

**Report
of the
WHO Informal Consultation
on
Health and Human Rights
Geneva, 4-5 December 1997**



GENEVA

The Office of Health Policy in Development wishes to express special gratitude and appreciation for “going the extra mile” in helping us to bring this report to fruition: Dr Manuel Carballo, Mrs Julia Häusermann, Dr Alan Hinman, Professor Aart Hendriks, Ms Monica Manrique, Mrs Isabel Monreal and Ms Brigit Toebes.

“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.”

*Preamble to the Constitution of the
World Health Organization*

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Preface

More than half a century has elapsed since WHO's founders drafted its Constitution, basing it on nine principles that are as applicable today as ever. At the dawn of a new century, and particularly since the World Conference on Human Rights in Vienna in June 1993, the world community has been working towards the realization of *all* human rights for *all* human beings. That same community has also been working towards the attainment of the highest standard of health for its peoples. However, many of these efforts have been undertaken in parallel, human rights advocates pursuing one set of objectives and health professionals another. It is time to recognize that *health* and *human rights* are not two mutually incompatible goals.

Several initiatives have been taken that will enhance the promotion of health as a human right, a significant step being the appointment of a new United Nations High Commissioner for Human Rights.

Within WHO, the Director-General has appointed a Senior Adviser on Health Policy in Development, with responsibility for health and human rights across the Organization. The primary objectives of the Health Policy in Development unit will be to strengthen and mainstream WHO's activities in all areas related to health and human rights, and to support Member States and the diverse organizations within the United Nations system in the review, design and implementation of practices in this field which will protect and promote health-related human rights.

It is clear that attention to health as a fundamental human right is gaining momentum. However, while few people will argue with the goal of achieving the highest attainable standard of health for all peoples, there is still much controversy over what constitutes the "right to health".

Accordingly, this was one of the major items on the agenda of the WHO Informal Consultation on Health and Human Rights, the first of its kind, convened on 4 and 5 December 1997. Experts in the areas of human rights, international law and public health, as well as representatives from the Office of the United Nations High Commissioner for Human Rights and other United Nations bodies, joined the WHO Secretariat from its headquarters and regions, with the following objectives:

- ✓ To advise WHO on the components of a proactive programme aimed at mainstreaming a health and human rights approach and concomitant obligations throughout WHO.
- ✓ To consider how to develop and strengthen partnerships with entities concerned with human rights within the United Nations system, with intergovernmental and non-governmental organizations, and with academic and other centres of expertise concerned with this issue.

Mrs Julia Häusermann was elected as Chair of the Consultation, and H.E. Gilberto Vergne Saboia as Vice-Chair. Dr Manuel Carballo, Dr Rebecca Cook, Dr Alan Hinman and Mr Raj Srinivasan were elected as Rapporteurs.

This report, which is a collective product of many contributors, is presented in four parts:

Part I places the Consultation in context, highlighting several of the milestones in WHO's journey over the last 50 years towards the attainment of health as a fundamental human right. The reflections of the WHO Task Force on Health in Development on this topic are also reviewed as part of an analysis of the evolution of approaches to health and human rights.

Part II summarizes the Consultation's discussions on specific issues, and points to WHO's strongest assets in the field of health and human rights.

Part III provides information on related perspectives and activities in the six WHO regions.

Part IV presents the recommendations of the Consultation and proposes measures which WHO might undertake, together with its partners, to promote and protect the "right to health".

The programme, list of participants and selected references can be found as annexes to this report.

Part I: Background to the Consultation

Beyond Alma-Ata

In 1977 the Thirtieth World Health Assembly decided in resolution WHA30.43 that “the main social target of governments and WHO should be the attainment by all the citizens of the world by the year 2000 of a level of health that will permit them to a socially and economically productive life”. In 1978 the Alma-Ata Declaration fully recognized the multisectoral character of health development and called for the coordination of health-related activities of different sectors. The primary health care approach was defined as the key, in national health strategies, to the achievement of an acceptable level of health for all. Primary health care was seen as the application of simple and effective measures, in terms of cost, technique and organization, to meet the fundamental needs of individuals, families and communities. Equity was one of the pillars of the primary health care concept.

The strategy promulgated by the International Conference on Primary Health Care at Alma-Ata was considered revolutionary, since it demystified health and put people at the centre of development. Furthermore, primary health care contained all the appropriate ingredients to promote health in the context of development, such as community participation in decision-making, the use of appropriate technology, accessible and affordable health services, in proximity to users, and health included as an integral part of community development. Primary health care also focused on vulnerable and disadvantaged groups, their health risks and poor health status. This drew attention to the need to integrate efforts to improve health and health status with efforts aimed at alleviating poverty. The crucial contribution that health makes to economic activity, to improving the environment, and - through these - to all processes of development was clearly recognized.

The commitment to Health for All was an attempt to give substance to the right to health. Ensuring the universal enjoyment of the right to health - providing for equity of access to health care, and individual and community participation in promoting and protecting health - has become an increasingly important goal of public policy. Equity is now affirmed as an overriding objective which must shape and direct any health care system. Primary care programmes, and other health programmes serving the needs of the most vulnerable and disadvantaged, have demonstrated how health can be a powerful means of social mobilization and participatory action.

However, the commitment to the right to health depends on the value assigned to health by individuals, States and the international community. That commitment should also be a determining factor in the way States allocate resources to development priorities. Yet the degree of commitment envisaged at the time WHO was founded did not find concrete expression in national and global policies. The right to health was not adequately translated into special claims on available resources, nor did health status become the test of social and economic development.

Health, Human Rights and Development

In 1992, to address these concerns, the Forty-fifth World Health Assembly established a WHO Task Force on Health and Development, with a mandate that included health as a human right and its implications for the development process.

The Task Force was aware from the start of the need to give the right to health more substance and operational content. At its various meetings, it recalled that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being, but that excessive materialism has undermined health and community values in favour of economic

efficiency and profit. The affirmation that the highest attainable standard of health is a human right challenges this trend by promoting health as a “social good” and defending the intrinsic value of health.

The right to health, like other fundamental human rights, must also be recognized to be non-negotiable. Thus, health is not a mere consumer good, and cannot be subordinated to economic considerations. There is therefore no need to enlist arguments of efficiency or profit in order to require that health is given the priority it deserves in public policy. Moreover, the “right to health” imposes a moral imperative on all individuals and every sector of society to avoid harm to the health of others. International human rights law obliges States to respect and protect the right of everyone to the highest attainable standard of physical and mental health and to take steps to ensure the progressive improvement of people’s health. When the basic human rights to health and to development are violated, sustainable development for present and future generations is imperilled.

An innovative contribution of the Task Force was the concept of the right to “health security”. Health security rests on equity. It encompasses the principle of universality in health care, so that all human beings may live with the knowledge that they can seek health care which is accessible, affordable, relevant and of quality. In its widest sense, however, it goes beyond the mechanisms and schemes that guarantee access to health care. Health security traces the entire life span of human beings. It embraces the right of every individual to the right to food in sufficient quantity and of good quality, the right to decent housing and to live and work in environments where known health risks are controlled, and the right to have access to education and information on health. It also requires freedom of choice and the empowerment of people through various forms of societal and economic support and fuller knowledge and awareness, so that they can make the right choices, cope with changing patterns of vulnerability, and keep themselves and their families healthy.

The Task Force on Health in Development also pointed out that, despite WHO's constitutional mandate and several initiatives undertaken to promote the right to the highest attainable standard of health, no coherent programme deals with the protection of health rights in the Organization. This lack of a single focus both reduces the impact of existing human rights and inhibits the evolution of more elaborate international standards. The Task Force therefore proposed the establishment of a programme to protect and promote health rights, involving institutions, networks, and collaborative work in conjunction with the United Nations Centre for Human Rights (now the Office of the High Commissioner for Human Rights).

Health for All in the 21st Century

Fifty years after the adoption of the WHO Constitution recognizing the right to the highest attainable standard of health, and 20 years after the adoption of the Health-for-All strategy, a global consultative process has resulted in the adoption by WHO's Executive Board in January 1998 of a new draft policy document, *Health for All in the 21st Century* (EB101/8), and a draft *World Health Declaration* (EB101/9), both of which will be submitted to the Fifty-first World Health Assembly in May 1998. These documents constitute a renewed commitment to Health for All as one of the governing principles of development. They recall that the goal of Health for All is to help to create conditions for people worldwide to reach and maintain the highest available level of health throughout their life span. All aspects of health policies and strategies must therefore be based on a set of key values. These values include: achievement of the highest attainable standard of health as a fundamental right; ethics; equity; and gender sensitivity. Thus, as the Informal Consultation stressed in its discussions, respect for human rights and the achievement of public health goals are complementary (see annex "Box on health and human rights" in *Health for All Policy for the Twenty-first Century*).

Part II: Discussions on Specific Issues

The Background

Development, health and human rights theories have emerged from different disciplines. This has resulted in the application of varying criteria for establishing the validity of theoretical models and for measuring their implementation. It has sometimes impeded dialogue and comprehension between these disciplines.

However, in some respects there has been a convergence of agenda over the last two decades. This is reflected in the report of the Secretary-General of the United Nations to the General Assembly on “Renewing the United Nations: A Programme for Reform” in which he states “A major task for the future will be to enhance the human rights programme and integrate it into the broad range of the Organization’s activities, including in the development and humanitarian affairs areas”.

In recognizing these different perspectives, the Informal Consultation took an important step forward in furthering dialogue between the health and human rights sectors. It was clear to the Consultation that a strong connection exists between WHO’s mandate and the universal promotion, protection and realization of human rights and it recognized the synergy that is created by bringing the experience of different disciplines to bear on this issue.

WHO's Constitution and the International Protection of Human Rights

The Constitution of the World Health Organization defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”.¹

The Constitution, adopted in 1946, was visionary in affirming that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being”. Two years later this right was enshrined in Article 25 of the Universal Declaration of Human Rights, and was protected by international law in the 1966 International Covenant on Economic, Social and Cultural Rights. Article 12 of the Covenant recognizes the “right of every-one to the enjoyment of the highest attainable standard of physical and mental health”. This right is frequently referred to in short hand as the “right to health”.

Additional protection is afforded at the global level by the International Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the Convention of the Rights of the Child (CRC), and at the regional level by, for example, the Protocol to the American Convention on Human Rights (San Salvador Protocol on Economic, Social and Cultural Rights).

Despite this, little attention has been paid to defining the parameters of the right to health and of the associated obligations of

¹Preamble to the Constitution of the World Health Organization, *Basic Documents*, 41st ed. Geneva, WHO, 1996. A proposed new draft of this definition reads as follows: “Health is a dynamic state of complete physical, mental, spiritual and social wellbeing and not merely the absence of disease or infirmity”, as proposed by the Executive Board of WHO in resolution EB/101.R2 of 22 January 1998. This text will be submitted to the Fifty-second World Health Assembly (May 1998).

States. This owes much to the failure of the international community to pay adequate attention to the whole range of economic, social and cultural rights, which in turn has been affected by global ideological, political and economic interests.²

What is the “right to health”?

The right to the highest attainable standard of physical and mental health does not presuppose that everyone can enjoy equal health status, nor does it claim a right to be always healthy. The right to health recognizes that people are biologically and genetically different, and therefore susceptible to different patterns of health. The right to health is, therefore, a claim of each individual to his or her own highest potential in terms of physical and mental health.

The fundamental basis of all human rights is the recognition of the equal worth and dignity of all individuals. The universality of human rights holds that all men, women and children are equally entitled to enjoyment of their human rights and freedoms without discrimination on any ground. These principles are critical for the achievement of health for all.

² See for example: Alston, Philip. *Making Economic and Social Rights Count: A Strategy for the Future*. *Political Quarterly*, 68: 2, April - June, 1997; and Häusermann, Julia. *Myths and Realities Concerning Economic, Social and Cultural Rights*, Chapter in *Human Rights*, ed. Peter Davies, London, Routledge, 1988.

The Legal Framework

Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) states:

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.

As of July 1997, 136 States were party to the International Covenant on Economic, Social and Cultural Rights.

State Obligations

The Consultation recognized that realization of the right to health necessarily imposes a number of duties upon States. In human rights literature a distinction is often made between obligations to respect, to protect, and to fulfil human rights (the so-called “tripartite typology of obligations”).³ The realization of these

³ Eide, Asbjorn. *The New International Economic Order and the Promotion of Human Rights*. Report by the Special Rapporteur on the right to food. United Nations document E/CN.4/Sub.2/1987/23, pp 14-15, paras.66-69; and Shue, Henry. *Basic Rights, Subsistence, Affluence and U.S. Foreign Policy*. New Jersey, 1980.

obligations typically requires States to take different measures.

Obligation to respect:

States are obliged to ensure that human rights are fully respected in the context of state policies, laws and actions, and those of its public officials. For example, States must ensure that their policies and actions do not cause harm to health, deliberately or indirectly.

Obligation to protect:

States are obliged to take all necessary measures to prevent others from violating individual integrity, dignity or well-being. States must also ensure legal protection against discrimination in the enjoyment of the highest attainable standard of physical and mental health. States are obliged to exercise due diligence in ensuring that individuals are protected from abuse of their human rights by third parties, including protection from the adverse health consequences of such actions.

Obligation to fulfil:

Article 2 of the International Covenant on Economic, Social and Cultural Rights obliges States to take steps towards achieving progressively the full realization of economic, social and cultural rights. The obligation can be broken up into the following components. States Parties are obliged to:

- take steps
- individually and through international assistance and cooperation (especially economic and technical)
- to the maximum of their available resources
- by all appropriate means
- including particularly the adoption of legislative measures.

Thus the State is obliged to *take some steps* towards the realization of the right. It is not permitted to ignore the problem. Although the term “progressive achievement” is used, the obligation to guarantee some rights in the Covenant is *immediate*. For instance, the

obligation concerning enjoyment of all human rights without discrimination is an immediate obligation.⁴

Margin of Discretion

Although Article 12 of the International Covenant on Economic, Social and Cultural Rights obliges States to create the conditions which would assure medical services to all in times of need, the Covenant stops short of saying how medical care is to be provided, i.e., whether through State-provided health care, private health care, or a mixture of the two.

Within this “margin of discretion” the State is free to decide which policies to adopt in order to ensure realization of human rights within the context of its political, economic, religious, cultural and other characteristics. Nevertheless, it remains under a duty to act, and it is accountable to the international community for its implementation of this obligation. The margin of discretion does not mean that a State is free to pick and choose which rights to implement, nor that it might ignore the rights of a particular section of the community.⁵

The United Nations Committee on Economic, Social and Cultural Rights, which is responsible for monitoring State compliance with

⁴*Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights, 1986.* United Nations Document, E/CN.4/1987/17, Annex

⁵ Häusermann, Julia, *The Right to the Highest Attainable Standard of Physical and Mental Health*, Working paper for the WHO Informal Consultation on Health and Human Rights; and Häusermann, Julia, *A Human Rights Approach to Development*, Discussion paper commissioned by the Department for International Development, United Kingdom Government, 1998.

the obligations under the International Covenant, has concluded that violations of State obligations occur when a State fails to take the necessary action to ensure at least minimum essential levels of each of the rights. Such a view was refined at an expert meeting to identify violations of economic, social and cultural rights held in Maastricht, Netherlands. The meeting concluded:

...a state Party in which any significant number of individuals is deprived of essential foodstuffs, of essential primary health care, of basic shelter and housing, or of the most basic forms of education, is *prima facie*, violating the Covenant.⁶

The Interdependence of Human Rights

The relationship between health status and the enjoyment of human rights is at once both simple and complex. In some circumstances the relationship is self-evident. For example, violence, conflict, torture and other violations of physical integrity have inevitable adverse consequences for life and health. In other circumstances the relationship is less direct, even though it is increasingly recognized that the enjoyment of health is affected by such factors as environmental and socioeconomic conditions.

The Consultation recalled that all human rights are universal, indivisible, interdependent and interrelated. Violations of any right, whether civil and political, or economic, social and cultural, are generally detrimental to health, while the promotion of health and the prevention of ill-health are best served by optimal respect for all human rights and the elimination of all forms of discrimination on whatever grounds.

The achievement by any individual of his or her own highest attainable standard of health is a prerequisite for the full enjoy-

⁶ Maastricht Guidelines on Violations of Economic, Social and Cultural Rights, adopted at an expert meeting in Maastricht, 22-26 January 1997.

ment of other human rights. At the same time, enjoyment of all other human rights is necessary for the realization of the highest attainable standard of physical and mental health.

For example, enjoyment of the highest attainable standard of physical and mental health is clearly dependent on enjoyment of the rights to adequate food, clothing and housing, the right to education, and the right to work and to just and favourable conditions of work.

This relationship between health and the standard of living was recognized in the Universal Declaration of Human Rights adopted by the United Nations General Assembly in 1948, Article 25 (1) of which provides inter alia:

Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and necessary social services...

Setting the standard of adequacy with reference to health and well-being recognizes the relationship between economic factors and health status. The impact of poverty on physical and mental health is far-reaching. Economic poverty is all too often synonymous with poverty of education and lack of access to the type of information needed to enhance opportunities for individual choice and betterment.

Health and Development

Health itself has been given inadequate priority in political, social, and economic terms, even though it is essential that the right to

health be promoted as a social “good”⁷ and an essential goal of development. Health has an intrinsic value in and of itself.⁸ This truth requires that the right to health, like other human rights, be recognized as non-negotiable. Health cannot be seen as a mere consumer good, but is a fundamental human right which cannot be set aside for economic gain, nor in the interests of economy. Social and economic inequalities as well as discrimination constitute tremendous obstacles to achieving the right to health.

Health and Equality

The Consultation stressed that the concept of equality is crucial to the realization of the right to health. The inequalities and discrimination which deny access to resources, technology and essential services undermine health status. Furthermore, discrimination and social rejection are known to contribute to anxiety, depression and chronic stress, as well as to substance abuse and suicide.

Economic and social inequalities are reflected in differential health status, and health status indicators - which are measurable - can thus be indicative of the denial of many of the human rights which are so vital for health and development in dignity.

Including human rights standards in health and development theory and practice can only strengthen the just and equitable access of all people to the resources of society. This approach promotes respect for human dignity and autonomy in a way that

⁷ See *Health in Development. Prospects for the 21st Century*. Report of the first meeting of the Task Force on Health in Development. 27-30 June 1994, Geneva, WHO. (WHO/DGH/94.5).

⁸ *Health: The Courage to Care. A critical analysis of WHO's leadership role in international health by the Task Force on Health in Development*. Geneva, WHO, 1997. (WHO/HPD/97.3).

allows people the opportunity to make, and implement, choices about their own health.

The Consultation therefore recognized that the right to the highest attainable standard of physical and mental health cannot be ensured simply through the provision of health care services – vital though these are. It requires action to address the structural, legal, cultural and other barriers which deny a significant portion of the world's population full enjoyment of the right to health. It calls for an effective common agenda that cuts across sectors, promoting and protecting health together with equitable betterment of the human condition in general.

The Benefits of a Joint Human Rights and Health Approach

In seeking to achieve the enjoyment by all of the right to the highest attainable standard of physical and mental health, public policy would benefit from addressing three vital concerns:

- protection, promotion and realization of a wide range of other human rights including: the right to a standard of living adequate for health and well-being; the right to work and to just and favourable conditions of work; the right to adequate food and housing; the right to education and to access to information; protection of the right to physical security and other civil and political rights; and the development of multisectoral policies for health which protect individuals from known health risks, and promote health and well-being;
- redress of inequalities and discrimination which contribute to disadvantaged health status;
- implementation of measures to ensure universal access to affordable health care and services of adequate quality.

In evaluating and monitoring these efforts, both the health and human rights communities have important roles to play. For instance, in assessing the adequacy of health services, joint analysis could be brought to bear on the development of minimum standards of quality, and guidelines for the progressive improvement of quality.

Not all morbidity and mortality is caused by inequality and discrimination, but preventable ill-health frequently follows the fault lines of society. When inequalities and discrimination contribute to ill-health, health status indicators can highlight underlying human rights violations. Therefore, health status data provide an important indicator of human rights abuses.

Core Contents of the Right to Health and State Obligations

The core content of a human right consists of those essential elements without which the right concerned would lose its significance as a right. The Consultation appreciated the need for further attention to be given to defining the core contents of the right to health and the role and responsibilities of States in promoting the enjoyment of the right to health. It recommended a joint approach between WHO and the human rights community in this regard. Such a clarification is essential in order that realization of the right to health can be measured.

Defining the core content would shed light on the immediate obligations of States.

Indicators for Measuring the Right to Health

International human rights law requires States Parties to realize the remaining obligations of the implementation of the right to health “progressively” and “to the maximum of their available resources”. The Consultation recognized the benefit of joint

development of appropriate indicators to measure the progressive realization of the right to health and compliance by States with their obligations.

Reliable indicators need to be sensitive to national and regional particularities and take into account that governments often encounter various obstacles that are beyond their control, and which hinder the realization of human rights at the same pace and in the same way as other countries and regions.

The Consultation concluded that addressing issues of inequality and discrimination requires the further collection, analysis and dissemination of health status data. The disaggregation of data (for example, by sex and majority/minority grouping) is important in identifying inequalities which are obstacles to the enjoyment of the right to the highest attainable standard of physical and mental health. The Consultation also recognized that WHO's unique experience in the field of health statistics can be of specific value in the development of adequate health indicators.

In closing, the Consultation again recognized the challenge that bringing health and human rights together represents, and commended WHO for taking up the challenge so affirmatively.

Part III: Regional perspectives

In the discussion of the issues raised in Part II above, the participants' reflections were generally of a global and cross-cutting nature. To be successful, however, it was agreed that approaches and applications for the promotion of health as a human right must be region- and country-specific and take particular cultural, social, political and economic characteristics into consideration. Moreover, in making the recommendations that follow, the Consultation acknowledged that the WHO Regions are at different levels of development in their integration of health as a human right, and are progressing at varying rates.

It was considered appropriate, therefore, to provide in this report an overview of the current and proposed status of activities to integrate a human rights approach to health in each WHO Region, the representatives of several of which delivered presentations during the Consultation.

African Region

Discrete health and human rights activities have been undertaken through regional programmes and by countries, involving a wide range of disciplines in disease control, health systems development, and health protection and promotion. Ethics and human rights, for example, are an integral part of the regional strategy on reproductive health.

The regional representative at the Consultation presented an overview of the health situation and constraints in the African Region. It was noted that Africa is going through a period of political transition, with campaigns for democracy, peace and good governance on the one hand and political instability and conflicts on the other. Africa is also characterized by a wide range of societal, cultural and religious groups with clearly divergent ethical views on matters from reproductive health to traditional

medicine. These different ethical positions are further affected by differing rates of national and subregional economic development, so that the more developed countries are engaged in organ transplants whereas the less developed have yet to cope with the management of long-term morbidities such as preventable complications of difficult labour. Amidst these poles, however, individuals are vulnerable in a hostile environment and remain poorly empowered to promote their own health within their communities.

To assist national policy-makers and planners in the Region to integrate ethical issues into their health-for-all policies and programmes, the WHO Regional Office for Africa has developed a regional proposal on “Ethics and Health”. The proposal is also aimed at developing competence in leadership in ethics and health at both regional and country level. The methodology will include a review of the regional status, priorities, best practices and existing expertise in ethics and health, with emphasis on networking and capacity-building. It is intended that one of the elements in mainstreaming health and human rights in the Region will be the formulation of model health legislation.

An outline for a human rights education course in the medical curriculum, prepared by WHO in collaboration with the Office of the United Nations High Commissioner for Human Rights and UNESCO, was also presented. The aim of such model training is to provide future health professionals and auxiliary health personnel with relevant knowledge and special skills so that they are better equipped to deal with violations of health and human rights standards. Medical students will thereby develop sensitivity and a sense of responsibility, and learn to enhance their catalytic role, especially in times of conflict.

Other planned priorities in the African Region include the strengthening of partnerships with regional bodies such as the

Organization of African Unity, nongovernmental organizations, professional bodies and banks, e.g. the African Development Bank, in the provision of technical assistance to countries.

Finally, it is hoped that, following an inventory of related health and human rights documentation, a regional resource centre can be established.

Region of the Americas

The Pan American Health Organization (PAHO), which serves as the WHO Regional Office for the Americas, has long addressed the issue of human rights from different perspectives and through different strategies. Health is one of the basic components of well-being and, as such, an essential element when evaluating the degree of social development in countries. This has led PAHO to support several initiatives aimed at monitoring the evolution and measuring the scope of the right to health, while defining mechanisms to realize them.

Since the Alma-Ata Declaration in 1978, for example, PAHO has supported countries in the Region to unite their efforts to achieve Health For All through socioeconomic development strategies, community participation and primary health care.

PAHO has also been a key player in the preparation and implementation of international conventions in support of health as a human right, particularly through subregional projects based on awareness-building and advocacy, and initiatives which address specific health issues such as women's health.

Three other initiatives warrant special attention, namely Growth with Equity, Democracy and Health and Advocacy with Political Leaders. The first of these relates to the impact of development on health, and proposes the following model: "a social process by which the population satisfies its essential needs in a sustainable manner through sufficient availability of goods and services,

adequate income, and equitable distribution of surpluses and the means for producing them in the context of democratic participation in decision-making and political freedom”. From the Growth with Equity perspective, therefore, the individual is an integral part of the development process, both contributing to and sharing in its benefits.

The objectives of the Democracy and Health initiative, established in 1990, are to:

- ▶ contribute to the consolidation of democracy through greater equity in the area of health;
- ▶ strengthen the role of the legislature in dealing with health issues;
- ▶ promote greater knowledge and information on the health situation;
- ▶ identify the challenges and priorities for health, with a view to orienting future action in the legislative area, including technical cooperation.

In addition to joint work with the Organization of American States to improve collaboration with parliaments in the Americas, the approach also includes activities with the European Parliament and other bodies to ensure that health is treated as beyond competing interests and partisan considerations, while reinforcing its status as a fundamental human right.

The purpose of Advocacy with Political Leaders is to build consensus among policymakers through an intensified, purposeful relationship with political leaders and institutions at the regional, subregional and national levels. As a means of combining the Health and Development and Democracy and Health initiatives, Advocacy with Political Leaders considers that health is an essential objective of human development and that the population’s capacity to develop socially and economically is in itself dependent of its health conditions.

Eastern Mediterranean Region

One of the basic principles of the Eastern Mediterranean Region's health strategy is the emphasis on health as a human right. Based on this principle, the Region is promoting several initiatives to promote community empowerment, enhance the role of women in health and development, and promote equity and accessibility to quality health care.

The Region's basic development needs initiative has been implemented in many of the countries. The initiative is based on the development of community-based, community-managed, community-owned, self-reliant, and sustainable development programmes. This approach will mobilize community members to identify their health and development needs and to work collectively to achieve them.

The Regional Office has established a technical unit to promote the role of women. The unit - Women, Health and Development (WHD) - has been active in addressing issues related to women in health and development in various Member States. Its aims are: to support and promote the role of women in environmental protection and national resources conservation as a practical demonstration of the use of women's potential in health, environment and sustainable development; to provide information on how women can provide a healthy environment in the home, how to communicate health messages to other community members, and how to promote healthy practices and combat unhealthy ones in the family and the community; and to establish intersectoral committees, national plans and information systems on the role of women in health and development. WHD has been also actively involved in removing impediments to health development in various Member States, such as violence against women and the effect of harmful practices on reproductive health.

The Regional Office is also promoting gender sensitivity and mainstreaming in various collaborative programmes with Member

States within the Region's culture and traditions. To ensure equity and accessibility to quality health services, regional technical programmes are emphasizing the importance of reaching vulnerable groups and all sectors of society within national comprehensive plans.

European Region

The right to the healthiest possible state, and equity in access to effective health services of reasonable quality, are essential human rights and the fundamental objectives of the European Health-For-All policy.

Many activities in the European Region are closely related to the domain of human rights. A review of current outputs and activities offers the following examples:

- ▶ The Conference on European Health Care Reforms, held in Ljubljana in 1996;
- ▶ Work on patients' rights and medical ethics, including the 1994 Declaration on the Promotion of Patients' Rights in Europe, adopted after the Amsterdam Conference of that year;
- ▶ The establishment of a WHO network on patients' rights and citizens' empowerment, to be supported by the creation of three new WHO collaborating centres;
- ▶ The ongoing work on health system reform in countries of central and eastern Europe/newly independent states (CCEE/NIS), including networks of health system change management support, i.e., MIDNET, EASTNET and CARNET;
- ▶ The strengthening of systems and capacity for immunization and communicable disease control in the CCEE/NIS, notably for polio, TB, diarrhoeal diseases, sexually transmitted diseases, HIV/AIDS, and diphtheria;
- ▶ Enhancing environmental health services in the CCEE/NIS,

together with the assessment of the impact of environmental factors, including radiation, on health;

- ▶ Improving basic public health prerequisites, e.g., water and sanitation, and solid waste disposal. A specific example here is the extensive survey of these factors conducted in Bosnia and Herzegovina in 1994 by the Regional Environmental Health Centre in Nancy;
- ▶ Work to promote family planning and sexual health in the CCEE/NIS, and to assess the special needs of women, for example in relation to violence;
- ▶ The promotion of satisfactory patterns of infant and young child feeding/nutrition;
- ▶ The strengthening of mechanisms for food safety, including surveillance and control;
- ▶ The promotion of health through various networks, including the European Network of Health-Promoting Schools, Healthy Cities, Healthy Regions, etc.;
- ▶ The development and dissemination of policies and practices to promote equity of access to health care, and quality of care, e.g., indicators and databases;
- ▶ The promotion of healthy working environments.

In particular, the Regional Office has been involved in the provision of humanitarian assistance to several CCEE/NIS countries affected by major health emergencies, including:

- ▶ an operational presence, public health assessment and health coordination, for example in relation to nongovernmental organizations;
- ▶ specific public health interventions, e.g. communicable disease control, mental and physical rehabilitation, and the environmentally sound destruction of expired donated drug stocks;
- ▶ the provision of drugs and supplies.

Latterly, in some post-conflict countries such as Bosnia and Herzegovina, the assistance has moved into health system recon-

struction and reform. Various regional activities have specifically promoted dialogue and reconciliation e.g., the “Peace through Health” initiative and the promotion of civil society, e.g., “Decentralized Cooperation”. Also noteworthy is the series of meetings organized with the Norwegian Medical Association to promote dialogue and reconciliation among the medical associations of the six republics emerging from the former Yugoslavia.

South-East Asia Region

In working towards Health-for-All objectives, the WHO Regional Office for South-East Asia emphasizes human rights as a fundamental principle of health care in its work with Member States, and not isolated issues. A few examples of initiatives being promoted by the Regional Office which underscore health and human rights are outlined below.

Under the Region’s primary health care intensification initiative, the right of access to health care, particularly of the disadvantaged and underserved, is emphasized. Methods have been devised to ensure that the poor and the underserved are fully involved in community participation efforts and are provided with the training to enhance their capacity for self-care.

The Health Ministers of the Region, at their 15th meeting held in August 1997, adopted the Declaration on Health Development in the South-East Asia Region in the 21st Century. The Ministers reaffirmed their faith in basic human rights, in the dignity and worth of the human person, and in the rights and obligations of individuals and the community in attaining the highest possible level of health. The Declaration emphasizes health and human rights as one of the cardinal principles on which future health development in the Region and its Member States should be founded.

The other principles relating to ethics and equity, Health for All and primary health care, community participation and empowerment, combating poverty and role of education enunciated in the Declaration complement and supplement the principle of health and human rights.

The Regional Health Declaration was endorsed by the Regional Committee for South-East Asia in September 1997. The Committee urged the countries to further adapt and integrate the principles and policies of the Declaration in national health policies and plans and to this end the following actions have been taken:

- A working group to coordinate the implementation of the Declaration has been formed in the Regional Office;
- A Regional Consultation on Implementation of the Regional Health Declaration was held in Colombo in February 1998.
- The health secretaries of countries of the Region, at their 3rd meeting held in Bangkok in February 1998, reviewed the actions taken to implement the Declaration.
- At its 33rd session, the Consultative Committee for Programme Development and Management considered a plan of action to implement the Declaration.

In addition, the Regional Office supported the International Conference on Global Health Law (New Delhi, December 1997), the first objective of which was “to recognize the highest attainable standard of health as a fundamental human right”. The Conference focused on the application of global health to promote and attain Health for All as part of overall development and in a spirit of social justice.

The Conference’s New Delhi Declaration on Global Health Law recognized that the use of legal mechanisms to ensure observance and adherence to ethical norms and standards is critical, as is increased investment in research on health law. The use of legislative and regulatory mechanisms was also proposed to

achieve decentralization, and an appropriate mix between private and public sectors, in the provision of health care.

The value of working with existing bodies in different regions, and strengthening an intersectoral approach, especially at government level, was highlighted. WHO was encouraged to play a greater role in developing and using national and international instruments to advance global health in a way that could complement the role of national governments. The Declaration also underlined WHO's determining role in evolving the basic principles of global health law as defined in various international covenants, agreements and instruments which emphasize the right to health as the fundamental right of every human being. As the section concludes, "All these international instruments have only one road to follow, i.e. the road to global health".

The Expanded Programme on Immunization in the Region is firmly based on a health and human rights approach. It is hoped that a global seminar can be organized in the near future to assess ways and means of achieving human rights in immunization, including training, networking and the dissemination of information.

Finally, the Regional Office is strongly advocating a gender perspective in health, particularly since the 1993 World Conference on Human Rights. Activities have included training and logistic support for the establishment of a Gender Issues Office in the Ministry of Health and Family Welfare in one country and the publication of a regional perspective on issues relating to women, health and development based on country profiles containing up-to-date, reliable and gender-disaggregated information from all countries in the Region.

Western Pacific Region

In the Western Pacific Region there are many populations that are relatively isolated from health facilities because of geography and racial or cultural differences. Health programmes of governments have addressed these problems for many years with the aim of ensuring equity of access to health facilities and to health itself. The regional policy framework *New Horizons in Health* has taken this a step forward by promoting both the action that individuals themselves can take to protect their health, and the development of public policies supportive of health. *New Horizons in Health* focuses on all stages of human life and on all settings in which people live, work and relax. The policy, which has been adopted by the Regional Committee for the Western Pacific, recognizes both the rights and the responsibilities of people. It envisages a world where self-reliant individuals prepare themselves for healthy living, are vigilant in protecting their environment, and continue to live comfortably and securely until the end of their lives. People need not die prematurely; the living should be able to lead productive lives, age gracefully and die with dignity. The policy has been adapted and adopted in many of the long-term health policies and plans of countries in the Western Pacific. For example, it forms the basis of the Healthy Islands initiative of the Ministers of Health of Pacific Island countries.

Other examples where WHO has been able to influence equity of access to health services include the provision of immunization to children in areas affected by civil strife, where normally government health services cannot operate.

Although health is a right, it does not come automatically. It is WHO's role to work with countries to address this and to promote the integration of health and human rights activities in all aspects of the Region's health development work, particularly on behalf of underserved and vulnerable groups.

Part IV: Recommendations

Although the right to health is more relevant today than ever before, it has yet to receive the full attention it deserves and to be brought from the margins into the mainstream of human rights promotion and protection. The coming years will witness an increased role of WHO in the human rights sector, in conjunction with its many intergovernmental and nongovernmental partners.

Participants considered that the Informal Consultation on Health and Human Rights represented an important first step in broader cooperation among health and human rights agencies. The main recommendations for action by WHO derived from its discussions and warranting immediate attention are listed in broad groupings below. They were made to enable WHO to accelerate and strengthen the operational bond between human rights and health activities, ensuring that when steps are taken to promote either of them there is an awareness of the impact each will have on the other and that conscious efforts are made to maximize that impact.

Collaboration with Member States

1. Cooperate with and provide technical assistance to Member States in addressing the protection and promotion of health and human rights, for example, collaboration in the treaty body reporting process.
2. Develop guidelines to assist countries in monitoring and implementing health-related human rights standards, using health outcomes as indicators of the enjoyment or denial of human rights.
3. Develop human rights education programmes in the health sector for students in the health professions, health professionals, community leaders and others.

Collaboration with Partner Organizations

4. Work with its partners to promote and protect health and human rights approaches, including the convening of regular meetings between WHO staff and members and secretariats of treaty bodies to define the elements of mutually beneficial collaboration and partnerships.
5. Work with treaty bodies to clarify what is meant by the “right to health”, the content and scope of this right, and what it implies for signatory States.
6. Work with its partners to emphasize health during the celebrations for the 50th anniversary of the Universal Declaration of Human Rights in 1998.
7. Assist treaty bodies as well as representatives of other organizations, including nongovernmental organizations, in the effective implementation of international human rights instruments.
8. Provide appropriate information to the treaty bodies to assist them in the reporting process; the information could also be made available to other organizations such as NGOs.
9. Review collection and analysis procedures to ensure that data are disaggregated to identify underlying inequities and discrimination in health status or access to services; distribute this information widely to human rights organizations, treaty bodies, and nongovernmental organizations.
10. Initiate, in conjunction with the Council for International Organizations of Medical Sciences (CIOMS) and other appropriate partners, a process of review and possible revision of the Principles of Medical Ethics relevant to the Role of Health

Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, adopted by the United Nations General Assembly in 1982. This process should take into account research findings on allegations of complicity by health professionals in violations of human rights.

Action in WHO

11. Mainstream health and human rights throughout the Organization; raise the level of awareness of WHO staff to enable them to recognize, encourage and learn from human rights activities; and ensure that staff understand the human rights implications of their work and integrate such considerations in programme planning in order to promote equity, prevent discrimination, and ensure universality of access.
12. Develop methodologies to monitor new variables that have an impact on health and other rights, such as economic globalization.
13. Establish a clearing-house function on health and human rights in collaboration with its partners.
14. Devote more resources, both financial and human, to support health and human rights activities at both headquarters and regional levels.
15. Convene follow-up meetings on health and human rights.

Part V: Annexes

Annex I: Programme

Opening Session

Introduction and welcoming address: *Dr I.C. Herrell, Secretary*

Presentation of objectives
Election of meeting officers

WHO's Mandate in the Field of Health and Human Rights
Review of health and human rights in WHO's Constitution
and in existing international human rights treaties:
Mr S.S. Fluss

Current health and human rights-related activities in WHO
Regional perspectives: *Dr M. Bolis, Dr Tshabalala and others*

Conceptual Framework of the "right to health"

Introduction: *Mrs Julia Häusermann*
Discussion

An Integrated Health and Human Rights Agenda

Initial human rights impact review within WHO: *Dr D. Yach,*
Ms F. Bergin

Remarks: *Dr M. Carballo*

Implementation issues: *Mr J. Pace*

Conceptual Issues

Working towards the enjoyment of existing rights

Ensuring access for all to health care and services

Inequalities and discrimination as barriers to the right to health

Other factors contributing to, or inhibiting, the enjoyment of the right to health

Partnerships and other institutional aspects

Evaluation of Discussions

WHO's programme on integrating health and human rights into its policies and activities

Open discussion on: elements, strategies, partnerships, resources

Conclusions and recommendations of the consultation

Discussion and review

Closing Session

Concluding remarks: *Mrs Julia Häusermann, Chair, and Dr I.C. Herrell, Secretary*

Annex 2: List of Participants

Mrs Affaf Abbass, Human Rights Officer, Research and Right to Development Branch, Office of the High Commissioner for Human Rights, Geneva, Switzerland

Ms Marge Berer, Chairperson, Gender Advisory Panel of the Special Programme of Research, Development and Research Training in Human Reproduction

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Annex 3: Box on “health and human rights”

THE RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH

What does the “right to health” imply?

- The enjoyment to the right to the highest attainable standard of health (often referred to as the “right to health”) is one of the fundamental rights of each individual to his or her own highest potential in terms of health.
- In interpreting the “right to health” it is accepted that:
 - * people’s biological and genetic differences may limit their health potential;
 - * access to health services is a necessary but not sufficient condition for realizing the “right to health”.

The “right to health” and human rights

- Health is a prerequisite for the full enjoyment of all other human rights. These rights are universal, indivisible and interdependent.

International and national policies and actions to ensure the “right to health”

- Through adoption of international and national human rights instruments Member States assume specific responsibilities and duties to promote and protect the health of their populations by:
 - * ensuring that sustainable health systems are accessible to all people;
 - * promoting intersectoral action to address the determinants and prerequisites of health.

International human rights instruments

The right to a standard of living adequate for health and well-being appears in the **Universal Declaration on Human Rights** (1948) and the right to the enjoyment of the highest attainable standard of physical and mental health is protected by law in the **International Covenant on Economic, Social and Cultural Rights** (1966). Other international instruments protect the “right to health” at the global and regional levels, such as the **Convention on the Rights of the Child** (1989), the **Convention on the Elimination of Discrimination against Women** (1979), the **Additional Protocol to the American Convention on Human Rights** (San Salvador Protocol on Economic, Social Cultural Rights, 1988), the **European Social Charter** (1961), and the **African Charter on Human and Peoples’ Rights** (1981).

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