



HUMAN RIGHTS DAY

ADVANCING THE DIALOGUE ON HEALTH & HUMAN RIGHTS

**WHO Headquarters
Geneva, Switzerland**

**10 December 2002
13h30 to 17h30**

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1. BACKGROUND

To commemorate Human Rights Day on 10 December 2002, the World Health Organization (WHO) convened a meeting which brought together a wide range of non-governmental organizations (NGOs) and intergovernmental organizations (IGOs). Some organizations from the health and/or development fields are actively integrating human rights into their work, while other human rights organizations are actively integrating health issues into their work.

The aim was to consider:

- New and existing strategies to advance health as a human right; and
- New and existing strategies to integrate human rights principles into health policies and programmes.

The objectives were to:

- Share information about what organizations are doing (including the approaches and thinking behind these approaches, existing and planned collaborative efforts with other actors);
- Consider the context in which this work is being undertaken and how this influences and impacts strategies; and
- Identify gaps in what needs to be done to better advance the work and possible strategic directions forward.

The meeting was an informal discussion around key issues identified under the above objectives. It represented an opportunity to take stock from a variety of perspectives and to consider how to move the health and human rights agenda forward. Below are some key points of discussion, analysis around these points and final conclusions and suggested ways forward drawn therefrom.¹

2. THE EVOLUTION OF THE RIGHT TO HEALTH

In President Roosevelt's Annual Message to Congress 1941, he elaborated on the four freedoms, which included placing freedom from want on an equal footing with freedom of speech and freedom from fear. Although the United States has since never endorsed economic and social rights, these ideas are reflected in the Universal Declaration of Human Rights. When the Universal Declaration of Human Rights was adopted in 1948, the international press barely reported on it. Now, 54 years later, it is the world's most translated document (over 300 languages) and widely known in all corners of the world.

In 1978 the Hague Academy of International Law convened a colloquium on the right to health.² Three aspects of the right to health were distinguished: negative, positive and egalitarian. In the "negative sense", the right to health signifies that the State should abstain from any act that could endanger an individual's health. The "positive aspect" means that the State must take a series of measures that would advance realization of the right to health. The "egalitarian aspect" means that there must never be discrimination in the enjoyment of the right to health.

¹ Rapporteur: Helena Nygren-Krug, WHO Health & Human Rights Adviser. Thanks to Annette Peters, Sarah Galbraith, Bukie Aje, Intern and Colin Bailey, Intern for their assistance in the preparation of this report. The views expressed in this document are those of the participants in WHO consultations and do not necessarily represent the stated views or policies of the World Health Organization.

² Right to Health as a Human Right: Colloquium 1978 of The Hague Academy of International Law
Rene-Jean Dupuy (Editor) Library Binding, March 1979.

See <http://btobsearch.barnesandnoble.com/booksearch/isbninquiry.asp?endeca=1&btob=Y&ean=9789028610286>

The right to health advanced from an individual aspiration of the human being to a social aim. This was reflected in the 1970s, for example, with the adoption of the Alma Ata Declaration.³ At the national level in India, for example, many health activists advocated the slogan of “health for all” by the year 2000. This reflected a concern for universal access to health-care and a commitment to an intersectoral approach to health. A parallel trend, with the emerging human rights discourse, was the articulation of social and economic rights in the International Covenant on Economic, Social and Cultural Rights.⁴ However, the next 15 to 20 years resulted in a retraction from the commitments made at the time of Alma Ata due to the politics of the Cold War.

The right to health ("the right to the highest attainable standard of health") has gained tremendous momentum in recent years as manifested by the adoption of the General Comment on the Right to Health⁵ and the appointment of a UN Special Rapporteur on the Right to Health. Many people in the South who are working in the spirit of the Alma Ata Declaration are very enthused about this renewed attention and hope that it will lead to a regeneration of the Alma Ata in the near future.

3. THE "JUSTICIABILITY" OF THE RIGHT TO HEALTH

Whether socio-economic rights are justiciable has been the subject of considerable debate. There are many challenges when it comes to taking a so-called “implementation approach” to economic, social and cultural rights. Nevertheless, litigation can be a useful strategy in “awakening” individuals, institutions, groups and in particular governments to their duties and obligations. Judicial activism and what is also referred to as public interest litigation has been effectively used in India to generate awareness and initiate change in favour of economic and social rights.

In some jurisdictions constitutional provisions on the right to health have generated significant jurisprudence, including recent decisions of the Constitutional Court of South Africa - in *Minister for Health v Treatment Action Campaign*⁶, the Court held that the Constitution required the government to devise and implement a comprehensive and coordinated programme to progressively realize the right of pregnant women and their newborn children to have access to treatment and care in order to combat mother-to-child transmission of HIV.

In *Grootboom v Oostenberg Municipality et al.*⁷ it was contended that economic and social rights were not justiciable and should therefore not be included in the text of the new Constitution. In response to this assertion the South-African Constitutional Court held "these rights are at least to some extent justiciable."⁷

Furthermore, the *Soobramoney v Minister of Health* case,⁸ the plaintiff Soobramoney claimed that the right to health enshrined in the South-African Constitution had been violated, because the plaintiff had

³ The International Conference on Primary Health Care, meeting in Alma-Ata September 1978, expressed the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world.

⁴ International Covenant on Economic, Social and Cultural Rights, Adopted and opened for signature, ratification and accession by General Assembly resolution 2200A (XXI) of 16 December 1966, *entry into force* 3 January 1976, in accordance with article 27. http://www.unhchr.ch/html/menu3/b/a_ceschr.htm.

⁵ General Comment No. 14 (2000). The right to the highest attainable standard of health, Article 12 of the International Covenant on Economic, Social and Cultural Rights.

⁶ *Minister of Health and Others v. Treatment Action Campaign and Others* 2002 (5) SA 721 (CC), 2002 10 BCLR 1033.

http://www.communitylawcentre.org.za/ser/casereviews/2002_5_SA_721.php and http://www.concourt.gov.za/cases.php?applicant=&respondent=&casenumber_first=&casenumber_second=&hearingdate_day=0&hearingdate_month=0&hearingdate_year=0&hearing_month_start=1&hearing_year_start=2002&hearing_month_stop=7&hearing_year_stop=2003&judgmentdate_day=0&judgmentdate_month=0&judgmentdate_year=0&judgment_month_start=0&judgment_year_start=0&judgment_month_stop=0&judgment_year_stop=0&keywords=&citations=&submit=Search

⁷ *Grootboom v Oostenberg Municipality et al.*, Constitutional Court of South Africa, Case CCT 11/00, 4 October 2000

⁸ *Soobramoney v. Minister of Health (Kwazulu-Natal)*, Constitutional Court of South Africa, CCT32/97, November 27, 1997

been denied renal dialysis. The Department of Health, however, argued that it could not provide dialysis because of a shortage of resources and how it had to allocate those resources. The Constitutional Court of South Africa held against Soobramoney, arguing that the right to health in the Constitution is expressly conditioned on available resources and that it is the government's duty to realize the right to health progressively. "The courts are not the proper place to resolve the agonizing personal and medical problems that underlie these choices. Important though review functions are, there are areas where institutional incapacity and appropriate constitutional modesty require us to be especially cautious. Our country's legal system simply cannot replace the more intimate struggle that must be borne by the patient, those caring for the patient and those who care about the patient. If resources were coexistent with compassion, I have no doubt as to what my decision would have been. Unfortunately the resources are limited and I can find no reason to interfere with the allocation undertaken by those better equipped than I to deal with the agonizing choices that had to be made in this case"(Justice Sachs concurring in the judgement).⁹

Regional human rights mechanisms have also adjudicated cases involving the right to health. A notable case in 2002 (SERAC and CESRO v Nigeria) was the finding by the African Commission on Human and People's Rights of a violation of the right to health by the Federal Republic of Nigeria, on account of violations against the Ogoni people in relation to the activities of oil companies in the Niger Delta.¹⁰

These cases, and numerous other laws and decisions at the international, regional and national levels, confirm the justiciability of the right to health.

4. INTERNATIONAL MECHANISMS FOR PROMOTING AND PROTECTING THE RIGHT TO HEALTH

Two important examples of existing mechanisms to promote and protect the right to health at the international level are the Committee on Economic, Social and Cultural Rights and the UN Special Rapporteur on the Right to Health.¹¹

The UN Committee on Economic, Social and Cultural Rights (the Committee) consists of 18 independent experts acting in their personal capacity to monitor the International Covenant on Economic, Social and Cultural Rights (ICESR), a treaty which has been ratified by approximately 150 states. Article 12 of that treaty concerns the right to health. The conception of the right to health is a broad one. It is not confined to health care; it extends also to what the Committee calls the underlying determinants of health e.g. good sanitation and safe drinking water. The states that have ratified this particular human rights treaty are bound under international law to take all reasonable measures to implement the right to health. If not, they may be in breach of their obligations. Article 12 thus constitutes an important standard against which to assess the laws, policies and practices of governments.

The Committee's role is to monitor states' compliance with Article 12 - the right to health - and in relation to the other provisions of the Covenant. It is an independent body working at the international level and is representative of different world cultures. The Committee works publicly and is informed by materials from states, specialized agencies and NGOs. This process is a modest way of holding states to account for their health laws, policies and programmes. It is not well-known and is unfortunately under-used. UN agencies and NGOs can provide strength to the concluding observations generated by the Committee by engaging in follow-up at the national level. Because UN agencies have a permanent institutional presence both in countries and internationally and have relevant information at their disposal, they could play an important role in ensuring consistent monitoring and support in the implementation of these concluding observations.

⁹ Justice Sachs concurring in the judgement. See paragraphs 58 and 59.

http://www.concourt.gov.za/files/soobram/soobram.html#N_33_

¹⁰ Communication 155/96 SERAC and CESR v Nigeria, Fifteen Annual Activity Report of ACHPR, 2001-2002, Annex V.

¹¹ Mr. Paul Hunt. See first report at <http://www.unhcr.ch/pdf/chr59/58AV.pdf>.

The United Nations Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Paul Hunt (New Zealand) was appointed in 2002 for a three-year term through a resolution of the UN Commission on Human Rights, the main policy-making body on human rights within the UN system.¹² His initial report to the Commission had two overarching and interrelated themes: poverty and stigma/discrimination.

These twin themes of poverty and discrimination enable the Special Rapporteur to look at a range of themes articulated in his mandate. Other issues of particular interest to the Special Rapporteur are mental health and the issue of right to health indicators - what they are and how they can be used.

In terms of specific projects, the Special Rapporteur wants to explore good practices demonstrating how policies and programmes have been made consistent with human rights. He wants to support countries in assessing the impact of policies and programmes on the right to health. If a new policy is adopted, its impact on the right to health of the most vulnerable must be assessed. Where a negative impact on the right to health is found, he suggests compensatory measures. The Special Rapporteur wants to work with States, UN agencies, associations of health professionals and non-governmental organizations (NGOs).

The three key objectives of his mandate are to:

- a) Raise the profile of health as a fundamental human right. We are far from health being understood as a human right on the same level as, for example, the right to a fair trial or freedom of expression. Networks of NGOs, governments and other actors can help ensure that it is understood as a fundamental human right.
- b) Increase the jurisprudential understanding of the right to health. We have General Comment 14, which sets out a normative framework, and there is a growing amount of national jurisprudence from South Africa, India and elsewhere which sheds light on what the right to health means in terms of governmental obligations and individual entitlements.
- c) Identify good practices on how the right to health has been respected, protected and fulfilled in various parts of the world, involving different actors, challenges and scenarios.

One distinction between the two mechanisms, the Special Rapporteur and the CESCR, is that the latter can only monitor the right to health of those countries which have ratified the CESCR treaty, whereas the Special Rapporteur can monitor the performance of all countries with respect to the right to health.

"In the urgent need for a far-reaching response to HIV/AIDS lies the opportunity. The devastation of HIV/AIDS has created pressure on rich nations to address AIDS. Similar pressure has been lacking to tackle the persistent rights violations that underlie the pandemic. AIDS has helped mobilize civil societies in poorer nations to challenge their governments and to address their needs. Some governments are frightened by the possibility of creating a new class of haves and have-nots based on access to anti-retroviral medication and of instability and collapse threatened by a population with too few adults and too many orphaned children. These forces can - and must - coalesce to compel all governments to confront the range of human rights violations, inequalities and discrimination that fuel the HIV/AIDS pandemic".

Mary Robinson, former President of Ireland and most recently United Nations High Commissioner for Human Rights. This story ran on page D11 of the Boston Globe on 12.8.2002 and was quoted at the meeting by Scott Jerbi, Ethics in Globalization Initiative.

¹² <http://www.unhcr.ch/Huridocda/Huridocda.nsf/TestFrame/5f07e25ce34edd01c1256ba60056deff?Opendocument>

5. MONITORING THE RIGHT TO HEALTH

The issue of monitoring the right to health raises more questions than answers. What are the elements of the right to health upon which we should focus for the purpose of monitoring? How will the balance be struck between monitoring the right to health, as enshrined in Article 12, and the monitoring of other provisions which are implicitly buried in Article 12, and even more broadly in General Comment 14? How will the monitoring be done – through individual case studies, group profiles, or large scale monitoring trends in which one could easily miss vulnerable groups? How can we disaggregate and address issues separately, where necessary, such as women's health? If we identify vulnerable populations, how can we ensure that targeting those will not contribute to stigmatization?

Governments often excuse failure to respect, protect and fulfil civil and political rights on the basis of lack of resources. This will be greatly amplified in the case of economic and social rights, such as the right to health. How is this factored in with respect to monitoring governmental performance? How can we access the information necessary to make any assessments as the growth in private health systems has introduced a notion of competition and of commercial confidentiality that may impede transparency and monitorability?

Who will do the monitoring? The UN human rights treaty monitoring bodies, including the Committee on Economic, Social and Cultural Rights, and the UN Special Rapporteur on the Right to Health constitute appropriate fora for monitoring at the international level. However, they have limited capacity to ensure effective and systematic monitoring. At the national level, civil society can reveal and highlight problems through coalitions and networks.

Despite many unresolved questions, we can be optimistic about the potential of monitoring economic and social rights. Reflecting on "lessons learned" from the experience of NGOs monitoring civil and political rights, the increase in quality should be noted. Twenty years ago, one might have expected a very rhetorical report from human rights NGOs and had to dissect it to extract hard evidence. But over time, the rhetoric in reports diminished and hard accurate evidence increased. Now, reports are professional, helpful and to the point. However, we are not at that stage with respect to monitoring and reporting on economic, social and cultural rights and particularly the right to health. Tools and approaches will develop with experience and over time.

“Monogamous women in East Africa have been documented to be infected with HIV. Although these women know about HIV and condoms are accessible in the marketplace, their risk factor is their inability to control their husbands’ sexual behavior or to refuse unprotected or unwanted sexual intercourse. Refusal may result in physical harm, or in divorce, the equivalent of social and economic death for the woman. Therefore, women’s vulnerability to HIV is now recognized to be integrally connected with discrimination and unequal rights, involving property, marriage, divorce, and inheritance. The success of condom promotion for HIV prevention in this population is inherently limited in the absence of legal and societal changes which, by promoting and protecting women’s rights, would strengthen their ability to negotiate sexual practice and protect themselves from HIV infection.

More broadly, the evolving HIV/AIDS pandemic has shown a consistent pattern through which discrimination, marginalization, stigmatization, and more generally, a lack of respect for the human rights and dignity of individuals and groups heighten their vulnerability to becoming exposed to HIV. In this regard, HIV/AIDS may be illustrative of a more general phenomenon in which individual and population vulnerability to disease, disability, and premature death is linked to the status of respect for human rights and dignity.”

Health and Human Rights, A Reader, ed., Jonathan M. Mann, Gruskin, S., Grodin, M., and Annas, G., Routledge, 1999, page 17.

6. A HUMAN RIGHTS-BASED APPROACH TO HEALTH

Traditionally, human rights work was "reactive" rather than "proactive" in the sense that it responded to human rights violations. Government practices that violated individual rights became a ground for seeking legal redress. It is now increasingly accepted that human rights standards must contribute to government policy formulation. In this context, human rights discourse is increasingly recognized as a useful framework for policy formulation and programming in health development.

In essence, the contribution of human rights to work in health development focuses upon three issues:

- a) Human rights bring internationally recognised and endorsed normative standards underpinned by human values;
- b) From those legal obligations on governments and others are derived;
- c) These generate accountability as an implicit component of States' obligations.

Together, these three items deeply empower poor, vulnerable and marginalized populations. The great challenge for the human rights community is to apply human rights to policies in a realistic, practical and pragmatic way and to demonstrate that this makes a difference. A rights perspective transforms the development discourse. Health for the poor is no longer about charity or benevolence, or a question of purchasing power. Instead, it is an entitlement of everyone by virtue of being born human. This perspective can leverage the poor's access to health. The rights approach also provides a strategy to monitor a government's performance in terms of its obligation to respect, protect, promote and fulfil the right to health.

The importance of addressing human rights universally means that countries in the North need to be assessed on an equal footing with the South. Universal coverage and access to health for all is the ultimate goal; thus equality and non-discrimination are key principles whether dealing with populations in developed or developing countries and in the context of inter-state relations and transfer of resources.

The effectiveness of human rights as a tool for improving health hinges on the political framework in which it is applied. Governments are elected or ousted on the basis of their social policies, including those relating to the right to health. Nevertheless, as governments change, the right to health remains enshrined as a legal obligation entered into by government. In this regard, rights can help shape promises made by governments and help ensure that they are fully realized in practice.

Using a human rights-based approach is essentially about human rights advancing policies and programmes to complement efforts to address health challenges at hand. Practically, this could entail using the human rights treaties that countries concerned are party to and contrasting these with national laws, policies and practices that may impact upon the health challenges at hand. Through national consultations, solutions can be identified and advocated. For example, the Futures Group POLICY Project, supported by USAID, has worked with the Tanzania Women Lawyers Association and the Ministry of Justice and Constitutional Affairs in using human rights as a framework for a formal review of national laws and policies related to HIV and AIDS. The review has been subject to consultations involving a wide range of stakeholders, including the Tanzania Parliamentarians AIDS Coalition (TAPAC) members and an inter-ministerial group, on how to generate positive change, e.g. by initiating law reform.

7. KEY STAKEHOLDERS

i. Governments

Governments constitute the prime duty bearers in human rights law. Yet given their diminished role and power as multi-nationals and other powerful actors dominate world markets, one must ask how the human rights discourse can manage globalization. Furthermore, even when governments are capable of generating positive change, the lack of political will remains a major obstacle. There is far more rhetoric on human rights than action on the ground, particularly with respect to translating international human rights law into concrete and binding legislative enactments which people can rely upon and use to their benefit.

Overall, the link between human rights, democracy, and development is complex. In today's wealthiest democracies, large segments of the population remain marginalized and unable to access health-care. For example, new democracies in Eastern Europe, which have recently shifted from planned to market economies, are facing a predicament where life expectancy is dropping, sometimes dramatically. The public systems of the past were faulty but the privatization process we are witnessing today does not guarantee a decrease in inequalities.

Another challenge in fulfilling socio-economic rights is the international economic order which can "straitjacket" a government's flexibility in devising appropriate health programmes. Human rights can support governments in making decisions that promote and protect the right to health given that "human rights are the first priority of governments".¹³ This includes decisions to allocate resources and effect change, benefiting the most marginalized segments of the population. However, there are internal pressures on governments from voters. The middle class has become more "consumerist" and "survivalist" and now there are instances of the middle class bringing lawsuits against the poor. This creates tensions, impeding fulfillment of economic and social rights and exacerbating the risk of violence in society.

ii. Health professionals

Health professionals are both victims and perpetrators of human rights violations, and constitute an essential element to ensure the fulfilment of the right to health. Human rights law emerged after the Second World War with professional bodies, such as the World Medical Association (WMA), created to avoid future atrocities like those committed during the war by physicians. Today there is concern regarding the collusion and participation of health professionals in human rights violations in the context of ethnic and religious conflict and in relation to health conditions associated with stigma and discrimination. In documenting and ascertaining human rights violations suffered by people living with HIV/AIDS, nation-wide research conducted by a human rights NGO devoted to economic and social rights, the Social and Economic Rights Action Center (SERAC) in Nigeria, found that the denial of medical care was the most frequent violation suffered and the major perpetrators were the health care professionals themselves.

Medical professional groups active in addressing human rights violations tend to use codes of ethics, such as the various WMA¹⁴ declarations codifying medical ethics. However, human rights NGOs are

¹³ Vienna Declaration and Programme of Action, Article 1.

¹⁴ e.g. The Tokyo Declaration, World Medical Association Declaration Guidelines for Medical Doctors Concerning Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment. Adopted by 29th WMA General Assembly, October 1975;

The Lisbon Declaration, World Medical Association Declaration on the Rights of the Patient. Adopted by the 34th World Medical Assembly Lisbon, Portugal, September/October 1981 and amended by the 47th General Assembly Bali, Indonesia, September 1995;

The Hamburg Declaration, WMA Declaration Concerning Support for Medical Doctors Refusing to Participate in, or Condone, the Use of Torture or Other Forms of Cruel, Inhuman or Degrading Treatment. Adopted by WMA General Assembly, November 1997.

addressing the same cases of health professionals as victims or perpetrators, but are using human rights law rather than codes of medical ethics. Human rights groups and health professional organizations could benefit from working closer together. In this context, the debate on linking human rights with ethics should not confine itself to medical ethics but broaden to incorporate religious and societal ethics.

Initially, NGOs consisting of medical professionals campaigned for the appointment of a UN Special Rapporteur on the Right to Health. They did so to address the plight of health professionals, knowing that health professionals working for the promotion of human rights are often victimized. Medical professional groups, including those that come under the umbrella of human rights NGOs, have predominantly focused on civil and political rights violations with severe health consequences, e.g. torture, political assassinations and executions, and disappearances. There was a desire to create a platform for human rights concerns within the medical profession and allow health professionals to exercise the role of a “whistle-blower”. Only recently has there been awareness among those groups of health as a human right, the right to health, which arose in the context of developing General Comment 14. Embracing the notion of the right to health was reported as quite a paradigm shift for health professionals. The question of how they can contribute to the human rights mechanisms, such as the Committee on Economic, Social and Cultural Rights, needs to be further explored.

iii. UN agencies and Bretton Woods Institutions

Since the announcement of the 1997 Secretary-General's reform programme for the United Nations¹⁵, staff members have been assigned across UN agencies to grapple with the human rights discourse. The trend amongst development agencies addressing human rights is also notable in relation to the Bretton Woods Institutions.

Among the UN agencies, UNICEF has been at the forefront in mainstreaming human rights. In 1997, it adopted Executive Guidelines for Rights-Based Programming. Its work on the protection of children is guided by the principles and standards established through the Convention on the Rights of the Child (CRC). A rights-based approach to programming is applied to all phases of the process – the design, implementation, monitoring and evaluation. UNDP adopted a policy on human rights in 1998 and launched HURIST¹⁶ to ensure its operationalization in development programming. In the past few years WHO is actively engaged in operationalizing a human rights-approach to public health. All the UN agencies come together under the undg (UN Development Group) and ECHA (Executive Committee on Humanitarian Affairs) to share methodologies and approaches in this regard.

iv. Human rights NGOs

Some long-established human rights organizations found through introspection that they had been “closet economic and social rights organizations”. For example, Amnesty International has long advocated in favour of health rights for prisoners and against torture for reasons which included health consequences. Pressure on human rights organizations traditionally involved in civil and political rights to broaden their scope is coming from their membership. In 2001, Amnesty International members voted to move cautiously into the field of economic, social and cultural rights. Key entry points for such human rights NGOs to start tackling health issues include discrimination in relation to health, and in particular HIV/AIDS and gender-based violence. In recent years, moreover, several human rights organizations focusing specifically on economic and social rights have emerged, and there is a growing number based in the South. The Social and Economic Rights Action Center (SERAC) is a non-governmental, nonpartisan organization concerned with promoting and protecting economic, social and cultural rights in Nigeria. SERAC's Right to Health Project is a research and

¹⁵ On 14 July 1997, the Secretary General of the UN issued his report on Renewing the United Nations: A Programme for Reform (A/51/950) in which he reiterated that human rights are inherent to the promotion of peace, security, economic prosperity and social equity.

¹⁶ HURIST is a joint Human Rights Strengthening programme of UNDP and OHCHR.

advocacy project which explores strategies for the full implementation of the right to health, including examining its interdependence with other rights to form a holistic approach.¹⁷

Human Rights Watch HIV/AIDS programme documents human rights abuses related to the HIV/AIDS epidemic, analyzes those abuses with respect to international law, makes recommendations and advocates for actions to address these abuses. It is based on four basic premises:

1. Rights violations fuel AIDS;
2. Rights abuses follow infection;
3. Research is fundamental to the fight against AIDS; and
4. Ensuring protection is essential to survival.¹⁸

8. STRATEGIES/WAYS FORWARD

(a) Identifying areas to address

We need to come together and identify those health development challenges where human rights could best play a role in generating positive change. In particular, we need to identify those areas where human rights principles could be more effectively brought to bear on influencing and addressing the challenges of globalization.

Issues highlighted as such included the following:

Poverty and inequality: Poverty reduction strategy papers (PRSPs) that are part of the HIPIC (Highly Indebted Poor Countries) initiative should be reviewed to see if those can be strengthened and nuanced to reflect health issues and the right to health and other health-related human rights. The UN MDGs have set clear targets and a majority of the world's governments have voluntarily committed themselves to those goals, but we are far from achieving them. How can human rights be used to leverage more weight to the MDGs? How can the right to health strengthen and play a constructive role in the preparation of MDG reports and in the delivery of MDGs? The fact that human rights provide a legal framework with monitoring mechanisms could potentially enhance accountability for attainment of the MDGs.

Movement of people: The globalization debate to date has been mostly about the increased movement of goods, and far less about the increasing movement of people. The "brain drain", whereby health professionals trained in the South gravitate to the North to exercise their skills, constitutes an impediment to the capacity of poor countries in fulfilling the right to health of their populations. Another neglected area requiring attention are migrants' increased vulnerability, due largely to discrimination, which poses health risks to themselves and the host community.

The legitimacy of governing institutions: People are feeling an increasing lack of control over their lives and resources, believing that decisions taken elsewhere are not responding to their aspirations. How can the growing cynicism about governing institutions be addressed? How can these institutions become more inclusive, transparent, participatory and democratic?

¹⁷ <http://www.wangonet.org/serac/>

¹⁸ <http://www.hrw.org/campaigns/aids/program.html>

The impact of trade agreements on the enjoyment of the right to health: We should monitor and help draw attention to the human rights dimensions of TRIPS (Trade-Related Aspects of Intellectual Property Rights¹⁹), the Doha Declaration and other important initiatives. What more can be done to develop toolboxes for developing countries when they are negotiating, for example, through the WTO?

The role of the private sector: The impact of the private sector on access to health needs to be examined. Governments' inability to provide health for all may be linked with the question of how health services are controlled and distributed in the private sector. In accordance with the principle of protecting the right to health, governments need to regulate the private sector to ensure access to health services, particularly for vulnerable population groups.

Stigma and discrimination: These constitute huge barriers to addressing a range of health challenges, such as HIV/AIDS and mental health. We should understand how to reduce internal and self-stigmatization, stigma applied by others and discriminatory practices. Strategies include holistic action at a range of levels, from sensitization at the individual level to enforcement of laws and policies at the national level.

Emergencies: With regard to conflict situations, and in the context of international humanitarian law, more awareness needs to be raised about the fact that civilians, rather than the military, are the victims in today's wars. Different legal frameworks intersect and dominate depending upon the situation at hand, including humanitarian, refugee and human rights law. Providing practical guidance on human rights to actors involved in humanitarian action means bringing these frameworks together in the form of simple "road maps" to promote and protect the right to health and to improve the overall human rights situation as much as possible.

(b) Proposed Activities

i. Networking

Better linkages need to be forged among all players and across all levels - national, regional and international. Human rights NGOs, professional bodies, development NGOs and UN agencies need to share experiences and forge strategies which build upon each other's comparative advantages and reinforce the overall agenda. Understanding the roles of the various actors and building on the strengths of the various institutions is, in other words, as important as forging networks that can replicate themselves at different levels - national, district and community.

Lack of sufficient support from the donor community constitutes a major impediment to developing a strong and vibrant health and human rights movement to advance the right to health. Within the human rights field, donors tend to prioritize activities in the realm of civil and political rights (as opposed to economic and social rights). They also tend to support projects, rather than institutional costs, to build long-term sustainable national capacity, and they require tangible and measurable results. Integrating human rights thinking and practice means adding new dimensions to public health practice, transforming how we perceive public health problems and solve them. Quick-fix solutions and tangible results are not easily achieved overnight and there is still a lack of practical tools to measure results. As a result, many human rights networks, particularly those operating in the South, face difficulties in sustaining their work. Politically volatile situations in many places also exacerbate the challenge of reporting measurable results.

ii. Adopting a multi-disciplinary approach

The human rights discourse has been excessively dominated by lawyers unfamiliar with social and economic issues. This partly explains the long-standing focus on civil and political rights, including

¹⁹ See http://www.wto.org/english/tratop_e/trips_e/trips_e.htm.

rule of law, administration of justice and "the litigation approach". In order to develop the more "underdeveloped" economic and social rights, including the right to health, a broader constituency including economists, development practitioners, public health professionals and epidemiologists need to be more engaged and at the forefront of the debate.

iii. Communication and sensitization activities

We need to devise more effective ways of communicating across professional disciplines, cultures, political perspectives, etc. The language of human rights, economics and international organizations is complex and can create barriers in communication between experts, let alone the wider civil society. For example, how can more effective information about the links between human rights and trade policy be developed for the general public?

At the national level, the media can be an effective tool to reach out to diverse and remote communities with an emphasis on their ability to transmit messages using local dialects. Public education is an important strategy. The strongest moment in a human rights campaign is when an individual says "It's my right" or "I have the right". However, the general public is not aware of health as a human right, or that they have entitlements and can make claims. There is a big task in advocating for a right to health up to a point where people say, "It's my right."

National and local public dialogue around health and human rights issues can be useful. It is important that the human rights debate not be limited to a discussion about how international human rights law translates into national law. It needs to provide a dynamic framework about how people who live by customary rules and traditions can engage in human rights as universal principles.

Efforts undertaken in Uganda to sensitize people upon HIV/AIDS and human rights by bringing together e.g. religious leaders, community leaders, people living with HIV/AIDS, professionals in the medical and legal field, and counselors showed that initially people within communities did not make the link between the issues seen on the ground, and what is articulated in international human rights law and in the national constitution. There was more convergence around problems than solutions: for example, although there was consensus that multiple partners increase the risk of HIV/AIDS, the debate, when it turned to gender equality and the issue of polygamy, produced less consensus. More sensitization is needed for local communities to take "ownership" and exercise leadership on health and human rights.

iv. Social mobilization and campaigning

The International Federation of Health and Human Rights Organizations (IFHHRO)²⁰ is an organization of 11 affiliated organizations in different countries. It is usually called Physicians for Human Rights in the United States, United Kingdom, South Africa, Israel, Palestine, recently in Armenia, Nigeria and Denmark, sometimes with different names in the Netherlands, Bangladesh and India. Observer organizations, such as Amnesty International, ICRC, WMA, International Council of Nurses, British Medical Association and Turkish Medical Association work in collaboration with IFHHRO on a variety of activities dealing with torture, political assassinations, and disappearances, always with a specific desire to create a platform of human rights concerns within the health profession.

We should do what the human rights movement has traditionally been good at, i.e. large-scale campaigns to mobilize and raise awareness around key injustices. How can we go back to the roots of human rights in terms that influence public debate around issues ripe for change? The power of social mobilization, and how the public at large can effect change through NGOs, is exemplified by the

²⁰ <http://home.quicknet.nl/qn/prive/jc.willeml/ifhro/index.htm>

coalition for the establishment of the permanent International Criminal Court. Maybe the time is ripe for a global campaign on the right to health?

In terms of campaigning and popularizing the issues around the right to health, it is interesting to note the experiences of South Africa, where one or two extraordinary individuals have managed to expose inequities, lobby support, and institute positive change. The same type of activism is lacking in the North, and we need to think about creative ways to reach out to "everyday citizens of the North", to show that health and human rights issues at home and in the South should concern and engage them.

Oxfam International's Make Trade Fair through which the Cut The Cost campaign in 2001 was launched in conjunction with a number of advocacy group in the North and the South advocated to cut the costs of vital medicines in terms of opportunistic infection and antiretrovirals.

www.oxfam.org

v. Monitoring and reporting

Health professionals, health agencies, and health development NGOs can use existing human rights mechanisms more effectively to heighten accountability for health. Urgent appeals on cases of alleged violations of the right to health and health-related rights can be put forward to the UN Special Rapporteur on the right to health and other relevant monitoring mechanisms. In terms of monitoring, moreover, more work is needed to develop common indicators for the monitoring of the right to health and, more broadly, indicators for human rights-based programming in health.

vi. Developing tools and providing technical assistance

Ministries of Health must be engaged in order to advance health as a human right and to integrate human rights in health policies and programmes. They need simple tools and checklists or human rights focal points in health ministries who can help to take this forward. We should take stock and critically review the existing health and human rights professionals toolkit, which addresses advocacy, litigation, policy development, monitoring, implementation and which questions whether the existing tools are adequate or whether new ones should be developed. Examples of areas requiring attention, which were flagged at the meeting, included:

Good and bad practices and procedures: Information on good practices which help to better promote and protect the right to health should be gathered from countries, international organizations, communities, and civil society organizations. Bad practices also need to be flagged. Investigating human rights violations makes it possible to ascertain the problems in policy and legislation. It is also important to look at best practices and best procedures; how are plans of action and legislative frameworks developed? Who is consulted? Better ways to consult through democratic and transparent processes with their populations over what governments and other relevant stake-holders are doing are needed.

Legislation and policy development: We need to develop tools to assist governments, including Ministries of Health, not only to formulate policy but also to entrench human rights principles in legislation, ensuring equality in access to and quality in health services, etc. It is necessary to go beyond policy instruments and enshrine human rights standards into legislation. Until the law enters into force, people will not be empowered. For example, to complement development goals, work should be undertaken to enshrine the right to minimum basic health care services in legislation.

We should also review a broad spectrum of existing laws, including employment, health, criminal and family law to evaluate their appropriateness in addressing health and human rights issues. The implementation of judicial decisions is another area ripe for review. Despite an active judiciary that

enforces laws in relation to economic and social rights, there has been poor implementation of judgements.

Human rights impact assessments: If a new policy is coming into force, e.g. deregulation, privatization or trade liberalization, a legitimate and fairly sober suggestion from the human rights community is that, before a policy's introduction, it should be assessed in the context of the right to health and other health-related human rights. More work is required to develop such tools which are user-friendly and practical.

Checklists and training: Simple checklists are needed to support public health practitioners and particularly ministries of health to integrate human rights concerns in every-day work. For example, human rights work in the field has demonstrated the importance of identifying every single possible actor that can either progress or regress the right to health. Having checklists which make explicit possible duty-bearers would be useful to public health programming. Likewise, to effectively address stigma and discrimination, it could be useful to develop checklists outlining the prohibited grounds of discrimination in relation to health and how to detect such practices, as well as devising effective remedies and prevention measures.

“The issue of non-retrogression is a "blind spot" in many development projects and programmes. The work on economic and social rights is so focused with going forward that we forget that it is so easy to go backwards. You can improve a slum and build new houses but if you do not do anything about the security of tenure; if you do not do anything about legal and other procedures to protect people in the event of an eviction, houses can go overnight when the bulldozers arrive. So you have to start by protecting peoples existing rights....”

Malcolm Langford, Centre on Housing Rights and Evictions (COHRE) (<http://www.cohre.org/>)

9. CONCLUSION

This meeting witnessed great convergence in terms of the challenges faced by the NGO community, whether active in development, human rights or public health. There was an interest and willingness among NGOs to work together to tackle today’s complex challenges more effectively. Yet there appears to be a lack of fora at the international levels, and particularly at the national levels, to engage with one another to generate effective collaboration.

Organizations which in the past had been characterized as traditionally humanitarian, development or human rights entities seem to be moving across these boundaries and placing more emphasis on preserving health and human dignity regardless of the specific context (whether during conflict or peacetime). In this context, there is an overall trend among NGOs, whether focusing on health as a human right or development issues, towards a “population approach”. There is also an increasing convergence around the pillars of a so-called human rights approach to health development as integral and essential to development cooperation and programming. These include an emphasis on vulnerable and marginalized populations with a strong emphasis on non-discrimination, participation and accountability. Finally, there was consensus around some of the many current challenges and a number of constructive ways forward.

"It is my conviction that human rights have something to contribute to the health community. I know that the health community has a lot to offer to the human rights community. It is crucial that we work closely together, learning from and helping each other. This will help us identify common ground and help us plot a common way forward."

Paul Hunt, UN Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Mental and Physical Health at the Human Rights Day meeting, WHO on December 10, 2002.

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