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# Global Justice And Human Rights: Health And Human Rights In Practice

**ABSTRACT:** The origin and justification of human rights, whether anchored in biological theory, natural law theory, or interests theory, as well as their cultural specificity and actual value as international legal instruments are subject to ongoing lively debates. As theoretical and rhetorical discourses challenge and enrich current understanding of the value of human rights and their relevance to democratic governance, they have found their way into public health in recent decades and play today an increasing role in the shaping of health policies, programs and practice. Human rights define the obligations of states to their people and towards each other, create grounds for governmental accountability and inspire recognition of, and action on, factors influencing people's attainment of the highest possible standard of health. This article highlights the evolution that has brought health and human rights together in mutually reinforcing ways. It draws from the experience gained in the global response to HIV/AIDS, summarizes key dimensions of public health and of human rights and suggests a manner in which these dimensions intersect in a framework for analysis and action.

**KEY WORDS:** Health, human rights, discrimination, global justice, HIV/AIDS

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## Introduction

Human rights constitute a set of normative principles and standards derived from moral philosophy which, following the atrocities perpetrated during World War II, gave rise in 1948, to the Universal Declaration of Human Rights (UDHR)<sup>1</sup>. This led to a series of treaties and conventions which extended the aspirational, but not legally binding, nature of the UDHR into instruments which would be binding under international human rights law. Among these treaties are the International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR) which came into force in 1976. These and, in fact, all other international human rights treaties and conventions contain articles relevant to health as defined in the preamble of the Constitution of the World Health Organization (WHO), 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.'<sup>2</sup>

1. *Universal Declaration of Human Rights*, G.A. Res. 217A (III) UN GAOP, Res. 71, UN Doc. A/810, 1948.

2. *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.

## Human Rights as Governmental Obligations

Human rights are legal claims that persons have on society simply on the basis of their being human. They are ‘what governments can do to you, cannot do to you and should do for you’.<sup>3</sup> Human rights are *inalienable* - individuals cannot lose these rights any more than they can cease being human beings. They are *indivisible* - individuals cannot be denied a right because it is deemed less important or non-essential. And they are *interdependent* - all human rights are part of a complementary framework, one right impacts on all others.<sup>4</sup>

Human rights 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. In this regard, governments have three sets of obligations towards their people:<sup>5</sup>

- 1) They 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.
- 2) They 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, health-related industries.
- 3) They have the obligation to *fulfill* human rights. This 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.

Even though people hold their human rights throughout their lives, they are nonetheless often constrained in their ability to fully realize them. 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 on the state of their personal health. From an advocacy perspective, until recently, claims for better fulfillment of civil and political rights have taken precedence over

3. S. Gruskin, ‘Is there a Government in the Cockpit: A Passenger’s Perspective on Global Public Health: The Role of Human Rights’, *Temple Law Review* 77/2 (2004), 313-334.

4. World Conference on Human Rights, Vienna, Austria (June 14-25), 1993, (Vienna Convention).

5. A. Eide, ‘Economic, Social and Cultural Rights as Human Rights’, in A. Eide, C. Krause, E. Rosas (eds.), *Economic, Social and Cultural Rights: a Textbook* (Dordrecht: Martinus Nijhoff, 1995); B. Toebes, *The Right to Health as a Human Right in International Law* (Antwerpen: Intersentia, 1999).

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.<sup>6</sup> 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 of health and rights remained apart until the 1980s, when reproductive health issues, mental health 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.<sup>7</sup>

### **Why Health and Human Rights?**

The connection between human rights and health may find distant roots in various movements of the 1960s. One was the expanding involvement of civil society in humanitarian health emergencies, whether in Asia, Latin America or Africa in response to the steady rise in the number and intensity of conflicts within and between states. This resulted in the creation of non-government organisations (NGOs), some of which engaged in human rights work (torture in particular), and others in health assistance in armed conflicts and natural disasters.

Meanwhile, building on the feminist movement, high income countries were battling on the reproductive health front where the focus of claims by women's activists was on reproductive choices and women's autonomy in making such choices. The right to family planning was recognized for the first time as a human right in the Declaration of Teheran, which resulted from the 1968 International Conference on Human Rights.<sup>8</sup> Thanks to sustained women's rights activism and advocacy, there is today a widespread recognition that the right of women to self-determination on the number and spacing of their children invokes a number of human rights and international human rights treaties, in particular the 1976 ICCPR and the 1979 Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW).<sup>9</sup> In the fields of disability and mental health, claims were also made that existing national policies were discriminatory and, in the case of mental health, amounted to torture and degrading treatment. Thus, the areas where health and human rights began to connect were prominently within the realm of civil and political rights (dignity and self-determination, equality and social justice), rather than economic, social and cultural rights, for which there was little attention and virtually no NGO movement devoted to the issues. HIV was about to change this.

6. 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.

7. J.M. Mann et al., 'Health and Human Rights', *Health and Human Rights* 1/1 (1994), 6-23.

8. *Proclamation of Tehgera*, proclaimed by the International Conference on Human Rights, Teheran, May 13, 1968.

9. R. J. Cook. 'International human rights and women's reproductive health', *Studies in Family Planning* 24/2 (1993),73-86.

Both health and human rights, together and independently from each other, have achieved a degree of prominence in the political and public discourse never witnessed before. The privileged attention these two fields attract is the result of four noteworthy factors.

First, the ICCPR and ICESCR came of age in the late 1980s. A few years after they came into force in 1976, their actual meaning and core contents started to be made explicit, actionable and measurable. Committees of experts (Treaty Monitoring Bodies) were established to monitor implementation of the provisions of the core human rights treaties. The Committee on the Elimination of Racial Discrimination (CERD), the first treaty body to be established, had monitored implementation of the International Convention on the Elimination of All Forms of Racial Discrimination since 1969, and The Human Rights Committee (HRC) was created in 1976 to monitor implementation of the ICCPR. Today there are seven Treaty Monitoring Bodies, each concerned with one of the existing core international human rights treaties. In 1981 the Human Rights Committee began to produce General Comments intended to explicate the core and normative contents of rights and states reporting obligation under the ICCPR. This process was followed by other Treaty Monitoring Bodies, including the Committee on Economic, Social and Cultural Rights in 1989.<sup>10</sup> By 1990 there was increasing clarity about state obligations to provide reports on their progress towards implementing their international human rights obligations, and the machinery was in place to process and analyze these reports and then to formulate ‘concluding observations’ on each of the six core treaties that were in force.<sup>11</sup>

Second, the decay of the world geopolitical ‘block’ ideologies of the late 1980s created a space for alternate paradigms to guide public policy and international relations. Human rights-and religious fundamentalism-gradually emerged as convenient substitutes for decaying political ideologies which, after *Glasnost* and the fall of the Berlin Wall, in 1989, were no longer playing their role as the marked, antagonistic references that defined the relationships between the state and its citizens and between states. Human rights entered the scene of geopolitical reconstruction and became common parlance, regardless of whether these principles and terms were appropriately used or abused by new political leaders.

Third, the emergence of AIDS in 1981 and the identification of its causal agent HIV in 1984, had brought in their trail a variety of human rights violations by those who were determined to apply the traditional ‘disease control’ approach - which had marked the earlier history of public health - against this mounting public health problem. Until then, in fact, 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-even if, in order to 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

10. Over 100 General Comments have so far been produced by the seven Treaty Monitoring Bodies, see <<http://www.ohchr.org/english/bodies/treaty/comments.htm>>

11. It should be noted that efficiency and impact varied from one Treaty Monitoring Body to the next.

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 been imposed too often on affected individuals without valid public health justification. The current resurgence of this issue in the context of systematic mandatory testing for HIV in health facilities, or within entire populations-proposed by some in order to enhance the early access to care and treatment by people found infected-illustrates that disease control methods blind to human rights have by no means vanished.<sup>12</sup>

Public health abuses had also been exemplified by the excessive institutionalization of people with physical or mental impairments where alternate care and support approaches had not been considered. And far from uncommon has been 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 influence the quality of services provided to individuals by, or on behalf of, the state.

Cognizant of the need to actively engage HIV-affected communities in the response to the fast spreading epidemic, human rights were seen as a prerequisite for open access to prevention and care by those who needed them most; away from fear, discrimination and other forms of human rights violations, including deprivations of entitlements such as employment or housing, which constrained their capacity to become the subjects and no-longer the objects of HIV programs.

There is a fourth reason explaining the privileged place health and human rights occupy in the public discourse, political debates and the media: both are at the top of human aspirations. There is hardly a proposed political agenda that does not refer to justice, security, health and employment opportunities. These and other aspirations contained in human rights treaties are often translated into national constitutions and legislation. Further, health, among all these aspirations, is arguably the most extensively measured component of well-being; it benefits from dedicated services and is commonly seen as a *sine-qua-non* for the fulfillment of all other aspirations. Efforts to evidence the synergy between health and human rights are therefore not only responding to demands from people, policy makers and political leaders, they have a great potential for helping decipher how human rights and all other elements of well-being interact.

Thus the fields of health and rights are illuminated today by their commonalties, and 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.

### **Health and Human Rights in Practice: From HIV to Health**

The evolution of thinking about HIV/AIDS provides the best illustration of how the understanding of the relationship between health and rights has expanded: from the initial recognition of negative effects of human rights violations among

12. S. Gruskin, 'Current Issues and concerns in HIV testing: a health and human rights approach', *Canadian HIV/AIDS Policy and Law Review* 9/3 (2004), 99-103.

people living with HIV, to principles which guided the formulation of a global strategy against HIV/AIDS, and beyond to the application of health and human rights principles to other health issues.

In the decade that followed the emergence of AIDS, tremendous efforts were made to induce behavioral change through intensified, targeted prevention. The initial approaches to HIV were focused on the reduction of risk of acquiring HIV infection through such measures as the creation of protective barriers: condoms to be used in casual sex, early diagnosis and treatment of sexually transmitted infection, and reduction in the number of sexual partners. Some of these efforts were successful on the project level, in particular where communities were educated and cohesive, as was the case for gay communities on the East and West Coast of the USA, Western Europe and Australia. Less immediately successful were interventions in communities which were experiencing social or economic stress, and in those that were hampered in their ability to confront HIV/AIDS as a result of strong cultural barriers to access information, or where prevention methods were culturally frowned upon, for example, the use of condoms. In sub-Saharan African countries, for example, early interventions were confronted with denial and rejection of prevention models which were seen by many as culturally insensitive. Gender-related issues were often at the core of this resistance to change. Stigma and discrimination directed towards people living with HIV, or those whose behaviors were associated with a risk of acquiring and transmitting infection (sex workers, injecting drug users and also people defined by their racial or ethnic characteristics), created obstacles to reaching those who, more than any others, needed open access to prevention and care.<sup>13</sup> For this reason, the protection of human rights as a means to combat discrimination became an integral part of the first Global Strategy on HIV/AIDS formulated by the WHO in 1987.<sup>14</sup> Never before had a disease-focused global strategy specifically considered human rights protection as a public health imperative.

The risk-reduction strategies of the late 1980s, however, confronted several obstacles. One was the difficulty of scaling-up successful projects to a national or international level. The other was the difficulty of replicating proven models in different social and cultural settings. Clearly, one size did not fit all. Research supported by empirical evidence showed that if the capacity of an individual to minimize or modulate a risk of exposure to HIV was closely related to specific behaviors or situations, these were in turn induced by a variety of pre-existing or incidental factors. In 1991, Jonathan Mann and myself began to describe the risk-vulnerability model, posing that in order to impact on risk-taking behaviors, it was necessary to recognize and act on factors which determined the likelihood of any individual engaging in such behaviors.<sup>15</sup> A broader perspective of an expanded response to HIV began to emerge, which bridged risk, as measured by

13. J.M. Mann and D. Tarantola, 'Responding to HIV/AIDS: A Historical Perspective', *Health and Human Rights* 2/5 (1998), 5-14, pp 5-8.

14. *The Global Strategy for AIDS Prevention and Control* (Geneva: World Health Organization, 1987), unpublished document (SPA/INF/87.1).

15. J.M. Mann and D. Tarantola, 'Assessing the Vulnerability to HIV infection and AIDS', in J.M. Mann, D. Tarantola, and T. Netter (eds.), *AIDS in the World* (Cambridge: Harvard University Press, 1992), 557-602.

the occurrence of HIV infection, to risk-taking behaviors and to their vulnerability determinants. Vulnerability factors could be categorized for simpler analysis as: *personal* (linked to personal history and status, agency, knowledge or skills); *societal* (linked to social, economic or cultural characteristics of the community within which they lived or had lived, as well as to policies and laws); and *program-related* (dependent on the capacity of programs-health and social programs in particular-to respond appropriately to people's needs and expectations and enroll their participation).<sup>16</sup>

There was nothing very new here for those who had been involved in the health promotion movement of the 1970s and 1980s. Linking health outcome to health determinants was already present in the public health discourse. What was new is the urgency of responding to the mounting HIV epidemic while involving a wide and complex assembly of determinants which touched many facets of society. The list of these determinants was just overwhelming. The first obstacle to surmount was to categorize these determinants in a logical fashion so that they could lend themselves to action by different actors in human development, and so that responsibilities could be assigned to particular sectors of government and non-governmental organizations which were active in these sectors. There was an already existing framework that was very well suited to this purpose and this was human rights. Vulnerability factors could be categorized as: civil, political, social, economic or cultural, and each factor of vulnerability to HIV (recognized through research or empirical evidence), could be easily linked to one or more specific human rights. From an initial focus on non-discrimination towards people known or assumed to live with HIV/AIDS, vulnerability reduction was now expanding the scope of possible interventions. Importantly, these interventions could build on commitments already expressed, and obligations subscribed to, by governments under international human rights law. These obligations were to become important in the face of a public health emergency, and made governments accountable for what they were and were not doing towards the realization of human rights.

In addition, the recognition of the diversity of points of entry into vulnerability reduction, either through law reform, education, redistribution of certain resources or attention to highly vulnerable communities, demanded the broadening of the set of actors. More partners were coming in and within a few years, by the mid-1990s, the number of governmental and non-governmental entities engaged in HIV/AIDS prevention both nationally and internationally had skyrocketed. This analytical and action framework, linking HIV to the neglect or violation of human rights, served as one of the founding principles of the 1996 Joint United Nations Program on HIV/AIDS (UNAIDS) first strategy, and it was elaborated in further versions of this global strategy on HIV/AIDS.<sup>17</sup>

Did this approach work? It helped redefine HIV not merely as a medical or behavioral issue, but in a societal context. In public perception, a shift began to occur away from a focus on individual stigma, to the recognition of human

16. J.M. Mann and D. Tarantola, 'Societal Vulnerability: contextual analysis', in J.M. Mann and D. Tarantola (eds.), *AIDS in the World II* (London: Oxford University Press, 1996), 444-462.

17. *UNAIDS Strategic Plan 1996-2000*, revised December 1995, (Geneva: UNAIDS, 1996).

rights violations which were the root causes of the epidemic. This paradigm shift helped marshal the engagement of multiple actors, and greater international and inter-institutional cooperation. It certainly helped bring human rights into focus and create multiple and expanding bridges between health and rights as it soon became clear that the same factors of vulnerability to diseases or conditions other than HIV could be recognized and acted upon within what was now called a 'health and human rights framework'.

Were there set-backs? Yes, several. There was criticism that meager resources available to HIV were now being diverted to economic and social development. In particular, there was a fear that a focus on broad-based prevention would discourage investments in research for new drugs and vaccines. And in South Africa in the late 1990s, the paradigm was somewhat misrepresented by the political leadership of the time who concluded that HIV was due to poverty, and not to a virus. Today, the current predominance of investments in HIV/AIDS care, and in treatment and support over prevention, is overshadowing the importance of societal changes that need to happen if the root causes of HIV are to be addressed.

Applying the above principles, the ongoing international movement to respond more effectively to HIV has nevertheless factored-in the combined reduction of risk, vulnerability and impact. These are spelt out in the Millennium Development Goals<sup>18</sup>, in several Declarations of the United Nations General Assembly Special Sessions on HIV/AIDS,<sup>19</sup> and in the core strategy of UNAIDS and its co-sponsoring UN Organizations.<sup>20</sup> The linkages between an effective global response to HIV, and the protection of human rights are commonly referred to in programs of action and statements by political leaders, even when human rights, in general, have tended to disappear from stated domestic policies and political agendas in some democracies which helped found them.

### **Health and Human Rights and/or the Right to Health**

The right to the highest attainable standard of health builds on, but is by no means limited to, Article 12 of the ICESCR.<sup>21</sup> It transcends virtually every single other right. 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

18. See <<http://www.un.org/millenniumgoals/goals.html>>

19. United Nations, *General Assembly Special Session on HIV/AIDS: Global Crisis-Global Action*, New York, June 25-27, 2001.

20. As of August 2007, the ten UNAIDS co-sponsoring organizations are: Office of the United Nations High Commissioner for Refugees (UNHCR), <http://w3.unaids.org/en/Cosponsors/unicef/default.asp> United Nations Children's Fund (UNICEF), World Food Program (WFP), United Nations Development Program (UNDP), United Nations Population Fund (UNFPA), United Nations Office on Drugs and Crime (UNODC), International Labour Organization (ILO), United Nations Educational, Scientific and Cultural Organization (UNESCO), World Health Organization (WHO) and the World Bank. See, for example, a description of the mandate, mission and contribution of each of the 10 co-sponsors of UNAIDS at <[www.unaids.org/en/Cosponsors/default.asp](http://www.unaids.org/en/Cosponsors/default.asp)>

21. 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.

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.<sup>22</sup> This recognition is based on empirical observation and on a growing body of evidence-based literature which establishes the impact of the lack of fulfillment of any and all of these rights on people's health status—education, non-discrimination, food and nutrition epitomize this relationship. Conversely, ill-health constrains the fulfillment of all rights, as the capacity of individuals to claim and enjoy all their human rights depends on their physical, mental and social well-being.

The right to health does not mean the right to be healthy, but the obligation on the part of the government to create the conditions necessary for individuals to improve their health. The right to health is defined in CERD (Convention on the Elimination of all forms of Racial Discrimination, 1965), in CEDAW (Convention on the Elimination of all forms of Discrimination against Women, 1979), and in CRC (Convention on the Rights of the Child, Article 24, 1989). It is also defined in regional treaties, including: The European Social Charter (1961, revised 1996), The African Charter on Human and People's Rights (1981), and the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (1988, 'Protocol of San Salvador').

In May 2000, the Committee on Economic, Social and Cultural Rights adopted a General Comment 14 on Article 12 of the International Covenant on Economic, Social and Cultural Rights: the right to the highest attainable standard of health.<sup>23</sup> It is a solid document that should, over time, contribute to the understanding, actions and accountability of states under international human rights law and their health-related obligations. General Comment 14 actualizes the interpretation of the right to health from the perspectives of accessibility, affordability, appropriateness and quality.<sup>24</sup> It lays out directions for the practical application of Article 12 and proposes a monitoring framework. It states that:

The right to health is closely related to and dependent upon the realization of other 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.<sup>25</sup>

22. V. Leary, 'The Right to Health', *Health and Human Rights* 1/1 (1994), 24-56.

23. 'General Comment 14 on the Right to the Highest Attainable Standard of Health', drafted under the leadership of E. Riedel, Rapporteur to the UN Committee on Economic, Social and Cultural Rights, Geneva, 20 May 2000.

24. 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: (i) *availability*, which essentially provides that governments have a responsibility to ensure that prevention and care facilities, including infrastructure, skilled human resources, goods and services are in place and appropriately funded; (ii) *accessibility*, which brings forward the government obligation to ensure these to all; (iii) *acceptability*, which 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 (iv) *quality of services*, which requires that these services are scientifically sound and conform to public health 'best practice'.

25. Article 3, 'General Comment 14 on the Right to the Highest Attainable Standard of Health'.

It is worth commenting here on two selected aspects of this document that have important implications for public health practice and for the application of health and human rights principles by Member States and the United Nations: progressive realization and limitations of rights in the interest of public health.

### **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.<sup>26</sup> 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 former Director-General of the 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.<sup>27</sup>

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.<sup>28</sup> 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 as health needs and technologies evolve.<sup>29</sup>

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

26. Article 2, *International Covenant on Economic, Social and Cultural Rights*.

27. 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

28. Adopted at the International Conference on Primary Health Care (Alma-Ata, 6-12 September 1978), and endorsed by the 32nd World Health Assembly in Resolution WHA32.30 (Geneva, May 1979).

29. This need was reflected in the World Health Declaration adopted by the 51st 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.

for health. Given that the advancement of health necessitates infrastructure and human 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 towards those they have set additionally for themselves. In low and medium income countries, progressive realization of rights may also require marshalling national and international resources for this purpose. In fact, under international human rights law, affluent countries do have an obligation to engage in international cooperation and assistance.<sup>30</sup>

### **Human Rights Limitations in the Interest of Public Health**

There is a deeply rooted belief in the health community that a health and human rights agenda will, when public health is at stake, deprive the state from measures such as isolation or quarantine and travel restrictions. Public health and care practitioners, acting on behalf of the state, are used to applying restrictions to individual freedom in cases where the enjoyment of these rights created a real or perceived threat to the population at large. Recently, the SARS and the Avian Flu epidemic have demonstrated that this could also be applied globally under newly adopted international health regulations (the only binding agreement under the auspices of WHO) which came into force in 2007.<sup>31</sup>

There are situations where there can be legitimate and valid restriction of rights under international human rights law, and this under two circumstances: national emergencies<sup>32</sup> and public health imperatives. In relation to public health imperatives, governments have the right to take the steps they deem necessary for the 'prevention, treatment and control of epidemic, endemic, occupational and other diseases'.<sup>33</sup>

Public health may therefore justify the limitation of certain rights under certain circumstances. Interference with freedom of movement when instituting quarantine or isolation for a serious communicable disease—such as, Ebola fever, syphilis, typhoid or untreated tuberculosis and more recently SARS and Avian Flu—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'.

30. Article 2, *International Covenant on Civil and Political Rights*.

31. WHO, *WHA58.3: Revision of the International Health Regulations*, 58th World Health Assembly, Geneva, 2005.

32. Article 4, *International Covenant on Civil and Political Rights*: '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'.

33. Article 16, *International Covenant on Civil and Political Rights*.

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 counterproductive. 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 through a structured process. The limitations under consideration must be in the interest of a legitimate objective of the 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, that is, in an unreasonable or otherwise discriminatory manner.<sup>34</sup>

#### **Four Directions for Public Health Action**

In May 2000, the World Health Assembly adopted a WHO Corporate Strategy.<sup>35</sup> Although initially intended to apply to the work of the organization, this strategy sets out a useful typology which can be used as the backbone for a health and human rights analysis. The Corporate Strategy addresses four directions for public health:

- *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.

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 disenfranchised

34. 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.

35. WHO, 'A corporate strategy for the WHO Secretariat', Executive Board, 105th Session, EB105-3, 10 December 1999.

36. R. Conninx et al., 'Tuberculosis in prisons in countries with high prevalence', *BMJ* 320 (2000), 440-442.

communities, in particular among prison inmates.<sup>36</sup> The AIDS epidemic is finding new vulnerable populations among the poor and those with unequal status in society, women in particular.<sup>37</sup> Hepatitis C is spreading, unabated, in communities of injecting drug users.<sup>38</sup> Discrimination compounds the effects of poverty, and 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 needed.

Ill health finds fertile ground in populations that live in the shadows of our societies. These people are usually 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, and counting while protecting people's dignity and privacy, is the beginning of a successful approach towards better health and rights.

Lifestyles are also affected by discrimination. 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 on 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 centres, 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 were 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, hepatitis B and C, 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.

37. UNAIDS, UNFPA & UNIFEM, *Women and HIV/AIDS: Confronting the Crisis* (Geneva: UNAIDS, 2004), pp. 1-9.

38. M. MacDonald, N. Crofts, & J. Kaldor, "Transmission of hepatitis C virus: rates, routes and cofactors", *Epidemiologic Reviews* 18 (1996) 137-148.

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 infectious diseases such as malaria and other water-borne 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, even though most governments in the world have ratified treaties guaranteeing the right of everyone to education. To protect the health of children it is essential for them to achieve better education and to 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 judgment. 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 reminded us; 'we may find it difficult to define dignity, but we know immediately what it is once our own dignity has been offended'.<sup>39</sup>

### **In Conclusion: Moving 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.<sup>40</sup> (See Table 1, next page.)

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39. '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.' Jonathan Mann, 'Medicine and Public Health, Ethics and Human Rights', in J.M. Mann et al. (eds.), *Health and Human Rights: A Reader* (New York: Routledge, 1999), 439-52.

40. S. Gruskin and D. Tarantola, 'Health and Human Rights', in *The Oxford Textbook of Public Health*, R. Detels et al. (eds.), 4th edition (Oxford: Oxford University Press, 2001)

DOMAINS OF HEALTH	GOVERNMENTAL OBLIGATIONS WITH RESPECT TO HUMAN RIGHTS		
	Respect	Protect	Fulfill
<b>1. Reduce morbidity, disability and mortality</b>	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.
<b>2. Promote healthy lifestyles</b>	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.
<b>3. Strengthen health systems</b>	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.
<b>4. Develop health-sensitive policies and programs</b>	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.

**Table 1. A Pathway to Health and Human Rights**

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 listed previously: 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 that 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.

An analytical framework can be applied to recognition of the points of convergence between health and rights in specific public health domains, for example, in 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.<sup>41</sup> Conversely, 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 at the same time contributing to the advancement of human rights.

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. 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, as well as practical tools for use in our daily work.

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41. L. Gostin and J.M. Mann, 'Toward the Development of a Human Rights Impact Assessment for the Formulation and Evaluation of Public Health Policies', in Mann et al. (1999), 54-71.

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