

is a necessary requirement in providing care for the donor;

b. In those jurisdictions that have universal health insurance, governmental services should ensure donors have access to appropriate medical care related to the donation event;

c. Health and/or life insurance coverage and employment opportunities of persons who donate organs should not be compromised;

d. All donors should be offered psychosocial services as a standard component of follow-up;

e. In the event of organ failure in the donor, the donor should receive:

- i. Supportive medical care, including dialysis for those with renal failure, and
- ii. Priority for access to transplantation, integrated into existing allocation rules as they apply to either living or deceased organ transplantation.

6. Comprehensive reimbursement of the actual, documented costs of donating an organ does not constitute a payment for an organ, but is rather part of the legitimate costs of treating the recipient.

a. Such cost-reimbursement would usually be made by the party responsible for the costs of treating the transplant recipient (such as a government health department or a health insurer);

b. Relevant costs and expenses should be calculated and administered using transparent methodology, consistent with national norms;

c. Reimbursement of approved costs should be made directly to the party supplying the service (such as to the hospital that provided the donor's medical care);

d. Reimbursement of the donor's lost income and out-of-pocket expenses should be administered by the agency

handling the transplant rather than paid directly from the recipient to the donor.

7. Legitimate expenses that may be reimbursed when documented include:

a. the cost of any medical and psychological evaluations of potential living donors who are excluded from donation (e.g., because of medical or immunologic issues discovered during the evaluation process);

b. costs incurred in arranging and effecting the pre-, peri- and post-operative phases of the donation process (e.g., long-distance telephone calls, travel, accommodation and subsistence expenses);

c. medical expenses incurred for post-discharge care of the donor;

d. lost income in relation to donation (consistent with national norms).

References for the Declaration of Istanbul

1. World Health Assembly Resolution 57.18, Human organ and tissue transplantation, 22 May 2004, http://www.who.int/gb/ebwha/pdf_files/WHA57/A57_R18-en.pdf.

2. The Ethics Committee of the Transplantation Society (2004). The Consensus Statement of the Amsterdam Forum on the Care of the Live Kidney Donor. *Transplantation* 78(4):491-92.

3. Barr ML, Belghiti J, Villamil FG, Pomfret EA, Sutherland DS, Gruessner RW, Langnas AN & Delmonico FL (2006). A Report of the Vancouver Forum on the Care of the Life Organ Donor: Lung, Liver, Pancreas, and Intestine Data and Medical Guidelines. *Transplantation* 81(10):1373-85.

4. Pruett TL, Tibell A, Alabdulkareem A, Bhandari M, Cronon DC, Dew MA, Dib-Kuri A, Gutmann T, Matas A, McMurdo L, Rahmel A, Rizvi SAH, Wright L & Delmonico FL (2006).

The Ethics Statement of the Vancouver Forum on the Live Lung, Liver, Pancreas, and Intestine Donor. *Transplantation* 81(10):1386-87.

5. Universal Declaration of Human Rights, adopted by the UN General Assembly on December 10, 1948, <http://www.un.org/Overview/rights.html>.

6. Based on Article 3a of the Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, Supplementing the United Nations Convention Against Transnational Organized Crime, http://www.uncjin.org/Documents/Conventions/dcatoc/final_documents_2/convention_%20traff_eng.pdf.

III. Basic Texts on the Right to Health

UN Texts on the Right to Health

[Refer to Section I.A. above for the text of Article 25 of the Universal Declaration of Human Rights (1948) and Article 12 of the International Covenant on Economic, Social and Cultural Rights (1966)]

I. THE CONSTITUTION OF THE WORLD HEALTH ORGANIZATION (1946)

Adopted by the International Health Conference, held in New York from 19 June to 22 July 1946, signed on 22 July 1946 by the representatives of 61 States and entered into force on 7 April 1948. [Available at <http://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf>]

Preamble

The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race,

religion, political belief, economic or social condition.

2. INTERNATIONAL CONVENTION ON THE ELIMINATION OF ALL FORMS OF RACIAL DISCRIMINATION (1965)

Adopted and opened for signature and ratification by General Assembly Resolution 2106 (XX) of 21 December 1965. Entered into force 4 January 1969. [Available at <http://www2.obchr.org/english/law/cerd.htm>]

Article 5

In compliance with the fundamental obligations laid down in article 2 of this Convention, States 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:

(e) Economic, social and cultural rights, in particular:

(iv) The right to public health, medical care, social security and social services;

3. CONVENTION ON THE ELIMINATION OF ALL FORMS OF DISCRIMINATION AGAINST WOMEN (1979)

Adopted and opened for signature, ratification and accession by General Assembly Resolution 34/180 of 18 December 1979. Entered into force 3 September 1981. [Available at <http://www.un.org/womenwatch/daw/cedaw/cedaw.htm>]

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 appropri-

ate 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. Notwithstanding the provisions of paragraph 1 of this article, 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.

4. CONVENTION ON THE RIGHTS OF THE CHILD (1989)

Adopted and opened for signature, ratification and accession by General Assembly Resolution 44/25 of 20 November 1989. Entered into force 2 September 1990. [Available at <http://www2.obchr.org/english/law/crc.htm>]

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;

(d) To ensure appropriate pre-natal and post-natal 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 co-operation 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.

5. GENERAL COMMENT 14: THE RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH (ARTICLE 12 OF THE INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS) (2000)

Adopted by the Committee on Economic, Social and Cultural Rights on 11 May 2000. UN document E/C.12/2000/4, 11 August 2000. [Available at <http://www.unhcr.ch/tbs/doc.nsf/%28symbol%29/E.C.12.2000.4.En>]

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 wellbeing 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 services⁶ 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 healthcare 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 ideas⁸ 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 services¹⁵

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 postnatal 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 inter-

national 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 ac-

countable 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 (prenatal 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 dy-

namic 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 obliga-

tions 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 fi-

ancial aid should be given to the most vulnerable or marginalized groups of the population.

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 postnatal 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.

B. Regional Texts on the Right to Health

I. EUROPEAN SOCIAL CHARTER (1961, AS REVISED IN 1996)

*Adopted on 3 May 1996. Entered into force 7 January 1999. European Treaty Series No. 163.
[Available at <http://conventions.coe.int/treaty/en/Treaties/Html/163.htm>]*

Article 11: The right to protection of health

With a view to ensuring the effective exercise of the right to protection of health, the Parties undertake, either directly or in cooperation with public or private organisations, to take appropriate measures designed inter alia:

1. To remove as far as possible the causes of ill health;

2. To provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health;

3. To prevent as far as possible epidemic, endemic and other diseases, as well as accidents.

2. AFRICAN (BANJUL) CHARTER ON HUMAN AND PEOPLES' RIGHTS (1981)

Adopted 27 June 1981. Entered into force 21 October 1986. OAU Doc. CAB/LEG/67/3 rev. 5, reprinted in 21 I.L.M. 58 (1982).

[Available at <http://www1.umn.edu/humanrts/instreet/z/afchar.htm>]

Article 16

1. Every individual shall have the right to enjoy the best attainable state of physical and mental health.

2. States Parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.

3. ADDITIONAL PROTOCOL TO THE AMERICAN CONVENTION ON HUMAN RIGHTS IN THE AREA OF ECONOMIC, SOCIAL AND CULTURAL RIGHTS, "PROTOCOL OF SAN SALVADOR" (1988)

Adopted by the General Assembly of the Organization of American States at San Salvador, El Salvador, on 17 November 1988. Entered into force 16 November 1999. O.A.S. Treaty Series No. 69 (1988). [Available at <http://www.oas.org/juridico/english/Treaties/a-52.html>]

Article 10

Right to Health

1. Everyone shall have the right to health, understood to mean the enjoyment of the highest level of physical, mental and social well-being.

2. In order to ensure the exercise of the right to health, the States Parties agree to recognize health as a public good and, particularly, to adopt the following measures to ensure that right:

a. Primary health care, that is, essential health care made available to all individuals and families in the community;

b. Extension of the benefits of health services to all individuals subject to the State's jurisdiction;

c. Universal immunization against the principal infectious diseases;

d. Prevention and treatment of endemic, occupational and other diseases;

e. Education of the population on the prevention and treatment of health problems, and

f. Satisfaction of the health needs of the highest risk groups and of those whose poverty makes them the most vulnerable.

4. REVISED ARAB CHARTER ON HUMAN RIGHTS (2004)

Adopted by the League of Arab States on 22 May 2004 entered into force 15 March 2008.

[Available at <http://www1.umn.edu/humanrts/instreet/loas2005.html>]

Article 39

1. The States parties recognize the right of every member of society to the enjoyment of the highest attainable standard of physical and mental health and the right of the citizen to free basic health-care services and to have access to medical facilities without discrimination of any kind.

2. The measures taken by States parties shall include the following:

(a) Development of basic health-care services and the guaranteeing of free and easy access to the centres that provide these services, regardless of geographical location or economic status.

(b) efforts to control disease by means

of prevention and cure in order to reduce the mortality rate.

(c) promotion of health awareness and health education.

(d) suppression of traditional practices which are harmful to the health of the individual.

(e) provision of the basic nutrition and safe drinking water for all.

(f) Combating environmental pollution and providing proper sanitation systems;

(g) Combating drugs, psychotropic substances, smoking and substances that are damaging to health.

C. Other General Texts on Health and Human Rights

I. DECLARATION OF ALMA-ATA (1978)

Adopted by the International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978. [Available at <http://www.euro.who.int/en/who-we-are/policy-documents/declaration-of-alma-ata,-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 well-being, 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 worldwide 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: reflects and evolves from the economic conditions and socio-cultural 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;

addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly; 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;

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; 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, 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; 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.

2. PEOPLES' CHARTER FOR HEALTH (2000)

Adopted on 8 December 2000 by the People's Health Assembly (PHA), a meeting of more than 1,400 people from over 90 countries in Savar, Bangladesh, from 4-8 December 2000. [Available at <http://www.phmovement.org/sites/www.phmovement.org/files/pbm-pcb-english.pdf>]

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 worldwide 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 policymaking.

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 percent.
- Demand measures to ensure occu-

pational 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.

3. THE LEADERS STATEMENT ON THE RIGHT TO HEALTH (2005)

*A project by Mr. Paul Hunt, United Nations Special Rapporteur on the Right to the Highest Attainable Standard of Health, and Realizing Rights: The Ethical Globalization Initiative
[Available at http://www.realizingrights.org/images/stories/RR_health_12_02_05.pdf]*

Everyone has the Right to Health. We believe health lies at the heart of our collective struggle to achieve a fairer, more humane world.

Health is not only a blessing to be wished for but a human right to be fought for.

The Right to Health: Keeping Our Promises

In 1946, the World Health Organization declared that the “enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without discrimination of race, religion, political belief, economic or social condition.”

Over 70% of all nations have ratified the International Covenant on Economic, Social and Cultural Rights which makes the right to health an international legal obligation that must be progressively realized at the national level. 99% have ratified the Convention on the Rights of the Child which includes protection of the right to health for children under age 18. The Universal Declaration of Human Rights not only urges States but also “every individual and every organ of society” to secure the observance of all human rights.

The right to the highest attainable standard of health is not a “right to be healthy”, nor does it mean

governments must put in place expensive health services beyond available public resources. But it does require governments to act:

To promote access to clean water, healthcare, adequate nutrition and sanitation without discrimination;

To invest in strong health systems;

To make sure that health care decisions are made accountably and with public participation;

To support low-income countries in their efforts to bring decent health to their peoples.

We refuse to accept a state of affairs in which life expectancy in rich countries approaches 80 years, while in some of the poorest it is below 40. Or where in some countries, of every 1,000 children born, more than 100 die before their fifth birthday, compared with fewer than 10 in high-income countries.

We will not stand by when every day, 30,000 children die of preventable illness and every minute, 5 more women join the 20 million already living with HIV/AIDS, and one more woman dies while giving birth.

We find it intolerable that more than 1 billion people—one person in five—lack access to safe water or that only ten percent of all health research and development spending is directed at the health problems of 90 percent of the world’s population.

We call for systemic changes to build strong health systems:

Funding of health systems must be increased through predictable, sustained and long-term investments, nationally and globally.

User fees for primary health care must be abolished, financial barriers to access eliminated, and systems to ensure financial protection implemented. Countries, rich and poor, must urgently confront the crisis of human resources: increase training, ensure that mid-level cadres of health workers are expanded and empowered, provide adequate and fair compensation for all health workers, and take measures to stem the exodus of scarce health workers from the public sector. Countries must adopt and implement laws, regulations and policies to strengthen health systems, improve women’s health, and establish tolerance and respect for women’s decisions in all matters pertaining to their health and well-being. HIV/AIDS programs and policies must be oriented to the strengthening of health systems and to the uncompromising protection of the health and rights of women and girls.

We call for these priorities to be reflected in poverty reduction and development strategies:

Political leaders must recognize the critical importance of health and empowerment, and of health systems, to achieving the Millennium Development Goals (MDGs), and Countries must endorse the ICPD (International Conference on Population and Development) target of universal access to reproductive health by 2015 as an additional target to MDG 5.

These commitments are not optional. All people have a human right to health.

We urge governments, as well as in-

ternational organizations, civil society groups, private companies, communities and individuals, to fulfill their responsibilities in ensuring the realization of the fundamental human right to health for all.

Signatories

Martti Ahtisaari, Former President of Finland

Bono, Lead singer, U2, Co-founder, DATA

Gro Harlem Brundtland, Former Prime Minister of Norway, Former Director-General of the World Health Organization

Sharan Burrow, President International Confederation of Free Trade Unions (ICFTU)

Kim Campbell, Former Prime Minister of Canada

Fernando Henrique Cardoso, Former President of Brazil

President Jimmy Carter, 39th President of the United States, Founder, The Carter Center

President Bill Clinton, 42nd President of the United States, Founder, The William J. Clinton Foundation

Shirin Ebadi, 2003 Nobel Peace Prize Laureate

Vigdís Finnbogadóttir, Former President of Iceland

Antonio Guterres, Former Prime Minister of Portugal

Vaclav Havel, Former President of Czechoslovakia and the Czech Republic

Paul Hunt, United Nations Special Rapporteur on the Right to the Highest Attainable Standard of Health

Lionel Jospin, Former Prime Minister of France

Hong Koo Lee, Former Prime Minister of Korea

Wangari Maathai, 2004 Nobel Peace Prize Laureate

Antonio M. Mascarenhas Monteiro, Former President of Cape Verde

Kumi Naidoo, Secretary General, CIVICUS, Chair, Global Call to Action against Poverty (GCAP)

Anand Panyarachun, Former Prime Minister of Thailand

Javier Perez de Cuellar, Former Prime Minister of Peru, Former Secretary-General of the United Nations

Peter Piot, Executive Director, UNAIDS, Under Secretary-General of the United Nations

Romano Prodi, Former President of the European Commission

Poul Nyrup Rasmussen, Former Prime Minister of Denmark

Mary Robinson, Former President of Ireland, Former United Nations High Commissioner for Human Rights

Jeffrey Sachs, Director, The Earth Institute at Columbia University, Spe-

cial Adviser to the United Nations Secretary-General on the Millennium Development Goals

Dr. Nafis Sadik, United Nations Special Envoy for HIV/AIDS in Asia and the Pacific, Former Executive Director, United Nations Population Fund (UNFPA)

Jenny Shipley, Former Prime Minister of New Zealand

Mario Soares, Former President of Portugal

His Royal Highness Prince El Hassan **Bin Talal**, Hashemite Kingdom of Jordan

The Most Reverend Desmond M. Tutu,

Anglican Archbishop Emeritus of Cape Town, 1984 Nobel Peace Prize Laureate

Cassam Uteem, Former President of Mauritius

Ernesto Zedillo, Former President of Mexico

IV. Protection of Life and Physical Integrity

A. The Right to Life

[Refer to Section I.A. above for the text of Article 3 of the Universal Declaration of Human Rights (1948) and Article 6 of the International Covenant on Civil and Political Rights (1966)]

I. EUROPEAN CONVENTION ON HUMAN RIGHTS (1950)

[Convention for the Protection of Human Rights and Fundamental Freedoms], signed at Rome on 4 November 1950, entered into force on 3 September 1953.

Council of Europe Treaty Series, No. 5, as amended

[Available at <http://www.echr.coe.int/ECHR/EN/Header/Basic+Texts/The+Convention+and+additional+protocols/The+European+Convention+on+Human+Rights/>]

Article 2

Right to life

1. Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.

2. Deprivation of life shall not be regarded as inflicted in contravention of

this Article when it results from the use of force which is no more than absolutely necessary:

(a) in defence of any person from unlawful violence;

(b) in order to effect a lawful arrest or to prevent the escape of a person lawfully detained;

(c) in action lawfully taken for the purpose of quelling a riot or insurrection.
