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The Right to Health

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ABBREVIATIONS

AIDS	Acquired immunodeficiency syndrome
HIV	Human immunodeficiency virus
NHRI	National human rights institution
OHCHR	Office of the United Nations High Commissioner for Human Rights
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Introduction

As human beings, our health and the health of those we care about is a matter of daily concern. Regardless of our age, gender, socio-economic or ethnic background, we consider our health to be our most basic and essential asset. Ill health, on the other hand, can keep us from going to school or to work, from attending to our family responsibilities or from participating fully in the activities of our community. By the same token, we are willing to make many sacrifices if only that would guarantee us and our families a longer and healthier life. In short, when we talk about well-being, health is often what we have in mind.

The right to health is a fundamental part of our human rights and of our understanding of a life in dignity. *The right to the enjoyment of the highest attainable standard of physical and mental health*, to give it its full name, is not new. Internationally, it was first articulated in the 1946 Constitution of the World Health Organization (WHO), whose preamble defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". The preamble further states that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."

The 1948 Universal Declaration of Human Rights also mentioned health as part of the right to an adequate standard of living (art. 25). The right to health was again recognized as a human right in the 1966 International Covenant on Economic, Social and Cultural Rights.

Since then, other international human rights treaties have recognized or referred to the right to health or to elements of it, such as the right to medical care. The right to health is relevant to all States: every State has ratified at least one international human rights treaty recognizing the right to health. Moreover, States have committed themselves to protecting this right through international declarations, domestic legislation and policies, and at international conferences.

In recent years, increasing attention has been paid to the right to the highest attainable standard of health, for instance by human rights treaty-monitoring bodies, by WHO and by the Commission on Human Rights (now replaced by the Human Rights Council), which in 2002 created the mandate of Special Rapporteur on the right of everyone to the highest attainable standard of physical and mental health. These initiatives have helped clarify the nature of the right to health and how it can be achieved.

This fact sheet aims to shed light on the right to health in international human rights law as it currently stands, amidst the plethora of initiatives and proposals as to what the right to health *may* or *should be*. Consequently, it does not purport to provide an exhaustive list of relevant issues or to identify specific standards in relation to them.

The fact sheet starts by explaining what the right to health is and illustrating its implications for specific individuals and groups, and then elaborates upon States' obligations with respect to the right. It ends with an overview of national, regional and international accountability and monitoring mechanisms.

I. WHAT IS THE RIGHT TO HEALTH?

A. Key aspects of the right to health[1]

- **The right to health is an inclusive right.** We frequently associate the right to health with access to health care and the building of hospitals. This is correct, but the right to health extends further. It includes a wide range of factors that can help us lead a healthy life. The Committee on Economic, Social and Cultural Rights, the body responsible for monitoring the International Covenant on Economic, Social and Cultural Rights,[2] calls these the "underlying determinants of health". They include:
  - Safe drinking water and adequate sanitation;
  - Safe food;
  - Adequate nutrition and housing;
  - Healthy working and environmental conditions;
  - Health-related education and information;
  - Gender equality.
- **The right to health contains freedoms.** These *freedoms* include the right to be free from non-consensual medical treatment, such as medical experiments and research or forced sterilization, and to be free from torture and other cruel, inhuman or degrading treatment or punishment.
- **The right to health contains entitlements.** These *entitlements* include:
  - The right to a system of health protection providing equality of opportunity for everyone to enjoy the highest attainable level of health;
  - The right to prevention, treatment and control of diseases;
  - Access to essential medicines;

[1] Many of these and other important characteristics of the right to health are clarified in general comment N° 14 (2000) on the right to health, adopted by the Committee on Economic, Social and Cultural Rights.

[2] The Covenant was adopted by the United Nations General Assembly in its resolution 2200A (XXI) of 16 December 1966. It entered into force in 1976 and by 1 December 2007 had been ratified by 157 States.

- Maternal, child and reproductive health;
- Equal and timely access to basic health services;
- The provision of health-related education and information;
- Participation of the population in health-related decision-making at the national and community levels.

- **Health services, goods and facilities must be provided to all without any discrimination.** Non-discrimination is a key principle in human rights and is crucial to the enjoyment of the right to the highest attainable standard of health (see section on non-discrimination below).

- **All services, goods and facilities must be available, accessible, acceptable and of good quality.**

  - Functioning public health and health-care facilities, goods and services must be *available* in sufficient quantity within a State.

  - They must be *accessible* physically (in safe reach for all sections of the population, including children, adolescents, older persons, persons with disabilities and other vulnerable groups) as well as financially and on the basis of non-discrimination. *Accessibility* also implies the right to seek, receive and impart health-related information in an accessible format (for all, including persons with disabilities), but does not impair the right to have personal health data treated confidentially.

  - The facilities, goods and services should also respect medical ethics, and be gender-sensitive and culturally appropriate. In other words, they should be medically and culturally *acceptable*.

  - Finally, they must be scientifically and medically appropriate and of *good quality.* This requires, in particular, trained health professionals, scientifically approved and unexpired drugs and hospital equipment, adequate sanitation and safe drinking water.

B. Common misconceptions about the right to health

- **The right to health is NOT the same as the *right to be healthy*.** A common misconception is that the State has to guarantee us good health. However, good health is influenced by several factors that are outside the direct control of States, such as an individual's biological make-up and socio-economic conditions. Rather, the right to health refers to the right to the enjoyment of a variety of goods, facilities, services and conditions necessary for its realization. This is why it is more accurate to describe it as the right to the *highest attainable standard* of physical and mental health, rather than an unconditional right to be healthy.

- **The right to health is NOT only a *programmatic goal* to be attained in the long term.** The fact that the right to health should be a tangible programmatic goal does not mean that no immediate obligations on States arise from it. In fact, States must make every possible effort, within available resources, to realize the right to health and to take steps in that direction without delay. Notwithstanding resource constraints, some obligations have an immediate effect, such as the undertaking to guarantee the right to health in a non-discriminatory manner, to develop specific legislation and plans of action, or other similar steps towards the full realization of this right, as is the case with any other human right. States also have to ensure a minimum level of access to the essential material components of the right to health, such as the provision of essential drugs and maternal and child health services. (See chapter III for more details.)

- **A country's difficult financial situation does NOT absolve it from having to take action to realize the right to health.** It is often argued that States that cannot afford it are not obliged to take steps to realize this right or may delay their obligations indefinitely. When considering the level of implementation of this right in a particular State, the availability of resources at that time and the development context are taken into account. Nonetheless, no State can justify a failure to respect its obligations because of a lack of resources. States must guarantee the right to health to the maximum of their available resources, even if these are tight. While steps may depend on the specific context, all States must move towards meeting their obligations to respect, protect and fulfil (see page 25 for further details).

C. The link between the right to health and other human rights

Human rights are interdependent, indivisible and interrelated.[3] This means that violating the right to health may often impair the enjoyment of other human rights, such as the rights to education or work, and vice versa.

The importance given to the "underlying determinants of health", that is, the factors and conditions which protect and promote the right to health beyond health services, goods and facilities, shows that the right to health is dependent on, and contributes to, the realization of many other human rights. These include the rights to food, to water, to an adequate standard of living, to adequate housing, to freedom from discrimination, to privacy, to access to information, to participation, and the right to benefit from scientific progress and its applications.

Links between the right to health and the right to water

Ill health is associated with the ingestion of or contact with unsafe water, lack of clean water (linked to inadequate hygiene), lack of sanitation, and poor management of water resources and systems, including in agriculture. Most diarrhoeal disease in the world is attributable to unsafe water, sanitation and hygiene. In 2002, diarrhoea attributable to these three factors caused approximately 2.7 per cent of deaths (1.5 million) worldwide.[4]

It is easy to see interdependence of rights in the context of poverty. For people living in poverty, their health may be the only asset on which they can draw for the exercise of other economic and social rights, such as the right to work or the right to education. Physical health and mental health enable adults to work and children to learn, whereas ill health is a liability to the individuals themselves and to those who must care for them. Conversely, individuals' right to health cannot be realized without realizing their other rights, the violations of which are at the root of poverty, such as the rights to work, food, housing and education, and the principle of non-discrimination.

[3] See Vienna Declaration and Programme of Action (A/CONF.157/23), adopted by the World Conference on Human Rights, held in Vienna, 14–25 June 1993.

[4] World Health Organization, *Water, sanitation and hygiene: Quantifying the health impact at national and local levels in countries with incomplete water supply and sanitation coverage*, Environmental Burden of Disease Series, No. 15 (Geneva, 2007).

D. How does the principle of non-discrimination apply to the right to health?

Discrimination means any distinction, exclusion or restriction made on the basis of various grounds which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise of human rights and fundamental freedoms. It is linked to the marginalization of specific population groups and is generally at the root of fundamental structural inequalities in society. This, in turn, may make these groups more vulnerable to poverty and ill health. Not surprisingly, traditionally discriminated and marginalized groups often bear a disproportionate share of health problems. For example, studies have shown that, in some societies, ethnic minority groups and indigenous peoples enjoy fewer health services, receive less health information and are less likely to have adequate housing and safe drinking water, and their children have a higher mortality rate and suffer more severe malnutrition than the general population.

The impact of discrimination is compounded when an individual suffers double or multiple discrimination, such as discrimination on the basis of sex *and* race or national origin or age. For example, in many places indigenous women receive fewer health and reproductive services and information, and are more vulnerable to physical and sexual violence than the general population.

Non-discrimination and equality are fundamental human rights principles and critical components of the right to health. The International Covenant on Economic, Social and Cultural Rights (art. 2 (2)) and the Convention on the Rights of the Child (art. 2 (1)) identify the following non-exhaustive grounds of discrimination: race, colour, sex, language, religion, political or other opinion, national or social origin, property, disability, birth or other status. According to the Committee on Economic, Social and Cultural Rights, "other status" may include health status (e.g., HIV/AIDS) or sexual orientation. States have an obligation to prohibit and eliminate discrimination on all grounds and ensure equality to all in relation to access to health care and the underlying determinants of health. The International Convention on the Elimination of All Forms of Racial Discrimination (art. 5) also stresses that States must prohibit and eliminate racial discrimination and guarantee the right of everyone to public health and medical care.

Non-discrimination and equality further imply that States must recognize and provide for the differences and specific needs of groups that generally face particular health challenges, such as higher mortality rates or vulnerability to specific diseases. The obligation to ensure non-discrimination requires specific health standards to be applied to particular

population groups, such as women, children or persons with disabilities (see chap. II). Positive measures of protection are particularly necessary when certain groups of persons have continuously been discriminated against in the practice of States parties or by private actors.

Along the same lines, the Committee on Economic, Social and Cultural Rights has made it clear that there is no justification for the lack of protection of vulnerable members of society from health-related discrimination, be it in law or in fact. So even if times are hard, vulnerable members of society must be protected, for instance through the adoption of relatively low-cost targeted programmes.[5]

Neglected diseases: a right-to-health issue with many faces

Neglected diseases are those seriously disabling or life-threatening diseases for which treatment options are inadequate or non-existent. They include leishmaniasis (kala-azar), onchocerciasis (river blindness), Chagas' disease, leprosy, schistosomiasis (bilharzia), lymphatic filariasis, African trypanosomiasis (sleeping sickness) and dengue fever. Malaria and tuberculosis are also often considered to be neglected diseases.[6]

There are clear links between neglected diseases and human rights:

- Neglected diseases almost exclusively affect poor and marginalized populations in low-income countries, in rural areas and settings where poverty is widespread. Guaranteeing the **underlying determinants of the right to health** is therefore key to reducing the incidence of neglected diseases.
- **Discrimination** is both a cause and a consequence of neglected diseases. For example, discrimination may prevent persons affected by neglected diseases from seeking help and treatment in the first place.
- **Essential drugs** against neglected diseases are often unavailable or inadequate. (Where they are available, they may be toxic.)
- **Health interventions and research and development** have long been inadequate and underfunded (although the picture has changed in recent years, with more drug development projects under way).[7] The obligation is on States to promote the development of new drugs, vaccines and diagnostic tools through research and development and through international cooperation.

[5] General comment N° 14, para. 18.

[6] However, they occur in both wealthy and low-income countries, and international attention and treatment options for them have dramatically increased in recent years (see, e.g., the Roll Back Malaria Partnership, http://www.rbm.who.int).

[7] Mary Moran and others, *The new landscape of neglected disease drug development* (London School of Economics and Political Science and The Wellcome Trust, 2005).

E. THE RIGHT TO HEALTH IN INTERNATIONAL HUMAN RIGHTS LAW

The right to the highest attainable standard of health is a human right recognized in international human rights law. The International Covenant on Economic, Social and Cultural Rights, widely considered as the central instrument of protection for the right to health, recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." It is important to note that the Covenant gives both mental health, which has often been neglected, and physical health equal consideration.

International Covenant on Economic, Social and Cultural Rights, art. 12

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
   (*a*) The provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child;
   (*b*) The improvement of all aspects of environmental and industrial hygiene;
   (*c*) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
   (*d*) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

Subsequent international and regional human rights instruments address the right to health in various ways. Some are of general application while others address the human rights of specific groups, such as women or children.

International human rights treaties recognizing the right to health

- The 1965 International Convention on the Elimination of All Forms of Racial Discrimination: art. 5 (*e*) (iv)
- The 1966 International Covenant on Economic, Social and Cultural Rights: art. 12
- The 1979 Convention on the Elimination of All Forms of Discrimination against Women: arts. 11 (1) (*f*), 12 and 14 (2) (*b*)
- The 1989 Convention on the Rights of the Child: art. 24
- The 1990 International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families: arts. 28, 43 (*e*) and 45 (*c*)
- The 2006 Convention on the Rights of Persons with Disabilities: art. 25.

In addition, the treaty bodies that monitor the International Covenant on Economic, Social and Cultural Rights, the Convention on the Elimination of All Forms of Discrimination against Women and the Convention on the Rights of the Child have adopted general comments or general recommendations on the right to health and health-related issues. These provide an authoritative and detailed interpretation of the provisions found in the treaties.[8] Numerous conferences and declarations, such as the International Conference on Primary Health Care (resulting in the Declaration of Alma-Ata[9]), the United Nations Millennium Declaration and Millennium Development Goals,[10] and the Declaration of Commitment on HIV/AIDS,[11] have also helped clarify various aspects of public health relevant to the right to health and have reaffirmed commitments to its realization.

Declaration of Alma-Ata, 1978

The Declaration affirms the crucial role of primary health care, which addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly (art. VII). It stresses that access to primary health care is the key to attaining a level of health that will permit all individuals to lead a socially and economically productive life (art. V) and to contributing to the realization of the highest attainable standard of health.

The right to health is also recognized in several regional instruments, such as the African Charter on Human and Peoples' Rights (1981), the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights, known as the Protocol of San Salvador (1988), and the European Social Charter (1961, revised in 1996). The American Convention on Human Rights (1969) and the European Convention for the Promotion of Human Rights and Fundamental Freedoms (1950) contain provisions related to health, such as the right to life, the prohibition on torture and other cruel, inhuman and degrading treatment, and the right to family and private life.

Finally, the right to health or the right to health care is recognized in at least 115 constitutions. At least six other constitutions set out duties in relation to health, such as the duty on the State to develop health services or to allocate a specific budget to them.

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[8] For more details on these treaty bodies, see Fact Sheet N° 30.

[9] Declaration of Alma-Ata, International Conference on Primary Health Care, Alma-Ata, USSR, September 1978.

[10] See http://www.un.org/millenniumgoals/.

[11] General Assembly resolution S-26/2 of 27 July 2001.

The right to health and health duties in selected national constitutions

Constitution of South Africa (1996):

Chapter II, Section 27: Health care, food, water and social security:

"(1) Everyone has the right to have access to

a. health-care services, including reproductive health care;

b. sufficient food and water; […]

(2) The State must take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of each of these rights.

(3) No one may be refused emergency medical treatment."

Constitution of India (1950):

Part IV, art. 47, articulates a duty of the State to raise the level of nutrition and the standard of living and to improve public health: "The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties…"

Constitution of Ecuador (1998):

Chapter IV: Economic, Social and Cultural Rights, art. 42: "The State guarantees the right to health, its promotion and protection, through the development of food security, the provision of drinking water and basic sanitation, the promotion of a healthy family, work and community environment, and the possibility of permanent and uninterrupted access to health services, in conformity with the principles of equity, universality, solidarity, quality and efficiency."

II. HOW DOES THE RIGHT TO HEALTH APPLY TO SPECIFIC GROUPS?

Some groups or individuals, such as children, women, persons with disabilities or persons living with HIV/AIDS, face specific hurdles in relation to the right to health. These can result from biological or socio-economic factors, discrimination and stigma, or, generally, a combination of these. Considering health as a human right requires specific attention to different individuals and groups of individuals in society, in particular those living in vulnerable situations. Similarly, States should adopt positive measures to ensure that specific individuals and groups are not discriminated against. For instance, they should disaggregate their health laws and policies and tailor them to those most in need of assistance rather than passively allowing seemingly neutral laws and policies to benefit mainly the majority groups.

To illustrate what the standards related to the right to health mean in practice, this chapter focuses on the following groups: women, children and adolescents, persons with disabilities, migrants and persons living with HIV/AIDS.

A. Women

Convention on the Elimination of All Forms of Discrimination against Women, art. 12

1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health-care services, including those related to family planning.
2. 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.

International Covenant on Economic, Social and Cultural Rights, art. 10 (2)

Special protection should be accorded to mothers during a reasonable period before and after childbirth. During such period working mothers should be accorded paid leave or leave with adequate social security benefits.

Women are affected by many of the same health conditions as men, but women experience them differently. The prevalence of poverty and economic dependence among women, their experience of violence, gender bias in the health system and society at large, discrimination on the grounds of race or other factors, the limited power many women have over their sexual and reproductive lives and their lack of influence in decision-making are social realities which have an adverse impact on their health. So women face particular health issues and particular forms of discrimination, with some groups, including refugee or internally displaced women, women in slums and suburban settings, indigenous and rural women, women with disabilities or women living with HIV/AIDS (see section below on HIV/AIDS), facing multiple forms of discrimination, barriers and marginalization in addition to gender discrimination.

Both the International Covenant on Economic, Social and Cultural Rights and the Convention on the Elimination of All Forms of Discrimination against Women require the elimination of discrimination against women in health care as well as guarantees of equal access for women and men to health-care services. Redressing discrimination in all its forms, including in the provision of health care, and ensuring equality between men and women are fundamental objectives of treating health as a human

right. In this respect, the Convention on the Elimination of All Forms of Discrimination against Women (art. 14) specifically calls upon States to ensure that "women in rural areas… participate in and benefit from rural development" and "have access to adequate health-care facilities,… counselling and services in family planning."

The Committee on the Elimination of Discrimination against Women further requires States parties to ensure women have appropriate services in connection with pregnancy, childbirth and the post-natal period, including family planning and emergency obstetric care. The requirement for States to ensure safe motherhood and reduce maternal mortality and morbidity is implicit here.

Sexual and reproductive health is also a key aspect of women's right to health. States should enable women to have control over and decide freely and responsibly on matters related to their sexuality, including their sexual and reproductive health, free from coercion, lack of information, discrimination and violence. The Programme of Action of the International Conference on Population and Development[12] and the Beijing Platform for Action[13] highlighted the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

Violence against women: a women's rights and right-to-health issue

Violence against women is a widespread cause of physical and psychological harm or suffering among women, as well as a violation of their right to health. The Committee on the Elimination of Discrimination against Women requires States to, among other things, enact and enforce laws and policies that protect women and girls from violence and abuse and provide for appropriate physical and mental health services. Health-care workers should also be trained to detect and manage the health consequences of violence against women, while female genital mutilation should be prohibited.[14]

States must exercise due diligence to prevent, investigate and prosecute such violence whether it is perpetrated by State actors or private persons. Survivors of any form of violence against women have the right to adequate reparation and rehabilitation that cover their physical and mental health.

[12] *Report of the International Conference on Population and Development, Cairo, 5–13 September 1994* (United Nations publication, Sales N° E.95.XIII.18).

[13] Beijing Declaration and Platform for Action, *Report of the Fourth World Conference on Women, Beijing, 4–15 September 1995* (United Nations publication, Sales N° E.96.IV.13), chap. I, resolution 1.

[14] See Committee on the Elimination of Discrimination against Women, general recommendations N° 19 (1992) on violence against women and N° 24 (1999) on women and health.

B. Children and adolescents

Children face particular health challenges related to the stage of their physical and mental development, which makes them especially vulnerable to malnutrition and infectious diseases, and, when they reach adolescence, to sexual, reproductive and mental health problems.

Most childhood deaths can be attributed to a few major causes—acute respiratory infections, diarrhoea, measles, malaria and malnutrition—or a combination of these. In this regard both the International Covenant on Economic, Social and Cultural Rights and the Convention on the Rights of the Child recognize the obligation on States to reduce infant and child mortality, and to combat disease and malnutrition. In addition, a baby who has lost his or her mother to pregnancy and childbirth complications has a higher risk of dying in early childhood. Infants' health is so closely linked to women's reproductive and sexual health that the Convention on the Rights of the Child directs States to ensure access to essential health services for the child and his/her family, including pre- and post-natal care for mothers.

Children are also increasingly at risk because of HIV infections occurring mostly through mother-to-child transmission (a baby born to an HIV-positive mother has a 25 to 35 per cent chance of becoming infected during pregnancy, childbirth or breastfeeding). Accordingly, States should take measures to prevent such transmission through, for instance: medical protocols for HIV testing during pregnancy; information campaigns among women on these forms of transmission; the provision of affordable drugs; and the provision of care and treatment to HIV-infected women, their infants and families, including counselling and infant feeding options.

Governments and health professionals should treat all children and adolescents in a non-discriminatory manner. This means that they should pay particular attention to the needs and rights of specific groups, such as children belonging to minorities or indigenous communities, intersex children[15] and, generally, young girls and adolescent girls, who in many contexts are prevented from accessing a wide range of services, including health care. More specifically, girls should have equal access to adequate nutrition, safe environments, and physical and mental health services. Appropriate measures should be taken to abolish harmful traditional practices that affect mostly girls' health, such as female genital mutilation, early marriage, and preferential feeding and care of boys.

[15] Intersex children are born with internal and external sex organs that are neither exclusively male nor exclusively female.

Children who have experienced neglect, exploitation, abuse, torture or any other form of cruel, inhuman or degrading treatment or punishment also require specific protection by States. The Convention on the Rights of the Child (art. 39) stresses the responsibility of the State for promoting children's physical and psychological recovery and social reintegration.

While adolescents are in general a healthy population group, they are prone to risky behaviour, sexual violence and sexual exploitation. Adolescent girls are also vulnerable to early and/or unwanted pregnancies. Adolescents' right to health is therefore dependent on health care that respects confidentiality and privacy and includes appropriate mental, sexual and reproductive health services and information. Adolescents are, moreover, particularly vulnerable to sexually transmitted diseases, including HIV/AIDS. In many regions of the world, new HIV infections are heavily concentrated among young people (15–24 years of age).[16] Effective prevention programmes should address sexual health and ensure equal access to HIV-related information and preventive measures such as voluntary counselling and testing, and affordable contraceptive methods and services.

Convention on the Rights of the Child, art. 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 prenatal 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

[16] Joint United Nations Programme on HIV/AIDS and World Health Organization, *AIDS epidemic update: December 2006*, p. 9.

knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;

(*f*) To develop preventive health care, guidance for parents and family planning education and services.

3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.

4. States Parties undertake to promote and encourage international cooperation with a view to achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries.

C. Persons with disabilities

Even though more than 650 million people worldwide have a disability of one form or another (two thirds of whom live in developing countries), most have long been neglected and marginalized by the State and society. It is only in recent years that persons with disabilities have brought about a paradigm shift in attitudes towards them. This has seen a move away from regarding them as "objects" of charity and medical interventions towards their empowerment as "subjects" of human rights, including but not limited to the right to health.

The right to health of persons with disabilities cannot be achieved in isolation. It is closely linked to non-discrimination and other principles of individual autonomy, participation and social inclusion, respect for difference, accessibility, as well as equality of opportunity and respect for the evolving capacities of children.[17]

Persons with disabilities face various challenges to the enjoyment of their right to health. For example, persons with physical disabilities often have difficulties accessing health care, especially in rural areas, slums and suburban settings; persons with psychosocial disabilities may not have access to affordable treatment through the public health system; women with disabilities may not receive gender-sensitive health services. Medical practitioners sometimes treat persons with disabilities as objects of treatment rather than rights-holders and do not always seek their free and informed consent when it comes to treatments. Such a situation is not only degrading, it is a violation of human rights under the Convention

[17] These and other principles are reflected in art. 3 of the Convention on the Rights of Persons with Disabilities, which was adopted by the United Nations General Assembly in its resolution 61/106 of 13 December 2006.

on the Rights of Persons with Disabilities and unethical conduct on the part of the medical professional.

Persons with disabilities are also disproportionately susceptible to violence and abuse. They are victims of physical, sexual, psychological and emotional abuse, neglect, and financial exploitation, while women with disabilities are particularly exposed to forced sterilization and sexual violence. Violence against persons with disabilities often occurs in a context of systemic discrimination against them in which there is an imbalance of power. It is now acknowledged that it is not the disability itself that may put people with disabilities at risk, but the social conditions and barriers they face, such as stigma, dependency on others for care, gender, poverty or financial dependency.

By way of illustration, one can note the neglect that persons with psychosocial or intellectual disabilities suffer. In many cases, they are treated without their free and informed consent—a clear and serious violation of their right to health. They are, moreover, often locked up in institutions simply on the basis of disability, which can have serious repercussions for their enjoyment of the right to health and other rights.

In other cases, these disabilities are often neither diagnosed nor treated or accommodated for, and their significance is generally overlooked. Adequate policies, programmes, laws and resources are lacking—for instance, in 2001, most middle- and low-income countries devoted less than 1 per cent of their health expenditures to mental health.[18] As a result, mental health care, including essential medication such as psychotropic drugs, is inaccessible or unaffordable to many. Access to all types of health care for persons with psychosocial or intellectual disabilities is complicated by the stigma and discrimination they suffer, contrary to the obligation on States to provide access to health care on an equal basis.

The newly adopted Convention on the Rights of Persons with Disabilities requires States to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by persons with disabilities, including their right to health, and to promote respect for their inherent dignity (art. 1). Article 25 further recognizes the "right to the enjoyment of the highest attainable standard of health without discrimination" for persons with disabilities and elaborates upon measures States should take to ensure this right.

[18] World Health Organization, *Mental Health Atlas:* 2005 (Geneva, 2005).

These measures include ensuring that persons with disabilities have access to and benefit from those medical and social services needed specifically because of their disabilities, including early identification and intervention, services designed to minimize and prevent further disabilities as well as orthopaedic and rehabilitation services, which enable them to become independent, prevent further disabilities and support their social integration.[19] Similarly, States must provide health services and centres as close as possible to people's own communities, including in rural areas. Furthermore, the non-discrimination principle requires that persons with disabilities should be provided with "the same range, quality and standard of free or affordable health care and programmes as provided to other persons", and States should "prevent discriminatory denial of health care or health services or food or fluids on the basis of disability" (see generally arts. 25 and 26 of the Convention).

Importantly, States must require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent. To this end, States are required to train health professionals and to set ethical standards for public and private health care. The Convention on the Rights of the Child (art. 23) recognizes the right of children with disabilities to special care and to effective access to health-care and rehabilitation services.

D. Migrants

Migration has become a major political, social and economic phenomenon, with significant human rights consequences. The International Organization for Migration estimates that, today, there are nearly 200 million international migrants worldwide. According to the International Labour Organization, 90 million of them are migrant workers. Although migration has implications for the right to health in both home and host countries, the focus here is on migrants in host countries. Their enjoyment of the right to health is often limited merely because they are migrants, as well as owing to other factors such as discrimination, language and cultural barriers, or their legal status. While they all face particular problems linked to their specific status and situation (undocumented or irregular migrants and migrants held in detention being particularly at risk),[20] many migrants

[19] See Committee on Economic, Social and Cultural Rights, general comment N° 5 (1994) on people with disabilities, and arts. 25 (*b*) and 26 of the Convention on the Rights of Persons with Disabilities.

[20] Persons granted refugee status or internally displaced persons do not fall into the category of migrants. See "Specific groups and individuals: migrant workers" (E/CN.4/2005/85).

will face similar obstacles to realizing their human rights, including their right to health.

States have explicitly stated before international human rights bodies or in national legislation that they cannot or do not wish to provide the same level of protection to migrants as to their own citizens. Accordingly, most countries have defined their health obligations towards non-citizens in terms of "essential care" or "emergency health care" only. Since these concepts mean different things in different countries, their interpretation is often left to individual health-care staff. Practices and laws may therefore be discriminatory.

Major difficulties faced by migrants—particularly undocumented migrants—with respect to their right to health:[21]

- Migrants are generally inadequately covered by State health systems and are often unable to afford health insurance. Migrant sex workers and undocumented migrants in particular have little access to health and social services;
- Migrants have difficulties accessing information on health matters and available services. Often the information is not provided adequately by the State;
- Undocumented migrants dare not access health care for fear that health providers may denounce them to immigration authorities;
- Female domestic workers are particularly vulnerable to sexual abuse and violence;
- Migrant workers often work in unsafe and unhealthy conditions;
- Migrant workers may be more prone to risky sexual behaviour owing to their vulnerable situation, far away from their families and their exclusion from major prevention and care programmes on sexually transmitted diseases and HIV/AIDS. Their situation is therefore conducive to the rapid spread of these diseases;
- Conditions in the centres where undocumented migrants are detained may also be conducive to the spread of diseases;
- Trafficked persons are subject to physical violence and abuse, and face formidable hurdles related to their right to reproductive health (sexually transmitted diseases, including infection with HIV/AIDS, unwanted pregnancies, unsafe abortions).

[21] See World Health Organization, *International Migration, Health and Human Rights*, Health & Human Rights Publication Series, No. 4 (December 2003), available at http://www.who.int, and Joint United Nations Programme on HIV/AIDS and International Organization for Migration, *Migrants' Right to Health*, UNAIDS Best Practice Collection (Geneva, 2001).

The International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (art. 28) stipulates that all migrant workers and their families have the right to emergency medical care for the preservation of their life or the avoidance of irreparable harm to their health. Such care should be provided regardless of any irregularity in their stay or employment. The Convention further protects migrant workers in the workplace and stipulates that they shall enjoy treatment not less favourable than that which applies to nationals of the State of employment in respect of conditions of work, including safety and health (art. 25).

The Committee on the Elimination of Racial Discrimination, in its general recommendation N° 30 (2004) on non-citizens, and the Committee on Economic, Social and Cultural Rights, in its general comment N° 14 (2000) on the right to the highest attainable standard of health, both stress that States parties should respect the right of non-citizens to an adequate standard of physical and mental health by, inter alia, refraining from denying or limiting their access to preventive, curative and palliative health services. The Special Rapporteur on Health has also stressed that sick asylum-seekers or undocumented persons, as some of the most vulnerable persons within a population, should not be denied their human right to medical care.

Finally, migrants' right to health is closely related to and dependent on their working and living conditions and legal status. In order to comprehensively address migrants' health issues, States should also take steps to realize their rights to, among other things, adequate housing, safe and healthy working conditions, an adequate standard of living, food, information, liberty and security of person, due process, and freedom from slavery and compulsory labour.

E. Persons living with HIV/AIDS

More than 25 million people have died of AIDS in the past 25 years, making it one of the most destructive pandemics in recent times. There are now about 33 million people living with HIV/AIDS. Since emerging as a major health emergency, the epidemic has had a serious and, in many places, devastating effect on human rights and development.

It is generally recognized that HIV/AIDS raises many human rights issues. Conversely, protecting and promoting human rights are essential for

preventing the transmission of HIV and reducing the impact of AIDS on people's lives. Many human rights are relevant to HIV/AIDS, such as the right to freedom from discrimination, the right to life, equality before the law, the right to privacy and the right to the highest attainable standard of health.

The links between the HIV/AIDS pandemic and poverty, stigma and discrimination, including that based on gender and sexual orientation, are widely acknowledged. The incidence and spread of HIV/AIDS are disproportionately high among certain populations, including women,[22] children, those living in poverty, indigenous peoples, migrants, men having sex with men, male and female sex workers, refugees and internally displaced people, and in certain regions, such as sub-Saharan Africa. The discrimination they suffer makes them (more) vulnerable to HIV infection. At the same time, the right to health of persons living with HIV/AIDS is undermined by discrimination and stigma. For example, fear of being identified with HIV/AIDS may stop people who suffer discrimination, such as sex workers or intravenous drug users, from voluntarily seeking counselling, testing or treatment.

Halting and reversing global epidemics relies heavily on addressing discrimination and stigma. Importantly, States should prohibit discrimination on the grounds of health status, including actual or presumed HIV/AIDS status, and protect persons living with HIV/AIDS from discrimination. State legislation, policies and programmes should include positive measures to address factors that hinder the equal access of these vulnerable populations to prevention, treatment and care, such as their economic status.

Universal access to care and treatment is also an important component of the right to health for persons living with HIV/AIDS. Equally, it is important to ensure the availability of medicines and strengthen HIV prevention by, for instance, providing condoms and HIV-related information and education, and preventing mother-to-child transmission. The *International Guidelines on HIV/AIDS and Human Rights* provide further guidance on ensuring the rights of persons living with HIV/AIDS.[23]

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[22] Women are today more vulnerable to infection than men. See Joint United Nations Programme on HIV/AIDS, *Report on the global AIDS epidemic* (Geneva, 2006).

[23] See Joint United Nations Programme on HIV/AIDS and Office on the United Nations High Commissioner for Human Rights, *International Guidelines on HIV/AIDS and Human Rights: 2006 Consolidated Version* (United Nations publication, Sales N° E.06.XIV.4), General Assembly resolution 60/1 of 16 September 2005 on the 2005 World Summit Outcome and General Assembly resolution 60/224 of 23 December 2005.

Women and HIV/AIDS

Gender inequality and failure to respect the rights of women and girls are significant factors in the HIV/AIDS pandemic in many regions of the world. For example, women's subordination to men in private and public life may prevent women and girls from negotiating safe sex practices. Women—young women in particular—are disproportionately vulnerable to infection. In addition, women have generally less access to available treatments and adequate information. They are also disproportionately affected by the burden of caregiving.

States should put in place laws and policies that challenge gender inequality and social norms that contribute to HIV/AIDS expansion. They should also provide equal access to HIV-related information, education, means of prevention and health services. Significantly, they should ensure women's sexual and reproductive rights, which are key to HIV prevention. In this respect preventing HIV transmission in pregnant women, mothers and their children is crucial (see also box on Treatment Action Campaign below). States should also protect women against sexual violence, which makes them more vulnerable to HIV infection and other sexually transmitted infections.

III. OBLIGATIONS ON STATES AND RESPONSIBILITIES OF OTHERS TOWARDS THE RIGHT TO HEALTH

States have the primary obligation to protect and promote human rights. Human rights obligations are defined and guaranteed by international customary law[24] and international human rights treaties, creating binding obligations on the States that have ratified them to give effect to these rights.

A. General obligations

International Covenant on Economic, Social and Cultural Rights, art. 2

1. Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and cooperation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.

[24] Customary law is evidence of a general practice of States accepted as law and followed out of a sense of legal obligation.

2. The States Parties to the present Covenant undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

Progressive realization

Through their ratification of human rights treaties, States parties are required to give effect to these rights within their jurisdictions. More specifically, article 2 (1) of the International Covenant on Economic, Social and Cultural Rights underlines that States have the obligation to progressively achieve the full realization of the rights under the Covenant. This is an implicit recognition that States have resource constraints and that it necessarily takes time to implement the treaty provisions. Consequently, some components of the rights protected under the Covenant, including the right to health, are deemed *subject to progressive realization*.

Not all aspects of the rights under the Covenant can or may be realized immediately, but at a minimum States must show that they are making every possible effort, within available resources, to better protect and promote all rights under the Covenant. Available resources refer to those existing within a State as well as those available from the international community through international cooperation and assistance, as outlined in article 2 (1).

The role of international assistance and cooperation is reflected in other instruments as well, such as the Charter of the United Nations, the Universal Declaration of Human Rights and the Convention on the Rights of the Child.[25] It is not a substitute for domestic obligations, but it comes into play in particular if a State is unable to give effect to economic, social and cultural rights on its own, and requires assistance from other States to do so. International cooperation is particularly incumbent upon those States that are in a position to assist others in this regard. States should thus have an active programme of international assistance and cooperation and provide economic and technical assistance to enable other States to meet their obligations in relation to the right to health.[26]

[25] Charter of the United Nations, Arts. 1 (3), 55 and 56; Universal Declaration of Human Rights, arts. 22 and 28; and Convention on the Rights of the Child, arts. 4 and 24.

[26] Committee on Economic, Social and Cultural Rights, general comment N° 3 (1990) on the nature of States parties' obligations and general comment N° 14, paras. 38–42.

While the concept of progressive realization applies to all rights under the Covenant, some obligations are *of immediate effect*, in particular the undertaking to guarantee that all rights are exercised on the basis of *non-discrimination* and the obligation to *take steps* towards the realization of the rights, including the right to health, which should be concrete, deliberate and targeted. In this regard, retrogressive measures are not permissible, unless a State can demonstrate that it has made every effort to use all resources at its disposal to meet its obligations.

Taking steps to realize the right to health

Taking steps to realize the right to health requires a variety of measures. As the most feasible measures to implement the right to health will vary from State to State, international treaties do not offer set prescriptions. The International Covenant on Economic, Social and Cultural Rights in article 2 (1) simply states that the full realization of the rights contained in the treaty must be achieved through "all appropriate means, including particularly the adoption of legislative measures."

The Committee on Economic, Social and Cultural Rights has underlined that States should, at a minimum, adopt 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. Setting indicators and benchmarks will be decisive in the formulation and implementation of such a strategy. Indeed, the right to health being subject to progressive realization, what is expected of a State will vary over time. So a State needs a device to monitor and measure these variable dimensions of the right to health. Indicators, especially when disaggregated, provide useful information on how the right to health is realized in a particular country. OHCHR has been developing a conceptual and methodological framework for such indicators.

A proposed framework for indicators[27]

For a human right, the identified indicators help to assess the steps taken by a State in meeting its obligations—from acceptance of international human rights standards (*structural* indicators) to efforts being made by the State to meet the obligations that flow from these standards (*process* indicators), on to the results of those efforts from the perspective of the population (*outcome* indicators). Indicators that illustrate the right to the highest attainable standard of health are, for instance, the number of international human rights treaties

[27] See "Report on indicators for monitoring compliance with international human rights instruments" (HRI/MC/2006/7), available at http://www.ohchr.org. This framework is being validated through expert consultations and workshops in 2007–2008.

relevant to the right to health that the State has ratified (*structural* indicator), the proportion of births attended by skilled health personnel (*process* indicator) and maternal mortality ratio (*outcome* indicator). It is also crucial that indicators be disaggregated by relevant population group and possible ground of discrimination.

Core minimum obligation

The Committee on Economic, Social and Cultural Rights has also stressed that States have a *core minimum obligation* to ensure the satisfaction of minimum essential levels of each of the rights under the Covenant. While these essential levels are, to some extent, resource-dependent, they should be given priority by the State in its efforts to realize the rights under the Covenant. With respect to the right to health, the Committee has underlined that States must ensure:

- The right of access to health facilities, goods and services *on a non-discriminatory basis,* especially for vulnerable or marginalized groups;
- Access to the *minimum essential food* which is nutritionally adequate and safe;
- Access to *shelter, housing and sanitation* and an adequate supply of *safe drinking water*;
- The provision of *essential drugs*;
- *Equitable distribution* of all health facilities, goods and services.

B. Three types of obligations

State obligations fall into three categories, namely the obligations to *respect, protect* and *fulfil.*

The obligation to respect

The obligation to respect requires States to refrain from interfering directly or indirectly with the right to health.

For example, States should refrain from denying or limiting access to health-care services; from marketing unsafe drugs; from imposing discriminatory practices relating to women's health status and needs; from limiting access to contraceptives and other means of maintaining sexual and reproductive health; from withholding, censoring or misrepresenting

health information; and from infringing on the right to privacy (e.g., of persons living with HIV/AIDS).

In addition, the Committee on Economic, Social and Cultural Rights underlined in its general comment N° 14 that States parties have to respect the enjoyment of the right to health in other countries.

The obligation to protect

The obligation to protect requires States to prevent third parties from interfering with the right to health.

States should adopt legislation or other measures to ensure that private actors conform with human rights standards when providing health care or other services (such as regulating the composition of food products); control the marketing of medical equipment and medicines by private actors; ensure that privatization does not constitute a threat to the availability, accessibility, acceptability and quality of health-care facilities, goods and services; protect individuals from acts by third parties that may be harmful to their right to health—e.g., prevent women from undergoing harmful traditional practices or third parties from coercing them to do so (by, for example, enacting laws that specifically prohibit female genital mutilation); ensure that third parties do not limit people's access to health-related information and services, including environmental health; and ensure that health professionals provide care to persons with disabilities with their free and informed consent.

In its general comment N° 14, the Committee on Economic, Social and Cultural Rights also stressed that States parties should prevent third parties from violating the right to health in other countries. It further noted that, when negotiating international or multilateral agreements, States parties should take steps to ensure that these instruments do not have an adverse impact on the right to health.

Protecting the right to health: patents and access to medicines

The Ministerial Conference of the World Trade Organization (WTO) adopted a landmark declaration in 2001 in Doha, on the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) and public health.[28] The Doha Declaration affirms that the TRIPS Agreement should not prevent member States from taking measures to protect public health. A related decision was passed in 2003 to clarify paragraph 6 of the Doha Declaration: this decision

[28] See http://www.wto.org.

functions as a waiver to allow, in specific circumstances, countries producing generic pharmaceutical products made under compulsory licences to export the products to importing countries that are unable to manufacture the medicines themselves.[29] States may use these clauses to ensure medicines are accessible and affordable to their own populations.

The obligation to fulfil

The obligation to fulfil requires States to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures to fully realize the right to health.

States must, for instance, adopt a national health policy or a national health plan covering the public and private sectors; ensure the provision of health care, including immunization programmes against infectious diseases and services designed to minimize and prevent further disabilities; ensure equal access for all to the underlying determinants of health, such as safe and nutritious food, sanitation and clean water; ensure that public health infrastructures provide for sexual and reproductive services and that doctors and other medical staff are sufficient and properly trained; and provide information and counselling on health-related issues, such as HIV/AIDS, domestic violence or the abuse of alcohol, drugs and other harmful substances.

Effective and integrated health systems, encompassing health care and the underlying determinants of health, are also key to ensuring the right to the highest attainable standard of health (see box).

National health systems

The Special Rapporteur on the right to the highest standard of health[30] has stressed that from a right-to-health perspective, a national health system should have several components: it should include an adequate system for the collection of health data to monitor the realization of the right to health; the data must be disaggregated on certain grounds, such as sex, age and urban/rural; it should include a national capacity to produce a sufficient number of well-trained health workers who enjoy good terms and conditions of employment; a process for the preparation of right-to-health impact assessments before major health-related policies are finalized; arrangements for ensuring participation

[29] Compulsory licensing is a process by which a Government allows someone else to produce the patented product or process without the consent of the patent owner. Such licensing is allowed for national emergencies, other circumstances of extreme urgency, or Government use. The HIV/AIDS pandemic, for example, could warrant compulsory licensing.

[30] A/HRC/4/28, paras. 90–92. See chapter IV below for more information on the Special Rapporteur.

in the formulation of health policies; effective, transparent and accessible mechanisms of accountability.

In addition, the Declaration of Alma-Ata highlighted the central function played by primary health care in a country's health system (art. VI). Hence, it stressed that States must formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system (art. VIII).

C. Do others have responsibilities too?

A State's obligation to protect human rights includes ensuring that non-State parties do not infringe upon human rights. With respect to health, States should, for instance, adopt legislation or other measures ensuring equal access to health care provided by third parties. In addition, there is an increasing debate about the extent to which other actors in society—individuals, intergovernmental and non-governmental organizations (NGOs), health professionals, and business—have responsibilities with regard to the promotion and protection of human rights.

This section addresses the role of United Nations agencies and the private sector. This is not to say that others may not have relevant responsibilities—for instance, the Special Rapporteur has highlighted the indispensable role of health professionals in the promotion and protection of the right to health.[31]

United Nations bodies and specialized agencies

The Charter of the United Nations declares that one of the purposes of the United Nations is promoting respect for human rights, and international human rights treaties envisage a particular role for United Nations bodies and specialized agencies in their implementation. For instance, the World Bank, the International Monetary Fund, and United Nations specialized agencies, such as the United Nations Children's Fund (UNICEF), are requested to cooperate effectively with States parties on the national implementation of all rights.

In recent years, reforms of the United Nations by the Secretary-General (in 1997, 2002 and 2005), as well as commentary by the Committee on Economic, Social and Cultural Rights, have highlighted the role and

[31] E/CN.4/2003/58, chap. IV, sect. F.

responsibilities of United Nations agencies and international financial institutions with respect to human rights. The Committee has noted, for instance, that 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.[32] In 2003, United Nations agencies agreed on the *United Nations Common Understanding*, affirming that all development programmes and assistance should realize human rights and be guided by human rights principles and standards.[33]

United Nations agencies, in particular UNICEF, the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Population Fund (UNFPA) and WHO, have stepped up their work on health and human rights.

WHO

The WHO Constitution affirms that the enjoyment of the highest attainable standard of health is a fundamental human right (preamble). It makes WHO responsible for providing leadership on global health matters, shaping the health research agenda, setting norms and standards, articulating evidence-based policy options, providing technical support to countries, and monitoring and assessing health trends (art. 2). It gives WHO extensive powers to establish health-related standards, such as the 1981 International Code of Marketing of Breast-milk Substitutes,[34] and adopt legally binding treaties and conventions, such as the 2003 Framework Convention on Tobacco Control.[35]

Furthermore, the WHO *Engaging for Health, Eleventh General Programme of Work 2006-2015: A Global Health Agenda* outlines seven priority areas, including promoting universal coverage, gender equality and health-related human rights. Within WHO, the Health and Human Rights Team, in the Department of Ethics, Trade, Human Rights and Health Law, works to: strengthen the capacity of WHO and its member States to integrate a human rights-based approach to health; advance the right to health in international law and international development processes; and advocate for health-related human rights.[36]

[32] General comment N° 14.

[33] *Frequently Asked Questions on a Human Rights-based Approach to Development Cooperation* (United Nations publication, Sales N° E.06.XIV.10), annex II.

[34] World Health Organization, *International Code of Marketing of Breast-milk Substitutes* (Geneva, 1981).

[35] This is the first treaty negotiated under WHO auspices. It is an evidence-based treaty that reaffirms the right of all people to the highest standard of health.

[36] See "health and human rights", at http://www.who.int/hhr/en/.

The private sector

Businesses can affect the right to health in several ways. Companies marketing pharmaceutical products or medical equipment may contribute positively to the enjoyment of the right to health but may also make health care more difficult to access or afford, for instance by keeping the price of medicines, such as those for HIV/AIDS treatment, high. Extractive and manufacturing industries may also indirectly infringe upon the right to health by polluting water, air and soil. The Committee on Economic, Social and Cultural Rights has underlined that States must protect against pollution or contamination by private companies and assess their impact on the environment.[37]

Businesses are considered to have some responsibilities with respect to human rights, although the exact nature and scope of these are unclear. Nevertheless, States are, ultimately, accountable for any violation of human rights.[38]

Increased attention has been paid to businesses recently. Some initiatives have attempted to define specific human rights standards applicable to them. The Commission on Human Rights has discussed the role of the private sector in relation to access to medication in the context of pandemics such as HIV/AIDS, while its Sub-Commission on the Promotion and Protection of Human Rights approved the "Norms on the responsibilities of transnational corporations and other business enterprises with regard to human rights."[39] In 2005, the United Nations Secretary-General appointed a Special Representative to identify and clarify standards of corporate responsibility and accountability with regard to human rights. The work is ongoing.[40]

Various voluntary initiatives have also been launched. For example, the United Nations Global Compact (http://www.unglobalcompact.org) defines 10 principles related to human rights, labour standards, environment and anti-corruption that companies signing up to it pledge to respect. Some companies have developed their own human rights policies, programmes and tools to incorporate human rights into their business operations, some of which deal with the right to health.

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[37] "Report of the Special Representative of the Secretary-General on the issue of human rights and transnational corporations and other business enterprises. Addendum: State responsibilities to regulate and adjudicate corporate activities under the United Nations core human rights treaties: an overview of treaty body commentaries" (A/HRC/4/35/Add.1).

[38] Ibid.

[39] E/CN.4/Sub.2/2003/12/Rev.2.

[40] See, e.g., A/HRC/4/35.

IV. MONITORING THE RIGHT TO HEALTH AND HOLDING STATES ACCOUNTABLE

Mechanisms of accountability are crucial for ensuring that the State obligations arising from the right to health are respected. How then are States parties' legal obligations monitored, and by whom? How can a State be held to account if it has violated the right to health? Monitoring and holding States accountable take place at national, regional and international levels, and involve a variety of actors, such as the State itself, NGOs, national human rights institutions or international treaty bodies.

A. Accountability and monitoring at the national level

Accountability compels a State to explain what it is doing and why and how it is moving, as expeditiously and effectively as possible, towards the realization of the right to health for all.[41] International human rights law does not prescribe an exact formula for domestic mechanisms of accountability and redress, so the right to health can be realized and monitored through various mechanisms. At a minimum, all accountability mechanisms must be accessible, transparent and effective.

States have the primary obligation to respect, protect and promote the human rights of the people living in their territory. So seeking the implementation of the right to health at the domestic level is particularly important. Where domestic mechanisms exist and function, they are often quicker and easier to access than regional or international mechanisms (see below).

Administrative, policy and political mechanisms

Administrative and political mechanisms are complementary or parallel means to judicial mechanisms of accountability. For instance, the development of a national health policy or strategy, linked to work plans and participatory budgets, plays an important role in ensuring accountability of the Government. Human rights-based indicators support the effective monitoring of key health outcomes and some of the processes to achieve them.

[41] A/HRC/4/28, paras. 46 and 87.

Reviews of policy, budgets or public expenditure, and governmental monitoring mechanisms (for example, health and labour inspectors assigned to inspect health and safety regulations in businesses and in the public health system) are important administrative mechanisms to hold the Government to account in relation to its obligations towards the right to health. Some health services have established systems, either internal or independent, which can receive complaints or suggestions and offer redress. Furthermore, assessments of various kinds, such as impact assessments, offer a way for policymakers to anticipate the likely impact of a projected policy and later to review the actual impact of policies on the enjoyment of the right to health.

Political mechanisms, such as democratic processes, and the monitoring and advocacy performed by NGOs also contribute to accountability. Civil society organizations are increasingly using monitoring methods based on indicators, benchmarks, impact assessments and budgetary analysis to hold Governments accountable in relation to the right to health.

Judicial mechanisms

Some of the most crucial measures related to domestic enforcement are the provision of judicial mechanisms for rights considered justiciable in accordance with the national legal system. Such mechanisms should provide remedies to individuals if their right to health is violated.

The incorporation into domestic laws of international instruments recognizing the right to health can significantly strengthen the scope and effectiveness of remedial measures. It enables courts to adjudicate violations of the right to health by direct reference to the International Covenant on Economic, Social and Cultural Rights.

Domestic courts, including supreme courts, have increasingly heard cases relating to the right to health. For instance, the courts in Argentina have ordered the State to ensure an uninterrupted supply of antiretroviral drugs to persons with HIV/AIDS,[42] to ensure the manufacturing of a vaccine against an endemic disease,[43] and to ensure the continued provision free of charge of a drug against bone disease.[44] Another issue examined by the

[42] See, e.g., Supreme Court of Justice, *Asociación Benghalensis y otros* v. *Ministerio de Salud y Acción Social*, case 323:1339, 1 June 2000.

[43] See, e.g., Federal Administrative Court, Chamber IV, *Viceconte, Mariela* v. *Estado nacional –- Ministerio de Salud y Acción Social s/amparo ley 16.986*, 2 June 1998.

[44] See, e.g., Supreme Court of Justice, *Campodónico de Beviacqua, Ana Carina* v. *Ministerio de Salud y Acción Social – Secretaría de Programas de Salud y Banco de Drogas Neoplásicas,* 24 October 2000.

courts has been the exclusion from and termination of health coverage, particularly by private health insurance.[45] In some cases the courts referred to Argentina's ratification of the International Covenant on Economic, Social and Cultural Rights and other treaties to reaffirm the constitutional status of the right to health.

The Treatment Action Campaign in South Africa illustrates how an NGO effectively used social mobilization, advocacy and resort to litigation jointly to ensure equal access to HIV/AIDS treatment.

The Treatment Action Campaign in South Africa: ensuring equitable access to treatment for persons living with HIV/AIDS

Making medicines available where they are most needed and using its resources adequately are two concrete examples of ways in which the Government can fulfil its obligations in relation to the right to health and be made accountable.

Minister of Health v. *Treatment Action Campaign*:[46] The South African Government had chosen not to roll out a national programme to reduce the risk of mother-to-child transmission of HIV. Instead, it identified two research sites per province that alone were authorized to distribute the drug nevirapine, thus restricting the availability of the drug, although its efficacy had already been well established. This meant that HIV-positive mothers who could not afford private health care and did not have access to the research sites could not receive nevirapine. In August 2001, the Treatment Action Campaign, a network of organizations and individuals campaigning for equitable and affordable access to HIV/AIDS treatment, filed a claim against the Government before the Pretoria High Court, demanding that the Government distribute the drug to pregnant women in all public hospitals, on the grounds that the governmental policy was unconstitutional and failed to respect its human rights obligations. The South African Constitution recognizes the right of everyone to have access to public health-care services and the right of children to special protection.

Decisions: In December 2001 the High Court decided in favour of the Treatment Action Campaign and held that the Government's restrictions were unreasonable. In its decision upon appeal, in July 2002, the Constitutional Court

[45] See, e.g., Supreme Court of Justice, *Etcheverry, Roberto E.* v. *Omint Sociedad Anónima y Servicios*, General Attorney's brief of 17 December 1999, Court decision of 13 March 2001.

[46] See *Minister of Health* v. *Treatment Action Campaign* (2002) 5 SA 721 (CC) (South Africa); and Mark Heywood, "Current developments: Preventing mother-to-child HIV transmission in South Africa: Background, strategies and outcomes of the Treatment Action Campaign's case against the Minister of Health", *South African Journal of Human Rights*, vol. 19, part 2 (2003).

upheld the Pretoria ruling and decided that the Government's policy "had not met its constitutional obligations to provide people with access to health-care services in a manner that is reasonable and takes account of pressing social needs". The Court confirmed that the policy discriminated against poor people who could not afford to pay for services.

The Government was required to remove restrictions on the availability of nevirapine at public hospitals and clinics that are not research sites, and to devise and implement within its available resources a comprehensive and coordinated programme to progressively realize the rights of pregnant women and their newborn children to have access to health services to combat mother-to-child transmission of HIV. These decisions led to the establishment of one of the largest programmes in Africa to reduce mother-to-child transmission.

National human rights institutions

National human rights institutions (NHRIs) are important domestic mechanisms promoting and protecting human rights. Their functions in this respect include advising the Government and recommending policy or legislative changes, handling complaints, carrying out investigations, ensuring the ratification and implementation of international human rights treaties, and providing training and public education.[47] NHRIs often have quasi-judicial functions and a mandate allowing them to contribute to the development of legislation. Most institutions may be categorized as commissions or ombudsmen. Some countries have specific health ombudsmen.

While most NHRIs have traditionally focused their work on civil and political rights, they are increasingly focusing on economic, social and cultural rights. They can provide another avenue for the protection of the right to health.

Selected national human rights commissions and the right to health

The mandate of the *National Human Rights Commission of India* (http://nhrc.nic.in) is to protect and promote rights guaranteed by India's Constitution and international treaties. The Commission has been very active with respect to the right to health. It has, for instance, advocated upgrading health-care facilities in the country and allocating medical staff to rural populations. It has also made several recommendations to the Government to ensure policies in favour of the right to health. For instance, it recommended

[47] See Principles relating to the status of national institutions ("Paris Principles"), General Assembly resolution 48/134 of 20 December 1993.

that facilities be created in villages; that a proper mechanism be established to ensure essential drugs are available at primary health centres; that public-private partnerships be set up to maximize the benefits of health-care facilities; and that immunization programmes of the Health Department be organized regularly so that childhood diseases are contained at the earliest opportunity. In a report published in February 2007 the Commission also denounced the lack of safe drinking water in many areas of the country.

The Commission has also worked for a ban on manual scavenging, which has a very negative impact on health. It recommended that the Government should rehabilitate and reintegrate freed manual scavengers, that banks should facilitate loans at a favourable rate of interest for them and that schooling should be provided for their children.

The *Parliamentary Ombudsman in Finland* (http://www.oikeusasiamies.fi) increasingly deals with right-to-health complaints, in particular with respect to patients' rights and the right to health care (guaranteed under the Constitution). In 2005, the Ombudsman examined several complaints related to the unavailability of adequate health services, access to quality treatment and the manner in which patients were treated. The Ombudsman consulted the National Board of Medico-legal Affairs to reach a decision on these cases.

The *National Human Rights Commission in Mexico* (www.cndh.org.mx) has been dealing increasingly with right-to-health complaints, in particular the refusal to provide or the inadequate provision of public health services, and medical negligence. In 2004, the Commission issued a general recommendation directed to relevant national and district ministers on the human rights of persons with psychosocial disabilities who had been institutionalized in reclusion centres. The recommendation was based on an inquiry and visits made to such centres throughout the country to examine their compliance with human rights standards.

B. Accountability at the regional level

As mentioned above, regional human rights conventions and treaties, such as the Protocol of San Salvador, recognize the right to health and other health-related rights.

Their bodies and courts, in particular the African Commission on Human and Peoples' Rights, the Inter-American Commission on Human Rights, the Inter-American Court of Human Rights, and the European Committee of Social Rights, play an important role in protecting the right to health.

The **Inter-American Commission on Human Rights** has successfully provided immediate relief to individuals living with HIV/AIDS.[48] In 2001, the Commission examined a claim by 27 people suffering from HIV/AIDS that El Salvador was not complying with its obligations in relation to the right to life, to health and other rights, by not providing triple therapy. The Commission recommended as interim measures that triple therapy and any necessary hospital, pharmaceutical and nutritional attention should be provided by the State to these individuals. El Salvador's Supreme Court, prompted by the Commission's criticism, ordered the State to provide triple therapy to the petitioners. The Law on the Prevention and Control of the Infection caused by the Human Immunodeficiency Virus was passed later that year and addressed many of the Commission's concerns.

C. International monitoring

United Nations treaty bodies

Implementation of the United Nations core human rights treaties is monitored by committees composed of independent experts, often referred to as *treaty bodies,*[49] such as the Committee on Economic, Social and Cultural Rights or the Committee on the Rights of the Child.

Monitoring of States parties' compliance with treaty provisions is primarily done through the examination of their regular reports on how they are implementing the rights nationally. The committees examine these reports together with other relevant information submitted by United Nations agencies and civil society organizations (these are also called shadow reports or parallel reports). The consideration of States parties' reports takes the form of a constructive dialogue with representatives of the State party.

The committees then issue *concluding observations*, which detail positive aspects, concerns and recommendations for further action. Implementation of the right to health has principally been considered by the Committee on the Elimination of Racial Discrimination, the Committee on Economic, Social and Cultural Rights, the Committee on the Elimination of Discrimination against Women and the Committee on the Rights of the Child. The Committee against Torture has focused on access to health

[48] Inter-American Commission on Human Rights, *Jorge Odir Miranda Cortez et al.* v. *El Salvador*, Report N° 29/11, Case 12.249, admissibility decision, 7 March 2001.

[49] For more information on the treaty-monitoring bodies, see Fact Sheets 10/Rev.1, 12, 15/Rev.1, 16/Rev.1, 22, 24/Rev.1 and 30.

for persons in detention, including those in psychiatric institutions, and rehabilitation for victims of torture and sexual violence.

In addition, the Human Rights Committee, the Committee against Torture, the Committee on the Elimination of Racial Discrimination, the Committee on the Elimination of Discrimination against Women, the Committee on Migrant Workers, the Committee on the Rights of Persons with Disabilities and the Committee on Enforced Disappearances have *individual complaints mechanisms*.[50] Persons claiming to be victims of human rights violations may submit a complaint to the relevant treaty body, which will then issue its findings and recommendations to the State party concerned (provided domestic remedies are exhausted). The Committee on the Rights of the Child and the Committee on Economic, Social and Cultural Rights do not have individual complaints mechanisms. In 2007, the international community began negotiating a draft optional protocol to the International Covenant on Economic, Social and Cultural Rights. The adoption of such a protocol would offer an additional avenue for individuals to submit complaints related to the right to health. It would allow complaints in relation to *all* aspects of the right to health, rather than being limited—as it currently is—to specific individuals, such as migrant workers, women or persons with disabilities,[51] under existing treaty-related mechanisms.

United Nations Special Rapporteur on the right to the highest attainable standard of health

"Special procedures" is the general name given to the mechanisms established and mandated by the Commission on Human Rights and, since March 2006, by the Human Rights Council to address issues of concern in all parts of the world. Although the mandates given to special procedure mechanisms may vary, they usually monitor, examine and report publicly either on human rights situations in specific countries or on major human rights themes worldwide.[52]

[50] The Committee on the Rights of Persons with Disabilities and the Committee on Enforced Disappearances will be set up once their conventions enter into force. See also Fact Sheet 7/Rev.1.

[51] Upon entry into force of the Optional Protocol to the Convention on the Rights of Persons with Disabilities.

[52] For more details, see Fact Sheet N° 27.

In its resolution 2002/31, the Commission on Human Rights created the mandate of Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Paul Hunt was appointed as the first Special Rapporteur in 2002.

Mandate of the Special Rapporteur on the right to health

- Gather, request, receive and exchange right-to-health information from all relevant sources;
- Maintain a dialogue and discuss possible cooperation with all relevant actors, including Governments, United Nations bodies, specialized agencies and programmes, in particular WHO and UNAIDS, as well as NGOs and international financial institutions;
- Report on the status throughout the world of the right to health, including laws, policies, good practices and obstacles;
- Make recommendations on appropriate measures that promote and protect the right to health.

In order to fulfil his mandate, the Special Rapporteur decided to focus his work on three major objectives:

- Promote and encourage others to promote the right to health as a fundamental human right;
- Clarify the content of the right to health;
- Identify good practices for making the right to health a reality in communities, nationally and internationally.

The Special Rapporteur's *methods of work* include conducting country missions; investigating areas of concern; reviewing communications from individuals or groups alleging violations of the right to health and intervening, where appropriate, with Governments in relation to alleged violations; and reporting annually to the General Assembly and the Human Rights Council.[53]

The Special Rapporteur's yearly reports have so far focused on: clarifying the sources and the content of the right to health, discrimination and stigma in relation to the right;[54] the right to sexual and reproductive health, exploring the relationship between poverty and the right to health, including through examining poverty reduction strategies, neglected

[53] Previously to the Commission on Human Rights. Ibid.
[54] E/CN.4/2003/58.

diseases, and the right to health and violence prevention;[55] mental disability and the right to health;[56] a health system accessible to all and right-to-health indicators;[57] the health and human rights movement.[58]

The Special Rapporteur can also receive *complaints from individuals or NGOs,* which, if deemed credible and serious, he could raise with Governments. Several alleged violations of the right to health have referred to a lack of access to health care, goods and services, or forced feeding of detainees or prisoners; the persecution of health professionals on account of their professional activities; discrimination against particular individuals or groups on the basis of their health status, including HIV/AIDS status; non-consensual medical treatment and forced sterilizations; abusive treatment of mental health patients; inadequate conditions in psychiatric facilities, such as lack of adequate nutrition and sanitation; and denial of health services for migrant workers.[59]

Individuals or groups wishing to submit information to the Special Rapporteur or draw his attention to violations of the right to health may contact him at OHCHR by post: United Nations Special Rapporteur on the right to health, OHCHR-UNOG, 8–14 avenue de la Paix, CH–1211 Geneva 10, Switzerland, or by e-mail: urgent-action@ohchr.org.[60]

Additionally, the right to health is a concern of several other mandates, such as the special rapporteurs on education, food, adequate housing, and violence against women, and the independent experts on human rights and extreme poverty, structural adjustment policies and foreign debt, and the adverse effects of the illicit movement and dumping of toxic and dangerous products and waste on the enjoyment of human rights.

[55] E/CN.4/2004/49.
[56] E/CN.4/2005/51.
[57] E/CN.4/2006/48.
[58] A/HRC/4/28.
[59] E/CN.4/2005/51/Add.1.
[60] See http://www.ohchr.org.

ANNEX

SELECTED INTERNATIONAL INSTRUMENTS AND OTHER DOCUMENTS RELATED TO THE RIGHT TO HEALTH (IN CHRONOLOGICAL ORDER)

International treaties

Charter of the United Nations (1945)

Constitution of the World Health Organization (1946)

European Social Charter (1961)

International Convention on the Elimination of All Forms of Racial Discrimination (1965)

International Covenant on Economic, Social and Cultural Rights (1966)

International Covenant on Civil and Political Rights (1966) and its two optional protocols (1966 and 1989)

Convention on the Elimination of All Forms of Discrimination against Women (1979) and its Optional Protocol (1999)

African Charter on Human and Peoples' Rights (1981)

Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984) and its Optional Protocol (2002)

Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (Protocol of San Salvador) (1988)

Convention on the Rights of the Child (1989) and its two optional protocols (2000)

ILO Convention No 169 concerning Indigenous and Tribal Peoples in Independent Countries (1989)

International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families (1990)

Convention on the Rights of Persons with Disabilities (2006) and its Optional Protocol (2006)

International declarations, norms and other standards

Universal Declaration of Human Rights (1948)

Declaration of Alma-Ata, International Conference on Primary Health Care (1978)

Declaration on the Elimination of Violence against Women (1993)

Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (1991)

Standard Rules on the Equalization of Opportunities for Persons with Disabilities (1993)

Universal Declaration on the Human Genome and Human Rights (1997)

International Guidelines on HIV/AIDS and Human Rights: 2006 Consolidated Version

General comments and recommendations by treaty bodies

Committee on the Elimination of Discrimination against Women, general recommendation N° 15 (1990) on the avoidance of discrimination against women in national strategies for the prevention and control of AIDS

Committee on the Elimination of Discrimination against Women, general recommendation N° 19 (1992) on violence against women

Committee on Economic, Social and Cultural Rights, general comment N° 6 (1995) on the economic, social and cultural rights of older persons

Committee on the Elimination of Discrimination against Women, general recommendation N° 24 (1999) on women and health

Committee on Economic, Social and Cultural Rights, general comment N° 14 (2000) on the right to the highest attainable standard of health

Committee on Economic, Social and Cultural Rights, general comment N° 15 (2002) on the right to water

Committee on the Rights of the Child, general comment N° 3 (2003) on HIV/AIDS and the rights of the child

Committee on the Rights of the Child, general comment N° 4 (2003) on adolescent health and development in the context of the Convention on the Rights of the Child

Committee on the Elimination of Racial Discrimination, general recommendation N° 30 (2004) on discrimination against non-citizens

Commission on Human Rights resolutions

Resolutions 2000/82 and 2001/27 on the effects of structural adjustment policies and foreign debt on the full enjoyment of all human rights, particularly economic, social and cultural rights

Resolution 2001/35 on the adverse effects of the illicit movement and dumping of toxic and dangerous products and wastes on the enjoyment of human rights

Resolutions 2002/31 and 2003/28 on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health

Resolutions 2001/33, 2002/32 and 2003/29 on access to medication in the context of pandemics such as HIV/AIDS

International conference outcome documents

World Declaration on the Survival, Protection and Development of Children and Plan of Action of the World Summit for Children (1990)

Rio Declaration on Environment and Development and Agenda 21 of the United Nations Conference on Environment and Development (1992)

Vienna Declaration and Programme of Action adopted by the World Conference on Human Rights (1993)

Cairo Declaration and Programme of Action, Report of the International Conference on Population and Development, Cairo (1994) - http://www.un.org/popin/icpd2.htm

United Nations Millennium Declaration, adopted by the United Nations General Assembly "Millennium Assembly of the United Nations" (2000)

Beijing Declaration and Platform for Action of the Fourth World Conference on Women (1995) and its follow-up, Beijing + 5 (2000)

Istanbul Declaration and the Habitat Agenda of the Second United Nations Conference on Human Settlements (Habitat II) (1996), and the Declaration on Cities and Other Human Settlements in the New Millennium of the Special Session of the General Assembly for an overall review and appraisal of the implementation of the outcome of the United Nations Conference on Human Settlements (Habitat II) (2001)

Declaration of Commitment on HIV/AIDS, "Global Crisis—Global Action", adopted by the United Nations General Assembly at its special session on HIV/AIDS (2001)

Durban Declaration and Programme of Action of the World Conference against Racism, Racial Discrimination, Xenophobia and Related Intolerance (2001)

Political Declaration and Madrid International Plan of Action on Ageing of the Second World Assembly on Ageing (2002)

Rome Declaration on World Food Security and World Food Summit Plan of Action (1996) and its follow-up, Declaration of the World Food Summit: Five Years Later, International Alliance Against Hunger (2002)

Selected websites

Office of the United Nations High Commissioner for Human Rights, www.ohchr.org

United Nations human rights treaty bodies, http://www.ohchr.org

Special Rapporteur on the right of everyone to the highest attainable standard of physical and mental health, including yearly reports and country visits, www.ohchr.org

Open-ended Working Group on an optional protocol to the International Covenant on Economic, Social and Cultural Rights, http://www.ohchr.org

United Nations Children's Fund (UNICEF), www.unicef.org

United Nations Population Fund (UNFPA), www.unfpa.org

United Nations Programme on HIV/AIDS (UNAIDS), www.unaids.org

World Health Organization (WHO), www.who.int

Human Rights Fact Sheets:*

No. 2 The International Bill of Human Rights (Rev.1)
No. 3 Advisory Services and Technical Cooperation in the Field of Human Rights (Rev.1)
No. 4 Combating Torture (Rev.1)
No. 6 Enforced or Involuntary Disappearances (Rev.2)
No. 7 Complaint Procedures (Rev.1)
No. 9 The Rights of Indigenous Peoples (Rev.2)
No. 10 The Rights of the Child (Rev.1)
No. 11 Extrajudicial, Summary or Arbitrary Executions (Rev.1)
No. 12 The Committee on the Elimination of Racial Discrimination
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No. 15 Civil and Political Rights: The Human Rights Committee (Rev.1)
No. 16 The Committee on Economic, Social and Cultural Rights (Rev.1)
No. 17 The Committee against Torture
No. 18 Minority Rights (Rev.1)
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No. 24 The International Convention on Migrant Workers and its Committee (Rev.1)
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No. 29 Human Rights Defenders: Protecting the Right to Defend Human Rights
No. 30 The United Nations Human Rights Treaty System – An Introduction to the Core Human Rights Treaties and the Treaty Bodies
No. 31 The Right to Health

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