

4.1 Health and human rights

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Introduction

Since the creation of the United Nations over 50 years ago, international responsibility for health and for human rights has been increasingly acknowledged. Yet the actual links between health and human rights had not been recognized even a decade ago. Generally thought to be fundamentally antagonistic, these two worlds had evolved along parallel but distinctly separate tracks until a number of recent events helped to bring them together.

Conceptually one can point to the HIV/AIDS pandemic, to women's health issues, including violence, and to the blatant violations of human rights which occurred in such places as the Balkans and the Great Lakes region in Africa as having brought attention to the intrinsic connections that exist between health and human rights. Each of these issues helped to illustrate distinct, but linked, pieces of the health and human rights paradigm. While the relationship between health and human rights with respect to these and similar issues may always have made sense intuitively, the development of a 'health and human rights' language in the last few years has allowed for the connections between health and human rights to be explicitly named, and therefore for conceptual, analytical, policy, and programmatic work to begin to bridge these disparate disciplines and to move forward. In the last few years human rights have increasingly been at the centre of analysis and action in regard to health and development issues. The level of institutional and state political commitment to health and human rights has, in fact, never been higher. This is true within the work of the United Nations system but, even more importantly, can also be seen in the work of governments and non-governmental organizations at both the national and international level.

From HIV/AIDS and human rights to health and human rights

The importance of the HIV/AIDS pandemic as a catalyst for beginning to define some of the structural connections between health and human rights cannot be overemphasized. The first time that human rights were explicitly named in a public health strategy was only in the late 1980s, when the call for human rights and for compassion and solidarity with people living with HIV/AIDS was embodied in the first World Health Organization (WHO) global response to AIDS (WHO 1987). This approach was motivated by moral outrage but also, even more importantly, by the recognition that protecting the human rights of people living with HIV/AIDS was a necessary element of the worldwide public health response to the emerging epidemics. The

implications of this call were far reaching. Framing this public health strategy in human rights terms—although initially focused on the rights of people living with HIV/AIDS rather than on the broad array of human rights influencing people's vulnerability to the epidemic—allowed it to become anchored in international law, thereby making governments and intergovernmental organizations publicly accountable for their actions towards people living with HIV/AIDS (Mann and Tarantola 1998). The ground-breaking contribution of this era lies in the recognition of the applicability of international law to HIV/AIDS issues and in the attention this approach then generated to the links between other health issues and human rights—and therefore to the ultimate responsibility and accountability of the state under international law for issues relating to health and well being (Mann *et al.* 1994).

International conferences and the United Nations system

The series of international conferences held in the past decade under the auspices of the United Nations system have also been of critical importance in helping to clarify the links between health and human rights. While all of these conferences, ranging from the World Summit for Children held in 1990 to the World Conference on Racism held in 2001, are relevant to health and human rights concerns, the two most crucial in articulating the health and human rights link were the 1994 International Conference on Population and Development and the 1995 Fourth World Conference on Women. These conferences brought together policy-makers, activists, and representatives from local, national, and international agencies, as well as government representatives. The negotiated documents resulted in the first concrete links between health and human rights in international consensus documents and helped to focus attention to the dual obligations of governments regarding both health and human rights (see in particular Chapters IV to VII of the *Report of the International Conference on Population and Development*, and Chapter IV (C) 'Women and health' and Chapter IV (I) 'Human rights of women' of the Fourth World Conference on Women (ICPD 1994; FWCW 1995)). These documents were of use to governments and others in shaping policy and programmatic work which explicitly dealt with these links, as well as to activists and non-governmental organizations in framing their advocacy for government responsibility for health in the human rights language of responsibility and accountability.

In recent years there has been a substantial increase in attention and resources devoted to implementation of health and human rights

within virtually all United Nations development agencies and programmes, due in large part to these international conference processes. All of the organizations and agencies of the United Nations have, albeit to varying degrees, begun to consider the relevance of human rights to their work in the health field (Alston 1997). The 1997 Programme for Reform put out by United Nations Secretary-General Kofi Annan, however, has been most crucial in moving the United Nations system's conceptual attention to human rights towards implementation and action within their own work. The Programme for Reform designates human rights as among the core activities of the United Nations system (UN 1997a; UNGA 1997). The document states that human rights are to be understood to cut across the four substantive fields of the United Nations' work: peace and security, economic and social affairs, development co-operation, and humanitarian affairs. Each of the agencies with responsibility for health currently has policy documents at various stages of elaboration which concern health and human rights, and technical staff responsible for the integration or implementation of human rights into at least some aspects of their work, a situation that would have been unimaginable even a few years ago.

1. The United Nations International Children's Emergency Fund (UNICEF) has restructured its policy and programmatic framework around the Convention on the Rights of the Child (UNICEF 2000).
2. The Joint United Nations Programme on HIV/AIDS (UNAIDS) recognizes human rights as a theme relevant to all aspects of its policy and programme work; see *UNAIDS Strategic Plan 1996 to 2000* (revised December 1995), pp. 5, 6, and 13 where the importance of contextual factors that increase vulnerability to HIV/AIDS is recognized, including existing discrimination against certain groups, and where human rights are cited as core values and guiding principles for the mission of UNAIDS.
3. A Memorandum of Understanding now exists between the United Nations Development Programme and the Office of the High Commissioner for Human Rights (UNDP 1999).
4. The United Nations Development Programme Human Development Report for the year 2000 has an explicit focus on human rights, and the WHO is currently preparing its first strategy on health and human rights (WHO 1999b).

Likewise, the bodies of the United Nations system with responsibility for human rights are also paying increasing attention to health-related concerns. This is most easily seen in the recent attention to HIV/AIDS and reproductive health by the human rights treaty monitoring bodies (UNHCHR 1996, 1997, 1998a, b). However, this commitment extends to the recent appointment of two health-related focal points in the Office of the High Commissioner for Human Rights: one responsible for integrating HIV/AIDS issues into the work of the human rights bodies and structures, and the other serving as a general liaison for all health and human rights issues.

State and non-state actors entering the arena of health and human rights

Governments are also increasingly recognizing the relevance of human rights to their health and development work, and calling for technical assistance in the field of human rights. This is true in

developing and industrialized countries alike. In Nepal, a comprehensive workshop was recently held on tuberculosis and human rights (WHO 1999b). An open debate in South Africa recently focused on the human rights implications of a proposed new regulation concerning AIDS reporting and AIDS-status disclosure to third persons (South Africa Government Gazette 1999). In Colombia, the Convention on the Elimination of All Forms of Discrimination Against Women is being used as a framework for mobilization around much of the work in family planning (Plata and Yanuzova 1993; Corporación Casa de la Mujer 1998). Within the United States, President Clinton issued an Executive Order in commemoration of Human Rights Day in 1998 that obliges the United States to respect and implement fully its obligations under the international human rights treaties to which it is a party and to 'promote respect for international human rights in our relationships with all other countries' (Clinton 1998). As a result, all United States federal agencies, including those with health-related responsibilities, have been directed to re-examine their policies and strategies from the perspective of international human rights standards.

Non-governmental organizations, such as Amnesty International and Human Rights Watch, are also increasingly considering the implications of the health and human rights connection for their own work. Non-governmental organizations that focus on health or development issues, many of which previously saw human rights as having little relevance to their work, are increasingly using not only the rhetoric of human rights but also its method of analysis to help shape their interventions. One prime example is the recent decision of the International Council of AIDS Service Organizations (ICASO) to name the promotion of human rights in the context of HIV/AIDS as one of its fundamental organizing principles (ICASO 1998). In addition, human rights non-governmental organizations are expanding their formerly tight focus on civil and political rights to pay increasing attention to economic, social, and cultural rights, including the right to health. These developments are helping to shape new forms of advocacy and to put increased pressure on governments to take responsibility for the health of their populations. The current challenge is to ensure that the increased rhetorical attention to rights translates into policies, national legislation, and actions that will effectively impact on the underlying conditions necessary for health, as well as the ways in which health policies, programmes, and services are conceptualized and delivered.

Academics and researchers are also increasingly finding the links between health and human rights to be of critical importance in expanding their domains of work (Alfredsson and Tomaševski 1998; Toebes 1999). Academic centres with an explicit focus on the links between health and human rights are beginning to appear in a number of places, some with a focus on specific substantive issues, and others concerned with health and human rights more broadly (for example, the François-Xavier Bagnoud Center for Health and Human Rights at the Harvard School of Public Health, as well as the Macfarlane Burnett Centre for Medical Research in Australia, the Programme on Gender, Sexuality, Health and Human Rights at the Mailman School of Public Health at Columbia University, The Netherlands Institute of Human Rights, and the Department of Community Health at the University of Cape Town, South Africa). In the last several years, institutions around the globe have begun to offer courses in health and human rights, international conferences on health and human rights have been held in a number of locations, and professional health journals

such as *The Lancet*, the *Journal of the American Medical Association*, and the *American Journal of Public Health* have devoted space to exploring health and human rights issues (Brenner 1996; Sonis *et al.* 1996; Leaning 1997; Fluss 1999). The first course on health and human rights was offered at the Harvard School of Public Health in 1992. Since then, courses on health and human rights have been increasingly offered in countries such as the United States, France, Sweden, Brazil, South Africa, and Zimbabwe. Efforts are currently under way to document existing courses on health and human rights.

Understanding the implications of linking health and human rights is of increasing importance to policy-makers, government officials, and activists—indeed, to anyone concerned with health issues, human rights issues, or the links between the two (Marks 1997). This chapter demonstrates the relationship between health and human rights, and provides a glimpse of some of the conceptual, analytical, and practical approaches to bringing health and human rights together that are currently being explored. It begins by explaining the basic concepts and procedures of human rights, with specific emphasis on their relation to health. It goes on to explore the framework of health as it relates to human rights promotion and protection. The next section considers the reciprocal relationships between health and human rights, with an emphasis on the human rights impact of public health policies and programmes and the impact of neglect or violation of human rights on health. Attention is then given to suggested methods for increasing the synergy between health and human rights, both as a method of analysis and as an approach to the design, implementation, and evaluation of health policies and programmes. This last section offers a useful method for considering the practical application of health and human rights concepts to policy and programmatic work.

What are human rights?

While human rights thinking and practice has a long history, the importance of human rights for governmental action and accountability was first widely recognized only after the Second World War. Agreement between nation-states that all people are 'born free and equal in dignity and rights' was reached in 1945 when the promotion of human rights was identified as a principal purpose of the newly created United Nations (UN 1945). The United Nations Charter established general obligations that apply to all its member states, including respect for human rights and dignity. Then, in 1948, the Universal Declaration of Human Rights was adopted as a common standard of achievement for all peoples and all nations (UN 1948). The basic characteristics of human rights are that they are the rights of individuals, which inhere in individuals because they are human, that they apply to people everywhere in the world, and that they are principally concerned with the relationship between the individual and the state. In practical terms, international human rights law is about defining what governments can do to us, cannot do to us, and should do for us. For example, governments obviously should not do things like torture people, imprison them arbitrarily, or invade their privacy. Governments should ensure that all people in a society have shelter, food, medical care, and basic education.

The Universal Declaration of Human Rights can well be understood to be the cornerstone of the modern human rights movement. The preamble to the Universal Declaration of Human Rights proposes that human rights and dignity are self-evident, the 'highest aspiration

of the common people', and the 'foundation of freedom, justice and peace'. 'Social progress and better standards of life' including the 'prevention of barbarous acts which have outraged the conscience of mankind', and, broadly speaking, individual and collective well being, are understood to depend upon the 'promotion of universal respect for and observance of human rights' (UN 1948). Although the Universal Declaration of Human Rights is not a legally binding document, nations have endowed it with a tremendous legitimacy through their actions, including invoking it legally and politically at the national and international levels. Portions of the Universal Declaration of Human Rights are cited in the majority of national constitutions drafted since it came into being, and governments often cite the Universal Declaration of Human Rights in their negotiations with other governments, as well as in their accusations against each other of violating human rights. A useful compilation can be found in Hannum (1998).

Under the auspices of the United Nations, more than 20 multilateral human rights treaties have been formulated since the adoption of the Universal Declaration of Human Rights. These treaties create legally binding obligations on the nations that have ratified them, thereby giving them the status and power of international law. Countries that become party to international human rights treaties accept certain procedures and responsibilities, including periodic submission of reports on their compliance with the substantive provisions of the texts to international monitoring bodies. The key international human rights treaties, the International Covenant on Economic, Social and Cultural Rights (UNICESCR 1966) and the International Covenant on Civil and Political Rights (UNICCPR 1966), further elaborate the content of the rights set out in the Universal Declaration of Human Rights and contain legally binding obligations for the governments that ratify them. As of January 2000, 142 countries had ratified the ICESCR and 144 had ratified the ICCPR. Together with the Universal Declaration of Human Rights and the United Nations Charter, these documents are often called the 'International Bill of Human Rights' (Humphrey 1976). Building upon these core documents, other international human rights treaties have focused on either specific populations (for example, the international Convention on the Elimination of All Forms of Racial Discrimination (UN 1965), the Convention on the Elimination of All Forms of Discrimination Against Women (UN 1979), and the Convention on the Rights of the Child (UNCRC 1989)), or on specific issues (for example, the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (UN 1984a)).

There are also regional human rights treaties, which essentially concern the same sets of rights but are only open for signature by states in the relevant region, such as the African Charter on Human and Peoples' Rights (1982), the American Convention on Human Rights (1969), and the European Convention on the Protection of Human Rights (1950). Only the Asian region does not contain such a treaty. Additionally, there are numerous international declarations, resolutions, and recommendations which, although not strictly binding in a legal sense, express the political commitment of governments to promote and protect human rights and provide broadly recognized norms and standards relevant to the topic at hand (for example, the Declaration on the Elimination of All Forms of Intolerance and of Discrimination Based on Religion or Belief (UN 1981, 1993a)).

In the past decade, the series of international conferences held under the auspices of the United Nations have, to a great degree,

helped give recognizable content to many of the rights contained in the various human rights treaties. Out of each of these conference processes has come a declaration and programme of action reflecting the consensus of the nations of the world. Though technically 'non-binding' commitments, these documents demonstrate that there is a consensus of the world community that international human rights treaty norms encompass the relationship between health and human rights, including reproductive rights, and that there are steps that ought to be taken at the local, national, and international levels to advance these concerns.

While these conference declarations and programmes of action represent nothing more than the political commitments of the governments present at their inception, the fact that they are then adopted at the next session of the United Nations General Assembly gives them a degree of formal standing. Although the declarations and programmes of action from the 1994 International Conference on Population and Development (ICPD 1994) and the 1995 Fourth World Conference on Women (FWCW 1995) have been of particular relevance, the 1993 World Conference on Human Rights (UN 1993c, 1998a) and the 1995 World Summit for Social Development (UN 1995b) have also helped explicate the relevance of the health and human rights framework to government action. Individually and collectively, these documents have been of critical importance in helping to elaborate provisions relevant to vulnerable groups, women's human rights, and broader concepts of health and human rights. Those commitments have helped to create new approaches for considering the extent of government accountability for health issues, as well as for determining the content of health issues using a rights framework. In so doing, these conference documents are helping to clarify the evolving meaning of the relationship between health and human rights and the steps needed for implementation (Gruskin 1998).

A human rights perspective on health

The specific rights that form the corpus of human rights law are found in the international human rights documents. While it is possible to identify different categories of rights, it is also critical to rights discourse and action to recognize that all rights are interdependent and interrelated, and that individuals rarely suffer neglect or violation of a particular right in isolation. For historical reasons, the rights described in the human rights documents have been divided into civil and political rights on the one hand and economic, social, and cultural rights on the other. Civil and political rights include the rights to liberty, to security of person, to freedom of movement, to vote, and not to be subjected to cruel, inhuman, or degrading treatment or punishment or to arbitrary arrest or detention. Economic, social, and cultural rights include the rights to the highest attainable standard of health, work, social security, adequate food, clothing and housing, and education, and the right to enjoy the benefits of scientific progress and its applications. Although the Universal Declaration of Human Rights contains both categories of rights, these rights were artificially split into two treaties due to Cold War politics, with the United States championing civil and political rights, and the former Soviet Union those rights considered to be more economic, social, and cultural in nature (Steiner and Alston 1996). Since the end of the Cold War, acknowledgement of the indivisibility and interdependence of rights has, once again, become commonplace (UN 1993c). The Convention

on the Rights of the Child, the first human rights treaty to be opened for signature after the end of the Cold War, is the only one so far to include civil, political, and economic and social rights considerations not only within the same treaty but within the same right. (See, in particular Article 6, which in guaranteeing the right to life includes both the more civil and political provision which states that 'every child has the inherent right to life' and the more economic and social provision in which 'State Parties shall ensure to the maximum extent possible the survival and development of the child' (UNCRC 1989).)

Health and government responsibility for health is codified in these documents in several ways. The right to the highest attainable standard of health appears in one form or another in most of them. More importantly, nearly every article of every document can be understood to have clear implications for health (Mann *et al.* 1994). While the rights to information, education, housing and safe working conditions, and social security, for example, are particularly relevant to the health and human rights relationship, specific reference must be made to three rights: the right to non-discrimination, the right to the benefits of scientific progress, and the right to health.

Non-discrimination

The principle of non-discrimination is key to human rights thinking and practice. Under international human rights law, all people should be treated equally and given equal opportunity. Within the international human rights framework, discrimination is a breach of a government's human rights obligations (Bilder 1992). Adverse discrimination occurs when a distinction is made against a person which results in their being treated unfairly or unjustly. In general, groups that are discriminated against tend to be those that do not share the characteristics of the dominant groups within a society. Thus, discrimination frequently reinforces social inequalities and denies equal opportunities. Common forms of discrimination include racism, gender-based discrimination, and homophobia. Each of the major human rights treaties specifically details the principle of non-discrimination with respect to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, and, as it is called, 'other status'.

Governmental responsibility for this right includes ensuring equal protection under the law, as well as in relation to such issues as housing, employment, and medical care. The prohibition of discrimination does not mean that differences should not be acknowledged, only that different treatment must be based on objective and reasonable criteria. Although the international human rights documents do not explicitly prohibit discrimination on the basis of health status, the United Nations Commission on Human Rights has stated that 'all are equal before the law and entitled to equal protection of the law from all discrimination and from all incitement to discrimination relating to their state of health' (UN 1992a, 1993b; UNCHR 1994).

Right to enjoy the benefits of scientific progress

Closely allied to many of the issues relevant to health is the right to 'enjoy the benefits of scientific progress and its applications', recognized explicitly in the ICESCR, Article 15. This right includes governmental obligations for the steps necessary to conserve, develop,

and diffuse science and scientific research, as well as freedom of scientific inquiry. The implications of this right for health issues have been explored recently with respect to access to drugs for the developing world, to name one important example (Lallemant *et al.* 1994; Reich 2000). In fact, this right is increasingly being cited by activist groups, non-governmental organizations, and others concerned by the large and growing disparities and inequities between wealthier and poorer populations regarding access to antiretroviral therapies and other forms of HIV/AIDS care. In addition, the relevance of this right to concerns about the development of vaccines that adequately respond to the specific needs of all populations, both in the North and the South, has recently been cited (Beloqui *et al.* 1998; Fluss and Little 1999). (See, for example, Statement from the Community AIDS Movement in Africa, presented at the Meeting on the International Partnership against HIV/AIDS in Africa, New York, United Nations Headquarters, 6–7 December 1999.) Unfortunately, while this right has long been recognized as relevant to governmental obligations under the ICESCR, its implications for health and health-related issues are only just beginning to be recognized.

The right to health

The human right to health should be understood, in the first instance, with reference to the description of health set forth in the preamble of the WHO Constitution and repeated in many subsequent documents (WHO 1946). Health is a ‘state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity’ (WHO 1946). This definition has important conceptual and practical implications, and it illustrates the indivisibility and interdependence of rights as they relate to health (Leary 1994; Tomaševski 1995a; Kirby 1999; Toebes 1999). Rights relating to discrimination, autonomy, information, education, and participation are an integral and indivisible part of the achievement of the highest attainable standard of health, just as the enjoyment of health is inseparable from that of other rights, whether categorized as civil and political, economic, social, or cultural. While the right to health has been set out in a number of international legal instruments, government obligations under this right are quite narrowly defined. As first elaborated in the ICESCR, the right is set forth only as ‘the right to the highest attainable standard of physical and mental health’, with obligations understood to encompass both the underlying preconditions necessary for health and the provision of medical care.

It is worth noting that the apparent tension between the broad definition of health proposed by the WHO, which includes the notion of social well being, and the more restrictive definition set out in the ICESCR reflects the very different purposes of these two documents. The WHO definition projects a vision of the ideal state of health as an eternal and universal goal to strive constantly towards, and has as its main purpose defining directions for the work of the Organization and its member states. The ICESCR definition differentiates the two attributes of health—physical and mental well being—and is specifically concerned with assigning particular responsibilities to the governmental health sector; it assigns obligations relevant to social well being to the same governments under other articles of the treaty. The right to health as stated in the ICESCR (Box 1) is the principal framework for understanding governmental obligations under the right to health.

Box 1 Article 12 of the United Nations International Covenant on Economic, Social and Cultural Rights (UNICESCR)

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

Governmental obligations for health under international human rights law

Governments are responsible not only for not directly violating rights, but also for ensuring the conditions which enable individuals to realize their rights as fully as possible. This is understood as an obligation to respect, protect, and fulfil rights, and governments are legally responsible for complying with this range of obligations for every right in every human rights document they have ratified (Eide 1995a,b; Maastricht Guidelines on Violations of Economic, Social and Cultural Rights 1997).

Respecting, protecting, and fulfilling human rights

Governmental obligations towards ensuring that every individual enjoys the right to health are summarized below as an illustration of the range of issues relevant to respecting, protecting, and fulfilling all human rights.

1. Respecting the right means that a state cannot violate the right directly. A government violates its responsibility to respect the right to health when it is immediately responsible for providing medical care to certain populations, such as prisoners or the military, and it arbitrarily decides to withhold that care.
2. Protecting the right means that a state has to prevent violations of rights by non-state actors and offer some sort of redress that people know about and can access if a violation occurs. This means that the state would be responsible for making it illegal to deny insurance or health care automatically to people on the basis

of a health condition, and that they would be responsible for ensuring some system of redress that people know about and can access if a violation does occur.

3. Fulfilling the right means that a state has to take all appropriate measures—including but not limited to legislative, administrative, budgetary, and judicial—towards fulfilment of the right, including the obligation to promote the right in question. A state could be found to be in violation of the right to health if it failed to allocate sufficient resources incrementally to meet the public health needs of the communities within its borders.

In all countries, resource and other constraints can make it impossible for a government to fulfil all rights immediately and completely. The human rights machinery recognizes this and acknowledges that, in practical terms, a commitment to the right to health requires more than just passing a law. It will require financial resources, trained personnel, facilities, and, more than anything else, a sustainable infrastructure. Therefore, realization of rights is generally understood to be a matter of progressive realization of making steady progress towards a goal (ICESCR Article 2.1; Alston and Quinn 1987). The principle of 'progressive realization' is fundamental to the achievement of human rights. This is critical for resource-poor countries that are responsible for striving towards human rights goals to the maximum extent possible. It is also of relevance to wealthier countries in that they are responsible for respecting, protecting, and fulfilling human rights not only within their own borders, but through their engagement in international assistance and co-operation (UN 1984b).

Valid limitations on human rights

In spite of the importance attached to human rights, there are situations where it is considered legitimate to restrict rights in order to achieve a broader public good. As described in the International Covenant on Civil and Political Rights, the public good can take precedence to 'secure due recognition and respect for the rights and freedoms of others; meet the just requirements of morality, public order, and the general welfare; and in times of emergency, when there are threats to the vital interests of the nation' (ICCPR Article 4). Public health is one such recognized public good. (The specific power of the state to restrict right in the state of public health can be understood to be derived from Article 12 (c) of the ICESCR, which gives governments the right to take the steps they deem necessary for the 'prevention, treatment and control of epidemic, endemic, occupational and other diseases'.) Traditional public health measures have generally focused on curbing the spread of disease by imposing restrictions on the rights of those already infected or thought to be most vulnerable to becoming infected. In fact, coercion, compulsion, and restriction have historically been significant components of public health measures (Smith 1911; Schmidt 1995; Cohen 1998). Although the restrictions on rights that have occurred in the context of public health have generally had as their first concern protection of the public's health, it is also true that the measures taken have often been excessive. Interference with freedom of movement when instituting quarantine or isolation for a serious communicable disease—for example, Ebola fever, syphilis, typhoid, or untreated tuberculosis—is an example of a restriction on rights that may be necessary for the public good and therefore could be considered legitimate under international human rights law. Conversely, arbitrary measures taken

by public health authorities that fail to consider other valid alternatives may be found to be abusive of both human rights principles and public health 'best practice'. In recent times, measures taken around the world in response to HIV/AIDS provides examples of this type of abuse (Cohen and Wiseberg 1990; UN 1992a, 1994; HRI 1998).

Certain rights are absolute, which means that restrictions may never be placed on them, even if justified as necessary for the public good. These include such rights as the right to be free from torture, slavery, or servitude, the right to a fair trial, and the right to freedom of thought. (See, for example, Article 4 of the ICCPR, which states that '[n]o derogation from articles 6, 7, 8 (paragraphs 1 and 2), 11, 15, 16, 18 may be made under this provision'.) Paradoxically, the right to life, which might at first glance appear to be inalienable, is not absolute; what is forbidden is the arbitrary deprivation of life. Interference with most rights can be legitimately justified as necessary under narrowly defined circumstances in many situations relevant to public health. (See, for example, Article 4 of the ICCPR, which states that '[i]n time of public emergency which threatens the life of the nation and the existence of which is officially proclaimed, the States Parties to the present Covenant may take measures derogating from their obligations under the present Covenant to the extent strictly required by the exigencies of the situation, provided that such measures are not inconsistent with their other obligations under international law and do not involve discrimination solely on the ground of race, colour, sex, language, religion or social origin'.)

Limitations on rights, however, are considered a serious issue under international human rights law, regardless of the apparent importance of the public good involved. When a government limits the exercise or enjoyment of a right, this action must be taken only as a last resort and will only be considered legitimate if the following criteria are met (UNECOSOC 1985).

1. The restriction is provided for and carried out in accordance with the law.
2. The restriction is in the interest of a legitimate objective of general interest.
3. The restriction is strictly necessary in a democratic society to achieve the objective.
4. There are no less intrusive and restrictive means available to reach the same goal.
5. The restriction is not imposed arbitrarily, i.e. in an unreasonable or otherwise discriminatory manner.

Whereas this approach, often called the Siracusa Principles because they were conceptualized at a meeting in Siracusa, Italy, has long been recognized by those concerned with human rights monitoring and implementation as relevant to analysing a government's actions, it has also recently begun to be considered a useful tool in a number of places by those responsible within government for health-related policies and programmes (WHO/UNAIDS 1999). This framework, although still rudimentary, may be helpful in identifying public health actions that are abusive, whether intentionally or unintentionally.

Human rights monitoring mechanisms relevant to health

The degree of governmental compliance with the obligations to respect, protect, and fulfil human rights are of direct relevance to the

people affected, but they are also of interest to the international community. The accountability of governments for their legal commitments is monitored at the international level through the reporting process and, in many places, at the national level by governments themselves through the creation of commissions and ombudspersons, as well as by non-governmental organizations.

Reporting under the human rights treaties

As mentioned above, once a government has ratified a human rights treaty, it is obliged to report every several years to the specific body responsible for monitoring government action under that treaty. Governments are responsible for showing the ways that they are and are not in compliance with the treaty provisions, and must show constant improvement in their efforts to respect, protect, and fulfil the rights in question (UN 1996). Each of the treaty bodies meets several times a year to review a number of the government reports submitted. The process is very formal, with the government under review submitting a copy of its report approximately 2 months before the meeting. The report is officially presented at the meeting by a high-ranking government official, and the treaty body engages in formal dialogue with the country in question. Health-oriented United Nations institutions, such as the WHO, UNAIDS, or UNICEF, are invited to provide the treaty bodies with information on the state of health and the performance of health systems in the country under review. Non-governmental organizations can also submit informal reports (often termed shadow reports) providing additional information, as well as stating their views on the situations and issues at stake. At the conclusion of the session, the treaty body prepares concluding comments and observations, which are made part of the substantive record. These comments address the extent to which the government in question is in compliance with its treaty provisions and provide concrete suggestions for actions to be taken by the country in order for it to be found in compliance at its next review. While this process can be extremely useful, there is, unfortunately, a tremendous backlog, largely because governments are often late with their reports, and none of the treaty bodies meets for a sufficient amount of time each year to cover all of the countries that are responsible for reporting to it.

All of the human rights treaty bodies have expressed a commitment to exploring the implications of health broadly defined, as well as the specific issues raised by both HIV/AIDS and reproductive health concerns, for governmental obligations under the treaties (UNDAW 1996; UNHCHR 1996; Boerefon and Toebes 1998; UNFPA 1998). While several of the treaties contain specific health-related provisions, the added impetus to pay attention to health in the context of monitoring work can largely be attributed to the interest generated from international conferences and the political commitments made there about governmental responsibility for ensuring the human rights of individuals in relation to health.

For each of the human rights treaties, general guidelines for reporting provide guidance to governments as to how to present the information about their compliance with their obligations to the treaty bodies (UN 1996). The information requested by the treaty bodies concerning health-related issues explains what governments are doing with respect to both the underlying preconditions for health and the ways in which health policies, programmes, and services are designed and implemented. From a health perspective, however, the actual information requested under current requirements is largely

insufficient to get at this range of issues. The general guidelines provided to governments for reporting on the right to health under the ICESCR are included in Box 2. They provide a concrete example of what the treaty body with primary responsibility for implementation of the right to health considers in determining if, and the degree to which, a government is in compliance with its obligations for the right to health.

The increasing links among the work of the treaty bodies, the United Nations specialized agencies, and non-governmental organizations are useful to the treaty monitoring process, but they are also beginning to contribute directly to the enhancement of the implementation of human rights at the country level by governments as well as other actors. The role of the technical and specialized agencies, funds, and programmes of the United Nations in the treaty monitoring process is growing, with respect to both provision of information and interactions with the treaty bodies and governments in question. This includes primarily UNICEF, UNAIDS, and the WHO but also, increasingly, the International Labour Organization, the United Nations Development Programme, and the United Nations Population Fund. These agencies and programmes have increasingly been providing the treaty bodies with statistical information and other data collected as part of their routine work concerning the country in question to assist the treaty bodies in their review of government compliance. They have also been providing treaty bodies with guidelines and other examples of 'best practice' they have produced, which can assist the treaty bodies in their analysis of the information provided by the government and in the drafting of their concluding comments and observations. To date, however, the input of these agencies has been somewhat uncoordinated, even within the same institution, often resulting in heavy servicing of some treaty bodies in some specific ways while virtually ignoring others. As a result, a country may be heavily questioned by one treaty body as to some specific aspect of their compliance with their health-related obligations under one treaty, but not questioned at all by another treaty body responsible for monitoring similar health-related obligations. In addition, owing to lack of resources and the relative newness of their engagement with this process, the United Nations agencies, funds, and programmes do not provide even the treaty bodies they do work with equivalent information on all countries reporting at a particular time. Thus, while one country may be heavily questioned by a treaty body as a result of information provided by a particular agency, the next country immediately under review may not even be questioned superficially on comparable issues. UNICEF has been involved in the treaty monitoring process in other ways as well. For example, it has expended considerable resources on helping governments to prepare their reports as well as increasingly framing technical assistance to countries according to the provisions of the Convention on the Rights of the Child (UNICEF 1998). This approach to the work of United Nations agencies and programmes at the country level has increasingly been considered of interest by the other technical agencies of the United Nations, especially UNAIDS and the WHO, and may help to frame some of their future work.

Non-governmental organizations have a critical role to play in monitoring government compliance with treaty provisions. Within countries, non-governmental organizations are increasingly using government obligations under the human rights treaties, as well as the concluding comments and observations of the treaty bodies, in their advocacy efforts. The input of non-governmental organizations is also

Box 2 Guidelines for reporting on Article 12 of the United Nations International Covenant on Economic, Social and Cultural Rights (UNICESCR) (UNECOSOC 1991; Alston 1991)

1. Please supply information on the physical and mental health of your population, both in the aggregate and with respect to different groups within your society. How has the health situation changed over time with regard to these groups? In case your government has recently submitted reports on the health situation in your country to the WHO you may wish to refer to the relevant parts of these reports rather than repeat the information here.
2. Please indicate whether your country has a national health policy. Please indicate whether a commitment to the WHO primary health care approach has been adopted as part of the health policy of your country. If so, what measures have been taken to implement primary health care?
3. Please indicate what percentage of your gross national product as well as of your national and/or regional budget(s) is spent on health. What percentage of those resources is allocated to primary health care? How does this compare with 5 years ago and 10 years ago?
4. Please provide, where available, indicators as defined by the WHO, relating to the following issues:
 - (a) infant mortality rate (in addition to the national value, please provide the rate by sex, urban/rural division, and also, if possible, by socio-economic or ethnic group and geographical area. Please include national definitions of urban/rural and other subdivisions)
 - (b) population access to safe water (please disaggregate urban/rural)
 - (c) population access to adequate excrete disposal facilities (please disaggregate urban/rural)
 - (d) infants immunized against diphtheria, pertussis, tetanus, measles, poliomyelitis, and tuberculosis (please disaggregate urban/rural and by sex)
 - (e) life expectancy (please disaggregate urban/rural, by socio-economic group, and by sex)
 - (f) proportion of the population having access to trained personnel for the treatment of common diseases and injuries, with regular supply of 20 essential drugs, within 1 hour's walk or travel
 - (g) proportion of pregnant women having access to trained personnel during pregnancy and proportion attended by such personnel for delivery. Please provide figures on the maternity mortality rate, both before and after childbirth
 - (h) proportion of infants having access to trained personnel for care.

(Please provide breakdowns by urban/rural and socio-economic groups for indicators (f) to (h).)
5. Can it be discerned from the breakdown of the indicators employed in paragraph 4, or by other means, that there are any groups in your country whose health situation is significantly worse than that of the majority of the population? Please define these groups as precisely as possible and give specifics. Which geographical areas in your country, if any, are worse off with regard to the health of their population?
 - (a) During the reporting period, have there been any changes in national policies, laws, and practices negatively affecting the health situation of these groups or areas? If so, please describe these changes and their impact.
 - (b) Please indicate what measures are considered necessary by your government to improve the physical and mental health situation of such vulnerable and disadvantaged groups in such worse off areas.
 - (c) Please explain the policy measures your government has taken, to the maximum of available resources, to realize such improvement. Indicate time-related goals and benchmarks for measuring your achievement in this regard.
 - (d) Please describe the effect of these measures on the health of the vulnerable and disadvantaged groups or worse-off areas under consideration, and report on the successes, problems, and shortcomings of these measures.
 - (e) Please describe the measures taken by your government in order to reduce the stillbirth rate and infant mortality and to provide for the healthy development of the child.
 - (f) Please list the measures taken by your government to improve all aspects of environmental and industrial hygiene.
 - (g) Please describe the measures taken by your government to prevent, treat, and control epidemic, endemic, and occupational and other diseases.
 - (h) Please describe the measures taken by your government to assure to all medical service and medical attention in the event of sickness.
 - (i) Please describe the effect of the measures listed in subparagraphs (e) to (h) on the situation of the vulnerable and disadvantaged groups in your society and in any worse-off areas. Report on difficulties and failures as well as on positive results.
6. Please indicate the measures taken by your government to ensure that the rising costs of health care for the elderly do not lead to infringements on these persons' right to health.
7. Please indicate what measures have been taken in your country to maximize community participation in the planning, organization, operation, and control of primary health care.
8. Please indicate what measures have been taken in your country to provide education concerning prevailing health problems and the measures of preventing and controlling them.
9. Please indicate the role of international assistance in the full realization of the right enshrined in Article 12.

crucial at the international level in that they are able to provide treaty monitoring bodies with the necessary additional outside information on the action (or inaction) of the government in question, which can then be used by the treaty body in its dialogue with that government. Although non-governmental organizations are sometimes present during the formal dialogue, this information is most often presented in shadow reports. There is no formal mechanism, however, for ensuring that non-governmental organization information reaches the treaty bodies, and, unfortunately, non-governmental organizations generally do not co-ordinate with each other on the information they provide. At times, the same information about a particular situation has been presented to a treaty body from numerous sources, while other potentially critical information of a more general nature is never provided. In addition, many local non-governmental organizations are unaware of or lack access to the treaty monitoring process, resulting in a number of problems. Firstly, only the most publicized cases come to the attention of the monitoring body. Secondly, the lack of functioning non-governmental organizations in a majority of countries results in both a dearth of information from countries with some of the worst human rights records and a privileging of the information provided by well-established international human rights non-governmental organizations such as Amnesty International and Human Rights Watch, which have more contacts and closer relationships with the treaty body members than other organizations do. This last point is of particular concern in relation to health-related human rights issues, as these issues often fall outside the purview of mainstream human rights organizations, and therefore little alternative information on health-related issues reaches the relevant bodies (UNAIDS 1997). As a result, while the utility of the involvement of non-governmental organizations to this process is at this point undisputed, mechanisms for ensuring their involvement in a comprehensive way, particularly with respect to health-related information, still remain to be worked out.

General recommendations and general comments concerning health

In the past 5 years, there have been increasing efforts to draft authoritative interpretations of the right to health in order to ensure state responsibility and accountability with respect to health in a structured way. These authoritative interpretations have taken the form of general comments or general recommendations, which are drafted and endorsed by the treaty monitoring body in question and which form the basis of the treaty body's formal understanding of the content of a particular right or issue. These general comments or general recommendations then help to serve as a guide for governments concerning the issues that they must consider in making their periodic reports under the guidelines, for non-governmental organizations in their monitoring of governmental action and for the treaty bodies themselves in their dialogue and interaction with governments in the context of the monitoring process (UN 1996). While these comments and recommendations are meant only to provide interpretation, their formulation does have real implications for whether or not a government is judged to be in compliance with its treaty obligations. For example, the right to health as formulated in international treaties contains no mention of primary health care. This is mainly because the concept of primary health care had not yet been internationally recognized at the time that the ICESCR was drafted.

While the guidelines for reporting contain substantive mention of primary health care, the relationship between a primary health care approach and government obligations under the treaty are not detailed. Thus, in the absence of a general comment or recommendation emphasizing a primary health care approach, it is difficult to judge a country that pays little or no attention to primary health care not to be in compliance with its health-related obligations.

Until very recently, no general comments or recommendations had been issued by any of the treaty bodies specifically related to health. In 1999, the United Nations Committee on the Elimination of Discrimination Against Women (UNCEDAW), which monitors governmental compliance under the Women's Convention, issued a General Recommendation on Health (UNCEDAW 1999), and in 2000 the Committee on Economic, Social and Cultural Rights, the body responsible for monitoring the ICESCR, issued a General Comment on the Right to Health (UNICESCR 2000). Nonetheless, a number of the general comments and recommendations previously issued by the treaty bodies have had clear health-related implications. These include the General Comments on disability (UN 1994), housing (UN 1997*b*), and food (UN 1995*a*) issued by the UNCESCR, and the General Recommendations concerning HIV/AIDS (UNCEDAW 1990*b*), female circumcision (UNCEDAW 1990*a*), and violence against women (UNCEDAW 1989) issued by the UNCEDAW.

At the outset of the twenty-first century, the translation of the right to health into guidelines and other tools useful to national and international monitoring of governmental and intergovernmental obligations is still in its infancy. The ICESCR General Comment on the Right to the Highest Attainable Standard of Health, which was adopted in 2000 (UNICESCR 2000), may help to provide some useful guidelines. In parallel, as described below, the WHO is developing a new set of tools and recommendations aimed at redirecting the attention given to monitoring global health indicators from disease-specific morbidity and mortality trends towards others that are more reflective of the degree to which health and human rights principles are respected, protected, and fulfilled (WHO 2000*c*). How and to what extent these instruments will be put to use and how effective they will be in advancing the health and human rights agenda has yet to be seen, but there are several factors that, even at this early stage, allow for guarded optimism. Firstly, the treaty bodies and international organizations concerned with health are doing this work based on open dialogue and a degree of collaboration that greatly exceeds the level and quality of interagency collaboration traditionally observed within the United Nations machinery. This is exemplified by the sharing of goals and the collective technical co-operation that has prevailed in the current processes of defining obligations and monitoring methods and standards relevant to health and human rights in the process of operationalizing both the international treaties and the recommendations promulgated at the international conferences (UNDAW 1996; UNDP 1998*b*; WHO 2000*b*). Potentially, this work will help not only to monitor what governments are doing, but also to build their capacity to incorporate health and human rights principles into their policies and programmes. In several countries, including Brazil, Thailand, and South Africa, human rights principles relevant to health have recently found their way into national legislation and new constitutions, thereby ensuring citizens the right to seek fulfilment of their right to care, for example, through national juridical means (Hannum 1998). As the methods and tools for monitoring and accountability of health-related issues mature, it is

likely that cases of human rights violations related to health will increasingly be heard both within countries and at the regional and international level. (See, for example, *Open Door Counselling Ltd and Dublin Well Women's Centre Ltd v. Ireland*, 1992, 15 EUR. H.R. Report 244.) A focus on monitoring and redress of violations of the right to health is but one means of ensuring action using the human rights documents. Equally important are the steps being taken to build national and international capacity to develop and reform public policy and laws in line with international human rights norms and standards as they apply to health (UNFPA 1998). This work requires institutional changes, as well as capacity building within both governmental systems and international organizations. The Director-General of the WHO has cited the need to integrate efforts towards this goal, noting: 'Even when governments are well-intentioned, they may have difficulty fulfilling their health and human rights obligations. Governments, the WHO and other intergovernmental agencies should strive to create the conditions favorable to health, even in situations where the base of public finance threatens to collapse' (Brundtland 1998).

The process of 'mainstreaming human rights', currently well underway in the United Nations system, is specifically aimed toward this goal (UN 1997a). Mainstreaming human rights is 'the process of assessing the human rights implications of any planned action, including legislation, policies or programmes, in all areas and at all levels. It is a strategy for making human rights an integral dimension of the design, implementation, monitoring and evaluation of policies and programmes in political, economic and social spheres' (UN 1997a). Two examples illustrate how this is done. In the 1990s, UNICEF adopted the Convention on the Rights of the Child (CRC), thereby ensuring that their policy and programmatic work would be guided by the principles and standards established by the CRC, as well as the Convention on the Elimination of All Forms of Discrimination Against Women. The 1996 Mission Statement says explicitly that pursuit of the rights of children and women is a fundamental purpose of the organization. These efforts have led to a restructuring of UNICEF and a rights-based approach to all programming efforts at all levels of its work (UNICEF 1998). In the WHO, a similar process began in 1999 with the aim of defining the goals of human rights mainstreaming for their national and international health work (WHO 1999c). The process was begun following the 1998 World Health Assembly Resolution that set out the need to 'promote and support the rights and principles, actions and responsibilities enunciated in the [World Health Declaration] through concerted action, full participation and partnership, calling on all peoples and institutions to share the vision of health for all in the twenty-first century, and to endeavor in common to realize it' (WHO 1998d). In 2000, work began towards a strategy document which would incorporate health and human rights into the policy and programme work of the WHO. Towards this aim, health and human rights are considered relevant to each of the WHO's four strategic directions (WHO 1999c):

- reducing excess mortality, morbidity, and disability, especially in poor and marginalized populations
- promoting healthy lifestyles and reducing risk factors to human health that arise from environmental, economic, social, and behavioural causes
- developing health systems that equitably improve health outcomes, respond to people's legitimate demands, and are financially fair

- developing an enabling policy and institutional environment in the health sector and promoting an effective health dimension to social, economic, environmental, and development policy.

These strategic directions are discussed more extensively below with specific reference to their health and human rights implications. To pursue these directions, the WHO is proposing to contribute to the building of skills and knowledge within the WHO and within countries; to perform an internal review of its policies and programmes to verify their conformity with health and human rights principles; to further its co-operation with the Office of the High Commissioner for Human Rights and the treaty monitoring bodies; to disseminate information; and to develop and refine human rights-sensitive monitoring and evaluation processes applicable nationally and internationally.

A health perspective on human rights

As stated above, over 50 years ago, the Constitution of the WHO projected a vision of health as a state of complete physical, mental, and social well being—a definition of health that is more relevant today than ever (WHO 1946). It recognized that the enjoyment of the highest attainable standard of health was one of the fundamental rights of every human being and that governments have a responsibility for the health of their peoples, which can be fulfilled only through the provision of adequate health and social measures. The 1978 Alma-Ata Declaration (WHO/UNICEF 1979) called on nations to ensure the availability of the essentials of primary health care, including:

- education concerning health problems and the methods for preventing and controlling them
- promotion of food supply and proper nutrition
- an adequate supply of safe water and basic sanitation
- maternal and child health care, including family planning
- immunization against major infectious diseases
- prevention and control of locally endemic diseases
- appropriate treatment of common disease and injuries
- provision of essential drugs.

In 1998, the World Health Assembly reaffirmed the commitment of nations to strive towards these goals in a World Health Declaration that stressed the 'will to promote health by addressing the basic determinants and prerequisites for health' and the urgent priority 'to pay the greatest attention to those most in need, burdened by ill health, receiving inadequate services for health or affected by poverty' (WHO 1998d). These ambitious objectives of health development must be examined from the perspective of the role of governments in ensuring equal and equitable access to medical care and health promotion while striving to create the underlying conditions necessary for health.

This section begins with a discussion of the traditional dichotomy between the roles and functions of medicine and those of public health, which will help begin to frame the content of governmental obligations towards individuals and populations for health under international human rights law. Health will then be placed in the broader context of human development in order to underscore the relevance of a broad array of governmental obligations, well beyond

the health sector, that may impact on health. The four strategic directions to health development mentioned above will then be presented as an approach relevant to the development of both a health and human rights analysis and monitoring and accountability. Finally, a new grouping of these issues will be proposed as an entry point into their analysis from a human rights perspective, leading to a pathway for action.

Medicine, public health, and human rights

Health as it connects to human rights analysis and implementation concerns two related but different disciplines: medicine and public health. Historically the territorial boundaries of medicine and public health reflected not only professional interest and skill, but also the environments within which these skills were practised: homes, clinics, hospitals, and clinical laboratories on the one hand; institutes, public health laboratories, offices, and field projects on the other (Detels *et al.* 1997). Recently, the apparent differences between the two professions—the first primarily understood to focus on the health of individuals, the second on the health of populations—have profoundly impacted the ways in which the relationship between health and human rights has been understood by different actors. From a rights perspective, this ancient division resulted in the assumption that, of the two, medicine was more concerned with the health and rights of the individual (for example, in creating conditions enabling a particular individual to access care), while the primary focus of public health was the protection of collective interests, even at the cost of arbitrarily restricting individual rights (Mann 1997*b*). For example, coercion and restrictions of rights had been critical to traditional smallpox eradication efforts (Fenner *et al.* 1988). Yet as the human rights approach has made increasingly clear, this stark differentiation between medicine and public health is no longer fully relevant either to human rights or to health. Although they apply different methods of work, both medicine and public health seek to ensure every person's right to achieve the highest attainable standard of health, and both have a strong focus on the individual. Medicine is more concerned with analysing, diagnosing, and treating disease, as well as preventing ill health in individuals through such methods as immunization, appropriate diet, or prophylactic therapies. Public health seeks to address health and ill health by focusing on individual and collective determinants, be they behavioural, social, economic, or other contextual factors.

Three sets of factors have contributed to blurring traditional boundaries between medicine and public health. Firstly, the transitions in health status through which many populations have been recently evolving have called for a closer understanding of the links between individual health, public health, and the environment (Shrader-Frechetter 1991; Gubler 1998). Current thinking about optimal strategies for disease control have evolved, as efforts to confront the most serious global health threats (including cancer, mental disorders, cardiovascular and other chronic diseases, reproductive and sexual health, infectious diseases, and violence) have increasingly emphasized the role of personal behaviour within a broad social context (Murray and Lopez 1996; WHO 1999*a*). The transition of the global disease burden from communicable to non-communicable diseases (which are heavily dependent on lifestyle), has evoked a medical need to care for patients in their own social contexts. There has been increasing understanding that behaviours and their social,

economic, and cultural contexts are inextricably linked with the biology of health and disease, and are therefore relevant to individual care (Krieger and Sidney 1996).

Secondly, the tools and technologies of each field have been found to be of increasing utility to the other. For example, new technologies developed through biomedical research in such fields as immunology, molecular biology, and genetics are of increasing relevance to public health (Barry and Molyneux 1992; Andrews 1995; Aluwihare 1998). Scientific discoveries in molecular virology have provided tools that are as useful to individual diagnosis and care as they are to epidemiology, vaccine development, and public health programmes (Hunter 1999). Likewise, traditional public health tools, drawn from epidemiology, ecology, and social and behavioural sciences, have demonstrated their usefulness in deciphering powerful determinants of health and of disease outcomes, thus creating stronger bridges between biomedical care and public health interventions (Terragni 1993; Krieger and Zierler 1997).

Thirdly, the human rights framework has shown that the state's human rights responsibilities to respect, protect, and fulfil rights relating to health include obligations concerning both medicine and public health. In the context of a health and human rights analysis, a challenge to the now artificial dichotomy between medicine and public health is not merely rhetorical or of analytical interest; it also brings into play the range of obligations of the state towards every individual. The health and human rights paradigm is relevant to clinical practice, community health, large-scale health programme development, implementation, and policy. The synergistic health and human rights perspective aims to guarantee that every individual can achieve the highest attainable standard of physical, mental, and social well being. Human rights are progressively being understood to offer an approach for considering the broader societal dimensions and contexts of the well being of individuals and populations, and therefore to be of utility to all those concerned with health.

Globalization and health development

The definition of health enshrined in the WHO Constitution was an important step in helping to move health thinking beyond a limited biomedical- and pathology-based perspective towards the more positive domain of well being, understood to include recognition of individuals and their need to realize aspirations, to satisfy needs, and to change or cope with their environments. The societal dimensions of this effort were emphasized in both the Alma-Ata Declaration (WHO 1979) and the Ottawa Charter for Health Promotion (1986). The Alma-Ata Declaration describes health as a social goal whose realization requires the action of many social and economic sectors in addition to the health sector. The Ottawa Charter proposes that the fundamental conditions and resources for health are peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice, and equity.

When the WHO was created to improve health 50 years ago, there were hopes that antibiotics and the progress achieved in vaccines and biomedical technology would provide the tools sufficient to enable individuals worldwide to reach the highest attainable standard of physical, mental, and social well being (Tomaševski 1995*b*). However, decades later, as reflected in both the Alma-Ata Declaration and the Ottawa Charter, it is clear that, regardless of the effectiveness of technologies, the underlying civil, cultural, economic, political, and

social conditions at both a global and local level have to be addressed as well. The major determinants of better health are increasingly understood to lie outside the health system and to include better education and information, as well as fulfilment of an array of rights which are relevant to, but not intrinsically connected with, the right to health (Carrin and Politi 1996). Thus health requires attention to the increasingly complex relationship of people to their environment and an understanding of respecting, protecting, and fulfilling human rights as a necessary prerequisite for the health of individuals and populations.

Globalization and the direct and indirect impacts of intensifying global flows of money, trade, information, culture, and people on health and related aspects of human development, have brought out a new set of human rights issues (Brundtland 2000). These issues need particular attention, as they have largely been ignored. The process of globalization has proceeded at a much faster pace than the development of policies aimed at maximizing its benefits to human development and preventing or mitigating its harmful effects.

Globalization, and the privatization of the means of production and services that inherently accompanies it, can contribute to the advancement of health through the sharing of information, technologies, and resources, as well as through the competition it generates to provide more effective, more widely available, and higher-quality services. Globalization can create new employment opportunities in some populations or sectors of the economy, but at times may do so to the detriment of others. It can also stimulate the spread of health hazards and disease as a result of intensified population mobility, or through the worldwide marketing of harmful substances, such as tobacco and alcohol. If poorly conceived and monitored, globalization can contribute to the widening of inequalities by increasing the autonomy and well being of some sectors of the population while producing negative consequences for others without access to safety nets to support the fulfilment of essential needs (Cooper Weil *et al.* 1990; UN 1995c; WHO 1995; Al-Mazrou *et al.* 1997; Hallack 1999; Heggenhougen 1999; Brundtland 2000). In the wake of globalization and privatization, increasing attention must be paid to the role of non-state actors because they are now influencing the health and well being of people to an unprecedented extent, comparable even to the influence of governments (UNHCHR 2000). The role of the state is to ensure that all human beings are guaranteed their basic human rights, including the right to the highest attainable standard of health, whether this obligation is fulfilled directly through government-run services or through private intermediaries. Governmental roles and responsibilities are increasingly being delegated to non-state actors (for example, biomedical research institutions, health insurance companies, care providers, health management organizations, and the pharmaceutical industry) whose accountability for what they do, do not do, or should do about people's health is poorly defined and inadequately monitored. There is a universal need to reinforce the commitment and capacity of governments to ensure that actions taken by the private sector and other actors in civil society relevant to health and other aspects of human development, both within and outside the boundaries of nation-states, are informed by and comply with human rights principles. Current structures are generally insufficient for non-governmental organizations or governments to monitor effectively and hold corporations operating on a national scale accountable. This problem is compounded when these companies are multinational (Hossain 1999; Orford 1999; UNHCHR 2000).

Attention to health reveals that multinationals are more than agents of economic change whose decisions are increasingly affecting the distribution of wealth, the fabric of society, and the creation of conditions favourable to advancing health; they are also increasingly the institutions called upon by political and social forces to create and operate alternative mechanisms to extend health and social services and to make available new and affordable vaccines and drugs (Kolodner 1994). Yet because they are multinational, they largely escape the realm of legal accountability within states, and, while they may choose to adopt ethical guidelines and codes of conduct, there is no international human rights law that directly applies to them or to their actions. The fora where world issues are debated have expanded from assemblies of governments—for example, under the United Nations umbrella—to gatherings and congresses such as the Davos forum that give a prominent role to these non-state actors, demonstrating that the state and non-state actors leading the world economy have become inseparable partners. From a health and human rights perspective, the desirable forms and extent of responsibility for multinational actors within the international legal system have yet to be defined in ways that help to shape international trade agreements effectively and to ensure their accountability. This is the next and most important challenge in the world of human rights, and it will have far-reaching health consequences.

Strategic directions to better health

Human rights can help to provide an approach for redefining the ways in which governments and the international community as a whole are accountable for what is done and not done about the health of people (Mann *et al.* 1994). This requires an understanding of the content of the health issues most relevant to the health and well being of individuals and populations, as well as of those actions which ought to be taken at the national level to move towards health development.

As the approaches set out by the WHO are relevant to all its member states, this discussion will be framed around the strategic framework laid out by the WHO in its 1999 corporate strategy (WHO 1999b). From a strategic perspective, the issues relevant to health development can be understood to lie along four converging axes: (a) reducing excess mortality, morbidity, and disability; (b) promoting healthy lifestyles and reducing risk factors to human health that arise from environmental, economic, social, and behavioural causes; (c) developing health systems that equitably improve health outcomes, respond to people's legitimate demands, and are financially fair; (d) developing an enabling policy and institutional environment in the health sector while promoting an effective health dimension to social, economic, environmental, and development policy. Each of these approaches is briefly discussed below.

Reducing excess mortality, morbidity, and disability

Recent WHO information reveals that six preventable or curable diseases cause 90 per cent of infectious disease deaths worldwide, as well as half of all premature deaths, most of which occur in children and young adults living in developing countries (Murray and Lopez 1996; WHO 1999a). Reduction of excess mortality, morbidity, and disability calls for a combination of sound health interventions—some of a clinical nature, such as diagnosis and treatment of communicable and non-communicable diseases, and others building on large-scale programmes to inform, immunize, or apply population-based prophylactic therapies. From a health and human rights

perspective, it is worth recognizing that the growing health disparity between the North and the South creates compelling needs both for every country to develop effective disease prevention and control programmes targeted to their specific needs, and for global sharing of technology and resources in order to enable poorer countries to accelerate progress in health development. Therefore, priority must be given both locally and globally to poor and marginalized communities.

Promoting healthy lifestyles and reducing risk factors to human health that arise from environmental, economic, social, and behavioural causes

Modern public health recognizes the influence of external factors on the ability of individuals to adopt healthy behaviours or to access care when ill health has set in. As stated above, health promotion is the process of enabling people to increase control over and improve their health. To do so, individuals or groups must be informed and able to identify and realize aspirations, satisfy needs, and change or cope with their environment. The concept of interventions aimed at reducing risk is familiar to those working on such health issues as HIV/AIDS and other sexually transmitted diseases, tobacco, and other types of substance use or occupational hazards (Mann *et al.* 1992; Mann and Tarantola 1996*b,c*; WHO 1998*b*). Risk reduction interventions can also bring attention to the inadequacy of public services to address such issues as reproductive health, access to safe blood transfusion, or access to clean water. Some authors have distinguished the notion of risk, defined as a statistical probability of suffering from ill health, from that of ‘vulnerability’, which impacts on risk via societal, programme-related, or individual factors (Mann and Tarantola 1996*b, c*; Tarantola 1998). Others have further extended this analysis by defining ‘susceptibility’ as the influence of external or individual factors on risk and ‘vulnerability’ as the degree to which individual, communities, or nations are able to cope effectively with the impacts of ill health (Barnett and Whiteside 1999). Still others have grouped these factors among the ‘underlying preconditions for health’, including policy, legal, and institutional environments, which have traditionally been dealt with as separate issues (Mann *et al.* 1994; Mann and Tarantola 1996*a*). All of these paradigms recognize the importance of integrating morbidity, mortality, and disability reduction programmes with interventions to mitigate or address the factors underlying the occurrence of these events. Reducing susceptibility or vulnerability requires understanding of who is affected and how and to what extent these people are exposed to and able to cope with the factors that impact on their health, and then designing interventions that can enable them to cope effectively. From a health and human rights perspective, this process is linked to the need to create conditions conducive to health through information, education, and the development or strengthening of health systems and social support programmes that promote healthy behaviours, impact on risk-taking behaviours, and increase individual and collective commitment and capacity to engage in these processes.

Developing health systems that equitably improve health outcomes, respond to people’s legitimate demands, and are financially fair

In this context, ‘health systems’ can be understood as the set of public or private structures, services, actions, and people whose main aim is to promote health and prevent and treat disease. In order to progress

towards these aims, health systems must be sufficiently accessible, efficient, and affordable, and of good quality (WHO 2000*d*). The WHO *World Health Report 2000* has proposed measures that reflect responsibility and create the grounds for accountability within health systems with regard to three dimensions of health: health outcome, fairness, and responsiveness (WHO 2000*d*). The responsibilities of health systems in relation to health outcomes largely determines the type of services, interventions, and technologies they offer. If analysed on the basis of health outcomes, the accountability demanded of health systems must take into consideration the capacity of these systems to recognize and respond to health issues, as well as such factors as personal behaviours or unforeseen social, economic, or environmental situations or events. From an accountability perspective, it is worth recognizing that some of these latter factors may impact on health outcomes but are beyond the responsibilities assigned to health systems. They must be taken into account in other ways—for example, in relation to governmental accountability for education, employment, freedom of movement or association, or in relation to other rights that impact on health.

Underlying this attention to the responsibility and accountability of health systems is the concept of equality, which implies that health systems are capable of defining and recognizing the characteristics and specific needs of populations within a nation who experience a disproportionate level of mortality, morbidity, and disability. This, in turn, requires that health data be collected and analysed with a degree of sensitivity and specificity sufficient to determine who is likely to require additional attention; what behaviours and practices have to be supported, induced, or changed; what service provisions have to be enhanced and in what ways; and what financial mechanisms are necessary to provide the safety nets necessary to ensure that those who need more actually receive more. Therefore, it follows that the information used to develop, monitor, and evaluate policies and programmes must accurately reflect characteristics that may be associated with discrimination and inequality, including sex, age, rural/urban location, and other relevant behavioural, social, or economic factors (Barton Smith 1998).

The WHO *World Health Report 2000* proposes that ‘the way health care is financed is perfectly fair when the burden that health spending represents on the household, or its relative health financial contribution is identical for all households, independent of their income, their health status or their use of the health system’ (WHO 2000*d*). Although the principle of fairness is not articulated as such in human rights treaties, it builds on an array of rights, such as non-discrimination, equality, and participation, that, together with obligations directly related to health, can be used to consider the responsibilities of governments for health systems. The financing of health systems must be considered from the perspective of competing human development priorities within a nation, as well as that of the intrinsic priorities within health systems themselves. No global benchmark can therefore be proposed to establish the minimum national spending for health systems, whether from public or private sources, and the debate must remain open as to the extent to which and the ways in which governments will invest in the health of their populations. Within health systems, the decisions concerning allocation of public funds for specific health initiatives can draw from epidemiological, economic, or political considerations and can use a variety of methods and processes, including cost-effectiveness analysis, as well as human rights considerations. The concept of financial

fairness implies that these systems should enable all individuals to seek and receive services that are commensurate to their needs and economically affordable.

Finally, the concept of responsiveness imposes on health systems a requirement that they be sensitive to people's aspirations, needs, and demands with full respect for human rights, and that they offer support and services. The principles of non-discrimination, protection of confidentiality (privacy), and respect for people's dignity are central to both the design of health systems and to the attitude and practices of health providers. From a health and human rights perspective, each of the components considered necessary for health systems to improve health outcomes equitably raises additional issues to be considered from the perspective of governmental responsibility and accountability.

Developing an enabling policy and institutional environment in the health sector while promoting an effective health dimension to social, economic, environmental, and development policy

If it is clear that policies and practices within health systems may impact positively or negatively on health, it is also clear that policies and practices concerned with the broad spectrum of human development may also impact significantly on health status and health-seeking behaviours (Cooper Weil *et al.* 1990). A large-scale industrial project may, for example, create selective migratory movements that may result in accentuated health hazards, whether these are linked to inadequate working conditions, housing, or social or cultural uprooting (Shenker 1992; ILO 1996). The association between enhanced vulnerability to HIV/AIDS among migrant labourers and economically motivated mobility in Africa and Asia provides one example (UNAIDS/IOM 1998). Similarly, factors such as the amount of pollution that industries have generated, or the impact that the use of pesticides in agriculture has had on the health of some populations, imply that health impacts must be considered at all stages of human development programmes (McMichael 1993). From a health and human rights perspective, this requires attention to health impacts in the design of human development programmes; this would include preventing or counterbalancing their potential negative health effects, as well as ensuring that health indicators are built into the monitoring of human development initiatives (WHO 1992; Watson *et al.* 1998).

The four strategic elements of health as briefly described above provide a useful framework for analysing the interface between health and rights. Indeed, each of these elements involves governmental obligations that are relevant to policies and programmes directly impacting on health, as well as those more broadly concerned with human development.

Health development and human rights

While the above categorization of strategic directions for health is useful because it reflects the approach being taken by the WHO and is guiding the current global health agenda, a perspective of governmental human rights obligations towards health development emerges more clearly if these strategies are divided into the following three domains.

1. The highest attainable standard of health. This is measured by morbidity, mortality, and disability, by positive health measures of growth and development in children, and by demographic

variables, reproductive health, healthy lifestyles, behaviours, and practices in adults. The focus here is on health outcomes affecting individuals and populations.

2. Access to health systems which provide affordable and good-quality preventive, curative, and palliative care services and related social support. The focus here is on health systems.
3. A societal and physical environment conducive to health promotion and protection, including access to education, information, and other positive expressions of rights necessary for health as well as protection from violence, environmental and occupational hazards, harmful traditional practices, and other factors that may impact directly and negatively on health. The focus here is on the societal and environmental preconditions for health.

The development and application of governmental policies transcends all three of these domains of health development and is equally relevant to governmental responsibilities both to promote and protect health and to respect, protect, and fulfil human rights (Roemer and Roemer 1990; UNDP 1998a). A systematic analysis of the responsibilities of governments for health, considered with respect to their obligations under international human rights law, begins to lead us towards the practice of health and human rights.

Recognizing the reciprocal impact of health and human rights

There are two approaches to analysing the relationship between health and human rights that help not only to illustrate their connection, but also to provide a framework for considering the implications of the health and human rights relationship for government responsibility and accountability (Mann *et al.* 1994). The first focuses consideration on the ways in which health policies, programmes, and practices can promote or violate rights in the ways they are designed or implemented. Health policies, programmes, and practices in and of themselves can promote and protect or, conversely, restrict and violate human rights, whether by design, neglect, or ignorance. The second approach examines how violations or lack of attention to human rights can have serious health consequences. The promotion, protection, restriction, or violation of human rights all can be seen to have direct and indirect impacts on health and well being. Looking at health through a human rights lens means recognizing not only the technical and operational aspects of health interventions but also the civil, political, economic, social, and cultural factors that surround them. These factors may include, for example, gender relations, religious beliefs, homophobia, or racism, which individually and in synergy influence the extent to which individuals are able to access services or to make and effect free and informed decisions about their lives—and, therefore, the extent of their vulnerability to ill health. Thus, health and human rights interact in numerous ways, both direct and indirect (Mann *et al.* 1994). Public health and human rights each recognize the ultimate responsibility of governments to create the enabling conditions necessary for people to make choices, cope with changing patterns of vulnerability, and keep themselves and their families healthy. Using human rights concepts, one can look at the extent to which governments are respecting, protecting, and fulfilling their obligations for all rights—civil political, economic, social, and

cultural—and how these government actions influence both the patterns of mortality, morbidity, and disability within a population and what is done about them.

The impact of health policies, programmes, and practices on human rights

A human rights framework can help to identify potential burdens on the lives of individuals and populations that are created by health policies, programmes, and practices. An obvious example, as was recognized in the International Conference on Population Development Programme of Action, is demographic goal-driven family planning programmes, which may by their very nature violate basic human rights (ICPD 1994). More subtle human rights issues may arise from health programmes that fail to provide services to certain populations or are not appropriately tailored to meet the needs of marginalized groups (Altman 1998; Beyrer 1998; Jackson 1998; Stevens 1998; Wodak 1998).

Responsibilities for public health are largely carried out through policies and programmes promulgated, implemented, and, at the very least, supported by the state. Therefore, a human rights approach to public health requires analysis of every stage of the design, implementation, and evaluation of health policies and programmes. This section teases out some of the issues that a human rights analysis can raise at various stages of policy and programme design and implementation. HIV/AIDS, sexual health, and reproductive health will serve as primary examples in this section because, in recent years, these issues have been especially important in illuminating the impact that health policies and programmes can have on human rights.

Human rights considerations arise at the initial formulation of health policies and programmes. Relevant issues would be raised, for example, if a state decides to approach a health issue in a particular way but refuses to disclose the scientific basis of its decisions or permit any debate on its merits, or if a government wilfully or neglectfully fails to consult with members of affected communities in reaching its decisions, or in any number of ways refuses to inform or involve the public in policy or programme development. Human rights issues may also interact with the development of health policies and programmes when prioritization of certain health issues is based less on actual need than on existing discrimination against certain population groups (Gilmore 1996). This can occur when, for example, minor health issues that predominantly impact the dominant group are systematically given higher priority in research, resource allocation, and policy and programme development than other more major health problems. Restrictive laws and policies that deliberately focus on certain population groups without sufficient data, epidemiological and otherwise, to support their approach may raise an additional host of human rights concerns. Two examples might be policies concerning the involuntary sterilization of women from certain population groups that are justified as necessary for their health and well being (Lombardo 1996; Comité Latinoamericano para la Defensa de los Derechos de la Mujer 1999), and sodomy statutes criminalizing same-sex sexual behaviour that are justified as necessary to prevent the spread of HIV/AIDS (UNHRC 1994).

Human rights also need to be considered when choosing which data are collected to determine the type and extent of health problems affecting a population, as this choice has a direct impact on the policies and programmes that are designed and implemented (Zierler *et al.*

2000). The choice of issues to be assessed and the way in which a population is defined in these assessments are of primary relevance (Braveman 1998). A state's failure to recognize or acknowledge health problems that particularly impact on a marginalized group, or to consider the impacts of particular health issues on all members of a population, may not only violate the right to non-discrimination, but may also lead to neglect of necessary services, which in turn may adversely affect the realization of other human rights (Cook 1994; Hendriks 1995; Miller *et al.* 1995). Examples of this would include the almost complete lack of attention and resources devoted to the early detection of cervical cancer by a number of governments, or state-controlled reproductive health programmes that exist for some population groups but exclude certain marginalized communities from their consideration and outreach (WHO 1994b). Likewise, the scarcity or absence of HIV-related services in a number of places can well be understood to have resulted in a disproportionate burden of health consequences that could have been prevented or alleviated through simple and affordable prevention messages and methods of early diagnosis and treatment.

Once a decision is made that a particular health problem will be dealt with, human rights issues can come into play in both the articulation and the implementation of the health policy or programme. An example is programmes that provide contraception to young boys but deny access to young girls, with the stated rationale that access might prompt girls to be sexually active (Radhakrishna *et al.* 1997; Youth Research 1997). From a human rights perspective, this distinction can be understood to be treating young girls unfairly and unjustly on the basis of their sex. The prohibition of discrimination in the human rights documents does not mean that differences should not be acknowledged, but rather that different treatment must be based on reasonable and objective criteria (Cook 1992; Coliver 1995). Therefore, applying different approaches to girls and boys in policy and programme development must be based on a valid recognition of gender-related differentials in risk and vulnerability with respect to the particular health issue and with an attempt to minimize the influence of prescribed gender roles and cultural norms in making this determination (Moody 1989; Holder 1992).

The severity of the devastating tuberculosis epidemic in developing countries, and in marginalized communities in affluent nations, draws attention to the relevance of a human rights analysis for the implementation of a health policy and programme (Raviglione *et al.* 1995; WHO 1999c). While the directly observed therapy strategy (DOTS) is widely recognized for its efficacy in controlling tuberculosis, the issues raised by the very different ways this strategy is administered in different countries, and to different population groups, demonstrates how discrimination may be relevant to the ways in which health programmes are implemented (WHO 2000a). Many health practitioners argue that the speed with which tuberculosis is spreading and the potential impact of individual non-compliance to treatment are likely to aggravate both the spread of the disease and the currently observed prevalence of multiple-drug resistance (WHO 1998c). The DOTS strategy aims to combat this by enrolling patients diagnosed with active tuberculosis in a programme where drugs are administered under the direct observation of a care provider, rather than self-administered by the patient (WHO 1994a). The strategy requires frequent visits by patients to the site where drugs are administered, which can potentially involve work absenteeism and in some cases out-of-pocket travel expenses. In small communities, the

strategy may also lead to breaches of the right to privacy, as frequent visits to a treatment point may be associated with the stigma commonly attached to the disease. In cases of non-compliance to regular treatment administered in this way, measures up to and including mandatory hospital admission may be taken to motivate defaulting patients to comply. There is ample evidence to suggest, however, that in a number of places the level of coercion exercised by health practitioners in the decision to apply DOTS, as well as in the application of mandatory institutionalization, is directly associated with the levels of discrimination against particular population groups within the society in question (Farmer *et al.* 1991; Bayer *et al.* 1993; Schmidt 1995; Efferen 1997; Heymann and Sell 1999).

Attention must also be given to whether health and social services take into account logistic, financial, and sociocultural barriers to access and enjoyment, as a failure to do so can result in discrimination in practice, if not in law (Focht-New 1996). This includes attention to the factors that may impact on service utilization, such as hours of service and accessibility via public transportation. Issues are also raised by decisions concerning the location of prevention and treatment services for certain health issues. An extreme example relates to the location of sexually transmitted disease diagnosis, prevention, and care services, which may be integrated into the reproductive health services generally available to women or offered only in centres dedicated to sexually transmitted disease prevention and treatment. Evidence suggests that individuals, and women in particular, are less likely to take advantage of sexually transmitted disease services that operate under this latter designation for fear of stigma and discrimination within the community if they are seen at the facility (Weiss and Gupta 1993; d'Cruz-Grote 1996).

Laws and policies that may seem neutral but neglect to detail sufficiently the steps necessary for their implementation may raise additional human rights issues. Illustrative of such a situation are laws and policies that mandate the reporting of HIV infection but fail to spell out the actors responsible for doing so, or fail to take into account a lack of infrastructure to ensure that privacy can be respected and that mechanisms for redress exist if breaches of confidentiality occur (Gruskin and Tarantola 2000). Indeed, collecting personal information from individuals about their health status (for example, HIV infection, cancer, or genetic disorders), or behaviours (for example, sexual orientation or the use of alcohol or other substances) has the potential for misuse by the state, whether directly or because this information is intentionally or inadvertently made available to others. In recent times the most explicit examples of the impact of misuse or neglect of privacy protections are found in the context of HIV/AIDS. Misuse of personal information related to HIV status has led to restrictions on the right to marry and found a family, and the right to work and education, as well as, in extreme cases, limitations on freedom of movement, arbitrary detention, or exile, and even cruel, inhuman, and degrading treatment. The release of information concerning a person's HIV status to others has, in many places, led to loss of employment and housing, as well as harassment and verbal and physical attacks (Cohen and Wiseberg 1990; Gruskin *et al.* 1996; UNDP 1998b).

Decisions on how data are collected have a direct influence on the policies and programmes that are put into place. For example, differentials determined by sex or gender roles in relation to HIV/sexually transmitted disease infection are generally not systematically considered in the collection and analysis of HIV/sexually

transmitted disease epidemiological data, nor are they sufficiently studied or built into the design of prevention and care programmes. In countries where the HIV/AIDS pandemic has matured, some 15- to 16-year-old girls attending antenatal clinics for their first pregnancy are already infected with HIV, and no information is available as to the cause of this infection (that is, whether it involved sex or another mode of transmission) (Tarantola and Gruskin 1998). The degree to which gender factors influence the relative risk of becoming infected through various routes of transmission during childhood, and how they may influence patterns of access to care and the quality of care provided to boys and girls once HIV infection has set in, remains unknown. There has been very little attention to the general failure to differentiate by sex in the collection and analysis of epidemiological information on 'children' younger than 15. This raises a host of human rights concerns and may result in neglect of the very real differences between female and male adolescents in the prevention and care programmes that do exist.

Violations of the right to information in the context of health policies and programmes must be mentioned specifically, as these can have substantial health impacts (Freedman 1999). Examples include decisions by governments to withhold or block access to valid scientific information that would enable people to participate in the improvement of their health, avoid disease, or claim and seek better care. Such is the case for young women who become unwillingly pregnant or acquire sexually transmitted diseases because they are denied information considered too sexually explicit for them—even though they became pregnant or infected because they were sexually active (Alan Guttmacher Institute 1998; Dowsett and Aggelton 1999).

The health and human rights approach determines whether health policies, programmes, and practices are valid from both a public health and a human rights perspective (IFRCRC/FXBC 1999). The first step in this analysis will always be to determine the stated justification for the measure—and then to consider the framework set forth in the Siracusa Principles mentioned above (UNECOSOC 1985). In analysing health policies and programmes, as Jonathan Mann was fond of saying: 'Assume all health policies and programmes are discriminatory or restrictive of rights until proven otherwise' (Mann 1997a).

The impact of neglect of violations of human rights on health

When health is understood to include physical, mental, and social well being, it seems reasonable to conclude that the violation or neglect of any human right will impact adversely on health. While this is certainly true with respect to specific rights, such as non-discrimination or education, the impact of neglect or violation of rights is also compounded by the number of rights brought into question by any particular situation. The health impacts of certain severe human rights violations, such as torture, imprisonment under inhumane conditions, summary executions, and disappearances have long been understood. Much work has been done in this field, and efforts in this regard continue to expand. Such efforts include exhumations of mass graves to ascertain how people have died, the coding and matching of genetic information to reunite families separated during war and massive political repression, examination of torture victims to bring perpetrators to justice and to assist with asylum claims, and entry into prisons and other state-run institutions, such as detention centres, to

assess health conditions and the health status of confined populations. The impacts on health of these human rights violations can be both obvious and subtle. For example, torture is a violation that causes immediate and direct harm to health. Yet only recently has the full impact of torture begun to be recognized, including the lifelong injury to the victim, the effects on the health of families and of entire communities, and the transgenerational damage (AI 1983; Goldfeld 1988). There is increasing recognition of the need to assess the duration and extent of the health impacts of such human rights violations, including the direct and immediate impact of being subjected to torture oneself, but also its severe and lifelong effects on survivors and the trauma associated with being forced to witness summary executions, rape, and other forms of torture and trauma perpetrated on others (Dawes 1990).

Health practitioners can—and in most cases do—have a strong positive influence on the promotion and protection of human rights within the populations they serve. Yet violations of human rights perpetrated by health professionals regularly occur. These include not only such egregious examples as doctor participation in torture and other severe violations of human rights, but also actions in the provision of treatment and care, for example when care providers make decisions concerning patient access to available prevention services, or when children with a chronic fatal disease or disability are denied immunization against measles and other preventable childhood infections (Savage 1998; UN 1998*b*; Ward and Myers 1999). In many countries, rich and poor, patients with diabetes, carcinoma, chronic renal syndrome, mental disability, haemophilia, or other severe health conditions may receive a lower standard of care than others not only with respect to the health issue in question but in general because their possibility of cure is regarded as limited (UN 1992*b*; Crofts *et al.* 1997).

A less obvious impact of neglect of human rights on health concerns the many children from poor or marginalized communities, where poor nutrition and ill health prevail, that have a below-average school enrolment and attendance rate and, as a result, below-average educational attainment (Swartz and Levett 1989; Brundtland 1999). The deprivation of these children from access to basic health services, coupled with the imposition of school fees, leads to a limitation of their ability to exercise their right to education, producing lifelong effects on their health and well being.

In addition to the impact of egregious violations of rights on health, the more subtle effects of neglect or violations of rights on health can also be considered. These would include exposures to ill health resulting from violations of such rights as work, free movement, association, and participation (Daniels *et al.* 1990; Berlinguer *et al.* 1996). The impact of neglect or violation of factors considered to form the underlying preconditions for health must also be considered. In addition to medical services, these have been understood to include such factors as adequate housing, education, food, safe drinking water, sanitation, access to information, and protection against discrimination. Understood in human rights terms, neglect of these rights, particularly in combination, can have serious negative consequences on health (Mann *et al.* 1994). No community is fully protected from neglect or violation of rights and its detrimental consequences to individual and public health (CESR 1999; UN 1999*a, b*). In particular, gender-based discrimination poses a pervasive threat to health. Girls and women who are denied access to education, information, and various forms of economic, social, and political participation are

particularly vulnerable to the impact of discrimination on their health. This is true when discrimination is recognized, tolerated, acknowledged, or even condoned by governments, but also when it remains insidiously hidden or deliberately ignored behind an accepted status quo (Dixon-Mueller 1990; Sullivan 1995).

One example, drawn from the world of reproductive health, dramatically illustrates this point. There is now general acknowledgement that violations of human rights, including systematic gender discrimination, create an environment of increased risk in relation to women's health (Cook 1995; Berer 1999). In this context, it is necessary to consider those factors that are understood to influence directly the reproductive health of women. Access to information, education, and quality services is critical, as are services adequately targeted to respond to the needs of women of different ages and from different communities. Underlying all this is the impact that gender roles and gender discrimination have on both health status and service delivery (Doyal 1995; WHO 1998*a*). The relevance of human rights to this analysis becomes clear when considering the gaps and inequalities in services and structures in relation to the social roles that construct male and female identity. Equally important is how these factors play out at the policy and programme level in terms of reproductive health research, policy, financing, and service delivery. Traditional public health focused on the need for information, education, contraception, counselling, and access to quality services. These elements of health practice were, and still are, central to improving women's reproductive health. However, even if these services are available, an individual woman has to be able to decide when and how she is going to access these services. This implies that she has to have the ability to control and make decisions about her life.

In this example, considering the impact that violation or neglect of human rights has on health highlights the societal context that would hinder or empower an individual woman's ability to make and act on the free and informed choices necessary for her reproductive health. From a broader policy and programme perspective, this insight reveals that linking the human rights framework to health implies recognizing that individual health is largely influenced by one's environment. This means that the integration of human rights in the design, implementation, and evaluation of health policies and programmes is necessary not only because of a government's human rights obligations, but also in purely pragmatic public health terms. Thus, attention to the civil, political, economic, social, and cultural factors that are relevant to a person's life, such as gender relations, racism, or homophobia, and the ways this combination of factors projects itself into who becomes ill and what is done about it, is central to sound health and human rights practice.

The process of documenting evidence on the health impacts resulting from violations or neglect of human rights must be thorough and thoughtful because of the multifarious effects on health of human rights neglect or violations. The involvement of communities that are disproportionately affected by human rights violations in the development, implementation, and monitoring of decisions affecting them is crucial to mitigating these impacts. Affected individuals working together in defence or advocacy groups—be they concerned with breast cancer, diabetes, renal syndromes, haemophilia, chronic disabilities, or other health issues—have been effective in bringing to light some of the more subtle mechanisms that come into play in linking health status with the human rights violations to which people are subjected (Steingraber 1997; UNAIDS 1999).

Optimizing health and human rights in practice

A crucial step in optimizing the relationship between health and human rights is to conduct a systematic review of how and to what extent governmental policies and programmes are respectful of human rights and of benefit to public health. Such a review, presented in Box 3, is proposed as a critical first step in improving new and existing policies and programmes through assessment of their validity, applicability, and soundness, while addressing their practical implications from both human rights and public health perspectives. The suggested questions can be used by policy-makers and public health and other government officials to help in the development, implementation, and evaluation of more effective policies and programmes, and by non-governmental organizations and other concerned actors as an advocacy tool to hold governments accountable for the ways they are and are not in compliance with their international legal obligations to promote and protect both public health and human rights.

Box 3 Issues to be addressed in assessing policies and programmes. The following questions may serve as starting points to help guide this analysis (Gruskin and Tarantola 2000)

- What is the specific intended purpose of the policy or programme?
- What are the ways and the extent to which the policy or programme may impact positively and negatively on health?
- Using the relevant international human rights documents, what and whose rights are impacted positively and negatively by the policy or the programme?
- Does the policy or programme necessitate the restriction of human rights?
- If so, have the criteria/preconditions to restrict rights been met?
- Are the health and other relevant structures and services capable of effectively implementing the policy or programme?
- What system of monitoring, evaluation, accountability, and redress exist to ensure that the policy or programme is progressing towards the intended effect and that adverse effects can be acted upon?

The importance of the human rights framework to policies and programmes is that it can provide a method of analysis and a framework for action, which can then be used to help shape specific interventions aimed at reducing the impact of health conditions on the lives of individuals and populations. This approach requires work with the international human rights documents to determine the specific rights applicable to a given situation, and then considering how and to what extent morbidity, mortality, disability, risk behaviours, and vulnerability to ill health are caused or exacerbated by insufficient realization of human rights. This analysis will be most effective if done in partnership with people with substantive knowledge of human rights.

A second level of analysis can be created by recognizing the convergence of the three health domains described above (health outcome, health systems, and underlying conditions for health) with

the three levels of governmental obligations that exist for each right—respect, protect, and fulfil (Table 1). Health practitioners will find this table most relevant to their work if they use the suggested health domains (first column of Table 1) as their entry point and then move to the right, seeking to identify how each level of governmental obligation can influence health policies and action within each of the three domains. Ultimately, such an analysis could be extended to examine how those approaches recognized as best health practice in each domain could contribute to the advancement of human rights with respect to each level of governmental obligation. The issues raised in Table 1 are not meant to be highly detailed, but simply to serve as examples of the issues this approach brings to light.

The questions proposed in Box 3 may be used to create an agenda for action to help guide the analysis of governmental obligations for health outcomes, health systems, and the societal preconditions for health proposed in Table 1. Human resource development in support of health requires that health training include the skills necessary to document and measure the health effects of neglect or violations of rights. Education and training of people working in human rights should likewise provide them with the skills necessary to analyse the complex relations between neglect or violation of rights and their health impact, in such a way that the information provided can be used to monitor and ensure government accountability. This joint approach is necessary if the health and human rights framework is to be practical and useful. Only when the many dimensions necessary for health are described, measured, and named in human rights terms can the full extent of the relationship between health and human rights be realized. Such a review offers a critical approach to assessing the validity, applicability, and soundness of new and existing policies and programmes, and to addressing their practical implications from both human rights and public health perspectives. Through this approach, the disciplines of health and of human rights come together most visibly, and national capacity building to ensure reasoned and sound analysis becomes a necessity.

Another dimension of developing the health and human rights relationship is the application of mechanisms, methods, and tools to monitor progress and shortcomings in implementation of health and human rights at the national and international level. An earlier section described the role of treaty bodies in engaging in dialogue with governments on their degree of compliance with their international legal obligations. The WHO, for its part, is developing monitoring methods and indicators that, although technically not binding on governments (with the exceptions of reporting under the International Health Regulations), set out international norms by which member states commit to abide in principle after passage at the World Health Assembly. Previously, the WHO's attempts to measure health on the national or international level selectively used morbidity, mortality, and disability indicators (WHO 1999a). This exercise was severely constrained by incomplete national data, differences in measurement methods across countries, and, even more importantly, an inability to relate health outcomes to the performance of health systems. Furthermore, most of these indicators were applied at a national aggregate level with insufficient attempts to disaggregate the data collected to reveal the disparities that exist within nations. It has been understood that measurement indicators and benchmarks that focus on the aggregate (national) level may not reveal important differentials that may be associated with a variety of human rights violations—in particular, discrimination.

Table 1 A pathway to health and human rights

Domains of health	Governmental obligations with respect to human rights		
	Respect	Protect	Fulfil
Health outcome	Government not to violate rights of people on the basis of their health status including in information collection and analysis, as well as in the design and provision of health and other services	Government to prevent non-state actors (including private health-care structures and insurance providers) from violating the rights of people on the basis of their health status including in the provision of health and other services	Government to take administrative, legislative, judicial, and other measures to promote and protect the rights of people regardless of their health status, including the generation of data concerning health outcomes for use in guiding health policies and the provision of health and other services, as well as providing legal means of redress that people know about and can access
Health systems	Government not to violate rights directly in the design, implementation, and evaluation of national health systems, including ensuring that they are sufficiently accessible, efficient, affordable, and of good quality for all members of the population	Government to prevent non-state actors (including private health-care structures and insurance providers) from violating rights in the design, implementation, and evaluation of health systems and structures, including ensuring that they are sufficiently accessible, efficient, affordable, and of good quality	Government to take administrative, legislative, judicial, and other measures including sufficient resource allocation and the building of safety nets, to ensure that health systems are sufficiently accessible, efficient, affordable, and of good quality, as well as providing legal means of redress that people know about and can access
Societal and environmental preconditions	Government not to violate the civil, political, economic, social, and cultural rights of people directly, recognizing that neglect or violations of rights impact directly on health	Government to prevent rights violations by non-state actors, recognizing that neglect or violations of rights impact directly on health	Government to take all possible administrative, legislative, judicial, and other measures, including the promotion of human development mechanisms, towards the promotion and protection of human rights, as well as providing legal means of redress that people know about and can access

Adapted from Tarantola and Gruskin (1998).

In order to improve the knowledge and understanding of health status and trends, and to relate these trends to health system performance, the WHO has developed the following five global indicators (WHO 2000c).

1. **Healthy life expectancy:** a composite indicator incorporating mortality, morbidity, and disability in a disability-adjusted life years measure. This indicator will reflect time spent in a state of less than full health.
2. **Health inequalities:** the degree of disparity in healthy life expectancy within the population.
3. **Responsiveness of health systems:** a composite indicator reflecting the protection of dignity and confidentiality in and by health systems, and people's autonomy (that is, their individual capacity to effect informed choice in health matters).
4. **Responsiveness inequality:** the disparity in responsiveness within health systems, bringing out issues of low efficiency, neglect, and discrimination.
5. **Fairness in financing:** measured by the level of health financing contribution of households.

The WHO has stated that it will collect this data through built-in health information systems, demographic and health surveys conducted periodically within countries, and other survey instruments. Data will thus be analysable by sex, age, race/birth (if warranted under national law), population groups (for example, indigenous populations), educational achievement, and other variables.

The WHO has also expressed its commitment to working with countries towards increasing their capacity to collect this information and also to determine additional data and targets that may be specifically suited to country-specific situations and needs. The WHO and other institutions concerned with health have stated their desire to use these data to assess trends in the performance of national health systems, inform national and international policies and programmes, make comparisons across countries, and monitor global health. This process is also intended to support the development of national benchmarks whereby targets will be set by individual governments with a view towards being able to compare their own health system performance with others, and to compare among regions and over time. These benchmarks will be chosen according to each country's set of health priorities and information needs (WHO 2000c).

The global indicators now being tested by the WHO, as well as its current efforts to enhance the capacity of member states to monitor

their health performances, appear to be in line with human rights principles. These developments, coupled with the increasing attention to health by the bodies responsible for monitoring governmental compliance with their human rights obligations, are promising steps for the future development and application of the health and human rights framework.

Conclusion

This chapter has outlined the health and human rights framework as a pathway towards enhancing the value and impact of health work by health policy-makers, programme developers, practitioners, and students. It is hoped that increased attention to this fundamental relationship can open new avenues to human development, and by so doing, marshal new resources towards improving individual and population health. Keeping in mind the tools proposed in the previous section, there are three levels on which this new synergy can be recognized, applied, and monitored. The first concerns the development of adequate monitoring tools reflecting both health and human rights concerns; the second, the application of the health and human rights framework to health practice; and the third, the creation of a significant research agenda to advance our collective understanding of the health and human rights relationship.

Firstly, on the level of health best practice and international human rights law, evidence-based health policy and programme development can be guided by a systematic human rights analysis. This process involves significant efforts to ensure that the information that is sought, collected, and analysed brings attention to both trends and disparities, and that this information is used to address these gaps. This would include attention to the relative successes and failures of progress achieved towards global goals, such as those to which countries have subscribed in such forums as the World Health Assembly or through the international conference processes.

It is of critical importance that the WHO and the human rights treaty bodies are currently and simultaneously engaged both in the process of setting out global indicators and in defining approaches towards the development of country-specific benchmarks consistent with international knowledge, practice, and experience. The prevailing state of health and resource availability within individual countries must, nonetheless, be taken into account to allow trends and disparities to be measured in relation to individual benchmarks. While the existence of this work is encouraging, there is a need to further develop, test, and apply indicators that capture the disparities that may prevail within a population, as well as those that can begin to suggest the differences between government unwillingness and incapacity. Relevant indicators have been developed in the economics field, where the Gini coefficient, for example, is used as a measure of economic heterogeneity within a population (Kennedy *et al.* 1998). Disaggregation of data would allow the attributes on which discrimination is often based, including sex, age, prior health status, disability, birth, or social status, to be taken into account. Policies and programmes could then aim to advance the health of populations by setting out higher goals for the population as a whole, while bringing increased attention to reducing the gaps between those who enjoy better health and better services and those who, for political, civil, economic, social, or cultural

reasons, are more vulnerable to ill health and to inadequate services and structures.

The second level on which health and human rights are beginning to converge is in ensuring that health systems and practice are sufficiently informed by human rights norms and standards. Sound formulation and implementation of health policies and programmes must seek to achieve the optimal balance between the promotion and protection of public health and the promotion and protection of human rights and dignity. Processes to arrive at this optimal balance can be built within national systems on the basis of the approach proposed in the previous sections, incorporating evidence collected in the ways suggested above and through participatory dialogues between decision-makers with expertise in public health, those with expertise in human rights, and concerned populations. The realization of such an approach requires additional efforts to create consultative mechanisms, as well as education and training in health and human rights.

Finally, the third level of convergence between health and human rights lies in the broad need for further research. Given that human rights are established, internationally agreed upon norms to which states have subscribed, the reciprocal impacts between human rights and health must be further researched and documented. There is a national and international obligation to increase research and documentation, as well as to conceptualize and implement policies and programmes that fully take these connections into account. The utility of this research will largely be predicated on the extent to which those with expertise in health collaborate with people knowledgeable about human rights in the conceptualization of their research agendas and in the steps necessary for carrying this work forward.

The challenges posed in linking health with human rights are immense. There is, however, increasing evidence that public health efforts that respect, protect, and fulfil human rights are more likely to succeed in public health terms than those that neglect or violate rights. National and international policy and decision-makers, health professionals, and the public at large all, to varying degrees, understand the fundamental links between health and human rights, and the way in which those links can provide new ways to analyse and conceive responses to health issues. To move the work of health and human rights forward will require building and strengthening the information and education available about human rights concepts and procedures. It will also require information exchange and stronger co-operation between those working on health and those working on human rights. When people are sufficiently knowledgeable about human rights, they will be able to identify the issues for which the synergy of human rights and health is critical, and to act accordingly. Human rights and health are progressing, in parallel, towards a common goal that will never be fully realized. Yet, together, they project a vision and an approach that may fundamentally and positively improve the lives of people everywhere in the world.

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