomes, health systems and the societal preconditions for health proposed in Figure 1. Human resource development in support of health requires that health training include the skills necessary to document and measure the health effects of neglect or violations of rights. Education and training of people working in human rights should likewise provide them with the skills necessary to analyze the complex relations between neglect or violation of rights and their health impact, in such a way that the information provided can be used to monitor and ensure government accountability. This joint approach is necessary if the health and human rights framework is to be practical and useful. Only when the many dimensions necessary for health are described, measured and named in human rights terms can the full extent of the relationship between health and human rights be realized. Such a review offers a critical approach to assessing the validity, applicability and soundness of new and existing policies and programs, and to addressing their practical implications from both human rights and public health perspectives. Through

this approach, the disciplines of health and of human rights come together most visibly, and national capacity building to ensure reasoned and sound analysis becomes a necessity.

Another dimension of developing the health and human rights relationship is the application of mechanisms, methods and tools to monitor progress and shortcomings in implementation of health and human rights at the national and international level. An earlier section described the role of treaty bodies in engaging in dialogue with governments on their degree of compliance with their international legal obligations. WHO, for its part, is developing monitoring methods and indicators that, although technically not binding on governments (with the exceptions of reporting under the International Health Regulations), set out international norms by which member states commit to abide in principle after passage at the World Health Assembly. In the past, WHO's attempts to measure health on the national or international level selectively used morbidity, mortality and disability indicators. This exercise was severely constrained by incomplete national data, differences in measurement methods across countries and, even more importantly, an inability to relate health outcomes to the performance of health systems. Furthermore, most of these indicators were applied at a national, aggregate level with insufficient attempts to disaggregate the data collected to reveal the disparities that exist within nations. It has been understood that measurement indicators and benchmarks that focus on the aggregate (national) level may not reveal important differentials that may be associated with a variety of human rights violations—in particular, discrimination.

In order to improve the knowledge and understanding of health status and trends, and to relate these trends to health system performance, WHO has developed the following five global indicators (WHO 2000b):

1. Healthy life expectancy: a composite indicator incorporating mortality, morbidity and disability in a disability-adjusted life years measure. This indicator will reflect time spent in a state of less-than-full health.
2. Health inequalities: the degree of disparity in healthy life expectancy within the population.
3. Responsiveness of health systems: a composite indicator reflecting the protection of dignity and confidentiality in and by health systems, and people's autonomy (i.e. their individual capacity to effect informed choice in health matters).
4. Responsiveness inequality: the disparity in responsiveness within health systems, bringing out issues of low efficiency, neglect and discrimination.
5. Fairness in financing: measured by the level of health financing contribution of households.

WHO has stated that it will collect this data through built-in health information systems, demographic and health surveys (DHS) conducted periodically in countries and other survey instruments. Data will thus be analyzable by sex, age, race/birth (if warranted under national law), population groups (e.g., indigenous populations), educational achievement and other variables.

WHO has also expressed its commitment to working with countries towards increasing their capacity to collect the above information and, additionally, to determine additional data and targets that may be specifically suited to country-specific situations and needs. WHO and other institutions concerned with health have stated their desire to use these data to assess trends in the performance of national health systems, inform national and international policies and programs, make comparisons across countries and monitor global health. This process is also intended to support the development of national benchmarks whereby targets will be set by individual governments with a view towards being able to compare their own health system performance with others, and to compare among regions and over time. These benchmarks will be chosen according to each country's set of health priorities and information needs (Ibid).

The global indicators now being tested by WHO, as well as its current efforts to enhance the capacity of member states to monitor their health performances, appear to be in line with human rights principles. These developments, coupled with the increasing attention to health by the bodies responsible for monitoring governmental compliance with their human rights obligations, are promising steps for the future development and application of the health and human rights framework.

9. Conclusion

This chapter has outlined the health and human rights framework as a pathway towards enhancing the value and impact of health work by health policy makers, program developers, practitioners, and students. It is hoped that increased attention to this fundamental relationship can open new avenues to human development, and by so doing, marshal new resources towards improving individual and population health. Keeping in mind the tools proposed in the previous section, there are three levels on which this new synergy can be recognized, applied and monitored. The first concerns the development of adequate monitoring tools reflecting both health and human rights concerns; the second, the application of the health and human rights framework to health practice; and the third, the creation of a significant research agenda to advance our collective understanding of the health and human rights relationship.

First, on the level of health best practice and international human rights law, evidence-based health policy and program development can be guided by a systematic human rights analysis. This process involves significant efforts to ensure that the information that is sought, collected and analyzed brings attention to both trends and disparities, and that this information is used to address these gaps. This would include attention to the relative successes and failures of progress achieved towards global goals, such as those to which countries have subscribed in such forums as the World Health Assembly or through the international conference processes.

It is of critical importance that WHO and the human rights treaty bodies are currently and simultaneously engaged both in the process of setting out global indicators and in defining approaches towards the development of country-specific benchmarks consistent with international knowledge, practice and experience. The prevailing state of health and resource availability within individual countries must, nonetheless, be taken into account to allow trends and disparities to be measured in relation to individual benchmarks. While the existence of this work is encouraging, there is a need to further develop, test and apply indicators that capture the disparities that may prevail within a population, as well as those that can begin to suggest the differences between government unwillingness and incapacity. Relevant indicators have been developed in the economics field, where the Gini coefficient, for example, is used as a measure of economic heterogeneity within a population (Kennedy et al. 1998). Disaggregation of data would allow the attributes on which discrimination is often based, including sex, age, prior health status, disability, birth or social status, to be taken into account. Policies and programs could then aim to advance the health of populations by setting out higher goals for the population as a whole, while bringing increased attention to reducing the gaps between those who enjoy better health and better services and those who, for political, civil, economic, social or cultural reasons, are more vulnerable to ill-health and to inadequate services and structures.

The second level on which health and human rights are beginning to converge is in ensuring that health systems and practice are sufficiently informed by human rights norms and standards. Sound formulation and implementation of health policies and programs must seek to achieve the optimal balance between the promotion and protection of public health and the promotion and protection of human rights and dignity. Processes to arrive at this optimal balance can be built within national systems on the basis of the approach proposed in the previous section, incorporating evidence collected in the ways suggested above and through participatory dialogues between decision-makers with expertise in public health, those with expertise in human rights and concerned populations. The realization of such an approach requires additional efforts to create consultative mechanisms, as well as education and training in health and human rights.

Finally, the third level of convergence between health and human rights lies in the broad need for further research. Given that human rights are established, internationally agreed-upon norms to which states have subscribed, the reciprocal impacts between human rights and health must be further researched and documented. There is a national and international obligation to increase research and documentation, as well as to conceptualize and implement policies and programs that fully take these connections into account. The utility of this research will largely be predicated on the extent to which those with expertise in health collaborate with people knowledgeable about human rights in the conceptualization of their research agendas and in the steps necessary for carrying this work forward.

The challenges posed in linking health with human rights are immense. There is, however, increasing evidence that public health efforts that respect, protect and fulfill human rights are more likely to succeed in public health terms than those that neglect or violate rights. National and international policy and decision-makers, health professionals and the public at large all, to varying degrees, understand the fundamental linkages between health and human rights, and the way in which those linkages can provide new ways to analyze and conceive responses to health issues. To move the work of health and human rights forward will require building and strengthening the information and education available about human rights concepts and procedures. It will also require information exchange and stronger cooperation between those working on health and those working on human rights. When people are sufficiently knowledgeable about human rights, they will be able to identify the issues for which the synergy of human rights and health is critical, and to act accordingly. Human rights and health are progressing, in parallel, towards a common goal that will never be fully realized. Yet, together, they project a vision and an approach that may fundamentally and positively improve the lives of people everywhere in the world.

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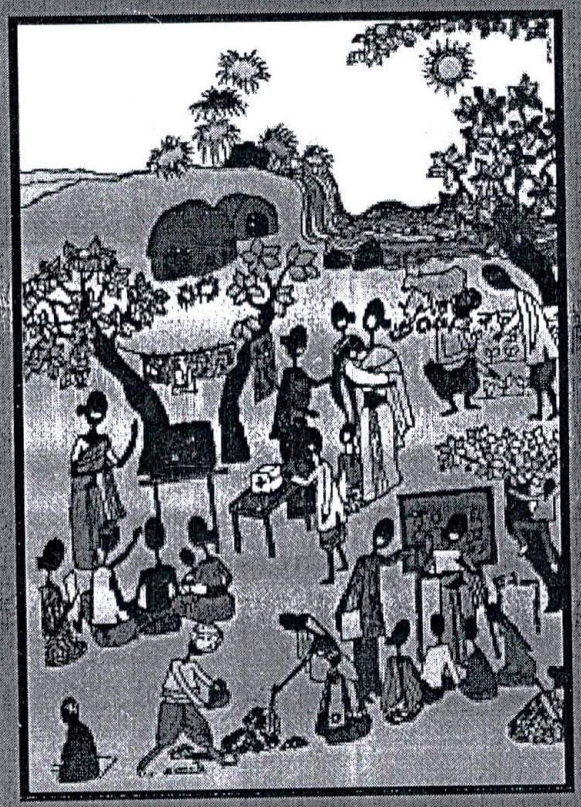
Session 2 Understanding the political economy of health and Social Determinants of Health

People's Health Assembly

background papers



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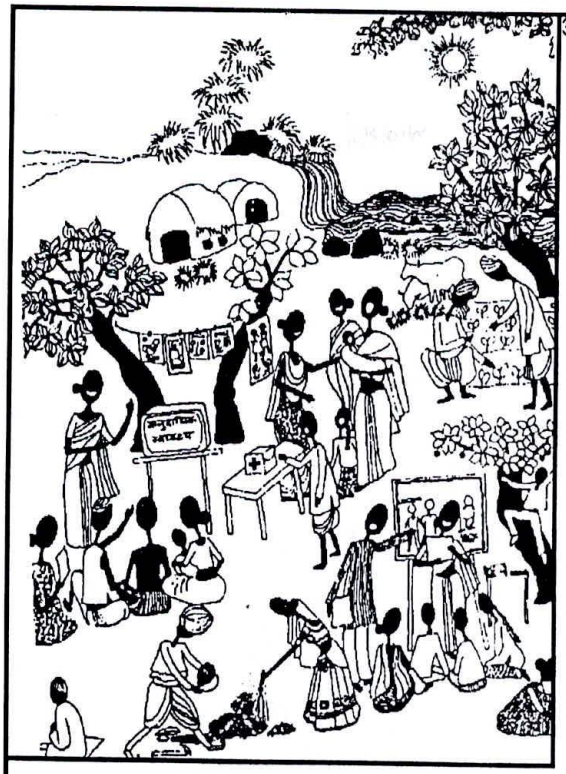

Cover picture taken from *Health for the Millions, Sept-Oct, Nov-Dec 1997*

Layout and design by *Janet-Maychin*

Table of Contents

PHA BACKGROUND PAPERS

These are five background discussion papers for the People's Health Assembly. The papers are draft versions. We would like you to discuss the papers, suggest additions or changes, and identify points where you may disagree. We would also like you to use the papers as a starting point for the identification of your own stories and case studies that you think illustrate some of the issues brought up (or others that you come to think about!).

At the end of the paper you will find a list of action points. Please add to this list, which we will use as an input for the *People's Charter for Health* which is currently being formulated.

Please submit your comments, stories and suggestions for action to the analytical drafting group coordinator Nadine Gasman, Fuente de Emperador 28, Tecamachalco C.P. 53950, Estado de México. MEXICO. Tel: 52-52-510283, Fax: 52-52-512518, e-mail: gasmanna@netmex.com If you have acccess to the internet, you should be able to find other PHA papers and the People's Charter for Health primer on the address www.pha2000.org.

For more information on the People's Health Assembly, please contact:
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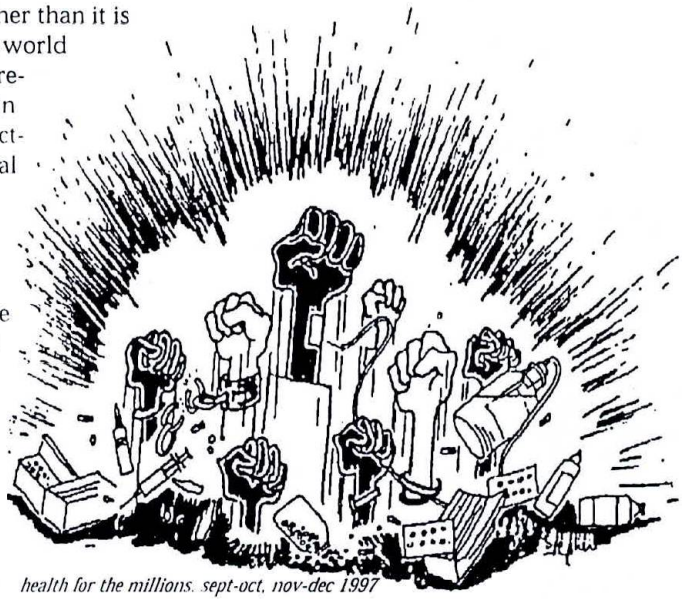
1 The Political Economy of the Assault on Health

by Mohan Rao and Rene Loewenson

Executive Summary

The world has never before been richer than it is today. Yet large populations of the world find themselves without adequate resources to provide for basic needs to remain healthy. While health indices like life expectancy has increased, and mortality in general and infant mortality rates in particular have decreased on average, the rates of improvement in these indices have declined in the last two decades. Indeed in many countries across the globe, there have been increases in levels of infant and child mortality even as life expectancy has declined.



health for the millions. sept-oct, nov-dec 1997

Inequalities between and within countries have widened sharply. While a small proportion of the world's population is becoming increasingly wealthier, unemployment, loss of assets and deprivation are increasing in a widening share of the world's communities, including the poor in rich countries.

These changes, moulding health and guiding health policy, are consequences of the manner in which structures of ownership, production and distribution of the world's wealth have been systematically changed over the last two decades. This paper traces some of the influences and factors which together have shaped policies across the world, drawing attention to the manner in which they impinge upon health and affect health services.

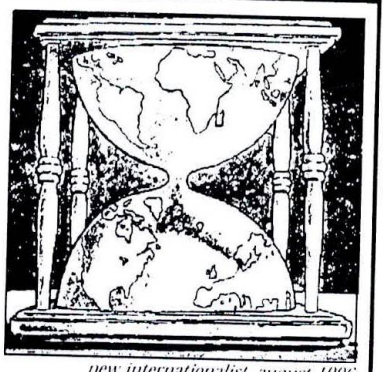
Economic policies around the world are being shaped by international financial institutions, in particular the International Monetary Fund (IMF) and the World Bank (WB). These neo-liberal policies are characterised by reducing the role of the state and increasing that of market forces. Globalistion, privatisation and liberalisation form the heart of this package of policies.

Third World countries indebted to international financial institutions are pressurised to implement the set of policies under the Structural Adjustment Programme (SAP). SAP policies applied in a uniform manner across the globe has increased indebtedness of these countries and accelerated the transfer of resources from poor communities and nations to rich ones. They have also had profound social consequences. They have led to the collapse of weak and under-funded systems of public health even as they increased levels of hunger and poverty, and thus diseases.

These SAP policies have also had profound political consequences as nation states implementing these policies have been weakened. At the same time multinational corporations (MNCs) have become increasingly powerful, controlling an increasing share of global resources. The free flow of speculative finance across borders in search of quick profits, have left a trail of devastation in people's lives.

In order to reclaim people's health it is necessary to address these wider issues of disempowerment, address issues of equity and participatory democracy, and for rebuilding national priorities with a focus on the needs of the majority of the population.

In 1960, the 20% of the world's people living in the richest countries had 30 times the income of the poorest 20%. Now they command 74 times more. The richest 20% of the world's population command 86% of the world GDP while the poorest 20% command merely 1%. More than 80 countries now have per capita incomes lower than they had a decade ago; 55 countries, mostly in sub-Saharan Africa, Eastern Europe and the Commonwealth of Independent States (CIS), have had declining per capita incomes.



new internationalist, august 1996

Although the world today is richer than ever before, nearly 1.3 billion people live on less than a dollar a day and close to 1 billion cannot meet their basic consumption requirements. More than 800 million people lack access to health services, and 2.6 billion to basic sanitation. Although people are living much longer today, around 1.5 billion are not expected to survive to age 60. Indeed life expectancy in some countries of sub-Saharan Africa is only around 40 years.

Despite population growth, per capita food production increased by nearly 25% between 1990 and 1997. But the overall consumption of the richest fifth of the world's people is 160 times that of the poorest fifth. 840 million people are undernourished, including 160 million children. Close to 340 million women are not expected to survive to age 40.

Introduction

The world has never before been richer than it is today. Yet large populations of the world find themselves without adequate resources to ensure good health. Despite the unprecedented advances in medical technology, around 800 million people lack access to appropriate and affordable health services. While life expectancy has increased—and mortality in general and infant mortality rates in particular—have decreased in most countries, the rates of improvement in these indices have declined in the last two decades. Indeed, in some countries, there has been an increase in levels of infant and child mortality. In other words, the increased opportunities for health have been distributed highly unequally around the world.

Inequalities between and within countries have been widening to levels seldom before witnessed. Unemployment, landlessness, loss of assets, and deprivation are increasing in a widening share of the world's communities. At the same time poverty has spread even within rich countries. Together, these factors profoundly affect the health of large sections of the population of the world.

Such factors are not an accident, but the consequence of the way in which structures of ownership, production and distribution of the world's wealth have been systematically changed over the last two decades. This paper briefly attempts to delineate some of these changes while drawing attention to the manner in which they impinge upon health and influence health services organisation.

A recent history of economic policies

Towards the end of the 1970s the long boom of post-war economic growth ground to a halt. Economists hesitated to use the term 'depression' to describe this phenomenon since it brought back memories of the 1930s, a period that had plunged the world into the horrors of fascism and the 2nd World War, but the 'recession' of the 1980s was similarly widespread and deep. These changes took place together with the collapse of the Soviet Union and the state-controlled economies of the socialist world. They also led to a reshaping of the capitalist world, particularly the pursuit of market policies and the opening of countries to transnational corporations (TNCs) through a complex of changes known as globalisation, privatisation and liberalisation.

The debt crisis

In the 1970s—and particularly following the rush of deposits in the wake of the oil-price increase—private Western banks encouraged countries in the Third World to borrow extensively to finance large-scale development projects. Indeed, so acute were the problems of uninvested capital that the banks resorted to bribing politicians and influential officials in the Third World to make commitments towards these projects, many of which were otherwise unviable. The projected returns failed to materialise, however, interest rates rose sharply. By the early 1980s, large num-

ethical consumer, june 1996

bers of now heavily indebted countries were unable to pay back their loans.

It was at this point that the International Monetary Fund (IMF) stepped in to bail out the Northern banks by offering loans to the indebted countries. The loans were primarily aimed at preventing the collapse of the private banks; they also served to involve the borrowing countries in a new framework of regulations in the economy, ostensibly aimed at improving their efficiency and competitiveness in the world market.[1] Thus the restructuring of Third World economies to ensure debt repayment began to drive economic policy.

Neoliberalism

Over the same period, right-wing economic policies took centre-stage in the USA and the UK. These policies, described variously as Reagonomics, Thatcherism or monetarism, reflected an ideological commitment to unbridled market principles, ignoring the remarkable role in these countries of state-directed economies. One of the significant lessons of post-war economic growth had been the singular role that the state could play, and indeed needed to play, in capitalist countries in order to avoid recurrent periods of crisis due to falling demand. For instance, state involvement in public health had been at the heart of the strategy to stabilise the economies, in a move to help capital growth and technological change. In the new environment of the 1980s, these policies (Keynesian) came under systematic attack from neo-liberal economists.

Reducing the role of the state and increasing that of market forces, irrespective of their social and long-term economic costs, were at the centre of the new model of economic growth. This was accompanied by the triumph of the ideology of individualism, competitive wealth-seeking and conspicuous consumption. Along with the decrease of community values has become the undermining of public initiatives and institutions, especially those that serve and protect the interests of the poor. In this ideology, public intervention and institutions are necessarily inefficient and wasteful, and markets the best way to both economic growth and overall development. Economic growth, it was maintained despite extensive evidence to the contrary, would trickle down to the less fortunate and thus result in overall development.

The contradiction between the prescription to the third world and the economic success stories

'The great post-war economic success stories of capitalist countries, with the rarest exceptions (Hong Kong), are stories of industrialisation-backed, supervised, steered, and sometimes planned processes managed by governments: from France and Spain in Europe to Japan, Singapore and South Korea. At the same time, the political commitment of governments to full employment and—to a lesser extent—to the lessening of economic inequality through, a commitment to welfare and social security explains part of the success[4]

'The greatest of neo-liberal regimes, President Reagan's in the USA, though officially devoted to fiscal conservatism and "monetarism", in fact used Keynesian methods to spend its way out of the depression of 1979–82 by running up a gigantic deficit and engaging in equally gigantic armaments build-up. So far from leaving the value of the dollar entirely to monetary rectitude and the market, Washington after 1984 returned to deliberate management.' [5]

Structural Adjustment Programmes (SAP)

At the height of her economic and political power in the new unipolar world, the USA— assisted by the Bretton Woods institutions (World Bank and International Monetary Fund)—found a way out of the impasse of falling rates of profit and increasing unemployment by opening-up potential markets in Third World countries.

The debt situation of these countries became the vehicle for introducing a set of policies brought together under the rubric of structural adjustment programmes (SAPs). Future loans from international financial institutions and access to other donor funds and to markets, became henceforth linked to accepting this broad package of macro-economic policies.

The structural adjustment programme (SAP) package comprises essentially the following measures:

- trade liberalisation removing the protection to local industry;
- reduction of import-export-tariffs;
- deregulation of the economy with fewer or no controls on foreign investments;
- abolition of price controls;
- removing the protective barriers to outflow of funds;
- cuts in government spending including funding of social sectors;
- devaluation of currencies to achieve export competitiveness;
- deregulation of labour laws and retrenchment of workers;
- cuts or removal of social subsidies; and
- public sector enterprise 'reform' typically through privatisation

It was believed that by adopting this package of policies, indebted countries would not only attract foreign investments but would also be in a position to pay for them by increasing their exports of primary commodities. The free flow of funds across borders, it was believed, would facilitate this process. At the same time, removing public subsidies and cutting public spending would enable indebted countries to mobilise larger funds for investment. Providing a stimulus to the private sector by loosening regulations and controls would provide the necessary stimulus to this sector to act as the engine of economic growth.

SAP, liberalisation and privatisation measures were applied in a uniform manner across three continents, beginning with Latin America and Africa in the early 1980s and in Asia in the late 1980s.

In the agricultural sector this led to a reinforcement of colonial patterns of agricultural production, stimulating the growth of export-oriented crops and reducing the production of food crops. The problem at the heart of this pattern of production was that it reinforced the pre-existing international division of labour and that it was implemented when the prices of primary commodities exported by Third World countries were low as never before. The more successful the countries were in increasing the volume of exports, in competition with other Third World countries exporting similar products, the less successful they were in raising foreign exchange to finance their imports. Thus many countries shifted backwards into being exporters of unprocessed raw materials and importers of manufactured goods, in keeping with the saying 'produce what you don't consume and consume what you don't produce'. Indeed as the range of products consumed by households in the South shrank, the acronym SAP increasingly came to be given new meanings: 'See And Pass' or 'Suffer And Perish'.

In the industrial sector, where the countries had been striving to break out of colonial patterns of dependent development, the withdrawal of state support plunged many enterprises into crisis. Such units were then allowed to close or were privatised or handed over to TNCs, typically with significant losses in employment. Just as the state reduced its commitment to critical sectors such as education and health, so also the free flow of capital across borders in search of labour, raw materials and markets weakened the state. Further, over this period, capital across the globe was increasingly being concentrated in fewer and fewer hands with an explosion of mergers and acquisitions.

Together these policies and processes increased indebtedness, increased the rate of exploitation of low-income communities across all countries, and shifted wealth from productive to speculative financial sectors where boom and bust became the order of the day. Many countries opened export-processing zones (EPZs) to attract foreign investment, driving down their own labour costs and forgoing tax revenues. Usually exempt from national labour laws, EPZs employed women in low-paid jobs, while tax concessions made it difficult for national governments to meet the long-term social costs of production incurred in these zones. Thus these policies also led to a significant increase in casual, poorly-paid and insecure forms of employment, and led to the collapse of already weak and underfunded sys-

tems of health, education and food security. They increased poverty in already poor countries even as a few people became richer and the middle and upper classes obtained access to consumer products manufactured in the rich countries.

Changes in food prices induced by SAP: Bolivia 1975 and 1984		
Food item	Hours worked to purchase 1,000 calories in	
	1975	1984
Barley	0.07	0.59
Sugar	0.16	0.40
Corn	0.17	0.64
Wheat flour	0.21	0.52
Dried beans	0.22	3.47
Rice	0.22	0.48
Bread	0.28	0.51
Oil	0.28	0.51
Dried peas	0.29	1.38
Potatoes	0.76	2.35
Onions	1.02	3.22
Powdered milk	1.05	3.95

Source: Susan George, A Fate Worse Than Debt : The World Financial Crisis and the Poor , PIRG, New Delhi, 1990, p.152

One consequence of these processes has been commonly described as the feminisation of poverty, as females increasingly had to strive to hold families together in various ways. More women entered the paid labour force, typically at lower wages and with inferior working conditions than men. Simultaneously, the extent of unpaid labour in households (predominantly performed by women) increased as public provision of basic goods and services declined. Young children, especially girls, were increasingly withdrawn from school to join the vast and underpaid labour market or to assist in running the household. The involvement of children and adolescents in crime and delinquency increased under these circumstances. Rising food prices meant that an increasing proportion of families were pushed under the poverty line, and women and girl children were disproportionately affected. Morbidity levels increased even as poor people were increasingly unable to access health institutions, which, under the reform measures, typically introduced payment for services. Given increasing levels of malnutrition, it is not surprising that infant and child mortality rates, which had hitherto shown a decline, either stagnated or in fact increased in a number of poor communities.

The growth promised by the initiation of SAP measures was particularly not achieved in Africa, which has shown reduced economic growth for more than two decades now. Per capita income for sub-Saharan Africa as a whole is lower than it was in 1960. It is thus not surprising that these last two decades are often described as lost decades for these countries.

Concentration of power

Global changes in production technologies and in the organisation of production have also taken place, with fewer and fewer corporations controlling such critical sectors as information, energy, transport and communication; this process has been described as transnationalisation. Multinational corporations were increasingly becoming transnational in their operations, spreading different components of their manufacturing processes to different countries where resources and conditions for their operations were optimal. Thus, around 100 TNCs control 33% of the world's productive assets, account for one- third of world production and employ only 5% of the global workforce. At the same time, the state sector in Third World countries, which was the only sector large enough to enable investment for wider development, has been pushed into a much less significant role. Such measures as the sale of public assets (often to TNCs), and fiscal policies that combined decreasing taxation of the richer segments of the population with decreasing subsidies to weaker segments, essentially meant a widening of income disparities. It is not surprising that income inequalities within countries have significantly increased.

Reduced public sector spending to enable debt repayment also meant that states could no longer play a critical role in maintaining measures for equitable development that they had in many cases initiated. Thus the package of SAP measures led to the collapse of the models of self-sufficient

import-substituting industrialisation that many of them had established in the immediate postcolonial years. The essential feature of this past was that socio-economic development in these countries was based on their being exporters of cheap primary commodities and importers of finished manufacturedg goods.

Many SAP-implementing countries fell from their initial debt into the debt trap wherein they had to take increasing loans merely to pay back the interest on their earlier loans. Since they now received less for the raw materials they exported, they were forced to undertake repeated devaluation and thus paid more for imported products. They became caught in a vicious cycle of low capital for initiating development, borrowing, devaluation, and less capital. Furthermore, the net flow of resources from the countries of the South to those of the North substantially increased. UNICEF, for instance, estimates that this outflow now amounts to 60 billion dollars annually. In Although these neoliberal policies have often been described as a neocolonialization, influential sectors in Third World countries have expressed their support for them. These sectors, which benefited disproportionately from postcolonial development in the 1950s and 1960s, have given up ideas of national self-sufficiency, independence and sovereignty, which guided them before. They now intent to reap the benefits as junior partners to foreign capital in search of quick profits, or the purchase of public assets at a low price through privatisation, these classes have lent open support to the policies of the World Bank and the IMF. Aiding this process has been the role of the global media, which transmits messages glorifying consumerism. Not to be underplayed is the role of illicit sources of money from trade in drugs, and rewards to politicians in the Third World for protecting these practices.

There have been two significant political ramifications of this process. First, international financial institutions and TNCs consolidated their position through institutional measures. Under the new world trading order, which emerged with the completion of the Uruguay Round of talks in Marrakech, the role of the Bretton Woods institutions and national governments was redefined. It was envisaged that in the articles of the new

other words, the SAP measures have been successful in increasing the rates of exploitation of the poor by the rich. Liberalised capital markets meant that trillions of dollars could flow in and out of a country within a single day. As the crises in East Asia have indicated, the free flow of capital in search of quick profits has left in its wake devastating poverty and social disruption.

As noted by the UNDP, free market expansion has outpaced systems to protect the social well-being of people and human development. Recent UNDP *Human Development Reports* note that more progress has been made in norms, standards, policies and institutions for open global markets than for people and their rights. They note that when economic growth through the market is left uncontrolled, it inevitably concentrates wealth and power in the hands of a select group of already powerful people, nations and corporations, while marginalising others.

International organisations and national elites

It is equally true that several global institutions of the United Nations have themselves been a part of this process. The World Health Organization (WHO), for instance, has increasingly forfeited its leadership role in health to the World Bank; indeed the total budget of the WHO is less than the health spending of the WB. It has also been suggested that the interests represented by the advanced capitalist countries have themselves increasingly influenced such institutions. Policy prescriptions such as the endorsement of the concept of Disability adjusted life years (DALYs) in health means an approach to health services development that increases the role of the private health sector and the pharmaceutical industry. The World Trade Organization (WTO) has become a forum of debate and struggle over the extent to which trade and industry, including the pharmaceutical industry, should have rights over governments to meaningfully protect resources and public health. Rapidly changing trade regulations demand capacities and negotiating abilities that many developing countries do not have.

The dominance of neoliberal policies across the globe was also linked to the collapse of the socialist economies. The ideological vacuum of alternatives to free-market promises at the global level led to the demoralisation of social movements that rejected first colonial and later neocolonial policies of development.

World Trade Organisation (which was to have been endorsed in Seattle), many aspects of SAP would become legally enforceable articles in international law. Third World countries would thus be at an increasing disadvantage, and less and less the owners of their own indigenous biological materials and knowledge.

The WTO has been criticised for its lack of transparency and democracy in decision-making, but the problem runs even deeper. In the profoundly uneven playing field on which the process of global economic change is taking place, even a transparent WTO would not pursue the values or principles that would enable the vast share of the world's population to access resources or enhance their productive capacities.

The second ramification is that national governments in many Third World countries, after losing support from the former socialist countries, failed to build stronger South to South links with neighbouring countries or with those producing similar primary commodities; instead they embarked on a competitive race to integrate into the global economy, thus pushing primary commodity and labour prices lower.

When populations in Third World countries resisted—and these sites of resistance are legion—their governments used severe measures to suppress them. Indeed, in many countries, scarce public resources were often typically directed to military and security expenditures. Thus, paradoxically, 'liberal' pro-market policies in much of the developing world have been associated with repressive politics.

ec issue 62, dec 1999/jan 2000

There have been many sites of resistance to these policies in many parts of the Third World. The Caracas anti-IMF riots in 1989 were sparked off by a 200% increase in the price of bread. Unofficial reports indicate that in January 1984 more than 1000 people were killed by the police firing in Tunis when protesting adjustment measures. Bread riots have also occurred in Nigeria in 1989. In 1990 anti-SAP riots took place in Morocco. The 1994 uprising in Chiapas, Mexico were also sparked off by SAP measures.[6]

Movement for change: setbacks and hopes

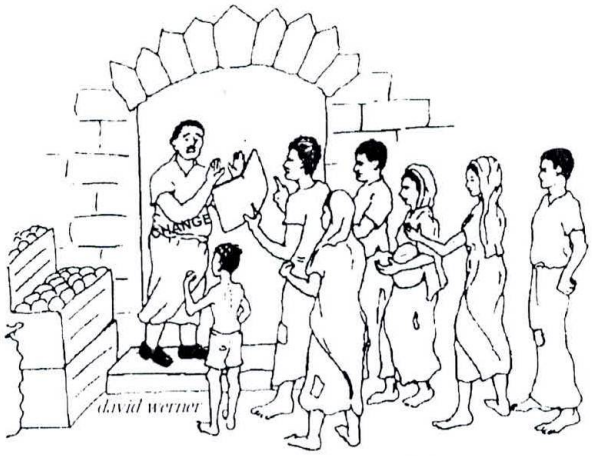
The last decade of the 20th century has seen the weakening of democratic movements and aspirations. This has occurred partly because of the preoccupation with survival among larger sections of the population and the weakening of trade unions in the face of privatisation and layoffs. It is also partly due to the increasing centralisation of decision-making at national and often international levels. Indeed decisions affecting large sections of the population in poor countries are often made at distant capitals in the West, with the national government mandated merely to implement such decisions.

It is in this situation that poor people fallback on their sectarian identities and turn on their equally poor neighbours in ethnic and religious conflicts. At the same time, increasing conflicts over scarce resources at the local level are breaking out in a number of places. In other cases a withdrawal into the family occurrs, with women bearing the brunt of this rise in violence.

While these are mechanisms for coping with an increasingly hostile world where people are marginalised and disempowered, they do not confront the sources of alienation and disempowerment. A political culture of dependence, withdrawal or passivity, even as governments have acted against the interests of their own poor people, strengthens the same forces of authority.

The situation is not, however, completely bleak.

There are significant positive developments that indicate confrontation with this unacceptable social and economic order. These are leading to organisation for change at many levels: local, national and international. Powerlessness is being addressed through a range of movements that organise in a representative and accountable manner, giving voice to the voiceless. Those movements that make links with others, pressurising governments for participatory democracy and to rebuild national priorities with a focus on the needs and aspirations of the majority of the population, must inevitably confront the wider sources of disempowerment. It is from this dimension of social movements confronting the current global political economy that there is hope for a more humane and human-centred type of development based on sustainability and equity. Within this larger struggle must be located the struggle for health for the people of the world.



Guyana in South America is the poorest country in the Western hemisphere. Since 1988, 80% of the government's revenues have gone on servicing foreign debt. Through the 1980s and 1990s, malnutrition, child death rates, unemployment and poverty rose dramatically as a result of the implementation of the SAP package. In 1992, following the election of a new President, the citizens of Guyana joined forces with the Bretton Woods Reform Organisation (BWRO) to create the first Alternative Structural Adjustment Programme, which envisaged a comprehensive economic policy to meet the basic needs of the entire population. The ASAP was based on the principle that a healthy economy does not rely on exports for income and imports for daily needs. The supporters of the ASAP also rejected the IMF freeze on social sector spending, and the President declared that raising the standard of living of the majority was the first objective.

Notes

[1] George, Susan, *A Fate Worse Than Debt: The World Financial Crisis and the Poor*, PIRG, New Delhi, 1990.
[2] Hobsbawm, Eric, *The Age of Extremes: The Short Twentieth Century 1914–1991*, Viking, New Delhi, 1994, p.269.
[3] Ibid, p.412.
[4] Hobsbawm, Eric, *The Age of Extremes: The Short Twentieth Century 1914–1991*, Viking, New Delhi, 1994, p.269.
[5] Ibid, p.412.
[6] Information from Chossudovsky, Michel, 'The Globalisation of Poverty and Ill Health' in *Lighten the Burden of Third World Health*, Health Systems Trust, Durban, 1999.

Questions:

- What has happened to the lives of ordinary people in your country or community in the last two decades? How similar are the experiences of different countries? Who have been the winners and losers?
- Why is 'free trade' a slogan primarily of the rich and influential countries?
- What has happened to the profile of health and disease in poor communities? What has caused these changes in health and ill-health?
- What actions have ordinary people taken to protect their rights to food, housing, jobs, health and health care? How far have these actions been coping mechanisms? How far have they confronted the causes of their problems collectively? What has been the response of the state?
- In what ways have countries acted together to improve their trade advantage in your region? In what way have they competed with each other? Which is more effective?
- What do ordinary people know about the international banks, financial institutions, world trade rules and markets that affect their lives?
- Have you ever thought of the range of products available in a typical supermarket in the West? How many of them emanate from the Third World? How is it that these are available to the middle class Westerner but not to large populations within the countries they come from?

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2 EQUITY and inequity today

some contributing social factors

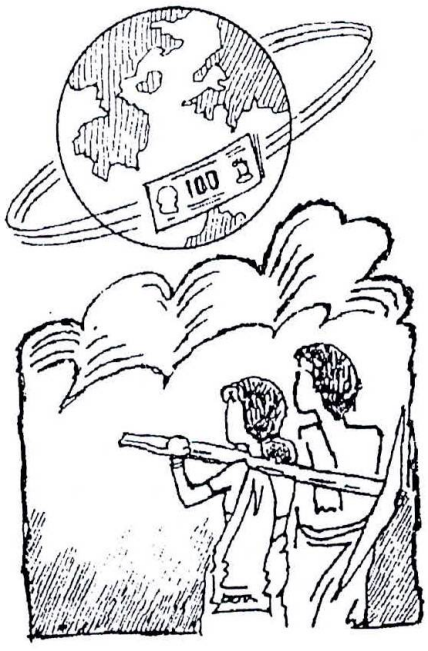
by Nadine Gasman and Maxine Hart

INTRODUCTION

The 1999 United Nations Human Development report begins: 'The real wealth of a nation is its people. And the purpose of development is to create an enabling environment for people to enjoy long, healthy and creative lives. This simple but powerful truth is too often forgotten in the pursuit of material and financial wealth.'[1]

The current trend of globalisation has contradictory implications. While the last 50 years have witnessed developments that augur better for the future of humanity—child death rates have fallen by half since 1965, and a child born today can expect to live a decade longer than a child born 20 years ago; the combined primary and secondary school enrolment ratio in developing countries has more than doubled—the world faces huge amounts of deprivation and inequality. ***Poverty is everywhere.*** Measured on the human poverty index—more than a quarter of the 4.5 billion people in developing countries still do not enjoy some of life's basic rights—survival beyond the age of 40, access to knowledge and adequate private and public services.

The quickening pace of globalisation has generated enormous social tensions that development policies have failed to tackle. The underlying assumption has been that once economic fundamentals are corrected, social issues will resolve themselves of their own accord, and that well-functioning markets will not just create wealth, but will also resolve problems of human welfare.[2]



Current events reveal with awful clarity the depth of this fallacy. Millions of people are poorer than ever before, with growing indices of inequality between countries and within countries. Most countries report erosion of their social fabric, with social unrest, more crime, and more violence in the home.

Neoliberal advisors in the 1980s developed a vision of the ideal country: its economy would be largely self-regulating through open competition between private firms; its public sector would be relatively passive—providing the minimum services necessary to conduct private business efficiently and to protect society's weakest members.

This dogmatic economic prescription, concludes the United Nations Research Institute in Social Development (UNRISD), has not only had limited value, but has been dangerous. Even those countries that have been held up as economic success stories have been social failures. Most people in highly indebted African and Latin American countries have suffered a sharp drop in living standards.

Between 1980 and 1990 the per capita income declined markedly in developing countries. An International Labour Organization study of 28 African countries showed that the real minimum wage fell by 20% and more than half of Africa's people now live in absolute poverty. In most Latin American countries the real minimum wage fell by 50% or more. Coupled with this, people have suffered from severe cuts in public services—affecting nutrition, health, education and transport.

The UN Human Development Report of 1999 goes further: a comparison between the size of income of the fifth of the world's people living in the richest countries and that of the fifth in the poorest showed a ratio of 74 to 1 in 1997, up from 60 to 1 in 1990 and 30 to 1 in 1960.

The advocates of adjustment

had hoped for a trade-off: long-term economic gain in return for short-term social cost. What they did not foresee was that the social impact could itself frustrate the desired economic effect. This temporary sacrifice for the poor is beginning to look like a permanent intensification of poverty. UNRISD explains: 'When the market goes too far in dominating social and political outcomes, the opportunities for and rewards of globalisation spread unequally and inequitably—concentrating power and wealth in a select group of people, nations and corporations, marginalising others. Globalisation in this era seeks to promote economic efficiency, generate growth and yield profits. But it fails on the goals of equity, poverty eradication and enhanced human security.'

Economic growth, an important input for human development, can only translate into human development if the expansion of private income is equitable, and only if growth generates public provisioning that is invested in human development—in schools and health centres rather than arms. Reduced public spending weakens institutions of redistribution—leading to inequalities.

FACTORS shaping inequality

Below are some of the major factors shaping inequality in a globalised environment:

Institutions

Institutions matter for development. In 1997, the World Bank warned: 'Without adequate institutions, the potential benefits of globalisation in terms of higher growth and investment rates will either not happen, or be too concentrated, thereby increasing, rather than decreasing inequalities and social tensions'. It adds further that 'good institutions are critical for macroeconomic stability in today's world of global financial integration'.[3]

UNRISD states: 'Social institutions have not just been ignored but they have been considered obstacles to progress and have been ruthlessly dismantled. This has happened at every level. At national level, many state institutions have been eroded and eliminated. And at local level, the imperatives of market forces have been undermining communities and families.'

The formal or semi-formal ties between states and society are increasingly unravelling, and being replaced by more diffuse arrangements. *States are growing weaker*, and state institutions are less able to fulfil basic responsibilities in areas that encourage personal development such as education, health, nutrition, land redistribution and welfare.
As states weaken, power is being transferred to institutions that ignore the social implications of their actions, while at the same time responsibility for absorbing the damage is being passed to non-governmental agencies or to communities and families that have themselves been so weakened that they are in no position to respond.

Political parties have become more diffuse and fragmented, particularly in the former Eastern Bloc countries where institutional chaos is common.

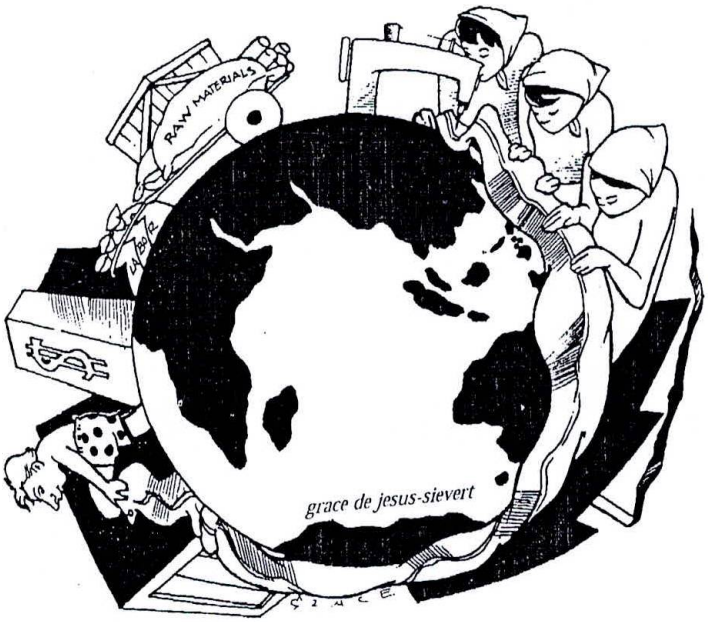
Trade Unions are being eroded—suffering from changes in working patterns. In countries with high unemployment, employers are finding it easier to avoid dealing with trade unions and are dealing directly with individual workers.

NGOs are increasing their influence and have been used to deliver services in many developing countries where governments are incapable of providing services. Accountability is thus undermined.

While many national institutions are being weakened, forcing communities and families to take on added burdens, other institutions are enjoying much greater freedom—without any commensurate increase in responsibility. This is especially true for *Transnational corporations (TNCs)*, which now control 33% of the world's productive assets, but only employ directly or indirectly 5% of the global workforce. TNCs are accused of exploiting cheap labour in developing countries, marketing dangerous products, avoiding taxation and causing serious environmental damage. Despite this, they remain untouched by any form of international regulation. In cases where national governments try to exert pressure on them, the companies move elsewhere.

Education

Persistent inequality and low quality characterise basic education systems in developing countries.



countries, employment creation has lagged behind GDP growth and the expansion of trade and investment. More than 35 million people are unemployed, and another 10 million are not taken into account in the statistics since they have given up looking for a job. Among youth, one in five is unemployed.

In both poor and rich countries, dislocations from economic and corporate restructuring and dismantled social protection have meant heavy job losses and worsening employment conditions. Jobs and incomes have become more precarious. The pressures of global competition have led countries and employers to adopt more flexible labour policies and work arrangements with no long-term commitment between employer and employee.

Education inequalities in access to school, attendance, quality of teaching and learning outcomes—perpetuates income and social inequalities. Poor children attend poor schools, have less opportunity to complete their basic education, and perform below their counterparts in private schools.

Misallocation of resources, inefficiencies and lack of accountability are prominent attributes of the organisational structure of education in most countries. According to the report by the UNHDP, one in seven children of primary school age is out of school.

Corruption

Corruption seriously weakens the ability of nations to ensure wealth is distributed fairly. Corrupt officials siphon off wealth from public and private sources, and discourage investment by those who fear profits will be stolen.

Weak governments allow *tax evasion* to flourish, undermining one of the key government tools for wealth redistribution by denying governments adequate resources to alleviate poverty and assist development.

Underground or informal economies have grown, further reducing national tax bases and feeding criminal organisations that grow up around the informal economies.

Employment and unemployment

Expansion of trade does not always mean more employment and better wages. In the OECD

Dislocation of populations

Migration is now a major global preoccupation, although it represents nothing new. In today's globalising world, migration is marked by uneven human opportunities and uneven human impacts. Whilst global employment opportunities are opening for some, they are closing for most others. For high-skilled labour, the market is more integrated, but the market for unskilled labour is highly restricted by national barriers.

While most migrants have some choice over when and how to leave, millions of others become refugees—driven from their homes and countries by famine, drought, floods, war, civil conflict, mass persecution, environmental degradation or misguided development programmes.

Dislocation of populations through wars and economic crises prevents stable growth in the sending countries and leaves them dependent on uncertain remittances from migrants. In Lesotho, 60% of households send labourers to work in South African mines, leaving females to cope with managing families. People who leave are often the youngest and most enterprising—predominantly male—leaving communities with high proportions of elderly people, women and young children.

An alarming outbreak of *national conflicts* based on race, religion or ethnic identity has fed social tensions and conflicts—especially when there are extremes of inequality between the marginal and the powerful. Inequalities are reflected in incomes, political participation, economic assets and social conditions—education, housing and employment. Apart from killing or maiming millions of people,

these wars weaken or destroy societies, devastate infrastructure and the environment, and bring public services to a standstill—undoing decades of development.

Global crime

Crime is a growth industry that is likely to intensify as a result of globalisation. Modern means of transportation, advanced communications and relaxed border controls have created opportunities for transnational crime. Organised crime is now estimated to gross US$1.5 trillion a year. Illicit trade in drugs, women, weapons and laundered money is contributing to the violence and crime that threaten neighbourhoods around the world.

A high proportion of modern-day criminal activity is associated with narcotic drugs. *Illicit drugs* have a corrosive effect in both consuming and producing countries. Drug syndicates, gangs and smugglers use any means necessary to protect their trade—whether it be murder, or bribery and corruption—undermining institutions and social systems such as traditional agricultural communities. The illegal drug trade in 1995 was estimated at about 8% of world trade.

All these factors have a direct effect on families, but especially on women and children. Around the world one in every three women has experienced violence in an intimate relationships, and about 1.2 million women and girls under 18 are trafficked for prostitution each year. About 300 000 children were soldiers in the 1990s, and 6 million were injured in armed conflicts[4].

Families and women

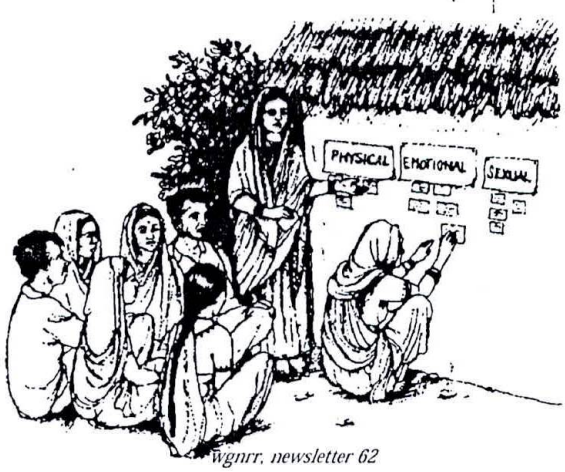
The weakening of families: The family has always offered the most basic form of security. When all else fails, people have assumed that they can rely on their family members for support. This has become especially important during the current era of economic restructuring that has seriously weakened the capacity of the state to provide for those in greatest need. Unfortunately, this is happening at a time when the family itself is coming under the greatest pressure it has known. In industrialised countries, around one third of marriages end in divorce, and 20% of children are born outside marriage. Many of the current social ills are blamed on the family—from high crime to teenage pregnancies, to drug taking.

One of the most widely discussed changes in the structure of the family is the rising proportion of *single-parent families*—generally women. Female-headed households are disadvantaged, not because women lacking a sense of responsibility towards their families, but rather because social and economic factors are stacked against them—women face discrimination in property, land, income and credit. Social and economic changes in recent years have made family life even harder for women. Many more women are working outside the home—in industrial countries women make up 40% of the official labour force. The economic crisis in many countries has increased women's workload in other ways. It has been found that women suffer more from cuts in public services—health cuts mean that women take care of sick relatives, and cuts in education mean that women spend more time supervising children, which UNRISD calls 'invisible adjustment'. Further, women spend more time growing their own food—and this has been transferred to their daughters at the expense of attending school.

A current problem, which is reaching unprecedented proportions, is the number of orphans as a result of the AIDS epidemic. Since the beginning of the epidemic there have been 13.2 million orphan in the world, most of them are in Sub-Saharan Africa. These children are taken care by their extended families or emerging institutions that have not only to ensure their survival but address the psychological, health and social needs. This increasing problem can only be expected to get worse in the future.

Children

The same pressures that have taken their toll of parents have also taken their toll of children. In the industrialised countries, the period 1950–1975 saw remarkable progress for children—whether measured by health, growth rates or education. These rates of progress are being brought to a halt. There is a steady rise in school drop-out rates, more cases of physical and sexual abuse, and rises in teenage violence and suicide. Children in



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developing countries come under even greater pressure. Whilst child survival rates have improved enormously over the last 30 years—infant and under-five mortality rates more than halved—those who survive live under greater stress.

In developing countries there are some 250 million child labourers –140 million are boys and 110 million girls[4]. Poverty and low wages are the underlying reasons for *child labour*: parents earn so little that their children have to work and employers are happy to take children as they will work for even lower wages. (children's wages may pay for their own schooling as well as keep the family together as a unit)

THE FUTURE

We face the challenge of setting up rules and institutions for stronger governance—local, national, regional and global—that put the health and well-being of each individual, community and nation at the centre. We need to create enough space for human, community and environmental resources to ensure that development works for people and not just for profit.

Globalisation expands the opportunities for unprecedented human advance for some, but shrinks those opportunities for others and erodes human security. It is integrating economies, culture and governance, but is fragmenting societies and ignoring the goals of equity, poverty eradication and human development.

Overcoming poverty must be seen as the main ethical and political challenge. Experience shows that the most appropriate programmes are long-term initiatives of a comprehensive/ multi-dimensional and multi-sectoral nature, aimed at breaking down the mechanisms that perpetuate poverty from one generation to another.

Development patterns need to be oriented to make ***equity***—that is, the reduction of social inequality—the central pillar. This should be the basic yardstick against which we measure development. ***Education*** and ***employment*** present two master keys for development. Education has an impact on equity, development and citizenship, and therefore needs to be assigned top priority in terms of social policy and public spending, especially important is education of girls. Latin American studies have indicated that 11–12 years of schooling (completed secondary education) are required if people are to have a chance of escaping poverty. At the same time, a high-quality job- creation process needs to be put in place.

Questions?

- What are the social factors that influence the health situation in your community or countries?
- Is violence a problem in your community?
- What is the status of Women and children?
- Is government responding to the people's needs? Why?

Notes

[1] UNDP. "United Nations Human Development Report". 1999. Geneva.
[2] United Nations Research Institute in Social Development. "States of disarray. The social effects of globalization". 1995. Geneva.
[3] Report Institutions Matter – World Bank Latin American and Caribbean studies 1998
[4] UNDP. "Human Development Report 2000. New York, USA.

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5 communication as if PEOPLE mattered

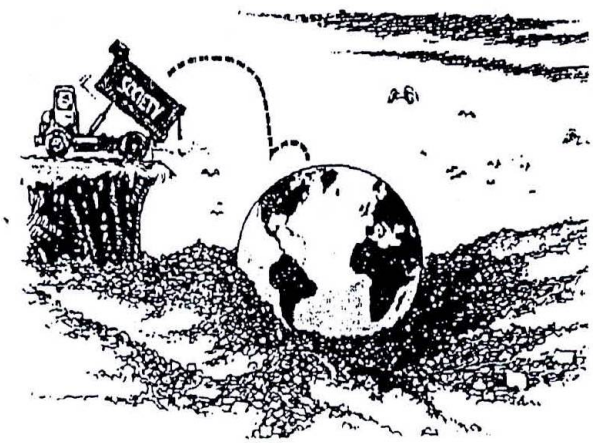
adapting health promotion and social action to the global imbalances of the 21st century

by David Werner

DEMOCRACY as a prerequisite for a HEALTHY SOCIETY

Why participation is essential – and how it is undermined

The well-being of an individual or community depends on many factors, local to global. Above all, it depends on **the opportunity of all people to participate as equals in the decisions that determine their well-being**. Unfortunately, history shows us that equality in collective decision-making—that is to say **participatory democracy**—is hard to achieve and sustain. Despite the spawning of so-called 'democratic governments' in recent decades, most people still have little voice in the policies and decisions that shape their lives. Increasingly, the rules governing the fate of the Earth and its inhabitants are made by a powerful minority who dictates the Global Economy. Thus **economic growth (for the wealthy) has become the yardstick of social progress, or 'development,' regardless of the human and environmental costs**



And the costs are horrendous! The top-down 'globalisation' of policies and trade—through which the select few profit enormously at the expense of the many—is creating a widening gap in wealth, health and quality of life, both between countries and within them. A complex of worldwide crises—social, economic, ecological and ethical—is contributing to ill-health and early death for millions. Increasingly, giant banks and corporations rule the world, putting the future well-being and even survival of humanity at risk. Driven more by hunger for private profit than for public good—the massive production of consumer goods far exceeds the basic needs of a healthy and sustainable society. Indeed, its unregulated growth compromises ecological balances and imperils the capacity of the planet for renewal.

Yet in a world where unlimited production and resultant waste have become a major health hazard, there are more hungry children than ever before. According to Worldwatch's *The State of the World, 1999*, **the majority of humanity is now malnourished**, half from eating too little and half from eating too much!

Mahatma Gandhi wisely observed: 'There is enough for everyone's need but not for everyone's greed.' Sadly, **greed has replaced need as the driver of our global spaceship**. Despite all the spiritual guidelines, social philosophies, and declarations of human rights that *Homo sapiens* (the species that calls itself wise) has evolved through the ages, the profiteering ethos of the market system has side-tracked our ideals of compassion and social justice. Humanity is running a dangerous course of increasing imbalance. To further fill the coffers of the rich, our neoliberal social agenda systematically neglects the basic needs of the disadvantaged and is rapidly despoiling the planet's ecosystems, which sustain the intricate web of life.

The dangers—although played down by the mass media—are colossal and well documented. Forward-looking ecologists, biologist, and sociologists sound the warning that our current unjust, un-

healthy model of economic development is both humanly and environmentally unsustainable.

'Yes, we know that,' say many of us who believe in Health for All and a sustainable future. 'We are deeply worried.... But what can we do?'

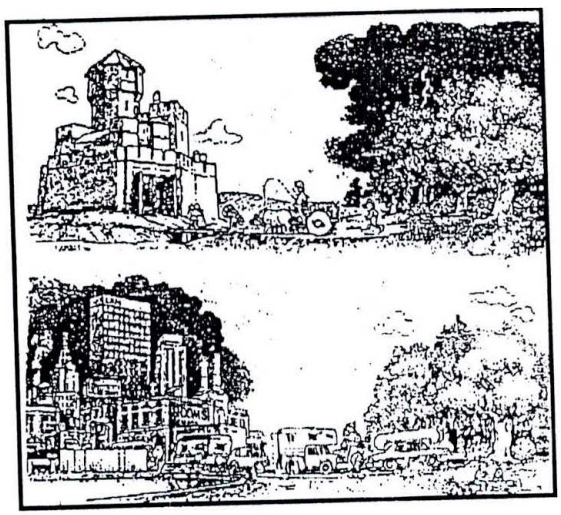
There are no easy answers. The forces shaping global events are gigantic, and those who accept them as inevitable so impervious to rational dissent, that many of us hide our heads in the sand like ostriches. And so humanity thunders headlong down the path of systemic breakdown—more polarisation of society, more environmental deterioration, more neglect of human rights and needs, more social unrest and violence—as if our leaders were incapable of thought and our populations anaesthetised.

What action can we take, then—individually and collectively—to change things for the better, for the common good?

The purpose of this background paper

The interrelated crises of our times—the ways that globalisation, corporate rule, and top-down, 'development' policies undermine democratic process and endanger world health—are discussed in other background papers for the People's Health Assembly. The purposes of this paper are:

1. to examine the strategies used by the world's ruling class to keep the majority of humanity disempowered and complacent in the face of the crushing inequalities and hazards it engenders;
2. to explore the methods and resources whereby enough people can become sufficiently aware and empowered to collectively transform our current unfair social order into one that is more equitable, compassionate, health-promoting, and sustainable.



TOP-DOWN MEASURES of SOCIAL CONTROL

Disinformation

With all the technology and sophisticated means of communication now available, how is it that so many people appear so unaware that powerful interest groups are undermining democracy, concentrating power and wealth, and exploiting both people and the environment in ways that put the well-being and even survival of humanity at stake? How can a small elite minority so successfully manipulate global politics to its own advantage, and so callously ignore the enormous human and environmental costs? How can the engineers of the global economy so effectively dismiss the emerging risk of unprecedented social and ecological disaster?

In short, what are the weapons used by the ruling class to achieve compliance, submission, and social control of their captive population?

True, riot squads have been increased, prison populations expanded, and military troops deployed to quell civil disobedience. But far more than tear-gas and rubber bullets, **disinformation has become the modern means of social control**. Thanks to the systematic filtering of news by the mass media, many 'educated' people have little knowledge of the injustices done to disadvantaged people in the name of economic growth, or of the resultant perils facing humanity. They are unconscious of the fact that the overarching problems affecting their well-being—growing unemployment, reduced public services, environmental degradation, renewed diseases of poverty, bigger budgets for weapons than for health care or schools, more tax dollars spent to subsidize wealthy corporations than to assist hungry children, rising rates of crime, violence, substance abuse, homelessness, more suicides among teenagers—are rooted in the undemocratic concentration of wealth and power. Despite their personal hardships, unpaid bills, and falling wages, ordinary citizens are schooled to rejoice in the 'successful economy' (and spend more). They pledge allegiance to their masters' flag, praise God for living in a 'free world,' and fail to see (or to admit) the extent to which the world's oligarchy (ruling minority) is undermining democracy and endangering our common future. And our textbooks and TVs keep us strategically misinformed.

One dollar, one vote: private investment in public elections

One way 'government by the people' is undermined is through the purchase of public elections by the highest bidders. In many so-called democracies a growing number of citizens (in some countries, the majority) don't even bother to vote. They say it makes no difference. Politicians, once elected, pay little heed to the people's wishes. The reason is that wealthy interest groups have such a powerful political lobby. Their big campaign donations (bribes?) help politicians win votes—in exchange for political favours. The bigger the bribe, the more campaign propaganda on TV and mass media. Hence more votes.

This institution of legal bribery makes it hard for honest candidates (who put human need before corporate greed) to get elected. Democratic elections are based on one person, one vote. With the deep pockets of big business corrupting elections, results are based on one dollar, one vote. This makes a mockery of the democratic process.

The erosion of participatory democracy by the corporate lobby has far-reaching human and environmental costs. Hence the biggest problems facing humanity today—poverty, growing inequality, and the unsustainable plundering of the planet's ecosystems—continue unresolved.

Sufficient wisdom, scientific knowledge and resources exist to overcome poverty, inequity, hunger, global warming and the other crises facing our planet today. But those with the necessary wisdom and compassion seldom govern. They rarely get elected because they refuse to sell their souls to the company store. Winners of elections tend to be wheelers and dealers who place short-term gains before the long-term well being of all.

To correct this unhealthy situation, laws need to be passed that stop lobbying by corporations and wealthy interest groups. In some countries, citizens' organisations are working hard to pass such campaign reforms. But it is hard to get them past legislators who pad their pockets with corporate donations. Only when enough citizens become fully aware of the issues at stake and demand a public vote to outlaw large campaign donations, will it be possible for them to elect officials who place the common good before the interests of powerful minorities.

But creating such public awareness is an uphill struggle—precisely because of the power of the corporate lobby and the deceptive messages of the mass media. To make headway with campaign

reforms, institutionalised disinformation must be exposed for what it is. To accomplish this, more honest and empowering forms of education and information sharing are needed.

Schooling for conformity, not change

It has been said that **education is power**. That is why, in societies with a wide gap between the haves and have-nots, **too much education can be dangerous**. Therefore, in such societies, schooling provides less education than indoctrination, training in obedience, and cultivation of conformity. **In general, the more stratified the society, the more authoritarian the schools.**

Government schools tend to teach history and civics in ways that glorify the wars and tyrannies of those in power, whitewash institutionalised transgressions, justify unfair laws, and protect the property and possessions of the ruling class. Such history is taught as gospel. And woe be to the conscientious teacher who shares with students 'people's history' of their corner of the earth.

Conventional schooling is a vehicle of disinformation and social control. It dictates the same top-down interpretations of history and current events, as do the mass media. It whitewashes official crimes and aggression. Its purpose is to instill conformity and compliance, what Noam Chomsky calls 'manufacturing consent.'

For example, although the United States has a long history of land-grabbing, neocolonial aggression and covert warfare against governments committed to equity, most US citizens take pride in their 'benevolent, peace-loving nation'. Many believe they live in a democracy 'for the people and by the people, with liberty and justice for all'—even though millions of children in the US go hungry, countless poor folks lack health care, prison populations expand (mainly with destitute blacks), and welfare cut-backs leave multitudes jobless, homeless and destitute.

the NEED for BOTTOM-UP approaches to communication

To see through the institutionalised disinformation, and to mobilise people in the quest for a healthier, more equitable society, we need alternative methods of education and information-sharing that are honest, participatory, and empowering. This includes learning environments that bring people together as equals to critically analyse their reality, plan a strategy for change, and take effective united action.

Fostering empowering learning methods is urgent in today's shrinking world, where people's quality of life, even in remote communities, is increasingly dictated by global policies beyond their control.

Alternative media and other means of people-to-people communication

There have been a number of important initiatives in the field of alternative media, communication, and social action for change.

The alternative press. While struggling to stay alive in recent years, the alternative press (magazines, flyers, bulletins, newsletters, progressive comic books) has provided a more honest, people-centred perspective on local, national and global events. Some of the more widely-circulating alternative magazines in English (often with translations into several other languages) include:

The New Internationalist
Z Magazine
Resurgence
The Nation
Third World Resurgence
Covert Action Quarterly
Multinational Monitor

Also, there are many newsletters and periodicals published by different watchdog groups such as the International Forum on Globalization, IBFAN, BankWatch, the National Defense Monitor and Health Action International, among others. It is important that we subscribe to and read (and encourage others to read) these progressive alternative writings.

Alternative community radio and TV. The role and potential of these is similar to that of the alternative press. Stations that do not accept advertising are less likely to belong to or sell out to the controlling elite. But to survive they need listener support.

Internet. Electronic mail and websites have opened up a whole new sphere of rapid, direct communication across borders and frontiers. The Web is, of course, a two-edged sword. The Internet is currently available to less than 2% of the world's people, mostly the more privileged. And instant electronic communications facilitate the global transactions and control linkages of the ruling class. But at the same time, E-mail and the World-Wide-Web provide a powerful tool for popular organisations and activists around the globe to communicate directly, to rally for a common cause and to organise international solidarity for action.

The potential of such international action was first demonstrated by the monumental worldwide outcry, through which non-government organisations (NGOs) and grassroots organisations halted the passage of the Multilateral Agreement on Investment (MAI). (The MAI was to have been a secret treaty among industrialised countries, giving even more power and control over Third World Nations.) The primary vehicle of communication for the protest against MAI was through the Internet.

Mass gatherings for organised resistance against globalised abuse of power. The turn of the Century was also a turning point in terms of people's united resistance against global trade policies harmful to people and the planet. The huge, well-orchestrated protest of the World Trade Organization (WTO) summit meeting in Seattle, Washington (now celebrated worldwide as the 'Battle in Seattle') was indeed a breakthrough. It showed us that **when enough socially committed people from diverse fields unite around a common concern, they can have an impact on global policy making.**

The agenda of the WTO summit in Seattle was to further impose its pro-business, anti-people and anti-environment trade policies. That agenda was derailed by one of the largest, most diverse, international protests in human history. Hundreds of groups and tens of thousands of people representing NGOs, environmental organisations, human rights groups, labour unions, women's organisations, and many others joined to protest and barricade the WTO assembly. Activists arrived from at least 60 countries. The presence of so-many grassroots protesters gave courage to many of the representatives of Third World countries to oppose the WTO proposals which would further favor affluent countries and corporations at the expense of the less privileged. In the end, the assembly fell apart, in part from internal

disaccord. No additional policies were agreed upon.

Perhaps the most important outcome of the Battle in Seattle was that, despite efforts by the mass media to denigrate and dismiss the protest, key issues facing the world's people were for once given center stage. It was a watershed event in terms of grassroots mobilisation for change. But the activists present agreed that it was just a beginning.

The People s Health Assembly, with its proposed 'People's Charter for Health' and plans for follow-up action, holds promise of being another significant step forward in the struggle for a healthier, more equitable approach to trade, social development, and participatory democracy. For that promise to be realised, people and groups from a wide diversity of concerns and sectors must become actively involved around our common concern: the health and well-being of all people and of the planet we live on.

EDUCATION *for* PARTICIPATION, EMPOWERMENT, *and* ACTION *for* change

The term 'Popular Education,' or 'Learner-centered education,' refers to participatory learning that enables people to take collective action for change. Many community-based health initiatives have made use of these enabling methodologies, adapting them to the local circumstances and customs. Particularly in Latin America, methods of popular education have been strongly influenced by the writings and awareness-raising 'praxis' of Paulo Freire (whose best known book is *Pedagogy of the Oppressed*.)

Education of the oppressed—the methodology of Paulo Freire

In the mid-1960s the Brazilian educator, Paulo Freire developed what he called **education for liberation**, an approach to adult literacy training, (which proved so revolutionary that Freire was jailed and then exiled by the military junta.) With his methods, non-literate workers and peasants learned to read and write in record time—because their learning focused on what concerned them most: the problems, hopes and frustrations in their lives. Together they critically examined these concerns, which were expressed in key words and provocative pictures. The process involved identification and analysis of their most oppressive problems, reflection on the causes of these, and (when feasible) taking action to 'change their world'.

Learning as a two-way or many-way process

With Freire's methodology, problem-solving becomes an open-ended, collective process. Questions are asked to which no one, including the facilitator have ready answers. 'The teacher is learner and the learners, teachers.' Everyone is equal and all learn from each other. The contrast with the typical classroom learning is striking. **In typical schooling**, the teacher is a superior being who 'knows it all'. He is the owner and provider of knowledge. He passes down his knowledge into the heads of his unquestioning and receptive pupils, as if they were empty pots. (Freire calls this the 'banking' approach to learning because knowledge is simply deposited.)

In education for change, the facilitator is one of the learning group, an equal. She helps participants analyse and build on their own experiences and observations. She respects their lives and ideas, and encourages them to respect and value one another's. She helps them reflect on their shared problems and the causes of these, to gain confidence in their own abilities and achievements, and to discuss their common concerns critically and constructively, in a way that may lead to personal or collective action. Thus, according to Freire, the learners discover their ability to 'change their world'. (For this reason Freire calls this a 'liberating' approach to learning).

The key difference between 'typical schooling' and 'education for change' is that **the one pushes ideas into the student's heads, while the other draws ideas from them**. Typical schooling trains students to conform, comply, and accept the voice of authority without question. Its objective is to maintain and enforce the status quo. It is disempowering. By contrast, education-for-change is enabling. It helps learners gain 'critical awareness' by analysing their own observations, drawing their own conclusions and taking collective action to overcome problems. It frees the poor and oppressed from the idea that they are helpless and must suffer in silence. It empowers them to build a better world—hence it is 'education for transformation'.

examples of GRASSROOTS health programmes that have combatted ROOT CAUSES of POOR HEALTH

Community-based health programmes in various countries have brought people together to analyse the root causes of their health-related problems and to 'take health into their own hands' through organised action. In places where unjust government policies have worsened the health situation, community health programmes have joined with popular struggles for fairer and more representative governments. The following are a few examples of programmes where people's collective 'struggle for health' has led to organised action to correct inequalities, unfair practices and/or unjust social structures.

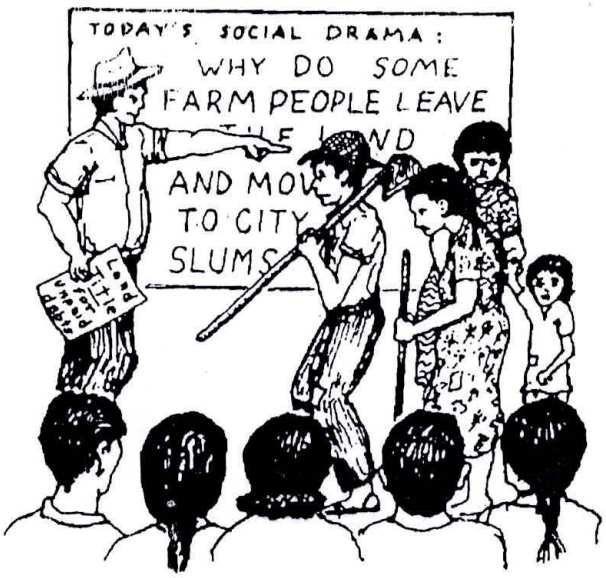
Gonoshasthaya Kendra (GK). GK is a community health and development programme in Bangladesh that began during the war for national independence. Village women, many of them single mothers (the most marginalised of all people), have become community health workers and agents of change. Villagers collectively analyse their needs and build on the knowledge and skills they already have. Repeatedly health workers have helped villagers take action to defend their rights.

One example of this is over water rights. In analysing their needs, families agreed that access to good water is central to good health. UNICEF had provided key villages with tube-wells. But rich landholders took control of the wells and made people pay so much for water that the poor often went without. Health workers helped villagers organise to gain democratic, community control of the wells. This meant more water and better health for the poor. And it helped people gain confidence that through organised action they could indeed better their situation.

Another example concerns schooling. Villagers know education is important for health. But most poor children of school age must work to help their families survive. So the GK communities started a unique school, which stresses cooperation, not competition. Each day the children able to attend the school practise teaching each other. After school these same children teach those unable to attend school. This process of teaching one another and working together to meet their common needs, sews seeds for cooperative action for change.

Jamkhed, India. For over three decades two doctors, Mabel and Raj Arole, have worked with poor village women, including traditional midwives. These health facilitators have learned a wide variety of skills. They bring groups of women together to discuss and try to resolve problems. In this way, they have become informal community leaders and agents of change. They help people rediscover the value of traditional forms of healing, while at the same time demystifying Western medicine, which they learn to use carefully in a limited way.

In Jamkhed, women's place relative to men's has become stronger. Women have found courage to defend their own rights and health and those of their children. As a result of the empowerment and skills-training of women, child mortality has dropped and the overall health of the community has improved dramatically.



The Philippines. In this island nation, during the dictatorship of Fernando Marcus, a network of community-based health programmes (CBHPs) evolved to help people deal with extreme poverty and deplorable health conditions. Village health workers learned to involve people in what they called **situational analysis**. Neighbours would come together to prioritise the main problems affecting their health, identify root causes and work collectively towards solutions.

In these sessions it became clear that **inequality—and the power structures that perpetuate it—were at the root of ill health**. Contributing to the dismal health situation were: unequal distribution of farm land (with huge land-holdings by transnational fruit companies), cut-backs in public services, privatisation of the health system, and miserable wages paid to factory and farm workers. The network of community-based programs urged authorities to improve this unjust situation. When their requests fell on deaf ears, they organised a popular demand for healthier social structures. These included free health services, fairer wages, redistribution of the land to the peasantry, and above all else, greater accountability by the government to its people.

The fact that the CBHP network was awakening people to the socio-political causes of the poor so threatened the dictatorship that scores of health workers were jailed or killed. But as oppression grew, so did the movement. The CBHP network joined with other movements for social change. Finally, the long process of awareness raising and cooperative action paid off. In the massive peaceful uprising of 1986, thousands of citizens confronted the soldiers, putting flowers into the muzzles of their guns. The soldiers (many of whom were peasants themselves, acquiesced. After years of organising and grassroots resistance, the dictatorship was overthrown. (Unfortunately, the overall situation has not changed greatly. With persistent domination by the US government and multinational corporations, gross inequities remain and the health of the majority is still dismal. The struggle for a healthier, more equitable society continues.)

Nicaragua. Similar to the CBHP in the Philippines under Marcus, in Nicaragua during the Somoza dictatorship a network of non-government community health programmes evolved to fill the absence of health and other public services. Grassroots health workers known as **Brigadistas de Salud** brought groups of people together to conduct **community diagnoses** of problems affecting their health, and to work together toward solutions. As in the Philippines, the ruling class considered such **community participation** subversive. Scores of health workers were 'disappeared' by the National Guard and paramilitary death squads. Many health workers went underground and eventually helped form the medical arm of the Frente Sandinista, the revolutionary force that toppled the dictatorship.

After the overthrow of Somoza, hundreds of Brigadistas joined the new health ministry. With their commitment to strong participation, they helped to organise and conduct national 'Jornadas de Salud' (Health Days). Their work included country-wide vaccination, malaria control, and tuberculosis control campaigns. At the same time, adult literacy programmes, taught mainly by school children, drastically increased the nation's level of literacy.

As a result of this participatory approach, health statistics greatly improved under the Sandinista government. Since the Sandinistas were ousted with the help of the US government, health services have deteriorated and poverty has increased. Many health indicators have suffered. But fortunately, communities still have the skills and self-determination necessary to meet basic health needs and assist one another in hard times.

Project Piaxtla, in rural Mexico. In the mountains of western Mexico in the mid-1960s a villager-run health programme began and gradually grew to cover a remote area unserved by the health system. Village health promoters, learning in part by trial and error, developed dynamic teaching methods to help people identify their health needs and work together to overcome them.

Over the years, Piaxtla evolved through three phases: 1) curative care, 2) preventive measures, and 3) socio-political action.
It was the third phase that led to the most impressive improvements in health. (In two decades, child mortality dropped by 80%.) Through Community Diagnosis, villagers recognised that a big

david werner

cause of hunger and poor health was the unconstitutional possession of huge tracts of farmland by a few powerful landholders, for whom landless peasants worked for slave wages. The health promoters helped the villagers organise, invade the illegally large holdings, and demand their constitutional rights. Confrontations resulted, with occasional violence or police intervention. But eventually the big landholders and their government goons gave in. In two decades, poor farmers reclaimed and distributed 55% of good riverside land to landless farmers. Local people agree that their struggle for fairer distribution of land was the most important factor in lowering child mortality. And as elsewhere, people's organised effort to improve their situation helped them gain the self-determination and skills to confront other obstacles to health.

The practical experience of Project Piaxtla and its sister programme, PROJIMO, gave birth to 'Where There Is No Doctor,' 'Helping Health Workers Learn,' 'Disabled Village Children' and the other books by David Werner that have contributed to community-based health and rehabilitation initiatives worldwide.

networking and COMMUNICATIONS among GRASSROOTS programmes and movements

From isolation to united struggle

In different but paralled ways, each of the community initiatives briefly described above developed enabling participatory methods to help local people learn about their needs, gain self-confidence, and work together to improve their well-being. Each forged its own approaches to what we referred to earlier as **education for change**.

At first community health initiatives in different countries tended to work in isolation, often unaware of each other's existence. There was little communication and sometimes antagonism between them. But in time this changed, partly due to growing obstacles to health imposed by the ruling class. (Nothing solidifies friendship like a common oppressor.) Programmes in the same country or region began to form networks or associations to assist and learn from each other. By joining forces, they were able to form a stronger, more united movement, especially when confronting causes of poor health rooted in institutionalised injustice and inequity.

National networks in Central America and the Philippines provided **strength in numbers** that gave community health programmes mutual protection and a stronger hand to overcome obstacles.

In the 1970s, community-based health programmes in several Central American countries formed **nationwide associations**. Then in 1982 an important step forward took place. Village health workers from CBHPs in the various Central American countries and Mexico met in Guatemala to form what became the **Regional Committee of Community Health Promotion**.

This Regional Committee has helped to build solidarity for the health and rights of people throughout Central America. Solidarity was particularly important during the wars of liberation waged in Central America (and later in Mexico), when villages were subjected to brutal and indiscriminate attacks by repressive governments and death squads.

Learning from and helping each other

One of the most positive aspects of networking among grassroots programmes and movements has been the cross-fertilisation of experiences, methods and ideas.

Central America. For example, in the 1970s, the Regional Committee and Project Piaxtla organised a series of **'intercambios educativos'** or **educational interchanges**. Community health workers from different programmes and countries came together to learn about each other's methods of confidence-building, community diagnosis, and organisation for community action.

At one of these Intercambios, representatives from Guatemala, in a highly participatory manner, introduced methods of 'conscientización' (awareness-raising) developed by Paulo Freire, as they had adapted them to mobilise people around health-related needs in Guatemala.

Likewise the village health promoters of Piaxtla, in Mexico, introduced to participants a variety of methods of discovery-based learning, which they had developed over the years (see below).

Reaching across the Pacific. An early step towards more global networking took place in 19??, when an educational interchange was arranged between community health workers from **Central America** and the **Philippines**. A team of health workers from Nicaragua, Honduras and Mexico visited a wide range of community-based health programmess, rural and urban, in the Philippines. In spite of language barriers, the sharing of perspectives and sense of solidarity that resulted were profound. Social and political causes of ill health in the two regions were similar. Both the Philippines and Latin America have a history of invasion and subjugation, first by Spain and then by the United States. Transnational corporations and the International Financial Institutions have contributed to polarising the rich and poor. And in both regions, the US has backed tyrannical puppet governments that obey the wishes of the global marketeers in exchange for loans and weapons to keep their impoverished populations under control.

Participants in the Latin American-Philippine interchange came away with a new understanding of the global forces behind poor health. They became acutely aware of the need for a worldwide coalition of grassroots groups and movements to gain the collective strength needed to construct a healthier, more equitable, more sustainable global environment.

the **life** and **death** of PRIMARY HEALTH CARE

Health for All? The United Nations established the World Health Organization (WHO) in 1945 to co-ordinate international policies and actions for health. WHO defined health as 'complete physical, mental, and social well-being, and not merely the absence of disease.'

But in spite of WHO and the United Nations' declaration of Health as a Human Right, the poorer half of humanity continued to suffer the diseases of poverty, with little access to basic health services. In 1987, WHO and UNICEF organised a watershed global conference in Alma Ata, USSR. It was officially recognised that the Western Medical Model, with its costly doctors in giant 'disease palaces,' had failed to reach impoverished populations. So the world's nations endorsed the **Alma Ata Declaration,** which outlined a revolutionary strategy called **Primary Health Care (PHC)**, to reach the goal of **Health for All by the Year 2000**. The vision of PHC was modeled after the successful grassroots community-based health programmes in various countries, as well as the work of 'barefoot doctors' in China. It called for **strong community participation in all phases**, from planning and implementation to evaluation.

Health for No One? We have entered the 21st century and are still a long way away from 'Health for All.' If our current global pattern of short-sighted exploitation of people and environment continue, we will soon be well on the road to 'Health for No One.' The current paradigm of economic development, rather than eliminating poverty, has so polarised society that combined social and ecological deterioration endangers the well-being of all. But sustainable well-being is of secondary concern to the dictators of the global economy, whose all-consuming objective is GROWTH AT ALL COST!

It has been said that Primary Health Care failed. But in truth, it has never been seriously tried. Because it called for and the full participation of the underprivileged along with an equitable economic order, the ruling class considered it subversive. Even UNICEF—buckling under to accusations by its biggest founder (the US government) that it was becoming 'too political'—endorsed a disembowelled version of PHA called **Selective Primary Health Care**. Selective PHC has less to do with a healthier, more equitable social order than with preserving the *status quo* of existing wealth and power.

The World Bank's take-over of health planning. The kiss of death to comprehensive PHC came in 1993 when the World Bank published its World Development Report, titled 'Investing in Health.' The Bank advocates a restructuring of health systems in line with its neo-liberal free-market ideology. It recommends a combination of privatisation, cost-recovery schemes and other measures that tend to place health care out of reach of the

poor. To push its new policies down the throat of poor indebted countries, it requires acceptance of unhealthy policies as a pre-condition to the granting of bail-out loans.

In the last decade of the 20th century, the World Bank took over WHO's role as world leader in health policy planning. The take-over was powered by money. The World Bank's budget for 'Health' is now triple that of WHO's total budget. With the World Bank's invasion of health care, comprehensive PHC has effectively been shelved. **Health care is no longer a human right. You pay for what you get.** If you are too poor, hungry and sick to pay, forget it. The bottom line is business as usual. Survival of the greediest!

COALITIONS for the health and well-being of HUMANITY

Primary Heath Care as envisioned at Alma Ata was never given a fair chance,—and globalisation is creating an increasingly polarised, unhealthy and unsustainable world. — In response, a number of international networks and coalitions have been formed. Their goal is to revitalise comprehensive PHC and to work towards a healthier, more equitable, more sustainable approach to development. Two of these coalitions, which have both participated in organising the People's Heath Assembly, are the following.

The Third World Health Network (TWHN), based in Malaysia, was started by the Third World Network, which has links to the International Consumers Union. The TWHN consists of progressive health care movements and organisations, mainly in Asia. One important contribution of the Network has been the collection of a substantial library of relevant materials, their lobby for North-South equity and the promotion of networking between Third World organisations.

The International People s Health Council (IPHC) is a coalition of grassroots health programmes, movements and networks. Many of its members are actively involved in community work. Like the TWHN, the IPHC is committed to working for the health and rights of disadvantaged people—and ultimately, of all people. Its vision is to advance towards a healthy global community founded on fairer, more equitable social structures. It strives towards a model of people-centred development, which is participatory, sustainable, and makes sure that all people's basic needs are met.

The IPHC is not just a South-South network for underdeveloped countries, but also includes grassroots struggles for health and rights among the growing numbers of poor and disadvantaged people in the Northern 'overdeveloped' countries.

For the last two years the Third World Network and the IPHC have worked closely together in the preparations for the People's Health Assembly.

METHODOLOGIES of EDUCATION for CHANGE

One of the most rewarding activities of the IPHC was a post-conference workshop held in Cape Town, South Africa, on Methodologies of Education for Change. Health educators from Africa, Central America, Mexico, North America, the Philippines and Japan—most with many years of experience— facilitated group activities. Each demonstrated some of the innovative learning and awareness-raising methods they use in their different countries. The challenge of the workshop was **to design or adapt methods of education for action to meet the new challenges of today's globalised and polarised world.**

From micro to macro, local to global: ways of making and understanding the links

The Cape Town Workshop participants agreed that a global grassroots movement needs to be mobilised to help rein in the unhealthy and unsustainable aspects of globalisation.

To do this, learning tools, methods, and teaching aids must be developed to help ordinary people see the links between their local problems and

global powers:

- People need to understand how their growing hardships at home (low wages, unemployment, rising food prices, cut-backs in services, growing violence, etc.) can be traced to the global forces that manage the flow of money and resources in ways that make the rich richer and the poor poorer.

- Villagers and shanty-town dwellers in the South need to understand how decisions by wealthy, powerful men in Northern cities lead to hunger, diarrhoea and the death of their children.

- They need to know who is responsible for the decisions that allocate vast amounts of money for weapons, pet food, tobacco, golf courses and trips to the moon, when millions of children don't get enough to eat.

- They need to understand how the World Bank and IMF put the squeeze on poor countries to keep paying interest on their huge foreign debt...and how structural adjustment programmes imposed by the Bank and IMF—which force poor countries to cut-back on public services—make poor families pay for health care and schooling.

Having become aware of the links between their local problems and global policies, people need to learn ideas and information about what they can do:

- They need to know what efforts are being made—locally, nationally and internationally—to oppose these harmful high-level policies and decisions.

- They need to know what they can do personally and collectively at the local level to help work toward the changes at the global level that can shape a healthier world.

No one has a road map through these vital issues. That is why Education for Change needs to be open-ended and fully participatory. It is why the facilitator and the learning group need to look for solutions—or at least ways of coping—together. This kind of learning process, in which people learn from each other and look for a way forward together, as equals, itself becomes a microcosm of the kind of equity-oriented, people-centred, participatory environment we aspire to achieve at the global level.

Storytelling, role play and theatre for awareness-raising and change

Storytelling can be an effective way to help people understand and identify with problematic situations, and consider possibilities for strategic action. This is especially true if the story is a true one, based on something that happened in the participants' village or neighbourhood— something they are all familiar with and which concerns them deeply.

Stories for change. Stories can be told in many ways: by **storytellers**, as **skits**, as **role-play** or **socio-dramas**, or as **puppet shows**. Some of the best stories or socio-dramas for analysing situations and exploring options for action are open-ended and constructed through the participation of the entire learning group. After a key theme or problem is identified, someone starts the story around that theme, and develops it to a point of crisis or crucial choice. Then another person continues the story, up to another crisis point. Then yet another person continues it. And so on. Or after the story has been developed to a critical point, participants can divide into smaller groups, each developing the story in a different direction. Thus it becomes a way of brainstorming alternatives for action in which everyone thoughtfully takes part.

From stories to theatre to action. In Project Piaxtla, Mexico, sometimes participatory stories or role-play evolved into a plan for community action. Health workers in training would develop it into a theatre skit or puppet show and present it to the whole village as 'farm workers' theatre'. At times this resulted in a collective course of action to cope with the underlying problem. Below are four examples of stories or role-play that evolved into community theatre and finally into organised action.[1]

- **Problem-based story:** A few rich families illegally possess most local farmland, resulting in landlessness, exploitative share-cropping, hunger, and high child mortality.

  Theatre skit (developed from story): Poor villages explore options of borrowing, renting, or invading and reclaiming unused illegally-held large land-holdings.
  Consequent action: Poor farm workers collectively occupy and farm the large holdings. Eventually they demand legal title, and redistribute the land among the landless.
  Results: Improved physical health (more food, fall in child mortality) and psychosocial health (self-confidence, empowerment, determination collectively to better

their lives).

- **Problem-based story:** Alcohol. Frequent drunkenness of men leads to violence, family discord and malnutrition of children (money spent on booze).

  Skit: 'Village Women Unite to Overcome Drunkenness.' Skit first shows miserable situation. Then women join together to close down the 'water holes' (illegal bars).
  Action: After the skit, when a rich man opens a bar in the village, the women organise a protest, demand closure of bar and protest against alcohol-related corruption by authorities.
  Results: Despite the brief jailing of health workers, the bar is shut down. Fewer killings. Better health. Newspaper articles inspire women in other villages to take similar action.

- **Problem-based story:** Village midwives, mimicking doctors, inject hormones (pituitrin) to speed birth and 'give force' to mother. This causes needless deaths, or defects in babies.

  Skit: Scene 1: Shows mother giving birth; hormone injected; baby born blue and dead. Scene 2: Same mother delivers without hormones. Baby healthy. Audience explains why.
  Action: Midwives and mothers jointly decide: No HORMONE SHOTS FOR NORMAL BIRTHS.
  To reduce bleeding, mothers breast-feed newborn babies at once (to free natural hormones).

Results: Fewer ruptured uteri; fewer epileptic, dead or brain-damaged babies; demystification of modern medicines; more appreciation of the body's own abilities.

- **Problem-based story:** Poor families borrow maize from the rich at planting time, pay back triple at harvest time; this leads to big debts, increased poverty and hunger.

  Skit: Shows how high interests on maize loans devastate poor farming families. Then families come together to form a co-operative grain bank—with success.
  Action: Health workers help villagers start the co-operative maize bank, which loans grain at low interest rates. They also build rat and insect-proof storage bins.
  Results: The maize bank pulls poor farmers out of debt. Eventually they are able to produce surplus grain and have no need borrow. Better fed, healthier children; fewer die.

Stories linking local problems to global policies

While the above stories and skits proved useful in their day, they are dated. They focused on local problems that to a large extent had local solutions. For example, landless villagers could join together and 'reclaim' land-holdings that were illegally large. But today many of the people's most disabling problems have their roots in international trade and the global economy. In preparation for the North American Free Trade Agreement (NAFTA), the Mexican government was forced to change its Constitution. Agrarian Reform laws, which had protected the land rights of poor farmers were annulled. As result, poor farmers are losing their ancestral land. Two million have migrated to city slums, where the glut of jobless workers has reduced real wages by 40%. Resulting hunger and despair have led to a wave of crime and violence. The village of Ajoya (where the above stories and skits helped people solve earlier problems) has had 10 kidnappings, frequent killings, and repeated hold-ups of buses. In their current 'community diagnoses', villagers see crime and violence as among their biggest health-related problems.

Similar situations now exist worldwide. A few years ago, when Mexican school-aged children did their own 'community diagnoses', they identified problems such as diarrhoea, coughs, skin sores and 'being too thin' as their biggest health-related problems. But today—whether in Mexico, the Philippines, Pakistan, South Africa, or the slums of Chicago (USA)—children tend to identify as their biggest health-related problems such things as crime, violence, drunkenness, drugs, fighting within families, beating of children and similar social issues. **These symptoms of system failure and social upheaval can often be traced to the global policies that are deepening poverty, undermining workers' rights, reducing jobs and**

wages, and cutting back on public services.

People in poor communities around the world suffer the effects of these global policies, often without even knowing such policies exist. They have little awareness of how decisions made by overfed men in suits sitting around a table at the World Bank translate into fewer health services and more costly medicines for their sick children.

For the new 'macro-problems' of the 21st Century, new kinds of awareness-raising stories are needed—stories that make the links between local problems and global events; stories that build a chain of causes from shanty-town hardships to global boardrooms.

In preparation for the People's Health Assembly, persons involved in community health activities (and in all sectors affecting the well-being of people or the environment) are being asked to **collect eye-opening stories that make this kind of 'micro-to-macro' or 'local-to-global' links**. One example of such a story—called 'The White Death'—is included in the Preparatory Packet for the PHA (and is briefly summarised in this paper).

The 'But why? game' and the 'chain of causes'—used with stories for situational analysis

Of various participatory learning methods to raise awareness of the root causes of poor health, ones involving **situational analysis of a true story** have proved successful in many countries. The process is in four parts:

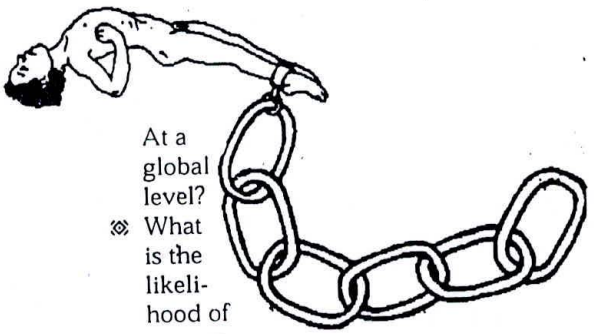
1. The story portrays a series of events that lead up to a tragic ending, such as the death of a child. (People's attention is captured better if the story is based on a recent, local sequence of events, which everyone is familiar with.)

2. After the story, participants play a (usually very serious) 'But why?' game, to itemise and analyzing the series of factors leading up to the child's death

3. Then they collectively build a 'chain of causes' linking the sick child to the grave.

4. Finally, the group discusses which links of the chain they may be able to break in order to prevent similar loss of health and life in the future. They ask themselves:

   - Which links can be broken by the informed action of a concerned individual?
   - Which links require action at the family or community level?
   - Which require action at a national level?



At a global level?

- What is the likelihood of successfully breaking different links?
- What are the preparations and resources needed? What are the risks?
- With which links can we most effectively begin to take action?'

'The Story of Luis'—presented in the handbook, *Helping Health Workers Learn*—has been used effectively as a teaching tool in health programmes around the world. Based in a Mexican village, this true story unveils the 'chain of causes' that lead to a boy's death from tetanus.[2]

The 'But why?' game (an example analysing a child's death from diarrhea). After the story to be analysed is told, the facilitator asks a series of questions and participants answer. In response to each answer the facilitator asks 'But why?'. Here is an example of how the 'But why?' game might develop from a story of a child's death from dehydration due to diarrhoea:

> **Juanita died from dehydration.... But why?**
> 'Because she had severe diarrhea.' ... **But why?**
> 'Because she swallowed harmful germs.' ... **But why?**
> 'Because the family didn't have a latrine or clean water.' ... **But why?**
> 'Because her father had no money to install them.' ... **But why?**
> 'Because, as a share-cropper, he had to pay half his harvest as rent?'... **But why?**
> 'Because he didn't own any land himself.' ... **But why?**
> 'Because the government failed to enforce the Agrarian Reform laws.' ... **But why?**
> 'Because rich land barons bribe politicians, and no one stops them.' ... **But why?**

When one series of causes is exhausted, the facilitator can ask questions exploring another series. A sequence of questions may lead from local to national factors (as above), or even international ones (as below). Note that answers need not come only from details of the story; participants can also draw on their own observation, knowledge and previous awareness-raising discussions.

Oral rehydration therapy (ORT) can help prevent death from dehydration. Yet Juanita didn't receive ORT ... But why?

'Because her mother couldn't afford commercial packets of oral rehydration salts (ORS), and hadn't learned to make a low-cost rehydration drink at home.' ... **But why?**

'Because the government, which used to give ORS packets free to poor families, now makes people pay.' ... **But why?**

'Because the World Bank required that health ministry introduce 'cost recovery' by charging for medicines and services.' ... **But why?**

'Because our country has a huge foreign debt and has to pay by cutting benefits to the poor.' ... **But why?** ... Etc.

Building the chain of causes. To extend the situational analysis of the 'But why?' game, the learning group can build a chain of causes. To make learning more dynamic, large links can be cut from cardboard. To add to the depth of the analysis, five categories of links can be labelled as:

PHYSICAL (things)
BIOLOGICAL (worms and germs)
CULTURAL (attitudes and beliefs)
ECONOMIC (money)
POLITICAL (power)

To these five—because it is increasingly important in the causal chains—some folks add:

ENVIRONMENTAL (nature of our surroundings)

Two additional figures can be made of cardboard, one representing the sick child and the other a tombstone. These figures are attached to a wall (or trees) about two metres apart. With the cardboard links, the group builds a 'chain of causes' from the child to her grave. Each participant has one or more cardboard links. The story is told again, using the method of the 'But why?' game. Each time a cause is stated, a person with a corresponding link (for example ECONOMIC) comes forward and hooks her link into the growing chain. Eventually the chain extends from child to grave.

The process of participatory analysis. Though the story may be based on the death of a real child and a sequence of real events, the process of analysis, with construction of the causal chain, can and should be somewhat open-ended. The sequence of causes (both in the 'But why?' game and using the cardboard links) can develop in a variety of directions, following the lead of the group. Participants may have knowledge of local events or factors not included in the original story. These add important new dimensions.

Discussion and debate—and the airing of different opinions—are encouraged. The purpose of the activity is to help participants explore issues in depth and form a comprehensive, multidimensional picture—like fitting together pieces of a puzzle.

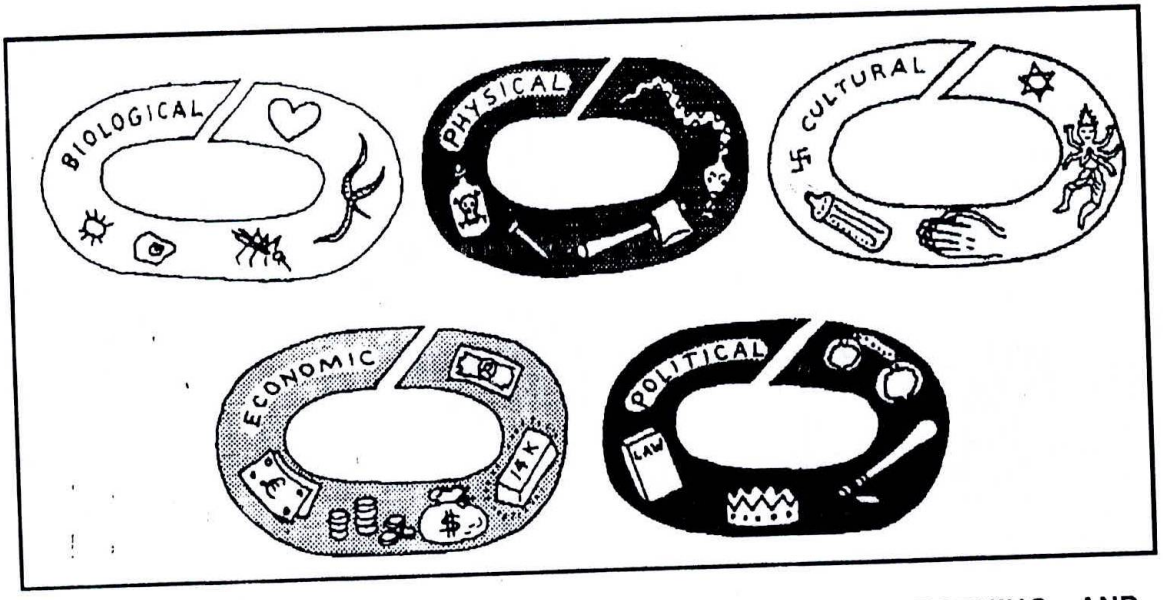
Some participants may argue that building a linear chain of causes is simplistic, that causal factors interlink in many ways, more like a web than a chain. Some programmes prefer to build a mosaic on a blackboard rather than connecting cardboard links. Teaching methods (like oral rehydration technology) can always be improved. Group criticism and collective improvement of the teaching methods should be actively encouraged. This, too, is 'education for change'.

Breaking the links. Perhaps the most important part of the 'chain of causes' activity is the follow-up discussion about WHAT TO DO. Studying the causal chain, the group considers **which links they may be able to break** and **what action to take**. Some links can be broken through individual action (such as a mother learning to make a homemade rehydration drink). Other links may require community action (such as putting in a communal potable water system). Yet others may require joining national or international networks or coalitions (such as participation in the campaign of Health Action International to restore the right to free essential medicines to families too poor to pay).

Examples of stories with local-to-global links: 'The White Death' and 'The Story of Sam'

The packet of materials for the People's Health Assembly titled 'Invitation to Participate in Pre-Assembly Activities,' includes as examples three stories that make local-to-global connections. The first two, 'The White Death' and 'The Story of Sam,' are designed to be followed by 'But why?' and 'chain of causes' activities.

'The White Death' is adapted from a story developed with village women in Sierra Leone, Africa. It tells of a woman who becomes ill and finally dies from 'weak blood' (anaemia), identified by the women as their most important health problem, and the biggest killer of women. Through group discussions and use of innovative teaching aids (such as a mosquito made from syringe and bits of a tin can) the women came to realise that 'weak blood' has many interrelated causes and to understand why it kills more women than men.



They found the causes for 'the white death' range from LOCAL to GLOBAL and from BIOLOGICAL (e.g., malaria) to CULTURAL (e.g. men have first grabs at available meat) to ECONOMIC and POLITICAL. (e.g. to produce money for foreign debt payment, the country is required by the World Bank to cut down native forests that used to have iron-rich game animals and herbal cures for malaria).

By piecing together this story from their own collective experiences, and then retelling it using 'But why?' questions and a 'chain of causes,' the women gained better understanding both of their own bodies and of the links between their local health problems and global economics.

With their new knowledge about the multiple causes of weak blood, the women were better able to take *personal action* such as growing and eating blood-strengthening foods, and *collective action* such as joining the growing trans-African movement to require the World Bank to be more responsive to human and environmental needs.

Stories like 'The White Death' and 'The Story of Sam'—and other stories that are pieced together locally around common concerns—can help ordinary persons understand how their local hardships are linked to global forces. Analysis of the stories can help prepare people to take meaningful part in the growing worldwide debate about **how economic and development policies should serve human and environmental needs**, and **how to make high-level decisions more transparent and more democratic**.

DISCOVERY-BASED LEARNING—AND LEARNING BY DOING

The effort to make global policies socially just and democratic will be an uphill battle. The world is unwisely ruled in a selfish, shortsighted way by a tiny privileged minority with huge wealth and power. To change this situation for the common good will require a vast united front of concerned people. Folks from all races, nations and walks of life—farmers and labourers; the jobless and the underpaid; the poor, the hungry and the sick; prisoners; illiterates, students and academics; the middle class, and even the very rich who worry for their children's future—must understand the big issues and what is at stake.

But understanding the issues is not easy. As we have already pointed out, **institutionalised disinformation is the modern tool of social control.** Schools, newspapers, television and market propaganda are designed to keep those on top on top by 'manufacturing consent'. For people to find their way through the maze of politically filtered information, cover-ups, and the Siren-like incentives to conform without questioning, requires—above all else—**an ability to observe and think for oneself**.

To transform our top-heavy system will require a massive uprising of peace-loving fighters for social justice—people who can sort their way through the beguiling veil of disinformation, and discover for themselves what is happening around them, for better and for worse. For such a massive movement of thoughtful, well-informed people to be formed, a simultaneous educational revolution is needed, one that espouses **a less authoritarian, more liberating approach to teaching and learning than most of us were schooled by**.

We have mentioned the enabling educational methods of Paulo Freire and others. A related approach is called 'discovery-based learning', now much used in community health education.

Discovery-based learning encourages participants to make their own observations and arrive at their own conclusions. The facilitator does not push ideas into people's heads, but helps to draw them out. This action-packed, problem-solving approach helps people think for themselves and gain confidence in their own perceptions and experience. In many community initiatives this empowering methodology has become a basic tool in 'education for change'.

Discovery-based learning and **learning by doing** go hand in hand. There is an old saying:

> If I hear it , I forget it.
> If I see it, I remember it.
> If I do it, I know it.

To this, health educators in Latin America have added,

> If I discover it, I use it.

When teaching methods enable learners to build on their own observations and discoveries, the knowledge they gain is their own. They can apply it, adapt it, and build on it more effectively. Also, it equips participants to learn about other things directly, to dig out the truth for themselves rather than to swallow unchewed what teachers and TV tell them. Thus it prepares people to be actors on life's stage, not just passive followers. It helps transform people living in quiet resignation into active agents of change.

The gourd baby—a tool for teaching that uses discovery-based learning

A classic example of discovery-based learning involves the 'gourd baby,' a teaching aid to help groups of mothers, school children, health workers, and others learn about diarrhoea and 'the return of liquid lost' (dehydration and rehydration). We include discussion of the gourd baby here, not because of the linkage of the high child death rate from diarrhoea to the global economy, but because the gourd baby is such a delightful tool for teaching community educators about an empowering and effective way of teaching.

The teaching aid is made from a hollow gourd, preferably the kind with a narrow neck separating two round ends. (A plastic bottle will also work.) The gourd, painted to look like a baby, has all the 'holes' that a real baby has (mouth, urine hole, butt hole, and two tiny eyeholes for tears. The mouth, urine and butt hole are stoppered with small plugs. The round opening at the top of the gourd represents the baby's fontanels (soft spot) and is covered with a small cloth.

The challenge for the facilitator is to help the learning group discover the signs of dehydration, without telling them. To do this, the group experiments with the gourd baby. They fill it with water, pull the plug to give it diarrhoea, and watch what happens. They observe the soft spot sink in, then the eyes stop forming tears, and the urine flow slowing down. They conclude that these signs occur because water (diarrhoea) is flowing out. Thus they discover the signs of dehydration. Because they discover these signs in a hands-on way (learning by doing) and by drawing their own conclusions from their direct observations (discovery-based learning) they never forget it.

Through similar hands-on experimentation with the gourd baby, learners observe that to prevent the 'baby' from dehydrating when it has 'diarrhoea,' they must replace at least as much fluid as the baby is losing. (This discovery is extremely important, since studies show that village mothers taught in the typical top-down way ('Do what I say and don't forget!') often give rehydration drink to their dehydrating baby as if it were a liquid medicine, a spoonful now and then. When their babies die, they spread the word that oral rehydration therapy doesn't work. So the underuse of ORT and corresponding overuse of costly, useless anti-diarrhoeal medicines continue worldwide.

Many benefits derive from the gourd baby methodology. Mothers who learn about diarrhoea management from their own observations are in a better position to question the many puzzling things they are told. For example, following standard advice, many mothers spend their last food money on commercial packets of oral rehydration salts (ORS) when they could get as good or better results by giving their baby home-made rice or maize porridge with a little salt. It is important that mothers learn to value their own experience and to critically question directives from outsiders unfamiliar with mothers' day-to-day circumstances, limitations, and abilities.[3]

community diagnosis as INTRODUCTION to discovery-based learning

Many health worker training programmes, as well as local gatherings to resolve unmet needs, use 'community diagnosis' or 'situational analysis' to start off the group process of identifying and prioritising health-related problems or other shared concerns.

There are many ways to conduct a community diagnosis. The most successful ones tend to be hands-on, action-based and designed to encourage full, thought-provoking participation.

One approach to community diagnosis that has been used effectively in many countries uses a flannel-board and small pieces of cloth with line drawings of different health-related problems. By using pictures rather than written words, non-literate people can participate in creating a graphic representation of the problems in their community and evaluate their relative importance.

First the group places on a large flannel-board (or blanket on a table tipped on its side) drawings of all the health-related problems they can think of. If there is no pre-existing drawing of the problem, the person who volunteers that problem creates a quick sketch to represent it. It is important the group include not just 'health problems' or 'sicknesses', such as diarrhoea and skin infections, but also 'health-related problems', such as poverty, smoking and unfair land tenure. (To help people understand the broad spectrum of 'health-related problems', it is often helpful to first tell a story using the 'But why?' game and 'chain of causes'.)

After the major problems affecting community health are put in rows on the flannel-board, the group systematically analyses their relative importance. To do this, they use small flannel figures, representing the different characteristics that need to be considered when weighing the relative importance of each problem.

Little round faces represent **frequency**: how often the problem appears in the community, and how many people it affects. Everyone is given several little faces, which they take turns placing next to the problems they consider most common. As more faces are added, the group tries to agree on a pattern of relative frequency.

Skulls represent relative **severity**: how likely the problem is to cause life-threatening illness or death. Persons place skulls of different sizes next to problems, trying to arrange them according to how relatively dangerous or deadly they are.

Three little faces, with arrows from one face to the others, represent **contagion**. Participants place these figures on the problems or illnesses that spread from person to person.

A long wiggle arrow represents a problem that is **chronic**. Participants place these figures on the problems that are long-lasting, or have long-lasting effects (like polio).

This graphic portrait of the relative frequency, severity, contagiousness and duration of the problems helps the participants weigh their relative importance in the community.

However, another factor also needs to be weighed: **How are the different problems interrelated? Which problems that contribute to or lead to some of the others problems?** Participants place pieces of yarn between problems where they believe there are causal links. The end result is a complex **web of causes**. It becomes clear that **some of the problems listed are 'root causes', which contribute to many of the other problems**.

The final step in this process of community diagnosis is to discuss **where to begin**. The graphic representations help the group get an overall picture of the relative importance of interrelated problems affecting the community's well-being. In constructing a plan of action for improving their situation, the group needs to consider:

- What is the relative importance of the different problems? (As investigated

above)

- Which are the underlying problems that contribute to many other problems? (Also investigated above)

- Which problems can be dealt with locally, safely, with limited investment and with positive, visible results? (It is often wise to start by taking action against problems that are likely to have fairly quick positive solutions that everyone can see and appreciate. Good early results help build confidence and bring more people on board, in order to tackle more difficult or risk-incurring problems at a later date.)

- What are the resources, human and otherwise, required to overcome the different problems?

Seeking answers to these questions helps the group decide where to begin. As discussed earlier, some problems can be resolved at the individual or family level, others at the community level. Many of the biggest, underlying problems that link back to the global power structure cannot be resolved at the local level. However, certain coping measures may help the community cope better with the hardships caused by the underlying global problems.

For example, faced with privatisation of health services or the introduction of user fees, a village might set up a community 'health insurance' plan. That way the whole community helps pay the emergency medical costs of one of its members, when disaster strikes.

Although it is often wise to begin by attacking easy-to-resolve local problems when planning local action, it is important not to lose sight of the underlying problems at the macro (or global) level. However, strategies for taking local action on global issues require a different approach. They involve networking or joining coalitions and taking part in key demonstrations. They may involve educational campaigns to raise local awareness so that more people vote for politicians who dare to take a stand for the interests and needs of the common people.

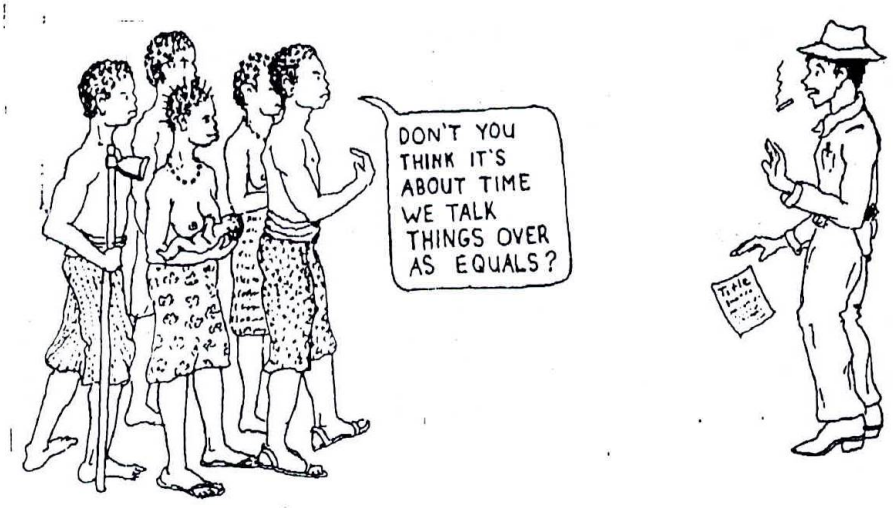
child-to-child

Empowering children to become CARING AGENTS of CHANGE

The children of today are the social architects of tomorrow. If children are to grow up to be independent thinkers and compassionate agents of change, they need to be encouraged to learn from experience and to draw conclusions from their own observations, not just to memorise lessons and do what they're told. If they are to help construct a more healthy, more caring world, children need a learning environment based on co-operation rather than competition, where helping one another to advance together—and giving friendly assistance to those who might fall behind—is valued more than getting top grades.

Child to Child is an innovative educational methodology in which school-aged children learn ways to protect the health and well-being of other children, especially those who are younger or have special needs. Launched during the International Year of the Child in 1979, Child-to-Child is now practised in over 60 developing countries as well as in Europe, the USA and Canada.

Child-to-Child does much more than impart information to kids about common health problems. At best, it is a liberating experience that helps children learn to think for themselves and work together to create a healthier, more caring environment. Children learn to reach out in a friendly, helpful way to those who are most vulnerable.



Child-to-Child emphasises learning through experience. (The gourd baby as a tool for 'discovery-based learning' was first developed through a Child-to-Child activity.) Rather than simply being told things, **children conduct their own surveys, perform their own experiments**, and discover answers for themselves. They are encouraged to think, observe, explore, analyse and invent. This makes learning an adventure, and fun. Children develop ways of looking critically and openly at life. The activities encourage independence of thought and co-operative spirit that helps form leaders in the process of change.

In Child-to-Child, children learn to work together and help each other. Older studentd organise to help teach younger ones. Younger ones conduct activities (storytelling, puppet shows, seeing and hearing tests) with pre-school children. Everybody teaches and everybody learns from each other.

Child-to-Child is pertinent to the process of social transformation. When introduced into schools as it has been in many countries, it can help make schooling more relevant to the immediate needs and lives of the children, their families and their communities. It introduces methods of 'education for change' into the classroom, counteracting and undermining the authoritarian, conformity-building, status-quo-conserving role of the conventional school system.

Latin America has taken the lead in introducing 'education for change' methodology into the Child-to-Child process. Typically, a group of children starts off by conducting their own 'community diagnosis' (as described above). Or they build 'chain of causes' stories (or draw composite pictures of 'our-community' to explore the interrelated problems in which they live.

We mentioned above how children in many parts of the world, in the process of their community diagnosis, now tend to say that **their most important problems affecting their well-being are violence, gangsters, drunken parents, fighting between parents, and cruel treatment by adults.** This 'diagnosis' makes it much more difficult for the children to take a lead in corrective action on their own. However, the mutual understanding and support that comes from sharing their common concerns can be of great assistance to children who fell lost and forgotten in a world where money rules and where democratic principals, human rights, and basic needs are grievously neglected.

Child-to-Child is important to the process of social transformation because it helps children develop skills and values based on kindness, understanding, defence of the underdog, and the joy that comes from working cooperatively for the good of all. It can help the children of today become more able and compassionate architects of tomorrow.

CONFIDENCE-BUILDING

To be fully healthy requires self-esteem. An internalised low self-image is one of the biggest obstacles to the full participation and involvement of people who have been marginalised, disempowered and kept in a subservient role. They have been told so often that they are worthless and ignorant and lazy that they begin to believe it. Their lack of respect for their own qualities prevents them from joining in the struggle for fairer social structures.

For this reason, 'education for change' puts a lot of

emphasis on confidence-building. It values and builds on the experience, ideas and opinions of participants. It helps villagers rediscover value in their traditional beliefs, customs and forms of healing. It demonstrates that the knowledge, understanding and compassion of individuals who cannot read or write can be as important to sustaining health as the knowledge and abilities of highly trained professionals.

People with little formal education to help them stand up for their rights must free themselves from the low self-image that has been thrust upon them. They need to discover that they have a wealth of knowledge, skills, and human qualities, which privileged folks often lack. To provide new insight and build the self-confidence of underprivileged people, stories that temporarily reverse social roles (as in Charles Dickens' 'The Prince and the Pauper') are especially helpful.

Fables for building confidence and self-esteem: an example. In the mountains of western Mexico, village health workers in training often began with low self-esteem. They saw themselves as too 'backward' to master even the most basic skills of health professionals. Doctors in the city hospitals—as if by God's will—were somehow smarter, better and more gifted than they were. From their limited exposure to school (for those who had any) they felt more comfortable passively memorising facts than actively learning through an open-ended, problem-posing process based on their own knowledge and experience.

For trainees with a low opinion of themselves and their abilities, the following fable— developed through group discussion —about a doctor in distress, proved enlightening.

Facilitator: Suppose a huge hurricane has destroyed the coastal city. Days later a doctor who survived the disaster arrives at our mountain village. Exhausted and hungry, he has only the clothes on his back.... How would you treat him?

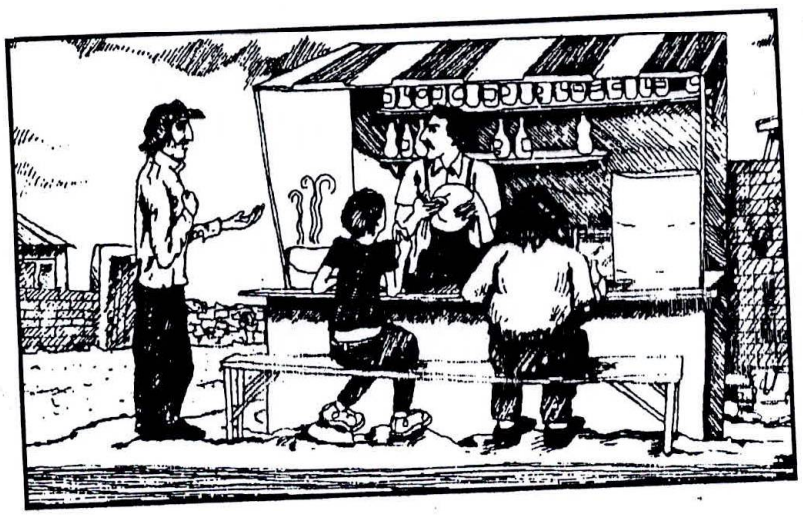
Villagers: Well, we'd give him something to eat. We'd probably invite him to stay in one of our huts until he figures out what to do.

Facilitator: Why would you do that?

Villagers: When a person needs help, we do what we can. Even for a stranger. If we didn't help each other in hard times, we wouldn't survive.

Facilitator: Suppose the doctor, lost without his medicines and hospital, decided to plant maize (corn) on the mountainside, like you folks do?

Villagers: He couldn't do it! Not without help. First, he'd have to cut down the brush with a machete, poor guy. I've seen those doctors' hands: their soft as silk! He'd get blisters in no time! And he doesn't know the poisonous snakes, scorpions and stinging trees. Or which wild fruits are edible. Or which cactus have drinkable water. Or how to keep the insects, birds and peccaries from eating his crops. Alone, he couldn't make it!



Facilitator: And would you help him learn to farm?

Villagers: It would be lots of work.... Like teaching a kid. It takes a person years to learn how to survive in these hills.

Facilitator: But you would help him?

Villagers: We couldn't just let him die!

Facilitator: For helping him

survive, how much would you ask him to pay you?

Villagers: To pay? How could we? You said he arrived with nothing.

Facilitator: You are very kind! ... Now let us imagine that tomorrow one of you breaks a leg. So you go to a doctor in the city. If you don't have any money, will he treat you?

Villagers: No way! ... That's true. My mother died because we had no money to pay the doctor!'

Facilitator: And yet you would help the doctor who has nothing, after the hurricane?

Villagers (after muttering among themselves):

'Spose so.

This sort of awareness raising dialogue helps people with little formal education realise they have a wealth of life-protecting knowledge, skills, and values—different from the 'highly educated,' but no less important. It helps them discover a new sense of self-worth and take pride in their own qualities and experience. The self-confidence they gain lets them stand up to others as equals, and become actors in building a more equitable and compassionate society.

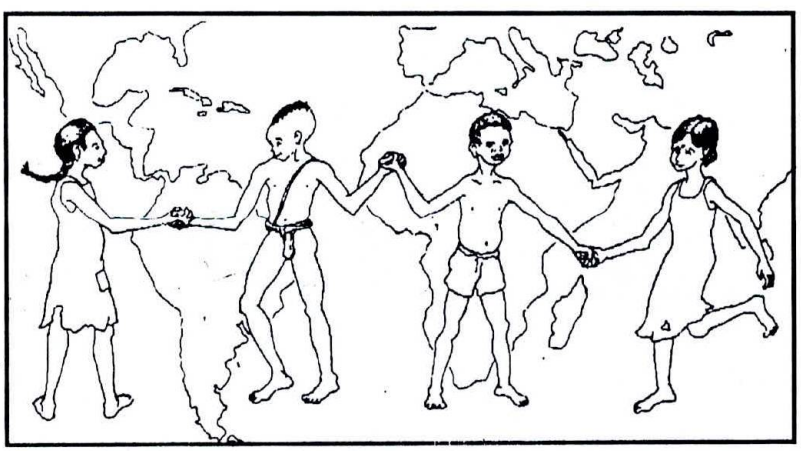
CONCLUSION: towards interaction to transform the WORLD

When, 40 years ago, Paulo Freire wrote that **with critical awareness disadvantaged people can 'transform the world'**, social scientists said he spoke metaphorically. 'Transform the world' meant to change and improve your local situation, your immediate surroundings. No doubt, our own back yard remains a good place to begin. In the words of E. F. Schumacher, 'Start small!'

But the world has changed since Freire's time. Globalisation— with its hazardous trade agreements, structural adjustment policies, cut-backs of public services, and institutionalised neglect of those in need—has made comprehensive change at the local level harder to achieve. Disadvantaged people—even nations—have less and less voice in decisions that shape their well-being.

Freire's insistence on 'transforming the world' was in some ways prophetic. Today, for local communities to overcome the injustices and inequities that diminish quality of life, they must join the growing international grassroots struggle literally to CHANGE THE WORLD. Not until the world's resources and power are more fairly shared, can sustainable well-being for all—or for anyone—be achieved.

To transform the world's power structure, we the world's people, in all our marvellous diversity, must learn to **respect our differences and embrace what we have in common**. We must work together as a family: locally, nationally and internationally. **To build the global solidarity we need, we must first of all find ways to communicate truthfully and directly, relying not on the *mass media* but on the *media of the masses.***



The Internet, for those with access to it, provides an avenue for fast and free (potentially liberating) communication. No less important are the communication tools of less privileged folks: storytelling, street theatre, neighbourhood 'rags,' awareness-raising comics and novellas, community radio and TV,

and the alternative press. As the Battle in Seattle made clear, well-planned protests, demonstrations, open forums and strategic civil disobedience also have their time and place. Such organised resistance serves not only to impede abuses of the power structure, but to raise awareness of more people.

We cannot transform the world in a day. Years of organised struggle will be needed to build the kind of compassionate, foresighted, global democracy in which solidarity defends diversity and safeguards the sustainable well-being of the planet and its people.

In building the foundations of action for change, education of children—and of us grown-ups, too—is essential. **The best education is not only free, but freeing.** It gives people tools for independent thought and social responsibility. It enables people to discover what makes our social order tick, and then to figure out a course of action to help improve the situation in which we co-exist.

The transformation of our schools (and colleges and universities) into centres of education for change is essential for social transformation. This is why Child-to-Child—with its participatory, problem-solving, child-led approach—is so important.

But we also need adult-to-adult (and adult-to-child) activities that bring diverse people together for the common good. At all social levels—cutting across the divisions of race, class, age, gender and areas of concern—people need to identify common ground and take collective action for change.

The role of non-government organisations is critically important. NGOs concerned with human well-being and with environmental protection need to work together. NGOs in a range of fields need to form networks and coalitions to take the unified action needed to have an impact on global decision-making. The International People's Heath Council is one such coalition.

The People's Health Assembly promises to be a big step forward. But if it is indeed to contribute to creating a healthier world in these difficult times, it must be much more than a single meeting of 600 or so people who fly to Bangladesh in December 2000. Preparatory activities and follow-up are as important as the December meeting itself, and need to be oriented towards education and action.

One of the most important aspects of the PHA, with its pre- and post-assembly activities, is what Paulo Freire called **critical awareness-raising.** Only when enough people from all countries and cultures and fields of endeavor become painfully aware of the enormous injustices and inequities of our present global system—and the dangers these inequities bear for our common future—can we collectively tip the scales of the global agenda to put the needs of the many before the greed of the privileged few.

Notes

[1] These short summaries are oversimplified. More detailed versions can be found in the book *Helping Health Workers Learn* by David Werner and Bill Bower.

[2] For details about the methods of story telling for participatory analysis using the 'But why?' game' and 'Chain of Causes', we suggest you read Chapter 26 of *Helping Health Workers Learn.*

[3] The gourd baby and discovery-based learning are discussed in the book *Helping Health Workers Learn.* The debate on oral rehydration therapy is covered in *Questioning the Solution: The Politics of Primary Health Care and Child Survival.*

A biologist and educator by training, *David Werner* has worked for the past 33 years in village health care, community based rehabilitation, and Child-to-Child health initiatives in the Third World, mainly Mexico. He has authored the books "Where There Is No Doctor" (now in 86 languages), "Helping Health Workers Learn," "Disabled Village Children," "Questioning the Solution: The Politics of Primary Health Care and Child Survival", and "Nothing About Us Without Us: Developing Innovative Technologies For, By and With Disabled Persons." He has been a consultant for UNICEF, WHO, the Peace Corps, UNDP, and UN ESCAP and has received awards and/or fellowships from the World Health Organization, the American Pediatric Association, The American Medical Writers Association, Guggenheim, and the Macarthur Foundation, among others. He is a founding member and North America coordinator of the International People's Health Council, co-founder and Director of HealthWrights (Workgroup for People's Health and Wrights), and a Visiting Professor at Boston University International School of Public Health.

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Social inequalities in health within countries: not only an issue for affluent nations

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Abstract

While interest in social disparities in health within affluent nations has been growing, discussion of equity in health with regard to low- and middle-income countries has generally focused on north–south and *between*-country differences, rather than on gaps between social groups *within* the countries where most of the world's population lives. This paper aims to articulate a rationale for focusing on within- as well as between-country health disparities in nations of all per capita income levels, and to suggest relevant reference material, particularly for developing country researchers. Routine health information can obscure large inter-group disparities within a country. While appropriately disaggregated routine information is lacking, evidence from special studies reveals significant and in many cases widening disparities in health among more and less privileged social groups within low- and middle- as well as high-income countries; avoidable disparities are observed not only across socioeconomic groups but also by gender, ethnicity, and other markers of underlying social disadvantage. Globally, economic inequalities are widening and, where relevant information is available, generally accompanied by widening or stagnant health inequalities. Related global economic trends, including pressures to cut social spending and compete in global markets, are making it especially difficult for lower-income countries to implement and sustain equitable policies. For all of these reasons, explicit concerns about equity in health and its determinants need to be placed higher on the policy and research agendas of both international and national organizations in low-, middle-, and high-income countries. International agencies can strengthen or undermine national efforts to achieve greater equity. The Primary Health Care strategy is at least as relevant today as it was two decades ago; but equity needs to move from being largely implicit to becoming an explicit component of the strategy, and progress toward greater equity must be carefully monitored in countries of all *per capita* income levels. Particularly in the context of an increasingly globalized world, improvements in health for privileged groups should suggest what could, with political will, be possible for all.

Keywords: Equity; Social inequalities in health; Developing countries

Background: wide and widening health inequalities within low- and middle- as well as high-income countries

Over the past decade, there has been a growing body of research and commentary on socioeconomic inequalities in health in western Europe and the United States (Bartley, Blane, & Montgomery, 1997; Braveman, Oliva, Reiter, & Egerter, 1989; Braveman, Egerter, & Marchi, 1999; Gilson, 1998; Kaplan, Pamuk, Lynch, Cohen, & Balfour, 1996; Kennedy, Kawachi, & Prothrow-Stith,

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1996; Krieger, Williams, & Moss, 1996; Kunst & Mackenbach, 1994; Lynch, Everson, Kaplan, Salonen, & Salonen, 1998; Mackenbach & Gunning-Schepers, 1997; Macintyre et al., 1989; Macintyre, 1997; Marmot et al., 1991; Marmot, Ryff, Bumpass, Shipley, & Marks, 1997; Pamuk, Makuc, Heck, Reuban, & Lochner, 1998; Pappas, Queen, Hadden, & Fisher, 1993; Roberts, 1997; Smith, Bartley, & Blane, 1990; Smith, 1997; Townsend, 1990, 1994; Wagstaff, 1992; Wilkinson, 1992a, b; World Health Organization Regional Office for Europe, 1994). Gender disparities also have received increasing consideration in affluent countries (Council on Ethical and Judicial Affairs, 1991; Arber & Cooper, 1999; Dunnell, Fitzpatrick, & Bunting, 1999; Fuhrer, Stansfeld, Chemali, & Shipley, 1999); scholars have pointed out the complexity of interpreting many of the observed gender differences (Macintyre, Hunt, & Sweeting, 1996) and emphasized the importance of examining how socially constructed gender roles and gender inequalities may adversely affect the health of men as well as women (Hunt & Annandale, 1999; Kawachi, Kennedy, Gupta, & Prothrow-Stith, 1999). Racial/ethnic disparities in health and health care in the US have been routinely monitored and discussed for decades (Braveman et al., 1989; Braveman, Egerter, Edmonston, & Verdon, 1994; Breslow & Klein, 1971; Council on Ethical and Judicial Affairs, 1990; Kochanek, Maurer, & Rosenberg, 1994; Maynard, Fisher, Passamani, & Pullum, 1986; Montgomery, Kiely, & Pappas, 1996; Schulman et al., 1999; United States Department of Health and Human Services, 1985; Wenneker & Epstein, 1989; Winkleby, Robinson, Sundquist, & Kraemer, 1999; Yergan, Flood, LoGerfo, & Diehr, 1987). Many scholars have pointed out the need to consider the extent to which the disparities were due to socioeconomic rather than to racial/ethnic factors per se (Bassett & Krieger, 1986; Kaufman, Cooper, & McGee, 1997; Keil, Sutherland, Knapp, & Tyroler, 1992; Muntaner, Nieto, & O'Campo, 1997; Navarro, 1990; Smith et al., 1998a; Terris, 1973; Williams, 1994; Williams, Lavizzo-Mourey, & Warren, 1994), which is made difficult by the lack of information adequately characterizing socioeconomic status/position in most US data sources. By contrast, discourse and documentation on health disparities affecting the populations of low- and middle-income countries, where two-thirds of the world's population resides (World Health Organization, 1998), have most often been limited to north–south and *between*-country differences (World Health Organization, 1995a; World Health Organization, 1998). Relatively little information is routinely available on health status or health care disparities between better- and worse-off groups *within* most countries, and particularly on how within-country social disparities may change over time.

While routine data on within-country health disparities are scarce, special studies have revealed ample evidence that wide gaps in health and health care among different socioeconomic groups within a country are not confined to the affluent nations (Bicego & Boerma, 1993; Breilh, Granda, Campana, & Betancourt, 1987; Cleland & van Ginneken, 1988; Cleland, Bicego, & Fegan, 1992; Evans, Whitehead, Diderichsen, Bhuyia, & Wirth, 2001; Gwatkin, Rutstein, Johnson, Pande, & Wagstaff, 2000; OPS/OMS, 1999; United Nations Development Programme, 1990, 1996a, b; Victora, Barros, Huttly, Teixeira, & Vaughan, 1992; World Bank, 1993; Suarez-Berenguela, 2000). In Venezuela, for example, poorer municipalities have had infant mortality rates three times higher than those in other municipalities (Pan American Sanitary Bureau/United Nations Economic Commission for Latin America and the Caribbean, 1994) and a 1992 study revealed low birthweight rates twice as high in the poorest compared with the most affluent neighborhoods of a city (OPS/OMS, 1999). In a state of Mexico, a 9-year difference in life expectancy was recently observed between people living in a poor county and those in a relatively well-off county (Evans et al., 2001). Marked differentials in child mortality have been demonstrated according to a range of socioeconomic factors in Ghana, Kenya, Lesotho, Liberia, Nigeria, Sierra Leone, Sudan, Indonesia, Nepal, Republic of Korea, Sri Lanka, Thailand, Chile, Jamaica (United Nations, 1985), Costa Rica, Honduras, Paraguay, and Jordan (United Nations, 1991), Peru (OPS/OMS, 1999; Valdivia, 2001), and Brazil (Victora & Barros, 2001; OPS/OMS, 1999). Adults in non-professional jobs in Sao Paulo, Brazil, during the late 1980s had death rates that were two to three times higher than those of professionals (World Bank, 1993). In Bolivia, most public spending on health services has gone toward care for people belonging to the upper 40% of income groups (Unidad de Analises de Politicas Sociales, 1993). In Indonesia during 1990, only 12% of public spending for health care was for services consumed by the poorest 20% of households, who would be expected both to need more health services because of poverty's role in illness and to be less able to pay for health care in the private sector; the wealthiest 20% of households consumed 29% of the government subsidy in the health sector (World Bank, 1993). In the Dominican Republic in 1996, the poorest quintile of the population paid 20% of their income for health care while the richest quintile paid less than 10% (OPS/OMS, 1999). None of these disparities would have been revealed by data routinely collected and analyzed.

Striking gender disparities in health and/or health care have been observed outside the industrialized countries, again generally only as a result of special studies (Standing, 1997). A study in India showed that female infants 1–23 months of age were almost twice as likely to die by the age of two as were males, and concluded that the most likely explanation was different

behavior of families toward male and female children rather than biological differences (Das Gupta, 1987). A United Nations agency report concluded that the death of one out of every 6 female infants in India, Bangladesh, and Pakistan was due to neglect and discrimination (United Nations Population Fund, 1989). Studies in Bangladesh found that boys under 5 years of age were given 16% more food than girls (United Nations, 1993). In some countries, surveys indicate that families are significantly more likely to immunize their male children (Kurz & Johnson-Welch, 1997; Martineau, White, & Bhopal, 1997; Sommerfelt & Piani, 1997). Examples of bias against girls in access to modern health services have been cited from Korea, Togo, Sierra Leone, Nigeria, Jordan, Algeria, Syria, and Egypt (Kutzin, 1993). A recent study in Chile found that women paid more for health care in both the public and private sectors because co-payments/uncovered expenses were greater for many reproductive health services used only by women but affecting the health of the entire society (Vega, Bedregal, & Jadue, 2001).

Racial/ethnic disparities in health and its determinants also have been observed within countries of diverse per capita income levels. In Guatemala, malnutrition rates during the 1980s were 40% higher among indigenous compared with non-indigenous children (Psacharopoulos, Morley, Fiszbein, Haeduck, & Wood, 1993). Studies of child mortality have demonstrated ethnic disparities within Peru, Sri Lanka, Thailand, and many African countries that persist even after control for other factors including some measures of socioeconomic status (United Nations, 1985). Until recently, more than four times as much money was spent on health care for whites as for blacks in South Africa (Yach & Harrison, 1995); reversing the health effects of apartheid is unlikely to be an easy or rapid process (Benatar, 1997). The likelihood of a child dying before reaching age two varied between ethnic groups in Kenya from 7.4% to 19.7%, and in Cameroon from 11.6% to 20.5% (World Bank, 1993).

In contrast with the lack of routine data on socioeconomic, gender, and ethnic disparities in health, urban–rural disparities and disparities between large subnational regions of developing countries are often relatively well documented on a routine basis. In Nigeria, the average life expectancy in the Borno region is only 40 years, 18 years less than in the Bendel region; adult literacy (12%) in Borno is one-quarter of the national average (United Nations Development Programme, 1994). In Peru, the infant mortality rate in some rural areas was recently estimated at 150 per 1000 live births, while in the capital city Lima it was 50 per 1000 (Pan American Sanitary Bureau/United Nations Economic Commission for Latin America and the Caribbean, 1994). Urban–rural gaps may be widening in many nations, along with disparities between different zones within the same city. For example, in Latin America between 1980 and 1994, the proportion of urban dwellers who were poor increased from 25% to 34%; the urban poor are now thought to make up the greatest segment of desperately poor people in the region (OPS/OMS, 1999).

What is equity in health?

Equity is an ethical concept that is as challenging to define precisely as its near-synonym *social justice*, which may mean different things to different people in different societies at different times. *Inequity* refers not to all inequalities, but to those inequalities that are considered unfair and avoidable (Whitehead, 1990). *Equity* implies that need rather than privilege be considered in the allocation of resources; as with *equity* and *fairness*, it is difficult to define *need* in precise terms (Mays, 1995; National Health Service Management Board, 1988). In operational terms, pursuing equity in health can be understood to mean striving to reduce avoidable disparities in physical and psychological well-being—and in the determinants of that well-being—that are systematically observed between groups of people with different levels of underlying social privilege, i.e., wealth, power, or prestige. The fact that an avoidable health disparity adversely affects a group at an underlying social disadvantage makes that disparity unfair, even in the absence of knowledge of the specific proximate causes of the disparity. In virtually every society in the world, social privilege varies among groups of people categorized not only by economic resources but also by gender, by geographic location, by ethnic or religious differences, and by age; other dimensions can be important as well, but these are nearly universal and they often interact with each other to make some groups—e.g., poor women in ethnic minority groups—particularly disadvantaged with respect to opportunities to be healthy.

Assessing health equity within a society requires examining inequalities in health (and in its determinants) between more and less socially advantaged groups within the society, focusing for practical reasons on those inequalities likely to be among the most important causes of ill health and also to be relatively avoidable. Thus, a rational focus on equity would lead one to prioritize the goal of trying to diminish gaps in ill health due to, for example, diarrheal disease, malnutrition, or adverse environmental exposures that, disproportionately and significantly affect disadvantaged groups; by contrast, less emphasis would be placed on searching for cures for rare genetic conditions that affect one ethnic group more than another, even though one might believe that ultimately all genetic conditions will be curable or preventable. It would make little sense from

an equity perspective to focus attention on reducing the widespread but genetically based gap in birth weight between male and female newborns, because it is unlikely to be a major source of subsequent health inequality, avoidable, or related to underlying differences in social advantage.

- "Social inequalities in health" or "health inequities" refer to avoidable disparities in health or its key determinants that are systematically observed between groups of people with different levels of underlying social privilege, i.e., wealth, power, or advantage.
- Virtually everywhere, social privilege varies not only by economic resources, but also by gender, racial or ethnic group, geographic location, and other characteristics.
- Equity implies consideration of need rather than social privilege in resource allocation.
- Assessing health equity requires examining avoidable disparities in health (and its determinants) between more and less socially advantaged groups.

For some, a commitment to equity in health means that all social groups should have a basic minimum level of well-being and services, but that at the same time it is acceptable for some social groups to have better health status or health care than others, as long as government does not pay directly or indirectly for the additional benefits. There may be substantial disagreement about what constitutes "minimum" levels of health and health care; implications would be quite different if "minimum" standards meant good, borderline, or poor levels (Jayasinghe, De Silva, Mendis, & Lie, 1998). Because health and health care are not commodities like furniture or automobiles, most people who promote an egalitarian perspective would contend that equity requires the reduction of all avoidable disparities that significantly shape opportunities to be healthy, not only ensuring a minimum standard for all (Gilson, 1998; World Health Organization, 1996).

Why care about equity—in general or in health in particular?

Evidence is accumulating in industrialized countries of a relationship between the magnitude of socioeconomic inequalities and poor health that cannot be explained by differences in absolute levels of income or poverty (Lynch et al., 1998; Kaplan et al., 1996; Kawachi & Kennedy, 1997; Kennedy et al., 1996; Kennedy, Kawachi, Glass, & Prothrow-Stith, 1998; Smith, 1996; Wilkinson, 1992a, b, 1996, 1997). Some researchers have raised methodologic concerns about this observed relationship, however (Deaton, 1999; Fiscella & Franks, 1997; Judge, 1995). Living in an inequitable society could harm health through many economic, social, psychological, and physiological pathways (Adler et al., 1994; Kaplan et al., 1996; Marmot et al., 1997). Income disparities may be linked with deleterious health effects in large part in so far as they reflect varying degrees of investment in human development, e.g., in public education, health care, or other social services (Kaplan et al., 1996; Kawachi, Kennedy, Lochner, & Prothrow-Stith, 1997; Kennedy et al., 1996; Lynch & Kaplan, 1997; Smith, 1996), rather than through a direct causal link. Some scholars believe that income disparities may have deleterious effects on health through their association with the degree of social cohesion (Kawachi & Kennedy, 1997; Kawachi et al., 1997; Wilkinson, 1997) and/or through physiologic effects of relative deprivation on those at the bottom of the social hierarchy (Wilkinson, 1997).

Some have argued for greater equity on pragmatic grounds. The United Nations Development Programme's (UNDP) Regional Director for Latin America and the Caribbean recently stated: "In our part of the world there is a consensus that reducing social inequity is not only an ethical, but also a political and economic imperative. Equity is good business." (United Nations Development Programme, 1996a) When he was head of the World Bank, Robert McNamara stated that the "pursuit of growth and financial adjustment without a reasonable concern for equity is ultimately socially destabilizing". (World Health Organization, 1995a) Soaring crime rates in Latin America in recent years have been attributed to failure to consider the effects of uncontrolled free-market reforms on vulnerable social groups, along with the associated dismantling of many state institutions (Anonymous, 1996). A recent article in The Economist (2001) urges governments and the rich to take measures to limit and buffer the effects of economic inequality in order to avoid social conflict.

Other pragmatic arguments for equity in health and health care may appeal to the self-interest of privileged groups, for example with respect to avoiding spill-over effects of poor health among the disadvantaged. Given contemporary population density and mobility, neglect of infectious disease control jeopardizes the health of the more affluent as well as that of the poor who provide services for them in their homes, shops, and restaurants. Similarly, spending on public health measures such as immunizations and control of highly infectious diseases among high-risk groups may even yield relatively short-term savings in prevention of epidemics. Failure to address geographic disparities in quality of care can lead to additional costs for the public sector in the short run; for example, when primary care services of adequate quality and convenience are not available near poor neighborhoods, many people will seek primary care at public sector sites such as hospital emergency rooms and

specialty-oriented outpatient clinics where such services are more costly to deliver.

Some pragmatic economic arguments for equity in health and health care are based on achieving greater long-term economic capacity and real productivity, which must be distinguished from short-term efficiencies. The WHO position paper for the 1995 World Summit for Social Development stated that "investment in health is essential for economic growth based on a productive workforce. To achieve this, growth needs to be accompanied by more equitable access to the benefits of development, as inequities have severe health consequences and pose an unacceptable threat to human well-being and security" (World Health Organization, 1995b). For example, malnutrition and poor health decrease worker productivity (Cornia, Jolly, & Stewart, 1987; World Bank, 1993). Similarly, the education of girls and women has been linked with improved child nutrition, decreased infant mortality, and lower pregnancy rates (Bansal, 1999; Cornia et al., 1987), all of which have been associated with economic growth. Poverty and lack of education are associated with high population growth rates which in turn make it far more difficult to alleviate poverty.

However, short-term gains in efficiency are more easily measurable than long-term societal progress; cost-effectiveness estimates are often based on outcomes measurable on a short-term basis. At times, the most rapid way to observe advances in indicators of overall growth may be to give more to those who already have the most and need the least; they are often best equipped to be immediately productive with a given additional input (Wagstaff, 1991). By leaving those in greater need continually further behind, however, this approach limits the capacity for long-term development of the society as a whole. Scientifically sound evidence of the aggregate "utility" of investing in equity may be lacking because the relevant information has not been collected or analyzed or because the impact may not be measurable in terms of the economic indicators being used, at least during the specified time frame. Nobel Prize-winning economist Amartya Sen has pointed out the importance of using health indicators themselves as indicators of development (Sen, 1993). The traditional economic measures of income or commodities need to be seen as instruments toward the end of human well-being itself, rather than as ends in themselves (Sen, 1998).

Global pressures are making it difficult for countries of every income level to achieve greater equity in health

In the face of powerful global economic, social, and political trends, many countries are finding it difficult to implement and sustain equity-promoting policies in sectors with major influences on health. Recent UNDP Human Development Reports have noted widening income inequalities in many countries, including Argentina, Bolivia, Brazil, Peru, Venezuela, Bangladesh, Thailand, Bulgaria, the Czech Republic, the Baltic States, Australia, the United Kingdom, and the United States of America (United Nations Development Programme, 1996b). In Latin America, absolute numbers of people living in poverty have increased markedly since 1980 and the proportion of people living in poverty has been stagnant overall (Anonymous, 1996; OPS/OMS, 1999) and increasing in some countries, such as Mexico (United Nations Development Programme, 1997). A recent Pan American Health Organization report (OPS/OMS, 1999) stated that in 1995, purchasing power parity was 417 times greater among the richest 1% of the population of Latin America than among the poorest 1%, which was the highest ratio in recorded history, and that it probably has worsened since (OPS/OMS, 1999).

While trends over time in disparities in *wealth* are relatively well documented on a routine basis, few countries have routinely collected data that permit examination of time trends in socioeconomic disparities in *health*. However, widening socioeconomic disparities in health status have been demonstrated in a number of industrialized countries. The *Black Report* on social inequalities in health in England showed that disparities in death rates between employed men who worked in the highest and lowest occupational class jobs widened consistently from 1949 to 1970 (Black, Morris, Smith, & Townsend, 1980). In addition to the widening gap between socioeconomic groups as reflected by occupational classes, death rates of unskilled workers in certain age groups rose in absolute terms during the 1960s (Gray, 1982) and 1970s (Marmot & McDowall, 1986; Harding, 1995). These trends accompanied widening income inequalities and occurred despite a serious commitment to equity in health services by the National Health Service (Smith et al., 1990). Since then, the health gap between social classes has persisted (Marmot et al., 1991) or widened (Scott-Samuel, 1997; Smith, 1997; Acheson et al., 1998), while income inequalities are "spiralling out of control" in Britain (Lewis et al., 1998; Townsend, 1994).

Markedly widening inequalities in income in the United States (Pamuk et al., 1998; United States Bureau of the Census, 1996) also have been accompanied by increases in socioeconomic disparities in various health measures. Socioeconomic disparities in US infant mortality rates widened significantly from 1964 to 1987–1988 (Singh & Yu, 1995). The association between poverty and fair or poor child health status also appeared to increase between around 1980 and around 1990 (Montgomery et al., 1996). Increases have been observed over time in the proportion of all adult deaths in the US that are likely to be due to poverty; some

studies have concluded that the relationship between mortality and socioeconomic status in the US has become stronger over time (Hahn et al., 1995; Pappas et al., 1993; Yeracaris & Kim, 1978), although apparently contradictory results also have been reported (Hahn et al., 1996). Comparable observations have been made in France and Hungary (Pappas et al., 1993) and in New South Wales, Australia (Burnley, 1998). While temporal association does not establish a causal relationship, it can suggest the need for further study and/or help confirm or disconfirm other evidence.

Even without data disaggregated by socioeconomic group, deteriorations in health measured at the aggregate level have been observed recently in some countries where income inequalities have widened and public service safety nets have been markedly reduced. Political and economic changes in Russia and throughout Eastern Europe have been accompanied by striking trends in health that are evident even in national averages. Between 1990 and 1994, life expectancy in Russia fell from 63.8 to 57.6 years among men and from 74.4 to 71.0 years among women (Leon et al., 1997). "According to the preliminary 1993 data available for several...Newly Independent States..., life expectancy dropped to the lowest levels seen for decades" (World Health Organization Regional Office for Europe, 1994). The specific direct or indirect role of income inequalities (exerting an effect through, for example, decreased social safety nets and/or decreased social cohesion), in contrast to heightened violence and alcoholism that could be related to social and political instability rather than to economic inequalities (Kaasik, Andersson, & Horte, 1998; Leon et al., 1997; Notzon et al., 1998; Walberg, McKee, Shkolnikov, Chenet, & Leon, 1998) cannot be confirmed. It appears likely that alcoholism played an important role; abandonment of a Gorbachev-era anti-alcohol campaign may have been key (Leon et al., 1997; Shkolnikov & Nemtsov, 1997). Some observers have thought that economic inequalities were likely to have had a substantial influence (Walberg et al., 1998). Similarly alarming trends are occurring in countries that historically placed a high priority on equity. For example, "as an unfortunate consequence of China's liberalization program of the past decade, government funding for public health has declined and the rural insurance system has now largely disintegrated. A recent study suggests that these new health policies have made the distribution of government spending for health in China more unequal and may be contributing to an increased incidence of easily treatable diseases such as tuberculosis" (Birdsall & Hecht, 1995).

The costs of foreign debt repayment and economic structural adjustment programs have resulted in cuts in social spending in many developing countries (Kanji, Kanji, & Manji, 1991; Lown, Bukachi, & Xavier, 1998; United Nations Children's Fund, 1991). These cuts have been widely associated with deteriorating conditions or a halting of previous trends toward improvements for vulnerable groups (Cornia et al., 1987; Jolly & Cornia, 1984; Kanji et al., 1991; Morales, 1993), although some have questioned whether that connection is causal or inevitable (Weil, Alicbusan, Wilson, Reich, & Bradley, 1990). In Zambia from 1980 to 1984, when implementation of that country's structural adjustment program was at its height, the proportion of hospital deaths attributed to malnutrition rose approximately 1.5- to 2-fold among children under age five (Kanji et al., 1991). Similarly, low birth weight rates in Nigeria almost doubled (from 7% to 13%) at a major hospital from 1984 to 1989 (Ibe, 1993). Women may suffer more than men from structural adjustment programs (Kanji et al., 1991; Jazairy, Alamir, & Panuccio, 1993).

The effects of structural adjustment programs may be difficult to distinguish from the effects of the economic crises that precipitated the imposition of structural changes in national economies. For example, during the early 1980s many countries experienced severe economic recessions that in themselves appeared to have demonstrable adverse effects on vulnerable populations, particularly children (Cornia et al., 1987; Jolly & Cornia, 1984). UNICEF (Jolly & Cornia, 1984) conducted a literature review and 11 case studies to study the effects of economic recession during the late 1970s and early 1980s in Italy, the US, and selected countries of Latin America, sub-Saharan Africa, and South Asia. The conclusion was that, in the face of global recession, "only in South Korea and Cuba—countries that have deliberately implemented policies to protect children and the poor even in times of relative economic adversity—have the broad trends towards improvement in child welfare continued almost unaffected" (Jolly & Cornia, 1984).

Regardless of the role of structural adjustment, real per capita public expenditures on health began to decrease in many countries during the late 1970s and that decline has continued. Accompanying the diminished investment,

> ...the quality and quantity of public subsidized health services has fallen correspondingly. Utilization levels, particularly at rural health facilities, have declined. Outreach services no longer function, drugs are often unavailable, and health staff are unsupervised and sometimes unpaid for long periods of time. Rural populations have faced higher costs for health care in terms of transport and time to get to hospitals in larger towns, or by payments to private providers of treatment and medication. "Free" care has come to mean unacceptably poor care. (Creese & Kutzin, 1995)

In Sri Lanka, for example, "there are data which indicate that despite the state sector providing a health service at zero user charges, 40–50% of the health care costs are borne by the household". (Jayasinghe et al., 1998).

During the final decade of the 20th century most developing country governments implemented cost-sharing mechanisms such as user fees to help finance health services (Collins, Quick, Musau, Kraushaar, & Hussein, 1996), often with the expectation that this would result in improved quality as well as sustainability of public services (Adeyi, Lovelace, & Ringold, 1998; Creese & Kutzin, 1995). Despite acknowledging that "there clearly are inequitable consequences in many cases...", some maintain that "user fees and co-payments are not necessarily at odds with equity". (Adeyi et al., 1998) However, some economists who have reviewed the experience in many countries have concluded that overall, compared with obtaining revenues for health services from general progressive taxation, cost recovery in the health sector appears to be inherently inequitable as well as inefficient (Creese, 1990; Creese, 1997). Outside of very protected circumstances, user fees and exemption mechanisms have generally proven to be difficult to implement without letting the most vulnerable people suffer; furthermore, re-investing user fees in improved quality of local services has proven an elusive goal (Creese, 1990; Creese, 1997; McPake, 1993). The costs of determining eligibility for fee waivers often exceed the returns in fees collected. When user fees were increased in Swaziland, there was a marked decline at government facilities in use of basic health services by patients previously exempted for poverty, including services for diarrheal disease, sexually transmitted disease, and infant immunizations; utilization remained diminished one year later, and increases in utilization of non-governmental facilities did not compensate for the decline (Yoder, 1989). A study in Ghana's Volta region, where user fees were markedly increased around 1985, determined that during 1995, exemptions for inability to pay were granted in fewer than 1 in 1000 patient encounters, while 15–30% of the population were estimated to be poor; the authors concluded that fees "are preventing access... or are posing significant financial hardships..." on the most vulnerable segment of the population (Nyonator & Kutzin, 1998).

The World Health Organization's 1978 Alma Ata declaration on Primary Health Care voiced a global commitment to attaining health for all; however, that commitment to equity crystallized during a period of widespread economic growth. During the 1980s and since, economic recession has been experienced at some time virtually worldwide, along with the economic and political effects of globalization of the world's economy. Measures taken in industrialized and non-industrialized countries to increase competitiveness in the global economy, along with structural adjustment programs in developing countries, have led to diminished *per capita* social spending in most countries. Globally, there has been a down-sizing of government and a marked trend toward privatization of many functions formerly within the public domain. To varying degrees, many countries have experienced a shift from centrally planned and regulated to market-dominated economies. In addition, in many nations, military spending has increasingly devoured scarce resources that potentially would be available for social development.

Worldwide, including in lower-income countries, economic globalization appears to be yielding unprecedented increases in wealth for those individuals and population groups who are socially positioned to profit most and most rapidly from the economic opportunities presenting under competitive conditions (Greider, 1997; Kanji et al., 1991; Mander & Goldsmith, 1996). The justification for not interfering with this markedly accelerated "the rich-get-richer" tendency in lower-income countries is the belief that societies can break out of the vicious cycle of poverty and underdevelopment only by placing the highest priority on short-term efficiency and overall economic growth, at the expense of social spending. The reasoning is that when adequate rates of growth are achieved the benefits will "trickle down" to all; according to this perspective, too much emphasis on equity now will jeopardize economic growth and perpetuate poverty and deprivation.

However, considerable evidence has accumulated to discredit the hypothesis that economic growth is automatically accompanied by benefits for all (United Nations Children's Fund, 1991; United Nations Development Programme, 1996b). The United Nations Development Programme's 1996 Human Development Report noted that "Widening disparities in economic performance are creating two worlds—ever more polarized.... The poorest 20% of the world's people saw their share of global income decline from 2.3% to 1.4% in the past 30 years. Meanwhile, the share of the richest 20% rose from 70% to 85%. That doubled the ratio of the shares of the richest and the poorest—from 30:1 to 61:1; furthermore, during 1970–1985 global GNP increased by 40%, yet the number of poor increased by 17%" (United Nations Development Programme, 1996b). The same report also commented that "Policy-makers are often mesmerized by the quantity of growth. They need to be more concerned with its structure and quality. Unless governments take timely corrective action, economic growth can become lopsided and flawed. Determined efforts are needed to avoid growth that is jobless, ruthless, voiceless, rootless and futureless"—in other words, growth *without* equitable, sustainable human development (United Nations Development Programme, 1996b). Kanji et al. (1991)

37

have described the emergence and consolidation of a new class of entrepreneurs within many developing countries, among whom gains in total national wealth are increasingly concentrated. Anand and Ravallion (1993) have argued that differences in social spending, i.e., public investment in expanding human capabilities, may have a more profound effect on health and overall human development in developing countries than differences in average income, and perhaps even more profound than direct poverty reduction when the latter is confined primarily to changes in income.

It is difficult to obtain timely evidence of the effects of economic and political changes on equity in health and health care. In the first place, it is always challenging to establish the causality of any observed pattern or trend in health, given the complex and multifactorial pathways almost invariably involved. Second, reliable information to document patterns and trends in social inequalities in health is often lacking or, when available, not presented in a manner likely to highlight the policy implications. Traditional methods for routine monitoring of health and health care often obscure large or growing disparities between groups. In most nations, routinely collected data on health and health care are rarely disaggregated meaningfully according to socioeconomic factors or other markers of social advantage such as gender and ethnicity. While poor countries often have limited data, even in higher-income countries routine methods of analyzing and presenting data as nationwide, provincial, or city-wide averages obscure large disparities between diverse groups within territories. In addition, there is lack of consensus on the best technical methods for measuring the magnitude of social inequalities in health (Mackenbach & Kunst, 1997; Wagstaff, Paci, & Van Doorslaer, 1991).

Conclusion: the need for international and national organizations to focus explicitly on equity in health and its basic determinants, within as well as between countries

International agencies could play an important role in supporting research and action on social inequalities in health that is relevant to the needs of low- and middle-income countries. For example, international agencies can encourage and support national researchers from low- and middle-income countries to apply their talents to work in this area, and can support exchange among researchers from different countries as well as efforts to translate research into policy. Research methods and suitable data sources need to be developed not only for one-time special studies but also for ongoing routine monitoring over time (Braveman, 1998). The Rockefeller Foundation's recently launched Equity Gauge initiative is focusing on these concerns, and particularly on ensuring close links between monitoring and systematic efforts for advocacy and to increase public participation in decision-making that shapes health (see www.rockfound.org). Globally, more knowledge is needed about the mechanisms through which economic inequalities damage health, apart from the obvious effects of extreme material deprivation. However, concern about the pathways through which relative social inequalities affect health in the absence of absolute material deprivation is unlikely to be perceived as a major research priority in lower income countries, where large proportions of the population continue to suffer extreme material deprivation measured in absolute terms. On the other hand, research on the mechanisms explaining the health effects of relative economic disparities could contribute to better understanding of effective approaches to mitigate poverty's health-damaging effects; such approaches should be undertaken simultaneously with efforts to attack poverty itself at its root causes, and are likely to require action by a range of social sectors, minimally including education, housing, labour, and finance, not only health services. Research is also needed to compare the costs of different approaches to reducing health inequalities while achieving improvements for all. While the fundamental reasons for pursuing equity are ethical, evidence of economic gains associated with social investment targeting health inequalities should be documented and disseminated; as noted earlier, an appropriate range of outcome measures that reflect progress in human development should be considered, including but not limited to traditional economic measures such as income, and the time frame for outcome measurement must be long enough.

While the technical challenges in describing equity and assessing the equity impact of policies are considerable, the most daunting challenges to achieving greater equity are of course political. Better information alone will not produce more equity. In general, for both national and international agencies and in countries of all average income levels, it is far more politically sensitive to talk about inequities *within* rather than *between* countries. In trying to promote greater equity, international organizations must respect national sovereignty and cultural differences, while recognizing that "cultural differences" can be invoked by privileged groups to justify the maintenance of inequities in settings where disadvantaged groups within a society are voiceless. International organizations can support efforts by national groups committed to achieving greater equity, by creating forums for exchange of ideas and experience within and between countries. In itself, the articulation of an explicit commitment to equity by other countries and international organizations can boost the morale of domestic movements for greater social justice. International agencies also can create forums for international exchange about equity goals

and about policy options for achieving greater equity, recognizing that notions of what is fair or just, as well as preferred approaches to achieving greater fairness or social justice, vary among different societies. As much as one may like to prescribe what is right and wrong for others, for practical reasons each society needs to achieve a sufficient level of consensus about what equity goals it will adopt, in order to move toward effective, sustainable actions to reduce inequities; on the other hand, it is important to note that a national consensus may be affected by participation in international discussions.

International agencies can undermine or strengthen national efforts to achieve greater equity. Multilateral lending agencies in particular must consider the short- and long-term effects on equity of the conditions imposed on debtor nations (e.g., dismantling public service safety nets and privatizing previously government functions), and develop approaches and criteria that are likely to distribute the burden of belt-tightening in a more equitable fashion than has often been the case (United Nations Children's Fund, 1991). Over the past decade UNICEF and advocacy groups called upon creditor and debtor nations to consider "debt swaps for investment in social development programmes" (United Nations Children's Fund, 1991). In response to these efforts and evidence of the impossibility of debt repayment by many countries, the World Bank and International Monetary Fund recently launched the Highly Indebted Poor Countries (HIPC) initiative; in 70 poor countries, debt forgiveness is being made conditional on detailed plans for poverty reduction. The obstacles are daunting and it remains to be seen whether the initiative will result in significant social investment effectively reaching disadvantaged groups. Domestic as well as international development agencies need to consider whether their actions adequately encourage and strengthen efforts to improve equity; despite the best intentions, development aid can be channeled in ways that bring relatively little benefit to disenfranchised groups (United Nations Children's Fund, 1991). The World Bank has recently produced fact sheets for many developing countries, showing a range of health and health care indicators disaggregated by an indicator of household wealth (Gwatkin et al., 2000); such information should be used routinely to assess who is—and who is not—benefitting from development aid as well as domestic policies. Failure to disaggregate health data according to socioeconomic levels could result in policy recommendations that neglect the top causes of ill health among the world's poorest and hence most needy populations, for whom the communicable diseases and perinatal conditions remain the major causes of suffering, disability, and premature death (Gwatkin, Guillot, & Heuveline, 1999). An increase in the overall amount of funds for non-military international assistance from the affluent nations (and particularly from those, notably the United States, who until recently have not fulfilled even their basic commitments (Wegman, 1999) could contribute to increased equity between countries as reflected by aggregate statistics; however, such an increase might not necessarily improve inequities within countries without systematic effort focused on that goal.

International and domestic governmental and non-governmental agencies also can provide support for bold experiments with policies and programmes. While rigorous evaluation of the costs and outcomes of different specific strategies to achieve greater health equity is scarce (Gepkens & Gunning-Schepers, 1996; Mackenbach & Gunning-Schepers, 1997), enough is known to suggest that action will be needed in certain general areas (Arblaster et al., 1996; Bansal, 1999; Bartley et al., 1997; Mills, 1998). Strategies that target childhood well-being and development seem particularly promising as a way to achieve greater equity in health across the life cycle. Consideration of the available evidence suggests that particularly under conditions of severe resource constraints, it is likely that the following will be needed: giving the highest priority to eliminating absolute material deprivation; ensuring universal, compulsory and free education at least up to the level required to understand and apply a health message and to function in the national economy; ensuring safe drinking water and sanitation for all; providing free basic health services, including maternal and child health services with family planning; promoting rural development; providing micro-credit to small businesses; favoring full employment; and generally improving the status of women (United Nations Development Programme, 1990, 1991, 1992, 1994, 1996a, b, 1997).

Any successful strategy to address socioeconomic disparities in health will need to be based on a recognition that the biggest threat to health equity is overall socioeconomic inequity. The powerful relationships between socioeconomic position and health have been demonstrated repeatedly (Bicego & Boerma, 1993; Breilh et al., 1987; United Nations Development Programme, 1996a, b; Victora et al., 1992; World Bank, 1993; World Health Organization, 1995a, b), even in affluent countries (Adler, 1993; Adler et al., 1994; Evans, Barer, & Marmor, 1994; Feinstein, 1993; Kaplan, 1996; Kaplan et al., 1996; Kaplan & Keil, 1993; Kunst et al., 1998; Lynch, Kaplan, & Salonen, 1997; Macintyre, 1986; McKeown & Lowe, 1974; Rappas et al., 1993; Smith & Egger, 1992; Smith et al., 1998a) and even in affluent countries with relatively equitable health care provision (Black et al., 1980; Blane, Smith, & Bartley, 1990; Eachus et al., 1996; Mackenbach, Kunst, & Cavelaars et al., 1997; Marmot et al., 1991; Townsend, 1990; Smith, Hart, Watt, Hole, & Hawthorne, 1998b). Widening social inequalities in health should raise concerns about the consequences of macroeconomic or

social policy, not only about inequalities in health services; while the health sector can play an important role in documenting and disseminating evidence, action by the health care sector alone may not be effective or efficient. Equity in health care must be addressed, because, while not the only determinant of health status, health services are an important and often more easily modifiable factor than some others (Egbuono & Starfield, 1982). However, advocates for equitable access to health services must also be vocal advocates for equitable distribution of other key determinants of health, such as education, safe water and sanitation, housing, and food security. Advocates for investment in health care services may unwittingly play a destructive role in the health outcomes of their societies, when such investment competes with investment in other potentially more powerful determinants of health; this tension is likely to be greatest in countries with the most limited overall resources.

When developing strategies to increase equity, particularly in low- and middle-income countries, it must be made clear that the goal is an equitable sharing of progress in improving health, and not an equal distribution of the health consequences of lack of development; Whitehead has articulated the need to "level up" rather than to "level down" (Whitehead, 1994). The Primary Health Care strategy to achieve Health for All, articulated and promoted by WHO from the late 1970s on, was specifically designed to achieve greater equity and overall progress in settings with severe resource constraints. It entails a commitment to universal coverage with (at least) the most effective health services; that will disproportionately benefit disadvantaged populations; reliance on low-technology, community-based solutions; emphasis on education, clean water, sanitation, and other living conditions fundamental to health; as well as a commitment to empowerment of those who have historically been marginalized. This strategy is at least as relevant today as it was two decades ago, when there was an expectation of growing rather than shrinking resources for social investment. There has been a notable silence at WHO recently about Health for All and Primary Health Care; this is unfortunate, creating the impression of stepping back from a commitment to equity, and should be addressed by member countries. As part of reaffirming the Health for All commitment, equity needs to move from being largely implicit to becoming an explicit component of the strategy, and progress toward greater equity in health needs to be monitored systematically to provide guidance for policy and programs at all levels.

Concerns about health equity in developing countries cannot be adequately addressed with an exclusive focus on closing north–south and between-country gaps. Globally, with increasing market orientation on all continents and in all political systems; there is a real risk that concerns about equity will be forgotten—or paid only token attention—on the policy agenda in the pursuit of short-term gains reflected in average statistics. It is of great importance to focus on equity in health, not only because health status should be a key indicator of human development, but also because in most societies, there is less tolerance for avoidable disparities in health than in wealth. Addressing health equity both requires and provides an opening for addressing equity in the determinants of health. At the beginning of the 21st century, large segments of the population within nations of very diverse per capita income levels remain on the other side of a deep divide, enjoying little or no benefit of the economic growth reflected in average national economic indicators or even average health statistics. Particularly in the context of an increasingly globalized world, improvements in health for privileged groups should suggest what could, with political will, be possible for all.

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Session 3 Sharing of Experiences and its linkages to "Health as Human Right"

Session 4 Understanding "Health As A Human Right" & Understanding Indian Constitutional Rights & Health And Operational Mechanisms

Community Health Cell, Bangalore

A PARADIGM SHIFT FROM 'CHARITY' TO 'RIGHTS AND DIGNITY'

- A write-up based on the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD)

- C. Mahesh

The process of drafting and adopting the Convention on the Rights of Persons with Disabilities by the member countries of the United Nations has now brought the issues of discrimination and exclusion faced by persons with disabilities to centre stage.

The universal definition and understanding of Disability has rightfully moved from being a merely 'Medical' to a 'Human Rights' framework and heralded a paradigm shift from 'charity' to 'rights based' approach.

Article 1 of the Convention says *"The purpose of the Convention is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity."*

In Oct 2007, India has become one of the first few countries to ratify this convention a move that has made all of us happy and proud indeed.

Questions usually addressed to persons with disabilities like *"When did you become disabled?", "How did you become disabled?"* should now make way to discussions and finding solutions on questions such as *"Are you getting the freedom and choice to live the way you have wanted at home and in society?", "Does your house/ educational institution / place of work have provisions to enable you to access the toilet safely/ independently?", "Are you able to make use of the public transport?", "Are you able to get education on an equal footing like everyone else?", "Are you getting opportunities for gainful employment?", "Are you able to benefit from the different development schemes from the Govt.?", "Do you get an equal share in the property?" , "Are you being restricted from setting-up your own family?".*

In 1995, India enacted *"The Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act"*. The various articles in the present Convention further strengthens the above Act by elaborating the various rights, obligations and monitoring mechanisms that the state parties (countries) need to build on/ adopt.

The Convention, in Article 1, further does not limit to only the 7 disabilities (Blindness, Low vision, Leprosy-cured, Hearing impairment, Loco motor disability, Mental retardation and Mental illness) that have been mentioned in the Persons with Disabilities Act but has opened up a wider definition as - *"People with disabilities who have long-term impairments, for example, physical, psycho-social, intellectual and who cannot get involved in society because of different reasons, such as attitudes, language, stairs, and laws, which prevent people with disabilities from being included in society."* This broad based definition and the recognition of various barriers posed by society assists us to develop a more holistic and sensitive approach in addressing the discriminations faced by persons with disabilities in society.

Following these developments, there is a huge need for creating awareness among persons with disabilities, their care givers, the society at large, and the Government and Non-Government

Organisations on the UNCRPD. There is also a need to develop appropriate strategies to review existing laws, policies, programmes and monitoring mechanisms of Govt. Non-Government Organisations and other agencies.

Further, this convention by design is not limited to only Govt. establishments. The Convention states that private businesses and organizations that are open to the public parties have to take initiatives to *"eliminate barriers that people with disabilities face in buildings, the outdoors, transport, information, communication and services".*

It is no longer enough to be content with providing a few *"good willed"* services such as a *"wheelchair"* or a *"hearing aid"* or *"disability pension"* . It is going to be whether the laws, policies, programmes and schemes are in line and reinforce the principles of the Convention that focus on Dignity, Ability to choose, Independence, Non-discrimination, Participation, Full inclusion, Respect for difference, Acceptance of disability as part of everyday life, Equality of opportunity, Accessibility, Equality of men and women and Respect for children.

By signing and ratifying this Convention, it is now legally binding on India and other countries of the UN to create and promote an environment where persons with disabilities are able to exercise their civil, political, social and cultural rights fairly and without prejudice.

It is time that Govt. representatives, representatives from Disabled People's Organisations, NGOs and other stake holders sit together and chalk out precise strategies as operation plan to take the Convention forward. If this is not done the Convention will be just another book on the shelf.

Finally, this Convention is about creating a society that recognizes and respects the diverse needs of humankind.

References:

1. The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) is at http://www.un.org/disabilities/
2. The Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act is at http://ccdisabilities.nic.in/

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C. Mahesh works for CBR Forum, as the Advocacy Coordinator in promoting the rights of persons with disabilities through supporting 87 of their community based rehabilitation programmes across the country. In addition he is actively involved with the Office of the Commissioner (Disabilities) Karnataka and other networks in promoting 'barrier-free' environment and advocating for the effective implementation of The Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act.

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A. THE INTERNATIONAL BILL OF HUMAN RIGHTS

1. Universal Declaration of Human Rights

Adopted and proclaimed by General Assembly resolution 217 A (III) of 10 December 1948

PREAMBLE

Whereas recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world,

Whereas disregard and contempt for human rights have resulted in barbarous acts which have outraged the conscience of mankind, and the advent of a world in which human beings shall enjoy freedom of speech and belief and freedom from fear and want has been proclaimed as the highest aspiration of the common people,

Whereas it is essential, if man is not to be compelled to have recourse, as a last resort, to rebellion against tyranny and oppression, that human rights should be protected by the rule of law,

Whereas it is essential to promote the development of friendly relations between nations,

Whereas the peoples of the United Nations have in the Charter reaffirmed their faith in fundamental human rights, in the dignity and worth of the human person and in the equal rights of men and women and have determined to promote social progress and better standards of life in larger freedom,

Whereas Member States have pledged themselves to achieve, in co-operation with the United Nations, the promotion of universal respect for and observance of human rights and fundamental freedoms,

Whereas a common understanding of these rights and freedoms is of the greatest importance for the full realization of this pledge,

Now, therefore,

The General Assembly,

Proclaims this Universal Declaration of Human Rights as a common standard of achievement for all peoples and all nations, to the end that every individual and every organ of society, keeping this Declaration constantly in mind, shall strive by

teaching and education to promote respect for these rights and freedoms and by progressive measures, national and international, to secure their universal and effective recognition and observance, both among the peoples of Member States themselves and among the peoples of territories under their jurisdiction.

Article 1

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.

Article 2

Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

Furthermore, no distinction shall be made on the basis of the political, jurisdictional or international status of the country or territory to which a person belongs, whether it be independent, trust, non-self-governing or under any other limitation of sovereignty.

Article 3

Everyone has the right to life, liberty and security of person.

Article 4

No one shall be held in slavery or servitude; slavery and the slave trade shall be prohibited in all their forms.

Article 5

No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.

Article 6

Everyone has the right to recognition everywhere as a person before the law.

Article 7

All are equal before the law and are entitled without any discrimination to equal protection of the law. All are entitled to equal protection against any discrimination in violation of this Declaration and against any incitement to such discrimination.

Article 8

Everyone has the right to an effective remedy by the competent national tribunals for acts violating the fundamental rights granted him by the constitution or by law.

Article 9

No one shall be subjected to arbitrary arrest, detention or exile.

Article 10

Everyone is entitled in full equality to a fair and public hearing by an independent and impartial tribunal, in the determination of his rights and obligations and of any criminal charge against him.

Article 11

1. Everyone charged with a penal offence has the right to be presumed innocent until proved guilty according to law in a public trial at which he has had all the guarantees necessary for his defence.

2. No one shall be held guilty of any penal offence on account of any act or omission which did not constitute a penal offence, under national or international law, at the time when it was committed. Nor shall a heavier penalty be imposed than the one that was applicable at the time the penal offence was committed.

Article 12

No one shall be subjected to arbitrary interference with his privacy, family, home or correspondence, nor to attacks upon his honour and reputation. Everyone has the right to the protection of the law against such interference or attacks.

Article 13

1. Everyone has the right to freedom of movement and residence within the borders of each State.

2. Everyone has the right to leave any country, including his own, and to return to his country.

Article 14

1. Everyone has the right to seek and to enjoy in other countries asylum from persecution.

2. This right may not be invoked in the case of prosecutions genuinely arising from non-political crimes or from acts contrary to the purposes and principles of the United Nations.

Article 15

1. Everyone has the right to a nationality.

2. No one shall be arbitrarily deprived of his nationality nor denied the right to change his nationality.

Article 16

1. Men and women of full age, without any limitation due to race, nationality or religion, have the right to marry and to found a family. They are entitled to equal rights as to marriage, during marriage and at its dissolution.

2. Marriage shall be entered into only with the free and full consent of the intending spouses.

3. The family is the natural and fundamental group unit of society and is entitled to protection by society and the State.

Article 17

1. Everyone has the right to own property alone as well as in association with others.

2. No one shall be arbitrarily deprived of his property.

Article 18

Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief, and freedom, either alone or in community with others and in public or private, to manifest his religion or belief in teaching, practice, worship and observance.

Article 19

Everyone has the right to freedom of opinion and expression; this right includes freedom to hold opinions without interference and to seek, receive and impart information and ideas through any media and regardless of frontiers.

Article 20

1. Everyone has the right to freedom of peaceful assembly and association.

2. No one may be compelled to belong to an association.

Article 21

1. Everyone has the right to take part in the government of his country, directly or through freely chosen representatives.

2. Everyone has the right to equal access to public service in his country.

3. The will of the people shall be the basis of the authority of government; this will shall be expressed in periodic and genuine elections which shall be by universal and equal suffrage and shall be held by secret vote or by equivalent free voting procedures.

Article 22

Everyone, as a member of society, has the right to social security and 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 and the free development of his personality.

Article 23

1. Everyone has the right to work, to free choice of employment, to just and favourable conditions of work and to protection against unemployment.

2. Everyone, without any discrimination, has the right to equal pay for equal work.

3. Everyone who works has the right to just and favourable remuneration ensuring for himself and his family an existence worthy of human dignity, and supplemented, if necessary, by other means of social protection.

4. Everyone has the right to form and to join trade unions for the protection of his interests.

Article 24

Everyone has the right to rest and leisure, including reasonable limitation of working hours and periodic holidays with pay.

Article 25

1. Everyone has the right to a standard of living adequate for the health and well-being of himself and of 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.

Article 26

1. Everyone has the right to education. Education shall be free, at least in the elementary and fundamental stages. Elementary education shall be compulsory. Technical and professional education shall be made generally available and higher education shall be equally accessible to all on the basis of merit.

2. Education shall be directed to the full development of the human personality and to the strengthening of respect for human rights and fundamental freedoms. It shall promote understanding, tolerance and friendship among all nations, racial or religious groups, and shall further the activities of the United Nations for the maintenance of peace.

3. Parents have a prior right to choose the kind of education that shall be given to their children.

Article 27

1. Everyone has the right freely to participate in the cultural life of the community, to enjoy the arts and to share in scientific advancement and its benefits.

2. Everyone has the right to the protection of the moral and material interests resulting from any scientific, literary or artistic production of which he is the author.

Article 28

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

Article 29

1. Everyone has duties to the community in which alone the free and full development of his personality is possible.

2. In the exercise of his rights and freedoms, everyone shall be subject only to such limitations as are determined by law solely for the purpose of securing due recognition and respect for the rights and freedoms of others and of meeting the just requirements of morality, public order and the general welfare in a democratic society.

3. These rights and freedoms may in no case be exercised contrary to the purposes and principles of the United Nations.

Article 30

Nothing in this Declaration may be interpreted as implying for any State, group or person any right to engage in any activity or to perform any act aimed at the destruction of any of the rights and freedoms set forth herein.

2. International Covenant on Economic, Social and Cultural Rights

Adopted and opened for signature, ratification and accession by General Assembly resolution 2200 A (XXI) of 16 December 1966

ENTRY INTO FORCE: 3 JANUARY 1976, IN ACCORDANCE WITH ARTICLE 27

PREAMBLE

The States Parties to the present Covenant,

Considering that, in accordance with the principles proclaimed in the Charter of the United Nations, recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world,

Recognizing that these rights derive from the inherent dignity of the human person,

Recognizing that, in accordance with the Universal Declaration of Human Rights, the ideal of free human beings enjoying freedom from fear and want can only be achieved if conditions are created whereby everyone may enjoy his economic, social and cultural rights, as well as his civil and political rights,

Considering the obligation of States under the Charter of the United Nations to promote universal respect for, and observance of, human rights and freedoms,

Realizing that the individual, having duties to other individuals and to the community to which he belongs, is under a responsibility to strive for the promotion and observance of the rights recognized in the present Covenant,

Agree upon the following articles:

PART I

Article 1

1. All peoples have the right of self-determination. By virtue of that right they freely determine their political status and freely pursue their economic, social and cultural development.

2. All peoples may, for their own ends, freely dispose of their natural wealth and resources without prejudice to any obligations arising out of international economic co-operation, based upon the principle of mutual benefit, and international law. In no case may a people be deprived of its own means of subsistence.

3. The States Parties to the present Covenant, including those having responsibility for the administration of Non-Self-Governing and Trust Territories, shall promote the realization of the right of self-determination, and shall respect that right, in conformity with the provisions of the Charter of the United Nations.

PART II

Article 2

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

2. The States Parties to the present Covenant 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.

3. Developing countries, with due regard to human rights and their national economy, may determine to what extent they would guarantee the economic rights recognized in the present Covenant to non-nationals.

Article 3

The States Parties to the present Covenant undertake to ensure the equal right of men and women to the enjoyment of all economic, social and cultural rights set forth in the present Covenant.

Article 4

The States Parties to the present Covenant recognize that, in the enjoyment of those rights provided by the State in conformity with the present Covenant, the State may subject such rights only to such limitations as are determined by law only in so far as this may be compatible with the nature of these rights and solely for the purpose of promoting the general welfare in a democratic society.

Article 5

1. Nothing in the present Covenant may be interpreted as implying for any State, group or person any right to engage in any activity or to perform any act aimed at the destruction of any of the rights or freedoms recognized herein, or at their limitation to a greater extent than is provided for in the present Covenant.

2. No restriction upon or derogation from any of the fundamental human rights recognized or existing in any country in virtue of law, conventions, regulations or custom shall be admitted on the pretext that the present Covenant does not recognize such rights or that it recognizes them to a lesser extent.

PART III

Article 6

1. The States Parties to the present Covenant recognize the right to work, which includes the right of everyone to the opportunity to gain his living by work which he freely chooses or accepts, and will take appropriate steps to safeguard this right.

2. The steps to be taken by a State Party to the present Covenant to achieve the full realization of this right shall include technical and vocational guidance and training programmes, policies and techniques to achieve steady economic, social and cultural development and full and productive employment under conditions safeguarding fundamental political and economic freedoms to the individual.

Article 7

The States Parties to the present Covenant recognize the right of everyone to the enjoyment of just and favourable conditions of work which ensure, in particular:

(*a*) Remuneration which provides all workers, as a minimum, with:

(i) Fair wages and equal remuneration for work of equal value without distinction of any kind, in particular women being guaranteed conditions of work not inferior to those enjoyed by men, with equal pay for equal work;

(ii) A decent living for themselves and their families in accordance with the provisions of the present Covenant;

(*b*) Safe and healthy working conditions;

(*c*) Equal opportunity for everyone to be promoted in his employment to an appropriate higher level, subject to no considerations other than those of seniority and competence;

(*d*) Rest, leisure and reasonable limitation of working hours and periodic holidays with pay, as well as remuneration for public holidays

Article 8

1. The States Parties to the present Covenant undertake to ensure:

(*a*) The right of everyone to form trade unions and join the trade union of his choice, subject only to the rules of the organization concerned, for the promotion and protection of his economic and social interests. No restrictions may be placed on the exercise of this right other than those prescribed by law and which are necessary in a democratic society in the interests of national security or public order or for the protection of the rights and freedoms of others;

(*b*) The right of trade unions to establish national federations or confederations and the right of the latter to form or join international trade-union organizations;

(*c*) The right of trade unions to function freely subject to no limitations other than those prescribed by law and which are necessary in a democratic society in the

interests of national security or public order or for the protection of the rights and freedoms of others;

(*d*) The right to strike, provided that it is exercised in conformity with the laws of the particular country.

2. This article shall not prevent the imposition of lawful restrictions on the exercise of these rights by members of the armed forces or of the police or of the administration of the State.

3. Nothing in this article shall authorize States Parties to the International Labour Organisation Convention of 1948 concerning Freedom of Association and Protection of the Right to Organise to take legislative measures which would prejudice, or apply the law in such a manner as would prejudice, the guarantees provided for in that Convention.

Article 9

The States Parties to the present Covenant recognize the right of everyone to social security, including social insurance.

Article 10

The States Parties to the present Covenant recognize that:

1. The widest possible protection and assistance should be accorded to the family, which is the natural and fundamental group unit of society, particularly for its establishment and while it is responsible for the care and education of dependent children. Marriage must be entered into with the free consent of the intending spouses.

2. Special protection should be accorded to mothers during a reasonable period before and after childbirth. During such period working mothers should be accorded paid leave or leave with adequate social security benefits.

3. Special measures of protection and assistance should be taken on behalf of all children and young persons without any discrimination for reasons of parentage or other conditions. Children and young persons should be protected from economic and social exploitation. Their employment in work harmful to their morals or health or dangerous to life or likely to hamper their normal development should be punishable by law. States should also set age limits below which the paid employment of child labour should be prohibited and punishable by law.

Article 11

1. The States Parties to the present Covenant recognize the right of everyone to an adequate standard of living for himself and his family, including adequate food, clothing and housing, and to the continuous improvement of living conditions. The States Parties will take appropriate steps to ensure the realization of this right, recognizing to this effect the essential importance of international co-operation based on free consent.

2. The States Parties to the present Covenant, recognizing the fundamental right of everyone to be free from hunger, shall take, individually and through inter-

national co-operation, the measures, including specific programmes, which are needed:

(*a*) To improve methods of production, conservation and distribution of food by making full use of technical and scientific knowledge, by disseminating knowledge of the principles of nutrition and by developing or reforming agrarian systems in such a way as to achieve the most efficient development and utilization of natural resources;

(*b*) Taking into account the problems of both food-importing and food-exporting countries, to ensure an equitable distribution of world food supplies in relation to need.

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 stillbirth-rate and of infant mortality and for the healthy development of the child;

(*b*) The improvement of all aspects of environmental and industrial hygiene;

(*c*) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;

(*d*) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

Article 13

1. The States Parties to the present Covenant recognize the right of everyone to education. They agree that education shall be directed to the full development of the human personality and the sense of its dignity, and shall strengthen the respect for human rights and fundamental freedoms. They further agree that education shall enable all persons to participate effectively in a free society, promote understanding, tolerance and friendship among all nations and all racial, ethnic or religious groups, and further the activities of the United Nations for the maintenance of peace.

2. The States Parties to the present Covenant recognize that, with a view to achieving the full realization of this right:

(*a*) Primary education shall be compulsory and available free to all;

(*b*) Secondary education in its different forms, including technical and vocational secondary education, shall be made generally available and accessible to all by every appropriate means, and in particular by the progressive introduction of free education;

(*c*) Higher education shall be made equally accessible to all, on the basis of capacity, by every appropriate means, and in particular by the progressive introduction of free education;

(*d*) Fundamental education shall be encouraged or intensified as far as possible for those persons who have not received or completed the whole period of their primary education;

(*e*) The development of a system of schools at all levels shall be actively pursued, an adequate fellowship system shall be established, and the material conditions of teaching staff shall be continuously improved.

3. The States Parties to the present Covenant undertake to have respect for the liberty of parents and, when applicable, legal guardians to choose for their children schools, other than those established by the public authorities, which conform to such minimum educational standards as may be laid down or approved by the State and to ensure the religious and moral education of their children in conformity with their own convictions.

4. No part of this article shall be construed so as to interfere with the liberty of individuals and bodies to establish and direct educational institutions, subject always to the observance of the principles set forth in paragraph 1 of this article and to the requirement that the education given in such institutions shall conform to such minimum standards as may be laid down by the State.

Article 14

Each State Party to the present Covenant which, at the time of becoming a Party, has not been able to secure in its metropolitan territory or other territories under its jurisdiction compulsory primary education, free of charge, undertakes, within two years, to work out and adopt a detailed plan of action for the progressive implementation, within a reasonable number of years, to be fixed in the plan, of the principle of compulsory education free of charge for all.

Article 15

1. The States Parties to the present Covenant recognize the right of everyone:

(*a*) To take part in cultural life;

(*b*) To enjoy the benefits of scientific progress and its applications;

(*c*) To benefit from the protection of the moral and material interests resulting from any scientific, literary or artistic production of which he is the author.

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 the conservation, the development and the diffusion of science and culture.

3. The States Parties to the present Covenant undertake to respect the freedom indispensable for scientific research and creative activity.

4. The States Parties to the present Covenant recognize the benefits to be derived from the encouragement and development of international contacts and co-operation in the scientific and cultural fields.

PART IV

Article 16

1. The States Parties to the present Covenant undertake to submit in conformity with this part of the Covenant reports on the measures which they have adopted and the progress made in achieving the observance of the rights recognized herein.

2. (*a*) All reports shall be submitted to the Secretary-General of the United Nations, who shall transmit copies to the Economic and Social Council for consideration in accordance with the provisions of the present Covenant;

(*b*) The Secretary-General of the United Nations shall also transmit to the specialized agencies copies of the reports, or any relevant parts therefrom, from States Parties to the present Covenant which are also members of these specialized agencies in so far as these reports, or parts therefrom, relate to any matters which fall within the responsibilities of the said agencies in accordance with their constitutional instruments.

Article 17

1. The States Parties to the present Covenant shall furnish their reports in stages, in accordance with a programme to be established by the Economic and Social Council within one year of the entry into force of the present Covenant after consultation with the States Parties and the specialized agencies concerned.

2. Reports may indicate factors and difficulties affecting the degree of fulfilment of obligations under the present Covenant.

3. Where relevant information has previously been furnished to the United Nations or to any specialized agency by any State Party to the present Covenant, it will not be necessary to reproduce that information, but a precise reference to the information so furnished will suffice.

Article 18

Pursuant to its responsibilities under the Charter of the United Nations in the field of human rights and fundamental freedoms, the Economic and Social Council may make arrangements with the specialized agencies in respect of their reporting to it on the progress made in achieving the observance of the provisions of the present Covenant falling within the scope of their activities. These reports may include particulars of decisions and recommendations on such implementation adopted by their competent organs.

Article 19

The Economic and Social Council may transmit to the Commission on Human Rights for study and general recommendation or, as appropriate, for information the

reports concerning human rights submitted by States in accordance with articles 16 and 17, and those concerning human rights submitted by the specialized agencies in accordance with article 18.

Article 20

The States Parties to the present Covenant and the specialized agencies concerned may submit comments to the Economic and Social Council on any general recommendation under article 19 or reference to such general recommendation in any report of the Commission on Human Rights or any documentation referred to therein.

Article 21

The Economic and Social Council may submit from time to time to the General Assembly reports with recommendations of a general nature and a summary of the information received from the States Parties to the present Covenant and the specialized agencies on the measures taken and the progress made in achieving general observance of the rights recognized in the present Covenant.

Article 22

The Economic and Social Council may bring to the attention of other organs of the United Nations, their subsidiary organs and specialized agencies concerned with furnishing technical assistance any matters arising out of the reports referred to in this part of the present Covenant which may assist such bodies in deciding, each within its field of competence, on the advisability of international measures likely to contribute to the effective progressive implementation of the present Covenant.

Article 23

The States Parties to the present Covenant agree that international action for the achievement of the rights recognized in the present Covenant includes such methods as the conclusion of conventions, the adoption of recommendations, the furnishing of technical assistance and the holding of regional meetings and technical meetings for the purpose of consultation and study organized in conjunction with the Governments concerned.

Article 24

Nothing in the present Covenant shall be interpreted as impairing the provisions of the Charter of the United Nations and of the constitutions of the specialized agencies which define the respective responsibilities of the various organs of the United Nations and of the specialized agencies in regard to the matters dealt with in the present Covenant.

Article 25

Nothing in the present Covenant shall be interpreted as impairing the inherent right of all peoples to enjoy and utilize fully and freely their natural wealth and resources.

PART V

Article 26

1. The present Covenant is open for signature by any State Member of the United Nations or member of any of its specialized agencies, by any State Party to the Statute of the International Court of Justice, and by any other State which has been invited by the General Assembly of the United Nations to become a party to the present Covenant.

2. The present Covenant is subject to ratification. Instruments of ratification shall be deposited with the Secretary-General of the United Nations.

3. The present Covenant shall be open to accession by any State referred to in paragraph 1 of this article.

4. Accession shall be effected by the deposit of an instrument of accession with the Secretary-General of the United Nations.

5. The Secretary-General of the United Nations shall inform all States which have signed the present Covenant or acceded to it of the deposit of each instrument of ratification or accession.

Article 27

1. The present Covenant shall enter into force three months after the date of the deposit with the Secretary-General of the United Nations of the thirty-fifth instrument of ratification or instrument of accession.

2. For each State ratifying the present Covenant or acceding to it after the deposit of the thirty-fifth instrument of ratification or instrument of accession, the present Covenant shall enter into force three months after the date of the deposit of its own instrument of ratification or instrument of accession.

Article 28

The provisions of the present Covenant shall extend to all parts of federal States without any limitations or exceptions.

Article 29

1. Any State Party to the present Covenant may propose an amendment and file it with the Secretary-General of the United Nations. The Secretary-General shall thereupon communicate any proposed amendments to the States Parties to the present Covenant with a request that they notify him whether they favour a conference of States Parties for the purpose of considering and voting upon the proposals. In the event that at least one third of the States Parties favours such a conference, the Secretary-General shall convene the conference under the auspices of the United Nations. Any amendment adopted by a majority of the States Parties present and voting at the conference shall be submitted to the General Assembly of the United Nations for approval.

2. Amendments shall come into force when they have been approved by the General Assembly of the United Nations and accepted by a two-thirds majority of

the States Parties to the present Covenant in accordance with their respective constitutional processes.

3. When amendments come into force they shall be binding on those States Parties which have accepted them, other States Parties still being bound by the provisions of the present Covenant and any earlier amendment which they have accepted.

Article 30

Irrespective of the notifications made under article 26, paragraph 5, the Secretary-General of the United Nations shall inform all States referred to in paragraph 1 of the same article of the following particulars:

(*a*) Signatures, ratifications and accessions under article 26;

(*b*) The date of the entry into force of the present Covenant under article 27 and the date of the entry into force of any amendments under article 29.

Article 31

1. The present Covenant, of which the Chinese, English, French, Russian and Spanish texts are equally authentic, shall be deposited in the archives of the United Nations.

2. The Secretary-General of the United Nations shall transmit certified copies of the present Covenant to all States referred to in article 26.

General Comment No. 14:

The right to the highest attainable standard of health

Committee on Economic,
Social, and Cultural Rights
Twenty-second session
25 April-12 May 2000
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SUBSTANTIVE ISSUES ARISING IN THE IMPLEMENTATION OF THE INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS

General Comment No. 14 (2000)

The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights)

1. Health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity. The realization of the right to health may be pursued through numerous, complementary approaches, such as the formulation of health policies, or the implementation of health programmes developed by the World Health Organization (WHO), or the adoption of specific legal instruments. Moreover, the right to health includes certain components which are legally enforceable. (1)

2. The human right to health is recognized in numerous international instruments. Article 25.1 of the Universal Declaration of Human Rights affirms: "Everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services". The International Covenant on Economic, Social and Cultural Rights provides the most comprehensive article on the right to health in international human rights law. In accordance with article 12.1 of the Covenant, States parties recognize "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health", while article 12.2 enumerates, by way of illustration, a number of "steps to be taken by the States parties ... to achieve the full realization of this right". Additionally, the right to health is recognized, *inter alia*, in article 5 (e) (iv) of the International Convention on the Elimination of All Forms of Racial Discrimination of 1965, in articles 11.1 (f) and 12 of the Convention on the Elimination of All Forms of Discrimination against Women of 1979 and in article 24 of the Convention on the Rights of the Child of 1989. Several regional human rights instruments also recognize the right to health, such as the European Social Charter of 1961 as revised (art. 11), the African Charter on Human and Peoples' Rights of 1981 (art. 16) and the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights of 1988 (art. 10). Similarly, the right to health has been proclaimed by the Commission on Human Rights, (2) as well as in the Vienna Declaration and Programme of Action of 1993 and other international instruments. (3)

3. The right to health is closely related to and dependent upon the realization of other human rights, as contained in the International Bill of Rights, including the rights to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information, and the freedoms of association, assembly and movement. These and other rights and freedoms address integral components of the right to health.

4. In drafting article 12 of the Covenant, the Third Committee of the United Nations General Assembly did not adopt the definition of health contained in the preamble to the Constitution of WHO, which conceptualizes health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". However, the reference in article 12.1 of the Covenant to "the highest attainable standard of physical and mental health" is not confined to the right to health care. On the contrary, the drafting history and the express wording of article 12.2 acknowledge that the right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment.

5. The Committee is aware that, for millions of people throughout the world, the full enjoyment of the right to health still remains a distant goal. Moreover, in many cases, especially for those living in poverty, this goal is becoming increasingly remote. The Committee recognizes the formidable structural and other obstacles resulting from

international and other factors beyond the control of States that impede the full realization of article 12 in many States parties.

6. With a view to assisting States parties' implementation of the Covenant and the fulfilment of their reporting obligations, this General Comment focuses on the normative content of article 12 (Part I), States parties' obligations (Part II), violations (Part III) and implementation at the national level (Part IV), while the obligations of actors other than States parties are addressed in Part V. The General Comment is based on the Committee's experience in examining States parties' reports over many years.

I. NORMATIVE CONTENT OF ARTICLE 12

7. Article 12.1 provides a definition of the right to health, while article 12.2 enumerates illustrative, non-exhaustive examples of States parties' obligations.

8. The right to health is not to be understood as a right to be *healthy*. The right to health contains both freedoms and entitlements. The freedoms include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.

9. The notion of "the highest attainable standard of health" in article 12.1 takes into account both the individual's biological and socio-economic preconditions and a State's available resources. There are a number of aspects which cannot be addressed solely within the relationship between States and individuals; in particular, good health cannot be ensured by a State, nor can States provide protection against every possible cause of human ill health. Thus, genetic factors, individual susceptibility to ill health and the adoption of unhealthy or risky lifestyles may play an important role with respect to an individual's health. Consequently, 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.

10. Since the adoption of the two International Covenants in 1966 the world health situation has changed dramatically and the notion of health has undergone substantial changes and has also widened in scope. More determinants of health are being taken into consideration, such as resource distribution and gender differences. A wider definition of health also takes into account such socially-related concerns as violence and armed conflict. (4) Moreover, formerly unknown diseases, such as Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome (HIV/AIDS), and others that have become more widespread, such as cancer, as well as the rapid growth of the world population, have created new obstacles for the realization of the right to health which need to be taken into account when interpreting article 12.

11. The Committee interprets the right to health, as defined in article 12.1, as an inclusive right extending not only 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.

12. The right to health in all its forms and at all levels contains the following interrelated and essential elements, the precise application of which will depend on the conditions prevailing in a particular State party:

(a) *Availability.* Functioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party. The precise nature of the facilities, goods and services will vary depending on numerous factors, including the State party's developmental level. They will include, however, the underlying determinants of health, such as safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs, as defined by the WHO Action Programme on Essential Drugs. (5)

(b) *Accessibility.* Health facilities, goods and services (6) have to be accessible to everyone without discrimination, within the jurisdiction of the State party. Accessibility has four overlapping dimensions:

Non-discrimination: health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds. (7)

Physical accessibility: health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS. Accessibility also implies that medical services and underlying determinants of health, such as safe and potable water and adequate sanitation facilities, are within safe physical reach, including in rural areas. Accessibility further includes adequate access to buildings for persons with disabilities.

Economic accessibility (affordability): health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.

Information accessibility: accessibility includes the right to seek, receive and impart information and ideas (8) concerning health issues. However, accessibility of information should not impair the right to have personal health data treated with confidentiality.

(c) *Acceptability.* All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.

(d) *Quality.* As well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires, *inter alia*, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.

13. The non-exhaustive catalogue of examples in article 12.2 provides guidance in defining the action to be taken by States. It gives specific generic examples of measures arising from the broad definition of the right to health contained in article 12.1, thereby illustrating the content of that right, as exemplified in the following paragraphs. (9)

Article 12.2 (a). The right to maternal, child and reproductive health

14. "The provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child" (art. 12.2 (a)) (10) may be understood as requiring measures to improve child and maternal health, sexual and reproductive health services, including access to family planning, pre- and post-natal care, (11) emergency obstetric services and access to information, as well as to resources necessary to act on that information. (12)

Article 12.2 (b). The right to healthy natural and workplace environments

15. "The improvement of all aspects of environmental and industrial hygiene" (art. 12.2 (b)) comprises, *inter alia*, preventive measures in respect of occupational accidents and diseases; the requirement to ensure an adequate supply of safe and potable water and basic sanitation; the prevention and reduction of the population's exposure to harmful substances such as radiation and harmful chemicals or other detrimental environmental conditions that directly or indirectly impact upon human health. (13) Furthermore, industrial hygiene refers to the minimization, so far as is reasonably practicable, of the causes of health hazards inherent in the working environment. (14) Article 12.2 (b) also embraces adequate housing and safe and hygienic working conditions, an adequate supply of food and proper nutrition, and discourages the abuse of alcohol, and the use of tobacco, drugs and other harmful substances.

Article 12.2 (c). The right to prevention, treatment and control of diseases

16. "The prevention, treatment and control of epidemic, endemic, occupational and other diseases" (art. 12.2 (c)) requires the establishment of prevention and education programmes for behaviour-related health concerns such as sexually transmitted diseases, in particular HIV/AIDS, and those adversely affecting sexual and reproductive health, and the promotion of social determinants of good health, such as environmental safety, education, economic development and gender equity. The right to treatment includes the creation of a system of urgent medical care in cases of accidents, epidemics and similar health hazards, and the provision of disaster relief and humanitarian assistance in emergency situations. The control of diseases refers to States' individual and joint efforts to, *inter alia*, make available relevant technologies, using and improving epidemiological surveillance and data collection on a disaggregated basis, the implementation or enhancement of immunization programmes and other strategies of infectious disease control.

Article 12.2 (d). The right to health facilities, goods and services (15)

17. "The creation of conditions which would assure to all medical service and medical attention in the event of sickness" (art. 12.2 (d)), both physical and mental, includes the provision of equal and timely access to basic preventive, curative, rehabilitative health services and health education; regular screening programmes; appropriate treatment of prevalent diseases, illnesses, injuries and disabilities, preferably at community level; the provision of essential drugs; and appropriate mental health treatment and care. A further important aspect is the improvement and furtherance of participation of the population in the provision of preventive and curative health services, such as the organization of the health sector, the insurance system and, in particular, participation in political decisions relating to the right to health taken at both the community and national levels.

Article 12. Special topics of broad application

Non-discrimination and equal treatment

18. By virtue of article 2.2 and article 3, the Covenant proscribes any discrimination in access to health care and underlying determinants of health, as well as to 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 and 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. The Committee stresses that 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. The Committee recalls General Comment No. 3, paragraph 12, which states that even in times of severe resource constraints, the vulnerable members of society must be protected by the adoption of relatively low-cost targeted programmes.

19. 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, especially with respect to the core obligations of the right to health. (16) Inappropriate health resource allocation can lead to discrimination that may not be overt. 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.

Gender perspective

20. The Committee 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. The disaggregation of health and socio-economic data according to sex is essential for identifying and remedying inequalities in health.

Women and the right to health

21. To eliminate discrimination against women, there is a need to 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, including sexual and reproductive services. A major goal should be reducing women's health risks, particularly lowering rates of maternal mortality and protecting women from domestic violence. The realization of women's right to health requires the removal of all barriers interfering with access to health services, education and information, including in the area of sexual and reproductive health. It is also important to undertake preventive, promotive and remedial action to shield women from the impact of harmful traditional cultural practices and norms that deny them their full reproductive rights.

Children and adolescents

22. Article 12.2 (a) outlines the need to take measures to reduce infant mortality and promote the healthy development of infants and children. Subsequent international human rights instruments recognize that children and adolescents have the right to the enjoyment of the highest standard of health and access to facilities for the treatment of illness. (17)

The Convention on the Rights of the Child directs States to ensure access to essential health services for the child and his or her family, including pre- and post-natal care for mothers. The Convention links these goals with ensuring access to child-friendly

information about preventive and health-promoting behaviour and support to families and communities in implementing these practices. Implementation of the principle of non-discrimination requires that girls, as well as boys, have equal access to adequate nutrition, safe environments, and physical as well as mental health services. There is a need to adopt effective and appropriate measures to abolish harmful traditional practices affecting the health of children, particularly girls, including early marriage, female genital mutilation, preferential feeding and care of male children. (18) Children with disabilities should be given the opportunity to enjoy a fulfilling and decent life and to participate within their community.

23. States parties should provide a safe and supportive environment for adolescents, that ensures the opportunity to participate in decisions affecting their health, to build life-skills, to acquire appropriate information, to receive counselling and to negotiate the health-behaviour choices they make. The realization of the right to health of adolescents is dependent on the development of youth-friendly health care, which respects confidentiality and privacy and includes appropriate sexual and reproductive health services.

24. In all policies and programmes aimed at guaranteeing the right to health of children and adolescents their best interests shall be a primary consideration.

Older persons

25. With regard to the realization of the right to health of older persons, the Committee, in accordance with paragraphs 34 and 35 of General Comment No. 6 (1995), reaffirms the importance of an integrated approach, combining elements of preventive, curative and rehabilitative health treatment. Such measures should be based on periodical check-ups for both sexes; physical as well as psychological rehabilitative measures aimed at maintaining the functionality and autonomy of older persons; and attention and care for chronically and terminally ill persons, sparing them avoidable pain and enabling them to die with dignity.

Persons with disabilities

26. The Committee reaffirms paragraph 34 of its General Comment No. 5, which addresses the issue of persons with disabilities in the context of the right to physical and mental health. Moreover, the Committee stresses the need to ensure that not only the public health sector but also private providers of health services and facilities comply with the principle of non-discrimination in relation to persons with disabilities.

Indigenous peoples

27. In the light of emerging international law and practice and the recent measures taken by States in relation to indigenous peoples, (19) the Committee deems it useful to identify elements that would help to define indigenous peoples' right to health in order better to enable States with indigenous peoples to implement the provisions contained in article 12

of the Covenant. The Committee considers that indigenous peoples have the right to specific measures to improve their access to health services and care. These health services should be culturally appropriate, taking into account traditional preventive care, healing practices and medicines. States should provide resources for indigenous peoples to design, deliver and control such services so that they may enjoy the highest attainable standard of physical and mental health. The vital medicinal plants, animals and minerals necessary to the full enjoyment of health of indigenous peoples should also be protected. The Committee notes that, in indigenous communities, the health of the individual is often linked to the health of the society as a whole and has a collective dimension. In this respect, the Committee considers that development-related activities that lead to the displacement of indigenous peoples against their will from their traditional territories and environment, denying them their sources of nutrition and breaking their symbiotic relationship with their lands, has a deleterious effect on their health.

Limitations

28. Issues of public health are sometimes used by States as grounds for limiting the exercise of other fundamental rights. The Committee wishes to emphasize that the Covenant's limitation clause, article 4, is primarily intended to protect the rights of individuals rather than to permit the imposition of limitations by States. Consequently a State party which, for example, restricts the movement of, or incarcerates, persons with transmissible diseases such as HIV/AIDS, refuses to allow doctors to treat persons believed to be opposed to a government, or fails to provide immunization against the community's major infectious diseases, on grounds such as national security or the preservation of public order, has the burden of justifying such serious measures in relation to each of the elements identified in article 4. Such restrictions must be in accordance with the law, including international human rights standards, compatible with the nature of the rights protected by the Covenant, in the interest of legitimate aims pursued, and strictly necessary for the promotion of the general welfare in a democratic society.

29. In line with article 5.1, such limitations must be proportional, i.e. the least restrictive alternative must be adopted where several types of limitations are available. Even where such limitations on grounds of protecting public health are basically permitted, they should be of limited duration and subject to review.

II. STATES PARTIES' OBLIGATIONS

General legal obligations

30. While the Covenant provides for progressive realization and acknowledges the constraints due to the limits of available resources, it also imposes on States parties various obligations which are of immediate effect. States parties have immediate obligations in relation to the right to health, such as the guarantee that the right will be exercised without discrimination of any kind (art. 2.2) and the obligation to take steps

(art. 2.1) towards the full realization of article 12. Such steps must be deliberate, concrete and targeted towards the full realization of the right to health. (20)

31. The progressive realization of the right to health over a period of time should not be interpreted as depriving States 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 article 12. (21)

32. As with all other rights in the Covenant, there is a strong presumption that retrogressive measures taken in relation to the right to health are not permissible. If any deliberately retrogressive measures are taken, the State party has the burden of proving that they have been introduced after the most careful consideration of all alternatives and that they are duly justified by reference to the totality of the rights provided for in the Covenant in the context of the full use of the State party's maximum available resources. (22)

33. The right to health, like all human rights, imposes three types or levels of obligations on States parties: the obligations to *respect*, *protect* and *fulfil*. In turn, the obligation to fulfil contains obligations to facilitate, provide and promote. (23) The obligation to *respect* requires States to refrain from interfering directly or indirectly with the enjoyment of the right to health. The obligation to *protect* requires States to take measures that prevent third parties from interfering with article 12 guarantees. Finally, the obligation to *fulfil* requires States to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health.

Specific legal obligations

34. In particular, States are under the obligation to *respect* the right to health by, *inter alia*, refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal immigrants, to preventive, curative and palliative health services; abstaining from enforcing discriminatory practices as a State policy; and abstaining from imposing discriminatory practices relating to women's health status and needs. Furthermore, obligations to respect include a State's obligation to refrain from prohibiting or impeding traditional preventive care, healing practices and medicines, from marketing unsafe drugs and from applying coercive medical treatments, unless on an exceptional basis for the treatment of mental illness or the prevention and control of communicable diseases. 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. (24)

In addition, States should refrain from limiting access to contraceptives and other means of maintaining sexual and reproductive health, from censoring, withholding or intentionally misrepresenting health-related information, including sexual education and

information, as well as from preventing people's participation in health-related matters. States should also refrain from unlawfully polluting air, water and soil, e.g. through industrial waste from State-owned facilities, from using or testing nuclear, biological or chemical weapons if such testing results in the release of substances harmful to human health, and from limiting access to health services as a punitive measure, e.g. during armed conflicts in violation of international humanitarian law.

35. Obligations to *protect* include, *inter alia*, the duties of States to adopt legislation or to take other measures ensuring equal access to health care and health-related services provided by third parties; 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; to control the marketing of medical equipment and medicines by third parties; and to ensure that medical practitioners and other health professionals meet appropriate standards of education, skill and ethical codes of conduct. States are also obliged to ensure that harmful social or traditional practices do not interfere with access to pre- and post-natal care and family-planning; to prevent third parties from coercing women to undergo traditional practices, e.g. female genital mutilation; and to take measures to protect all vulnerable or marginalized groups of society, in particular women, children, adolescents and older persons, in the light of gender-based expressions of violence. States should also ensure that third parties do not limit people's access to health-related information and services.

36. The obligation to *fulfil* requires States parties, *inter alia*, to give sufficient recognition to the right to health in the national political and legal systems, preferably by way of legislative implementation, and to adopt a national health policy with a detailed plan for realizing the right to health. States must ensure provision of health care, including immunization programmes against the major infectious diseases, and ensure equal access for all to the underlying determinants of health, such as nutritiously safe food and potable drinking water, basic sanitation and adequate housing and living conditions. Public health infrastructures should provide for sexual and reproductive health services, including safe motherhood, particularly in rural areas. States have to ensure the appropriate training of doctors and other medical personnel, the provision of a sufficient number of hospitals, clinics and other health-related facilities, and the promotion and support of the establishment of institutions providing counselling and mental health services, with due regard to equitable distribution throughout the country. Further obligations include the provision of a public, private or mixed health insurance system which is affordable for all, the promotion of medical research and health education, as well as information campaigns, in particular with respect to HIV/AIDS, sexual and reproductive health, traditional practices, domestic violence, the abuse of alcohol and the use of cigarettes, drugs and other harmful substances. States are also required to adopt measures against environmental and occupational health hazards and against any other threat as demonstrated by epidemiological data. For this purpose they should formulate and implement national policies aimed at reducing and eliminating pollution of air, water and soil, including pollution by heavy metals such as lead from gasoline. Furthermore, States parties are required to formulate, implement and periodically review a coherent national

policy to minimize the risk of occupational accidents and diseases, as well as to provide a coherent national policy on occupational safety and health services. (25)

37. The obligation to *fulfil (facilitate)* requires States *inter alia* to take positive measures that enable and assist individuals and communities to enjoy the right to health. States parties are also obliged to *fulfil (provide)* a specific right contained in the Covenant when individuals or a group are unable, for reasons beyond their control, to realize that right themselves by the means at their disposal. The obligation to *fulfil (promote)* the right to health requires States to undertake actions that create, maintain and restore the health of the population. Such obligations include: (i) fostering recognition of factors favouring positive health results, e.g. research and provision of information; (ii) ensuring that health services are culturally appropriate and that health care staff are trained to recognize and respond to the specific needs of vulnerable or marginalized groups; (iii) ensuring that the State meets its obligations in the dissemination of appropriate information relating to healthy lifestyles and nutrition, harmful traditional practices and the availability of services; (iv) supporting people in making informed choices about their health.

International obligations

38. In its General Comment No. 3, the Committee drew attention to the obligation of all States parties to take steps, individually and through international assistance and cooperation, especially economic and technical, towards the full realization of the rights recognized in the Covenant, such as the right to health. In the spirit of article 56 of the Charter of the United Nations, the specific provisions of the Covenant (articles 12, 2.1, 22 and 23) and the Alma-Ata Declaration on primary health care, States parties should recognize the essential role of international cooperation and comply with their commitment to take joint and separate action to achieve the full realization of the right to health. In this regard, States parties are referred to the Alma-Ata Declaration which proclaims that the existing gross inequality in the health status of the people, particularly between developed and developing countries, as well as within countries, is politically, socially and economically unacceptable and is, therefore, of common concern to all countries. (26)

39. To comply with their international obligations in relation to article 12, States parties have to respect the enjoyment of the right to health in other countries, and 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. 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. (27) States parties should ensure that the right to health is given due attention in international agreements and, to that end, should consider the development of further legal instruments. In relation to the conclusion of other international agreements, States parties should take steps to ensure that these instruments do not adversely impact upon the right to health. Similarly, 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 agreements and international measures of these institutions.

40. States parties have a joint and individual responsibility, in accordance with the Charter of the United Nations and relevant resolutions of the United Nations General Assembly and of the World Health Assembly, to cooperate in providing disaster relief and humanitarian assistance in times of emergency, including assistance to refugees and internally displaced persons. Each State should contribute to this task to the maximum of its capacities. 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. Moreover, given that some diseases are easily transmissible beyond the frontiers of a State, the international community has a collective responsibility to address this problem. The economically developed States parties have a special responsibility and interest to assist the poorer developing States in this regard.

41. 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. In this regard, the Committee recalls its position, stated in General Comment No. 8, on the relationship between economic sanctions and respect for economic, social and cultural rights.

42. 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. State parties should therefore provide an environment which facilitates the discharge of these responsibilities.

Core obligations

43. In General Comment No. 3, the Committee confirms that States parties have a core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights enunciated in the Covenant, including essential primary health care. Read in conjunction with more contemporary instruments, such as the Programme of Action of the International Conference on Population and Development, (28) the Alma-Ata Declaration provides compelling guidance on the core obligations arising from article 12. Accordingly, in the Committee's view, these core obligations include at least the following obligations:

(a) To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups;

(b) To ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone;

(c) To ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water;

(d) To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs;

(e) To ensure equitable distribution of all health facilities, goods and services;

(f) To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process; they shall include 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 devised, as well as their content, shall give particular attention to all vulnerable or marginalized groups.

44. The Committee also confirms that the following are obligations of comparable priority:

(a) To ensure reproductive, maternal (pre-natal as well as post-natal) and child health care;

(b) To provide immunization against the major infectious diseases occurring in the community;

(c) To take measures to prevent, treat and control epidemic and endemic diseases;

(d) To provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them;

(e) To provide appropriate training for health personnel, including education on health and human rights.

45. For the avoidance of any doubt, the Committee wishes to emphasize that it is particularly incumbent on States parties and other actors in a position to assist, to provide "international assistance and cooperation, especially economic and technical" (29) which enable developing countries to fulfil their core and other obligations indicated in paragraphs 43 and 44 above.

III. VIOLATIONS

46. When the normative content of article 12 (Part I) is applied to the obligations of

States parties (Part II), a dynamic process is set in motion which facilitates identification of violations of the right to health. The following paragraphs provide illustrations of violations of article 12.

47. In determining which actions or omissions amount to a violation of the right to health, it is important to distinguish the inability from the unwillingness of a State party to comply with its obligations under article 12. This follows from article 12.1, which speaks of the highest attainable standard of health, as well as from article 2.1 of the Covenant, which obliges each State party to take the necessary steps to the maximum of its available resources. A State which is unwilling to use the maximum of its available resources for the realization of the right to health is in violation of its obligations under article 12. If resource constraints render it impossible for a State to comply fully with its Covenant obligations, it has the burden of justifying that every effort has nevertheless been made to use all available resources at its disposal in order to satisfy, as a matter of priority, the obligations outlined above. It should be stressed, however, that a State party cannot, under any circumstances whatsoever, justify its non-compliance with the core obligations set out in paragraph 43 above, which are non-derogable.

48. Violations of the right to health can occur through the direct action of States or other entities insufficiently regulated by States. The adoption of any retrogressive measures incompatible with the core obligations under the right to health, outlined in paragraph 43 above, constitutes a violation of the right to health. Violations through *acts of commission* include the formal repeal or suspension of legislation necessary for the continued enjoyment of the right to health or the adoption of legislation or policies which are manifestly incompatible with pre-existing domestic or international legal obligations in relation to the right to health.

49. Violations of the right to health can also occur through the omission or failure of States to take necessary measures arising from legal obligations. Violations through *acts of omission* include the failure to take appropriate steps towards the full realization of everyone's right to the enjoyment of the highest attainable standard of physical and mental health, the failure to have a national policy on occupational safety and health as well as occupational health services, and the failure to enforce relevant laws.

Violations of the obligation to respect

50. Violations of the obligation to respect are those State actions, policies or laws that contravene the standards set out in article 12 of the Covenant and are likely to result in bodily harm, unnecessary morbidity and preventable mortality. Examples include the denial of access to health facilities, goods and services to particular individuals or groups as a result of de jure or de facto discrimination; the deliberate withholding or misrepresentation of information vital to health protection or treatment; the suspension of legislation or the adoption of laws or policies that interfere with the enjoyment of any of the components of the right to health; and the failure of the State to take into account its legal obligations regarding the right to health when entering into bilateral or multilateral

agreements with other States, international organizations and other entities, such as multinational corporations.

Violations of the obligation to protect

51. Violations of the obligation to protect follow from the failure of a State to take all necessary measures to safeguard persons within their jurisdiction from infringements of the right to health by third parties. This category includes such omissions as the failure to regulate the activities of individuals, groups or corporations so as to prevent them from violating the right to health of others; the failure to protect consumers and workers from practices detrimental to health, e.g. by employers and manufacturers of medicines or food; the failure to discourage production, marketing and consumption of tobacco, narcotics and other harmful substances; the failure to protect women against violence or to prosecute perpetrators; the failure to discourage the continued observance of harmful traditional medical or cultural practices; and the failure to enact or enforce laws to prevent the pollution of water, air and soil by extractive and manufacturing industries.

Violations of the obligation to fulfil

52. Violations of the obligation to fulfil occur through the failure of States parties to take all necessary steps to ensure the realization of the right to health. Examples include the failure to adopt or implement a national health policy designed to ensure the right to health for everyone; insufficient expenditure or misallocation of public resources which results in the non-enjoyment of the right to health by individuals or groups, particularly the vulnerable or marginalized; the failure to monitor the realization of the right to health at the national level, for example by identifying right to health indicators and benchmarks; the failure to take measures to reduce the inequitable distribution of health facilities, goods and services; the failure to adopt a gender-sensitive approach to health; and the failure to reduce infant and maternal mortality rates.

IV. IMPLEMENTATION AT THE NATIONAL LEVEL

Framework legislation

53. The most appropriate feasible measures to implement the right to health will vary significantly from one State to another. Every State has a margin of discretion in assessing which measures are most suitable to meet its specific circumstances. The Covenant, however, 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. This requires the adoption of a national strategy to ensure to all the enjoyment of the right to health, based on human rights principles which define the objectives of that strategy, and the formulation of policies and corresponding right to health indicators and benchmarks. The national health strategy should also identify the

resources available to attain defined objectives, as well as the most cost-effective way of using those resources.

54. The formulation and implementation of national health strategies and plans of action should respect, *inter alia*, the principles of non-discrimination and people's participation. In particular, the right of individuals and groups to participate in decision-making processes, which may affect their development, must be an integral component of any policy, programme or strategy developed to discharge governmental obligations under article 12. Promoting health must involve effective community action in setting priorities, making decisions, planning, implementing and evaluating strategies to achieve better health. Effective provision of health services can only be assured if people's participation is secured by States.

55. The national health strategy and plan of action should also be based on the principles of accountability, transparency and independence of the judiciary, since good governance is essential to the effective implementation of all human rights, including the realization of the right to health. In order to create a favourable climate for the realization of the right, States parties should take appropriate steps to ensure that the private business sector and civil society are aware of, and consider the importance of, the right to health in pursuing their activities.

56. States should consider adopting a framework law to operationalize their right to health national strategy. The framework law should establish national mechanisms for monitoring the implementation of national health strategies and plans of action. It should include provisions on the targets to be achieved and the time-frame for their achievement; the means by which right to health benchmarks could be achieved; the intended collaboration with civil society, including health experts, the private sector and international organizations; institutional responsibility for the implementation of the right to health national strategy and plan of action; and possible recourse procedures. In monitoring progress towards the realization of the right to health, States parties should identify the factors and difficulties affecting implementation of their obligations.

Right to health indicators and benchmarks

57. National health strategies should identify appropriate right to health indicators and benchmarks. The indicators should be designed to monitor, at the national and international levels, the State party's obligations under article 12. States may obtain guidance on appropriate right to health indicators, which should address different aspects of the right to health, from the ongoing work of WHO and the United Nations Children's Fund (UNICEF) in this field. Right to health indicators require disaggregation on the prohibited grounds of discrimination.

58. Having identified appropriate right to health indicators, States parties are invited to set appropriate national benchmarks in relation to each indicator. During the periodic reporting procedure the Committee will engage in a process of scoping with the State party. Scoping involves the joint consideration by the State party and the Committee of

the indicators and national benchmarks which will then provide the targets to be achieved during the next reporting period. In the following five years, the State party will use these national benchmarks to help monitor its implementation of article 12. Thereafter, in the subsequent reporting process, the State party and the Committee will consider whether or not the benchmarks have been achieved, and the reasons for any difficulties that may have been encountered.

Remedies and accountability

59. 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. (30) 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.

60. 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 and should be encouraged in all cases. (31) Incorporation enables courts to adjudicate violations of the right to health, or at least its core obligations, by direct reference to the Covenant.

61. Judges and members of the legal profession should be encouraged by States parties to pay greater attention to violations of the right to health in the exercise of their functions.

62. States parties should respect, protect, facilitate and promote the work of human rights advocates and other members of civil society with a view to assisting vulnerable or marginalized groups in the realization of their right to health.

V. OBLIGATIONS OF ACTORS OTHER THAN STATES PARTIES

63. The role of the United Nations agencies and programmes, and in particular the key function assigned to WHO in realizing the right to health at the international, regional and country levels, is of particular importance, as is the function of UNICEF in relation to the right to health of children. When formulating and implementing their right to health national strategies, States parties should avail themselves of technical assistance and cooperation of WHO. Further, when preparing their reports, States parties should utilize the extensive information and advisory services of WHO with regard to data collection, disaggregation, and the development of right to health indicators and benchmarks.

64. Moreover, coordinated efforts for the realization of the right to health should be maintained to enhance the interaction among all the actors concerned, including the various components of civil society. In conformity with articles 22 and 23 of the Covenant, WHO, The International Labour Organization, the United Nations

Development Programme, UNICEF, the United Nations Population Fund, the World Bank, regional development banks, the International Monetary Fund, the World Trade Organization and other relevant bodies within the United Nations system, should cooperate effectively with States parties, building on their respective expertise, in relation to the implementation of the right to health at the national level, with due respect to their individual mandates. In particular, the international financial institutions, notably the World Bank and the International Monetary Fund, should pay greater attention to the protection of the right to health in their lending policies, credit agreements and structural adjustment programmes. When examining the reports of States parties and their ability to meet the obligations under article 12, the Committee will consider the effects of the assistance provided by all other actors. The adoption of a human rights-based approach by United Nations specialized agencies, programmes and bodies will greatly facilitate implementation of the right to health. In the course of its examination of States parties' reports, the Committee will also consider the role of health professional associations and other non-governmental organizations in relation to the States' obligations under article 12.

65. The role of WHO, the Office of the United Nations High Commissioner for Refugees, the International Committee of the Red Cross/Red Crescent and UNICEF, as well as non governmental organizations and national medical associations, is of particular importance in relation to disaster relief and humanitarian assistance in times of emergencies, 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.

Adopted on 11 May 2000.

Notes

1. For example, the principle of non-discrimination in relation to health facilities, goods and services is legally enforceable in numerous national jurisdictions.

2. In its resolution 1989/11.

3. The Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care adopted by the United Nations General Assembly in 1991 (resolution 46/119) and the Committee's General Comment No. 5 on persons with disabilities apply to persons with mental illness; the Programme of Action of the International Conference on Population and Development held at Cairo in 1994, as well as the Declaration and Programme for Action of the Fourth World Conference on Women held in Beijing in 1995 contain definitions of reproductive health and women's health, respectively.

4. Common article 3 of the Geneva Conventions for the protection of war victims (1949); Additional Protocol I (1977) relating to the Protection of Victims of International Armed Conflicts, art. 75 (2) (a); Additional Protocol II (1977) relating to the Protection of Victims of Non-International Armed Conflicts, art. 4 (a).

5. See WHO Model List of Essential Drugs, revised December 1999, WHO Drug Information, vol. 13, No. 4, 1999.

6. Unless expressly provided otherwise, any reference in this General Comment to health facilities, goods and services includes the underlying determinants of health outlined in paras. 11 and 12 (a) of this General Comment.

7. See paras. 18 and 19 of this General Comment.

8. See article 19.2 of the International Covenant on Civil and Political Rights. This General Comment gives particular emphasis to access to information because of the special importance of this issue in relation to health.

9. In the literature and practice concerning the right to health, three levels of health care are frequently referred to: *primary health care* typically deals with common and relatively minor illnesses and is provided by health professionals and/or generally trained doctors working within the community at relatively low cost; *secondary health care* is provided in centres, usually hospitals, and typically deals with relatively common minor or serious illnesses that cannot be managed at community level, using specialty-trained health professionals and doctors, special equipment and sometimes in-patient care at comparatively higher cost; *tertiary health care* is provided in relatively few centres, typically deals with small numbers of minor or serious illnesses requiring specialty-trained health professionals and doctors and special equipment, and is often relatively expensive. Since forms of primary, secondary and tertiary health care frequently overlap and often interact, the use of this typology does not always provide sufficient distinguishing criteria to be helpful for assessing which levels of health care States parties must provide, and is therefore of limited assistance in relation to the normative understanding of article 12.

10. According to WHO, the stillbirth rate is no longer commonly used, infant and under-five mortality rates being measured instead.

11. *Prenatal* denotes existing or occurring before birth; *perinatal* refers to the period shortly before and after birth (in medical statistics the period begins with the completion of 28 weeks of gestation and is variously defined as ending one to four weeks after birth); *neonatal*, by contrast, covers the period pertaining to the first four weeks after birth; while *post-natal* denotes occurrence after birth. In this General Comment, the more generic terms pre- and post-natal are exclusively employed.

12. 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.

13. The Committee takes note, in this regard, of Principle 1 of the Stockholm Declaration of 1972 which states: "Man has the fundamental right to freedom, equality and adequate conditions of life, in an environment of a quality that permits a life of dignity and well-being", as well as of recent developments in international law, including General Assembly resolution 45/94 on the need to ensure a healthy environment for the well-being of individuals; Principle 1 of the Rio Declaration; and regional human rights instruments such as article 10 of the San Salvador Protocol to the American Convention on Human Rights.

14. ILO Convention No. 155, art. 4.2.

15. See para. 12 (b) and note 8 above.

16. For the core obligations, see paras. 43 and 44 of the present General Comments.

17. Article 24.1 of the Convention on the Rights of the Child.

18. See World Health Assembly resolution WHA47.10, 1994, entitled "Maternal and child health and family planning: traditional practices harmful to the health of women and children".

19. Recent emerging international norms relevant to indigenous peoples include the ILO Convention No. 169 concerning Indigenous and Tribal Peoples in Independent Countries (1989); articles 29 (c) and (d) and 30 of the Convention on the Rights of the Child (1989); article 8 (j) of the Convention on Biological Diversity (1992), recommending that States respect, preserve and maintain knowledge, innovation and practices of indigenous communities; Agenda 21 of the United Nations Conference on Environment and Development (1992), in particular chapter 26; and Part I, paragraph 20, of the Vienna Declaration and Programme of Action (1993), stating that States should take concerted positive steps to ensure respect for all human rights of indigenous people, on the basis of non-discrimination. See also the preamble and article 3 of the United Nations Framework Convention on Climate Change (1992); and article 10 (2) (e) of the United Nations Convention to Combat Desertification in Countries Experiencing Serious Drought and/or Desertification, Particularly in Africa (1994). During recent years an increasing number of States have changed their constitutions and introduced legislation recognizing specific rights of indigenous peoples.

20. See General Comment No. 13, para. 43.

21. See General Comment No. 3, para. 9; General Comment No. 13, para. 44.

22. See General Comment No. 3, para. 9; General Comment No. 13, para. 45.

23. According to General Comments Nos. 12 and 13, the obligation to fulfil incorporates an obligation to *facilitate* and an obligation to *provide*. In the present General Comment, the obligation to fulfil also incorporates an obligation to *promote* because of the critical importance of health promotion in the work of WHO and elsewhere.

24. General Assembly resolution 46/119 (1991).

25. Elements of such a policy are the identification, determination, authorization and control of dangerous materials, equipment, substances, agents and work processes; the provision of health information to workers and the provision, if needed, of adequate protective clothing and equipment; the enforcement of laws and regulations through adequate inspection; the requirement of notification of occupational accidents and diseases, the conduct of inquiries into serious accidents and diseases, and the production of annual statistics; the protection of workers and their representatives from disciplinary measures for actions properly taken by them in conformity with such a policy; and the provision of occupational health services with essentially preventive functions. See ILO Occupational Safety and Health Convention, 1981 (No. 155) and Occupational Health Services Convention, 1985 (No. 161).

26. Article II, Alma-Ata Declaration, Report of the International Conference on Primary Health Care, Alma-Ata, 6-12 September 1978, in: World Health Organization, "Health for All" Series, No. 1, WHO, Geneva, 1978.

27. See para. 45 of this General Comment.

28. Report of the International Conference on Population and Development, Cairo, 5-13 September 1994 (United Nations publication, Sales No. E.95.XIII.18), chap. I, resolution 1, annex, chaps. VII and VIII.

29. Covenant, art. 2.1.

30. Regardless of whether groups as such can seek remedies as distinct holders of rights, States parties are bound by both the collective and individual dimensions of article 12. Collective rights are critical in the field of health; modern public health policy relies heavily on prevention and promotion which are approaches directed primarily to groups.

31. See General Comment No. 2, para. 9.

People's
Health
Movement

People's Health Movement

People's Charter for Health

English

People's Charter For Health

INTRODUCTION

In 1978, at the Alma-Ata Conference, ministers from 134 member countries in association with WHO and UNICEF declared "Health for All by the Year 2000" selecting Primary Health Care as the best tool to achieve it.

Unfortunately, that dream never came true. The health status of third world populations has not improved. In many cases it has deteriorated further. Currently we are facing a global health crisis, characterized by growing inequalities within and between countries .New threats to health are continually emerging . This is compounded by negative forces of globalization which prevent the equitable distribution of resources with regard to the health of people and especially that of the poor.

Within the health sector, failure to implement the principles of primary health care, as originally conceived in Alma-Ata has significantly aggravated the global health crisis.

Governments and the international bodies are fully responsible for this failure.

It has now become essential to build up a concerted international effort to put the goals of health for all to its rightful place on the development agenda. Genuine, people-centered initiatives must therefore be strengthened in order to increase pressure on decision- makers, governments and the private sector to ensure that the vision of Alma- Ata becomes a reality.

Several international organizations and civil society movements, NGOs and women's groups deciples to work together towards this objective. This group together with others committed to the principles of primary health care and people's perspectives organized the "People's Health Assembly" which took place form 4-8 December 2000 in Bangladesh, at Savar, on the campus of the Gonoshasthasthaya Kendra or GK (peoples Health Centre).

1453 participants form 92 countries came to the Assembly which was the culmination of eighteen months of preparatory action around the globe. The preparatory process elicited unprecedented enthusiasm and participation of a broad cross section of people who have been involved in thousands of village meetings, district level workshops and national gatherings.

The plenary sessions at the Assembly covered five main themes: Health, Life and Well-Being; Inequality, Poverty and Health; Health Care and Health Services; Environment and Survival; and The Ways Forward. People from all over the world presented testimonies of deprivation and service failure as well as those of successful people's initiatives and organization. Over a hundred concurrent sessions made it possible for participants to share and discuss in greater detail different aspects of the major themes and give voice to their specific experiences and concerns. The five days event gave participants the space to express themselves in their own idiom. They put forward the failures of their respective governments and international organizations and decided to fight together so that health and equitable development become top priorities in the policy makers agendas at the local, national and international levels.

Having reviewed their problems and difficulties and shared their experiences, they have formulated and finally endorsed the People's Charter for Health. The charter from now on will be the common tool of a worldwide citizens' movement committed to make the Alma- Ata dream reality.

We encourage and invite everyone who shares our concerns and aims to join us by endorsing the charter.

PREAMBLE

Health is a social, economic and political issue and above all a fundamental human right. Inequality, poverty, exploitation, violence and injustice are at the root of ill-health and the deaths of poor and marginalised people. Health for all means that powerful interests have to be challenged, that globalisation has to be opposed, and that political and economic priorities have to be drastically changed. This Charter builds on perspectives of people whose voices have rarely been heard before, if at all. It encourages people to develop their own solutions and to hold accountable local authorities, national governments, international organisations and corporations.

VISION

Equity, ecologically-sustainable development and peace are at the heart of our vision of a better world - a world in which a healthy life for all is a reality; a world that respects, appreciates and celebrates all life and diversity; a world that enables the flowering of people's talents and abilities to enrich each other; a world in which people's voices guide the decisions that shape our lives. There are more than enough resources to achieve this vision.

THE HEALTH CRISIS

"Illness and death every day anger us. Not because there are people who get sick or because there are people who die. We are angry because many illnesses and deaths have their roots in the economic and social policies that are imposed on us."

(A voice from Central America)

In recent decades, economic changes world-wide have profoundly affected people's health and their access to health care and other social services.

Despite unprecedented levels of wealth in the world, poverty and hunger are increasing. The gap between rich and poor nations has widened, as have inequalities within countries, between social classes, between men and women and between young and old.

A large proportion of the world's population still lacks access to food, education, safe drinking water, sanitation, shelter, land and its resources, employment and health care services. Discrimination continues to prevail. It affects both the occurrence of disease and access to health care.

The planet's natural resources are being depleted at an alarming rate. The resulting degradation of the environment threatens everyone's health, especially the health of the poor. There has been an upsurge of new conflicts while weapons of mass destruction still pose a grave threat.

The world's resources are increasingly concentrated in the hands of a few who strive to maximise their private profit. Neoliberal political and economic policies are made by a small group of powerful governments, and by international institutions such as the World Bank, the International Monetary Fund and the World Trade Organisation. These policies, together with the unregulated activities of transnational corporations, have had severe effects on the lives and livelihoods, health and well-being of people in both North and South.

Public services are not fulfilling people's needs, not least because they have deteriorated as a result of cuts in governments' social budgets. Health services have become less accessible, more unevenly distributed and more inappropriate.

Privatisation threatens to undermine access to health care still further and to compromise the essential principle of equity. The persistence of preventable ill health, the resurgence of diseases such as tuberculosis and malaria, and the emergence and spread of new diseases such as HIV/AIDS are a stark reminder of our world's lack of commitment to principles of equity and justice.

PRINCIPLES OF THE PEOPLE'S CHARTER FOR HEALTH

- The attainment of the highest possible level of health and well-being is a fundamental human right, regardless of a person's colour, ethnic background, religion, gender, age, abilities, sexual orientation or class.
- The principles of universal, comprehensive Primary Health Care (PHC), envisioned in the 1978 Alma Ata Declaration, should be the basis for formulating policies related to health. Now more than ever an equitable, participatory and intersectoral approach to health and health care is needed.
- Governments have a fundamental responsibility to ensure universal access to quality health care, education and other social services according to people's needs, not according to their ability to pay.
- The participation of people and people's organisations is essential to the formulation, implementation and evaluation of all health and social policies and programmes.
- Health is primarily determined by the political, economic, social and physical environment and should, along with equity and sustainable development, be a top priority in local, national and international policy-making.

A CALL FOR ACTION

To combat the global health crisis, we need to take action at all levels - individual, community, national, regional and global - and in all sectors. The demands presented below provide a basis for action.

HEALTH AS A HUMAN

RIGHT Health is a reflection of a society's commitment to equity and justice. Health and human rights should prevail over economic and political concerns.

This Charter calls on people of the world to:

- Support all attempts to implement the right to health.
- Demand that governments and international organisations reformulate, implement and enforce policies and practices which respect the right to health.
- Build broad-based popular movements to pressure governments to incorporate health and human rights into national constitutions and legislation.
- Fight the exploitation of people's health needs for purposes of profit.

TACKLING THE BROADER DETERMINANTS OF HEALTH

Economic challenges

The economy has a profound influence on people's health. Economic policies that prioritise equity, health and social well-being can improve the health of the people as well as the economy.

Political, financial, agricultural and industrial policies which respond primarily to capitalist needs, imposed by national governments and international organisations, alienate people from their lives and livelihoods. The processes of economic globalisation and liberalisation have increased inequalities between and within nations. Many countries of the world and especially the most powerful ones are using their resources, including economic sanctions and military interventions, to consolidate and expand their positions, with devastating effects on people's lives.

This Charter calls on people of the world to:

- Demand transformation of the World Trade Organisation and the global trading system so that it ceases to violate social, environmental, economic and health rights of people and begins to discriminate positively in favour of countries of the South. In order to protect public health, such transformation must include intellectual property regimes such as patents and the Trade Related aspects of Intellectual Property Rights (TRIPS) agreement.
- Demand the cancellation of Third World debt.
- Demand radical transformation of the World Bank and International Monetary Fund so that these institutions reflect and actively promote the rights and interests of developing countries.
- Demand effective regulation to ensure that TNCs do not have negative effects on people's health, exploit their workforce, degrade the environment or impinge on national sovereignty.
- Ensure that governments implement agricultural policies attuned to people's needs and not to the demands of the market, thereby guaranteeing food security and equitable access to food.
- Demand that national governments act to protect public health rights in intellectual property laws.
- Demand the control and taxation of speculative international capital flows.
- Insist that all economic policies be subject to health, equity, gender and environmental impact assessments and include enforceable regulatory measures to ensure compliance.
- Challenge growth-centred economic theories and replace them with alternatives that create humane and sustainable societies. Economic theories should recognise environmental constraints, the fundamental importance of equity and health, and the contribution of unpaid labour, especially the unrecognised work of women.

Social and political challenges

Comprehensive social policies have positive effects on people's lives and livelihoods. Economic globalisation and privatisation have profoundly disrupted communities, families and cultures. Women are essential to sustaining the social fabric of societies everywhere, yet their basic needs are often ignored or denied, and their rights and persons violated.

Public institutions have been undermined and weakened. Many of their responsibilities have been transferred to the private sector, particularly corporations, or to other national and international institutions, which are rarely accountable to the people. Furthermore, the power of political parties and trade unions has been severely curtailed, while conservative and fundamentalist forces are on the rise. Participatory democracy in political organisations and civic structures should thrive. There is an urgent need to foster and ensure transparency and accountability.

This Charter calls on people of the world to:

- Demand and support the development and implementation of comprehensive social policies with full participation of people.
- Ensure that all women and all men have equal rights to work, livelihoods, to freedom of expression, to political participation, to exercise religious choice, to education and to freedom from violence.
- Pressure governments to introduce and enforce legislation to protect and promote the physical, mental and spiritual health and human rights of marginalised groups.
- Demand that education and health are placed at the top of the political agenda. This calls for free and compulsory quality education for all children and adults, particularly girl children and women, and for quality early childhood education and care.
- Demand that the activities of public institutions, such as child care services, food distribution systems, and housing provisions, benefit the health of individuals and communities.
- Condemn and seek the reversal of any policies, which result in the forced displacement of people from their lands, homes or jobs.
- Oppose fundamentalist forces that threaten the rights and liberties of individuals, particularly the lives of women, children and minorities.
- Oppose sex tourism and the global traffic of women and children.

Environmental challenges

Water and air pollution, rapid climate change, ozone layer depletion, nuclear energy and waste, toxic chemicals and pesticides, loss of biodiversity, deforestation and soil erosion have far-reaching effects on people's health. The root causes of this destruction include the unsustainable exploitation of natural resources, the absence of a long-term holistic vision, the spread of individualistic and profit-maximising behaviours, and over-consumption by the rich. This destruction must be confronted and reversed immediately and effectively.

This Charter calls on people of the world to:

- Hold transnational and national corporations, public institutions and the military accountable for their destructive and hazardous activities that impact on the environment and people's health.
- Demand that all development projects be evaluated against health and environmental criteria and that caution and restraint be applied whenever technologies or policies pose potential threats to health and the environment (the precautionary principle).
- Demand that governments rapidly commit themselves to reductions of greenhouse gases from their own territories far stricter than those set out in the international climate

change agreement, without resorting to hazardous or inappropriate technologies and practices.

- Oppose the shifting of hazardous industries and toxic and radioactive waste to poorer countries and marginalised communities and encourage solutions that minimise waste production.
- Reduce over-consumption and non-sustainable lifestyles - both in the North and the South. Pressure wealthy industrialised countries to reduce their consumption and pollution by 90 per cent.
- Demand measures to ensure occupational health and safety, including worker-centred monitoring of working conditions.
- Demand measures to prevent accidents and injuries in the workplace, the community and in homes.
- Reject patents on life and oppose bio-piracy of traditional and indigenous knowledge and resources.
- Develop people-centred, community-based indicators of environmental and social progress, and to press for the development and adoption of regular audits that measure environmental degradation and the health status of the population.

War, violence, conflict and natural disasters

War, violence, conflict and natural disasters devastate communities and destroy human dignity. They have a severe impact on the physical and mental health of their members, especially women and children. Increased arms procurement and an aggressive and corrupt international arms trade undermine social, political and economic stability and the allocation of resources to the social sector.

This Charter calls on people of the world to:

- Support campaigns and movements for peace and disarmament.
- Support campaigns against aggression, and the research, production, testing and use of weapons of mass destruction and other arms, including all types of landmines.
- Support people's initiatives to achieve a just and lasting peace, especially in countries with experiences of civil war and genocide.
- Condemn the use of child soldiers, and the abuse and rape, torture and killing of women and children.
- Demand the end of occupation as one of the most destructive tools to human dignity.
- Oppose the militarisation of humanitarian relief interventions.
- Demand the radical transformation of the UN Security Council so that it functions democratically.
- Demand that the United Nations and individual states end all kinds of sanctions used as an instrument of aggression which can damage the health of civilian populations.
- Encourage independent, people-based initiatives to declare neighbourhoods, communities and cities areas of peace and zones free of weapons.

- Support actions and campaigns for the prevention and reduction of aggressive and violent behaviour, especially in men, and the fostering of peaceful coexistence.
- Support actions and campaigns for the prevention of natural disasters and the reduction of subsequent human suffering.

A PEOPLE-CENTERED HEALTH SECTOR

This Charter calls for the provision of universal and comprehensive primary health care, irrespective of people's ability to pay. Health services must be democratic and accountable with sufficient resources to achieve this.

This Charter calls on people of the world to:

- Oppose international and national policies that privatise health care and turn it into a commodity.
- Demand that governments promote, finance and provide comprehensive Primary Health Care as the most effective way of addressing health problems and organising public health services so as to ensure free and universal access.
- Pressure governments to adopt, implement and enforce national health and drugs policies.
- Demand that governments oppose the privatisation of public health services and ensure effective regulation of the private medical sector, including charitable and NGO medical services.
- Demand a radical transformation of the World Health Organization (WHO) so that it responds to health challenges in a manner which benefits the poor, avoids vertical approaches, ensures intersectoral work, involves people's organisations in the World Health Assembly, and ensures independence from corporate interests.
- Promote, support and engage in actions that encourage people's power and control in decision-making in health at all levels, including patient and consumer rights.
- Support, recognise and promote traditional and holistic healing systems and practitioners and their integration into Primary Health Care.
- Demand changes in the training of health personnel so that they become more problem-oriented and practice-based, understand better the impact of global issues in their communities, and are encouraged to work with and respect the community and its diversities.
- Demystify medical and health technologies (including medicines) and demand that they be subordinated to the health needs of the people.
- Demand that research in health, including genetic research and the development of medicines and reproductive technologies, is carried out in a participatory, needs-based manner by accountable institutions. It should be people- and public health-oriented, respecting universal ethical principles.
- Support people's rights to reproductive and sexual self-determination and oppose all coercive measures in population and family planning policies. This support includes the right to the full range of safe and effective methods of fertility regulation.

PEOPLE'S PARTICIPATION FOR A HEALTHY WORLD

Strong people's organisations and movements are fundamental to more democratic, transparent and accountable decision-making processes. It is essential that people's civil, political, economic, social and cultural rights are ensured. While governments have the primary responsibility for promoting a more equitable approach to health and human rights, a wide range of civil society groups and movements, and the media have an important role to play in ensuring people's power and control in policy development and in the monitoring of its implementation.

This Charter calls on people of the world to:

- Build and strengthen people's organisations to create a basis for analysis and action.
- Promote, support and engage in actions that encourage people's involvement in decision-making in public services at all levels.
- Demand that people's organisations be represented in local, national and international fora that are relevant to health.
- Support local initiatives towards participatory democracy through the establishment of people-centred solidarity networks across the world.

The People's Health Assembly and the Charter

The idea of a People's Health Assembly (PHA) has been discussed for more than a decade. In 1998 a number of organisations launched the PHA process and started to plan a large international Assembly meeting, held in Bangladesh at the end of 2000. A range of pre- and post-Assembly activities were initiated including regional workshops, the collection of people's health-related stories and the drafting of a People's Charter for Health. The present Charter builds upon the views of citizens and people's organisations from around the world, and was first approved and opened for endorsement at the Assembly meeting in Savar, Bangladesh, in December 2000. The Charter is an expression of our common concerns, our vision of a better and healthier world, and of our calls for radical action. It is a tool for advocacy and a rallying point around which a global health moment can gather and other networks and coalitions can be formed.

Join Us - Endorse the Charter

We call upon all individuals and organisations to join this global movement and invite you to endorse and help implement the People's Charter for Health.

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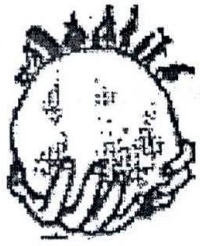
Amendment

- After the endorsement of the PCH on December 8, 2000, it was called to the attention of the drafting group that action points number 1 and 2 under Economic challenges could be interpreted as supporting the social clause proposed by WTO, which actually serves to strengthen the WTO and its neoliberal agenda. Given that this countervails the PHA demands for change of the WTO and the global trading system, the two paragraphs were merged and amended.
- The section of War, Violence and Conflict has been amended to include natural disasters. A new action point, number 5 in this version, was added to demand the end of occupation. Furthermore, action point number 7, now number 8, was amended to read to end all kinds of sanctions. An additional action point number 11 was added concerning natural disasters.



THE MUMBAI DECLARATION

from

The III International Forum for the Defence of the People's Health

Mumbai, India
14-15 January 2004
(A Forum held before the World Social Forum, 16-21st January 2004)

PREAMBLE

We, the 700 delegates from 44 countries[1], gathered at the III International Forum for the Defence of the People's Health at Mumbai on 14th and 15th of January 2004, reaffirm the validity and relevance of the People's Charter for Health, the foundational document of the People's Health Movement, which describes increasing and serious threats to health in the early 21st century.

Since the Charter's adoption in December 2000 at the first People's Health Assembly, at GK Savar, Bangladesh, the health of the world's poor has worsened and more threats to people's health have emerged.

Social, political, economic and environmental threats to health identified as the basic causes of ill health and the inequitable distribution of health within and between countries have increased.

Social, political, economic and environmental threats to health identified as the basic causes of ill health and the inequitable distribution of health within and between countries have increased

The III International Forum for the Defense of the People's Health provided opportunities to hear inspiring testimonies, from the world's poor and health activists:

- *Denouncing the denial of health to their communities and their efforts to overcome this injustice.*
- *Threats to health from the unfair system of global trade and the imperialist policies of developed countries including unjust wars and efforts to counter them*
- *The Demands for acknowledgement of health as a universal human right and the implementation of Comprehensive Primary Health Care as a strategy to achieve Health for All.*

The Forum recognized the particular discrimination suffered by many groups which makes achieving Health for All even more difficult. These included women, people with disabilities, sex workers, children living in difficult circumstances (including street children), migrant workers, people with mental disorders, Dalit people, Indigenous peoples in rich and poor countries, and all those affected by wars, disasters and conflicts.

The Forum demanded Health for All, Now! and reiterated that Another World in which health is a reality for All is necessary and possible.

The Forum brought together all the concerns and experiences shared into a **Declaration** for action, entitled ***"The Mumbai Declaration"***. This Declaration is an update on the state of people's health across the globe at the beginning of 2004 and calls on People's Health Movement, Civil Society and Governments to evolve action in six key areas to achieve the goal of "Health for All Now!" dream.

- *End Corporate led Globalisation*
- *End war and occupation*
- *Implement Comprehensive and sustainable Primary Health Care*
- *Confront the HIV/AIDS epidemic with Primary Health Care and Health Systems approach*
- *Reverse Environmental damage caused by unsustainable development strategies*
- *End discrimination in the Right to Health*

End corporate-led globalization

Corporate-led globalization continues to be a major threat to health. Since the People's Charter for Health was adopted in 2000, the International Monetary Fund, the World Bank and the World Trade Organisation have continued to advance the economic health of corporations at the expense of global health.

The protection of intellectual property (through trade agreements such as the Trade Related aspects of Intellectual Property Rights, TRIPS) and unfair trading practices (through the General Agreement on Trade in Services, GATS) have caused enormous damage to people's health.

The tobacco industry offers a clear example: Tobacco kills, yet transnational companies continue to target youth and marginalized communities with their tobacco marketing strategies.

The epidemic of privatizations of water, electricity, education and health care, imposed by Structural Adjustment Packages (SAPs), has limited access to or removed the foundation upon which public health is built.

Public-private partnerships, as promoted by World Bank, Global Funds and International health agencies including WHO, have removed responsibility for health from the public sector, essentially privatizing health and treating it as a commodity rather than a human right. User fees have further decreased people's access to health care services.

This Declaration;

Calls for Action by People's Health Movement and Civil Society to;

- Pressure the World Bank and the International Monetary Fund to acknowledge their culpability in the current health care crisis, especially the damage caused by Structural Adjustment Programs;

1 Argentina, Australia, Bangladesh, Belgium, Brazil, Cambodia, Cameroon, Canada, Costa Rica, Cuba, Denmark, Ecuador, Egypt, France, Germany, Guatemala, Hong Kong, India, Iran, Italy, Kenya, Korea, Lebanon, Malaysia, Mauritius, Netherlands, Nicaragua, Nigeria, Norway, Pakistan, Palestine, Peru, Philippines, South Africa, Sri Lanka, Sweden, Switzerland, Tanzania, Thailand, USA, UK, Vietnam, Zambia, Zimbabwe.

- Build the Campaign "No To Intellectual Property Rights" in our traditional systems of medicine and our seeds, to resist the efforts of the WTO and translational corporations to patent, own and trade in them;
- Demand the representation and active participation of people's organisations, health workers, and farmers in policy-making processes related to Access to Health
- Expose, shame and stop government officials, academic institutions, and civil society organisations from accepting money from the tobacco and other industries which undermine public interest initiatives internationally and nationally.

Calls for Action by Governments

- Regulate the entry and behaviour of the corporate sector in the social services such as health, education, transportation, etc., and ensure that public health concerns always take precedence over trade agreements and corporate profit;
- Resist "TRIPS-plus" through bilateral or regional trade agreements driven by the United States government and the institutions it controls;
- Ensure negotiations on "Free Trade" treaties and the like are transparent and democratic and not conducted behind closed doors;
- Resist pressure to privatise health essential industries (health care, electricity, water and education) and renationalise these industries;
- Sign, ratify and implement the Framework Convention on Tobacco Control (FCTC);

End War and Occupation

Since 2000, war, occupation and militarism have become ever more devastating threats to people's health. The violent imposition of imperial will has led to death, injury, and social and environmental destruction for untold numbers of people.

Actions in support of international law and pro-health and against the war in Iraq; the occupation of Iraq and Palestine; the construction of the Wall in Palestine are urgently needed

This Declaration;

Calls for Action by People's Health Movement and Civil Society to;

Strengthen the international anti-war movement through:

- Building the global campaign: "No to War, No to WTO, Fight for People's Health";
- Monitoring the impact of war, occupation, and militarization through a global "Occupation Watch";
- Targeting corporations which benefit from the war in Iraq, invasions and military occupations and those that enrich themselves (e.g. arms industry, pharmaceutical and food companies) by fostering ill-health through a "Boycott Bush" campaign;
- Establish peace initiatives at various levels based on justice and equality.

Calls for Action by Governments

- Refuse to take part in unjust and imperialist wars and occupations
- Work for world peace as a key determinant of health.

Since 2000, war, occupation and militarism have become ever more devastating threats to people's health. The violent imposition of imperial will has led to death, injury, and social and environmental destruction for untold numbers of people.

Implement Comprehensive and Sustainable Primary Health Care

Since 2000, the Global Fund and other international health programmes of WHO, UNICEF and World Bank have continued to promote selective and vertical health programs which corrupt and weaken Comprehensive Primary Health Care as defined in the WHO Alma Ata Declaration.

Health professionals educated in the developing world and migrating to the developed world represent a transfer of billions of dollars from South to North. This unrequited training investment further burdens health systems already suffering from a precarious lack of human resources. The "brain drain" flows not only from developing to developed countries, but also from the public to the private sector.

Traditional and alternative systems of medicine are vibrant parts of Comprehensive Primary Health Care. Traditional Birth Attendants provide the first and often the only access to reproductive health in many areas of the world. These knowledge and traditions should be validated and their skills reinforced through continuing education, and support to the revitalization of local health traditions.

New areas, relevant to Primary Health Care, not adequately addressed in the Alma Ata Declaration need to be promoted in an integrated way. These include gender, environment, disability, mental health and traditional systems of health.

This Declaration;

Calls for Action by People's Health Movement and Civil Society to;

- Demand that universities and other training institutions incorporate Comprehensive Primary Health Care into the curriculum for all health professionals updated to address gender, environment, disability, mental health, traditional systems and other issues ;
- Lobby for widespread adoption of Community Health Workers and Traditional Birth Attendants as integral members of multi-disciplinary Primary Health Care teams.

Calls for Action by Governments

- Develop national policies on traditional and alternative medical systems and include them in national health programmes;
- Involve marginalised sectors in decision-making regarding policies that affect them;
- Strengthen health systems in the context of access, quality and equity;
- Establish Comprehensive Primary Health Care services based on the principles and strategies of Alma Ata outlined in this declaration and related to local needs and updated to address gender, environment, disability, mental health, traditional systems and other issues.

WHO has recently become stronger in its technical support to HIV/AIDS and has made an official commitment to pursue its 3 X 5 goal (3 million persons with AIDS receiving Anti-retroviral Treatment (ARV) treatment by 2005) through strengthened health systems.

PHM is concerned that the 3 X 5 initiative focuses on treatment alone, ignoring the complexity of the epidemic.

Calls for Action by WHO

To reaffirm the principles of Alma Ata and ensure that comprehensive approaches that focus on primary health care and strengthen health systems are the basis of all WHO global and regional strategies.

Confront the HIV/AIDS epidemic

The HIV/AIDS epidemic has continued to worsen since 2000, especially in Africa and increasingly in Asia and elsewhere. Spreading along migration routes related to globalization and to social and economic distress due to war, global trade and economic policies, HIV/AIDS is now associated with the resurgence of other communicable diseases of poverty, such as tuberculosis.

Access to ARV treatment has increased the life expectancy and quality of life of those who can afford it. The majority of AIDS patients being impoverished are denied access to treatment in violation of the principles of the international covenant on social, economic and cultural rights. Children orphaned by HIV/AIDS and women who are more vulnerable take a heavy toll.

WHO has recently become stronger in its technical support to HIV/AIDS and has made an official commitment to pursue its 3 X 5 goal (3 million persons with AIDS receiving Anti-retroviral Treatment (ARV) treatment by 2005) through strengthened health systems. Yet addressing the HIV/AIDS epidemic requires contextual solutions. We are however, particularly concerned that:

- The 3 x 5 initiative focuses on treatment alone, ignoring the complexity of the epidemic;
- High drug costs can lead to long-term dependency on donors;
- There is inadequate involvement of persons living with and affected by HIV/AIDS and civil society in planning, implementation and evaluation
- There is inadequate budgetary and related commitments on improving health systems, particularly Primary health Care to provide drugs and general health services and information in the long term.
- There is inadequate attention to life skill education, women's health empowerment and utilization of traditional systems of medicine.

While endorsing concern about the HIV/AIDS epidemic, the need for Primary Health Care oriented and Health Systems strengthening approaches to other communicable and non-communicable diseases in an integrated way is urgently required.

This Declaration;

Calls for Action by People's Health Movement and Civil Society to;

- Continue campaigns for the rights of people in poor countries to receive ARV treatment delivered through comprehensive PHC services.
- Facilitate Public Interest Litigations to oppose changes in Patent laws that is expected to escalate the ART prices.
- Make the links between the spread of HIV/AIDS and the underlying societal determinants such as poverty, war, displacement and participate in efforts to redress these injustices

Calls for Action by Governments

- Develop a comprehensive Primary Health Care oriented and health systems' strengthening approach to address the HIV/AIDS epidemic through interventions, including:
  - Peer education that includes sexual and reproductive health and rights information;
  - Oppose stigma and promote respect of and care for people living with HIV/AIDS;
  - Increased access to basic services by people living with HIV/AIDS;
  - Immediate availability of ARV drugs;
  - Support those affected by the epidemic through empowerment.

Calls to WHO

- To evolve a comprehensive approach emphasizing Primary Health care and health systems' strengthening approaches including preventive information and services and ARV treatment;
- Work towards reduction of high drug costs;
- Enhance involvement of people, affected communities and civil society in its planning and initiatives through proactive dialogue.

Reverse Environmental Destruction

The People's Charter for Health recognized that environment, livelihood, and people's health are interconnected and environmental degradation is a major threat to global health. Since 2000, continuing environmental destruction has had a highly negative impact on health.

Rivers around the world, like the Abra in the Philippines and the Narmada in India, are in danger of being destroyed, as are the lives and health of the people and communities who depend on these rivers.

Toxins in pesticides, fertilizers, defoliants (such as Agent Orange and those of the "War on Drugs" of Plan Colombia), waste from US Military Bases (such as those in the Philippines), dust from exploded depleted uranium ordinance (such as that used in Iraq, Puerto Rico), and medical and nuclear waste as well as from mining run-off and exploration for petroleum; are all poisoning our environment and represent a critical hazard to health.

This Declaration;

Calls for Action by People's Health Movement and Civil Society to;

- Monitor environmental damage caused by unsustainable development strategies with specific focus on pesticides, industrial and military toxic wastes, etc.;
- Link PHM with other organisations working for environmental justice at the grassroots,
- national and international levels. Join them in their struggles and invite them to join in our struggle for the People's Health.

Calls for Action by Governments

- Pass legislation to ensure governments can hold corporations accountable for environmental damages.

Women's right to health, including sexual and reproductive health, is violated not only by current socio-economic and political structures but also by religious and cultural fundamentalism. Trafficking of women and girls is a major public health problem, little addressed by governments where the trafficking is most rampant

End Discrimination in the Right to Health

The People's Health Charter asserted the right to health for all people. We reaffirm this by noting that the marginalized groups listed below suffer particular and on-going health problems requiring urgent attention:

- Around the world, many **women** lack access to basic health care, endangering them and their families. Women's right to health, including sexual and reproductive health, is violated not only by current socio-economic and political structures but also by religious and cultural fundamentalism. Population control policies violated human rights, including the use of disincentives and such reprehensible practices as forced sterilization of women. Newer contraceptives and reproductive technologies often ignore hazards to women's health and other ethical and moral issues;
- **Trafficking of women and girls** is a major public health problem. little addressed by governments where the trafficking is most rampant;
- Sex-selective abortion is a misuse of technology that discriminates against the **girl child**;
- The rights of **sexual minorities and sex workers,** including access to health care, must be respected;
- The health and human rights of **persons with mental disorders** are currently ignored or inadequately addressed throughout the world. There is an urgent need to provide effective community based programs for persons with mental illnesses.

- The unjust social systems like caste in India and ethnic discrimination in other parts of the world have created a health apartheid and human rights reality for the **socially marginalised**;
- **Indigenous people** in developed and developing countries suffer health problems at a higher rate than the general population of the country in which they reside. As they are forced to follow the hegemonic cultural and development paradigms, they are being deprived of traditional knowledge and traditional systems of medicine and access to basic resources;
- The health and other human rights of **persons with disabilities** are currently ignored or inadequately addressed throughout the world;
- **Migrant workers** living and working in the developed and developing world suffer poorer health than the general population surrounding them. Their basic human rights are denied through lack of access to health, education, housing, etc.;
- **Children living in difficult circumstances**, such as street children, AIDS orphans, children of war, etc. face increasing discrimination. Corporate-led globalization only increases the poverty in which they live and robs them of a dignified future.

This Declaration;

Calls for Action by People's health Movement and Civil Society

- Make concerted efforts to incorporate all the above marginalized populations, the "unheard and unseen", into their networks and facilitate their access to and influence in mainstream discourse.
- Ensure gender equity within the movement and within their own networks and communities

Calls for Action by Governments

- Make concerted efforts to incorporate the needs of marginalized populations, the "unheard and unseen", in health and development strategies and social policies in a Right's context.
- Ensure availability of disaggregated data on health status and access to health services for different groups (age, sex, region, ethnicity etc.,) in the community to make discrimination to the right to health more transparent and enable actions to be taken.

IN CONCLUSION

We, the members of the People's Health Movement and the participants of the III International Health Forum for the Defense of People's Health commit ourselves to promoting the People's Charter for Health 2000 and the concerns and calls for action of the Mumbai Declaration 2004.

- We believe that an Another World is Possible;
- A Healthy World is Possible;
- Health for All Now! is Possible;

Join us – Endorse the People's Charter for Health 2000 – Endorse the Mumbai Declaration 2004

- SIGN ON AND PROMOTE the **People's Charter for Health** (visit http://www.phmovement.org/charter/index.html)
- SUPPORT the **Million Signature Campaign** demanding Health for All, Now! (visit www.TheMillionSignatureCampaign.org)
- PROMOTE the Mumbai Declaration

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By WHO and UNAIDS

- Evolve a comprehensive approach that strengthens primary health care and health systems, with built-in indicators of progress.
- Stop narrowly-focused vertical programmes.
- Urge all governments to follow the UN's International Guidelines on HIV infection and AIDS and Human Rights.
- Include non-priority countries in the 3x5 initiative.
- Take appropriate action in 'low prevalence countries'.
- Start immediate action for sub-Saharan African countries.
- Monitor the impact of trade agreements on health.

By World Bank, International Monetary Fund and World Trade Organization

- Be accountable for social disasters caused by anti-poor macroeconomic policies.
- Cancel debts of all poor countries, especially those identified as vulnerable to HIV and AIDS.
- Stop free trade agreements, privatisation of essential services, and the commercialisation of health care.
- Finance HIV and AIDS interventions with grants instead of loans.
- Remove pharmaceutical patents that adversely affect availability of generic drugs.

We call upon all individuals and organisations to endorse and implement the People's Charter on HIV and AIDS and join the People's Health Movement (PHM). PHM has an active presence in about 100 countries.

Largely based on the People's Charter for Health of the People's Health Movement.

Developed through an active participatory process involving people from various walks of life, including persons living with HIV and AIDS.

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People's Charter on HIV and AIDS

Designed by Books for Change, Bangalore, India

Launched at the XV International AIDS Conference, Bangkok, Thailand, 16 July 2004

People's Health Movement

PEOPLE'S CHARTER ON HIV AND AIDS

PREAMBLE

Health is a social, economic and political issue and, above all, a fundamental human right. Inequality, poverty, exploitation, violence and injustice are at the root of ill health. Achieving health for all means that powerful interests working against people's well-being have to be challenged, corporate globalisation has to be opposed and political and economic priorities have to be drastically changed.

HIV and AIDS is a development issue that calls for social and political action. It is also a public health issue that requires people-oriented health and medical interventions. Such responses require democracy, pro-people inter-sectoral policies, good governance, people's participation and effective communication. They should be rooted in internationally accepted human rights and humanitarian norms.

The special needs of women and children as infected persons, their dependents and caregivers should be addressed.

In the current context, People's Charter on HIV and AIDS recognises the devastating impact of war and conflict on health systems and how it amplifies the vulnerabilities of people to HIV and AIDS.

People's Charter on HIV and AIDS draws upon perspectives of communities affected and infected with HIV and AIDS and those vulnerable to the infection. It encourages people to develop their own solutions and hold accountable local authorities, national governments, international organisations and corporations to their promises and responsibilities.

VISION

As stated in the People's Charter for Health: 'Equity, ecologically sustainable development, social justice and peace are at the heart of our vision of a better world – a world in which a healthy life for all is a reality; a world that respects, appreciates and celebrates all life and diversity; a world that enables the flowering of people's talents and abilities to enrich one another; a world in which people's voices guide the decisions that shape our lives'.

PERSPECTIVES

The AIDS pandemic is one of the greatest humanitarian crises of all times. It has caused death and misery, destroyed families and communities, derailed development and reversed health gains achieved over decades in one stroke. HIV and AIDS is already wiping out a generation in Africa. Two decades after it began its onslaught, the disease is still spreading fast, gaining a firm foothold in all parts of the world.

HIV and AIDS spreads along migration routes charted out by globalised trade. Social and economic distress due to conflict, war, disasters, skewed international trade and unjust economic policies make more and more people vulnerable to the infection.

The landmark Alma Ata Declaration of 1978 promised Health for All by 2000 through primary health care. Verticalisation, changing economic priorities, invasion of private interests into political decision-making and a lack of political will led to a total breakdown of the public health and primary health care systems during the 1980s and 1990s. The spread of HIV and AIDS also contributed to the non-achievement of these goals.

Poverty, hunger and ill health are increasing because of neo-liberal economic policies. In this context, integrated, adequately-resourced health systems based on primary health care and public health are urgently required.

Lack of sensitisation and training of health personnel have created negative attitudes towards persons living with HIV and AIDS. Such attitudes and practices lead to stigma and discrimination that impede interventions.

It is essential to ensure that health care is safe and that people undergoing treatment at health care facilities are not exposed to HIV or other infections.

A CALL FOR ACTION

By People and Social Movements

- Mobilise and strengthen capacities of communities in health promotion, disease prevention and care.
- Empower women and youth as key players in HIV interventions.
- Build alliances among positive people's networks, women's movements, health and social activists, trade unions, student groups, academics and other progressive constituencies.
- Intensify the campaign for equitable and universal access to anti-retroviral (ARV) treatment through comprehensive primary health care.
- Facilitate legal measures and mass campaigns to change intellectual property rights regimes that escalate drug prices.
- Oppose policies dictated by multilateral financial and trade institutions that disregard people's right to health and health care.
- Expose links between the spread of HIV and AIDS and the underlying societal determinants such as poverty, war and displacement, and participate in efforts to redress these injustices.

By Health Professionals and Health Workers

- Provide responsible care and quality treatment to persons living with HIV and AIDS.
- Stop stigma and discrimination in institutions of care and treatment.
- Respect patients' right to dignity and privacy.
- Follow ethical and regulatory principles in drug trials.
- Provide adequate preventive measures to avoid transmission of infection in health care institutions.
- Support People's Health Movement initiatives that address the larger social, political and economic issues.

By Governments

- Develop and strengthen comprehensive approaches based on primary health care to include HIV and AIDS interventions.
- Enhance involvement of people and civil society in planning and implementation.
- Ensure greater involvement of persons living with HIV and AIDS at all levels.
- Ensure occupational safety of health workers.
- Increase access to basic services to people living with HIV and AIDS.
- Ensure easy, affordable and sustained availability of quality generic ARV and other essential drugs.
- Allocate adequate resources for public health.
- Implement guidelines for transparent, scientific and ethical clinical trials.
- Make nutritional inputs and psycho-social support part of HIV and AIDS care.
- Develop programmes for life skill education and women's health empowerment.
- Promote traditional systems of medicine with enough resources.
- Promote harm reduction policies and programmes for all vulnerable sections including sex workers, drug users, sexual minorities and street children.

By Corporates

- Place people above profits.
- Make available diagnostic and prognostic tests that are affordable.
- Ensure the availability of ARV and essential medicines at affordable rates.

Declaration of Alma-Ata

International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978

The International Conference on Primary Health Care, meeting in Alma-Ata this twelfth day of September in the year Nineteen hundred and seventy-eight, expressing the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world, hereby makes the following

Declaration:

I

The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

II

The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.

III

Economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace.

IV

The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.

V

Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.

VI

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and

community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

VII

Primary health care:

1. reflects and evolves from the economic conditions and sociocultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience;

2. addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;

3. includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;

4. involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors;

5. requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate;

6. should be sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need;

7. relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

VIII

All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors. To this end, it will be necessary to exercise political will, to mobilize the country's resources and to use available external resources rationally.

IX

All countries should cooperate in a spirit of partnership and service to ensure primary health care for all people since the attainment of health by people in any one country directly concerns and benefits every other country. In this context the joint WHO/UNICEF report on

primary health care constitutes a solid basis for the further development and operation of primary health care throughout the world.

X

An acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of independence, peace, détente and disarmament could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part, should be allotted its proper share.

The International Conference on Primary Health Care calls for urgent and effective national and international action to develop and implement primary health care throughout the world and particularly in developing countries in a spirit of technical cooperation and in keeping with a New International Economic Order. It urges governments, WHO and UNICEF, and other international organizations, as well as multilateral and bilateral agencies, non-governmental organizations, funding agencies, all health workers and the whole world community to support national and international commitment to primary health care and to channel increased technical and financial support to it, particularly in developing countries. The Conference calls on all the aforementioned to collaborate in introducing, developing and maintaining primary health care in accordance with the spirit and content of this Declaration.

HHR training: 4th – 5th Feb 2008

The Framework of Indian Constitution

The Indian Constitution provides a framework for a welfare/socialist pattern of development. While civil and political rights are enshrined as fundamental rights that are justiciable, social and economic rights like health, education, livelihoods etc. are provided for only as directive principles for the State and hence not justiciable. The latter comes under the domain of planned development, which the State steers through the Five Year Plans and other development policy initiatives.

The issue of health is situated in the larger context of right to life and right to life with dignity.

Article 21 of the Indian Constitution, a fundamental right reads: "No person shall be deprived of his life or personal liberty except through procedure established by law." The scope of this article has been expanded to explicate the meaning of right to life. While for a long time it was interpreted literally as right to exist - right not to be killed. Over the years it has come to be accepted that life does not only mean animal existence but the life of a dignified human being with all its concomitant attributes. This would include a healthy environment and effective health care facilities and such other related but essential elements.

It has however, to be borne in mind that fundamental rights are enforceable by and large only against the State. At the moment the fundamental rights prescribes the duty and the obligations of the State vis a vis the citizens and hence when one is talking about right to health and health care as a fundamental right it is referring to the State's obligation and not the obligation of private players- either individual practitioners or private hospitals or nursing homes.

'Right to health' is inseparable from 'right to life', and 'right to medical facilities' as a concomitant of 'right to health' is also part and parcel of right to life. Life is not mere existence but a life of dignity, well-being and all that makes it complete. In a welfare state, the corresponding duty to the right to health and medical facility lies with the State.

Part 3 of the Constitution prescribes the fundamental rights of the citizens. These rights are enforceable against the State in a Court of law. This Chapter does not anywhere categorically state that the right to health or healthcare is a fundamental right. However, it does prescribe right to life as a fundamental right. It is an expanded meaning given to this term that has allowed the Courts to prescribe that right to health and health care is a fundamental right.

Part 4 of the Constitution lists the Directive Principles of State Policy. These are the principles which should be followed by the State as the guiding principles while enacting laws and policies but have traditionally been believed not to be enforceable in Courts of law. A citizen cannot go to Court for enforcing a claim which is purely based on

Directive Principles. The importance of these principles, however lie in the fact that the in interpreting fundamental rights the Courts can use the Directive Principles so as to interpret fundamental rights as much in consonance with the Directive Principles as possible. The obligation of the State to provide health care facilities is set out in the 'Directive Principles of State Policy'. The relevant provisions of the Directive Principles which cast a duty on State to ensure good health for its citizens are:

Article 38. State to secure a social order for the promotion of welfare of people-

1) *State shall strive to promote the welfare of people by securing and protecting as effectively as it may a social order in which justice, social, economic and political, shall inform all the institutions of the national life.*
2) *State shall, in particular, strive to minimize the inequalities in income, and endeavour to eliminate inequalities in status, facilities and opportunities, not only amongst individuals but also amongst groups of people residing in different areas or engaged in different vocations.*

In other words, no person will be deprived of a healthy life because he cannot afford it. State must provide facilities that an economically better off person can afford out of his own pocket.

Article 39. Certain principles of policy to be followed by State- The State shall, in particular, direct its policy towards securing-

e) that health and strength of workers, men and women, and the tender age of children are not abused and that citizens are not forced by economic necessity to enter avocations unsuited to their age or strength;

f) that children are given opportunities and facilities to develop in a healthy manner and in conditions of freedom and dignity and that childhood and youth are protected against exploitation and against moral and material abandonment.

Articles 41, 42 and 47 of the Directive Principles[1] enshrined in Part IV of the Constitution provide the basis to evolve right to health and healthcare:

41. Right to work, to education and to public assistance in certain cases: The State shall, within the limits of its economic capacity and development, make effective provision for securing the right to work, to education and to public assistance in cases of unemployment, old age, sickness and disablement, and in other cases of undeserved want.
42. Provision for just and humane conditions of work and maternity relief: The State shall make provision for securing just and humane conditions of work and for maternity relief.

Article 47. Duty of 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

[1] "The courts are much more aware of and attentive to their obligation to implement socio-economic uplift programmes and to ensure decent welfare for all. The state has a duty to all citizens to adhere to that part of the Constitution which describes the directive principles as 'fundamental' to the governance of the country. The courts have therefore been using the directives as an instrument to determine the extent of public interest in order to limit the extension of fundamental rights. In doing so they have upheld a number of statutes on the grounds of public interest, which in other circumstances may have been nullified." (De Villiers, 1992).

particular, the State shall endeavour to bring about prohibition of the consumption except for medical purposes of intoxicating drinks and of drugs which are injurious to health."

Expansion of the scope of article 21 and health: Though the explicit recognition of the fundamental right to health should have preceded the fundamental right to good environment in India right to health as a fundamental right grew as an off shoot of the environmental litigation. Pollution free environment as a fundamental right presupposes right to health as a fundamental right. However, the development of jurisprudence in this branch has been reverse as right to decent environment was recognized first and from that followed the right to public health, health and health care.

Secondly, the right to health care has also been debated by the courts in the context of rights of Government employees to receive health care. A number of observations of the Court concerning the importance of these rights are to be found in cases dealing with denial or restriction of health care facilities for Government employees.

While dealing with the issue of fundamental right to health and health care the Courts have also dealt with specific categories such as under trials, convicts and mentally ill persons. The Courts have recognized that mere imprisonment will not deprive a person of right to health and health care.

There are other international laws, treaties and declarations, which India is a party to and which have a bearing on right to health. Provisions in most of these also relate to fundamental rights and directive principles of the Indian Constitution as well as relate to many policy initiatives taken within the country.[2]

Thus social security, social insurance, decent standard of living, and public health coupled with the policy statements over the years, which in a sense constitutes the interpretation of these constitutional provisions, and supported by international legal commitments, form the basis to develop right to health and healthcare in India. The only legal/constitutional principle missing is the principle of justiciability. In the case of education the 93rd amendment to the Constitution has provided limited justiciability. With regard to healthcare there is even a greater need to make such gains because often in the case of health it is a question of life and death. As stated earlier, for a small part of the working population right to healthcare through the social security/social insurance route exists. The fact that this exists shows that for the larger population too it could be worked out. And that afew people enjoy this privilege is also a sign of discrimination and inequity, and this violates not only the non-discrimination principle of international law, but it also violates Article 14 of the constitution, Right to Equality, under the chapter of Fundamental Rights.

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[2] For instance the impact of CEDAW, Cairo and Bejing Declarations is closely linked to the formulation of a policy on women and women's empowerment, and setting up of the national and state Commissions on Women, the Rashtriya Mahila Kosh and of formulation of many development programs for women like DWACRA, savings and credit programs etc.. Similarly the various human rights treaties like those dealing with racial discrimination, torture, civil and political rights etc.and the UNCHR have been instrumental in India setting up the National and State Human Rights Commissions. The NHRC has presently set up a separate cell to monitor ICESCR as also for right to public health.

Basic social services are now being recognised as fundamental rights with the 86th amendment in the constitution accepting Education as a fundamental right. Despite the controversy and problems regarding the actual provisions of the Bill, it is now being accepted that essential social services like education can be enshrined in the fundamental rights of the Constitution. This forms an appropriate context to establish the Right to health care as a constitutionally recognised fundamental right.

The social and economic justification

It is now widely recognised that besides being a basic human right, provision of adequate health care to a population is one of the essential preconditions for sustained and equitable economic growth. The proponents of 'economic growth above all' may do well to heed the words of the Nobel Laureate economist Amartya Sen and the academic-activist Jean Dreze:

'Among the different forms of intervention that can contribute to the provision of social security, the role of health care deserves forceful emphasis ... A well developed system of public health is an essential contribution to the fulfilment of social security objectives.

...we have every reason to pay full attention to the importance of human capabilities *also as instruments* for economic and social performance. ... Basic education, good health and other human attainments are not only directly valuable ... these capabilities can also help in generating economic success of a more standard kind ...'[3]

Legal Framework

Justiciability: With regard to the question of justiciability of international law there is a problem in India. Like its colonial exploiter Britain, India follows the principle of dualism. This means that for international law to be applicable in India, it needs to be separately legislated. Since none of the international human rights treaties have been incorporated or transformed into domestic laws in India, they thus have only an evocative significance and may be used by the Courts or petitioners to derive inspiration from them. (Nariman,1995) Thus on a number of occasions many of these human right treaties, which India has ratified, have been used by the Indian Courts in conjunction with fundamental rights.[4] While international law may be invoked, as discussed above, the absence of justiciability is a major stumbling block. International law has its importance in providing many principles but in India's case, as we have seen above, there is substantial leeway within our own legal framework to evolve the right to health and healthcare. The emphasis needs to shift to critical principles as laid down in the directive principles and each of these, like health, education, social security, livelihood, housing

[3] Jean Dreze and Amartya Sen, India: Economic Development and Social Opportunity, Oxford University Press, 1995

[4] In a judgment on sexual harassment at the work place, in which the CEDAW and Beijing Declaration was invoked, the Supreme Court outlined this approach as follows – Any international convention not inconsistent with the fundamental rights and in harmony with its spirit must be read into these provisions to enlarge the meaning and content thereof, to promote the object of the constitutional guarantee (Vishaka v/s State of Rajasthan, writ petition number 666-70 of 1992, quoted in Toebes, 1998)

etc. so that each of these can be separately constituted as independent rights. This is the only way of bringing right to health and healthcare on the national agenda, and of course the support of international treaties will have their role in cementing this demand.

In an important judgement (Paschim Banga Khet Mazdoor Samity and others v. State of West Bengal and another, 1996), the Supreme Court of India ruled that -
"In a welfare state the primary duty of the Government is to secure the welfare of the people. Providing adequate medical facilities for the people is an essential part of the obligations undertaken by the Government in a welfare state. ... Article 21 imposes an obligation on the State to safeguard the right to life of every person. ... The Government hospitals run by the State and the medical officers employed therein are duty bound to extend medical assistance for preserving human life. **Failure on the part of a Government hospital to provide timely medical treatment to a person in need of such treatment results in a violation of his right to life guaranteed under Article 21.** (emphasis added)"

Similarly in the case *Bandhua Mukti Morcha v. Union of India and others, 1982* concerning bonded workers, the Supreme Court gave orders interpreting Article 21 as mandating the right to medical facilities for the workers

Role of Public Interest Litigations In Promoting Right To Health As Fundamental Right:

There were two developments in the 1980s which led to a marked increase in health related litigation. First was the establishment of consumer courts which made it cheaper and speedier to sue doctors and hospitals for medical negligence and deficiency in service. Second, the growth of public interest litigation, wider interpretation of right to life as a fundamental right and one of its off shoots being recognition of health and health care as a fundamental right.

The Public interest litigation movement in India started in late 1970s. Its foundation is the enforcement of fundamental rights guaranteed under the Constitution of India. Any citizen could trigger off the judicial mechanism by claiming violation of fundamental rights, either of himself or of other individuals or of citizenry at large. Fundamental rights existed even before late 1970s. The real push for the PIL movement came from an expanded interpretation of the fundamental right to life which is enshrined in Article 21 of the Constitution. This reads:

> *"No person shall be deprived of his life or personal liberty except through procedure established by law."*

Till the 1970s by and large the courts had interpreted 'life' literally i.e. right to exist. It was in late 1970s onwards that an expanded meaning started to be given to the word 'life'. Over the years it has come to be accepted that life does not only mean merely animal existence but the life of a dignified human being with all its concomitant

attributes. This has been interpreted to include a healthy environment and effective health care facilities.

As already mentioned in the Chapters above, to begin with, the right to health as a fundamental right grew as an off shoot of the environmental litigation. Pollution free environment as a fundamental right presupposes right to health as a fundamental right. Logically, the explicit recognition of the fundamental right to health should have preceded the fundamental right to good environment. However, the development of jurisprudence in this branch has been reverse. To begin with, right to decent environment was recognized and from that followed the right to public health, health and health care. Even while dealing directly with right to health, the first issues concerned employees' health within a work place.

HC only

Annex 1 Examples of international, regional, and national instruments relevant to the right to health [1]

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) [2]

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. [3]

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 [4]

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[5]

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 [6]

- 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 [1]

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) [2]

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) [3]

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) [4]

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) [5]

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) [6]

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) [7]

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 [8]

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

Global Indicator	*ICPD goal*
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 *ICPD+5 ,21st Special Session, Agenda item 8, §7*
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 *ICPD Principle 8, 7.12, 7.14(c), 7.16* Provide universal access to a full range of safe and effective family planning methods, as part of comprehensive sexual and reproductive health care *ICPD 7.2, 7.4, 7.6, 7.14 (a)* 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 *ICPD+5 ,21st Special Session, Agenda item 8, §53*
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 *ICPD 8.21*
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 *ICPD 8.17, 8.22*
5 Births attended by skilled health personnel	All births should be attended by trained persons *ICPD 8.22* 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 *ICPD+5 ,21st Special Session, Agenda item 8, §64*
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 *ICPD 8.22*

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 *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*
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 *ICPD+5 ,21st Special Session, Agenda item 8, §70*
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 *ICPD+5 ,21st Special Session, Agenda item 8, §70*

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 [9]

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: [10]

- 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 [11]

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.

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/.

10 World Health Organization. Measuring Access to Reproductive Health Services: Summary Report of a WHO/UNFPA Technical Consultation 2–3 December 2003. Geneva: 2004. WHO/RHR/04.07. Available at http://www.who.int/reproductive-health/pages_resources/listing_global_mtg.en.html.

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/.

Session 5 Towards Realizing Health As A Human Right

Community Health Cell, Bangalore

The Right to Health Care is a Basic Human Right!

Towards attaining the Right to Health Care...

The Government of India has been unable to fulfill it's commitment of 'Health for All by 2000 A.D.' till now. In fact, primary health care services are becoming more and more difficult to obtain especially for people living in urban slums, villages or remote tribal regions. The condition of government hospitals is worsening day by day. Nowadays, in most of the government hospitals there is inadequate staff, the supply of medicines is insufficient and the infrastructure is also inadequate. The facilities for safe deliveries or abortions are also very inadequate. Given the fact that women do not even get adequate treatment for minor illnesses such as anaemia, services for problems such as the health effects of domestic violence remain almost completely unavailable. At the village level, there is no resident health care provider to treat illnesses or implement preventive measures. All hospitals are located in cities, and here too public hospitals are increasingly starved of funds and facilities. Thus there is lack of availability of government health care services on one hand and the exorbitant cost of private health services on the other. This often leaves common people in rural areas with no other option but to resort to treatment from quack doctors who often practice irrationally. Thus most of the population is being deprived of the basic Right to Health Care, which is essential for healthy living.

The Indian Constitution has granted the 'Right to Life' as a basic human right to every citizen of India under article 21. In article 47 of the Directive Principles of the Indian Constitution, the Government's responsibility concerning public health has also been laid down. Yet the Government is backtracking from fulfilling this responsibility. This is obvious from the fact that the Government's proportion of expenditure on public health services has been declining every successive year.

What can be done in the near future to establish the Right to Health Care?

The year 2003 was the silver jubilee year of the 'Health for All' declaration. On this occasion, Jan Swasthya Abhiyan launched a nationwide campaign to establish the Right to Health Care as a basic human right. Some of the following activities are being taken up as part of this campaign:

- Documentation of **individual case studies involving denial of health care**. Information is being collected in a specific format with the help of questionnaires. The cases where denial of health services has led to the loss of life, physical damage or severe financial loss of the patient are being emphasised. These case studies will be presented to the National Human Rights Commission. It is hoped that they would help us to depict the real status of provision of the primary health services by the government and strengthen our demand for improving public health services as well as help us in dialoguing with the public health system.
- Similarly, situations of **structural denial of health care,** where Primary Health Centres, Community Health Centres or public hospitals are regularly denying basic health services to people are being documented. Questionnaires have been prepared to help in such documentation, based on which the demand for adequate services and facilities may be raised.
- **Jan Sunwais** on the Right to Health Care are being organised at the local, district and state level. JSA linked organisations can organise such Jan Sunwais to highlight the state of public health services, and instances of denial of health care / structural denial of health care can be presented in these programmes.
- The National Human Rights Commission, in collaboration with Jan Swasthya Abhiyan, is organising **Public Hearings on Health and Human Rights** in various regions of the country from mid-2004 onwards. These regional hearings would be followed by a national public hearing. JSA linked organizations and individuals can present case studies during these public hearings and ask for effective action by state health authorities and investigation by the NHRC.

These are some of the steps being planned to move towards establishing the Right to Health Care. Let us join this campaign and strengthen the movement to achieve health care and Health for All!

Jan Swasthya Abhiyan – People's Health Movement India

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Right to Health Care Campaign – A Campaign towards revitalisation of Public Health Systems in Karnataka

– ~~A proposal~~ for the Revitalisation of Primary Health Centers ~~thereby accessible, affordable~~ and available primary health care in Karnataka

1.0 Background

India is independent of colonial rule for sixty years, but the Indian State has failed to provide its citizens the basic requirements like food security, health care, housing and education, which are the basis for reasonable human existence. Due to rampant poverty and lack of social equity large sections of population have been denied adequate nutrition, clean drinking water and sanitation, basic education, good quality housing and a healthy environment, which are all prerequisites for health. A highly inequitable health system has denied quality health care to all those who cannot afford it.

The first National Health Policy (NHP) of 1983 made its motto 'Health Care for All by 2000' which has not happened, while the subsequent National Health Policy 2002 welcomes the participation of the private sector in all areas of health activities thus in a sense endorsing inequity. The failure of National Health Policies to introduce social justice and equity has *precipitated* the issue of the need for a comprehensive legislative framework to *ensure all peoples the right* to a healthy life. *Thus there is an urgent need for the promulgation of a comprehensive legislative framework on Right to Health Care that would be the prelude to an enforceable fundamental right to Health Care, with Universal Access to health care as the ultimate aim.*

Characteristics of the Current Health Scenario

The National Health Policy 2002 clearly acknowledges that the public health care system grossly falls short of gross requirements and is functioning in a far from satisfactory manner. That morbidity and mortality due to easily curable diseases continues to be unacceptably high, and that resource allocations are generally insufficient are also spelt out in the policy document

Increasing private health sector expenditure vs. shrinking public health expenditure

Public spending on health care in India is as low as 0.9% of the Gross Domestic Product (GDP) in contrast to a total health expenditure of 5% of GDP, making public health expenditure a mere 17% of total health spending in the country. Decreasing public health expenditure has adversely affected the health outcomes. In India, the under-five mortality rate is 95 per 1000 whereas Sri Lanka has only 3% of GDP is the total health expenditure, the under-5 mortality is only 19 per 1000. This difference is due to the fact that in Sri Lanka public health expenditure accounts for as much as 45.4% of total health expenditure.

India has one of the most privatised health systems in the world, denying the poor access to even basic health care. Across the country the unregulated growth of the private health practice and misuse of public health functionaries is distinct. In 1993-94 the expenditure on private health care was 1.5 times more the total public health expenditure. In 2002-03 the private health expenditure was nearly 5.4 times the public health expenditure. The crushing burden of paying for their health care is put on the people of this country, including the poorest, resulting in out-of-pocket expenditure on private health care services, which is as high as 82 per cent in the country. NHP 2002 in principle, *'welcomes the participation of the private sector in all areas of health activities'* – primary, secondary or tertiary. This is in contrast to the basic goal of NHP-1983 of providing *'universal, comprehensive primary health care services, relevant to actual needs and priorities of the community'*.

India has a very large and unregulated private health sector

In 2001 of all registered hospitals 73% were in the private sector and 27% in the public sector. While public hospitals follow some norms and standards in provision of health care, as defined in hospital manuals and government regulations, the private sector is bound by no such norms and operates completely unregulated. The professional associations show scant concern for ethics and self-regulation to ensure adequate standards of health care provision. The private sector is governed completely by the whims of the market, and has a focus on curative care. *Various studies show that private health sector accounts for over 70% of all primary care sought, and over 50% of all hospital care. This is not an acceptable scenario in a country in which three-fourth of the population lives at or below subsistence levels.*

A lopsided health policy resulting in urban-rural disparities

The population distribution in the country is 70% rural; the distribution of health services, however, does not reflect this. There are 17,000 hospitals (34 per cent rural), 25,670 dispensaries (40 per cent rural) and about one million beds (23 per cent rural) at present in the country. In addition the rural areas have 24,000 PHCs and 140,000 sub-centres. However, the comparison between urban and rural areas shows that-

Indicators	Urban (in %)	Rural (in %)
Hospitals	4.48	0.77
Dispensaries	6.16	1.37
Hospital beds per 100,000 population	308	44

Unequal access to health care and poor outcomes based on socio-economic status

Those in the lowest socio-economic strata in India are severely deprived of health care facilities, leading to poor health outcomes, as accessibility to basic health care depends on the socio-economic status of an individual. For resource poor households access and outcomes as compared to the socio-economically well off class are significantly more adverse for the former.

Women are at a higher risk of having untreated ailments in rural areas (18.3%) than in urban areas (8.8%); for men it is (15.8%) in rural areas and (8.1%) in urban areas. Non-availability of essential determinants of health like water supply and sanitation, lack of hygiene and access to food contributes further to poor health outcomes. According to the National Family Health Survey of India 1998 Piped water is available to only 25% of the rural population and 75% of urban population. 50% of the urban population and 75% of the rural population does not purify/filter the water. Flush and pit toilets are available to only 19% of the rural population as against 81% of those in towns and cities. Electricity for domestic use is accessible to 48% rural and 91% urban dwellers. For cooking fuel 73% of people in the villages still use wood. 48% urban households but only 6% rural households access LPG and biogas. 41% village houses are semi permanent whereas only 9% of urban houses are so.

2.0 Need and Rationale

Health as a Human Right

The increased Structural Adjustment Programs (SAPs) have had a serious toll on the health of the people with the Public Health System in the country being constantly undermined in favour of Private Sector. The Indian health scenario is characterized by a declining public health system, resulting in urban-rural disparities and putting the onus of health care on out-of-pocket expenditure, which is overburdening the impoverished masses of the country. The unrestrained growth of the private health sector has resulted in denial of health care to the people of this country thus making a mockery of the concept of Welfare State enshrined in the Constitution of India in Article 38. Health forms an integral part of Life with Dignity as enshrined in Article 21 of the Indian Constitution. The State is increasingly abdicating its primary duty of the Welfare State and has failed to provide basic primary health care services, which are easily available, accessible and affordable to all. This has resulted in increasing denial of health care to the People especially the marginalised. It is time to work towards establishing Health as a Human Right in the country to make Health For All a reality in terms of accessibility to and affordability of Basic Health Care to people. The recommendations of National Health Policies have not been implemented in letter or spirit.

For complete article on this go to http://www.cehat.org/rthc/policybrief2.pdf

1. Under the above scenario we have a situation in India wherein we are increasingly moving towards the "Buying" of health care and as a result of which Health as a Human Right is given the go-by.
2. Increased privatisation has pushed families Below the Poverty Line (BPL) and as a result medical care is the second most cause for rural indebtedness. On an average a rural family spends 50% of its lifetime income on medical care alone.
3. Human Rights have no place in Private sector. Only profits and money do the talking.
4. Under the garb of Public Private Partnerships (PPP) the Karnataka Government is busy handing over the PHCs to the private parties, One thing that needs to be

borne in mind, by privatisation even though we might think that service delivery might improve, it would only be in the area of some medical care delivery and not in the prevention and promotion of health which are the essential components of Primary Health Care

3.0 Efforts towards addressing the Right to Health Care by the People's Health Movement in India

- The First National People's Health Assembly (PHA-I) was held in Kolkata in December 2000 when people from all over the country representing 22 major networks working in varied sectors like Science Popularisation, Labour Issues, Livelihood, Health Resource generation etc., came together in solidarity to analyse, debate and act on why "Health for All by 2000 A.D" didn't happen. The Assembly resulted in the formation of People's Health Movement, India (Jan Swasthya Abhiyan, JSA)

- During the Assembly a People's Health Charter was brought out which is the largest consensus document on Health and translated to various languages. This charter brought out the concerns of the Civil Society regarding Health scenario in this country and also action points for making "Health for All" a reality

- JSA alongwith all its state chapters conducted joint public hearings with the National Human rights Commission in 2004 on the denial to health care. NHRC gave strong recommendations to the state to make health care accessible to all. A number of flaws in the health system such as pending vacancies, availability of drugs etc. were asked to be corrected. Karnataka too was part of the southern regional public hearing held in Chennai.

- In march 2004, just before the National General Elections JSA held a dialogue with the mainstream political parties on the Issue of Health and as a result of which the Common Minimum Program for the first time talked about health issues and the budget increase

- JSA's involvement in the National Rural Health Mission (NRHM) and subsequent development of standards as guidelines for primary health centres was also an important step. The states have been actively involved in planning and monitoring of this Mission by means of Rural Health Watch

4.0 Janaarogya Andolana Karnataka (JAAK):

Janaarogya Andolana, Karnataka (JAAK) or People's Health Movement in Karnataka works under the broad framework of Right to Healthcare. Some of the efforts that have been undertaken to address the Right to Health issues in Karnataka

- It has brought together a number of state level networks / organisations around the issue of Health Rights

- Karnataka was also very actively involved in the First People Health Assembly. Health Messages were taken to the people by street theatre and culminated in the first State Health Assembly at Davanagere in 2000

- In Karnataka a health task force was constituted in 2000 to look into the public health system. A number of eminent health activist experts who were part of People's Health Movement were part of this task force and their recommendations were enshrined in the Karnataka Health Policy document which was passed by the state cabinet.

- Karnataka was also part of the NHRC Public Hearing on the denials of Health Care in 2003. The documentation of cases of denial of health care by members of JAAK

- Public hearings were held where the cases were presented before Government officials and NHRC members. The NHRC gave some specific recommendations to the Central Government, State Government and civil society based on the public hearings and subsequent discussions

- In 2005, the second State health Assembly was held in Karnataka before the 2nd International People's Health Assembly at Cuenca in Ecuador, South America.

- Janaarogya Andolana, Karnataka has made several efforts in the past years to mobilise people around the health issues.

- Since 2006, a statewide campaign has been launched towards revitalisation of the Primary Health Care in Karnataka

5.0 Right to Healthcare Campaign in Karnataka

As a part of the strategy to achieve right to healthcare, it was felt that the functioning of healthcare institutions especially the Primary health Centres, needed to be addressed urgently, as they played a key role in the delivery of health care.

"*Primary Health Centres are the cornerstone of rural health services- a first port of call to a qualified doctor of the public sector in rural areas for the sick and those who directly report or referred from Sub-centres for curative, preventive and promotive health care.* "(IPHS 2006) [i]

Karnataka is one of those states where privatisation of medical education, privatisation of health care has taken place in an intense manner. Despite many

recommendations and a health policy in place, the Primary Health Care that should be available to people at the village is not being available to them due to several reasons.

The meeting of JAA-K to commemorate World Health Day in April 2006 was a turning point for this campaign. The people from various districts who had collected information on the state of Primary Health Centres (PHCs) and presented it before the Government officials, were very disappointed with the Government's response. They decided to take up the issue and follow it up with renewed vigour. That led to the formation of an issue based group within JAA-K who took up the issue of **Revitalising Primary Health Centres** as their primary focus. This group has been meeting regularly to discuss the issues further, to collect information related to PHCs from various sources, to create awareness on the issues related to primary health care, to bring in Non-Governmental Organisations (NGOs) and Community Based Organisations (CBOs) from various districts of Karnataka to join the campaign, to prioritise issues, and to plan a strategy to revitalise primary health centres

Towards this, state-wide consultations were held involving number of people from various districts, different networks, federations of community based organisations and human rights groups. The common issues that have emerged are,

- Health care to people is not available to people in the Primary Health Centres in many of the districts due to the staff including medical doctors/nurses not being appointed, appointed staff sent to deputations to other jobs, the remaining being involved in their private practice and being highly irregular to PHCs.

- Supply of essential drugs is inadequate. The prescribed budget is Rs.75,000/- for a populations of 30,000 (a paltry Rs.2.50 per head per annum)

- In many PHCs equipments are in very rusty conditions and many of the PHCs the sputum testing instruments like microscopes are not available for a basic disease like TB.

- Another major finding was that Infrastructure of PHCs was not adequate to address the health needs of the people – not having electricity connection, buildings not being repaired for number of years, the PHC staff not having residence with living conditions, not having water supply, lack of labour rooms, pharmacy etc are the major findings.

- Rampant corruption in PHCs by way of taking money for services, drugs being sold to the nearby medical stores where people are made to purchase from, etc.

- The rude behaviour and unfriendly attitude of the staff was of great concern.

For the first phase of the campaign, it was decided that the Primary health Centres would be the main focus, as it was supposed to meet much of the healthcare needs of the population. JAA-K members have been meeting regularly to identify issues and to prioritise them for the campaign. Of the many issues discussed, it was decided to focus on 4 broad areas initially –

i) **Staff**
ii) **Medicines**
iii) **Equipments**
iv) **Infrastructure**

This campaign builds on the efforts that have already taken place in Karnataka and in the country on implementing certain standards in the functioning of primary health centres. Though the earlier efforts built up a consciousness on the standards, and did make some changes in the system, there is much more to be achieved. Some of the documents which are being specifically used in shaping the strategy of this campaign include the Indian Public Health Standards for Primary Health Centres (Government of India, March 2006) developed through the National Rural Health Mission; Karnataka Health Policy 2004; National Human Rights Commission (NHRC) Recommendations on Right to Health Care – 2004; Recommendations of the Karnataka Task Force on Health 2001 and some Supreme Court & High Court rulings related to health.

The Actions that have happened so far in Karnataka

1. Since April 2006, serious efforts have been made to take the health issues to the other partner organisations / networks so that health is put on the agenda of action in these organisations / networks

2. District Level forums to work on health have been emerging

3. Mobilisation of the people on health issues have happened at the community level resulting in some action at the local level by the people

4. The Study of the Primary Health Centers and their consolidation have been undertaken in 13 districts and many more districts are undertaking them now.

5. On February 1, 2007 a simultaneous mass action happened in 13 district headquarters demanding Right to Health Care. The problems associated with the Health System were presented to the concerned district authorities

6. Districts where the campaign took roots were: Chamarajanagar, Mysore, Shimoga, Kolar, Bangalore rural, Bangalore Urban, Tumkur, Chitradurga, Dharwad, Gadag, Belgaum, Raichur and Koppal.

7. Media Advocacy was undertaken by the districts to highlight the state of health system

Success Stories

As a result of all these efforts there have been very marginal improvements and responses from the Health Administration. Some places corruption has marginally come down, while in some other place the PHC / Sub center buildings are coming up. Elsewhere appointments of the staff has happened etc., At the state level the state has acknowledged the detrimental effect of arrack on health and has banned the same. O.P.Ds in Public Hospitals have been asked to open in the evenings between 5.30 pm and 8.30pm. Some of the PHCs are sought to be converted into 24 / 7 to cater to emergencies. Major Systemic changes are yet to happen and hence the necessity for a political advocacy

6.0 Objectives of the current Campaign

- Working towards making Health as a Human Right and to put health on the agenda of various people's movements, organisations, networks and CBOs;
- To revitalize the functioning of the Primary Health Centres with adequate staff, adequate supply of essential medicines, adequate and basic infrastructure;
- To make PHCs more accountable to the communities;
- To increase people's accessibility to Primary Health Centres and right to primary health care;
- To evolve a cadre based network of people to work towards the process of health as human right;
- To do strong advocacy with the political system for making health a major Political agenda

7.0 Interventions Planned

Strategies:

1. Organic evolution of district level health action fora;
2. Community Based advocacy towards making the health system respond to people by using Research, Right to Information Act, public hearings, media, mass actions
3. Utilisation of all the various forums of the partner organisations / networks to promote health advocacy and action. Mobilisation of communities , CBOs, networks and Movements.
4. Building state level and district level cadre for the long term health movement by capacity building, awareness, trainings;

5. Continuous perspective building of the people's movements, organisations, networks and CBOs;

6. State level Policy and Political advocacy linked to the local action and advocacy

8.0 Action Plans

The Action Plan envisaged is for a minimum of 3 years to

Formation of District Health Action Forum:

- District meetings, sensitization, perspective building
- Consolidation with trainings
- Evolving the functional systems in the forum

Community Based Advocacy:

- Survey and documentation of status of Health Systems
- Documentation of cases of denial of health care
- Using tools of like PHC survey and findings, lobbying with the district health officer, Zilla panchayats, Right to Information Act, public hearings etc.,
- Dialogue with the Health Systems
- Mass actions by people at the local level
- Formation of People's Health Watch committees at the panchayat and PHC level
- Community participation, ownership and monitoring of the Health Systems

Local Actions: At the village, Sub-center, PHC and Taluka level people will take action to dialogue with the local health officials. They will also use Signature Campaigns, letter camapaigns to pressurise the Health System to respond for better health care.

State-wide coordinated action: Every district simultaneously will hold various programmes to address issues of public health and primary health centres. A series of small scale mass actions are planned to keep sustained pressure on the state to heed to people's grievances

- Public Hearings on the Denials of Health Care and by Health Systems
- Advocacy with the elected representatives in Panchayat, MLAs, ZP Members, TP members, MPs etc.,
- Public Rally in the District etc.,
- Press Conference and Media dissemination

On October 08, 2007 on the same day a simultaneous state-wide action in all the District Headquarters has been planned to demand Health Rights. It would be in the form of a public event either a rally, protest, memorandum submission, dialogue with the district health authorities, presentation of the denial of health cases in front of the district authorities, public hearing etc.,

State level Public actions: The state working group consisting of delegates from each district and state level core group will plan state level action which represents all districts to take up issue with the state health ministry, directorate of health services, legislative assembly using media campaign, protest meetings etc.

1. **Planning process was initiated towards this end during the state level meeting on July 15th 2007, it was decided that a state-wide and state level political Advocacy convention or Rally to be planned.** Also to build up the campaign at the local level, each District was to make its own specific plans

2. District Level Action Plan preparation by all the partner organisations in that District before 20.08.2007. For this District level meetings where the organisations come together and decide the action plan has been planned.

3. The subsequent state level meeting on 20.08.2007 where all the districts brought their action plan on board (Please find the list of Action Plan prepared by the various districts in Kannada enclosed)

4. Training sessions will be planned for the various districts depending on their action plans.

5. In December 2007 – January 2008, a state level political action has been planned in Bangalore. This is envisaged more as a political advocacy event with the dialogue to be held with the various political parties to pressurise the state to increase health budget etc.,

This marks the first stage of the 3 years plan. Ongoing plans include

Cadre building:

Cadre building for the state by identifying

- At the district level 2 to 3 persons who would have the potential of being health activists
- 1 to 2 persons from amongst the NGOS, networks
- Capacity building of the cadre on broader determinants of health through regular residential workshops

Fellowship:

- Identification of the potential people in the various districts who have the time and the interest to take up health related issues at the district level on a consistent basis in the coming years
- Training and capacity building of these people on all health related issues and grooming them into being health activists
- These Actvists would then be the fulcrum around whom the Districts would rally around for relaisation of their Health Rights

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ಜನಾರೋಗ್ಯ ಆಂದೋಲನ– ಕರ್ನಾಟಕ

JANAAROGYA ANDOLANA KARNATAKA – (JAAK)

ಸರ್ವರಿಗೂ ಆರೋಗ್ಯ ಇಂದೇ ಎಂಬ ಗುರಿಯತ್ತ ಜನ ಆರೋಗ್ಯ ಚಳುವಳಿ

REPORT ON STATE WIDE PUBLIC ACTION DEMANDING RIGHT TO HEALTH ON OCT 29, 2007

A placard read "100 crore rupees for one MLA, but only Rs.2.50 for ensuring health care per Kannadiga per year"! The placard said it all- the apathy and neglect of the public health system by the successive Governments of the state of Karnataka and the simmering anger among the people against a very corrupt and self-centered political system. More than 6000 people carrying such placards, in across 17 districts, came out on streets demanding Health as their fundamental right in a statewide "People's Health Action Day" organized by Jana Arogya Andolana – Karnataka (JAAK). We were demanding for urgent and concerted action from the Government in realizing People's right to health.

The "People's Health Action Day" was a call given by JAAK to the people of Karnataka to protest against the government apathy and neglect of the Public Health System which has resulted in large scale denial of the right to healthcare of the citizens especially the poor and rural people and to demand for revitalization of primary health centers. JAAK coordinated the Karnataka State "People's Health Action Day" on October 29, 2007 across 17 districts in Karnataka.

First and foremost, we would like to celebrate the great success of "People's Health Action Day" held on 29th October across 17 districts of Karnataka. The encouraging news of a large and enthusiastic participation of people from across Karnataka stands testimony for our concerted actions and growing strength of JAAK. Let us all take a moment to celebrate the growing strength of JAAK and we hope this moment will serve as the stimulus for further action and struggle towards our goal of "Health for All – NOW"!

The news from various districts is slowly pouring in into the secretariat and we have contacted almost all the districts. The initial estimates of people's participation across the state stands at more than 3000. The district wise participation of people stands as below:

Karnataka State People's Health Action day on 29.10.2007.		
Sl. no	Name of the districts	No of people participated
1	Chamarajanagar (Including a rally in Kollegal taluk head quarters with more than 200 women participants)	500
2	Chitradurga	500
3	Shivamoga	100
4	Dhavanagere	120
5	Bhagalkote	350
6	Dharwad	400
7	Gadag	400

8	Raichur	100
9	Chikkaballpur	300
10	Bangalore urban	50
11	Bangalore rural/city	250
12	Kolar	85
13	Belgam	40
14	Mandya	Press meet
15	Haveri	Planning for 2nd November
16	Tumkur	Not happened
17	Mysore	Not happened

Coordinated by respective district level forums, people held rallies in district headquarters raising awareness on Government inaction in its obligation to provide health care to the people, registering protest against such inaction and submitted memorandums to the Government servants including the District Health Officer, Chief Executive Officer of Z.P. and the Deputy Commissioner demanding accountability. The memorandums highlighted the sorry plight of the public health system in the respective districts and listed out local issues of urgent concern and requiring immediate corrective measures to revitalize an almost dead public health system. Some of the cross cutting issues of grave concern emerging from the collective action day were rampant corruption in the public health system, non-availability of doctors and nurses during the working hours, non-availability of medicines and diagnostic facilities, shortage of doctors and nurses in rural areas, privatization of and introduction of user fees in medical education and public health system. And adding to the feathers of privatization, commercialization and corruption in healthcare sector, the feather of apathy is evident from the fact that in the year 2006-07, the state has returned Rs.120 crores of the 160 crores allocated to National Rural Health Mission (NRHM), illustrating the highly ineffective and almost defunct situation of the public health system in the state. In lieu with the gross deficiencies identified the protestors were demanding for recruitment of and equitable distribution of health staff in rural areas, increased budgetary allocations for buying drugs and providing diagnostic facilities, strengthening health system at various levels, operationalizing round the clock service providing health centers, regulation of private health care sector, stopping the privatization of government health services, ending the corruption in public health system, improving the basic infrastructure of health facilities, providing adequate housing and facilities to government health staff, making public system more accessible and responsive to the needs of people living with disability and HIV-AIDS and effective implementation of NRHM.

We, the JAAK secretariat, would like to congratulate all the JAAK district forums for the enormous time and efforts they have put in mobilizing people and making "People's Health Action Day" a meaningful and successful one.

JAAK is now planning to hold a 2-day State Level meeting (with two representatives from each district JAAK forum) on 12th and 13th of November at Bangalore with the following agenda:

- Share and reflect on the "People's Health Action Day" experiences from different districts
- Collate a compilation report and meet the Director of State Health and Family Welfare department to have a formal dialogue on the status of public health in the state
- Plan and strategize for the follow-up action on the state wide "People's Action Day" and give renewed momentum for the JAAK

Dr. Prakash Rao, Premdas, Prabha, Basavaraju, Prasanna, Obalesh

The State Steering Committee,
Jana Arogya Andolana - Karnataka

Bangalore
29th Oct 2007.

One of the indirect results (cant ascribe as a Direct fallout) of this sustained campaign has been the ban on arrack sales in Karnataka (which was promised to us by the Health Minister during a Dialogue one of the Partner networks GMO had, at their annual meeting, with inputs from JAAK). Also in the recent budget announcement the evening OPD hours have been extended in the Government Hospitals with the Medical Officers paid at Rs. 300 per hour extra. Unfortunately this has been done to the Hospitals and not the PHCs.

All those who were involved in the campaign from the various districts also attended the State Level Health Assembly on March 21st preceding the Second National Health Assembly (NHA-2) held in Bhopal from March 23rd to March 25th. About 100 people participated in NHA-2 from Karnataka

What could have been better?

1. We have to still reach a critical mass of Districts as 13 is still not enough show of Strength. We are working towards the same.
2. Capacity building of the District level people hasn't happened enough. People are still looking towards the small core of people to deliver. As a result of this some of the Districts aren't having people who can take this forward by themselves.
3. Organisations are appreciating that working on Health is important and are coming for the campaigns/events but the process oriented approach is still missing with Organisations allotting specific people within themselves to work on and towards health (also partly due to conflicting priorities)

What Next?

1. We are in the process of collating and consolidating all the data from the Districts. This would be the next step
2. We are planning a State level convention in which a dialogue with the System (political parties, Government, Department) is envisaged
3. Regional Level Workshops for capacity building of the District level workers
4. Dialogue and connection with the other Movements like Right to Food, Campaign Against Water Privatisation, Women's groups, Anti-arrack groups etc., is to be strengthened

A Rally in Tumkur District under JAAK Banner

SHG women members handing over the Memorandum to the DHO in Gadag District

Mysore District people handing over the memorandum to the DC of the District

NOVARTIS BOYCOTT CAMPAIGN

About the Campaign

Novartis, the Swiss Multinational pharmaceutical company, has filed a case in the Chennai High Court against the order of the Chennai Patent office rejecting the patent application filed by them for getting a patent on imatinib mesylate, the trade name being 'Gleevec'. Imatinib mesylate is extremely useful in the treatment of chronic myeloid leukemia (CML). Currently it is being produced in its generic form by NATCO, Cipla, Ranbaxy and Hetero as well as by Novartis under the brand name Gleevec. Treatment with Gleevec, the Novartis' brand costs Rs. 1.2 lakh (2500 US dollars) per month, whereas the Indian generic versions cost about Rs. 8000 (175 US dollars)! If product patent is granted to Novartis for imatinib mesylate, the Indian generic versions will be forced to go out of the market, while the treatment of the CML would cost Rs. 1.2 lakh per month and this would go out of the reach of 99% of the patients of CML. Novartis' price is a clear example of excessive pricing which it has enforced across the world. There is no explanation as to why Novartis is not offering different prices depending on the circumstances in a country like India. It is clear that they are only interested in placing profits before patients' lives.

The Novartis' claim for patent on the beta crystalline form of imatinib mesylate is objectionable. This is because though this beta crystalline form is less hygroscopic is easier to process, stores better, it doesn't satisfy the two essential criteria of patentability – innovative step and non-obviousness to those familiar with the art. Imatinib mesylate is not a new molecule. Converting the already existing drug in to crystalline form is not an innovative step or is not non-obvious. To claim a patent on the crystalline salt form of imatinib mesylate is entirely unacceptable.

Novartis claims that those patients, who cannot afford to purchase Gleevec, receive the drug free of charge, through Novartis's Glivec International Patient Assistance Programme (GIPAP). Novartis says that 6,700 patients get free Gleevec, whereas in India 20,000 patients suffer from chronic myeloid leukemia every year. Dr. Purvish Parikh, professor and chief of medical oncology, Tata Memorial Hospital, has filed an affidavit based on his experience, debunking the claim of the Company about GIPAP.

Novartis claims that Chennai Patent Office's rejection of Novartis patent for Gleevec violates TRIPS. If so then this claim should be taken to the special international dispute redressal mechanism under WTO, which deals with such matters. However, instead, Novartis has decided to approach Chennai High Court in India. It has dragged the Indian Government and cancer patients to court and challenged the constitutional validity of an extremely important public health safeguard in India's patent law. This is highly questionable. Put all these facts together we sincerely feel that the act of the company to get patent for Gleevec is motivated by desire to get huge profits at the cost of the patients suffering from Chronic Myeloid Leukemia. If Novartis wins this case, other MNCs would also claim patents for similar, already well-known medicines and there will be the danger of making a series of medicines out of the reach of ordinary Indians. Since India also supplies cheaper, generic drugs to the tune of thousands of crores to many developing countries, this will also be adversely affected. Patents in India threaten a key source of affordable medicines. India produces affordable medicines that are vital to many people living in developing countries. For example, over half the medicines currently used for AIDS treatment in developing countries come from India.

Hence hundreds of thousands of people all over the world have signed an online 'drop the case' letter to Novartis, asking to drop the case that it has filed in the Chennai High Court. 'Drop the Case' campaign has been launched by Doctors Without Borders (http://www.doctorswithoutborders.org/) – winner of Nobel Prize Award for best medical relief during the year 1999. Many reputed personalities including heads of nations have publicly appealed to Novartis to withdraw the court case. Few among leading personalities that have appealed are Mr. Erik Solheim, Minister of International Development, Norway (for details Deccan Herald date 2nd May 2007), Mr Henry A Waxman, Chairman, Congress of United States (for details click on the URL mentioned above), Dr. Anbumani Ramdoss, Health Minister, India and several others. But in spite of all these appeals Novartis hasn't complied. Moreover Novartis is continuously trying to influence the Indian government to bring in laws and policies that create monopolies on drugs that keep them out of the hands of our patients. Novartis played a role in trying to influence an important government report to recommend patents on small improvements in drugs and is now trying to push for monopolies like data exclusivity. Therefore we feel time has now come for all of us to put more pressure on Novartis, by boycotting its products hence, this appeal.

The Community of Practising Medical Doctors play an important link between the people and the pharmaceutical industry as the latter depend on the prescribing Medical Doctors for the sale of their products. We in DAF-K sincerely feel that you have an important role to play in bringing pressure on the industry by boycotting the drugs produced by Novartis company till they stop their actions that prevent patients from getting medicines. This includes dropping all their legal actions relating to imatinib mesylate including the upcoming appeal to the patent controller's order and stopping their actions in trying to influence the Indian government to introduce laws and policies that create monopolies on drugs and that place profits before patients. DAF-K feels strongly that you should take up "Boycott Novartis Products Campaign" as the Company has not responded positively to earlier appeals from various people all over the world to withdraw its wholly unjustified and anti-people stand about the imatinib mesylate patent. In fact DAF-K is compelled to call for this boycott as last resort and seek your support because Novartis has failed to respond to all other approaches by leading global organisations and state heads. We are sure you are interested in the welfare of the human society and will certainly join this Campaign to make the drug available and affordable to poor patients. This will not only help with respect to Gleevec but will send shock signals to other pharmaceutical companies who would indulge in similar acts.

DOWNLOADED FROM THE OFFICILA WEBSITE OF THE CAMPAIGN
http://novartisboycott.org/ ON 29TH Jan 2008

National Rural Health Mission

A Promise of

Better Healthcare Service for the Poor

A summary of

Community Entitlements

and

Mechanisms for Community Participation and Ownership

for

Community Leaders

Prepared for

Community Monitoring of NRHM - First Phase

National Rural Health Mission

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Contents

Preface

The National Rural Health Mission has been launched with the objective of improving the access to quality healthcare services for the rural poor, especially women and children. The Mission recognizes that good health is an important component of overall socio-economic development and an improved quality of life.

The most significant aspect of NRHM is that it is not a new health scheme or programme but a new approach to providing healthcare services. Some of the important components of this approach is that it

- recognizes the importance of integrating the determinants of health, like nutrition, water and sanitation with healthcare systems
- aims at decentralizing planning and management
- integrates organizational structures -i.e. the different vertical health schemes
- improves delivery of healthcare services through upgrading and standardizing health centres
- introduces standards and guarantees for service quality and triangulated monitoring systems for assuring quality
- provides mechanisms for community participation and management

This short briefing note has been prepared by pooling together all the manuals and guidelines that have been prepared to guide the implementation of NRHM and highlights its key components which relate to Entitlements, Mechanisms for Community Participation and Yardsticks for Community Monitoring. It is expected that this information will prove useful for all those involved in the Community Monitoring processes at the district, block and village levels.

This briefing note has been prepared as a part of the Community Monitoring of NRHM (first phase) being implemented by the Advisory Group on Community Action.

An Introduction to NRHM

The Government of India launched the National Rural Health Mission (NRHM) on the 12th of April 2005.The vision of the mission is to undertake architectural correction of the health system and to improve access to rural people, especially poor women and children to equitable, affordable, accountable and effective primary health care throughout the country with special focus on 18 states, which have weak public health indicators and/or weak infrastructure.

18 special focus states are Arunachal Pradesh, Assam, Bihar, Chattisgarh, Himachal Pradesh, Jharkhand, Jammu and Kashmir, Manipur, Mizoram, Meghalaya, Madhya Pradesh, Nagaland, Orissa, Rajasthan, Sikkim, Tripura, Uttaranchal and Uttar Pradesh.

NRHM is a 7 years programme ending in the year 2012. It has time bound goals and its progress will be reported publicly by the government.

Some of the goals of the Mission:

- Reduction in child and maternal mortality
- Universal access to public health care services along with public services for food and nutrition, sanitation and hygiene
- Prevention and control of communicable and non-communicable diseases, including locally endemic diseases
- Access to integrated comprehensive primary health care

Some of the Core Strategies through which the mission seeks to achieve its goals:

- Train and enhance capacity of Panchayati Raj Institutions (PRIs) to own, control and manage public health services
- Promote access to improved healthcare at household level through (ASHA)
- Health Plan for each village through Village Health Committee
- Strengthening existing sub-centre, PHCs and CHCs
- Preparation and Implementation of an inter-sectoral District Health Plan
- Integrating vertical Health and Family Welfare programmes at National, State, Block, and District levels

Unlike previous health programmes, the government has clearly defined the roles of Non governmental organization (NGOs) in the Mission. NGO's are not only included in institutional arrangement at National, State and District Levels but also they are supposed to play an important role in monitoring, evaluation and social audit.

Source of Information: Mission document http://mohfw.nic.in/NRHM/Documents/NRHM%20Mission%20Document.pdf

For more Information on NRHM vision, goals, objectives, strategies and outcomes go to:

1) Framework for Implementation. http://mohfw.nic.in/NRHM/Documents/NRHM%20-%20Framework%20for%20Implementation.pdf

2) Website on NRHM by Ministry of Health and Family Welfare http://mohfw.nic.in/NRHM/NRHM.htm

Service Guarantees and Important Schemes and Provisions under NRHM

Accredited Social Health Activist (ASHA)

With the launch of NRHM, the Government of India proposed Accredited Social Health Activist (ASHA) to act as the interface between the community and the public health system.

Since Sub centers were serving much larger population than they were expected to and ANMs were heavily overworked, one of the core strategies of NRHM is to promote access to improved healthcare at household level through ASHA.

- ASHA is a Health Activist in the community
- Every village will have 1 ASHA for every 1000 persons
- She will be selected in a meeting of the Gram Sabha
- She will be chosen from women (married/widowed/ divorced between 25-45 years) residing in the village with minimum education up to VIIIth class.
- ASHA is accountable to the Panchayat
- ASHA will work from the Anganwadi Centre
- ASHA is honorary volunteer and she is entitled to receive performance based compensation. Her services to the community are Free of cost
- ASHA will receive trainings on care during pregnancy, delivery, post partum period, New born care, sanitation and hygiene

Roles and Responsibilities

ASHA is responsible for creating Awareness on Health including

- Providing information to the community on nutrition, hygiene and sanitation
- Providing information on existing health services and mobilizing and helping the community in accessing health related services available at Health Centers
- Registering pregnant women and helping poor women to get BPL certification
- Counseling women on birth preparedness, safe delivery, breast feeding, contraception RTI/STI and care of young child
- Arranging escort/accompany pregnant women and children requiring treatment/admission to the nearest health centre.
- Promoting universal immunization
- Providing primary medical care for minor ailments. Keeping a drug kit containing generic AYUSH and allopathic formulations for common ailments
- Promoting construction of household toilets
- Facilitating preparation and implementation of the Village Health Plan through AWW, ANM,SHG members under the leadership of village health committee
- Organizing Health Day once/twice a month at the anganwadi with the AWW and ANM
- ASHA is also a Depot holder for essential services like IFA, OCP, Condoms, ORS DDK etc, issued by AWW

Timeline: Fully trained ASHA for every 1000 population/large-isolated habitations in 18 Special Focus States-30% by year 2007, 60% by 2009 and 100% by 2010

Source of Information:

(1) Guidelines on ASHA- It has been envisaged that states will have flexibility to adapt these guidelines keeping their local situations in view. http://mohfw.nic.in/Guidelines%20on%20ASHA-Annex%201.pdf

(2) Framework for Implementation (*) http://mohfw.nic.in/NRHM/Documents/NRHM%20-%20 Framework %20for%20Implementation.pdf

For more Information on ASHA go to:

1) Guidelines on JSY http://mohfw.nic.in/dofw%20website/JSY_features_FAQ_Nov_2006.htm

2) Website of Ministry of Health and Family Welfare http://mohfw.nic.in/NRHM

Auxiliary Nurse Midwife (ANM)

ANM is a government paid health worker who provides free maternal and childcare services within a sub center area. The Mission seeks to provide minimum two ANMs at each Sub Health Centre to be fully supported by the Government of India.

Primary tasks of ANM

- Registration of all pregnancies (ANM along with ASHA will ensure that all BPL women get benefits under Janani Suraksha Yojna)
- Ensure Minimum 4 antenatal check ups along with 100 IFA tablets and two T.T. Injections to pregnant women
- Appropriate and prompt referral in case of high-risk pregnancies
- Provide Skilled Attendance at home deliveries, post partum care and contraceptive advice
- Newborn Care (full immunization and Vitamin A doses to children, prevention and control of childhood diseases like malnutrition, infections etc.
- Curative Services like treatment for minor ailments
- Maintenance of all relevant records concerning mother, child and eligible couples in the area
- Providing information on different family planning and Contraception methods and Provision of Contraceptives
- Counseling and correct information on safe abortion services
- Coordinates services with AWWs, ASHA, Village Health & Sanitation Committee and PRI for observance of Health Day at AWW center at least once a month
- Coordination and supervision of ASHA
- The Untied grant to the Sub Center is kept in a joint account, which is operated, by the ANM and the local Sarpanch

ANM is answerable to Village Health and Sanitation committee, which will oversee her work.

Source of Information:

Framework for Implementation http://mohfw.nic.in/NRHM/Documents/ NRHM%20-%20Framework%20for %20 Implementation.pdf

For more Information on JSY go to:

1) Guidelines on JSY http://mohfw.nic.in/dofw%20website/JSY_features_FAQ_Nov_2006.htm

2) Website of Ministry of Health and Family Welfare - http://mohfw.nic.in/NRHM

JANANI SURAKSHA YOJANA (JSY)

JSY is meant to reduce maternal mortality and neo-natal mortality by promoting deliveries at health institutions by skilled personnel like doctors and nurses.

JSY is a 100% centrally sponsored scheme. It integrates cash assistance to women from poor families for enabling them to deliver in health institutions along with anti natal and post natal care.

The scheme applies differently to LPS and HPS.While states having low institutional delivery rates have been named as Low Performing States (LPS), the remaining states have been named as High Performing States (HPS). LPS states include the states of Uttar Pradesh, Uttaranchal, Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Assam, Rajasthan, Orissa and HPS states include Maharashtra and Tamilnadu.

Eligibility for Cash Assistance:

LPS States All pregnant women delivering in Government health centres like Sub-centre, PHC/CHC/FRU/general wards of District and state Hospitals or accredited private institutions. No age constraint

HPS States BPL pregnant women, aged 19 years and above

LPS & HPS All SC and ST women delivering in a government health centre like Sub-centre, PHC/CHC/FRU/general ward of District and state Hospitals or accredited private institutions. No age constraint

Limitations of Cash Assistance for Institutional Delivery:

In LPS States All births, delivered in a health centre – Government or Accredited Private health institutions.

In HPS States Upto 2 live births.

Scale of Cash Assistance for Institutional Delivery

Category	Rural Area		Total	Urban Area		Total
	Mother's Package	ASHA's Package	Rs.	Mother's Package	ASHA's Package	Rs.
LPS	1400	600	2000	1000	200	1200
HPS	700		700	600		600

Generally the ANM/ASHA should carry out the entire disbursement process.

Assistance for Home Delivery

In LPS and HPS States, BPL pregnant women, aged 19 years and above, preferring to deliver at home is entitled to cash assistance of Rs. 500/- per delivery. Such cash assistance would be available only upto 2 live births and the disbursement would be done at the time of delivery or around 7 days before the delivery by ANM/ASHA/any other link worker. The rationale is that beneficiary would be able to use the cash assistance for her care during delivery or to meet incidental expenses of delivery.

Role of ASHA or other link health worker associated with JSY

Along with fulfilling their usual duties of providing anti natal and post natal care to woman, ASHA/other health workers would be responsible for

- Identifying pregnant woman as a beneficiary of the scheme
- Assisting the pregnant woman to obtain necessary certifications
- Identifying a functional Government health centre or an accredited private health institution for referral and delivery
- Escorting the beneficiary women to the health center and stay with her till the woman is discharged

Source of Information: Website of Ministry of Health and Family Welfare

For more Information on need of BPL certification, Disbursement of Cash Assistance, flow of fund (from state district authority to ANM to ASHA), ASHA's package under JSY, Subsidizing cost of Caesarean Section , Grievance Redressal cell, display of names of JSY beneficiaries in health centers go to: http://mohfw.nic.in/dofw%20website/JSY_features_FAQ_Nov_2006.htm

Service Guarantees from Sub Health Center

(Services provided at the Sub Center are Free of Cost for a person from BPL family)

Maternal Health

Antenatal care:

- Early registration of all pregnancies
- Minimum four antenatal check-ups
- General examination such as weight, BP, anaemia, abdominal examination, height and breast examination
- Iron and Folic Acid supplementation
- T.T.Injection, treatment of anaemia, etc.
- Minimum laboratory investigations like haemoglobin, urine albumen and sugar
- Identification of high-risk pregnancies and appropriate and prompt referral

Intranatal care:

- Promotion of institutional deliveries
- Skilled attendance at home deliveries as and when called for
- Appropriate and prompt referral

Postnatal care:

- A minimum of 2 postpartum home visits
- Initiation of early breast-feeding within half-hour of birth
- Counselling on diet and rest, hygiene, contraception, essential new born care, infant and young child feeding and STI/RTI and HIV/AIDS

Child Health

- Promotion of exclusive breast-feeding for 6 months
- Full Immunization of all infants and children
- Correct doses of Vitamin A
- Prevention and control of childhood diseases like malnutrition, infections, etc.

Family Planning and contraception

- Provision of contraceptives and counseling to adopt appropriate Family planning methods
- Counselling and appropriate referral for safe abortion services (MTP) for those in need

Adolescent health care

Providing education, counselling and referral services Assistance to school health services.

Control of local endemic diseases Disease surveillance

- Disinfection of water sources
- Promotion of sanitation including use of toilets and appropriate garbage disposal

Curative Services

- Provide treatment for minor ailments including and First Aid in accidents and energencies
- Appropriate and prompt referral
- Organizing Health Day at Anganwadi centres at least once in a month

Training, Monitoring and Supervision

- Training of Traditional Birth Attendants and ASHA
- Coordinated services with AWWs, ASHA, Village Health and Sanitation Committee, PRI

Record of Vital events

- Recording and reporting of Vital statistics including births and deaths, particularly of mothers and infants

- Maintenance of all the relevant records concerning mother, child and eligible couples in the area

The Sub Health Centre will be accountable to the Gram Panchayat and shall have a local Committee for its management, with adequate representation of Village Health and Sanitation Committee.

ANM and Multi purpose Health worker MPW works from the Subcentre and deliver the above-mentioned service with the help of ASHA.

Funds

- The Gram Panchayat SHC Committee has the mandate to undertake construction and maintenance of SHC. An annual maintenance grant of Rupees 10,000 will be available to every SHC
- Every SHC gets Rs.10,000 as Untied grants for local health action. The resources could be used for any local health activity for which there is a demand. The fund would be kept in a joint account to be operated by the ANM and the local Sarpanch

Time Line:

- 2 ANM Sub Health Centres strengthened/ established to provide service guarantees as per IPHS, in 1,75000 places - 30% by 2007, 60% by 2009, 100% by 2010
- Untied grants provided to each Sub Centre to promote local health action. 50% by 2007, 100% by 2008
- Annual maintenance grant provided to every Sub Centre - 50% by 2007, 100% by 2008
- Procurement and logistics streamlined to ensure availability of drugs and medicines at Sub Centres- 50% by 2007,100% by 2008

Source of Information:

1) Framework for Implementation http://mohfw.nic.in/NRHM/Documents/NRHM%20-%20Framework%20for%20Implementation.pdf

For more Information go to:

1) Guidelines for VHSCs, SCs, PHCs AND CHCs http://mohfw.nic.in/NRHM/Documents/Guidelines_of_untied_funds_NRHM.pdf

2) IPHS for Subcenters http://mohfw.nic.in/NRHM/Documents/IPHS_for_SUBCENTRES.pdf

Services Guarantees from Primary Health Centre (PHC)

(All services provided at PHC are free of cost for BPL families)

Every PHC has to provide OPD services, Inpatient Service, referral service and 24 hours emergency service for all cases needing routine and emergency treatment including treatment of local diseases.

All services provided by Sub centers are also provided by PHC.

Some additional services provided in a PHC are as follows:

Maternal Health

- 24-hour delivery services both normal and assisted
- Appropriate and prompt referral for cases needing specialist care
- Pre-referral management (Obstetric first-aid)
- Facilities under Janani Suraksha Yojana

Family Planning

- Permanent methods of Family Planning
- Facility for Medical Termination of Pregnancies (wherever trained personnel and facility exists)

Treatment of RTI/ STIs
Basic laboratory services
Referral services

Appropriate and prompt referral of cases needing specialist care including:

- Stabilisation of patient

- Appropriate support for patient during transport
- Providing transport facilities

A Charter of Citizen's Health Rights should be prominently displayed outside all PHCs.

The Primary Health Centre (not at the block level) will be responsible to the elected representative of the Gram Panchayat where it is located.

The Block level PHC will have involvement of Panchayti Raj elected leaders in its management even though Rogi Kalyan Samiti would also be formed for day-to-day management of the affairs of the hospital.

The Mission seeks to provide minimum three Staff Nurses to ensure round the clock services in every PHC.

Funds

- Each PHC is entitled to get an annual maintenance grant of Rs. 50,000 for construction and maintenance of physical infrastructure. Provision for water, toilets, their use and their maintenance, etc, has to be priorities. PHC level Panchayat Committee/Rogi Kalyan Samiti will have the mandate to undertake and supervise improvement and maintenance of physical infrastructure
- Every PHC is entitled to get Rs. 25,000 as Untied grants for local health action. The resources could be used for any local health activity for which there is a demand

Time Line:

- 30,000 PHCs strengthened/established with 3 Staff Nurses to provide service guarantees as per IPHS - 30% by 2007, 60% by 2009 and 100% by 2010
- Untied grants provided to each PHC to promote local health action - 50% by 2007 and 100% by 2008
- Annual maintenance grant provided to every PHC - 50% by 2007 and 100% by 2008
- Procurement and logistics streamlined to ensure availability of drugs and medicines at PHCs - 50% by 2007 and 100% by 2008

Source of Information:
Framework for Implementation http://mohfw.nic.in/NRHM/Documents/NRHM%20-%20Framework%20for%20Implementation.pdf

For more Information go to:
Guidelines for VHSCs, SCs, PHCs AND CHCs http://mohfw.nic.in/NRHM/Documents/Guidelines_of_untied_funds_NRHM.pdf

Service Guarantees from Community Health Centre (CHC)

- Care of routine and emergency cases in surgery and medicine
- 24-hour delivery services including normal and assisted deliveries
- Essential and Emergency Obstetric Care including surgical interventions
- Full range of family planning services
- Safe Abortion Services
- Newborn Care and Routine and Emergency Care of sick children
- Diagnostic services through the microscopy centers
- Blood Storage Facility
- Essential Laboratory Services
- Referral Transport Services
- All National Health Programmes should be delivered through the CHCs. e.g. HIV/AIDS Control Programme, National Leprosy Eradication Programme, National Programme for Control of Blindness

Over the Mission period, the Mission aims at bringing all the CHCs on a par with the IPHS to provide round the clock hospital-like services. According to IPHS, it is mandatory to display Charter of Citizen's Health Rights outside all CHCs. The dissemination and display of charter is the

responsibility of Block Health Monitoring and Planning Committee.

According to IPHS, it is mandatory for every CHC to have "Rogi Kalyan Samiti" to ensure accountability.^

Mission also seeks to provide separate AYUSH set up in each CHC.

Funds

- Every CHC gets Annual maintenance grant of Rs. 1 lakh for construction and maintenance of physical infrastructure. Rogi Kalyan Samiti/Block Panchayat Samiti has a mandate to undertake construction and maintenance of CHC
- Every CHC gets Rupees 50,000 as Untied grants for local health action. The resources could be used for any local health activity for which there is a demand

Time Line

- 6500 CHCs strengthened/established with 7 Specialists and 9 Staff Nurses to provide service guarantees as per IPHS-30% by 2007,50% by 2009 and 100% by 2012
- Untied grants provided to each CHC to promote local health action- 50% by 2007 and 100% by 2008
- Annual maintenance grant provided to every CHC -50% by 2007 and 100% by 2008
- Procurement and logistics streamlined to ensure availability of drugs and medicines at CHCs-50% by 2007 and 100% by 2008

Source of Information:

1) Framework for Implementation http://mohfw.nic.in/NRHM/Documents/NRHM%20-%20Framework%20for%20Implementation.pdf

2) IPHS for CHC(^) http://mohfw.nic.in/NRHM/Documents/Draft_CHC.pdf

For more Information on Guidelines for Village Health and Sanitation Committees, Sub Centres. PHCs and CHCs go to: http://mohfw.nic.in/NRHM/Documents/Guidelines_of_untied_funds_NRHM.pdf

AYUSH

The term AYUSH covers **A**yurveda, **Y**oga & Naturopathy, **U**nani, **S**iddha and **H**omeopathy. These systems are popular in a large number of States in the country. e.g. Ayurved system is popular in the States of Madhya Pradesh, Rajasthan, and Orissa, the Unani system is particularly popular in Tamil Nadu and Maharashtra.This is to imply that the AYUSH systems of medicine and its practices are well accepted by the community, particularly, in rural areas. The medicines are easily available and prepared from locally available resources, economical and comparatively safe.

One of the objectives of the mission is to revitalize local health traditions and mainstream AYUSH into the public health system.

Modalities For Integration

- For mainstreaming, the personnel of AYUSH may work under the same roof of the Health Infrastructure, i.e., PHC, CHC; However, separate space should be allocated exclusively for them in the same building
- The Doctors under the Systems of AYUSH are required to practice as per the terms & conditions laid down for them by the appropriate Regulatory Authorities
- Provision of one Doctor of any of the AYUSH systems as per the local acceptability assisted by a Pharmacist in PHC
- Provision of one Specialist of any of the AYUSH systems as per the local acceptability assisted by a Pharmacist in CHC
- Supply of appropriate medicines pertaining of AYUSH systems
- The already existing AYUSH infrastructure should be mobilized. AYUSH dispensaries that are not functioning well should be merged with the PHC or CHC barring which, displacement of AYUSH clinic is not advised
- Cross referral between allopathic and AYUSH streams should be encouraged based on the need for the same

- AYUSH Doctors shall be involved in IEC, health promotion and also supervisory activities
- The IPHS pertaining to AYUSH and also the detailed manpower and other requirements and financial projections for the same will be provided by the Department of AYUSH for further consideration

Source of Information:
Mainstreaming of AYUSH Systems in the National Health Care Delivery System- Mohfw.nic.in/ayush%2015th%20march.pdf

For more Information go to:
Website of Department of AYUSH http://indianmedicine.nic.in/

Community Participation in NRHM

Village Health and Sanitation Committee (VHSC)

Village level Health and Sanitation Committee will be responsible for the Village Health Plans.

This committee would be formed at the level of the revenue village (more than one such villages may come under a single Gram Panchayat).

Composition

The Village Health Committee would consist of:

- Gram Panchayat members from the village
- ASHA, Anganwadi Sevika, ANM
- SHG leader, the PTA/MTA Secretary, village representative of any Community based organisation working in the village, user group representative

The chairperson would be the Panchayat member (preferably woman or SC/ST member) and the convenor would be ASHA; where ASHA not in position it could be the Anganwadi Sevika of the village.

Training

The members would be given orientation training to equip them to provide leadership as well as plan and monitor the health activities at the village level.

Grants available

- Every village with a population of upto 1500 gets an annual Untied grant of up to Rs. 10,000, after constitution and orientation of VHSC. The Untied grant to be used by this committee for household surveys, health camps, sanitation drives, revolving fund etc.
- A revolving fund for providing referral and transport facilities for emergency deliveries as well as immediate financial needs for hospitalization would also be operated by the VHSC

Some roles of the VHSC

- Create Public Awareness about the essentials of health programmes, with focus on People's knowledge of entitlements to enable their involvement in the monitoring
- Discuss and develop a Village Health Plan based on an assessment of the village situation and priorities identified by the village community
- Analyse key issues and problems related to village level health and nutrition activities, give feedback on these to relevant functionaries and officials. Present an annual health report of the village in the Gram Sabha
- Participatory Rapid Assessment to ascertain the major health problems and health related issues in the village. Mapping will be done through participatory methods with involvement of all strata of people. The health mapping exercise shall provide quantitative and qualitative data to understand the health profile of the village
- Maintenance of a village health register and health information board/calendar: The health register and board will have information about mandated services, along with services actually rendered to all pregnant women, new born and infants, people suffering from chronic diseases etc. Similarly dates of visit and activities expected to be performed during each visits by health functionaries may be displayed and monitored by means of a Village health calendar
- Ensure that the ANM and MPW visit the village on the fixed days and perform the stipulated activity; oversee the work of village health and nutrition functionaries like ANM, MPW and AWW

- Get a bi-monthly health delivery report from health service providers during their visit to the village. Discuss the report submitted by ANM and MPW and take appropriate action

Time Line
Village Health and Sanitation Committee constituted in over 6 lakh villages and untied grants provided to them - 30% by 2007, 100% by 2010

Untied grants provided to each Village Health and Sanitation Committee to promote local health action. 50% by 2007, 100% by 2008

Source of Information:
Framework for implementation http://mohfw.nic.in/NRHM/Documents/NRHM%20-%20Framework%20for%20Implementation.pdf

For more Information go to:
Guidelines for VHSCs, SCs, PHCs AND CHCs http://mohfw.nic.in/NRHM/Documents/Guidelines_of_untied_funds_NRHM.pdf

PHC Monitoring and Planning Committee

This Committee monitors the functioning of Sub-centres operating under jurisdiction of the PHC and developes PHC health plan after consolidating the village health plans.

Composition

- 30% members from PRI (from the PHC coverage area; 2 or more sarpanchs of which at least one is a woman)
- 20% members non-official representatives from VHSC, (under the jurisdiction of the PHC, with annual rotation to enable representation from all the villages)
- 20% members representatives from NGOs / CBOs and People's organizations working on Community health and health rights in the area covered by the PHC
- 30% members representatives of the Health and Nutrition Care providers, including the Medical Officer – Primary Health Centre and at least one ANM working in the PHC area
- Chairperson: Panchayat Samiti member, Executive chairperson: Medical officer of the PHC, Secretary: NGO/CBO representatives

Role & Responsibilities

- Consolidation of the village health plans and charting out the annual health action plan in order of priority
- Presentation of the progress made at the village level, achievements, actions taken and difficulties faced followed by discussion on the progress of the achievements of the PHC, concerns and difficulties faced and support received to improve the access to health facilities in the area of that particular PHC
- Ensure that the Charter of citizen's health rights is disseminated widely and displayed out side the PHC informing the people about the medicine facilities available at the PHC, timings of PHC and the facilities available free of cost. A suggestion box can be kept for the health care facility users to express their views about the facilities. These comments will be read at the coordination committee meeting to take necessary action
- Monitoring of the physical resources like, infrastructure, equipments, medicines, water connection etc at the PHC and inform the concerned government officials to improve it
- Discuss and develop a PHC Health Plan based on an assessment of the situation and priorities identified by representatives of village health committees and community based organizations
- Share the information about any health awareness programme organized in the PHC's jurisdiction, its achievements, follow up actions, difficulties faced etc.
- Coordinate with local CBOs and NGOs to improve the health scenario of the PHC area

- Review the functioning of Sub-centres operating under jurisdiction of the PHC and taking appropriate decisions to improve their functioning

- Initiate appropriate action on instances of denial of right to health care reported or brought to the notice of the committee

Time Line:
Systems of community monitoring put in place - 50% by 2007 and 100% by 2008.

Source of Information:
Framework for implementation http://mohfw.nic.in/NRHM/Documents/NRHM%20-%20Framework%20for%20Implementation.pdf

Block Monitoring and Planning Committee

This Committee monitors the progress made at the PHC level health facilities in the block, including CHC and develops annual action plan for the Block after consolidating PHS level health plans.

Composition

- 30% members representatives of the Block Panchayat Samiti (Adhyaksha/Adhyakshika or members with at least one woman)

- 20% members non-official representatives from the PHC health committees in the block, with annual rotation to enable representation from all PHCs over time

- 20% members representatives from NGOs/ CBOs and People's organizations working on Community health and health rights in the block, and involved in facilitating monitoring of health services

- 20% members officials such as the BMO, the BDO, selected MO's from PHCs of the block

- 10% members representatives of the CHC level Rogi Kalyan Samiti

- Chairperson: Block Panchayat Samiti representative, Executive chairperson: Block medical officer, Secretary: NGO / CBO representatives

Role & Responsibilities

- Consolidation of the PHC level health plans and charting out of the annual health action plan for the block.

- Review of the progress made at the PHC levels, difficulties faced, actions taken and achievements made, followed by discussion on any further steps required to be taken for further improvement of health facilities in the block, including the CHC

- Analysis of records on neonatal and maternal deaths; and the status of other indicators, such as coverage for immunization and other national programmes

- Monitoring of the physical resources like, infrastructure, equipments, medicine, water connection etc at the CHC; similar exercise for the manpower issues of the health facilities that come under the jurisdiction of the CHC

- Coordinate with local CBOs and NGOs to improve the health services in the block

- Review the functioning of Sub-centres and PHCs operating under jurisdiction of the CHC and taking appropriate decisions to improve their functioning

- Initiate appropriate action on instances of denial of right to health care reported or brought to the notice of the committee; initiate an enquiry if required and table report within two months in the committee. The committee may also recommend corrective measures to the district level

Time Line:
Systems of community monitoring put in place - 50% by 2007 and 100% by 2008.

Source of Information:
Framework for implementation http://mohfw.nic.in/NRHM/Documents/NRHM%20-%20Framework%20for%20Implementation.pdf

District Health Monitoring and Planning Committee

This Committee contributes to the development of District Health plan.

Composition

- 30% members representatives of the Zilla Parishad (esp. convenor and members of its Health committee)
- 25% members district health officials, including the District Health Officer/Chief Medical Officer and Civil Surgeon or officials of parallel designation, along with representatives of the District Health planning team including management professionals
- 15% members non-official representatives of block committees, with annual rotation to enable successive representation from all blocks
- 20% members representatives from NGOs/CBOs and People's organizations working on Health rights and regularly involved in facilitating Community based monitoring at other levels (PHC/block) in the district
- 10% members should be representatives of Hospital Management Committees in the district
- Chairperson: Zilla Parishad representative, preferably convenor or member of the Zilla Parishad Health committee, Executive chairperson: CMO/CMHO/DHO or officer of equivalent designation, Secretary: NGO/CBO representatives

Role & Responsibilities

- Discussion on the reports of the PHC health committees
- Financial reporting and solving blockages in flow of resources if any
- Infrastructure, medicine and health personnel related information and necessary steps required to correct the discrepancies
- Progress report of the PHCs emphasising the information on referrals utilisation of the services, quality of care etc.
- Contribute to development of the District Health Plan, based on an assessment of the situation and priorities for the district. This would be based on inputs from representatives of PHC health committees, community based organisations and NGOs
- Ensuring proper functioning of the Hospital Management Committees
- Discussion on circulars, decisions or policy level changes done at the state level; deciding about their relevance for the district situation
- Taking cognizance of the reported cases of the denial of health care and ensuring proper redressal

Time Line:
Systems of community monitoring put in place- 50% by 2007 and 100% by 2008.

Source of Information:
Framework for implementation http://mohfw.nic.in/NRHM/Documents/NRHM%20-%20Framework%20for%20Implementation.pdf

State Health Monitoring and Planning Committee

This Committee reviews and contributes to the development of State Health plan.

Composition

- 30% of total members should be elected representatives, belonging to the State legislative body (MLAs/MLCs) or Convenors of Health committees of Zilla Parishads of selected districts (from different regions of the state) by rotation

- 15% would be non-official members of district committees, by rotation from various districts belonging to different regions of the state
- 20% members would be representatives from State health NGO coalitions working on Health rights, involved in facilitating Community based monitoring
- 25% members would belong to State Health Department
- Secretary Health and Family Welfare, Commissioner Health, relevant officials from Directorate of Health Services (incl. NRHM Mission Director) along with Technical experts from the State Health System Resource Centre/Planning cell
- 10% members would be officials belonging to other related departments and programmes such as Women and Child Development, Water and Sanitation, Rural development
- The Chairperson would be one of the elected members (MLAs)
- The executive chairperson would be the Secretary Health and Family Welfare
- The secretary would be one of the NGO coalition representatives

Role & Responsibilities

- The main role of the committee is to discuss the programmatic and policy issues related to access to health care and to suggest necessary changes
- This committee will review and contribute to the development of the State health plan, including the plan for implementation of NRHM at the state level; the committee will suggest and review priorities and overall programmatic design of the State health plan
- Key issues arising from various District health committees, which cannot be resolved at that level (especially relating to budgetary allocations, recruitment policy, programmatic design etc.) would be discussed an appropriate action initiated by the committee. Any administrative and financial level queries, which need urgent attention, will be discussed
- Institute a health rights redressal mechanism at all levels of the health system, which will take action within a time bound manner. Review summary report of the actions taken in response to the enquiry reports
- Operationalising and assessing the progress made in implementing the recommendations of the NHRC, to actualize the Right to health care at the state level
- The committee will take proactive role to share any related information received from GOI and will also will share achievements at different levels. The copies of relevant documents will be shared

Time Line:
Systems of community monitoring put in place - 50% by 2007 and 100% by 2008.

Source of Information:
Framework for implementation http://mohfw.nic.in/NRHM/Documents/NRHM%20-%20Framework%20for%20Implementation.pdf

Rogi Kalyan Samiti (RKS)

For efficient management of Health Institutions NRHM has proposed Rogi Kalyan Samiti (RKS)/Patient Welfare Committee/Hospital Management Committee (HMC) . This initiative is taken to bring in the community ownership in running of rural hospitals and health centres, which will in turn make them accountable and responsible.#

Broad Objectives of RKS#

- Ensure compliance to minimal standard for facility and hospital care
- Ensure accountability of the public health providers to the community

- Upgrade and modernize the health services provided by the hospital
- Supervise the implementation of National Health Programme
- Set up a Grievance Mechanism System

Apart from this, RKS at PHC and CHC will have the mandate to undertake and supervise improvement and maintenance of physical infrastructure. RKS would also develop annual plans to reach the IPHS standards.*

RKS would be a registered society. It may consists of following members#

- Group of users i.e. people from community
- Panchayati Raj representatives
- NGOs
- Health professionals

According to IPHS, it is mandatory for every CHC to have "Rogi Kalyan Samiti" to ensure accountability.^

Grants

To motivate the states to set up RKSs, a support of Rs.5.0 lakhs per rural hospital, Rs.1.00 lakh per CHC and Rs.1.00 per PHC per annum would be given to these societies through states. The societies would be eligible for these grants only where they are authorized by the States to retain the user charges at the institution level.*

Time Line*:

- Rogi Kalyan Samitis/Hospital Development Committees established in all CHCs/Sub Divisional Hospitals/ District Hospitals - 50% by 2007, 100% by 2009
- One time support to RKSs at Sub Divisional/ District Hospitals - 50% by 2007, 100% by 2008

Source of Information:

1) Framework for implementation (*) http://mohfw.nic.in/NRHM/Documents/NRHM%20%20Framework%20for%20Implementation.pdf

2) Guidelines for IPHS for CHC(^)

3) Guidelines for Rogi Kalyan Samiti (#) http://mohfw.nic.in/NRHM/RKS.htm

Some Frameworks for Community Monitoring

Indian Public Health Standards (IPHS)

IPHS are being prescribed to provide optimal expert care to the community and to achieve and maintain an acceptable standard of quality of care. These standards help in monitoing and improving the functioning of public health centers.#

IPHS for CHCs provides for "Assured services" that should be available in a Community health centre along with minimum requirements for delivering these services such as:

- Minimum clinical and supporting manpower requirement
- Equipments
- Drugs
- Physical Infrastructure
- Charter of Patients' rights
- Requirement of quality control
- Quality assurance in service delivery-standard treatment protocol#

Similar standards are being developed for PHCs & Sub Center.*

Over the Mission period, the Mission aims at bringing all the CHCs on a par with the IPHS in a gradual manner. In the process, all the CHCs would be operationalized as first Referral Units (FRUs) with all facilities for emergency obstetric care. *

It will be for the States to decide on the configuration of PHCs to meet IPH Standards and offer 24X7 services including safe delivery. The RKS would develop annual plans to reach the IPH standards.*

Time line*
In the first six months since the launch of the mission, following work should have been completed:

- Selection of and 2 CHCs in each State for upgradation to IPHS
- Release of funds for upgradation of two CHCs per district to IPHS
- 2 ANM Sub Health Centres strengthened/ established to provide service guarantees as per IPHS, in 1,75000 places- 30% by 2007, 60% by 2009 and 100% by 2010
- 30,000 PHCs strengthened/established with 3 Staff Nurses to provide service guarantees as per IPHS - 30% by 2007, 60% by 2009 and 100% by 2010
- 6500 CHCs strengthened/established with 7 Specialists and 9 Staff Nurses to provide service guarantees as per IPHS - 30% by 2007, 50% by 2009 and 100% by 2012

Source of Information:
1) Framework for Implementation (*) http:// mohfw.nic .in/NRHM/Documents/NRHM%20-%20Framework %20for%20Implementation.pdf

2) IPHS for CHC (#) - http://mohfw.nic. in/NRHM/ Documents/Draft_CHC.pdf

For more Information go to:
Link given on Ministry of Health and Family Welfare website: http://mohfw.nic.in/NRHM/iphs.htm

Charter of Citizen's Health Rights

Charter of Citizen's Health Rights seeks to provide a framework which enables citizens to know.

- What services are available?
- The quality of services they are entitled to.

- The means through which complaints regarding denial or poor qualities of services will be addressed.#

A Charter of Citizen's Health Rights should be prominently displayed outside all District Hospitals, CHCs and PHCs. While IPHS makes the display mandatory for every CHC.*

The dissemination and display of charter is the responsibility of Health Monitoring and Planning Committee at that level. E.g. Block Health Monitoring and Planning Committee has the responsibility to ensure display of the charter at CHC.*

While the Charter would include the services to be given to the citizens and their rights in that regard, information regarding grants received, medicines and vaccines in stock etc. would also be exhibited. Similarly, the outcomes of various monitoring mechanisms would be displayed at the CHCs in a simple language for effective dissemination.*

The charter seeks to increase transparency that would help the community to better monitor the health services.*

Source of Information:
1) Framework for implementation(*) http://mohfw.nic.in/NRHM/Documents/NRHM%20-%20Framework%20for%20Implementation.pdf

2) IPHS for CHC(#)- http://mohfw.nic.in/NRHM/Documents /Draft_CHC.pdf

For more information go to:
Link given on Ministry of Health and Family Welfare website: http://mohfw.nic.in/NRHM/iphs.htm

Concrete Service Guarantees

Concrete Service Guarantees that NRHM provide are the benchmarks against which mission functioning can be monitored and its success can be measured. These guarantees are as follows:

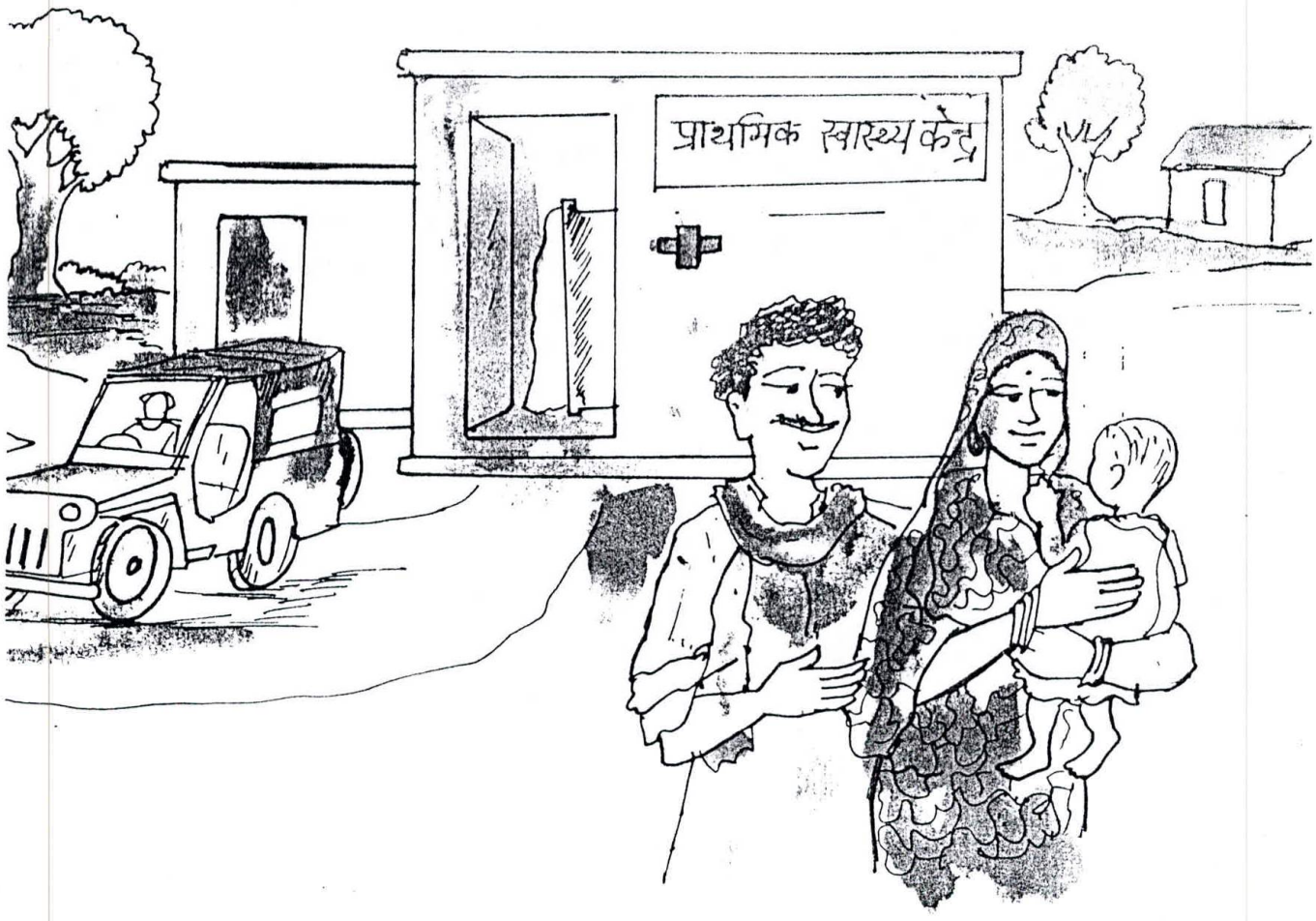
- Skilled attendance at all Births
- Emergency Obstetric care
- Basic neonatal care for new born
- Full coverage of services related to childhood diseases/health conditions
- Full coverage of services related to maternal diseases/health conditions
- Full coverage of services related to low vision and blindness due to refractive errors and cataract.
- Full coverage for curative and restorative services related to leprosy
- Full coverage of diagnostic and treatment services for tuberculosis
- Full coverage of preventive, diagnostic and treatment services for vector borne diseases
- Full coverage for minor injuries/illness (all problems manageable as part of standard outpatient care upto CHC level)
- Full coverage of services inpatient treatment of childhood diseases/health conditions
- Full coverage of services inpatient treatment of maternal diseases/health conditions including safe abortion care (free for 50% user charges from APL)
- Full coverage of services for Blindness, life style diseases, hypertension etc.
- Full coverage for providing secondary care services at Sub-district and District Hospital
- Full coverage for meeting unmet needs and spacing and permanent family planning services
- Full coverage of diagnostic and treatment services for RI/STI and counseling for HIV–AIDS services for adolescents
- Health education and preventive health measures

Time Line:
SHCs/PHCs/CHCs/Sub Divisional Hospitals/ District Hospitals fully equipped to develop intra health sector convergence, coordination and service guarantees for family welfare, vector borne disease programmes, TB, HIV/AIDS, etc.-30% by 2007, 50% by 2008, 70% by 2009 and 100% by 2012

Institution-wise assessment of performance against assured service guarantees carried out-30% by 2008, 60% by 2009 and 100% by 2010.

Source of Information:
Framework for Implementation http://mohfw.nic.in /NRHM/Documents/NRHM%20-%20Framework %20for%20Implementation.pdf

For more information on:
Institution wise service guarantees go to Annex–III of Framework for Implementation.



250

Annexure

Model Citizens Charter for CHCs and PHCs

1. Preamble

Community Health Centres and Primary Health Centres exist to provide health care to every citizen of India within the allocated resources and available facilities. The Charter seeks to provide a framework which enables citizens to know.

- what services are available?
- the quality of services they are entitled to.
- the means through which complaints regarding denial or poor qualities of services will be addressed.

2. Objectives

- to make available medical treatment and the related facilities for citizens.
- to provide appropriate advice, treatment and support that would help to cure the ailment to the extent medically possible.
- to ensure that treatment is best on well considered judgment, is timely and comprehensive and with the consent of the citizen being treated.
- to ensure you just awareness of the nature of the ailment, progress of treatment, duration of treatment and impact on their health and lives, and
- to redress any grievances in this regard.

3. Commitments of the Charter

- to provide access to available facilities without discrimination.
- to provide emergency care, if needed on reaching the CHC/PHC.
- to provide adequate number of notice boards detailing the location of all the facilities.
- to provide written information on diagnosis, treatment being administered.
- to record complaints and designate appropriate officer, who will respond at an appointed time, that may be same day in case of inpatients and the next day in case of out patients.

4. Component of service at CHCs

- access to CHCs and professional medical care to all.
- making provision for emergency care after main treatment hour whenever needed.

- informing users about available facilities, costs involved and requirements expected of them with regard to the treatment in clear and simple terms.
- informing users of equipment out of order.
- ensuring that users can seek clarifications and assistance in making use of medical treatment and CHC facility.
- informing users about procedures for reporting in-efficiencies in services or nonavailability of facilities.

5. Grievance redressal

- grievances that citizens have will be recorded.
- there will be a designated officer to respond to the request deemed urgent by the person recording the grievance.
- aggrieved user after his/her complaint recorded would be allowed to seek a second opinion within the CHC.
- to have a public grievance committee outside the CHC to deal with the grievances that are not resolved within the CHC.

6. Responsibilities of the users

- users of CHC would attempt to understand the commitments made in the charter.
- user would not insist on service above the standard set in the charter because it could negatively affect the provision of the minimum acceptable level of service to another user.
- instruction of the CHC's personnel would be followed sincerely, and
- in case of grievances, the redressal mechanism machinery would be addressed by users without delay.

7. Performance audit and review of the charter

- performance audit may be conducted through a peer review every two or three years after covering the areas where the standards have been specified.

252

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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

254

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.[1]

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.)

'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[2]

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.[3]

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

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

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

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

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

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

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

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

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 heath 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[4]

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.[5]

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

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* (CESR) 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.[6] 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".[7]

For further information, see 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

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

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

Case study 10.5.3

The American-based *International Anti-Povery 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

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

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."[8] 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

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.[9]

For more information see 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, inter-disciplinary 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/

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.[10] 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.[11] 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".[12]

For further information, see 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

Case study 10.7.2

In 1998, the *Latin American and Caribbean Committee for the Defense of Women's Rights (Comité de Amércia 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[sic] 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 and 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
The Peoples Charter for Health is available at 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.
To order a CD-Rom version, email 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:

'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'.[14]

- 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.

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

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

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.

'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[15]

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.)

Case study 10.9.1

In Argentina, a domestic legal suit (*amparo*[16]) 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

969

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".[17] 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.[18]

For further information, see 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,"[19] 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."[20]

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."[21] 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 pregannt 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

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[22] 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.[23] 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 People's Rights, including the right to enjoy the best attainable standard of physical and mental health.[24]

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

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 onYamin 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 byNGOs 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.

THE ASSESSMENT OF THE RIGHT TO HEALTH AND HEALTH CARE AT THE COUNTRY LEVEL

A People's Health Movement Guide

October 2006

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1. Introduction

The People's Health Movement (PHM) **Right to Health and Health Care** Campaign (RTHHC) is designed to focus national and international attention on how the right to health and health care can be implemented worldwide with a relatively small shift of resources. Using this guide to evaluate the status of this right in your country can be the first step in the Campaign.

[**Note:** Bolded words and phrases are defined in the Glossary in Annex IV].

The RTHHC centers on the right to health care because PHM has been a leader in the promotion of the **Primary Health Care Strategy** as the best strategy to acheive health for all. However, each country participating in the campaign may also look at any other health issues using the framework of the guide. The RTHHC will denounce any documented violations of the right to health, including those related to the **social determinants of health**. Once your country assessment is finished, it can be used in different ways, depending on the situation in your country, in addition to following the RTHHC process as set out in the campaign proposal (See it at www.phmovement.org).

The main focus of this assessment is on **government** responsibilities. By answering a series of five main questions you will be able to demonstrate how your government is fulfilling (or not fulfilling) its committments to promote the wellbeing of its people. You will then develop **policy demands** that will be presented at the national and international levels during the latter stages of the campaign. You can also choose to hold non-state actors (such as corporations, or non-governmental organizations) accountable for their role in violations to the right to health. In that sense, this assessment guide and the RTHHC provide the opportunity for claim-holders and civil society actors to work together to challenge the private exploitation of the health sector.

1.1. Who can use this guide?

This assessment tool is designed for PHM national circles, **NGO**s, health organizations and **human rights** organizations that will be participating in the PHM Campaign. The **assessment** process should be used to attract as many people from diverse groups to the RTHHC. Its purpose is to get a country diagnosis of how the right to health and health care is being upheld for poor and marginalized populations. The results will be used to lobby governments for corrective actions. For PHM, the purpose is to get an overview of the status of the right to health and health care in about forty countries in five continents. This information will also serve to generate support at the international level, and at WHO, to more actively advocate for the health rights of the underserved.

2. Analysing the denial of the right to health and health care

2.1. What is meant by denial of the Right to Health?

There is an existing body of **international covenants** and **consensus documents** which mandates the **Right to Health** for all. Most country **governments** have committed themselves, to varying degrees, to implement the Right to Health, including the right to health and health care, by signing certain of these international covenants. Many national constitutions also recognise the Right to Health and mention the obligation of the state to provide health care and public health services.

The non-fulfillment of these **state obligations** may be considered a denial of the Right to Health. To demonstrate this denial, essentially you have to do two things:

1. Examine the national level obligations of your government related to the Right to Health in detail.[1]
2. Examine whether all these obligations are being carried out and, if not, determine what characteristics this denial has in your country.

On the basis of this analysis, you can make recommendations for improvements that will lead to a better implementation of people's health rights.

2.2. How can you assess the denial of the right to health?

By following this assessment guide, you will be undertaking a five step process to document most aspects of the denial of the **Right to Health** in your country. Moreover, you will be proposing ways of improving the realization of this right for all.

The five key questions this assessment asks are:

I. What are your **government**'s commitments?
II. Are your government's policies appropriate to fulfill these **obligations**?
III. Is the health system of your country adequately implementing interventions to realize the right to health and health care for all?
IV. Does the **health** status of different social groups and the population as a whole reflect a progression in their right to health and health care?
V. What does the denial or fulfillment of the Right to Health in your country mean in practice?

These questions lead to the five steps we suggest you follow in applying this guide.

2.3. What do the five steps assess?

STEP I. What are your government's commitments?

[1] In case your government has not signed a major treaty or covenant, you can still judge the obligations against widely accepted international norms.

Government commitments are the standards you can hold your government accountable for. Only if your government made a committment under national or international law can you hold the government legally responsible for the impact its policies have on the Right to Health.

You will list the major commitments made by your government concerning the right to health and health care based on it having signed these international covenants. You will also examine provisions in your constitution, your national laws and **policy** agendas. In the case that your government has not signed a particular covenant, this too needs to be noted.

The right to health and health care is closely related to and dependent upon the realization of other **human rights**. Other rights affected are the rights to life, to food, to housing, to privacy, to work, to access to information, to education, to freely associate and assemble, to human dignity, to equal treatment, to non-**discrimination**.[2]

STEP II. Are your government's policies appropriate to fulfill these obligations?

You will examine major **health**-related policies and programmes to determine whether they are adequate to fulfill the right to health and health care committments your **government** has made. This will include looking at budgetary allocations at national and provincial levels. Special attention must be given to trends over time (the past 5 to 10 years) to assess whether **health** policies have been changed due to 'reforms' that may have increased health rights **violations**.[3]

The influence of larger political and economic factors (e.g., structural adjustment) and the role of external agencies (such as the World Bank) should be analysed in relation to the evolution of health policies. Decisions by the WB can and do have an important impact on **human rights**. Fragmentation into national **vertical programmes**, often promoted by different donor agencies, should also be noted.

STEP III. Is the health system of your country adequately implementing interventions to realize the right to health and health care for all?

You will look at the actual structure and functioning of the **health** system in your country. to evaluate:
- **Availability** of health facilities and hospital beds per capita (urban and rural); availability of doctors, nurses and other health personnel especially in rural areas; availability of medicines and medical supplies, and other parameters you may add.
- **Access** to immunisation programmes and perinatal care, average health care expenditure per household and other good **indicators** of access.
- **Acceptability**, **appropriateness** and **accountability** of health services by assessing aspects like decentralisation, **participation** in decision-making, mechanisms for accountability to the community, provision of relevant information and other as relevant.

In a separate section, you will look specifically at the **private health sector** -- particularly the mechanisms for its regulation (if any)-- and at the pharmaceutical industry, including price control mechanisms.

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[2] Based on: ICESCR General Comment 14, paragraphs 3 and 8

[3] Violation is a concept that clarifies the ways in which the government and other actors fail to address people's rights. Violations can occur through an action, or through failure to act. [Based on ICESCR General Comment 14, paragraphs 48-49, and Maastricht guidelines on violations of ESC Rights, paragraphs 14 and 15].

Moving beyond averages, you will investigate **health care inequities**. By comparing health care **availability** and **access** for the more privileged versus the less privileged segments of society, you will assess to what extent the less privileged are being denied improved conditions that are attainable with existing national resources. You will also be looking at the provision of health care for vulnerable groups and groups with special needs -- those whose health rights are most likely to be violated.

STEP IV. Does the health status of different social groups and the population as a whole reflect a progression in their right to health and health care?

Here, you will look at the ultimate impact the health system, and at how several of **the social determinants of health** are being addressed. More specifically, you will review major health indices and other indicators, which will tell you to what extent the right to health and health care of various social groups is being respected and fulfilled. Health inequities will be assessed by comparing health status indicators for the more privileged with those of the less privileged.

The presentation of specific case studies can provide real-life examples of how individuals have suffered a denial of health care due to existing policies and/or their ineffective implementation (Optional).

STEP V. What does the denial or fulfillment of the Right to Health in your country mean in practice?

The final step is to systematically contrast the **obligations** outlined in Step I with the realities documented in Steps II, III and IV, and briefly highlight the main areas of denial of health rights in your country. Looking at recent trends will help assess whether the country is moving forward or backward in the realization of this right. You will be judging whether your **government** is doing all it is capable of to realize the **Right to Health**, and if its efforts are inadequate, in the light of its existing capacity.[4]

Lack of capacity in itself is no justification for bad or non-existent **health** policies. The government can take many measures that do not require extensive resources. Even in times of severe resource constraints, the government has to protect vulnerable groups through targeted programmes.[5] Governments can (and if necessary, should) expand their capacity by seeking international assistance.[6] Lack of resources is sometimes the result of lack of priority, when governments spend large amounts on issues other than health, such as military expenditures, or when they fail to implement reasonable taxation policies.

[4] Note there may be a difference between what the government wanted to achieve and the effect a policy has had in practice, i.e., a different effect than foreseen or no effect at all.
[5] ICESCR General Comment 14, paragraph 18.
[6] ICESCR article 2 and General Comment 14, paragraph 38.

2.4. Before you start

Please keep the following in mind while carrying out the assessment.

Time: A full assessment may take one to two months and provides comprehensive **human rights lobbying** arguments. The data collection is the most time consuming part of the process. Sound lobbying arguments need to be based on facts and not all the required information will be readily available.

Selectiveness: You need to answer only the questions you find relevant for your own assessment. Questions that have little or no relevance to your country's situation should be skipped. You can also be selective in the level of detail. Only go into detail if you expect that the information will be necessary for your analysis or lobbying. At some points you may want to add questions that are specific to your situation.

Preparation: First, read through all the annexes for necessary background information. Then go through the steps without answering the questions to get an idea of the information you will need to collect. Also, check if there are any existing reports on the human rights implications of the health system you can build upon. Make a work plan to help organize the process you will follow.

You will need to involve people from within your organization and from other organizations to help with data collection and to discuss the findings. The more people from different sectors of the country are involved, the more credibility your report will have. More people involved also means more lobbying power.

Finding the information: You may find relevant information to answer this assessment's questions in: **government policy** documents/websites, websites of **human rights** organizations and **health** organizations (see annex iii on sources and resources), interviews with the people involved, and government and **NGO** reports to United Nations (UN) bodies.

A final note: The government cannot be blamed for each individual health problem. After all, the **Right to Health** does not mean that people have the right to be healthy. However, you can hold your government accountable for what it does or does not do to prevent and reduce health problems.

3. The Assessment Guide

Chapter 3 outlined the main purpose of each step. The following section provides suggestions for more specific questions to answer or issues to consider.

STEP I. What are your government's commitments?

International treaties signed by a **government** and/or **ratified** by its legislature are as legally binding as any law. The commitments your government has made by ratifying human rights treaties often require changes at the national level. For instance, it must recognize the right to health and health care in its political and legal system.[7] It has to abandon any laws or measures that have a discriminatory impact. Inclusion of the provisions of a **treaty** in national legislation makes it easier for people to claim their rights.

Look in Annex III for references on treaties, consensus documents, and other agreements your governement may have signed.

MAIN AREAS TO ASSESS	RELEVANT ISSUES TO EXPLORE
What international covenants, treaties, and consensus documents has your government ratified/signed-on to?	• Which treaties has your country **ratified**? First consider the major international treaties (**ICESCR, CEDAW** and **CRC**) and regional treaties. • Has your country expressed any **reservations** or **limitations** on those? (You can find information on treaties and **ratification** on the websites of the **UNHCHR**, www.ohchr.org/english/law/index.htm, and the Human Rights Library of the University of Minnesota, www.umn.edu/humanrts/treaties.htm.) • Which consensus documents has your country signed? Millennium Development Goals (**MDGs**), **Beijing Platform for Action**, International Conference on Population and Development (**ICPD**), others. • Also consider other bilateral or multilateral agreements that may influence **policy**. For example, free trade agreements allowing international companies to compete with local industry (e.g., the **GATS**), agreements with the World Trade Organization (**WTO**), the World Bank (**PRSPs**) or other funding institutions.

[7] ICESCR General Comment 14, paragraphs 34-36 and 60.

National constitution, laws and policy goals.

International Covenant on Economic, Social and Cultural Rights (ICESCR) Article 12: *"The state parties to the present covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health"*

ICESCR General Comment 14 specifies the desirability of a national legislation on Right to health: *"56. States should consider adopting a framework law to operationalise their Right to Health in their national strategy. The framework law should establish national mechanisms for monitoring the implementation of national health strategies and plans of action."*

GC 14 also stipulates: *"The obligation to fulfil requires State parties, inter alia, to give sufficient recognition to the Right to Health in the national political and legal systems, preferably by way of legislative implementation". "...and to adopt a national health policy with a detailed plan for realizing the Right to Health".*

"States must ensure provision of health care... including immunization programmes against the major infectious diseases, and ensure equal access for all to the underlying determinants of health, such as nutritiously safe food and potable drinking water, basic sanitation and adequate housing and living conditions."
"Public health infrastructures should provide for sexual and reproductive health services, including safe motherhood, particularly in rural areas."

- Does the constitution or any relevant law commit the **government** to provide **health** services for the population?
- Are there any specific constitutional or legal provisions applicable against which one can assess the right to health and health care?
- Do official documents recognize the basic concept of comprehensive and universal **primary health care**? Are they in any way committed to "Health for All"? Do they refer to the **Alma Ata Declaration** of 1978?
- Are there specific commitments related to women's health and nondiscrimination concerning women? Commitments related to children's health? To other vulnerable groups such as disabled people, people living with AIDS, refugees, migrants, adolescents, ethnic minorities, male and female sex workers, incarcerated men and women, and mentally ill people?
- Do official documents speak of the need for the **availability** of essential drugs and the need of price controls for drugs?
- Do policies place targets regarding public health investment as percentage of the **GDP**? [8]
- Do policies mandate equitable distribution of resources to all segments of the population (e.g., urban-rural, different geographical areas, different ethnic groups)?

Step 1 Conclusion

Summarise your government's current **obligations** regarding the **Right to Health** and Health Care.

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[8] For example:

- Countries to raise the level of tax revenue to at least 20% of their GDP;
- Public health expenditure (including government and donor financing) to be at least 5% of the GDP;
- Government expenditures on health to be at least 15% of total government expenditures;
- Direct out-of-pocket payments to be less than 20% of total health care expenditures;
- Expenditures on district health services (up to and including level 1 hospital services) to be at least 50% of total public health expenditures --of which half (25% of total) is to be spent on primary level health care;
- Expenditures on district health services (up to and including level 1 hospital services) to be at last 40% of total public and private health expenditures;
- The ratio of total expenditures on district health services in the highest spending district over that of the lowest spending district to be no more than 1.5.

These indicators would complement service output and outcome indicators such as immunization coverage, rates of skilled attendance of deliveries, completed TB treatment rates and maternal, peri-natal and child mortality rates. [Global Health Watch 2005-2006, p.85].

STEP II. Are your government's policies appropriate to fulfill these obligations?

In addition to what is explained in Section 2 under this step, consider answering the following:

MAIN AREAS TO ASSESS	RELEVANT ISSUES TO EXPLORE
Which are the main policies and programmes that guide the health system in your country?	Checklist: • Five-year national **health policy** or plan, • **Reproductive** health policy and/or family planning policy, • Women's health policy, • Policies targeting AIDS, tuberculosis, mental health or other conditions, • Drug policy including (or not) essential medicines price controls, • Programmes to provide health care to the poor, • Other. Pay specific attention to what policies and programmes say regarding: • **Primary health care**; • Services to remote areas; • Village health workers; • Decentralization; • Privatization. What external factors have influenced these policies (e.g., debt, war, the impact of HIV/AIDs, other)? Are there any programs that already prioritize vulnerable groups for services? What are these groups and in what way are they targeted?

Step II continued

Who participates or participated in the development and implementation of health policies and programmes?	What are the perceptions of affected groups regarding their major health problems and how they relate to the main national health policies? Have they received adequate information? [Rather than just talking about people, it is a good idea to talk with them and find out their views]. Checklist of **participation**: • village/community committees, • voting in elections and referenda (local, regional and national), • patients' associations and volunteer organizations, • **government-NGO** partnerships, • any consultation in the development, monitoring and evaluation stages of policy, • representative committees that monitor the implementation of services, • oral and written reports to international organizations and to national and international conferences. • government advisory bodies Where can people go to make a complaint (mechanisms for redress)? Are these mechanisms being used? Do these mechanisms effectively redress problems?
What are the main changes taking place in your health system that concern you as public health-oriented advocates?	Checklist of areas of concern: • Health sector reform (Have 'reforms' involving reduced public subsidies or 'cost-effective measures' –based on **policy** prescriptions by international institutions – been implemented in some form in the country?). • Privatisation (Have any public **health** services been privatised? If so, these should be listed and the impact of this privatisation on **access** to health services should be documented). • **Participation** in decision-making (Understood as the involvement of the beneficiaries in all health-related decision-making, as well as in the development, implementation and monitoring of policies, plans and strategies). • User fees. • The dismantling of **primary health care** programmes. • National **vertical programmes** • Population control and Family Planning. • Women's health and **reproductive** health policies. • Pharmaceutical and drug policies. • Other.

What is the budget allocated to health? How is health care financed? A change in the health budget caused by a shift in allocations within the total national budget indicates a change in priority. A decrease in the total budget makes it more difficult to improve health rights. However, it does not relieve the **government** of its responsibility to at least protect 'vulnerable' members of society.	What is the government expenditure on health as percentage of GDP? What is the overall (public and private) per capita spending on health care? (See footnote 9) What is the percentage of government spending as a proportion of the total expenditure on health care? Has this percentage been falling? Does the health care system function to transfer money from taxpayers and patients to private enterprises? What is the government per capita spending in rural areas compared to urban areas? (In 2000, the World Health Organization estimated that $60 per person per year was needed for reasonable health care.) How does the above compare with other countries with the same level of development? Is the budget for health decreasing or increasing, i.e., has government spending in the health sector diminished in relative or absolute terms? If so, can you quantify the cuts made in the budget? As a result, do fixed expenditures (especially salaries) now tend to take up a larger part of total expenditures? Can you quantify this in percentage? Which areas have been most affected by budget cutbacks or by increased investments, e.g. infrastructure, salaries, medical supplies, rural health services, **secondary & tertiary health care**? Are expenditure patterns on health care skewed in favour of urban areas? Have investments correspondingly fallen in rural health services? Are there significant public-private inequalities in health expenditure and coverage?
What kind of health staff is available? Is it sufficient? ***ICESCR, GC 14:*** "States have to ensure the appropriate training of doctors and other medical personnel, the provision of a sufficient number of hospitals, clinics and other health-related facilities, and…the establishment of institutions providing counselling and mental health services, with due regard to equitable distribution throughout the country."	A functioning health system requires sufficient staff that is well trained, **gender** sensitive and motivated. Checklist of staffing issues: • Ratio of doctors to population in rural areas compared to urban, • **Availability** of staff in different regions (particularly minority areas), • Representation of different ethnic, religious and cultural groups among staff. • Balance between female and male staff, especially in decision-making positions, • Number and **quality** of staff available for special sectors of the health system, e.g., the private sector or foreign-funded programmes, • Emigration of health staff, • Is the training of health staff adequate for the needs of the country?

Step II continued

Have public health services been privatized?	Have **health** programmes suffered due to reduced funding or privatization? If so, this change should be quantified to the extent possible. Are health services sub-contracted to profit making companies or to **NGO**'s? What are the largest for-profit health-related corporations in your country? Does the government provide incentives, tax holidays and subsidies to the private sector (including the private pharmaceutical and the medical equipment industry)? More about this is found in step III.
To what extent do other international actors expand or limit the capacity of the government to implement health programmes?	Look at the positive and negative influences of technical and financial assistance on the right to health and health care. What are the priorities of those other actors? (Donor countries are usually more willing to fund activities that correspond to their priorities). Checklist international actors: • other governments, • international donors • International agencies such as the World Bank, IMF, WTO, UNDP, EU, WHO. ILO, UNICEF, UNFPA, • transnational and multinational corporations.

Step II Conclusion:
Summarise the appropriateness or inappropriateness of the government's health sector policies and programmes in relation to the right to health and health care.

Step III. Is the health system of your country adequately implementing interventions to realize the right to health and health care for all?

In addition to what is said in Section 2 under this step, consider answering the following:

MAIN AREAS TO ASSESS	RELEVANT ISSUES TO EXPLORE
What is the situation regarding the *availability* of relevant health services, goods and facilities? What does the government do to insure *availability*? What are the trends in *availability*, especially for marginalized groups? **ICESCR General Comment 14, paragraph 12**: *"Functioning public health and health-care facilities, goods and services, as well as programmes, must be available in sufficient quantity in the country".*	Checklist of **indicators** of **availability**: • Services are functioning, • They are available in sufficient quantity throughout the country, • The inputs needed for adequate functioning exist at health care delivery points (water, sanitation, buildings, personnel, drugs, workplace environment), • The **availability** of appropriate mental health and HIV and AIDS treatment and care, • The **availability** of emergency medical care for accidents and disasters, • Programmes that discourage the use of alcohol, tobacco, drugs and other harmful substances. Checklist of vulnerable or marginalized groups: • Girls, adolescent and older women; • Refugees, internally displaced people and migrants; • Ethnic minorities and indigenous populations; • Sex workers; • People with physical or mental disabilities; • People living with HIV/AIDS; • Incarcerated men and women. • Other, as relevant in your country.
What does the government do to guarantee the *quality* of services? **ICESCR General Comment 14, paragraph 12d**: *"Health facilities, goods and services must be scientifically, as well as medically appropriate and of good quality. This requires, among other, skilled medical personnel, approved and unexpired drugs and hospital equipment, safe and potable water and adequate sanitation".*	Checklist of **indicators** of **quality**: • **Government** licenture or certification of **health** personnel requires demonstration of minimum skills consistent with international standards, • The drugs, equipment, buildings and sanitation in health facilities are scientifically and medically appropriate, • The government promotes international standards of care for mental health and HIV/AIDS services, • Measures are taken to discourage irrational use of drugs and of inappropriate technologies.

Step III continued

What does the government do to guarantee access to health care services, goods and facilities? What have been the trends in this respect? ICESCR General Comment 14, paragraph 12b: "Health facilities, goods and services must be accessible to everyone without discrimination, within the jurisdiction of the State party"	Vulnerable and marginalized groups are particularly important to consider. Access includes physical access, economic access (affordability) and information access. Checklist of indicators of physical access: • Existence of services at community level (distance or travel time to services), • Access to buildings for persons with disabilities, • A safe and supportive environment for youth, • Barriers which the poor face to access health facilities such as high fees for services, absence of convenient and affordable public transport, • Opening hours. Checklist of indicators of economic access: • Average percentage of household income spent on health, • Proportion of household income spent on health by the poorest 25% of the population (or any other indicator of equity of access), • Free services (where called-for) for safe pregnancy, childbirth and post-partum care, • Sufficient funds are available to run health care facilities, • Health insurance and health care for the poor, • Prices of drugs: Have there been substantial increases? Does the government subsidize them?
Has *privatization* affected the availability and access of health services for the poor and marginalized groups?	See the checklist on vulnerable and marginalised groups above. Consider mechanisms to regulate the actions of the private sector, the application of user fees, economic barriers to hospitalization.
Legal precedents	Have there been any court cases concerning the right to health and health care, i.e., where your government or other actors have been taken to court over health issues? Document these cases.

What does the government do to guarantee the *acceptability* of health care services, goods and facilities?

CEDAW General Recommendation 24, paragraphs 12 and 22: 12. *States parties should report on their understanding of how policies and measures on health care address the health rights of women from the perspective of women's needs and interests and how it addresses distinctive features and factors which differ for women in comparison to men, such as:*

(a) Biological factors which differ for women in comparison with men;
(b) Socio-economic factors that vary for women in general and some groups of women in particular. For example, for women and men in the home and workplace, for different forms of violence for the girll child and adolescent girl Some cultural or traditional practices such as female genital mutilation also carry a high risk of death and disability;
(c) Psychosocial factors which vary between women and men including depression, as well as conditions that lead to eating disorders;
(d) Lack of confidentiality affects women detering them from seeking treatment. Women are less willing to seek medical care for diseases of the genital tract, for contraception, for incomplete abortion and in cases where they have suffered sexual or physical violence

22. States parties should also report on measures taken to making health care more acceptable to women, e.g., seeking their informed consent, respecting their dignity and, guaranteeing confidentiality. States parties should not permit forms of coercion, such as non-consensual sterilization, mandatory testing for sexually transmitted diseases or mandatory pregnancy testing as a condition of employment.

Do the services and goods correspond to users' needs and expectations?

Checklist of **indicators** of **acceptability**:

- Respect for patients' dignity,
- Respect for confidentiality,
- Sensitivity to women's and minorities' special needs and perspectives,
- Respect for the culture of minorities and communities.

Step III Conclusion

Summarise the adequacy of the current **health** delivery system to achieve the right to health and health care.

Step IV. Does the health status of different social groups and the population as a whole reflect a progression in their right to health and health care?

In addition to what is said in Section 2 under this step, consider answering the following:

MAIN AREAS TO ASSESS	RELEVANT ISSUES TO EXPLORE
General health indicators	• Life expectancy by income quintile, • Main causes of death for adults, disaggregated for women and men, rural and urban areas
What is the government doing to remove barriers to the enjoyment of health rights of the poor, minorities, and marginalized groups?	• Measures taken to meet their specific health needs, • **Participation** of the groups concerned in decision making, • Measures taken to reduce the stigma of HIV/ AIDS, mental illness and and other medical conditions, • Measures taken to reduce marginalization of women heads of household, minority groups and the poor. • Examples of instances in which the right to health and health care was realized?
Health status of women **CRC Article 24, 2:** *(State Parties shall.take appropriate measures "(d) To ensure appropriate pre-natal and post-natal health care for mothers." "(f) To develop preventive health care, guidance for parents and family planning education and services."*	• Differences in under 5 mortality rates between girls and boys, • Maternal mortality rates, • Percentage of women that die in childbirth, • Percentage of births attended by medically trained personnel in rural areas, • Trends of these in the last 5-10 years, • Are family planning policies aiming at giving women informed choice or only at controlling population growth?

Health status of children **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 health 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."* *"(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 breastfeeding, hygiene and environmental sanitation and the prevention of accidents."*	• Infant mortality rates, disaggregated by sex and rural/urban areas, • How many avoidable/preventable child deaths per day? • Which are the major killers? • Immunization coverage rates, • Trends of these in the last 5-10 years.
Considering the above, is the current health system discriminatory? A policy violates the right to non-discrimination if it: • negatively affects some groups, but not others; • positively affects groups that were already advantaged (thereby widening the gap); • affects all groups equally, without taking into account significant differences between those groups; • reaffirms stereotypes, which maintain certain groups in an inferior position. A policy is considered <u>not</u> discriminatory if it has a positive effect on only disadvantaged groups, on the condition that it is a temporary special measure with the specific aim of reducing the gap between advantaged and disadvantaged groups.[9]	If yes, on which basis are people discriminated against? Checklist of grounds for discrimination: • sex and **gender**, • age, • race and ethnicity, • health status/disability, • sexual orientation, • language, • religion, • political or other viewpoint, • income, • national or social origin.

Step IV Conclusion

Summarise the **human rights** impact (negative or positive) of the health care system in your country on different vulnerable groups.

[9] HeRWAI, 2006, page 38

Step V. What does the denial or fulfillment of the Right to Health in your country mean in practice?

Here you will be looking at the fulfilment of relevant **State obligations**. The most relevant **core obligations** for the **Right to Health** are listed and defined below. A detailed explanation of the concepts of core obligations can be found in ANNEX II. You are asked to select the obligations which are most relevant to the present situation, and to explore the difference between what your **government** has promised to do (Step II) and what the government has actually achieved (Step IV). This difference provides strong arguments to improve the right to health and health care situation, and will help you to determine the **violations** for which you can hold your government accountable. Be aware that quantity is not a factor in determining if a violation has occurred. If discrimination takes place, it is a violation of human rights, regardless of the number of people who are discriminated against.

MAIN AREAS TO ASSESS	RELEVANT ISSUES TO EXPLORE
Which of the core obligations are not being fulfilled? **ICESCR General Comment 14** specifies certain Core obligations of States related to the Right to Health: *43. "States parties have a core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights enunciated in the Covenant, including essential primary health care."* *"(a) To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups;"* *"(d) To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs;"* *"(e) To ensure equitable distribution of all health facilities, goods and services;"* *"(f) To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process; they shall include 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 devised, as well as their content, shall give particular attention to all vulnerable or marginalized groups."*	**Core obligations** require your **government** to ensure, at the very least, minimum essential levels of: • **Access** to **health** facilities, goods, and services on a non-discriminatory basis, especially for vulnerable or marginalized groups, • Access to food, • Access to shelter, housing, water and sanitation, • Access to essential drugs. The following core obligations are of comparable priority: • **Reproductive**, maternal (pre-natal, as well as post-natal) and child health care; • Immunisation against major infectious diseases; • Measures to prevent, treat and control epidemic and endemic diseases; • Education and access to information concerning health; • Training for health personnel, including education on health and **human rights**. • Equitable distribution of all health facilities, goods and services; • A national public health strategy and plan of action. Are these ensured?

Is the government moving forwards towards a universal right to health and health care? **The Universal Declaration of Human Rights, Article 25**: *"Everyone has the right to a standard of living adequate for ... health and well-being of himself and his family, including food, clothing, housing, medical care and the right to security in the event of ... sickness, disability.... Motherhood and childhood are entitled to special care and assistance..."*	The obligation of **progressive realization** requires **governments** to do whatever they can to improve the health of their people. This means that if the government <u>can</u> achieve more, it has the obligation to do so. Can it? Is it?
Or, is the government failing to maintain its achievements regarding health rights?	The obligation of **non-retrogression** is applicable only if: • the deterioration is avoidable, • the **government** has not done all it can to prevent the deterioration, • the government has not asked for international assistance to address the problem, and/ or • the government has not protected vulnerable groups against the deterioration.
Which of the violations you found are a result of the government's failure to meet its obligations to respect, protect and fulfil health rights? **ICESCR GC 14**: *"52. Violations of the obligation to fulfill occur through the failure of States parties to take all necessary steps to ensure the realization of the Right to Health. Examples include the failure to adopt or implement a national health policy designed t o ensure the Right to Health for everyone; insufficient expenditure or misallocation of public resources which results in the non-enjoyment of the Right to Health by individuals or groups, particularly the vulnerable or marginalized; the failure to monitor the realization of the Right to Health at the national level, for example by identifying Right to Health indicators and benchmarks; the failure to take measures to reduce the inequitable distribution of health facilities, goods and services; the failure to adopt a gender-sensitive approach to health; and the failure to reduce infant and maternal mortality rates."*	The **government** fails to **respect** people's health rights if its policies reduce people's chances to enjoy good health. The government fails to **protect** people's health rights if its policies permit others to endanger people's health. The obligation to **fulfil** means that the government has to take positive measures that enable and assist people to enjoy their health rights. It is a good idea here to refer to the commitments you identified in Step II.

Step V continued

Which of its commitments is the government more specifically violating?	Refer to all commitments identified in Step I to respond to this question.
Who are the responsible duty-bearers for each major violation?	Which **government** agencies or departments are responsible for the denial or **violations** of people's health rights? Which individuals in the government? Which other national actor(s)? Do foreign governments or international actors have an influence on the violations?
Is lack of resources a major obstacle?	If yes: • Has the **government** used the resources it does have to the maximum extent? • Has the government attempted to obtain international technical and financial assistance? • Have other (donor) governments or international institutions extended the necessary assistance? • Document any examples of efforts to take steps that did not require additional resources. Base your answer on your findings in Step III.

Step V Conclusion

Summarise the denials/**violations** for which you can hold your **government** accountable.

4. What needs to be done to challenge the key elements of the denial of the Right to Health in your country?

In today's world the technical means exist to provide basic **health**-related services for all people. Even some developing countries with comparatively low per capita incomes have achieved significant progress towards securing the right to health and health care for all their citizens.

However, a range of political and economic factors, **policy** decisions, and gaps in implementation, lead to some denial of health rights in every country. In the final step of this guide you will compile the information you have gathered the form of recommendations to improve **government** health policy. You will then use these recommendations or demands to prepare your national action plan to realise the right to health and health care. Further on in the PHM campaign, all the countries which have gone through this process will meet to share their findings and plans, and decide on what international steps can and should be taken to support their common goals.

We suggest that the policy recommendations and action plan be developed in a participatory process that includes people who are usually left out of policy discussions. You will present the cases of violations of the right to health and health care you documented with this assessment tool. Participants will decide what changes should be made to stop these violations, and what should be done to bring about those changes. It is expected that each country will have different policy ideas and activist strategies that come out of that particular country context.

The final product of your work will include a summary of the findings of the assessment, the **policy** and action recommendations, and at least a draft action plan. As we share this work internationally, common problems and solutions will emerge. We will build a groundswell of understanding of and support for human rights as the basis for development. Backed by all those who have contributed to the RTHHC, PHM will then take those common demands to the pertinent international institutions.

4.1.Developing your policy recommendations

Having carried out this assessment, you have clearly identified **human rights** gaps in the area of health care in your country, and you have documented them with qualitative and quantitative data. Use the following questions to help you decide which **violation**s you will prioritize in the recommendations or demands.

- Can you confidently say there are repeated and continued violations of the right to health and health care?
- Which of the violations you document are of major concern in your country at this time?
- Can several of the specific violations you have documented be addressed by changes in one policy area?
- Do beneficiaries and **NGO**s you have worked with on the assessment share your findings? Are they willing to start mobilising to challenge relevant duty bearers?

For each of the violations you have identified in Step V, try to formulate a recommendation to bring the **government** into compliance with its health rights obligations. Consider the following in formulating the recommendations:

- **Policy stage:** The stage the respective policy is in may determine the type of solution or recommendation to be made and whom you need to approach.
- **Objectivity:** Try to be as realistic as possible. In many cases, no easy solution will be available. This does not release the government from its obligations. The recommendation you may choose might be to undertake further research into the causes of and possible solutions to a specific health problem identified.
- **Type and basis of your arguments:** Depending on who needs to be convinced, it may be strategic to use more legal, more medical or more political arguments.
- **Groups affected:** Try to find solutions that suit the groups most affected by the policy (or absence of it). It is best to involve the most affected groups in the development of your recommendations.
- **Ownership:** Whenever possible, you should involve the responsible policy-makers/duty bearers in the search for alternatives. This will increase their ownership of the suggestions and their chances for acceptance.
- **Preparedness:** In Step V, you identified the main obstacles to the government meeting its obligations. The government will probably refer to those obstacles when confronted with your findings. What will your counter-arguments be? Build your case in advance of such a dialogue.
- **Include benchmarks: Benchmarks** make it easier to monitor achievements. For each of your recommendations try to set benchmarks that will measure the impact of the policy changes. Preferably, these benchmarks should be related to those already set by the government, or proposed by WHO or other respected organization. If you are not able to formulate them yourself, you can also insist the government achieves its own benchmarks, adjusts them or sets new ones as needed.

If policy change is not the solution, what action should the government take? Be prepared to make such recommendations. Consider things such as: scrapping bad policies; setting up a compensation mechanism for affected groups; or the publication of regulations to control the actions of, for example, the private sector.

4.2. Questions to answer in preparing your action plan

To which government department or person should you direct your lobbying efforts?
To increase the chances that your recommendations are implemented, it is important to consider whom you are presenting the information to. The governmental level, role and competencies of the department or person will determine if they are able to actually make the changes you are demanding. Do they need authorization from a higher level? Have certain government responsibilities been delegated to the municipal or regional level? Should you aim your **lobbying** at those developing the **policy** or at those implementing or evaluating the policy? Are there procedures you must follow to get the attention of a particular department? Some governments or policy-makers are not aware of their **human rights** obligations. You may need to explain to them what their obligations are in relation to the **Right to Health**.

Which other governments, funding agencies or other actors should you approach to point out how their funding or actions should contribute to the the realization of the right to health and health care in your coutry?

These other actors may be able to put external pressure on governments or on private actors and may have an influence on the situation itself. When aiming your lobbying at these other actors keep in mind what their exact role/ mandate is and what they are most sensitive to.

What is the most strategic time to present your findings?
The response to this question requires some knowledge of the government's agenda or the agenda of other actors you may want to approach. What deadlines are involved in changing a given policy? A conference, a debate in parliament, a visit of a high-level official, etc. can all provide strategic entry points to present your findings. It may also help to coordinate your actions with the international level of the right to health and health care Campaign.

What options are available to you to increase pressure on the government?
It is a good idea to identify other things you can do, besides lobbying, to pressure the government, for example public interest litigation (i.e., suing the government for the **violation** of human rights), going public using the local press, or mobilizing the affected community(ies) for mass actions. Begin thinking about how the global PHM can support and endorse your demands.

When and how will you check whether changes have really led to an improvement of the right to health and health care?
This check is necessary, because even if the government accepts your recommendations, this does not mean that the desired results will be achieved. It is possible that the changes you suggested were not adequate to improve health rights, or that other factors hampered their successful implementation. Use the **benchmarks** you defined earlier to set up a monitoring plan in advance.

What awareness-raising activities should you use to inform the public about your findings and recommendations?
Lobbying the government should be accompanied by **advocacy** work, to make people aware of their health rights and how they are being violated. This can be done through the media, organizing a conference or workshop, producing and distributing a leaflet or video, etc. Disseminating your findings to other organizations with an interest in health rights is a good strategy to involve more people in the right to health and health care Campaign.

How much time and which resources (financial and in terms of skills) does your organization need to implement your action plan? Can these resources be made available?
Developing a time frame and a budget will help to make a realistic action plan and will be useful if you need to ask for outside assistance and funding. If you do not have experience with **lobbying**, share your findings with more experienced organizations and invite them to get involved in the Campaign.

5. Concluding remarks and contact information

Always keep in mind that this exercise on which you are embarking is part of a global effort to reverse the **violations** of the right to health and health care both in rich and poor countries.

We again recommend that you review the campaign proposal as posted at the PHM website (www.phmovement.org) under 'Right to Health'. This will help you understand the campaign in its entirety and to keep things in perspective,

At any time, you can seek further advice from others in the People's Health Movement.

- The PHM website: www.phmovement.org
- The PHM Global Secretariat: secretariat@phmovement.org
- The PHA Exchange listserve: pha-exchange@lists.kabissa.org
- The Right to Health and Health Care Campaign core group members are available to support you. We also welcome your feedback:

Saskia Bakker (Netherlands), s.baskker@hom.nl
Ariel Frisancho (Peru), afrisanchoarroyo@yahoo.es
Abhay Shukla (India,) abhayseema@vsnl.com
Cristianne Rocha (Brazil), cristianne.rocha@terra.com.br
Claudio Schuftan (Vietnam), claudio@hcmc.netnam.vn
Laura Turiano (USA), phm@turiano.org
[The names and email addresses of regional coordinators will be added at a later stage].
When you complete your assessment, we ask you to send a copy of your summary results and tentative action plans to the campaign core group at PHM: phm@turiano.org

Congratulations on your work with the right to health and health care Campaign. You will hear from the core group when we are ready to launch phase II of the campaign.

Annex I. CONCEPTS AND DEFINITIONS

What is the right to health and health care?

The right to health includes the availability, access, acceptability and quality of health care. Health is a fundamental right that influences all aspects of life, so it is important to look at health in a broad way. It is closely related to other human rights. Although we focus our analysis on the right to health, this does not mean it is considered more important than others are.

What is the principle of non-discrimination?

The principle of non-discrimination is a cornerstone of human rights. It means that all people have the same human rights even if they are different in some way from others. For example, discrimination based on sex is one common type of discrimination.[10] Women and men should have equal access to health care. However, non-discrimination does not mean treating everyone the same. Such an approach disadvantages women as a result of past discrimination. Women require different treatment from men due to biological factors, socio-economic factors, and psychosocial factors.[11]

States have important obligations with regard to discrimination:

- to eliminate not only their own discriminatory practices, but also those of individuals.
- to address direct as well as indirect discrimination. An example of an indirect discriminatory law is one that requires everyone to pay the same amount for health care, even though the cost is unaffordable for people without paid work, such as elderly widows.
- to implement temporary special measures (where necessary) to reverse the effects of past discrimination on particular groups.
- to take measures to ensure that women and men can, and do, participate in society on an equal basis, such as removing barriers which women face access their rights.

What is the principle of participation?

The participation of the general population in all health-related decision-making at the community, national and international levels is an important aspect of the right to health. Individuals and groups should be involved in making decisions about health policies.[12] They should also have an opportunity to make complaints about the negative effects of laws and policies. Because of traditional gender roles, women tend to participate less than men in political and public life.[13] Involving women in decision-making therefore requires specific attention by the government.

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[10] Universal Declaration of Human Rights, article 2; CEDAW article 1 and 2; ICESCR Articles 2 and 3, General Comment 16

[11] CEDAW article 1, ICESCR general comment 24, paragraph 12

[12] ICESCR general comment 14, paragraph 54, see also paragraph 11 and 17

[13] CEDAW general recommendation 19, paragraph 11

What is policy?

A policy is a plan of action. A policy can refer to a nationwide five-year health strategy or to decisions about a particular disease or region. The process by which policies are developed can involve local or national government, NGOs, or individuals. This assessment mostly concentrates on government policy. The government policy process follows a number of stages (at least in theory):

- Agenda-setting: the process by which problems come to the attention of government;
- Policy formulation: the process by which policy options are identified by government;
- Decision-making: the process by which the government adopts a certain course of action (or non-action);
- Policy implementation: the process by which the government puts the policy into effect;
- Policy evaluation: the process by which the results of policies are monitored both by the government and by civil society and which may lead to a new set of stages.

During the stages of agenda setting, policy formulation and evaluation, people's organizations may have a particularly strong role. In other stages participation may be more difficult.

What are health reforms, PRSPs, MDGs and how do they influence health policies?

Many countries throughout the world have introduced health sector reforms to control the costs of health services. These reforms have serious implications for the right to health.

A much-debated trend is the privatization of health related services, whereby the government allows and often stimulates the private sector to take over the provision of certain services (e.g., in health clinics) or goods (e.g., the distribution of contraceptives). In some countries, health sector reforms are the result of **Poverty Reduction Strategy Plans** (PRSP), which governments write to be eligible for loans from the IMF, the World Bank and other donors. PRSPs determine the direction of health policies and their budgets.

The **Millennium Development Goals** (MDGs) also have a considerable influence on health rights. This influence may be positive because the MDGs prompt governments to take action on many health related issues. But the MDGs may also have a negative effect if attention and resources are drawn away from important areas. For example, sexual and reproductive rights do not have a prominent place in the MDGs and may not receive necessary funding.

Similar discussions are taking place concerning the effects of the General Agreement on Trade in Services (**GATS**) and the Agreement on Trade-Related Aspects of Intellectual Property Rights (**TRIPS**) on the price of health services and drugs.

This right to health and health care assessment can show how these agreements impact the health rights of certain groups. In addition, the progress reports that countries make for the PRSPs, the MDGs, etc. may provide useful information for our analysis.

How does globalization effect a government's responsibility for the right to health and health care?

Governments' first responsibility regarding the right to health is at the national level. But in a globalized world, governments have a growing responsibility at the international level. First of all, a country's actions often have impacts beyond its national borders. Air and water pollution are clear examples of such influence. Secondly, governments help each other on a bilateral basis, such as through development cooperation. According to human rights treaties, governments have the obligation to support each other in implementing health rights. A third way in which governments have international influence is through multilateral institutions. Influential international institutions such as the World Bank are owned by the governments of member nations, which have ultimate decision-making power within the organization. Last but not least, governments monitor each other through international agreements. These may be bilateral or multilateral; legally binding, such as UN human rights treaties, or morally binding, such as the Miliennium Development Goals. It is clear that in a globalized world, decisions at the local, national and international levels influence each other.

Annex II WHAT ARE HUMAN RIGHTS?

Human rights are the rights possessed by all persons, by virtue of their common humanity. The first and most influential document describing human rights is the **Universal Declaration of Human Rights** of 1948. It is the predecessor of the major human rights treaties. The declaration recognizes the *inherent dignity and equality of all human beings*, the notion that lies at the heart of all human rights. Some other features of human rights are listed below:

- Human rights are fundamental, because individuals need them to survive, to develop and to contribute to society. They are the primary means for every person to develop their full potential.
- Human rights are not granted by governments or by international law. Every individual has human rights and is entitled to all of his or her human rights by virtue of being human.
- Human rights are inalienable. They cannot be taken away from a person or denied to a person by the State.
- Human rights are universal. This means that every human being is entitled to human rights, regardless of gender, race, age, ethnicity, citizenship, religion, disability or other status.
- Human rights are **indivisible**; they are closely connected. The realization of the right to health, for example, is closely connected to the realization of other human rights, such as the right to education, food and an adequate standard of living.

Women's rights are human rights

Even though all general human rights treaties include a provision on the equality of men and women, this has not proven sufficient to eliminate discrimination against women. The Convention on the Elimination of all forms of Discrimination Against Women (**CEDAW**) was developed to focus on the elimination of discrimination of women in a broad sense. By adopting this treaty in 1979, States recognized that special attention was needed to women's human rights. CEDAW clearly defines what discrimination against women means and what States should do to prevent it. 25 years after its adoption there is still a gap between respect for women's rights on paper and in practice: CEDAW provides a good basis to claim justice and equality for women throughout the world.

Why a human-rights approach?

Human rights treaties are the foundation of a **human-rights based approach**. States have the obligation to **respect, protect and fulfill** the human rights laid down in the treaties they have signed and **ratified**. Using the example of poor people's right to health and health care, this means that governments are not allowed to violate their health rights (the obligation to respect) and that they should restrain others – companies for example – from violating them (obligation to protect). Moreover, the government should do all it can to make sure that poor people achieve the highest attainable standard of health (obligation to fulfill). In other words, when speaking of human rights we do not speak of mere aspirations by States, or of the needs of those claiming their rights, but of obligations for governments. Keeping this in mind, it can be said that:

- A human rights based approach is based on the idea that every human being has rights. States are responsible for the realization of these. Citizens can hold the State accountable for its obligations to respect, protect and fulfill human rights.
- The basis of a human-rights approach is that a human rights violation needs to be addressed, even when the number of people involved is small or not precisely known. In other words, each human rights violation stands on alone and should be taken seriously. A decrease in numbers of a certain type of human rights violation is a positive development, but does not excuse other violations still taking place.

- A rights approach to poor people's health care means monitoring the way they enjoy, exercise and claim their health rights.

Why use international human rights treaties?

A human rights **treaty** (or **covenant** or **convention**) is a written document binding States under international law. All countries that have agreed to be bound by international human rights treaties through **ratification** or **accession** have a legal obligation to implement these rights and principles at the national level[14].

Human rights treaties lay down important principles. **CEDAW**, for example, states that women and men must have equal rights with regard to health care and -- at the same time -- that governments must examine the specific health needs of women. Committees of independent experts (**treaty-monitoring bodies**) monitor the implementation of a certain treaty. They study reports on the implementation of the treaty that States have to submit regularly. NGOs and PHM circles can provide important input to this process via so-called **shadow reports**. Some treaties offer the possibility for individuals to submit complaints to a treaty-monitoring body. Annex III on Sources and Resources provides links to the most relevant international and regional treaties.

[14] This is the main difference with consensus documents, such as the MDG's, the outcome documents of world conferences and the UN General Assembly resolutions, which entail a moral, but not legal, duty to implementation.

Annex III. SOURCES AND RESOURCES

Resources on lobbying and advocacy

Short guide on lobbying. Website of the Education and Training Unit, South Africa.
http://www.etu.org.za/toolbox/docs/organise/weblobby.htm
Short overview of the basics of lobbying. Website of the Democracy Center.
http://www.democracyctr.org/resources/lobbying.html
Online lobbying guide that can be downloaded. Website of the Independent Sector.
http://www.independentsector.org/programs/gr/lobbyguide.html
Good list of resources for advocacy, focus on ICDP Agenda. Website of the Asia-Pacific Alliance. http://www.asiapacificalliance.org/SITE_Default/Resources_for_Advocacy_Default.asp
Good list of general resources on advocacy. Organization focuses on HIV/AIDS.
http://www.aidsmap.com/en/docs/32364953-087A-45D3-AEED-E773BE45593D.asp
General tips on advocacy. Website of the Ugandan AIDS Advocacy network.
http://www.phrusa.org/campaigns/aids/uganda/toolkit/eightsteps_advocacy.php

Health indicators, data sources

PAHO gender differences in health and development in 48 countries in the Americas, focusing on women's reproductive health, access to key health services and major causes of death. http://www.paho.org/english/DPM/GPP/GH/GenderBrochure.pdf PAHO Country

Health Profiles.
http://www.paho.org/english/sha/profiles.htm UNDP Human Development Reports 1990-2005.
http://hdr.undp.org/reports/global/2005/ UNFPA Population and Reproductive Health

Country Profiles.
http://www.unfpa.org/profile UNFPA State of the World Report 2005.
http://www.unfpa.org/swp/2005/english/ch1/index.htm UN Statistics Division.
http://unstats.un.org/unsd/default.htm WHO Health indicators per country.
http://www.who.int/countries/en/ (also available in Spanish and French)

WHO World Statistical Information System.
http://www3.who.int/whosis/menu.cfm WORLD BANK

GenderStats; gender statistics and indicators.
http://devdata.worldbank.org/genderstats/home.asp

International treaties

CEDAW Convention on the Elimination of All Forms of Discrimination against Women.
http://www.un.org/womenwatch/daw/cedaw/index CEDAW the Optional Protocol.
http://www.un.org/womenwatch/daw/cedaw/protocol/text.htm
CEDAW General Recommendations. (see especially Recommendation 25 on health and 19 on violence against women)
http://www.un.org/womenwatch/daw/cedaw/recomm.htm
ICESCR International Covenant on Economic, Social and Cultural Rights.
http://www.ohchr.org/english/law/cescr.htm http://66.36.242.93/treaties/cescr.php
ICESCR General Comments. (see especially Comment 14 on health and 16 on equal rights for women and men)
http://www.ohchr.org/english/bodies/cescr/comments.htm
CERD International Convention on the Elimination of All Forms of Racial Discrimination.

http://www.unhchr.ch/html/menu3/b/d_icerd.htm
CRC Convention on the Rights of the Child.
http://www.unhchr.ch/html/menu3/b/k2crc.htm
CMC. Convention on the Protection of the Rights of All Migrant Workers
http://www.unhchr.ch/html/menu3/b/m_mwctoc.htm
UDHR Universal Declaration of Human Rights.
http://www.unhchr.ch/udhr/

Regional treaties and organizations

Africa
African Charter on Human and Peoples' Rights (1981).
http://www1.umn.edu/humanrts/instree/z1afchar.htm
Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa.
http://www.achpr.org/english/_info/women_en.html African Union. http://www.africa-union.org/home/Welcome.htm African Commission on Human Rights.
http://www.achpr.org/english/_info/index_women_en.html

Europe
European Convention on Human Rights (1950).
http://www.hri.org/docs/ECHR50.html European Social Charter (1961).
http://www1.umn.edu/humanrts/euro/z31escch.html
Council of Europe.
http://www.coe.int/t/e/Human_Rights/
European Court of Human Rights.
http://www.echr.coe.int/echr
EU and Gender Equality.
http://europa.eu.int/comm/employment_social/gender_equality/index_en.html
EU and Health.
http://europa.eu.int/comm/health/ph_overview/overview_en.htm
OSCE.
http://www.osce.org/odihr/13371.html

The Americas
American Convention on Human Rights (1969).
http://www.oas.org/juridico/english/Treaties/b-32.htm
Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (1988).
http://www.oas.org/juridico/english/Treaties/a-53.htm
Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women, 'Convention of Belem do Para' (1994).
http://www.oas.org/cim/English/Convention%20Violence%20Against%20Women.htm
Organization of American States.
http://www.oas.org/main/main.asp?sLang=E&sLink= http://www.oas.org/key_issues/eng Inter-American Commission.
http://www.cidh.org/basic.eng.htm Inter-American Court.
http://www.corteidh.or.cr/index_ing.html

Consensus documents

Beijing plus 5 and Beijing Platform for Action.
http://www.un.org/womenwatch/daw/followup/beijing+5.htm

Declaration of Alma Ata (1978).
http://www.phmovement.org/charter/almaata.html

Declaration of Commitment on HIV/AIDS, 'Global Crisis-Global Action' (2001).
http://www.un.org/ga/aids/coverage/FinalDeclarationHIVAIDS.html

Declaration on the Elimination of Violence against Women (1993).
http://www.unhchr.ch/huridocda/huridoca.nsf/(Symbol)/A.RES.48.104.En?Opendocument

Declaration on the Right to Development (Vienna Declaration and Programme of Action) (1993).
http://www.hri.ca/vien-na+5/vdpa.shtml

Declaration on the Rights of Disabled Persons (1975).
http://www.unhchr.ch/html/menu3/b/72.htm

ICPD Programme of Action (Cairo Programme of Action) Report of the International Conference on Population and Development (1994).
http://www.iisd.ca/linkages/Cairo/program/p00000.html

Maastricht Guidelines on Violations of Economic, Social and Cultural Rights, Maastricht, January 1997.
http://www1.umn.edu/humanrts/instree/Maastrichtguidelines_.html

Millennium Declaration (MDGs) (2000).
http://www.developmentgoals.org

People's Charter for Health.
http://www.phmovement.org/pdf/charter/phm-pch-english.pdf

Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (1991).
http://www.unhchr.ch/html/menu3/b/68.htm

Resources on treaties

ABA-CEELI. The CEDAW Assessment Tool: An Assessment Tool Based on the Convention to Eliminate All Forms of Discrimination against Women.
http://www.rightsconsortium.org/resources/assessment/CEDAWtool.pdf

Office of the United Nations High Commissioner for Human Rights.
www.ohchr.org/english/law/index.htm

Human Rights Library of the University of Minnesota.
www1.umn.edu/humanrts/treaties.htm

Treaty Body Database on the Implementation of CEDAW and Other UN Human Rights Conventions.
www.unhchr.ch/tbs/doc.nsf

Women's Human Rights Net provides information about women's human rights throughout the world. Also available in French and Spanish.
www.whrnet.org

Other documents of interest

OHCHR, Draft Guidelines: a Human Rights Approach to Poverty Reduction Strategies, 2002, CESCR. http://www.unhchr.ch/development/povertyfinal.html

WHO: 25 Questions and Answers on Health and Human Rights, WHO Health and Human Rights Publication Series, Issue No.1, 2002. http://www.who.int/hhr/activities/publications/en

Special Rapporteur on Violence against Women: Cultural Practices in the Family That Are Violent towards Women, Report of the Special Rapporteur, January 2002.
www.unhchr.ch/Huridocda/Huridoca.nsf/0/42e7191fae543562c1256ba7004e963c/$FILE/G0210428.pdf

Annex IV. GLOSSARY

Accession: When a State becomes party to a treaty after it has already been negotiated and signed by other States (generally when the treaty has already entered into force). It has the same legal effect as ratification. The conditions under which accession may occur and the procedure involved depend on the provisions of the treaty.[15]Also see Ratification.

Advocacy: A process aimed at influencing policy decisions and lawmaking at national and international levels. Actions designed to draw a community's attention to an issue and to direct policymakers to a solution.[16]Advocacy requires the existence of explicit mechanisms for the participation of organizations of civil society.

Availability requirement: Functioning public health and healthcare facilities, goods and services, and programs must be available in sufficient quantity within the State party.[17]

Access requirement: Health facilities, goods and services must be accessible to everyone without discrimination, within the jurisdiction of the State party.[18]It is of particular importance to consider the removal of barriers faced by vulnerable and marginalized groups. Access includes:

- Physical access: facilities within safe physical reach for all sections of the population, especially vulnerable or marginalized groups.
- Economic access (affordability): affordable for all, including socially disadvantaged groups. For example, poorer households should not be disproportionately burdened with health expenses as compared to richer households.
- Information access: the right to seek, receive, and impart information and ideas concerning health issues. Access of information should not impair the right to have personal health data treated with confidentiality.

Acceptability requirement: All health facilities, goods and services must maintain the standards of medical ethics, such as insuring the confidentiality of individual medical information, and actually improving the health status of those concerned. These services must also be culturally appropriate for the people being served. People's traditional healing practices and medicines must be treated respectfully.[19]

Important note: Acceptability may not be used as an excuse for practices that exclude (e.g. when reproductive health services and information are denied to adolescent girls 'to protect their honor'). Another limitation of the term acceptability is where traditional practices harm women's health rights (e.g. in the case of female genital mutilation). Such practices are considered discriminatory.

Quality requirement: Health facilities, goods and services must be scientifically as well as medically valid and of good quality. This requires, among other things, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.[20]

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15 http://untreaty.un.org/English/guide.asp#accession
16 Women, Law and Development International, 1997. page 163.
17 ICESCR general comment 14, paragraph 12.
18 ICESCR general comment 14, paragraph 12.
19 ICESCR general comment 14, paragraph 12.
20 ICESCR general comment 14, paragraph 12.

Beijing Platform for Action: Consensus document adopted by the 1995 Fourth World Conference on Women in Beijing, which reviews and reaffirms women's human rights in all aspects of life; signed by representatives at the Conference and morally but not legally binding. The Beijing Plus 5 document followed it, and its progress was reviewed after 10 years, during the 49$^{Th.}$ session of the Commission on the Status of Women (2005).[21]

Benchmark: Self-set goals or targets to be reached at some future date. National and international benchmarks are the framework for measuring progress in implementing the right to health and are normally used for assessing the effectiveness of policies and if progress has been made in all sections of the population.[22]

Bilateral: between two countries.

Cairo Program of Action: Outcome document of the International Conference on Population and Development, adopted by the United Nations in September 1994, in Cairo, Egypt.

Civil and Political Rights: The classical rights of citizens to liberty and equality. In principle, citizens should be able to exercise these rights without interference from the government. Civil and political rights include the right to life, to a fair trial, to free practice of religion, to think and express oneself, to vote, to take part in political life and to have access to information.[23]

Civil society: the voluntary civic and social organizations and institutions that form the basis of a functioning society as opposed to the force-backed structures of a state. The term civil society is currently often used by critics and activists as a reference to sources of resistance to globalization[24].

Claim-holder: a person who is entitled to a right that a duty bearer must provide. One individual may have both claim-holder and duty-bearer roles. The relationships between claim-holders and duty-bearers form a pattern that links individuals and communities to each other and to higher levels of society (see duty-bearer).

Committee(s): Treaty-monitoring bodies created under various conventions to monitor the implementation of the treaty. Committees consist of independent experts. They examine State reports about the application of the treaty and deal with cases involving violations of rights. See also CEDAW, Human Rights Committee and ICESCR. The term 'Human rights committee' is meant to refer specifically to the treaty-monitoring body of the International Covenant on Civil and Political Rights (ICCPR).

Convention: See Treaty

Consensus documents: Statements of political agreement that have been adopted by declaration. Though they are not legally binding, they are important because governments feel a moral obligation to abide by them. They are also called political documents. One of the oldest and most influential consensus documents is the Universal Declaration for Human Rights. Other famous examples are the Beijing Platform for Action and the Millennium Development Goals.

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[21] http://www.un.org/womenwatch/daw/csw/index.html
[22] Asher, 2004, page 89.
[23] Kooijmans, 2000, page 255.
[24] http://en.wikipedia.org/wiki/Civil_society

Convention on the Elimination of All Forms of Discrimination against Women: CEDAW was adopted in 1979 and entered into force in 1981. It is the first legally binding international document prohibiting discrimination against women and obligating governments to take affirmative steps to advance the equality of women.[25]Currently, 180 countries are party to CEDAW. In 1999, an optional protocol (see **Optional Protocol**) to CEDAW was adopted, which entered into force in 2000. It established two new procedures: a procedure for individual complaints to the Committee, and an inquiry procedure on the basis of which the Committee can start an investigation about an alarming situation in a specific country.

CEDAW (the Committee): Treaty body of the Convention on the Elimination of All Forms of Discrimination against Women. The Committee consists of a group of 23 independent experts who monitor the implementation of the Convention by State parties. The experts have been elected on the basis of their knowledge of relevant topics. They are nominated by governments of State parties, but operate independently from the governments.

Core obligations: What must be done to ensure the minimum content of each right.

Covenant: See Convention. See also International Covenant on Economic, Social and Cultural Rights (ICESCR) and International Covenant on Civil and Political Rights (ICCPR).

De facto: 'In reality' or 'in fact'. A situation that actually exists, whether lawful or not.[26] See also: de jure.

De jure: 'By law' or 'by right'.[27] How a situation should be, according to the law. In reality, the actual situation does not always conform with the law. For example, according to the law of a certain State (de jure), everyone may have equal access to health care, but, in practice (de facto), due to local customs women need their husband's or father's permission to see a doctor. See also: de facto.

Declaration (document): Document that contains agreed-upon standards but is not legally binding. UN conferences, such as the 1993 UN Conference on Human Rights in Vienna and the 1995 World Conference for Women in Beijing, usually produce two sets of declarations: one written by government representatives and one by NGOs. The UN General Assembly often issues influential but legally non-binding declarations.[28]

Declaration (statement): Sometimes a State wants to make a general statement about a treaty, for example, the way it interprets a definition/word included in the treaty. This is done by way of a declaration. In cases where the treaty prohibits reservations, States sometimes (abusively) make use of declarations in order to limit the content of certain provisions or scope of application.[29]

Determinants of health: Conditions that make it possible to live in health, such as access to safe water, adequate food and housing, and safe and healthy working conditions. Resource distribution, gender differences and access to health-related education and information (including information on sexual and reproductive health) are also health determinants. Determinants are not necessarily directly related to health care. However, their analysis helps to make clear where barriers lie to claiming health rights.

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[25] http://www.un.org/womenwatch/daw/cedaw/index
[26] http://www.hyperdictionary.com/search.aspx?define=de+facto
[27] http://www.hyperdictionary.com/search.aspx?define=de+jure
[28] http://www1.umn.edu/humanrts/edumat/hreduseries/tb1b/Section3/hrglossary.html
[29] Information ON ratifications, reservations and declarations to specific treaties can be found on the UNHCHR website: http://www.ohchr.org/english/bodies/index.htm

Discrimination: "Any distinction, exclusion or restriction...which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by" a group "of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field."[30] Groups that often face discrimination include women, ethnic and religious minorities, homosexuals, and people with disabilities.

Duty-bearer: a person who is obligated to provide the rights a claim-holder is entitled to. One individual may have both claim-holder and duty-bearer roles. The relationships between claim-holders and duty-bearers form a pattern that links individuals and communities to each other and to higher levels of society (see claim holder).

Economic, Social and Cultural Rights: Rights that give people social and economic security. These rights demand an active government policy. Examples are the right to food, education, shelter and health care and the right to preserve and develop one's cultural identity.[31]

GATS: General Agreement on Trade in Services, developed with the aim of creating a credible and reliable system of international trade rules; ensuring fair and equitable treatment of all participants; stimulating economic activity through guaranteed policy bindings; and promoting trade and development through progressive liberalization. Controversial for its limitations to the freedom of people and their governments to make democratic choices about the way their services are run and the effect it may have on the quality and availability of essential services across the world.[32]

Gender: While 'sex' refers to the biological differences between males and females, gender describes the socially-constructed roles, rights and responsibilities that communities and societies consider appropriate for men and women. We are born as males and females, but becoming girls, boys, women or men is something that we learn from our families and societies. It is this learned behavior that forms gender identity and determines gender roles. These are not necessarily the same all over the world, or even within a country or region.[33]

General Recommendations/ General Comments: Documents written by the Committees that monitor the implementation of human rights treaties explaining how a particular treaty should be interpreted and applied. Very relevant general recommendations in the context of this assessment instrument are CEDAW General Recommendation 24 concerning women and health and ICESCR General Comments 14 on the right to the highest attainable standard of health.

Government: The word government is used in this assessment tool in a broad sense. It covers the law and policy-making forces, as well as the government institutions that are responsible for the implementation of policies. It also includes the local, regional and national government levels. While local and regional authorities may have considerable responsibilities in developing and implementing policies, the national (central) government has the final responsibility to ensure that human rights are respected.

Grassroots organizations: Organizations set up by the local community and/or involving the community.

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[30] CEDAW article 1

[31] Kooijmans, 2000, page 255.

[32] http://www.wto.org/english/tratop_e/serv_e/gatsqa_e.htm and http://www.peopleandplanet.org/tradejustice/gats/

[33] http://www.unicef.org/gender/index_bigpicture.html

Health: Health is a state of complete physical, mental and social well being and not merely the absence of disease or infirmity. It is not confined to health care, but includes socio-economic factors and extends to the underlying determinants of health, such as resource distribution, gender, food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions and a healthy environment.[34] See also **right to health** and **primary, secondary and tertiary health care.**

Human rights: The rights possessed by all persons, by virtue of their common humanity, to live a life of freedom and dignity. These rights and freedoms are irrespective of citizenship, nationality, race, ethnicity, language, gender, sexuality or abilities. They are universal and indivisible. Human rights become enforceable when they are codified as Conventions, Covenants or Treaties, or when they become recognized as Customary International Law.[35]

Human rights approach: See rights-based approach.

Indicator: An indicator is a variable or measurement conveying information that may be qualitative or quantitative, but which is consistently measurable. Indicators related to women's health rights are, for example, maternal mortality rate, women suffering from epidemic diseases (both transmittable and non-transmittable), life expectancy of women, male-female ratio, nutritional level of women of all age groups, incidence of violence against women, female literacy rate, etc. Data regarding these indicators should be present in disaggregated form for all age groups and other socio-cultural and economic sub-groups.[36]

Indivisibility of rights: The indivisibility of human rights is the basic assumption of the human rights system, first formulated in 1948 in the Universal Declaration of Human Rights. It states that all human rights (civil and political as well as economic, social and cultural rights) are interrelated and cannot be separated. In order to ensure the realization of human rights, their implementation must therefore be comprehensive. It is impossible to fully realize civil and political rights if economic, social and cultural rights are being ignored.

International Covenant on Civil and Political Rights (ICCPR or CCPR): Adopted in 1966 and entered into force in 1976, the ICCPR declares that all people have a broad range of civil and political rights. It has been ratified by 154 countries as of October 2005. See also Civil and Political Rights.[37]

International Covenant on Economic, Social and Cultural Rights (ICESCR): Adopted in 1966, and entered into force in 1976, the ICESCR declares that all people have a broad range of economic, social and cultural rights. By October 2005 the treaty had been signed and ratified by 151 countries. A group of 18 independent experts monitors its implementation. See also Economic, Social, Cultural Rights.[38]

Life-cycle approach: Health is a lifetime concern. Health policies need to be tailored to the differing challenges people face at different times in life. Discrimination or other human rights violations that occur in infancy can determine the course of peoples' lives.[39]

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[34] Adapted from ICESCR general recommendation 14, paragraphs 4 and 20.
[35] Human Development Report 2000 Glossary: http://www.undp.org/hdr2000/english/presskit/glossary.pdf
[36] WHO, 25 questions on Health and Human Rights, http://www.who.int/hhr/activities/publications/en/index.html
[37] http://www.unhchr.ch/tbs/doc.nsf
[38] http://www.un.org/Depts/Treaty/final/ts2/newfiles/part_boo/iv_boo/iv_3.html
[39] 24 http://www.unfpa.org/rh/lifecycle.htm

Limitation: A State may have reasons to limit certain rights included in the ICESCR. For example, public health measures to control a contagious disease might infringe upon some rights. This is permitted only if the limitation is primarily intended to protect the rights of individuals, determined by national law, compatible with the nature of the rights protected by the ICESCR and pursues legitimate aims (e.g. not using the limitation to increase the military budget). Moreover, the limitation must be aimed at the general welfare of society (e.g. not just the elite) and it must be proportional. The least restrictive alternative must be chosen.[40]

Lobbying: The practice of seeking to influence the legislature or policy development to reflect a certain point of view. Lobbying can be conducted by an individual, a group, an organization or an association.

Millennium Development Goals: The eight Millennium Development Goals (MDGs) form a blueprint agreed to by all the world's countries and all the world's leading development institutions. They range from halving extreme poverty to halting the spread of HIV/AIDS and providing universal primary education, all by the target date of 2015. In the UN Millennium Declaration, UN member states also stress values such as freedom, equality and solidarity.[41]

Monitoring and reporting procedure: Treaties have a monitoring and reporting procedure to check the implementation of the treaty in each country. In some cases the report resembles a 'self-inspection' -- governments report on their own compliance with human rights obligations. In others, a monitoring body (e.g. NGOs) initiates the report on government behavior.

Non-governmental organizations (NGOs): Organizations formed by people outside the government. They can operate on an international, national, regional or local scale on the basis of different mandates, agendas and priorities. NGOs play a substantial role in influencing UN policy by writing shadow reports.

Non-retrogression: The principle that governments are not allowed to remain passive in a situation where human rights deteriorate, nor can they take measures that reduce the enjoyment of rights. If a government takes retrogressive measures, it must prove that it had no other option, for example, due to a severe crisis. In such a situation the government also has to demonstrate that it has protected the rights of the most vulnerable groups.[42]

Optional protocol: A separate treaty associated with a parent treaty, under which state parties to the parent treaty may choose to undertake additional obligations.[43] The optional protocol to ICESCR grants individuals the right to send a complaint to the ICESCR Committee. The optional protocol to CEDAW also creates the possibility for the CEDAW Committee to review individual complaints ('communications') and, above that, enables the Committee to start an inquiry procedure.

Participation: The process through which stakeholders (individuals and organizations) influence and share control over priority setting, policy-making, resource allocation and access to public good and services.[44]

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[40] See ICESCR article 4 and paragraphs 28 and 29 of general comment 14.
[41] http://www.ohchr.org/english/issues/millenium-development/resources.htm
[42] ICESCR General Comment 14, paragraph 32
[43] http://www.un.org/womenwatch/daw/cedaw/protocol/whatis.htm
[44] World Bank at http://lnweb18.worldbank.org/ESSD/sdvext.nsf/66ByDocName/ ParticipationatProjectProgramPolicyLevel

Policy: A purposive course of action followed by an actor or set of actors in dealing with a problem or a matter of concern. Policies can vary considerably in scope. The term policy can refer to a nationwide 5-year health strategy as well as to decisions of a more limited scope, such as a reduction of the funding to the maternity wards in a certain district. The actors can be local or national governments, organizations, enterprises or individuals.[45]

Poverty Reduction Strategy Papers (PRSP): One of the conditions a country may have to fulfill in order to receive help and debt relief is to make a PRSP. A PRSP describes the macroeconomic, structural and social policies and programs that a country will pursue over several years to promote broad-based growth and reduce poverty.[46]

Primary health care strategy: An integrated approach to improving health and socioeconomic development defined in the Alma Ata Declaration (1978). It emphasizes community education and participation, addressing social determinants of health, immunization; prevention and treatment of common and endemic disease, maternal/child and reproductive health, and access to essential drugs.

Primary, secondary and tertiary health care: Primary health care is provided at relatively low cost by health professionals and/or generally trained doctors working within the community and dealing with common and relatively minor illnesses. Secondary health care is provided at relatively higher cost by specialty-trained health professionals in centers, usually hospitals, and typically deals with relatively common minor or serious illnesses that cannot be managed at community level. Tertiary health care is provided in relatively few centers, typically deals with small numbers of minor or serious illnesses requiring specialty-trained health professionals, doctors and special equipment, and is often relatively expensive. Forms of primary, secondary and tertiary health care frequently overlap and often interact.[47]

Progressive realization: The principle that governments must do all they can to improve the situation regarding human rights, including the right to health. They must take deliberate, concrete and targeted steps towards the full realization of the right to health and eliminate discrimination in health care. The speed of progress depends on the specific situation of the state and may differ from country to country.[48]

Ratification/ ratified: The official promise of a state to uphold a treaty or convention and adhere to the legal norms that it specifies.[49]

Reproductive rights: The rights that enable all women, without discrimination on the basis of nationality, class, ethnicity, race, age, religion, disability, sexuality or marital status, to decide whether or not to have children. This includes the right to safe, legal abortion. These rights are basic human rights.[50]

Reservation: In cases where States object to one or several articles of a human rights treaty it is common to make use of a reservation. The reservation is a written statement that narrows the content of the article, limits where it can be applied, or rejects the whole provision. The reservation is only valid if it is compatible with the object and purpose of the treaty, if the treaty does not prohibit reservations, and if other States Parties do not object to the reservation.

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[45] James Anderson in Howlet and Ramesh, 1995, page 6.
[46] http://www.imf.org/external/np/exr/facts/prsp.htm
[47] ICESCR general comment 14, paragraph 19.
[48] ICESCR article 2 and article 12; ICESCR General Comment 14 paragraphs 30 and 31.
[49] http://www.undp.org/hdr2000/english/presskit/glossary.pdf
[50] http://www.wgnrr.org/home.php?page=1&type=menu

Respect/ protect/ fulfill: States parties have the obligations to respect, protect and fulfil human rights. The obligation to respect requires States parties to refrain from interfering with the enjoyment of rights. The obligation to protect requires States parties to prevent rights abuses by third parties. The obligation to fulfill requires States parties to pro-actively engage in activities that ensure the realization of rights. Fulfill also requires States to take measures necessary to ensure that each person may obtain basic rights whenever they, for reasons beyond their control, are unable to realize these rights through the means at their disposal.[51]

Rights-based approach: Because States are responsible for the realization of human rights, citizens can hold the State accountable for its obligations to respect, protect and fulfill them. The basis of a human rights approach is that a human rights violation needs to be addressed, even when the number of people involved is small or not known exactly. In other words, each human rights violation stands alone and should be taken seriously. A decrease in a certain type of human rights violation is a positive development, but does not justify other violations still taking place.

Right to health: Health is a fundamental right that influences all aspects of life and is closely related to other human rights. It is important to look at health as a whole. People who are ill cannot fully enjoy their right to education or participation. Lack of food and housing, make it difficult to live in good health. The right to health includes the availability, accessibility, acceptability and quality of health care. See also health and primary, secondary and tertiary health care, and health determinants.

Shadow report: Reports created by one or more NGOs that analyze the status of implementation of human rights obligations/commitments at the national level. In these reports, NGOs provide information that supplements government reports and thus assist the committees that monitor the treaties to address concerns that are omitted, neglected or misreported by the government.[52] Shadow reports are also referred to as alternative reports.

Social determinants of health: the social factors affecting health, including education, access to safe and healthy food, employment, and opportunity and control over one's life.[53]

Special Rapporteur: An official appointed to compile information on a subject, usually for a limited period.

Special Rapporteur on Health: In April 2002, the commission on Human Rights appointed Paul Hunt as the Special Rapporteur. The Special Rapporteur's duties are to gather and exchange information on the right to health; discuss possible areas of cooperation with all relevant actors, including governments, relevant United Nations bodies, specialized agencies, NGOs and international financial institutions; report on the status of the right to health and make recommendations on measures that promote and protect the right to health.[54]

State obligations: 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 a Convention. See Respect, protect, fulfill.

[51] http://shr.aaas.org/pubs/rt_health/rt_health_manual.pdf
[52] http://swf.u2u.org/women2000.txt
[53] http://www.unhchr.ch/Huridocda/Huridoca.nsf/0/9854302995c2c86fc1256cec005a18d7?Opendocument
[54] http://www.unhchr.ch/Huridocda/Huridoca.nsf/0/9854302995c2c86fc1256cec005a18d7?Opendocument

State(s) Party(ies): Those countries that have ratified a covenant, convention or treaty and are thereby legally bound to conform to its provisions.[55] See also State obligations.

Treaty: A contract or other written instrument binding two or more states under international law; used synonymously with Convention and Covenant. All countries that have agreed to be bound by a treaty through ratification or accession have a legal obligation to implement these rights and principles at the national level.[56] See also Ratification and accession.

TRIPS: WTO Agreement on Trade-Related Aspects of Intellectual Property Rights, obliging the 44 member countries of the WTO to protect the intellectual property rights on marketed products and production processes. Intellectual property rights such as copyrights and patents are intended to compensate the costs that manufacturers have invested in research and development.[57]

Universal Declaration of Human Rights (UDHR): Adopted by the General Assembly on 10 December 1948. Primary UN document establishing human rights standards and norms. All member states have agreed to uphold the UDHR. Although the declaration was intended to be non-binding, over time its various provisions have become so respected by States that it can now be said to be Customary International Law.[58]

Violation of human rights: Breach of the commitments in a treaty (convention / covenant) or an action/omission which is incompatible with the treaty.

Vertical program: An intervention to decrease morbidity or mortality that focuses on a specific disease or technological solution, such as a campaign to promote oral rehydration therapy to treat diarrhea. This is in contrast to changing more fundamental causes of illness such as malnutrition or improving heath systems in general.

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55 Human Development Report 2000 Glossary on Human Rights and Development.
56 http://untreaty.un.org/English/guide.asp#treaties
57 http://www.wemos.nl/en-GB/Content.aspx?type=Themas&id=1548
58 http://www.un.org/Overview/rights.html

Annex V. LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
CAT	Convention against Torture
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CEDAW/the Committee	Committee on the Elimination of Discrimination against Women
CERD	Convention on the Elimination of Racial Discrimination
CESCR	Committee on Economic, Social and Cultural Rights
CRC	Convention on the Rights of the Child
DOTS	Directly Observed Treatment (for tuberculosis)
HERWAI	Health Rights of Women Assessment Instrument
HIV	human immunodeficiency virus
HOM	Humanistisch Overleg Mensenrechten (Dutch abbreviation for Humanist Committee on Human Rights)
GATS	General Agreement on Trade in Services
ICPD	International Conference on Population and Development
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
ILO	International Labor Organization
IMF	International Monetary Fund
MDGs	Millennium Development Goals
NGO	Non-governmental organization
PHC	Primary Health Care
PHM	People's Health Movement
PRSP	Poverty Reduction Strategy Paper
UN	United Nations
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNHCHR	United Nations High Commissioner for Human Rights
UNICEF	United Nations Children's Fund
WHO	World Health Organization
WPF	World Population Foundation
WTO	World Trade Organization