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Integrating Human Rights in Health

Human rights in the context of public health

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This presentation on health and human rights is structured around, and seeks to answer, the following questions: Why is the World Health Organization addressing human rights? What are the linkages between health and human rights? What is the right to health? What is a human rights-based approach to health? How can a human rights-based approach strengthen WHO's mandate to support governments improve health?

The human rights movement emerged after the Second World War. The United Nations Charter of 1945 set out the promotion and encouragement of respect for human rights as one of the main purposes of the United Nations. A year later, in 1946, the WHO (World Health Organization) adopted its own constitution, which contains the first articulation of health as a human right at the international level. It enshrines the enjoyment of the highest attainable standard of physical and mental health as a fundamental human right without discrimination.

In 1948, the Universal Declaration of Human Rights was adopted, setting out economic, social, cultural, civil and political rights with the same emphasis. When the time had arrived to convert the provisions of the Declaration into binding law, the Cold War had overshadowed and polarized human rights into two separate categories. The West argued that civil and political rights had priority and that economic and social rights were mere aspirations. The Eastern bloc argued the contrary: that rights to food, health and education were paramount and civil and political rights secondary. Hence two separate treaties were created in 1966 - the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the International Covenant on Civil and Political Rights (ICCPR).

Since the end of the Cold War, a new era for the promotion and the protection of human rights has emerged marked by the World Conference on Human Rights in 1993, whereby the international community endorsed the interdependence of all human rights. The distinction between economic, social, cultural, civil and political rights is now considered artificial - both require the state to enact laws and policies and invest resources to ensure realization.

However, fifty years of neglect has resulted in the underdevelopment of economic and social rights in terms of their definition, scope and content, thereby impeding their practical realization.

Every country in the world is now party to at least one human rights treaty that recognizes health-related human rights. This means that WHO's Member States have committed themselves to various human rights obligations (having ratified human rights treaties) relevant to health. WHO's public health guidance to Member States should, therefore, strive to promote and reinforce those human rights obligations. The integration of human rights in public health within WHO also constitutes part of the UN reform process. In 1997, the UN Secretary-General adopted the UN reform programme which set out human rights as a cross-cutting activity of the UN, encouraging all UN agencies to mainstream human rights in their work.

What are the linkages between health and human rights?

Promoting and protecting health and respecting, protecting and fulfilling human rights are inextricably linked:

- Violations or lack of attention to human rights can have serious health consequences (e.g. harmful traditional practices, slavery, torture and inhuman and degrading treatment, violence against women and children).
- Health policies and programmes can promote or violate human rights in their design or implementation (e.g. freedom from stigma and discrimination, rights to participation, privacy and information).
- Vulnerability to ill-health can be reduced by taking steps to respect, protect and fulfil human rights (e.g. freedom from discrimination on account of race, ethnicity, sex and gender roles, rights to health, food and nutrition, education, information and adequate housing).

What is the right to health?

The awakening to the linkages between health and human rights in the 80s and early 90s focused primarily attention to a range of civil and political rights dimensions of public health. There was not the same effort to link the struggle to generate greater social justice through public health with economic and social rights, including the right to health. Although WHO adopted the Declaration of Alma Ata on primary health care which set out health as a human right and the World Health Declaration in 1998, the immaturity and controversy around the scope, content and application of the right to health meant that it remained little more than a slogan for advocacy.

With the advent of the new millennium, both the international human rights and public health movements have demonstrated trends of increased awareness and more systematic application of human rights beyond HIV/AIDS to a range of public health challenges, as well as recognition of the right to health as an important tool to tackle health inequalities. This trend began with a recognition of the importance of human rights to economic and social issues; this is evidenced in the deliberations of the UN human rights mechanisms, such as the Commission on Human Rights - the main human rights policy-making body - and the UN human rights treaty bodies. This in turn led to the evolution of the "right to health" (shorthand for "the right to the highest attainable standard of physical and mental health") in international law, as well as in the context of national legal frameworks.

In 2000, the UN Committee on Economic Social and Cultural Rights adopted General Comment 14 setting out the normative scope and content of the right to health. Importantly, the Committee interpreted the right to health as an inclusive right extending not only to accessible, affordable, culturally acceptable, and good quality health care but also to the underlying determinants of health, such as access to safe and potable water, adequate sanitation, and access to health-related education and information.

The General Comment sets out four criteria by which to evaluate the right to health:

(1) Availability. Functioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity. This should include 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.

(2) 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, 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, including in rural areas.
- 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.
- 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.

(3) Acceptability. All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.

(4) Quality. Health facilities, goods and services must 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.

The right to health obligates governments to take steps individually and through international assistance and cooperation, especially economic and technical, to the maximum of available resources, with a view to achieving progressively the full realization of the right to health. This means taking deliberate, concrete and targeted steps and demonstrating, when reporting to international human rights monitoring mechanisms, how governments are moving as expeditiously and effectively as possible towards the realization of the right to health.

This principle of progressive realization of human rights1 is relevant to both poorer and wealthier countries, as it acknowledges the constraints due to the limits of available resources, but requires all countries to show constant progress in moving towards full realization of rights. Any deliberately retrogressive measures require the most careful consideration and need to be fully justified by reference to the totality of the rights provided for in the human rights treaty concerned and in the context of the full use of the maximum available resources. In this context, it is important to distinguish the inability from the unwillingness of a State Party to comply with its obligations. Steps towards the full realization of rights must be deliberate, concrete and targeted as clearly as possible towards meeting a government's human rights obligations.2 It is also incumbent for countries to cooperate and assist one another in accordance with the principle of international cooperation and assistance enshrined both in the UN Charter and the UN Covenant on Economic, Social and Cultural Rights. Finally, in the context of progressive realization, it is important to note that there are certain immediate obligations, which includes the principle of non-discrimination.

In 2002, the UN Commission on Human Rights, the main UN policy-making body on human rights, appointed a UN Special Rapporteur on the Right to Health - an independent expert tasked with monitoring and reporting on the enjoyment of the right to health globally. Also in recent years, the Commission on Human Rights has adopted resolutions recognizing that access to medications in the context of pandemics such as HIV/AIDS, tuberculosis and malaria is one fundamental element for achieving progressively the full realization of the right to health. At the national level, constitutional provisions on the right to health are beginning to generate significant jurisprudence. For example, in Minister for Health v Treatment Action Campaign (2002), the South African Constitutional Court held that the Constitution required the government to devise and implement a comprehensive and coordinated programme to progressively realize the right of pregnant women and their newborn children to have access to treatment and care in order to combat mother-to-child transmission of HIV.

What is a human rights-based approach to health?

We have now reached a stage where public health work is increasingly embracing the discourse of health and human rights. This means being explicit about the right to health as the goal of public health and being systematic in seeking to maximize the positive human rights impact of public health on all human rights. Process therefore becomes important as well as outcome. Public health targets need to be oriented within the framework of the right to health (e.g. maximizing access of vulnerable population groups) but also ensuring that other relevant human rights are promoted and protected along the way (e.g. freedom from discrimination, right to participation, right to health-related information and education.) Finally, the incorporation of accountability mechanisms is essential to a human rights approach.

In the UN system this approach is commonly referred to as a rights-based approach. Although different UN agencies have developed their own human rights policies (e.g. UNDP, UNESCO, ILO, UNHCR) as well as agency-specific practical tools for programming based on human rights (e.g. UNICEF's executive guidelines for human rights programming), the key elements used are the same. A common understanding of a rights-based approach to programming was endorsed this year by UN agencies and adopted by the UNDG (the UN Development Group) and ECHA (the Executive Committee for Humanitarian Affairs), respectively, as follows:

1. All programmes of development co-operation, policies and technical assistance should further the realization of human rights as laid down in the Universal Declaration of Human Rights and other international human rights instruments.
2. Human rights standards contained in, and principles derived from, the Universal Declaration of Human Rights and other international human rights instruments guide all development cooperation and programming in all sectors and in all phases of the programming process.
3. Development cooperation contributes to the development of the capacities of 'duty-bearers' to meet their obligations and/or of 'rights-holders' to claim their rights.

How can a human rights-based approach strengthen WHO's mandate to support governments improve health?

WHO is now working actively to further integrate a human rights approach to its work. This will make human rights an integral dimension of the design, implementation, monitoring and evaluation of health-related policies and programmes in all spheres - political, economic and social.

Overall, the three main objectives of WHO's work on health and human rights are to:

- Advance the Right to Health in international law and international development processes through advocacy, input to UN mechanisms and development of indicators.

- Strengthen WHO's capacity to adopt a human rights-based approach in its work through policy development, research and training.
- Support governments in adopting a human rights-based approach in health development through development of tools, training and projects.

The human rights work provides support to WHO's commitment to tackle the complex relationship between poverty and ill-health. Within countries, human rights principles, such as freedom from discrimination and the right to participation, focus attention on vulnerable population groups. Many of these groups are identified in specific human rights instruments. Vulnerable and marginalized groups in societies tend to bear an undue proportion of health problems. National averages can conceal discrimination and fail to address vulnerability. The challenge facing development practitioners is to generate systemic change in law, policy and practice at all levels and across sectors to improve the health of vulnerable population groups. Human rights principles also focus on addressing power imbalances in society and the enhancement of government accountability and transparency.

WHO works to support Ministries of Health within governmnets and the human rights framework can further enhance this support in several ways. Firstly, as endorsed at the World Conference on Human Rights in Vienna (1993), human rights are the first priority of governments which means that health as a human right must be high on the priority agenda of governments. Human rights obligations, including the right to health, are enshrined in international and national law providing a solid and robust framework against which governments can be monitored and held accountable. These obligations pertain to the Governments as a whole, includes ministries of trade, finance and planning thus supporting policy coherence and action in favour of health. Finally, in the context of gloabliation where there is increased reliance on non-state actrors to carry out public health functions, e.g. pharmaceuticals and health insurance companies, the human rights framework can support governments in regulating these non-state actors in favour of promoting and protecting the right to health.

Examples of specific activities which the Health and Human Rights Team in WHO has undertaken so far:

- Developed three on-line databases on health and human rights actors; national constitutions/legislation/case law; and a bibliography
- Conducted training on health and human rights to WHO staff and to Ministries of Health
- Compiled good practices of a human rights-based approach to health in the context of poverty reduction strategies
- Disseminated advocacy materials (e.g. cartoons to address stigma/discrimination in the context of HIV/AIDS and to raise awareness and understanding of health as a human right)
- Seized opportunities of integrating human rights norms and principles across WHO technical programmes and within the framework of UN initiatives (e.g. CCA/UNDAFs)
- Convened consulations to identifty appropriate indicators to monitor the progressive realization of the right to health

- Provided guidance on human rights in relation to public health broadly and in relation to specific challenges such as migration and discrimination through materials (see website for information resources, including 25 Questions and Answers on Health and Human Rights and the Health and Human Rights Working Paper Series.)

Conclusion

WHO's work in the area of health and human rights is vast and wide-ranging. It entails not only bringing health to the external human rights agenda, and more broadly advancing the right to health in international law and development processes, but also bringing human rights norms, standrads and principles into the work on health development in countries. It involves integrating human rights principles, norms, and standards into existing health programming, possibly resulting in new ways of perceiving and addressing problems, but also interacting with new actors and using new mechanisms.

Human rights work is a cross-cutting activity in WHO and in all parts of the organization, there is increased attention being paid to human rights. This reflects a recognition that there are many potential advantages to WHO becoming more active and explicit in linking human rights to its public health agenda. Couching health as a human right helps keep health higher on the political agenda and means that health is the responsibility of the government as a whole. Finally, health as a human right means that health is not a good or a commodity but a fundamental entitlement of every human being. This shifts the normative foundation of WHO's work from responding to needs to the fulfillment of rights and from the optional realm of charity to the mandatory realm of law.

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Notes

(1) ICESCR, Article 2 (1)

(2) ICESCR General Comment 3 on the nature of States parties obligations adopted by the Committee on Economic, Social and Cultural Rights, Fifth Session 1990 (E/1991/23)

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