

THE ASSESSMENT OF THE RIGHT TO HEALTH AND HEALTH CARE AT THE COUNTRY LEVEL

A People's Health Movement Guide

October 2006

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1. Introduction

The People's Health Movement (PHM) **Right to Health and Health Care** Campaign (RTHHC) is designed to focus national and international attention on how the right to health and health care can be implemented worldwide with a relatively small shift of resources. Using this guide to evaluate the status of this right in your country can be the first step in the Campaign.

[**Note:** Bolded words and phrases are defined in the Glossary in Annex IV].

The RTHHC centers on the right to health care because PHM has been a leader in the promotion of the **Primary Health Care Strategy** as the best strategy to achieve health for all. However, each country participating in the campaign may also look at any other health issues using the framework of the guide. The RTHHC will denounce any documented violations of the right to health, including those related to the **social determinants of health**. Once your country assessment is finished, it can be used in different ways, depending on the situation in your country, in addition to following the RTHHC process as set out in the campaign proposal (See it at www.phmovement.org).

The main focus of this assessment is on **government** responsibilities. By answering a series of five main questions you will be able to demonstrate how your government is fulfilling (or not fulfilling) its commitments to promote the wellbeing of its people. You will then develop **policy** demands that will be presented at the national and international levels during the latter stages of the campaign. You can also choose to hold non-state actors (such as corporations, or non-governmental organizations) accountable for their role in violations to the right to health. In that sense, this assessment guide and the RTHHC provide the opportunity for claim-holders and civil society actors to work together to challenge the private exploitation of the health sector.

1.1. Who can use this guide?

This assessment tool is designed for PHM national circles, **NGOs**, health organizations and **human rights** organizations that will be participating in the PHM Campaign. The assessment process should be used to attract as many people from diverse groups to the RTHHC. Its purpose is to get a country diagnosis of how the right to health and health care is being upheld for poor and marginalized populations. The results will be used to lobby governments for corrective actions. For PHM, the purpose is to get an overview of the status of the right to health and health care in about forty countries in five continents. This information will also serve to generate support at the international level, and at WHO, to more actively advocate for the health rights of the underserved.

2. Analysing the denial of the right to health and health care

2.1. What is meant by denial of the Right to Health?

There is an existing body of **international covenants** and **consensus documents** which mandates the **Right to Health** for all. Most country **governments** have committed themselves, to varying degrees, to implement the Right to Health, including the right to health and health care, by signing certain of these international covenants. Many national constitutions also recognise the Right to Health and mention the obligation of the state to provide health care and public health services.

The non-fulfillment of these **state obligations** may be considered a denial of the Right to Health. To demonstrate this denial, essentially you have to do two things:

1. Examine the national level obligations of your government related to the Right to Health in detail.¹
2. Examine whether all these obligations are being carried out and, if not, determine what characteristics this denial has in your country.

On the basis of this analysis, you can make recommendations for improvements that will lead to a better implementation of people's health rights.

2.2. How can you assess the denial of the right to health?

By following this assessment guide, you will be undertaking a five step process to document most aspects of the denial of the **Right to Health** in your country. Moreover, you will be proposing ways of improving the realization of this right for all.

The five key questions this assessment asks are:

- I. What are your **government's** commitments?
- II. Are your government's policies appropriate to fulfill these **obligations**?
- III. Is the health system of your country adequately implementing interventions to realize the right to health and health care for all?
- IV. Does the **health** status of different social groups and the population as a whole reflect a progression in their right to health and health care?
- V. What does the denial or fulfillment of the Right to Health in your country mean in practice?

These questions lead to the five steps we suggest you follow in applying this guide.

2.3. What do the five steps assess?

STEP I. What are your government's commitments?

¹ In case your government has not signed a major treaty or covenant, you can still judge the obligations against widely accepted international norms.

Government commitments are the standards you can hold your government accountable for. Only if your government made a commitment under national or international law can you hold the government legally responsible for the impact its policies have on the Right to Health.

You will list the major commitments made by your government concerning the right to health and health care based on it having signed these international covenants. You will also examine provisions in your constitution, your national laws and **policy** agendas. In the case that your government has not signed a particular covenant, this too needs to be noted.

The right to health and health care is closely related to and dependent upon the realization of other **human rights**. Other rights affected are the rights to life, to food, to housing, to privacy, to work, to access to information, to education, to freely associate and assemble, to human dignity, to equal treatment, to non-**discrimination**.²

STEP II. Are your government's policies appropriate to fulfill these obligations?

You will examine major **health**-related policies and programmes to determine whether they are adequate to fulfill the right to health and health care commitments your **government** has made. This will include looking at budgetary allocations at national and provincial levels. Special attention must be given to trends over time (the past 5 to 10 years) to assess whether **health** policies have been changed due to 'reforms' that may have increased health rights **violations**.³

The influence of larger political and economic factors (e.g., structural adjustment) and the role of external agencies (such as the World Bank) should be analysed in relation to the evolution of health policies. Decisions by the WB can and do have an important impact on **human rights**. Fragmentation into national **vertical programmes**, often promoted by different donor agencies, should also be noted.

STEP III. Is the health system of your country adequately implementing interventions to realize the right to health and health care for all?

You will look at the actual structure and functioning of the **health** system in your country. to evaluate:

- **Availability** of health facilities and hospital beds per capita (urban and rural); availability of doctors, nurses and other health personnel especially in rural areas; availability of medicines and medical supplies, and other parameters you may add.
 - **Access** to immunisation programmes and perinatal care, average health care expenditure per household and other good **indicators** of access.
 - **Acceptability, appropriateness and accountability** of health services by assessing aspects like decentralisation, **participation** in decision-making, mechanisms for accountability to the community, provision of relevant information and other as relevant.
- In a separate section, you will look specifically at the **private health sector** -- particularly the mechanisms for its regulation (if any)-- and at the pharmaceutical industry, including price control mechanisms.

² Based on: ICESCR General Comment 14, paragraphs 3 and 8

³ Violation is a concept that clarifies the ways in which the government and other actors fail to address people's rights. Violations can occur through an action, or through failure to act. [Based on ICESCR General Comment 14, paragraphs 48-49, and Maastricht guidelines on violations of ESC Rights, paragraphs 14 and 15].

Moving beyond averages, you will investigate **health care inequities**. By comparing health care **availability** and **access** for the more privileged versus the less privileged segments of society, you will assess to what extent the less privileged are being denied improved conditions that are attainable with existing national resources. You will also be looking at the provision of health care for vulnerable groups and groups with special needs -- those whose health rights are most likely to be violated.

STEP IV. Does the health status of different social groups and the population as a whole reflect a progression in their right to health and health care?

Here, you will look at the ultimate impact the health system, and at how several of **the social determinants of health** are being addressed. More specifically, you will review major health indices and other indicators, which will tell you to what extent the right to health and health care of various social groups is being respected and fulfilled. Health inequities will be assessed by comparing health status indicators for the more privileged with those of the less privileged.

The presentation of specific case studies can provide real-life examples of how individuals have suffered a denial of health care due to existing policies and/or their ineffective implementation (Optional).

STEP V. What does the denial or fulfillment of the Right to Health in your country mean in practice?

The final step is to systematically contrast the **obligations** outlined in Step I with the realities documented in Steps II, III and IV, and briefly highlight the main areas of denial of health rights in your country. Looking at recent trends will help assess whether the country is moving forward or backward in the realization of this right. You will be judging whether your **government** is doing all it is capable of to realize the **Right to Health**, and if its efforts are inadequate, in the light of its existing capacity.⁴

Lack of capacity in itself is no justification for bad or non-existent **health** policies. The government can take many measures that do not require extensive resources. Even in times of severe resource constraints, the government has to protect vulnerable groups through targeted programmes.⁵ Governments can (and if necessary, should) expand their capacity by seeking international assistance.⁶ Lack of resources is sometimes the result of lack of priority, when governments spend large amounts on issues other than health, such as military expenditures, or when they fail to implement reasonable taxation policies.

⁴ Note there may be a difference between what the government wanted to achieve and the effect a policy has had in practice, i.e., a different effect than foreseen or no effect at all.

⁵ ICESCR General Comment 14, paragraph 18.

⁶ ICESCR article 2 and General Comment 14, paragraph 38.

2.4. Before you start

Please keep the following in mind while carrying out the assessment.

Time: A full assessment may take one to two months and provides comprehensive **human rights lobbying** arguments. The data collection is the most time consuming part of the process. Sound lobbying arguments need to be based on facts and not all the required information will be readily available.

Selectiveness: You need to answer only the questions you find relevant for your own assessment. Questions that have little or no relevance to your country's situation should be skipped. You can also be selective in the level of detail. Only go into detail if you expect that the information will be necessary for your analysis or lobbying. At some points you may want to add questions that are specific to your situation.

Preparation: First, read through all the annexes for necessary background information. Then go through the steps without answering the questions to get an idea of the information you will need to collect. Also, check if there are any existing reports on the human rights implications of the health system you can build upon. Make a work plan to help organize the process you will follow.

You will need to involve people from within your organization and from other organizations to help with data collection and to discuss the findings. The more people from different sectors of the country are involved, the more credibility your report will have. More people involved also means more lobbying power.

Finding the information: You may find relevant information to answer this assessment's questions in: **government policy** documents/websites, websites of **human rights** organizations and **health** organizations (see annex iii on sources and resources), interviews with the people involved, and government and **NGO** reports to United Nations (UN) bodies.

A final note: The government cannot be blamed for each individual health problem. After all, the **Right to Health** does not mean that people have the right to be healthy. However, you can hold your government accountable for what it does or does not do to prevent and reduce health problems.

3. The Assessment Guide

Chapter 3 outlined the main purpose of each step. The following section provides suggestions for more specific questions to answer or issues to consider.

STEP I. What are your government's commitments?

International treaties signed by a **government** and/or **ratified** by its legislature are as legally binding as any law. The commitments your government has made by ratifying human rights treaties often require changes at the national level. For instance, it must recognize the right to health and health care in its political and legal system.⁷ It has to abandon any laws or measures that have a discriminatory impact. Inclusion of the provisions of a **treaty** in national legislation makes it easier for people to claim their rights.

Look in Annex III for references on treaties, consensus documents, and other agreements your government may have signed.

MAIN AREAS TO ASSESS	RELEVANT ISSUES TO EXPLORE
What international covenants, treaties, and consensus documents has your government ratified/signed-on to?	<ul style="list-style-type: none">• Which treaties has your country ratified? First consider the major international treaties (ICESCR, CEDAW and CRC) and regional treaties.• Has your country expressed any reservations or limitations on those? (You can find information on treaties and ratification on the websites of the UNHCHR, www.ohchr.org/english/law/index.htm, and the Human Rights Library of the University of Minnesota, www.umn.edu/humanrts/treaties.htm.)• Which consensus documents has your country signed? Millennium Development Goals (MDGs), Beijing Platform for Action, International Conference on Population and Development (ICPD), others.• Also consider other bilateral or multilateral agreements that may influence policy. For example, free trade agreements allowing international companies to compete with local industry (e.g., the GATS), agreements with the World Trade Organization (WTO), the World Bank (PRSPs) or other funding institutions.

⁷ ICESCR General Comment 14, paragraphs 34-36 and 60.

Step I continued

National constitution, laws and policy goals.

International Covenant on Economic, Social and Cultural Rights (ICESCR) Article 12: *“The state parties to the present covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”*

ICESCR General Comment 14 specifies the desirability of a national legislation on Right to health: *“56. States should consider adopting a framework law to operationalise their Right to Health in their national strategy. The framework law should establish national mechanisms for monitoring the implementation of national health strategies and plans of action.”*

GC 14 also stipulates: *“The obligation to fulfil requires State parties, inter alia, to give sufficient recognition to the Right to Health in the national political and legal systems, preferably by way of legislative implementation”. “...and to adopt a national health policy with a detailed plan for realizing the Right to Health”.*

“States must ensure provision of health care... including immunization programmes against the major infectious diseases, and ensure equal access for all to the underlying determinants of health, such as nutritiously safe food and potable drinking water, basic sanitation and adequate housing and living conditions.”

“Public health infrastructures should provide for sexual and reproductive health services, including safe motherhood, particularly in rural areas.”

- Does the constitution or any relevant law commit the **government** to provide **health** services for the population?
- Are there any specific constitutional or legal provisions applicable against which one can assess the right to health and health care?
- Do official documents recognize the basic concept of comprehensive and universal **primary health care**? Are they in any way committed to “Health for All”? Do they refer to the **Alma Ata Declaration** of 1978?
- Are there specific commitments related to women’s health and nondiscrimination concerning women? Commitments related to children’s health? To other vulnerable groups such as disabled people, people living with AIDS, refugees, migrants, adolescents, ethnic minorities, male and female sex workers, incarcerated men and women, and mentally ill people?
- Do official documents speak of the need for the **availability** of essential drugs and the need of price controls for drugs?
- Do policies place targets regarding public health investment as percentage of the **GDP**?⁸
- Do policies mandate equitable distribution of resources to all segments of the population (e.g., urban-rural, different geographical areas, different ethnic groups)?

Step 1 Conclusion

Summarise your government’s current **obligations** regarding the **Right to Health** and Health Care.

⁸ For example:

- Countries to raise the level of tax revenue to at least 20% of their GDP;
- Public health expenditure (including government and donor financing) to be at least 5% of the GDP;
- Government expenditures on health to be at least 15% of total government expenditures;
- Direct out-of-pocket payments to be less than 20% of total health care expenditures;
- Expenditures on district health services (up to and including level 1 hospital services) to be at least 50% of total public health expenditures --of which half (25% of total) is to be spent on primary level health care;
- Expenditures on district health services (up to and including level 1 hospital services) to be at last 40% of total public and private health expenditures;
- The ratio of total expenditures on district health services in the highest spending district over that of the lowest spending district to be no more than 1.5.

These indicators would complement service output and outcome indicators such as immunization coverage, rates of skilled attendance of deliveries, completed TB treatment rates and maternal, peri-natal and child mortality rates. [Global Health Watch 2005-2006, p.85].

STEP II. Are your government's policies appropriate to fulfill these obligations?

In addition to what is explained in Section 2 under this step, consider answering the following:

MAIN AREAS TO ASSESS	RELEVANT ISSUES TO EXPLORE
<p>Which are the main policies and programmes that guide the health system in your country?</p>	<p>Checklist:</p> <ul style="list-style-type: none"> • Five-year national health policy or plan, • Reproductive health policy and/or family planning policy, • Women's health policy, • Policies targeting AIDS, tuberculosis, mental health or other conditions, • Drug policy including (or not) essential medicines price controls, • Programmes to provide health care to the poor, • Other. <p>Pay specific attention to what policies and programmes say regarding:</p> <ul style="list-style-type: none"> • Primary health care; • Services to remote areas; • Village health workers; • Decentralization; • Privatization. <p>What external factors have influenced these policies (e.g., debt, war, the impact of HIV/AIDs, other)?</p> <p>Are there any programs that already prioritize vulnerable groups for services? What are these groups and in what way are they targeted?</p>

Step II continued

<p>Who participates or participated in the development and implementation of health policies and programmes?</p>	<p>What are the perceptions of affected groups regarding their major health problems and how they relate to the main national health policies? Have they received adequate information? [Rather than just talking about people, it is a good idea to talk <u>with</u> them and find out their views].</p> <p>Checklist of participation:</p> <ul style="list-style-type: none"> • village/community committees, • voting in elections and referenda (local, regional and national), • patients' associations and volunteer organizations, • government-NGO partnerships, • any consultation in the development, monitoring and evaluation stages of policy, • representative committees that monitor the implementation of services, • oral and written reports to international organizations and to national and international conferences. • government advisory bodies <p>Where can people go to make a complaint (mechanisms for redress)? Are these mechanisms being used? Do these mechanisms effectively redress problems?</p>
<p>What are the main changes taking place in your health system that concern you as public health-oriented advocates?</p>	<p>Checklist of areas of concern:</p> <ul style="list-style-type: none"> • Health sector reform (Have 'reforms' involving reduced public subsidies or 'cost-effective measures' –based on policy prescriptions by international institutions – been implemented in some form in the country?). • Privatisation (Have any public health services been privatised? If so, these should be listed and the impact of this privatisation on access to health services should be documented). • Participation in decision-making (Understood as the involvement of the beneficiaries in all health-related decision-making, as well as in the development, implementation and monitoring of policies, plans and strategies). • User fees. • The dismantling of primary health care programmes. • National vertical programmes • Population control and Family Planning. • Women's health and reproductive health policies. • Pharmaceutical and drug policies. • Other.

Step II continued

<p>What is the budget allocated to health? How is health care financed?</p> <p>A change in the health budget caused by a shift in allocations within the total national budget indicates a change in priority. A decrease in the total budget makes it more difficult to improve health rights. However, it does not relieve the government of its responsibility to at least protect 'vulnerable' members of society.</p>	<p>What is the government expenditure on health as percentage of GDP? What is the overall (public and private) per capita spending on health care? (See footnote 9)</p> <p>What is the percentage of government spending as a proportion of the total expenditure on health care? Has this percentage been falling? Does the health care system function to transfer money from taxpayers and patients to private enterprises?</p> <p>What is the government per capita spending in rural areas compared to urban areas? (In 2000, the World Health Organization estimated that \$60 per person per year was needed for reasonable health care.) How does the above compare with other countries with the same level of development?</p> <p>Is the budget for health decreasing or increasing, i.e., has government spending in the health sector diminished in relative or absolute terms? If so, can you quantify the cuts made in the budget?</p> <p>As a result, do fixed expenditures (especially salaries) now tend to take up a larger part of total expenditures? Can you quantify this in percentage?</p> <p>Which areas have been most affected by budget cutbacks or by increased investments, e.g. infrastructure, salaries, medical supplies, rural health services, secondary & tertiary health care?</p> <p>Are expenditure patterns on health care skewed in favour of urban areas? Have investments correspondingly fallen in rural health services?</p> <p>Are there significant public-private inequalities in health expenditure and coverage?</p>
<p>What kind of health staff is available? Is it sufficient?</p> <p><i>ICESCR, GC 14:</i> "States have to ensure the appropriate training of doctors and other medical personnel, the provision of a sufficient number of hospitals, clinics and other health-related facilities, and...the establishment of institutions providing counselling and mental health services, with due regard to equitable distribution throughout the country."</p>	<p>A functioning health system requires sufficient staff that is well trained, gender sensitive and motivated.</p> <p>Checklist of staffing issues:</p> <ul style="list-style-type: none"> • Ratio of doctors to population in rural areas compared to urban, • Availability of staff in different regions (particularly minority areas), • Representation of different ethnic, religious and cultural groups among staff. • Balance between female and male staff, especially in decision-making positions, • Number and quality of staff available for special sectors of the health system, e.g., the private sector or foreign-funded programmes, • Emigration of health staff, • Is the training of health staff adequate for the needs of the country?

Step II continued

<p>Have public health services been privatized?</p>	<p>Have health programmes suffered due to reduced funding or privatization? If so, this change should be quantified to the extent possible.</p> <p>Are health services sub-contracted to profit making companies or to NGO's? What are the largest for-profit health-related corporations in your country?</p> <p>Does the government provide incentives, tax holidays and subsidies to the private sector (including the private pharmaceutical and the medical equipment industry)?</p> <p>More about this is found in step III.</p>
<p>To what extent do other international actors expand or limit the capacity of the government to implement health programmes?</p>	<p>Look at the positive and negative influences of technical and financial assistance on the right to health and health care.</p> <p>What are the priorities of those other actors? (Donor countries are usually more willing to fund activities that correspond to their priorities).</p> <p>Checklist international actors:</p> <ul style="list-style-type: none">• other governments,• international donors• International agencies such as the World Bank, IMF, WTO, UNDP, EU, WHO, ILO, UNICEF, UNFPA,• transnational and multinational corporations.

Step II Conclusion:

Summarise the appropriateness or inappropriateness of the government's health sector policies and programmes in relation to the right to health and health care.

Step III. Is the health system of your country adequately implementing interventions to realize the right to health and health care for all?

In addition to what is said in Section 2 under this step, consider answering the following:

MAIN AREAS TO ASSESS	RELEVANT ISSUES TO EXPLORE
<p>What is the situation regarding the <i>availability</i> of relevant health services, goods and facilities? What does the government do to insure <i>availability</i>? What are the trends in <i>availability</i>, especially for marginalized groups?</p> <p>ICESCR General Comment 14, paragraph 12: <i>“Functioning public health and health-care facilities, goods and services, as well as programmes, must be available in sufficient quantity in the country”.</i></p>	<p>Checklist of indicators of availability:</p> <ul style="list-style-type: none"> • Services are functioning, • They are available in sufficient quantity throughout the country, • The inputs needed for adequate functioning exist at health care delivery points (water, sanitation, buildings, personnel, drugs, workplace environment), • The availability of appropriate mental health and HIV and AIDS treatment and care, • The availability of emergency medical care for accidents and disasters, • Programmes that discourage the use of alcohol, tobacco, drugs and other harmful substances. <p>Checklist of vulnerable or marginalized groups:</p> <ul style="list-style-type: none"> • Girls, adolescent and older women; • Refugees, internally displaced people and migrants; • Ethnic minorities and indigenous populations; • Sex workers; • People with physical or mental disabilities; • People living with HIV/AIDS; • Incarcerated men and women. • Other, as relevant in your country.
<p>What does the government do to guarantee the <i>quality</i> of services?</p> <p>ICESCR General Comment 14, paragraph 12d: <i>“Health facilities, goods and services must be scientifically, as well as medically appropriate and of good quality. This requires, among other, skilled medical personnel, approved and unexpired drugs and hospital equipment, safe and potable water and adequate sanitation”.</i></p>	<p>Checklist of indicators of quality:</p> <ul style="list-style-type: none"> • Government licence or certification of health personnel requires demonstration of minimum skills consistent with international standards, • The drugs, equipment, buildings and sanitation in health facilities are scientifically and medically appropriate, • The government promotes international standards of care for mental health and HIV/AIDS services, • Measures are taken to discourage irrational use of drugs and of inappropriate technologies.

Step III continued

<p>What does the government do to guarantee access to health care services, goods and facilities? What have been the trends in this respect?</p> <p>ICESCR General Comment 14, paragraph 12b: “Health facilities, goods and services must be accessible to everyone without discrimination, within the jurisdiction of the State party”</p>	<p>Vulnerable and marginalized groups are particularly important to consider. Access includes physical access, economic access (affordability) and information access. Checklist of indicators of physical access:</p> <ul style="list-style-type: none"> • Existence of services at community level (distance or travel time to services), • Access to buildings for persons with disabilities, • A safe and supportive environment for youth, • Barriers which the poor face to access health facilities such as high fees for services, absence of convenient and affordable public transport, • Opening hours. <p>Checklist of indicators of economic access:</p> <ul style="list-style-type: none"> • Average percentage of household income spent on health, • Proportion of household income spent on health by the poorest 25% of the population (or any other indicator of equity of access), • Free services (where called-for) for safe pregnancy, childbirth and post-partum care, • Sufficient funds are available to run health care facilities, • Health insurance and health care for the poor, • Prices of drugs: Have there been substantial increases? Does the government subsidize them?
<p>Has <i>privatization</i> affected the availability and access of health services for the poor and marginalized groups?</p>	<p>See the checklist on vulnerable and marginalised groups above. Consider mechanisms to regulate the actions of the private sector, the application of user fees, economic barriers to hospitalization.</p>
<p>Legal precedents</p>	<p>Have there been any court cases concerning the right to health and health care, i.e., where your government or other actors have been taken to court over health issues? Document these cases.</p>

Step III continued

What does the government do to guarantee the *acceptability* of health care services, goods and facilities?

CEDAW General Recommendation 24, paragraphs 12 and 22: 12. *States parties should report on their understanding of how policies and measures on health care address the health rights of women from the perspective of women's needs and interests and how it addresses distinctive features and factors which differ for women in comparison to men, such as:*

(a) Biological factors which differ for women in comparison with men;

(b) Socio-economic factors that vary for women in general and some groups of women in particular. For example, for women and men in the home and workplace, for different forms of violence for the girl child and adolescent girl. Some cultural or traditional practices such as female genital mutilation also carry a high risk of death and disability;

(c) Psychosocial factors which vary between women and men including depression, as well as conditions that lead to eating disorders;

(d) Lack of confidentiality affects women deterring them from seeking treatment. Women are less willing to seek medical care for diseases of the genital tract, for contraception, for incomplete abortion and in cases where they have suffered sexual or physical violence

22. States parties should also report on measures taken to making health care more acceptable to women, e.g., seeking their informed consent, respecting their dignity and, guaranteeing confidentiality. States parties should not permit forms of coercion, such as non-consensual sterilization, mandatory testing for sexually transmitted diseases or mandatory pregnancy testing as a condition of employment.

Do the services and goods correspond to users' needs and expectations?

Checklist of **indicators** of **acceptability**:

- Respect for patients' dignity,
- Respect for confidentiality,
- Sensitivity to women's and minorities' special needs and perspectives,
- Respect for the culture of minorities and communities.

Step III Conclusion

Summarise the adequacy of the current **health** delivery system to achieve the right to health and health care.

Step IV. Does the health status of different social groups and the population as a whole reflect a progression in their right to health and health care?

In addition to what is said in Section 2 under this step, consider answering the following:

MAIN AREAS TO ASSESS	RELEVANT ISSUES TO EXPLORE
General health indicators	<ul style="list-style-type: none"> • Life expectancy by income quintile, • Main causes of death for adults, disaggregated for women and men, rural and urban areas
What is the government doing to remove barriers to the enjoyment of health rights of the poor, minorities, and marginalized groups?	<ul style="list-style-type: none"> • Measures taken to meet their specific health needs, • Participation of the groups concerned in decision making, • Measures taken to reduce the stigma of HIV/ AIDS, mental illness and other medical conditions, • Measures taken to reduce marginalization of women heads of household, minority groups and the poor. • Examples of instances in which the right to health and health care was realized?
<p>Health status of women</p> <p>CRC Article 24, 2: <i>(State Parties shall take appropriate measures “(d) To ensure appropriate pre-natal and post-natal health care for mothers.” “(f) To develop preventive health care, guidance for parents and family planning education and services.”</i></p>	<ul style="list-style-type: none"> • Differences in under 5 mortality rates between girls and boys, • Maternal mortality rates, • Percentage of women that die in childbirth, • Percentage of births attended by medically trained personnel in rural areas, • Trends of these in the last 5-10 years, • Are family planning policies aiming at giving women informed choice or only at controlling population growth?

Step IV continued

<p>Health status of children</p> <p>CRC Article 24: <i>“1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.”</i></p> <p><i>“2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:”</i></p> <p><i>“(a) To diminish infant and child mortality.”</i></p> <p><i>“(b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care.”</i></p> <p><i>“(c) To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution.”</i></p> <p><i>“(e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents.”</i></p>	<ul style="list-style-type: none"> • Infant mortality rates, disaggregated by sex and rural/urban areas, • How many avoidable/preventable child deaths per day? • Which are the major killers? • Immunization coverage rates, • Trends of these in the last 5-10 years.
<p>Considering the above, is the current health system discriminatory?</p> <p>A policy violates the right to non-discrimination if it:</p> <ul style="list-style-type: none"> • negatively affects some groups, but not others; • positively affects groups that were already advantaged (thereby widening the gap); • affects all groups equally, without taking into account significant differences between those groups; • reaffirms stereotypes, which maintain certain groups in an inferior position. <p>A policy is considered <u>not</u> discriminatory if it has a positive effect on only disadvantaged groups, on the condition that it is a temporary special measure with the specific aim of reducing the gap between advantaged and disadvantaged groups.⁹</p>	<p>If yes, on which basis are people discriminated against?</p> <p>Checklist of grounds for discrimination:</p> <ul style="list-style-type: none"> • sex and gender, • age, • race and ethnicity, • health status/disability, • sexual orientation, • language, • religion, • political or other viewpoint, • income, • national or social origin.

Step IV Conclusion

Summarise the **human rights** impact (negative or positive) of the health care system in your country on different vulnerable groups.

⁹ HeRWAI, 2006, page 38

Step V. What does the denial or fulfillment of the Right to Health in your country mean in practice?

Here you will be looking at the fulfilment of relevant **State obligations**. The most relevant **core obligations** for the **Right to Health** are listed and defined below. A detailed explanation of the concepts of core obligations can be found in ANNEX II. You are asked to select the obligations which are most relevant to the present situation, and to explore the difference between what your **government** has promised to do (Step II) and what the government has actually achieved (Step IV). This difference provides strong arguments to improve the right to health and health care situation, and will help you to determine the **violations** for which you can hold your government accountable. Be aware that quantity is not a factor in determining if a violation has occurred. If discrimination takes place, it is a violation of human rights, regardless of the number of people who are discriminated against.

MAIN AREAS TO ASSESS	RELEVANT ISSUES TO EXPLORE
<p>Which of the core obligations are not being fulfilled?</p> <p>ICESCR General Comment 14 specifies certain Core obligations of States related to the Right to Health:</p> <p>43. <i>“States parties have a core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights enunciated in the Covenant, including essential primary health care.”</i></p> <p><i>“(a) To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups;”</i></p> <p><i>“(d) To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs;”</i></p> <p><i>“(e) To ensure equitable distribution of all health facilities, goods and services;”</i></p> <p><i>“(f) To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process; they shall include methods, such as Right to Health indicators and benchmarks, by which progress can be closely monitored; the process by which the strategy and plan of action are devised, as well as their content, shall give particular attention to all vulnerable or marginalized groups.”</i></p>	<p>Core obligations require your government to ensure, at the very least, minimum essential levels of:</p> <ul style="list-style-type: none"> ● Access to health facilities, goods, and services on a non-discriminatory basis, especially for vulnerable or marginalized groups, ● Access to food, ● Access to shelter, housing, water and sanitation, ● Access to essential drugs. <p>The following core obligations are of comparable priority:</p> <ul style="list-style-type: none"> ● Reproductive, maternal (pre-natal, as well as post-natal) and child health care; ● Immunisation against major infectious diseases; ● Measures to prevent, treat and control epidemic and endemic diseases; ● Education and access to information concerning health; ● Training for health personnel, including education on health and human rights. ● Equitable distribution of all health facilities, goods and services; ● A national public health strategy and plan of action. <p>Are these ensured?</p>

Step V continued

<p>Is the government moving forwards towards a universal right to health and health care?</p> <p>The Universal Declaration of Human Rights, Article 25: <i>“Everyone has the right to a standard of living adequate for ... health and well-being of himself and his family, including food, clothing, housing, medical care and the right to security in the event of ... sickness, disability.... Motherhood and childhood are entitled to special care and assistance...”</i></p>	<p>The obligation of progressive realization requires governments to do whatever they can to improve the health of their people. This means that if the government <u>can</u> achieve more, it has the obligation to do so.</p> <p>Can it? Is it?</p>
<p>Or, is the government failing to maintain its achievements regarding health rights?</p>	<p>The obligation of non-retrogression is applicable only if:</p> <ul style="list-style-type: none"> • the deterioration is avoidable, • the government has not done all it can to prevent the deterioration, • the government has not asked for international assistance to address the problem, and/ or • the government has not protected vulnerable groups against the deterioration.
<p>Which of the violations you found are a result of the government’s failure to meet its obligations to respect, protect and fulfil health rights?</p> <p>ICESCR GC 14: <i>“52. Violations of the obligation to fulfill occur through the failure of States parties to take all necessary steps to ensure the realization of the Right to Health. Examples include the failure to adopt or implement a national health policy designed to ensure the Right to Health for everyone; insufficient expenditure or misallocation of public resources which results in the non-enjoyment of the Right to Health by individuals or groups, particularly the vulnerable or marginalized; the failure to monitor the realization of the Right to Health at the national level, for example by identifying Right to Health indicators and benchmarks; the failure to take measures to reduce the inequitable distribution of health facilities, goods and services; the failure to adopt a gender-sensitive approach to health; and the failure to reduce infant and maternal mortality rates.”</i></p>	<p>The government fails to respect people’s health rights if its policies reduce people’s chances to enjoy good health.</p> <p>The government fails to protect people’s health rights if its policies permit others to endanger people’s health.</p> <p>The obligation to fulfil means that the government has to take positive measures that enable and assist people to enjoy their health rights.</p> <p>It is a good idea here to refer to the commitments you identified in Step II.</p>

Step V continued

Which of its commitments is the government more specifically violating?	Refer to all commitments identified in Step I to respond to this question.
Who are the responsible duty-bearers for each major violation?	Which government agencies or departments are responsible for the denial or violations of people's health rights? Which individuals in the government? Which other national actor(s)? Do foreign governments or international actors have an influence on the violations?
Is lack of resources a major obstacle?	If yes: <ul style="list-style-type: none">• Has the government used the resources it does have to the maximum extent?• Has the government attempted to obtain international technical and financial assistance?• Have other (donor) governments or international institutions extended the necessary assistance?• Document any examples of efforts to take steps that did not require additional resources. Base your answer on your findings in Step III.

Step V Conclusion

Summarise the denials/**violations** for which you can hold your **government** accountable.

4. What needs to be done to challenge the key elements of the denial of the Right to Health in your country?

In today's world the technical means exist to provide basic **health**-related services for all people. Even some developing countries with comparatively low per capita incomes have achieved significant progress towards securing the right to health and health care for all their citizens.

However, a range of political and economic factors, **policy** decisions, and gaps in implementation, lead to some denial of health rights in every country. In the final step of this guide you will compile the information you have gathered in the form of recommendations to improve **government** health policy. You will then use these recommendations or demands to prepare your national action plan to realise the right to health and health care. Further on in the PHM campaign, all the countries which have gone through this process will meet to share their findings and plans, and decide on what international steps can and should be taken to support their common goals.

We suggest that the policy recommendations and action plan be developed in a participatory process that includes people who are usually left out of policy discussions. You will present the cases of violations of the right to health and health care you documented with this assessment tool. Participants will decide what changes should be made to stop these violations, and what should be done to bring about those changes. It is expected that each country will have different policy ideas and activist strategies that come out of that particular country context.

The final product of your work will include a summary of the findings of the assessment, the **policy** and action recommendations, and at least a draft action plan. As we share this work internationally, common problems and solutions will emerge. We will build a groundswell of understanding of and support for human rights as the basis for development. Backed by all those who have contributed to the RTHHC, PHM will then take those common demands to the pertinent international institutions.

4.1. Developing your policy recommendations

Having carried out this assessment, you have clearly identified **human rights** gaps in the area of health care in your country, and you have documented them with qualitative and quantitative data. Use the following questions to help you decide which **violations** you will prioritize in the recommendations or demands.

- Can you confidently say there are repeated and continued violations of the right to health and health care?
- Which of the violations you document are of major concern in your country at this time?
- Can several of the specific violations you have documented be addressed by changes in one policy area?
- Do beneficiaries and **NGOs** you have worked with on the assessment share your findings? Are they willing to start mobilising to challenge relevant duty bearers?

For each of the violations you have identified in Step V, try to formulate a recommendation to bring the **government** into compliance with its health rights obligations. Consider the following in formulating the recommendations:

- **Policy stage:** The stage the respective policy is in may determine the type of solution or recommendation to be made and whom you need to approach.
- **Objectivity:** Try to be as realistic as possible. In many cases, no easy solution will be available. This does not release the government from its obligations. The recommendation you may choose might be to undertake further research into the causes of and possible solutions to a specific health problem identified.
- **Type and basis of your arguments:** Depending on who needs to be convinced, it may be strategic to use more legal, more medical or more political arguments.
- **Groups affected:** Try to find solutions that suit the groups most affected by the policy (or absence of it). It is best to involve the most affected groups in the development of your recommendations.
- **Ownership:** Whenever possible, you should involve the responsible policy-makers/duty bearers in the search for alternatives. This will increase their ownership of the suggestions and their chances for acceptance.
- **Preparedness:** In Step V, you identified the main obstacles to the government meeting its obligations. The government will probably refer to those obstacles when confronted with your findings. What will your counter-arguments be? Build your case in advance of such a dialogue.
- **Include benchmarks: Benchmarks** make it easier to monitor achievements. For each of your recommendations try to set benchmarks that will measure the impact of the policy changes. Preferably, these benchmarks should be related to those already set by the government, or proposed by WHO or other respected organization. If you are not able to formulate them yourself, you can also insist the government achieves its own benchmarks, adjusts them or sets new ones as needed.

If policy change is not the solution, what action should the government take? Be prepared to make such recommendations. Consider things such as: scrapping bad policies; setting up a compensation mechanism for affected groups; or the publication of regulations to control the actions of, for example, the private sector.

4.2. Questions to answer in preparing your action plan

To which government department or person should you direct your lobbying efforts?

To increase the chances that your recommendations are implemented, it is important to consider whom you are presenting the information to. The governmental level, role and competencies of the department or person will determine if they are able to actually make the changes you are demanding. Do they need authorization from a higher level? Have certain government responsibilities been delegated to the municipal or regional level? Should you aim your **lobbying** at those developing the **policy** or at those implementing or evaluating the policy? Are there procedures you must follow to get the attention of a particular department? Some governments or policy-makers are not aware of their **human rights** obligations. You may need to explain to them what their obligations are in relation to the **Right to Health**.

Which other governments, funding agencies or other actors should you approach to point out how their funding or actions should contribute to the the realization of the right to health and health care in your country?

These other actors may be able to put external pressure on governments or on private actors and may have an influence on the situation itself. When aiming your lobbying at these other actors keep in mind what their exact role/ mandate is and what they are most sensitive to.

What is the most strategic time to present your findings?

The response to this question requires some knowledge of the government's agenda or the agenda of other actors you may want to approach. What deadlines are involved in changing a given policy? A conference, a debate in parliament, a visit of a high-level official, etc. can all provide strategic entry points to present your findings. It may also help to coordinate your actions with the international level of the right to health and health care Campaign.

What options are available to you to increase pressure on the government?

It is a good idea to identify other things you can do, besides lobbying, to pressure the government, for example public interest litigation (i.e., suing the government for the **violation** of human rights), going public using the local press, or mobilizing the affected community(ies) for mass actions. Begin thinking about how the global PHM can support and endorse your demands.

When and how will you check whether changes have really led to an improvement of the right to health and health care?

This check is necessary, because even if the government accepts your recommendations, this does not mean that the desired results will be achieved. It is possible that the changes you suggested were not adequate to improve health rights, or that other factors hampered their successful implementation. Use the **benchmarks** you defined earlier to set up a monitoring plan in advance.

What awareness-raising activities should you use to inform the public about your findings and recommendations?

Lobbying the government should be accompanied by **advocacy** work, to make people aware of their health rights and how they are being violated. This can be done through the media, organizing a conference or workshop, producing and distributing a leaflet or video, etc. Disseminating your findings to other organizations with an interest in health rights is a good strategy to involve more people in the right to health and health care Campaign.

How much time and which resources (financial and in terms of skills) does your organization need to implement your action plan? Can these resources be made available?

Developing a time frame and a budget will help to make a realistic action plan and will be useful if you need to ask for outside assistance and funding. If you do not have experience with **lobbying**, share your findings with more experienced organizations and invite them to get involved in the Campaign.

5. Concluding remarks and contact information

Always keep in mind that this exercise on which you are embarking is part of a global effort to reverse the **violations** of the right to health and health care both in rich and poor countries.

We again recommend that you review the campaign proposal as posted at the PHM website (www.phmovement.org) under 'Right to Health'. This will help you understand the campaign in its entirety and to keep things in perspective,

At any time, you can seek further advice from others in the People's Health Movement.

- The PHM website: www.phmovement.org
- The PHM Global Secretariat: secretariat@phmovement.org
- The PHA Exchange listserv: pha-exchange@lists.kabissa.org
- The Right to Health and Health Care Campaign core group members are available to support you. We also welcome your feedback:

Saskia Bakker (Netherlands), s.bakker@hom.nl

Ariel Frisancho (Peru), afrisanchoarroyo@yahoo.es

Abhay Shukla (India,) abhayseema@vsnl.com

Cristianne Rocha (Brazil), cristianne.rocha@terra.com.br

Claudio Schuftan (Vietnam), claudio@hcmc.netnam.vn

Laura Turiano (USA), phm@turiano.org

[The names and email addresses of regional coordinators will be added at a later stage].

When you complete your assessment, we ask you to send a copy of your summary results and tentative action plans to the campaign core group at PHM: phm@turiano.org

Congratulations on your work with the right to health and health care Campaign. You will hear from the core group when we are ready to launch phase II of the campaign.

Annex I. CONCEPTS AND DEFINITIONS

What is the right to health and health care?

The right to health includes the availability, access, acceptability and quality of health care. Health is a fundamental right that influences all aspects of life, so it is important to look at health in a broad way. It is closely related to other human rights. Although we focus our analysis on the right to health, this does not mean it is considered more important than others are.

What is the principle of non-discrimination?

The principle of non-discrimination is a cornerstone of human rights. It means that all people have the same human rights even if they are different in some way from others. For example, discrimination based on sex is one common type of discrimination.¹⁰ Women and men should have equal access to health care. However, non-discrimination does not mean treating everyone the same. Such an approach disadvantages women as a result of past discrimination. Women require different treatment from men due to biological factors, socio-economic factors, and psychosocial factors.¹¹

States have important obligations with regard to discrimination:

- to eliminate not only their own discriminatory practices, but also those of individuals.
- to address direct as well as indirect discrimination. An example of an indirect discriminatory law is one that requires everyone to pay the same amount for health care, even though the cost is unaffordable for people without paid work, such as elderly widows.
- to implement temporary special measures (where necessary) to reverse the effects of past discrimination on particular groups.
- to take measures to ensure that women and men can, and do, participate in society on an equal basis, such as removing barriers which women face access their rights.

What is the principle of participation?

The participation of the general population in all health-related decision-making at the community, national and international levels is an important aspect of the right to health. Individuals and groups should be involved in making decisions about health policies.¹² They should also have an opportunity to make complaints about the negative effects of laws and policies. Because of traditional gender roles, women tend to participate less than men in political and public life.¹³ Involving women in decision-making therefore requires specific attention by the government.

¹⁰ Universal Declaration of Human Rights, article 2; CEDAW article 1 and 2; ICESCR Articles 2 and 3, General Comment 16

¹¹ CEDAW article 1, ICESCR general comment 24, paragraph 12

¹² ICESCR general comment 14, paragraph 54, see also paragraph 11 and 17

¹³ CEDAW general recommendation 19, paragraph 11

What is policy?

A policy is a plan of action. A policy can refer to a nationwide five-year health strategy or to decisions about a particular disease or region. The process by which policies are developed can involve local or national government, NGOs, or individuals. This assessment mostly concentrates on government policy. The government policy process follows a number of stages (at least in theory):

- Agenda-setting: the process by which problems come to the attention of government;
- Policy formulation: the process by which policy options are identified by government;
- Decision-making: the process by which the government adopts a certain course of action (or non-action);
- Policy implementation: the process by which the government puts the policy into effect;
- Policy evaluation: the process by which the results of policies are monitored both by the government and by civil society and which may lead to a new set of stages.

During the stages of agenda setting, policy formulation and evaluation, people's organizations may have a particularly strong role. In other stages participation may be more difficult.

What are health reforms, PRSPs, MDGs and how do they influence health policies?

Many countries throughout the world have introduced health sector reforms to control the costs of health services. These reforms have serious implications for the right to health.

A much-debated trend is the privatization of health related services, whereby the government allows and often stimulates the private sector to take over the provision of certain services (e.g., in health clinics) or goods (e.g., the distribution of contraceptives). In some countries, health sector reforms are the result of **Poverty Reduction Strategy Plans (PRSP)**, which governments write to be eligible for loans from the IMF, the World Bank and other donors. PRSPs determine the direction of health policies and their budgets.

The **Millennium Development Goals (MDGs)** also have a considerable influence on health rights. This influence may be positive because the MDGs prompt governments to take action on many health related issues. But the MDGs may also have a negative effect if attention and resources are drawn away from important areas. For example, sexual and reproductive rights do not have a prominent place in the MDGs and may not receive necessary funding.

Similar discussions are taking place concerning the effects of the General Agreement on Trade in Services (**GATS**) and the Agreement on Trade-Related Aspects of Intellectual Property Rights (**TRIPS**) on the price of health services and drugs.

This right to health and health care assessment can show how these agreements impact the health rights of certain groups. In addition, the progress reports that countries make for the PRSPs, the MDGs, etc. may provide useful information for our analysis.

How does globalization effect a government's responsibility for the right to health and health care?

Governments' first responsibility regarding the right to health is at the national level. But in a globalized world, governments have a growing responsibility at the international level. First of all, a country's actions often have impacts beyond its national borders. Air and water pollution are clear examples of such influence. Secondly, governments help each other on a bilateral basis, such as through development cooperation. According to human rights treaties, governments have the obligation to support each other in implementing health rights. A third way in which governments have international influence is through multilateral institutions. Influential international institutions such as the World Bank are owned by the governments of member nations, which have ultimate decision-making power within the organization. Last but not least, governments monitor each other through international agreements. These may be bilateral or multilateral; legally binding, such as UN human rights treaties, or morally binding, such as the Millennium Development Goals. It is clear that in a globalized world, decisions at the local, national and international levels influence each other.

Annex II WHAT ARE HUMAN RIGHTS?

Human rights are the rights possessed by all persons, by virtue of their common humanity. The first and most influential document describing human rights is the **Universal Declaration of Human Rights** of 1948. It is the predecessor of the major human rights treaties. The declaration recognizes the *inherent dignity and equality of all human beings*, the notion that lies at the heart of all human rights. Some other features of human rights are listed below:

- Human rights are fundamental, because individuals need them to survive, to develop and to contribute to society. They are the primary means for every person to develop their full potential.
- Human rights are not granted by governments or by international law. Every individual has human rights and is entitled to all of his or her human rights by virtue of being human.
- Human rights are inalienable. They cannot be taken away from a person or denied to a person by the State.
- Human rights are universal. This means that every human being is entitled to human rights, regardless of gender, race, age, ethnicity, citizenship, religion, disability or other status.
- Human rights are **indivisible**; they are closely connected. The realization of the right to health, for example, is closely connected to the realization of other human rights, such as the right to education, food and an adequate standard of living.

Women's rights are human rights

Even though all general human rights treaties include a provision on the equality of men and women, this has not proven sufficient to eliminate discrimination against women. The Convention on the Elimination of all forms of Discrimination Against Women (**CEDAW**) was developed to focus on the elimination of discrimination of women in a broad sense. By adopting this treaty in 1979, States recognized that special attention was needed to women's human rights. CEDAW clearly defines what discrimination against women means and what States should do to prevent it. 25 years after its adoption there is still a gap between respect for women's rights on paper and in practice: CEDAW provides a good basis to claim justice and equality for women throughout the world.

Why a human-rights approach?

Human rights treaties are the foundation of a **human-rights based approach**. States have the obligation to **respect, protect and fulfill** the human rights laid down in the treaties they have signed and **ratified**. Using the example of poor people's right to health and health care, this means that governments are not allowed to violate their health rights (the obligation to respect) and that they should restrain others – companies for example – from violating them (obligation to protect). Moreover, the government should do all it can to make sure that poor people achieve the highest attainable standard of health (obligation to fulfill). In other words, when speaking of human rights we do not speak of mere aspirations by States, or of the needs of those claiming their rights, but of obligations for governments. Keeping this in mind, it can be said that:

- A human rights based approach is based on the idea that every human being has rights. States are responsible for the realization of these. Citizens can hold the State accountable for its obligations to respect, protect and fulfill human rights.
- The basis of a human-rights approach is that a human rights violation needs to be addressed, even when the number of people involved is small or not precisely known. In other words, each human rights violation stands on alone and should be taken seriously. A decrease in numbers of a certain type of human rights violation is a positive development, but does not excuse other violations still taking place.

- A rights approach to poor people's health care means monitoring the way they enjoy, exercise and claim their health rights.

Why use international human rights treaties?

A human rights **treaty** (or **covenant** or **convention**) is a written document binding States under international law. All countries that have agreed to be bound by international human rights treaties through **ratification** or **accession** have a legal obligation to implement these rights and principles at the national level¹⁴.

Human rights treaties lay down important principles. **CEDAW**, for example, states that women and men must have equal rights with regard to health care and -- at the same time -- that governments must examine the specific health needs of women. Committees of independent experts (**treaty-monitoring bodies**) monitor the implementation of a certain treaty. They study reports on the implementation of the treaty that States have to submit regularly. NGOs and PHM circles can provide important input to this process via so-called **shadow reports**. Some treaties offer the possibility for individuals to submit complaints to a treaty-monitoring body. Annex III on Sources and Resources provides links to the most relevant international and regional treaties.

¹⁴ This is the main difference with consensus documents, such as the MDG's, the outcome documents of world conferences and the UN General Assembly resolutions, which entail a moral, but not legal, duty to implementation.

Annex III. SOURCES AND RESOURCES

Resources on lobbying and advocacy

Short guide on lobbying. Website of the Education and Training Unit, South Africa.

<http://www.etu.org.za/toolbox/docs/organise/weblobby.htm>

Short overview of the basics of lobbying. Website of the Democracy Center.

<http://www.democracctr.org/resources/lobbying.html>

Online lobbying guide that can be downloaded. Website of the Independent Sector.

<http://www.independentsector.org/programs/gr/lobbyguide.html>

Good list of resources for advocacy, focus on ICDP Agenda. Website of the Asia-Pacific Alliance. http://www.asiapacificalliance.org/SITE_Default/Resources_for_Advocacy_Default.asp

Good list of general resources on advocacy. Organization focuses on HIV/AIDS.

<http://www.aidsmap.com/en/docs/32364953-087A-45D3-AEED-E773BE45593D.asp>

General tips on advocacy. Website of the Ugandan AIDS Advocacy network.

http://www.phrusa.org/campaigns/aids/uganda/toolkit/eightsteps_advocacy.php

Health indicators, data sources

PAHO gender differences in health and development in 48 countries in the Americas, focusing on women's reproductive health, access to key health services and major causes of death.

<http://www.paho.org/english/DPM/GPP/GH/GenderBrochure.pdf> PAHO Country

Health Profiles.

<http://www.paho.org/english/sha/profiles.htm> UNDP Human Development Reports 1990-2005.

<http://hdr.undp.org/reports/global/2005/> UNFPA Population and Reproductive Health

Country Profiles.

<http://www.unfpa.org/profile> UNFPA State of the World Report 2005.

<http://www.unfpa.org/swp/2005/english/ch1/index.htm> UN Statistics Division.

<http://unstats.un.org/unsd/default.htm> WHO Health indicators per country.

<http://www.who.int/countries/en/> (also available in Spanish and French)

WHO World Statistical Information System.

<http://www3.who.int/whosis/menu.cfm> WORLD BANK

GenderStats; gender statistics and indicators.

<http://devdata.worldbank.org/genderstats/home.asp>

International treaties

CEDAW Convention on the Elimination of All Forms of Discrimination against Women.

<http://www.un.org/womenwatch/daw/cedaw/index> CEDAW the Optional Protocol.

<http://www.un.org/womenwatch/daw/cedaw/protocol/text.htm>

CEDAW General Recommendations. (see especially Recommendation 25 on health and 19 on violence against women)

<http://www.un.org/womenwatch/daw/cedaw/recomm.htm>

ICESCR International Covenant on Economic, Social and Cultural Rights.

<http://www.ohchr.org/english/law/cescr.htm> <http://66.36.242.93/treaties/cescr.php>

ICESCR General Comments. (see especially Comment 14 on health and 16 on equal rights for women and men)

<http://www.ohchr.org/english/bodies/cescr/comments.htm>

CERD International Convention on the Elimination of All Forms of Racial Discrimination.

http://www.unhchr.ch/html/menu3/b/d_icerd.htm

CRC Convention on the Rights of the Child.

<http://www.unhchr.ch/html/menu3/b/k2crc.htm>

CMC. Convention on the Protection of the Rights of All Migrant Workers

http://www.unhchr.ch/html/menu3/b/m_mwctoc.htm

UDHR Universal Declaration of Human Rights.

<http://www.unhchr.ch/udhr/>

Regional treaties and organizations

Africa

African Charter on Human and Peoples' Rights (1981).

<http://www1.umn.edu/humanrts/instree/z1afchar.htm>

Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa.

http://www.achpr.org/english/_info/women_en.html African Union. <http://www.africa-union.org/home/Welcome.htm>

African Commission on Human Rights.

http://www.achpr.org/english/_info/index_women_en.html

Europe

European Convention on Human Rights (1950).

<http://www.hri.org/docs/ECHR50.html> European Social Charter (1961).

<http://www1.umn.edu/humanrts/euro/z31escch.html>

Council of Europe.

http://www.coe.int/t/e/Human_Rights/

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<http://www.echr.coe.int/echr>

EU and Gender Equality.

http://europa.eu.int/comm/employment_social/gender_equality/index_en.html

EU and Health.

http://europa.eu.int/comm/health/ph_overview/overview_en.htm

OSCE.

<http://www.osce.org/odihr/13371.html>

The Americas

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<http://www.oas.org/juridico/english/Treaties/b-32.htm>

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

<http://www.oas.org/juridico/english/Treaties/a-53.htm>

Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women, 'Convention of Belem do Para' (1994).

<http://www.oas.org/cim/English/Convention%20Violence%20Against%20Women.htm>

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<http://www.phmovement.org/charter/almaata.html>

Declaration of Commitment on HIV/AIDS, 'Global Crisis-Global Action' (2001).

<http://www.un.org/ga/aids/coverage/FinalDeclarationHIVAIDS.html>

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<http://www.hri.ca/vien-na+5/vdpa.shtml>

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Maastricht Guidelines on Violations of Economic, Social and Cultural Rights, Maastricht, January 1997.

http://www1.umn.edu/humanrts/instree/Maastrichtguidelines_.html

Millennium Declaration (MDGs) (2000).

<http://www.developmentgoals.org>

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<http://www.phmovement.org/pdf/charter/phm-pch-english.pdf>

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

<http://www.unhchr.ch/html/menu3/b/68.htm>

Resources on treaties

ABA-CEELI. The CEDAW Assessment Tool: An Assessment Tool Based on the Convention to Eliminate All Forms of Discrimination against Women.

<http://www.rightsconsortium.org/resources/assessment/CEDAWtool.pdf>

Office of the United Nations High Commissioner for Human Rights.

www.ohchr.org/english/law/index.htm

Human Rights Library of the University of Minnesota.

www1.umn.edu/humanrts/treaties.htm

Treaty Body Database on the Implementation of CEDAW and Other UN Human Rights Conventions.

www.unhchr.ch/tbs/doc.nsf

Women's Human Rights Net provides information about women's human rights throughout the world. Also available in French and Spanish.

www.whrnet.org

Other documents of interest

OHCHR, Draft Guidelines: a Human Rights Approach to Poverty Reduction Strategies, 2002, CESCR. <http://www.unhchr.ch/development/povertyfinal.html>

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[www.unhchr.ch/Huridocda/Huridoca.nsf/0/42e7191fae543562c1256ba7004e963c/\\$FILE/G0210428.pdf](http://www.unhchr.ch/Huridocda/Huridoca.nsf/0/42e7191fae543562c1256ba7004e963c/$FILE/G0210428.pdf)

Annex IV. GLOSSARY

Accession: When a State becomes party to a treaty after it has already been negotiated and signed by other States (generally when the treaty has already entered into force). It has the same legal effect as ratification. The conditions under which accession may occur and the procedure involved depend on the provisions of the treaty.¹⁵ Also see Ratification.

Advocacy: A process aimed at influencing policy decisions and lawmaking at national and international levels. Actions designed to draw a community's attention to an issue and to direct policymakers to a solution.¹⁶ Advocacy requires the existence of explicit mechanisms for the participation of organizations of civil society.

Availability requirement: Functioning public health and healthcare facilities, goods and services, and programs must be available in sufficient quantity within the State party.¹⁷

Access requirement: Health facilities, goods and services must be accessible to everyone without discrimination, within the jurisdiction of the State party.¹⁸ It is of particular importance to consider the removal of barriers faced by vulnerable and marginalized groups. Access includes:

- Physical access: facilities within safe physical reach for all sections of the population, especially vulnerable or marginalized groups.
- Economic access (affordability): affordable for all, including socially disadvantaged groups. For example, poorer households should not be disproportionately burdened with health expenses as compared to richer households.
- Information access: the right to seek, receive, and impart information and ideas concerning health issues. Access of information should not impair the right to have personal health data treated with confidentiality.

Acceptability requirement: All health facilities, goods and services must maintain the standards of medical ethics, such as insuring the confidentiality of individual medical information, and actually improving the health status of those concerned. These services must also be culturally appropriate for the people being served. People's traditional healing practices and medicines must be treated respectfully.¹⁹

Important note: Acceptability may not be used as an excuse for practices that exclude (e.g. when reproductive health services and information are denied to adolescent girls 'to protect their honor'). Another limitation of the term acceptability is where traditional practices harm women's health rights (e.g. in the case of female genital mutilation). Such practices are considered discriminatory.

Quality requirement: Health facilities, goods and services must be scientifically as well as medically valid and of good quality. This requires, among other things, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.²⁰

¹⁵ <http://untreaty.un.org/English/guide.asp#accession>

¹⁶ Women, Law and Development International, 1997, page 163.

¹⁷ ICESCR general comment 14, paragraph 12.

¹⁸ ICESCR general comment 14, paragraph 12.

¹⁹ ICESCR general comment 14, paragraph 12.

²⁰ ICESCR general comment 14, paragraph 12.

Beijing Platform for Action: Consensus document adopted by the 1995 Fourth World Conference on Women in Beijing, which reviews and reaffirms women's human rights in all aspects of life; signed by representatives at the Conference and morally but not legally binding. The Beijing Plus 5 document followed it, and its progress was reviewed after 10 years, during the 49th session of the Commission on the Status of Women (2005).²¹

Benchmark: Self-set goals or targets to be reached at some future date. National and international benchmarks are the framework for measuring progress in implementing the right to health and are normally used for assessing the effectiveness of policies and if progress has been made in all sections of the population.²²

Bilateral: between two countries.

Cairo Program of Action: Outcome document of the International Conference on Population and Development, adopted by the United Nations in September 1994, in Cairo, Egypt.

Civil and Political Rights: The classical rights of citizens to liberty and equality. In principle, citizens should be able to exercise these rights without interference from the government. Civil and political rights include the right to life, to a fair trial, to free practice of religion, to think and express oneself, to vote, to take part in political life and to have access to information.²³

Civil society: the voluntary civic and social organizations and institutions that form the basis of a functioning society as opposed to the force-backed structures of a state. The term civil society is currently often used by critics and activists as a reference to sources of resistance to globalization²⁴.

Claim-holder: a person who is entitled to a right that a duty bearer must provide. One individual may have both claim-holder and duty-bearer roles. The relationships between claim-holders and duty-bearers form a pattern that links individuals and communities to each other and to higher levels of society (see duty-bearer).

Committee(s): Treaty-monitoring bodies created under various conventions to monitor the implementation of the treaty. Committees consist of independent experts. They examine State reports about the application of the treaty and deal with cases involving violations of rights. See also CEDAW, Human Rights Committee and ICESCR. The term 'Human rights committee' is meant to refer specifically to the treaty-monitoring body of the International Covenant on Civil and Political Rights (ICCPR).

Convention: See Treaty

Consensus documents: Statements of political agreement that have been adopted by declaration. Though they are not legally binding, they are important because governments feel a moral obligation to abide by them. They are also called political documents. One of the oldest and most influential consensus documents is the Universal Declaration for Human Rights. Other famous examples are the Beijing Platform for Action and the Millennium Development Goals.

²¹ <http://www.un.org/womenwatch/daw/csw/index.html>

²² Asher, 2004, page 89.

²³ Kooijmans, 2000, page 255.

²⁴ http://en.wikipedia.org/wiki/Civil_society

Convention on the Elimination of All Forms of Discrimination against Women: CEDAW was adopted in 1979 and entered into force in 1981. It is the first legally binding international document prohibiting discrimination against women and obligating governments to take affirmative steps to advance the equality of women.²⁵ Currently, 180 countries are party to CEDAW. In 1999, an optional protocol (see **Optional Protocol**) to CEDAW was adopted, which entered into force in 2000. It established two new procedures: a procedure for individual complaints to the Committee, and an inquiry procedure on the basis of which the Committee can start an investigation about an alarming situation in a specific country.

CEDAW (the Committee): Treaty body of the Convention on the Elimination of All Forms of Discrimination against Women. The Committee consists of a group of 23 independent experts who monitor the implementation of the Convention by State parties. The experts have been elected on the basis of their knowledge of relevant topics. They are nominated by governments of State parties, but operate independently from the governments.

Core obligations: What must be done to ensure the minimum content of each right.

Covenant: See Convention. See also International Covenant on Economic, Social and Cultural Rights (ICESCR) and International Covenant on Civil and Political Rights (ICCPR).

De facto: 'In reality' or 'in fact'. A situation that actually exists, whether lawful or not.²⁶ See also: de jure.

De jure: 'By law' or 'by right'.²⁷ How a situation should be, according to the law. In reality, the actual situation does not always conform with the law. For example, according to the law of a certain State (de jure), everyone may have equal access to health care, but, in practice (de facto), due to local customs women need their husband's or father's permission to see a doctor. See also: de facto.

Declaration (document): Document that contains agreed-upon standards but is not legally binding. UN conferences, such as the 1993 UN Conference on Human Rights in Vienna and the 1995 World Conference for Women in Beijing, usually produce two sets of declarations: one written by government representatives and one by NGOs. The UN General Assembly often issues influential but legally non-binding declarations.²⁸

Declaration (statement): Sometimes a State wants to make a general statement about a treaty, for example, the way it interprets a definition/word included in the treaty. This is done by way of a declaration. In cases where the treaty prohibits reservations, States sometimes (abusively) make use of declarations in order to limit the content of certain provisions or scope of application.²⁹

Determinants of health: Conditions that make it possible to live in health, such as access to safe water, adequate food and housing, and safe and healthy working conditions. Resource distribution, gender differences and access to health-related education and information (including information on sexual and reproductive health) are also health determinants. Determinants are not necessarily directly related to health care. However, their analysis helps to make clear where barriers lie to claiming health rights.

²⁵ <http://www.un.org/womenwatch/daw/cedaw/index>

²⁶ <http://www.hyperdictionary.com/search.aspx?define=de+facto>

²⁷ <http://www.hyperdictionary.com/search.aspx?define=de+jure>

²⁸ <http://www1.umn.edu/humanrts/edumat/hreduseries/tb1b/Section3/hrglossary.html>

²⁹ Information ON ratifications, reservations and declarations to specific treaties can be found on the UNHCHR website: <http://www.ohchr.org/english/bodies/index.htm>

Discrimination: “Any distinction, exclusion or restriction...which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by” a group “of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.”³⁰ Groups that often face discrimination include women, ethnic and religious minorities, homosexuals, and people with disabilities.

Duty-bearer: a person who is obligated to provide the rights a claim-holder is entitled to. One individual may have both claim-holder and duty-bearer roles. The relationships between claim-holders and duty-bearers form a pattern that links individuals and communities to each other and to higher levels of society (see claim holder).

Economic, Social and Cultural Rights: Rights that give people social and economic security. These rights demand an active government policy. Examples are the right to food, education, shelter and health care and the right to preserve and develop one’s cultural identity.³¹

GATS: General Agreement on Trade in Services, developed with the aim of creating a credible and reliable system of international trade rules; ensuring fair and equitable treatment of all participants; stimulating economic activity through guaranteed policy bindings; and promoting trade and development through progressive liberalization. Controversial for its limitations to the freedom of people and their governments to make democratic choices about the way their services are run and the effect it may have on the quality and availability of essential services across the world.³²

Gender: While ‘sex’ refers to the biological differences between males and females, gender describes the socially-constructed roles, rights and responsibilities that communities and societies consider appropriate for men and women. We are born as males and females, but becoming girls, boys, women or men is something that we learn from our families and societies. It is this learned behavior that forms gender identity and determines gender roles. These are not necessarily the same all over the world, or even within a country or region.³³

General Recommendations/ General Comments: Documents written by the Committees that monitor the implementation of human rights treaties explaining how a particular treaty should be interpreted and applied. Very relevant general recommendations in the context of this assessment instrument are CEDAW General Recommendation 24 concerning women and health and ICESCR General Comments 14 on the right to the highest attainable standard of health.

Government: The word government is used in this assessment tool in a broad sense. It covers the law and policy-making forces, as well as the government institutions that are responsible for the implementation of policies. It also includes the local, regional and national government levels. While local and regional authorities may have considerable responsibilities in developing and implementing policies, the national (central) government has the final responsibility to ensure that human rights are respected.

Grassroots organizations: Organizations set up by the local community and/or involving the community.

³⁰ CEDAW article 1

³¹ Kooijmans, 2000, page 255.

³² http://www.wto.org/english/tratop_e/serv_e/gatsqa_e.htm and <http://www.peopleandplanet.org/tradejustice/gats/>

³³ http://www.unicef.org/gender/index_bigpicture.html

Health: Health is a state of complete physical, mental and social well being and not merely the absence of disease or infirmity. It is not confined to health care, but includes socio-economic factors and extends to the underlying determinants of health, such as resource distribution, gender, food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions and a healthy environment.³⁴ See also **right to health** and **primary, secondary and tertiary health care**.

Human rights: The rights possessed by all persons, by virtue of their common humanity, to live a life of freedom and dignity. These rights and freedoms are irrespective of citizenship, nationality, race, ethnicity, language, gender, sexuality or abilities. They are universal and indivisible. Human rights become enforceable when they are codified as Conventions, Covenants or Treaties, or when they become recognized as Customary International Law.³⁵

Human rights approach: See rights-based approach.

Indicator: An indicator is a variable or measurement conveying information that may be qualitative or quantitative, but which is consistently measurable. Indicators related to women's health rights are, for example, maternal mortality rate, women suffering from epidemic diseases (both transmittable and non-transmittable), life expectancy of women, male-female ratio, nutritional level of women of all age groups, incidence of violence against women, female literacy rate, etc. Data regarding these indicators should be present in disaggregated form for all age groups and other socio-cultural and economic sub-groups.³⁶

Indivisibility of rights: The indivisibility of human rights is the basic assumption of the human rights system, first formulated in 1948 in the Universal Declaration of Human Rights. It states that all human rights (civil and political as well as economic, social and cultural rights) are interrelated and cannot be separated. In order to ensure the realization of human rights, their implementation must therefore be comprehensive. It is impossible to fully realize civil and political rights if economic, social and cultural rights are being ignored.

International Covenant on Civil and Political Rights (ICCPR or CCPR): Adopted in 1966 and entered into force in 1976, the ICCPR declares that all people have a broad range of civil and political rights. It has been ratified by 154 countries as of October 2005. See also Civil and Political Rights.³⁷

International Covenant on Economic, Social and Cultural Rights (ICESCR): Adopted in 1966, and entered into force in 1976, the ICESCR declares that all people have a broad range of economic, social and cultural rights. By October 2005 the treaty had been signed and ratified by 151 countries. A group of 18 independent experts monitors its implementation. See also Economic, Social, Cultural Rights.³⁸

Life-cycle approach: Health is a lifetime concern. Health policies need to be tailored to the differing challenges people face at different times in life. Discrimination or other human rights violations that occur in infancy can determine the course of peoples' lives.³⁹

³⁴ Adapted from ICESCR general recommendation 14, paragraphs 4 and 20.

³⁵ Human Development Report 2000 Glossary: <http://www.undp.org/hdr2000/english/presskit/glossary.pdf>

³⁶ WHO, 25 questions on Health and Human Rights,

<http://www.who.int/hhr/activities/publications/en/index.html>

³⁷ <http://www.unhcr.ch/tbs/doc.nsf>

³⁸ http://www.un.org/Depts/Treaty/final/ts2/newfiles/part_boo/iv_boo/iv_3.html

³⁹ ²⁴ <http://www.unfpa.org/rh/lifecycle.htm>

Limitation: A State may have reasons to limit certain rights included in the ICESCR. For example, public health measures to control a contagious disease might infringe upon some rights. This is permitted only if the limitation is primarily intended to protect the rights of individuals, determined by national law, compatible with the nature of the rights protected by the ICESCR and pursues legitimate aims (e.g. not using the limitation to increase the military budget). Moreover, the limitation must be aimed at the general welfare of society (e.g. not just the elite) and it must be proportional. The least restrictive alternative must be chosen.⁴⁰

Lobbying: The practice of seeking to influence the legislature or policy development to reflect a certain point of view. Lobbying can be conducted by an individual, a group, an organization or an association.

Millennium Development Goals: The eight Millennium Development Goals (MDGs) form a blueprint agreed to by all the world's countries and all the world's leading development institutions. They range from halving extreme poverty to halting the spread of HIV/AIDS and providing universal primary education, all by the target date of 2015. In the UN Millennium Declaration, UN member states also stress values such as freedom, equality and solidarity.⁴¹

Monitoring and reporting procedure: Treaties have a monitoring and reporting procedure to check the implementation of the treaty in each country. In some cases the report resembles a 'self-inspection' -- governments report on their own compliance with human rights obligations. In others, a monitoring body (e.g. NGOs) initiates the report on government behavior.

Non-governmental organizations (NGOs): Organizations formed by people outside the government. They can operate on an international, national, regional or local scale on the basis of different mandates, agendas and priorities. NGOs play a substantial role in influencing UN policy by writing shadow reports.

Non-retrogression: The principle that governments are not allowed to remain passive in a situation where human rights deteriorate, nor can they take measures that reduce the enjoyment of rights. If a government takes retrogressive measures, it must prove that it had no other option, for example, due to a severe crisis. In such a situation the government also has to demonstrate that it has protected the rights of the most vulnerable groups.⁴²

Optional protocol: A separate treaty associated with a parent treaty, under which state parties to the parent treaty may choose to undertake additional obligations.⁴³ The optional protocol to ICESCR grants individuals the right to send a complaint to the ICESCR Committee. The optional protocol to CEDAW also creates the possibility for the CEDAW Committee to review individual complaints ('communications') and, above that, enables the Committee to start an inquiry procedure.

Participation: The process through which stakeholders (individuals and organizations) influence and share control over priority setting, policy-making, resource allocation and access to public good and services.⁴⁴

⁴⁰ See ICESCR article 4 and paragraphs 28 and 29 of general comment 14.

⁴¹ <http://www.ohchr.org/english/issues/millennium-development/resources.htm>

⁴² ICESCR General Comment 14, paragraph 32:

⁴³ <http://www.un.org/womenwatch/daw/cedaw/protocol/whatis.htm>

⁴⁴ World Bank at <http://inweb18.worldbank.org/ESSD/sdvext.nsf/66ByDocName/> ParticipationatProjectProgramPolicyLevel

Policy: A purposive course of action followed by an actor or set of actors in dealing with a problem or a matter of concern. Policies can vary considerably in scope. The term policy can refer to a nationwide 5-year health strategy as well as to decisions of a more limited scope, such as a reduction of the funding to the maternity wards in a certain district. The actors can be local or national governments, organizations, enterprises or individuals.⁴⁵

Poverty Reduction Strategy Papers (PRSP): One of the conditions a country may have to fulfill in order to receive help and debt relief is to make a PRSP. A PRSP describes the macroeconomic, structural and social policies and programs that a country will pursue over several years to promote broad-based growth and reduce poverty.⁴⁶

Primary health care strategy: An integrated approach to improving health and socioeconomic development defined in the Alma Ata Declaration (1978). It emphasizes community education and participation, addressing social determinants of health, immunization; prevention and treatment of common and endemic disease, maternal/child and reproductive health, and access to essential drugs.

Primary, secondary and tertiary health care: Primary health care is provided at relatively low cost by health professionals and/or generally trained doctors working within the community and dealing with common and relatively minor illnesses. Secondary health care is provided at relatively higher cost by specialty-trained health professionals in centers, usually hospitals, and typically deals with relatively common minor or serious illnesses that cannot be managed at community level. Tertiary health care is provided in relatively few centers, typically deals with small numbers of minor or serious illnesses requiring specialty-trained health professionals, doctors and special equipment, and is often relatively expensive. Forms of primary, secondary and tertiary health care frequently overlap and often interact.⁴⁷

Progressive realization: The principle that governments must do all they can to improve the situation regarding human rights, including the right to health. They must take deliberate, concrete and targeted steps towards the full realization of the right to health and eliminate discrimination in health care. The speed of progress depends on the specific situation of the state and may differ from country to country.⁴⁸

Ratification/ ratified: The official promise of a state to uphold a treaty or convention and adhere to the legal norms that it specifies.⁴⁹

Reproductive rights: The rights that enable all women, without discrimination on the basis of nationality, class, ethnicity, race, age, religion, disability, sexuality or marital status, to decide whether or not to have children. This includes the right to safe, legal abortion. These rights are basic human rights.⁵⁰

Reservation: In cases where States object to one or several articles of a human rights treaty it is common to make use of a reservation. The reservation is a written statement that narrows the content of the article, limits where it can be applied, or rejects the whole provision. The reservation is only valid if it is compatible with the object and purpose of the treaty, if the treaty does not prohibit reservations, and if other States Parties do not object to the reservation.

⁴⁵ James Anderson in Howlet and Ramesh, 1995, page 6.

⁴⁶ <http://www.imf.org/external/np/exr/facts/prsp.htm>

⁴⁷ ICESCR general comment 14, paragraph 19.

⁴⁸ ICESCR article 2 and article 12; ICESCR General Comment 14 paragraphs 30 and 31.

⁴⁹ <http://www.undp.org/hdr2000/english/presskit/glossary.pdf>

⁵⁰ <http://www.wgnrr.org/home.php?page=1&type=menu>

Respect/ protect/ fulfill: States parties have the obligations to respect, protect and fulfil human rights. The obligation to respect requires States parties to refrain from interfering with the enjoyment of rights. The obligation to protect requires States parties to prevent rights abuses by third parties. The obligation to fulfill requires States parties to pro-actively engage in activities that ensure the realization of rights. Fulfill also requires States to take measures necessary to ensure that each person may obtain basic rights whenever they, for reasons beyond their control, are unable to realize these rights through the means at their disposal.⁵¹

Rights-based approach: Because States are responsible for the realization of human rights, citizens can hold the State accountable for its obligations to respect, protect and fulfill them. The basis of a human rights approach is that a human rights violation needs to be addressed, even when the number of people involved is small or not known exactly. In other words, each human rights violation stands alone and should be taken seriously. A decrease in a certain type of human rights violation is a positive development, but does not justify other violations still taking place.

Right to health: Health is a fundamental right that influences all aspects of life and is closely related to other human rights. It is important to look at health as a whole. People who are ill cannot fully enjoy their right to education or participation. Lack of food and housing, make it difficult to live in good health. The right to health includes the availability, accessibility, acceptability and quality of health care. See also health and primary, secondary and tertiary health care, and health determinants.

Shadow report: Reports created by one or more NGOs that analyze the status of implementation of human rights obligations/commitments at the national level. In these reports, NGOs provide information that supplements government reports and thus assist the committees that monitor the treaties to address concerns that are omitted, neglected or misreported by the government.⁵² Shadow reports are also referred to as alternative reports.

Social determinants of health: the social factors affecting health, including education, access to safe and healthy food, employment, and opportunity and control over one's life.⁵³

Special Rapporteur: An official appointed to compile information on a subject, usually for a limited period.

Special Rapporteur on Health: In April 2002, the commission on Human Rights appointed Paul Hunt as the Special Rapporteur. The Special Rapporteur's duties are to gather and exchange information on the right to health; discuss possible areas of cooperation with all relevant actors, including governments, relevant United Nations bodies, specialized agencies, NGOs and international financial institutions; report on the status of the right to health and make recommendations on measures that promote and protect the right to health.⁵⁴

State obligations: State party obligations describe what a state must do, and must not do, in order to ensure that the population of the country is able to enjoy the rights set out in a Convention. See Respect, protect, fulfill.

⁵¹ http://shr.aaas.org/pubs/rt_health/rt_health_manual.pdf

⁵² <http://swf.u2u.org/women2000.txt>

⁵³ <http://www.unhchr.ch/Huridocda/Huridoca.nsf/0/9854302995c2c86fc1256cec005a18d7?Opendocument>

⁵⁴ <http://www.unhchr.ch/Huridocda/Huridoca.nsf/0/9854302995c2c86fc1256cec005a18d7?Opendocument>

State(s) Party(ies): Those countries that have ratified a covenant, convention or treaty and are thereby legally bound to conform to its provisions.⁵⁵ See also State obligations.

Treaty: A contract or other written instrument binding two or more states under international law; used synonymously with Convention and Covenant. All countries that have agreed to be bound by a treaty through ratification or accession have a legal obligation to implement these rights and principles at the national level.⁵⁶ See also Ratification and accession.

TRIPS: WTO Agreement on Trade-Related Aspects of Intellectual Property Rights, obliging the 44 member countries of the WTO to protect the intellectual property rights on marketed products and production processes. Intellectual property rights such as copyrights and patents are intended to compensate the costs that manufacturers have invested in research and development.⁵⁷

Universal Declaration of Human Rights (UDHR): Adopted by the General Assembly on 10 December 1948. Primary UN document establishing human rights standards and norms. All member states have agreed to uphold the UDHR. Although the declaration was intended to be non-binding, over time its various provisions have become so respected by States that it can now be said to be Customary International Law.⁵⁸

Violation of human rights: Breach of the commitments in a treaty (convention / covenant) or an action/omission which is incompatible with the treaty.

Vertical program: An intervention to decrease morbidity or mortality that focuses on a specific disease or technological solution, such as a campaign to promote oral rehydration therapy to treat diarrhea. This is in contrast to changing more fundamental causes of illness such as malnutrition or improving health systems in general.

⁵⁵ Human Development Report 2000 Glossary on Human Rights and Development.

⁵⁶ <http://untreaty.un.org/English/guide.asp#treaties>

⁵⁷ <http://www.wemos.nl/en-GB/Content.aspx?type=Themas&id=1548>

⁵⁸ <http://www.un.org/Overview/rights.html>

Annex V. LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
CAT	Convention against Torture
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CEDAW/the Committee	Committee on the Elimination of Discrimination against Women
CERD	Convention on the Elimination of Racial Discrimination
CESCR	Committee on Economic, Social and Cultural Rights
CRC	Convention on the Rights of the Child
DOTS	Directly Observed Treatment (for tuberculosis)
HERWAI	Health Rights of Women Assessment Instrument
HIV	human immunodeficiency virus
HOM	Humanistisch Overleg Mensenrechten (Dutch abbreviation for Humanist Committee on Human Rights)
GATS	General Agreement on Trade in Services
ICPD	International Conference on Population and Development
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
ILO	International Labor Organization
IMF	International Monetary Fund
MDGs	Millennium Development Goals
NGO	Non-governmental organization
PHC	Primary Health Care
PHM	People's Health Movement
PRSP	Poverty Reduction Strategy Paper
UN	United Nations
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNHCHR	United Nations High Commissioner for Human Rights
UNICEF	United Nations Children's Fund
WHO	World Health Organization
WPF	World Population Foundation
WTO	World Trade Organization