THE RIGHT TO HEALTH

A fundamental human right affirmed by the United Nations and recognized in regional treaties and numerous national constitutions

Part of a series of the Human Rights Programme of the Europe - Third World Centre (CETIM)

Acknowledgement
This brochure received support from the state (canton) of Geneva. It is part of the CETIM's Human Rights Program, itself supported by (July 2006) the Swiss Agency for Development and Cooperation (DDC), the city of Geneva and the city of Lancy, the Municipalities of Thônex and Plan-les-Ouates, Caritas/Switzerland.
Moreover, Mr. François Ndagijimana et Ms. Sanna Boman also contributed to the research.

Copyright
The brochure is available in French, English and Spanish.
Its reproduction and/or translation into other languages is authorized and encouraged, provided the original edition is mentioned and the CETIM is informed.

The Right to Health
© Europe-Third World Centre (CETIM)
ISBN: 2-88053-048-2
Geneva, August 2006

Cover design: Régis Golay

CETIM
Rue Amat 6, CH - 1202 Geneva, Switzerland
Tel. +41 (0)22 731 59 63
Fax +41 (0)22 731 91 52
Email: cetim@bluewin.ch
Website: www.cetim.ch

Printing: Imprimerie du Lion, Genève

Already published in the Series

- The Right to food (2005)
- Transnational Corporations and Human Rights (2005)
- The Case for a Protocol to the ICESCR! (2005)

Coming Brochures in the Series

- The Right to Development (2006)
- Displaced Persons (2006)
- The Right to Adequate Housing (2007)
- The External Debt of the Southern Countries and its Effect on the Enjoyment of Human Rights (2007)
- The Effect of the War on Terror on the Enjoyment of Human Rights (2007)

The ***Human Rights Program*** *of the CETIM is dedicated to the defence and promotion of all human rights, a commitment based on the principle that human rights are totally inseparable and indivisible. Within that commitment, however, the CETIM has a particular focus on economic, social and cultural rights and the right to development, still much neglected in our times when not denied outright. Its objective includes combating the impunity accompanying the numerous violations of these rights and helping the communities, social groups and movements victimized by these violations to be heard and to obtain redress.*

Through this **series** of informational brochures**,** the CETIM hopes to provide a better knowledge of the documents (conventions, treaties, declarations etc.) and existing official instruments to all those engaged in the struggle for the advancement of human rights.

CETIM Publications on Related Topics

- Les médicaments et le tiers monde (1981)
- Pesticides sans frontières (1982)
- L'aide alimentaire: un marché de dupes (1982)
- La civilisation du sucre (1985)
- Alcool et pouvoir des transnationales (1986)
- Marchands de sang: un commerce dangereux (1986)
- La biotechnologie & l'agriculture du tiers monde: espoir ou illusion (1988)
- Nos déchets toxiques: l'Afrique a faim, « v'là nos poubelles! » (1989)
- La sève de la colère: forêts en péril, du constat aux résistances (1990)
- La nature sous licence ou le processus d'un pillage (1994)

To be published at the end of 2006 : La santé pour tous *(proposed title)*

TABLE OF CONTENTS

Introduction

I. The right to health, a recognized right

A. Definition and substance

B. Pertinent texts

1. At the international level
2. At the regional level
3. At the national level

II. The right to health, an indissociable and interdependent right

A. The right to health and its relation to other human rights

1. Health and food
2. Health and housing
3. Health and education
4. Health and information
5. Heath and work
6. Health and intellectual property

B. Health and environment

1. Pollution
2. Industrial activities and toxic waste
3. The nuclear industry
4. Arms and armed conflicts
5. Natural disasters
6. Measures taken (or governments' positions)

III. The implementation of the right to health

A. Monitoring mechanisms

1. At the regional level
2. At the international level

B. Implementation of the right to health at the national level: some examples

1. The United States
2. Cuba
3. Finland

C. International obligations of various stake holders

1. Governments
2. International organizations and institutions
3. The private (business) sector
4. Civil society

Conclusion

IV. Annexes

1. General Observation No. 14 on the right to health
2. Extracts from the General Observation No. 17 on human rights and intellectual property
3. The Alma-Ata Declaration
4. Main web sites for reference regarding the instances to which one may appeal

THE RIGHT TO HEALTH

A fundamental human right affirmed by the United Nations and recognized in regional treaties and numerous national constitutions

Brochure prepared by

Melik Özden, director of the CETIM's Human Rights Program and permanent representative of the CETIM to the United Nations in Geneva

Part of a series of the Human Rights Programme of the Europe-Third World Centre (CETIM)

INTRODUCTION

At first glance, it might seem misplaced to speak of health as a right when ever increasing segments of the world's population are witnessing a steady degradation in the state of their health, to the point where their very existence is threatened.

According to the most recent figures from the World Health Organization (WHO), 1.7 million persons died from tuberculosis in 2004 at the same time as 8.9 million new cases were registered.[1] From 350 to 500 million human beings suffer from malaria, of whom a million – mostly children – die from each year.[2] AIDS killed more than three million persons in 2005.[3] Thus, these three devastating illnesses are responsible for more than six million deaths every year, the overwhelming majority of which occur in the South. Moreover, it is estimated that the world – including the countries of the North – needs some 4.3 million additional health care professionals (doctors, nurses, midwives etc.).[4] And environmental degradation is more than ever a threat to everybody's health.

Yet, the right to health is recognized in many international human rights instruments. Also recognized is that the realization of the right to health is closely tied to, and dependent on, the realization of other human rights, mainly economic, social and cultural rights.

Further, most of the world's disease – like most of its death – results from the non-satisfaction of basic needs, the lack of, and/or non-access to, sanitation, potable water and food being surely the greatest and most pressing. The development of public health in the nineteenth century in Europe and the United States shows that the most significant interventions for the improvement of the health of populations do not involve health services per se. Rather, the realization of the right to health is dependent on the realization of economic, social and cultural rights: food; housing; hygiene; proper work conditions; the exercise of various freedoms, in particular those associated with trade unions; etc. It is also directly related to peace and security.

In other words, the preservation and promotion of health imply more than just access to medical care and medicines.

The iniquitous international order responsible for widespread inequalities and poverty prevents the realization of the right to health. Macro-economic policies – in particular inequitable trade agreements, the debt burden and the continuous appropriation of national resources (both human and material) –

---

1 Press release, 22 March 2006 http://www.who.int/mediacentre/news/releases/2006/pr15/en/index.html .

2 WHO figures cited by the Voice of America, 19 April 2006.

3 UNAIDS annual report, http://www.unaids.org/epi/2005/doc/EPIupdate2005_pdf_en/Epi05_02_en.pdf .

4 *World health report 2006*, May 2006: http://www.who.int/whr/2006/en/index.html .

imposed on developing countries by the international financial institutions have brought in their wake a substantial increase in poverty and in the inequalities between countries and within countries.

As non-democratic organizations, the IMF and the World Bank – to which one can add the World Trade Organization[5] – have favored capital and private transnational corporations over people, and they continue to make economic and social decisions at the national and international level that deeply affect people's lives.

The inextricable connections between the military-industrial complexes and the power centers of the rich countries represent a permanent threat to world peace and security as well as a colossal diversion of resources from social and public needs.

These structures keep the majority of the world's population in a state of powerlessness and fear rather than in the state of democracy and peace requisite for the realization of the right to health.

However, some thirty years ago already, the international community seemed to have become aware of this situation and of the importance of international cooperation if it were to be rectified, and it declared: "The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries."[6]

Today, the situation is dramatically worse. Although almost every country has a ministry of health (with varying freedom to act), and although *all countries*, as members of the World Health Organization, have committed themselves to implementing the provisions of its charter, it is indisputable that the recognition of the right to health, such as it is expressed in international instruments, is not enough for its realization The affirmation of health as a human right and the definition of its relation to other human rights are essential to clarify the obligations of those variously involved in its realization.

Thus, this brochure, divided into three parts:

I. the right to health, a recognized right;
II. the right to health, an interdependent an indissociable right;
III. the implementation of the right to health.

---

[5] The belief that the WTO is democratic owes its currency to its statutory provision that enshrines the principle of "one country, one vote" (the World Bank and the IMF have no such undertaking). In practice, however, this is an illusion, for the great powers exercise within the WTO a preponderance whose most flagrant example is their use of separate negotiations, which "everything thing depends on" according to the media. In the eyes of the media, this "democracy" is seen as an intolerable source of deadlock! Yet it is difficult to characterize as "democratic" an organization whose fundamental orientations are so unalterable as to be as good as cast in stone and whose mission of imposing them on the whole world has taken on the allure of a divinely ordained mission.

[6] *Declaration of Alma Ata*, paragraph II, International Conference on Primary Health Care, Alma Ata, USSR, 6-12 Sept. 1978. Full text in Annex 3.

I. THE RIGHT TO HEALTH, A RECOGNIZED RIGHT

After defining and clarifying the substance of the right to health (section A), we shall explore the texts that recognize and protect it (section B).

A. Definition and substance

The absence of illness does not mean that one is in good health

According to the constitution of the World Health Organization (WHO),

> *"Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity.*
> *"The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, political belief, economic or social condition."*[7]

The right to health: an individual inalienable right

The states parties to the *International Covenant on Economic, Social and Cultural Rights* (ICESCR) recognize

> *"the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."*[8]

For the Committee on Economic, Social and Cultural Rights (CESCR), the main body at the international level monitoring the realization of the right to health, health

> *"is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity."*[9]

The right to health: an indissociable and interdependent right

The *Universal Declaration of Human Rights*, which is the basis of all human rights as well as the primary human rights instrument in force, mentions the right to health in article 25, in connection with a catalog of other economic, social and cultural rights:

---

[7] WHO Constitution, preamble, par. 1, 2, adopted by the International Health Conference (New York), 19-22 July 1946: http://www.yale.edu/lawweb/avalon/decade/decad051.htm.

[8] Art. 12.1, of the *International Convention on Economic, Social and Cultural Rights*: http://www.unhchr.ch/html/menu3/b/a_cescr.htm .

[9] Committee on Economic, Social and Cultural Rights, *General Comment No. 14 (2000)*, par. 1. Full text in Annex 1; also: http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En?OpenDocument .

"(1) everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

"(2) Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection."

B. Pertinent Texts

Besides the international instruments cited above, which constitute the basis of the right to health, several regional and international conventions and treaties recognize this right. Following are the main ones.

1. At the international level

Nobody should be excluded

Among the international instruments that include the right to health, the *International Convention on the Elimination of All Forms of Racial Discrimination*[10] states in article 5 (e) (iv) that:

"... States Parties undertake... to guarantee the right of everyone... to public heath, medical care, social security and social services".

Equality must be respected

According to article 11.1 (f) of the *International Convention on the Elimination of All Forms of Discrimination Against Women*[11]:

"States Parties shall take all appropriate measures... to ensure on a basis of equality of men and women... the right to protection of health..."

According to article 12.1 of the same convention:

"States parties shall take all appropriate measures to eliminate discrimination against women in the field of health care..."

Specific measures for children

The *Convention on the Rights of the Child*[12] states, among other things, in article 24.1, that:

"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 access to such health care services. "

In paragraph 2.c, it requires the states parties, among other things, to take measures:

"To combat disease and malnutrition, including within the frame work of primary health care, through, inter alia, the application of readily available technology and through the provision of adequately nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution."

---

[10] Adopted 21 Dec. 1965: http://www.unhchr.ch/html/menu3/b/d_icerd.htm .

[11] Adopted 18 Dec. 1979: http://www.unhchr.ch/html/menu3/b/e1cedaw.htm .

[12] Adopted 20 Nov. 1989: http://www.unhchr.ch/html/menu3/b/k2crc.htm .

Numerous United Nations world summits have referred to the right to health

It is noteworthy that that right to health figures in several paragraphs of the *Vienna Declaration and Program of Action*.[13] Also, the *Program of Action of the United Nations International Conference on Population and Development*[14] and the *Declaration and Program of Action* of the Fourth World Conference on Women[15] contain definitions concerning, respectively, reproductive health and women's health.[16]

Disabled persons' right to health

In addition to the above mentioned texts and notwithstanding the allusions, both direct and indirect, of the right to health that figure in numerous international treaties dealing with human rights as well as with humanitarian law, the United Nations General Assembly has adopted four texts specifically devoted to the right of handicapped persons. They are: 1. the *Declaration on the Rights of Mentally Retarded Persons,*[17] 2. the *Declaration on the Rights of Disabled Persons,*[18] 3. the *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care,*[19] 4. the *Standard Rules on Equalization of Opportunities for Disabled Persons.*[20]

In spite of all these affirmations, the Commission on Human Rights Special Rapporteur on the right to health[21] has declared that "the legal content of the right is not yet well established"[22]

In our opinion, this not the reason for the deplorable lack of realization of the right to health. There is abundant legislation on the right to health, be it on the international, regional or national level. The definition of the WHO as well as the above mentioned article 12 of the *International Covenant of Economic, Social and Cultural Rights* – to which much of the national and regional legislation owes its inspiration – constitute a sufficient framework within which to conceive policies for realizing the right to health at both the national and

[13] Adopted by the World Conference on Human Rights (Vienna), 14-25 June 1993. See in particular par. 11, 18, 24, 31 and 41.

[14] Held in Cairo, 5-13 Sept. 1994.

[15] Held in Beijing, 4-15 Sept. 1995.

[16] Committee on Economic, Social and Cultural Rights, *General Comment No. 14 (2000)*. See Annex 1.

[17] Adopted 20 Dec. 1971; General Assembly Resolution 2856 (XXVI): http://daccessdds.un.org/doc/RESOLUTION/GEN/NR0/328/72/IMG/NR032872.pdf?OpenElement .

[18] Adopted 9 Dec. 1975; General Assembly Resolution 3447(XXX): http://www.unhchr.ch/html/menu3/b/72.htm .

[19] Adopted 17 Dec. 1991; General Assembly Resolution 46/119: http://www.unhchr.ch/html/menu3/b/68.htm .

[20] Adopted 20 Dec. 1993; General Assembly Resolution 48/96: http://www.un.org/esa/socdev/enable/dissre00.htm .

[21] See chapter III.2.

[22] *The right of everyone to the enjoyment of the highest attainable standard of physical and mental health: Report of the Special Rapporteur, Paul Hunt, submitted in accordance with Commission resolution 2002/31*, 13 Feb. 2003, E/CN.4/2003/58, par. 39: http://www.unhchr.ch/Huridocda/Huridoca.nsf/0/9854302995c2c86fc1256cec005a18d7/ .

international level. Moreover, we have *General Observation No 14* of the Committee on Economic, Social and Cultural Rights, which provides significant clarifications on the substance and the scope of this right and which the rapporteur himself has abundantly cited to describe "the contours and the content" of this right in his first report.[23]

2. At the regional level

Several regional instruments regarding human rights recognize the right to health. Following are the main texts.

According to the *European Social Charter*[24]

> *"With a view to ensuring the effective exercise of the right to protection of health, the Contracting Parties undertake, either directly or in co-operation with public or private organizations, to take appropriate measures designed inter alia: 1. to remove as far as possible the causes of ill-health; 2. to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health; 3. to prevent as far as possible epidemic, endemic and other diseases."*[25]

In its article 16, the *African Charter on Human and Peoples' Rights*[26] guarantees:

> *"Every individual shall have the right to enjoy the best attainable state of physical and mental health. States Parties to the present charter shall take the necessary measures to protect the health of their people and ensure that they receive medical attention when they are sick."*

For the Americas, the *Protocol of San Salvador* states: "Everyone shall have the right to health, understood to mean the enjoyment of the highest level of physical, mental and social well being." It then goes on to list the measures to be taken by the states parties.[27]

3. At the national level

According to a WHO study, still under way, more than 60 constitutional provisions mention the right to health or the right to medical care, and more than 40 of them speak of rights related to health, such as the right to reproductive health, the right of disabled persons to material aid and the right to a healthy environment.[28] (See also chapter III.B.)

---

[23] Ibid.

[24] Adopted 18 Oct. 1961, revised in 1966: http://www.coe.int/T/E/Human_Rights/Esc/ .

[25] Art. 11, "The right to the protection of health". Several articles of the Charter are also devoted to related rights. For example, art. 12, "The right to social security"; art. 13, "The right to social and medical assistance"; art. 14 "The right to benefit from social welfare services".

[26] Adopted 27 June 1981: http://www1.umn.edu/humanrts/instree/z1afchar.htm .

[27] Art. 10, *Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights "Protocol of San Salvador"*, adopted at San Salvador, 17 Nov. 1988: http://www.cidh.org/Basicos/basic5.htm .

[28] ICJ, *Rights to Health Database, Preliminary Proposal, 2002,* quoted by the Special Rapporteur on the Right to Health of the Commission on Human Rights in his first report, par. 20: E/CN.4/2003/58: http://www.unhchr.ch/Huridocda/Huridoca.nsf/0/9854302995c2c86fc1256cec005a18d7/ .

II. THE RIGHT TO HEALTH, AN INDISSOCIABLE AND INTERDEPENDENT RIGHT

A. The right to health and its relation to other human rights

As the Committee on Economic, Social and Cultural Rights rightly recalls, the right to health, like other human rights,

> *"is closely related to and dependent upon the realization of other human rights, as contained in the International Bill of Rights,[29] including the right to food, to housing, to work, to education, to human dignity, to life, to non-discrimination, to equality, the prohibition against torture, the right to privacy, to access to information, and the freedoms of association, assembly and movement. These and other rights and freedoms address integral components of the right to health."*[30]

This implies that its realization depends on different factors, which do not derive directly from medical services but from the realization of other rights, including civil and political rights such as the participation in decision-making and the right of association, indispensable, for example, to the planning and setting up of an effective and non-discriminatory system of health care.

In this chapter, we shall deal primarily with the relation between the right to health and economic, social and cultural rights, given the preeminence of economic, social and cultural rights in the realization of the right to health.

1. Health and Food

The right to health depends above all on a healthy and balanced diet. However, at present, some one billion persons suffer from famine or malnutrition; almost a billion and a half persons do not have access to an adequate quantity of potable water, and almost four billion persons do not have access to proper sanitation.

In such conditions, expecting a person afflicted by hunger and thirst to be healthy is a fantasy. Moreover, the lack of food and potable water is the cause of numerous illnesses, just as is the degradation of the environment (see below). Yet, the right to food, which includes naturally the right to water, is among the fundamental rights of all human beings and requires action by governments in particular and by the international community in general, in both "normal" situations and "emergency" situations.[31]

---

[29] The *International Bill of Rights* comprises the *Universal Declaration of Human Rights*, the *International Covenant on Economic, Social and Cultural Rights* and the *International Covenant on Civil and Political Rights.*

[30] *General Comment No. 14 (2000)*, par. 3. See Annex 1.

[31] Cf. the CETIM brochure *The Right to Food*, Geneva, Sept. 2005: http://www.cetim.ch/en/publications_details.php?pid=122 .

If the above-cited figures seem alarming, the measures announced as well as certain measures implemented now and then in specific situations by the international community are nowhere near what is needed. Worse, the economic policies of most governments, often devised under pressure from the international financial institutions, only aggravate poverty, as has been shown by numerous studies.

2. Health and housing

The right to health is closely related to the right to adequate housing with running water, for "a house without water would be unlivable".[32] Being deprived of adequate housing can entail not only the violation of many other human rights such as the right to education, the right to work, civil and political rights (including the right to privacy), but can result in numerous illnesses.

It is indisputable that, in this area, the policies of most governments are contrary to the right to adequate housing. In fact, public subsidies very often favor the privileged rather than those in need. Moreover, on the pretext of "economic development" and "national security", many governments organize forced evictions, depriving millions of persons of housing, very often offering them no compensation or alternative housing.

3. Health and education

Education is not only "useful" and necessary for finding a good job or for taking part in social life, but also for keeping a sound mind in a sound body (mens sana in corpore sano) and for preventing illness and accidents.

In most countries, the level of education is still far from satisfactory. This is due not only to factors such as armed conflict and lack of means but also sometimes to a lack of political will or to reasons related to religion.

4. Heath and information

Access to information can turn out to be crucial not only to good health but to simply staying alive, especially when there are epidemics or pandemics (see III.A.4). It is also crucial to preventing many illnesses that can be mortal or incurable. This also holds for the prevention of accidents.

It is essential that information be conveyed in such a way that the layman can understand it. It goes without saying that that bringing information down to a level where the general public can understand it does not mean distorting it or creating disinformation.

It is worth recalling here the reprehensible aggressiveness of the private (business) sector, which, in the name of free trade, inundates the world with advertising that is often little more than outright lies, in order to sell products

[32] Annual report of the Special Rapporteur on the Right to Adequate Housing of the Commission on Human Rights, E/CN.4/2002/59: http://www.unhchr.ch/Huridocda/Huridoca.nsf/(Symbol)/E.CN.4.2002.59.En?Opendocument .

that are, or could be, harmful to health, advertising that pressures governments and international institutions in order to avoid regulation of commercial activities (see illustrations 1 and 2). There are also cases of pharmaceutical companies "creating" illnesses – in order to maintain or increase their profits – instead of educating the public and preventing illness.[33]

Political authorities often become involved in this through disaster management. For example, several governments of the countries affected by the Chernobyl catastrophe (see below) issued disinformation instead of informing their citizens properly.[34] Although in such a situation these authorities usually give the excuse that they are trying to avoid inciting panic, they still have an obligation to inform their fellow citizens and take all appropriate measures.

Unfortunately, governments are not the only culprits. The international organizations sometimes also contribute to the disinformation, as was the case recently on the occasion of the twentieth anniversary of the Chernobyl catastrophe. The International Atomic Energy Agency (IAEA) continues to play down the effect of the nuclear catastrophe (see also II.B.3). As this organization's mandate is the promotion of nuclear energy, its lack of neutrality and concomitant support of the nuclear lobby are "understandable". However, it is inadmissible that the IAEA should put pressure on U.N. organizations such as the WHO,[35] whose mandate is the protection of public health. Dr Makoto Nakajima, former director general of the WHO, recently declared that "all U.N. organizations are equal in the U.N. hierarchy, but when it comes to atomic matters, it is the IAEA, directly under the authority of the Security Council, which takes precedence."[36] This subordination of the WHO to the IAEA is formalized in a 1959 agreement between the two organizations. Thus, any work of the WHO concerning radiation and health must be approved by the IAEA before it can go ahead. The IAEA, for its part, employs no radiation biologists or public health experts yet has the last word in setting safety – hence, health – standards in the area of ionizing radiation.[37]

[33] See Ray Moynihan and Allan Cassels, "Selling to the worried well", *Le Monde diplomatique*, May 2006, based on their book: *Selling Sickness: How the World's Biggest Pharmaceutical Companies are Turning us all into Patients* (New York: Nation Books, 2005).

[34] Regarding the Russian and Belorus governments, which were directly concerned by the catastrophe, from the outset, they have adopted a policy of minimizing the consequences, firing and sometimes imprisoning high level civil servants who, backed by solid research, have suggested a version other than that diffused in official stilted communications. (Article by Philippe de Rougemont in *le Courrier* (Geneva), 28 April 2006.)

[35] In 2003, the IAEA created *The Chernobyl Forum*, gathering under its aegis various U.N. agencies such as the WHO, the UNEP, the FAO and the UNDP. These agencies were associated with its Chernobyl report, highly equivocal and much contested for the figures it presented regarding deaths and illnesses due to radiation. For example, the report claims that only a tiny number of the liquidators were affected by high-level radiation.

[36] Report by Swiss Italian Television, "Nuclear Lies", quoted in *Le Courrier*, 28 April 2006.

[37] Ibid.

Illustration 1

Breastmilk and Deceptive Advertising

Although the *International Code for the Marketing of Breastmilk Substitutes*, adopted by the WHO in 1981, forbids all promotion of breastmilk substitutes, transnational corporations, such as Nestlé and Wyeth, not only continue their promotional campaigns for their products and attempt to discredit breastfeeding, but also put pressure on the WHO and on governments to avoid or limit the implementation of the Code.[38] In a study conducted in seven countries, the International Baby Food Action Network (IBFAN)[39] presented as many case studies of decades-long industry efforts to discredit breastfeeding and how industry has opposed any and all regulation of its business activities.[40]

According to research carried out by UNICEF, the rate of breastfeeding is dropping in Kenya but rising in Brazil (even though Brazil was compromised by the participation of Nestlé[41] in its "Zero Hunger" program, which allowed Nestlé to distribute infant formula).[42]

Illustration 2

The Tobacco Industry and the Framework Convention for Tobacco Control

As some five million persons die each year from illnesses linked to the use of tobacco products, the WHO drafted a *Framework Convention for Tobacco Control*. Ratified by 125 countries,[43] it entered into force 27 February 2005. One of its main provisions is a prohibition on advertising, on tobacco product promotion and on sponsorships involving tobacco products.

---

[38] IBFAN Press Release, 21 January 2004. (See following note)

[39] Founded in 1979, the International Baby Food Action Network (IBFAN) is made up of civil society associations working in over one hundred countries throughout the world to reduce newborn and young child morbidity and mortality by improving the health and well being of babies and young children, of mothers and their families, and by protecting, promoting and supporting breastfeeding as well as best practices for infant feeding. IBFAN is fighting for a full and universal implementation of the *International Code for the Marketing of Breastmilk Substitutes* and the subsequent World Health Assembly resolutions that clarify it. See www.ibfan.org .

[40] IBFAN report "Using international tools to stop corporate malpractice – does it work? Checks and balances in the global economy", Jan. 2004: http://www.ibfan.org/english/pdfs/casestudies04.pdf .

[41] "According to investment bank UBS Warburg, 46% of Nestlé's income comes from 'less healthy foods' and is at risk if regulations are brought in. With such massive sums at stake on one hand and the health and well-being of millions on the other, treading the path ahead will require the same courage from campaigners as that shown on the infant feeding issue." IBFAN press release of 21 Jan. 2004, "Strategies used by industry to undermine WHO marketing requirements exposed in new IBFAN report": http://www.ibfan.org/site2005/Pages/article.php?art_id=124&iui=1 .

[42] Ibid.

[43] See www.who.int/tobacco/framework/countrylist/en/ .

Yet the industry is far from admitting defeat. According to Corporate Accountability International,[44] industry spared no effort to undermine the Convention by trying to obtain a seat at the Conference of the States Parties and by proposing voluntary guidelines in countries supporting the Convention – with a view to avoiding binding legislation. This was the case with British American Tobacco (BAT) and Philip Morris[45] in Guatemala[46]. Moreover, the tobacco industry continues to spend millions of dollars every year to burnish its image in the court of public opinion, for example BAT, which gives Nigerian journalists a lap-top computer and 100,000 naïra (US$ 2,200 corrected for purchasing power parity) to encourage them to write articles favorable to the company[47].
All the same, convention or no convention, according to the International Covenant on Economic, Social and Political Rights, governments have the obligation to take measures to protect public health from harmful products, and they fail in this duty if they do not discourage "the production, marketing and consumption of tobacco, of narcotics and of other harmful substances".[48]

5. *Health and work*

For every adult, work means above all an income sufficient to cover one's own needs and those of one's dependents and some sort of acknowledged status within society. The realization of the right to work allows, in theory, the realization of many other human rights: food, housing, education, health etc. The right to work is more than a human right (article 6 of the *International Covenant on Economic, Social and Cultural Rights*) in that it also allows an individual carry out his duties toward the society in which he lives, participating in production and in its development.

But work can also be harmful to health. Many jobs are dangerous (in the industrial sector, in particular – see below) or, in an attempt to reduce production costs, on-the-job worker protection is sometimes reduced to a negligible level. For child workers, the on-the-job danger to which they are subjected is not limited to the time and place of work.

Under pain of firing and/or a shutting down of the production facility, the incessant demand for ever greater productivity and a faster work pace subjects workers to severe hardship and, depending on the work, can threaten their physical and mental health even as the on-the-job accident rate rises. In recent

[44] Formerly Infact, the lead organization of the umbrella group of NGOs that worked for the adoption of the *Framework Convention for Tobacco Control.*

[45] This company has not hesitated to bribe scientists to attain its goals. Thus, Professor Ragnar Rylander, an environmental doctor and "independent researcher" at the Universities of Stockholm, Göteborg and Geneva, was "one of the best paid consultants and secretly employed" by Philip Morris for several decades to support by means of his studies "a message of skepticism concerning the effects of passive smoking" (Geneva Court of Justice, 13-15 Dec. 2003 and press release of the University of Geneva, 29 October 2004. Cf. *Infiltration: Une taupe au service de Philip Morris*, les éditions Georg, Geneva, May 2005).

[46] *Global Tobacco Treaty Action Guide: Protecting National Health Policies from International Tobacco Industry Interference.* Corporate Accountability International, Sept. 2005: http://www.stopcorporateabuse.org/files/pdfs/GlobalTobaccoTreatyActionGuide.pdf .

[47] Ibid.

[48] *General Comment No. 14*, paragraph 5. See Annex 1.

years, this has produced a noticeable increase of research, publications, films etc. in this area.[49]

6. Health and intellectual property

The origin of the idea that "Everyone has the right to the protection of the moral and material interests resulting from any scientific, literary or artistic production of which he is the author"[50], known – wrongly? – by the term intellectual property, is no doubt to be found in the *Berne Convention for the Protection of Literary and Artistic Works*.[51] The goal here is to "to encourage the active contribution of creators to the arts and sciences and to the progress of society as a whole".[52]

In our time, the initial intention behind this human right has been perverted, and transnational corporations use it in their unbridled search for profit by patenting "their inventions". Patents in pharmaceuticals and biotechnology, for example, may pose many problems (see illustration 3). Thus, very often, pharmaceutical and agro-business transnationals obtain the patents for "their products" after modifying several genes or molecules or after simply obtaining them through biopiratry.[53] They can then market them under a 20-year monopoly in accordance with WTO agreements.

However, the accumulation of knowledge and the result of research are often the fruit of several generations – or, indeed, of centuries! For this reason, this knowledge should be considered the common patrimony of humanity, following the example of Dr Jonas Salk, who, in 1955, after discovering a vaccine for polio, was asked by Edward R. Murrow, "Who owns the patent on this vaccine?" Salk, incredulous, replied, "Well, the people, I would say. There is no patent. Could you patent the sun?"[54]

---

[49] See, inter alia, Christophe Dejour, *Souffrance en France: la banalisation de l'injustice sociale*, éditions du Seuil, février 2000.

[50] The *Universal Declaration of Human Rights*, art. 27.2, and the *International Covenant on Economic, Social and Political Rights*, art. 15.1c.

[51] Adopted 9 Sept. 1886, amended several times: http://www.wipo.int/treaties/en/ip/berne/trtdocs_wo001.html .

[52] Committee on Economic, Social and Cultural Rights, Thirty-fifth session, Geneva, 7-25 Nov. 2005 *General Comment No. 17*, par. 4: http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/E.C.12.GC.17.En?OpenDocument . See also Annex 2.

[53] *Biopiratry* is a term for the appropriation of living organisms, primarily used to describe the patents taken out by major private genetic engineering companies starting in the 1990s in order to arrogate to themselves an exclusive right on genes, the human genome, plants and, in a broader sense, everything that is alive, notably the resources of the peoples of the Third World. It is also used to describe an illegal use of natural resources, point-blank theft (carried out through the legislative channel and approved by a United States court), which consists of the legal appropriation of a natural resource for the profit of a private enterprise, under the pretext that the company in question is the first in the race for a patent. *Biopiratry* is discussed at http://fr.wikipedia.org/wiki/Biopiraterie (available only in French).

[54] "Patents Could Block the Way to a Cure" by Howard Markel, *The New York Times*, 24 Aug. 2001.

It is precisely this sort of thing that the Committee on Economic, Social and Cultural Rights condemned in its 2001 statement:

> *"Whereas human rights are dedicated to assuring satisfactory standards of human welfare and well-being, intellectual property regimes, although they traditionally provide protection to individual authors and creators, are increasingly focused on protecting business and corporate interests and investments."*[55]

Moreover, the Committee on Economic, Social and Cultural Rights distinguishes between intellectual property and human rights, for the former are instruments that "often with the exception of moral rights, may be allocated, limited in time and scope, traded, amended and even forfeited". Governments should, then, use them "for the benefit of society as a whole", whereas "human rights are timeless expressions of fundamental entitlements of the human person".[56]

In this perspective, the patent system, such as it is conceived in the WTO *Agreement on Trade-Related Aspects of Intellectual Property Rights* (TRIPS, which entered into force in 1995), is a contradiction of the principle of human rights.

In a statement delivered to the Commission on Human Rights in 1995, the CETIM drew attention to the predictable harmful consequences of the TRIPS agreement: "The TRIPS agreement constitutes a mechanism aiming to privatize common intellectual property and to deprive civil society of its intellectual capacities so that businesses can monopolize intelligence."[57]

Five years after its adoption, the Sub-Commission for the Promotion and the Protection of Human Rights stated regarding the TRIPS agreement:

> *"since the implementation of the TRIPS Agreement does not adequately reflect the fundamental nature and indivisibility of all human rights, including the right of everyone to enjoy the benefits of scientific progress and its applications, the right to health, the right to food and the right to self-determination, there are apparent conflicts between the intellectual property rights regime embodied in the TRIPS Agreement, on the one hand, and international human rights law, on the other"*.[58]

Ten years after its entry into force, the TRIPS agreement every day demonstrates the validity of the criticism initially leveled at it: whether it be for impoverished persons living with HIV/AIDS in the countries of the South who have no access to medicines or for the small farmers who must every year pay fees for using their seeds.

---

[55] Committee on Economic, Social and Cultural Rights, Twenty-seventh session, Geneva, 12-30 Nov. 2001, *Human Rights and Intellectual Property*, E/C.12/2001/15, par. 6: http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/1e1f4514f8512432c1256ba6003b2cc6?Opendocument .

[56] *General Comment No 17*, par. 1, 2. See Annex 2.

[57] Oral statement of the CETIM on biotechnologies and the GATT agreements on intellectual property.

[58] *Intellectual Property Rights and Human Rights*: E/CN.4/SUB.2/RES/2000/7, par. 2: http://www.unhchr.ch/Huridocda/Huridoca.nsf/0/c462b62cf8a07b13c12569700046704e?Opendocument .

Illustration 3

Patents on Life Threaten the Right to Food and to Health

Patents concern not only medicines and persons living with HIV/AIDS. Promoted and supported by the WTO intellectual property system, patents on life threaten the right to life and to health. The following are several examples.

Many patents are filed each year by corporations and universities. Although the tropical and subtropical countries contain 90% of animal and vegetable species (in other words, the preponderant quantity of the biological patrimony of our planet), 97% of patents are held by companies and research institutes based in the industrialized countries.[59]

Further, according to a study carried out in 1989, “about a quarter of all medicines are derived from tropical forest plants, of which three quarters are based on information obtained by indigenous populations”.[60] It goes without saying that the indigenous peoples “receive almost nothing of the resulting profit”.[61]

Occasionally – rarely – this sort of biopiratry is stopped. This was the case with Indian Bismanti rice, which had been patented in 1997 under the name of Texmati (a cross between Basmati and a variety of rice from the United States) by the Rice Tec, Inc., a Texas corporation. It took an intervention by the Indian government for the United States Patent Office to cancel the patent in 2001.[62] It is noteworthy that the “success” of this battle is the result of the Indian government’s intervention in order to save its “national heritage”. Economic considerations certainly played a role. While it is indisputably preferable that countries feed their own people before exporting food products, the problem is even more serious than this, for, with the patent system, national production is threatened.

The agro-business giant Monsanto recently declared that it might once more begin marketing *Terminator* (sterile seeds), whereas in 1999, under pressure from public opinion, it had decided to stop selling it.[63] The goal of agro-business is clear: make farmers dependent on the companies, forcing them to buy new seeds every year by preventing them from using any of their harvest to replant their fields during the following sowing season. In the long run, this can threaten food sovereignty and aggravate the undernourishment prevailing in many regions of the world.

For the time being, the threat seems to have been avoided, mostly owing to a concerted mobilization of social movements such as Via Campesina. In fact, in spite of the efforts of Canada, Australia, the United States and New Zealand, the states parties to the United Nations Convention on Biological Diversity decided, unanimously, at the Eighth Conference of the Parties (Curitiba, Brazil,

---

[59] The bulletin of Swissaid, *Le Monde*, No 1, January 2006.

[60] “Biotechnology and medicinal Plants” in *Rural Advancement Fund International*, No. 5, 1989, quoted by Andrew Grey in *La nature sous licence ou le processus d’un pillage* (éditions CETIM, Nov. 1994).

[61] Ibid.

[62] *Solidaire*, No. 163, Dec. 2001.

[63] 21 Feb. 2006, press release from *Ban Terminator* : http://www.banterminator.org/ .

March 2006) to maintain the international moratorium on Terminator technology.[64]

As for genetically modified organisms (GMOs), they threaten organic and traditional farming and violate the precautionary principle.[65] Yet, many governments are currently in favor of this technology, whose consequences could turn out to be disastrous for future generations.

B. Health and environment

Since the Stone Age, humankind has altered and tried to control the environment. If this effort has generally been beneficial for survival and comfort, it has greatly influenced life on earth and, consequently, the health of humankind. This is even more the case now, as the tendency seems to be accelerating.

According to the WHO, almost one third of all illnesses are caused by environmental degradation.[66] This figure alone demonstrates the importance of a healthy environment (which is also a human right[67]) to health and to the enjoyment of other human rights.

If the right to a healthy environment is not mentioned explicitly in the international human rights instruments, "there has been a growing recognition of the connection between environmental protection and human rights".[68] The Committee on Economic, Social and Cultural Rights, in addition to its *General Comment No 14* already cited, has listed, inter alia, in its *General Comment No 15*, "violations of states parties arising from pollution and diminution of water resources affecting health"[69] among the failures of governments to fulfill their obligations under the *International Convention on Economic, Social and Cultural Rights*. There are also many international conventions on the protection of the environment, which, in spite of their weaknesses and faults, are in the same vein.[70]

---

64 31 March 2006, press release from *Ban Terminator*: http://www.banterminator.org/ .

65 Among other sources: the annual report of the Special Rapporteur of the United Nations Human Rights Commission on the Right to Food, Jean Ziegler, 9 Feb. 2004, E/CN.4/2004/10: http://www.unhchr.ch/huridocda/huridoca.nsf/(Symbol)/E.CN.4.2004.10.En?Opendocument .

66 WHO press release, 9 May 2002: http://www.who.int/mediacentre/news/releases/release36/en/index.html .

67 The right to a healthy environment is recognized in much national and regional legislation.

68 "Summary", *Human rights and the environment as part of sustainable development: Report of the Secretary General*, presented to the sixty-first session of the Commission on Human Rights (2005), E/CN.4/2005/96: http://daccessdds.un.org/doc/UNDOC/GEN/G05/103/71/PDF/G0510371.pdf?OpenElement .

69 Committee on Economic, Social and Cultural Rights, Twenty-ninth session, 11 to 29 Nov. 2002, *General Comment No. 15 (2002)*: http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/a5458d1d1bbd713fc1256cc400389e94?Opendocument .

70 For example the *Stockholm Convention on Persistent Organic Pollutants*, the *Rotterdam Convention on the Prior Iinformed Consent Procedure for Certain Hazardous Chemicals and Pesticides in Iinternational Trade*, the *Basle Convention on the Control of Transboundary Movements of Hazardous Wastes and Disposal*, the Rio de Janeiro *Convention on Biodiversity*, the *Cartegeña Convention on Biosafety*, the *Kyoto Protocol to United Nations Framework*

The degradation of the environment results from various industrial activities, toxic waste, the armament industry and armed conflicts as well as from "natural" disasters – which are not always as "natural" as claimed.

1. Pollution

Hardly a day goes by without the media making some mention of pollution of some sort and the danger it constitutes for health. The sources of pollution are many. Among them, the intensive and abusive recourse to chemical substances and to sources of energy (petroleum, coal and nuclear material in particular) in almost every area of life, which present particular dangers and can contaminate land, sea and air for long periods.

For example, the United Nations Environment Program (UNEP) recently warned the international community about the disturbing pollution of water sources:

> *"Freshwater shortages are likely to trigger increased environmental damage over the next 15 years, according to an international report of the world's waters. "Falls in river flows, rising saltiness of estuaries, loss of fish and aquatic plant species and reductions in sediments to the coast are expected to rise in many areas of the globe by 2020."*[71]

According to the 1,500 experts mandated by the UNEP to draft the above cited report, the consequences of this phenomenon, due in large part to human activity, will be catastrophic:

> *"farmland losses, food insecurity and damage to fisheries along with rises in malnutrition and disease"*.[72]

The explosion of the Jilin Petrochemical factory in China, on 13 November 2005, which polluted – with carcinogenic agents – the Amur River that flows through northeast China and eastern Siberia, only confirms the validity of the UNEP's preoccupations.[73] Moreover, the UNEP considers that the petroleum spills in the Antilles Sea, the Niger basin and the Benguela current in South Africa are "extremely serious".[74]

2. Industrial activities and toxic waste

As industrial activities and industrial-level agriculture are based largely on petrochemical substances, they represent a major source of pollution. While

---

Convention on Climate Change…

[71] UNEP press release, "Global International Waters Assessment Report Launched", 21 March 2006: http://www.unep.org/Documents.Multilingual/Default.asp?DocumentID=471&ArticleID=5234&l=en .

[72] Ibid.

[73] An estimated 100 tons of benzene and nitrobenzene, highly carcinogenic agents, were spilled into the Songhua River. The pollution slick, initially 80 kilometers long, then flowed into the Amur River and affected many cities, including Songyuan (430,000 inhabitants), Harbin (5 million inhabitants), Jiamusi (600,000 inhabitants), Kharbarovsk (600,000 inhabitants) and Kosomolsk-on-the-Amur (200,000 inhabitants). See: http://en.wikipedia.org/wiki/2005_Jilin_chemical_plant_explosions .

[74] See note 71.

these activities have meant gigantic progress over a period of several decades, hence a positive effect on life in general, they have also contributed – and continue to contribute – to the destruction of the environment at a dizzying speed and thus to the progressive destruction of the earth.

As emphasized above, the intensive and abusive recourse to these substances in all areas (manufacturing of household appliances and products, of vehicles, of pharmaceuticals and prepared foods, of motor-vehicle transport infrastructure, of pesticides/herbicides, of fertilizers…) – substances that are currently to be found in daily life in such mundane articles as household appliances and food – not only presents threats to health but implies the exhaustion of non-renewable resources.

Today, world production of chemical substances stands at some 400 million tons, including some 100,000 substances registered in the European Union alone.[75] However, according to the WHO: "…chronic even low-level exposure to various chemicals may result in damage to the nervous and immune systems, impairment of reproductive function and development, cancer and organ specific damage."[76] Further, "Toxic chemicals may constitute serious threats to human rights, the most serious being the right to life of the 47,000 persons estimated by WHO to die every year as a result of poisoning from chemicals like pesticides".[77]

Moreover, the consequences of industrial accidents can also be very serious. For example, the explosion at the Union Carbide pesticide factory in Bhopal (India) in 1984 caused the immediate death of several thousand persons and affected – and continues to affect – hundreds of thousands of others.[78]

The situation is similar regarding the transfer of toxic products and wastes, such as the dismantling of ships contaminated by asbestos or the shipping of electronic waste "from strong economies and powerful industries to weaker economies and disempowered communities".[79]

And stocking dangerous and toxic waste can pose problems even years afterward. For example, "the Asian tsunami stirred up hazardous waste deposits on beaches around North Hobyo and Warsheik, south of Benadir [northern Somalia], causing health problems – including acute respiratory infections,

---

[75] Commission on Human Rights, Sixty-second session, *Adverse effects of the illicit movement and dumping of toxic and dangerous products and wastes on the enjoyment of human rights*, *Report of the Special Rapporteur Mr. Okechukwu Ibeanu*, E/CN.4/2006/42 (20 Feb. 2006), E/CN.4/2006/42, par. 20: http://daccessdds.un.org/doc/UNDOC/GEN/G06/109/55/PDF/G0610955.pdf?OpenElement .

[76] "Chemical Hazards": http://www.who.int/ceh/risks/cehchemicals/en/ .

[77] Ibid.

[78] See the CETIM brochure on transnational corporations: http://www.cetim.ch/en/publications_details.php?pid=130 .

[79] Commission on Human Rights, Sixty-second session, *Adverse effects of the illicit movement and dumping of toxic and dangerous products and wastes on the enjoyment of human rights*, *Report of the Special Rapporteur Mr. Okechukwu Ibeanu,* E/CN.4/2006/42 (20 February 2006), E/CN.4/2006/42, par. 8: http://daccessdds.un.org/doc/UNDOC/GEN/G06/109/55/PDF/G0610955.pdf?OpenElement .

mouth bleeding and skin conditions – to several people living in the northern areas of the country".[80]

3. The Nuclear Industry

If the handling of chemical substances and toxic waste presents dangers not only for the workers in the industrial sector – including industrial-scale agriculture – but also for public health in general, nuclear waste, which cannot be eliminated through the cycle of natural decay, constitutes a permanent danger for all humanity, particularly given the relatively limited knowledge in this area.

For example, the Chernobyl catastrophe (see also chapter II.A.4) of 26 April 1986 continues to make victims: "among the liquidators,[81] there have already been more than 25,000 deaths and more than 200,000 invalids, and among the populations exposed to the contamination, the number of deaths will be – depending on the estimations – anywhere from 40,000 to 560,000 from cancer, with as many non-fatal cancers, not to mention congenital deformities among children and animals."[82]

4. Arms and armed conflicts

There is no doubt that the armaments industry, which continually creates new monsters – conventional weapons as well as chemical, biological and nuclear – is the most dangerous sector, not only for health but for the right to life, for its purpose is the death of human beings and the destruction of the environment.

Although in recent years, specialists have been talking of "surgical strikes" when discussing wars, it is common knowledge that the use of arms such as uranium/depleted uranium weapons causes irreversible damage to the environment.[83]

Wars and armed conflicts not only cause wounded and dead but destroy the environment within which life is lived with all its concomitant activities

---

[80] UNEP report, *After Tsunami: Rapid Environmental Assessment*, cited in, *Adverse effects of the illicit movement and dumping of toxic and dangerous products and wastes on the enjoyment of human rights*, E/CN.4/2006/42 (20 Feb. 2006), par. 9: http://daccessdds.un.org/doc/UNDOC/GEN/G06/109/55/PDF/G0610955.pdf?OpenElement .

[81] Those who worked to put out the fire after the explosion then to build the sarcophagus within which the reactor was then encased.

[82] *Infonucléaire*: http://www.dissident-media.org/infonucleaire/special_tcherno.html . According to the WHO, the Chernobyl death toll is 9,000, and some 240,000 liquidators, who were working within a radius of 30 kilometers from the reactor, received the highest doses of radiation. Regarding the Chernobyl population, 116,000 persons were evacuated immediately, but 230,000 were settled in the contaminated region in the years following the explosion. Fact Sheet No. 303, April 2006, http://www.who.int/mediacentre/factsheets/fs303/en/index.html .

[83] Used on a huge scale by the United States in Afghanistan and in Iraq. See, inter alia, the joint statement of the CETIM to the fifty-sixth session of the Commission on Human Rights: E/CN.4/2000/NGO/136: http://daccessdds.un.org/doc/UNDOC/GEN/G00/115/75/IMG/G0011575.pdf?OpenElement .

(fields, lodging, live stock, food, work education, information etc.) for any number of persons, sometimes in the millions. They can also cause epidemics and the spread of various illnesses because essential needs (water, food, sanitation etc.) cannot be satisfied, Thus, in spite of the *Geneva Conventions* and the *Convention Relating to the Status of Refugees*, it is usually the civilian populations that pay the highest price, as numerous studies in this area have shown.

It is indisputable that government policies in this regard have remained unchanged since the Alma Ata Declaration:

> *"An acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of independence, peace, détente and disarmament could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part, should be allotted its proper share."*[84]

5. Natural disasters

Natural disasters such as earthquakes, floods and hurricanes also constitute threats to life and health in that they cause many deaths and injuries and deprive the survivors of their means of subsistence (food, housing, agricultural activity etc.). If, in certain regions of the world, such disasters are cyclic, experts attribute their recent increase in frequency to erosion from deforestation, intensive urbanism[85] and increased emissions of greenhouse gases (climate change).

In this regard, the Committee on Economic, Social and Cultural Rights recalls that:

> *"States parties have a joint and individual responsibility, in accordance with the Charter of the United Nations and relevant resolutions of the United Nations General Assembly and of the World Health Assembly, to cooperate in providing disaster relief and humanitarian assistance in times of emergency, including assistance to refugees and internally displaced persons. Each State should contribute to this task to the maximum of its capacities."*[86]

6. Measures taken (or governments' positions)

The international community has been well aware of the problems posed by environmental degradation since the 1972 United Nations Conference on the Human Environment, which resulted in the founding of the United Nations Environment Program (UNEP), and it has adopted numerous conventions[87] related to the environment. However, these conventions not only have their weak

---

84 *Declaration of Alma Ata*, par. X. See Annex 3

85 Currently, 50% of the world's population lives in urban centers, and a score of cities comprise over 10 million inhabitants each. Urban experts predict that this rate will reach 70% by 2050: http://www.univparis12.fr/1142951146546/fiche_actualite/ .

86 *General Comment No. 14 (2000)* par. 40. See Annex 1.

points but, often, they are ignored in practice. And the few timid measures that have been taken remain largely inadequate given new discoveries. This is primarily due to a way of life (the consumer society) that has been promoted for decades and that favors economic activity at the expense of any other consideration.

For example, in spite of the creation of the Africa Stockpiles Program in 2000, some 50,000 tons of obsolete pesticides stocked on the African continent over the past four decades are still awaiting donations in order to be cleaned up.[88]

The situation is the same for the REACH system, adopted recently by the European Union Council of Ministers, which – contrary to the proposal of the European Parliament:

> *"leaves the door open for carcinogens, chemicals that are toxic to reproduction (e.g. phthalate DEHP) and hormone disrupting substances (e.g. biphenyl A) to stay on the market, even though safer alternatives exist".*[89]

The *Kyoto Protocol* to the *United Nations Framework Convention on Climate Change*, which sets a calendar for the reduction of greenhouse gas emissions, has been completely diverted from its initial purpose, as might have been expected. In practice, it "allows polluting businesses to buy CO2 emission rights from those who pollute less. A European Carbon Bourse has been set up. (…) It consists of eliminating the gratuitous emission of these gases, which is to be regulated by a system of quotas by the ton, or 'pollution permits', which one can buy according to the principle of supply and demand".[90]

It is noteworthy that the choice of "green" or "clean" (biofuel) energies risks having serious repercussions on food production and on the environment, hence on the right to food and to health.

In fact, liquid combustibles obtained from vegetation of various sorts (cultivated or wild) are claimed to be an alternative to petroleum products.[91] A Swiss daily newspaper recently reported the enthusiasm of investors who, between 1999 and 2004, had invested almost US$ 4.4 billion in the energy

---

[87] The most important these are: the *Stockholm Convention on Persistent Organic Pollutants*, the *Rotterdam Convention on the Prior Iinformed Consent Procedure for Certain Hazardous Chemicals and Pesticides in Iinternational Trade*, the *Basle Convention on the Control of Transboundary Movements of Hazardous Wastes and Disposal*, the Rio de Janeiro *Convention on Biodiversity*, the *Cartegeña Convention on Biosafety*, the *Kyoto Protocol to United Nations Framework Convention on Climate Change.*

[88] Commission on Human Rights, Sixty-second session, *Adverse effects of the illicit movement and dumping of toxic and dangerous products and wastes on the enjoyment of human rights, Report of the Special Rapporteur Mr. Okechukwu Ibeanu,* E/CN.4/2006/42 (20 Feb. 2006), par. 71: http://daccessdds.un.org/doc/UNDOC/GEN/G06/109/55/PDF/G0610955.pdf?OpenElement .

[89] Ibid., par. 69.

[90] *Le Monde*, 16 Feb. 2006.

[91] There are, generally speaking, three main sorts of biofuels: those obtained from oleaginous plants (literally, an oleaginous plant is one that produces oil), primarily rapeseed and sunflower; those obtained from alcohols (methanol and ethanol); those obtained from methane contained in biogas. See http://www.manicore.com/documentation/carb_agri.html .

sector, most of which for "projects involving renewable energy".[92] The truth of the matter, however, lies elsewhere. According to Jean Marc Jancovici, it would be necessary to increase the present agriculture area of France by three to four times to produce enough vegetation for 50 million tons petroleum.[93] The damage to the environment and, consequently, to the health of people, can be easily imagined. Moreover, the "biofuels" currently in use would be minor additives to petroleum products, for they can not even be used in their pure state.[94]

The directives of the Committee on Economic, Social and Cultural Rights are quite clear, saying that governments should:

> *"also refrain from unlawfully polluting air, water and soil, e.g. through industrial waste from State-owned facilities, from using or testing nuclear, biological or chemical weapons if such testing results in the release of substances harmful to human health, and from limiting access to health services as a punitive measure, e.g. during armed conflicts in violation of international humanitarian law."*[95]

[92] *Le Temps*, 8 Feb. 2006.
[93] http://www.manicore.com/documentation/carb_agri.html .
[94] Ibid.
[95] *General Comment No. 14*, par. 34. See Annex 1.

III. THE IMPLEMENTATION OF THE RIGHT TO HEALTH

The realization of the right to health supposes the removal of various obstacles such as poverty, lack of primary health care, the privatization of the public sector, pandemics, the lack of financial means etc. There are monitoring mechanisms at the international and regional level. This chapter looks at them (A) before considering as examples the systems in several systems (B) and clarifying the obligations imposed by international law on various participants (C).

A. Monitoring mechanisms

Independent of health ministries and other instances, there are specific mechanisms for monitoring the right to health. They are limited, however, and recourse to them is rare. This situation obtains even though right to redress and compensation in case of violation of this right should be the rule, as the Committee on Economic, Social and Cultural Rights has unequivocally declared:

> *"Any person or group victim of a violation of the right to health should have access to effective judicial or other appropriate remedies at both the national and international level. All victims of such violations should be entitled to adequate reparation, which may take the form of restitution, compensation, satisfaction or guarantees of non-repetition."*[96]

1. At the regional level

The European Committee on Social Rights

In accordance with article 11 of the *European Social Charter*, the European Committee on Social Rights[97] receives collective complaints about violations of the right to health, as well as violations of the right to social security (art. 12), the right to social and medical assistance (art. 13) and the right to benefit from social welfare services (art. 14).

Since the entry into force of the collective complaint mechanism in 1998, 33 complaints have been filed with the Committee[98] of which a third concerned hygienic conditions in the work place, the consequences of industrial activities on health[99] and the social, legal and economic protection of children and adolescents[100].

---

[96] *General Comment No. 14*, par. 59. See Annex 1.

[97] Charged with monitoring observance of the *European Social Charter*. See note 24.

[98] According to the list established by the Committee. See http://www.coe.int/t/e/human_rights/esc/4_collective_complaints/list_of_collective_complaints/default.asp#P62_4430 .

[99] See, inter alia, case no, 22/2003, Confédération générale du travail (CGT) v. France, and no. 30/2005, Marangopoulos Foundation for Human Rights (MFHR) v. Greece, both at http://www.coe.int/t/e/human_rights/esc/4_collective_complaints/list_of_collective_complaints/default.asp#P62_4430 .

The Inter-American Commission on Human Rights

Charged with monitoring the implementation of the *American Convention on Human Rights*, the Inter-American Commission on Human Rights (like the Inter-American Court on Human Rights) cannot receive complaints concerning violations of economic, social and cultural rights, as opposed to violations of civil and political rights.

On the other hand, the states parties to the *Protocol of San Salvador,*[101] which deals with economic, social and cultural rights, including the right to health (art. 10), are required to submit periodic reports to the Organization of American States General Assembly regarding their implementation of the *Protocol* (art. 19.1).

The African Commission on Human and Peoples' Rights

Besides the periodic reports presented by the states parties to the African human rights treaties, the African Commission on Human and Peoples' Rights can receive both individual and collective complaints concerning violations of the right to health, in accordance with, inter alia, the *African Charter on Human and Peoples' Rights* (art. 16) and the *African Charter on the Rights and Welfare of the Child* (art. 13 and 14).

Although the protocol to the *African Charter on Human and Peoples' Rights* that established the African Court on Human and Peoples' Rights entered into force in January 2004, it has not yet been activated and, for this reason, has not yet – to the best of our knowledge – received any complaints.

2. At the international level

The following committees, with the exception of the Committee on Economic, Social and Cultural Rights,[102] are bodies created in accordance with duly ratified international conventions. They are composed of 10 to 23 independent experts, elected by the states parties to each convention for a term of four years, renewable.[103]

The Committee on Economic, Social and Cultural Rights

This committee is the United Nations body that monitors the implementation of the *International Covenant on Economic, Social and Cultural Rights* (ICESCR).[104] The states parties to this treaty are required to submit periodic reports to the Committee on Economic, Social and Cultural Rights regarding the treaty's implementation. However, for the time being, the Committee cannot

[100] See, inter alia, case no. 19/2003, World Organization Against Torture (OMCT) v. Italy, and case no. 18/2003, World Organization Against Torture (OMCT) v. Ireland, both at http://www.coe.int/T/E/Human_Rights/Esc/4_Collective_complaints/List_of_collective_complaints/RC18_on_merits.pdf#search=%22OMCT%20v.%20Ireland%22 .

[101] See note 27.

[102] See the CETIM brochure *The Case for a Protocol the ICESCR*, Feb. 2006, www.cetim.ch .

[103] For further information, see the site of the Office of the High Commissioner for Human Rights: http://www.ohchr.org/english/bodies/ .

[104] Adopted in 1966 and entered into force in 1976.

receive complaints regarding violations of economic, social and cultural rights, such as the right to health (art. 12 of the ICESCR), for there is still no protocol to the treaty authorizing the referral of such cases to the Committee.[105]

The Committee for the Elimination of Racial Discrimination (CERD)

The CERD oversees implementation by the states parties to the *Convention on the Elimination of All Forms of Racial Discrimination*[106]. Besides the review of the states parties' periodic reports, the CERD can receive both individual and collective complaints, in accordance with article 14[107] of the *Convention*, as in the case of discrimination regarding the respect of economic, social and cultural rights such as "the right to public health, medical care, social security and social services" (art. 5.e.iv).

The Committee on the Elimination of Discrimination against Women

This committee oversees the implementation of the Convention on the Elimination of All Forms of Discrimination against Women.[108] It reviews the periodic reports submitted by the states parties and, since the entry into force of the 2000 optional protocol, has been authorized to receive both individual and collective complaints of discrimination concerning a list of rights, including the right to health (art. 12).[109]

The Committee on the Rights of the Child

This U.N. body monitors the implementation by the states parties of the *Convention on the Rights of the Child,*[110] including the right to health (art. 24).[111] It also oversees the implementation of the Convention's two optional protocols, one dealing with the implication of children in armed conflict, the other with the sale of children, child prostitution and child pornography. The Committee[112] reviews the states parties' periodic reports and the complementary reports of those states parties to the optional protocols.

The Committee on Migrant Workers

This is the most recent U.N. body, created after the 2003 entry into force of the *International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families.*[113] The states parties are required to submit periodic reports on the implementation of the *Convention* to the Committee, which reviews each report and makes known its concerns and recommendations to the state party in the form of "concluding observations". It can also receive complaints from states parties (art. 76) as well as from individuals

[105] See note 102.
[106] Adopted in 1965 and entered into force in 1969.
[107] This article stipulates that the state party must make a declaration recognizing the authority of the CERD:
[108] Adopted in 1979 and entered into force in 1981.
[109] Other articles, notably 11 and 14, also deal with this question.
[110] Adopted in 1989 and entered into force in 1991.
[111] Several other articles of this convention also deal with health, such as 17, 23 and 25.
[112] This Committee still has no procedure allowing it to receive complaints.
[113] Adopted in 1999.

(art. 77), the latter only from citizens of a state party accused of violating rights stipulated in the *Convention*, including the right to medical care (art. 28), starting from the time that ten states parties accept the authority of the Committee in this area.[114]

Further, the **Human Rights Committee** (which deals with civil and political rights) and the **Committee against Torture** can also receive complaints for certain aspects of the right to health, such as the right to life or the obligation not to be an accomplice to, or to submit others to, acts of torture or other cruel, degrading and inhuman treatment.

The Commission on Human Rights Special Rapporteur on the Right to Health

Appointed in 2002 by the Commission on Human Rights, the Special Rapporteur on the Right to Health has a mandate that includes, inter alia, "to report on the status, throughout the world, of the realization of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, … and on developments relating to this right, including on laws, policies and good practices most beneficial to its enjoyment and obstacles encountered domestically and internationally to its implementation; to make recommendations on appropriate measures to promote and protect the realization of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health…"[115]

As is the case with the other special rapporteurs, the Special Rapporteur on the Right to Health submits a report each year to the Commission on Human Rights, conducts missions of inquiry in various countries (in theory two per year) regarding the respect of this right, and can send "urgent appeals" to governments concerning allegations received from NGOs, communities or individuals.

Following the creation of the Human Rights Council (April 2006), all existing mandates of the Commission on Human Rights were transferred to this new body. At the time of writing,[116] a consensus had developed among the Council's states members to extend these mandates, including that of the Special Rapporteur on the Right to Health. The Council, however, has reserved the right to review all mandates in the future in order to "improve and rationalize" them.[117]

[114] See http://www.ohchr.org/english/bodies/cmw/index.htm .
[115] Res. E/CN.4/RES/2002/31, par. 5.c, 5.d: http://ap.ohchr.org/documents/alldocs.aspx?doc_id=4900 .
[116] May 2006.
[117] See par. 6 of the General Assembly resolution (A/RES760/251) that replaced the Commission with the Human Rights Council: http://ap.ohchr.org/documents/alldocs.aspx?doc_id=4900 .

B. Implementation of the right to health at the national level: some examples

This chapter discusses the implementation of the right to health at the national level, with three countries as examples. The Committee on Economic, Social and Economic Rights has set minimal obligations for states parties for this implementation, as follows:

> *"a) To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups;*
>
> *"(b) To ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone;*
>
> *"(c) To ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water;*
>
> *"(d) To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs;*
>
> *"(e) To ensure equitable distribution of all health facilities, goods and services;*
>
> *"(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."*[118]

Health care systems vary immensely from country to country, according to the political and ideological regime in power, yet the quality and accessibility of the system does not necessarily depend on the amount of money spent (see below).

1. The United States

According to the National Center for Health statistics, the United States devotes more of its GDP to health costs (15% in 2002 and still rising) than does any other industrialized country.[119]

In the United States, health insurance can be private or public. Private insurance is the most common, especially among those under-sixty-five – in 2005, 68.3% of the under-sixty-five population.[120] Most of these are covered through their employer or the employer of a family member (under group plans, generally much less expensive than individual policies). In such cases, some (or all, depending on the individual's employment contract) of the

[118] *General Comment No. 14*, par. 43. See Annex 1.

[119] *Health, United States 2005. With Chartbook of Trends in the Health of Americans*, National Center for Health Statistics, Hyattsville, Maryland, 2005.

[120] R. Cohen and M. Martinez, *Health Insurance Coverage: Estimates from the National Health Interview Survey*, January-September 2005, http://www.cdc.gov/nchs/nhis.htm .

premium is paid by the employer, the rest by the employee. Loss of employment ends participation in the employer's group plan. Most jobs do not offer insurance benefits.

There are also two federally financed health insurance programs, one of which is Medicare, for the elderly (over 65), covering some 17% of the population.[121] It pays for hospital stays, visits to the doctor and some of medicine costs. (Prices of prescription medicines in the United States are by far the highest in the world. People living near the Canadian border used to go to Canada to have their prescriptions filled for a fraction of the cost in the United States, but the Bush administration has made this illegal.)

Medicaid, the other program, is for the poor[122] and is administered by the states through their social welfare programs. Each state has its own criteria in determining eligibility.

In spite of these two public insurance programs, a considerable and steadily growing part of the population has no health insurance. According to the survey *Health Insurance Coverage: Estimates from the National Health Interview Survey, January-September 2005,*[123] at the time of the survey, 18.8% of those between 18 and 64 were without health insurance as was 8.8% of those under 18. For those over 65, it was 0.9%. Between 1997 and 2005, for all ages, 14.1% to 15.4% of the population had no health insurance (about 45 million persons).

These figures also demonstrate the rift between the different strata of the population: for those of Hispanic origin, the rate of those without health insurance is over 30%; for those of African origin, it is 17%, for those of European origin, it is 10%.[124]

Currently, the system is under scathing attack within the country. According to an ABCNEWS/Washington Post survey[125] two out of three Americans would prefer a universal health care system to the present one based primarily on one's job. Thus, a large part of the population is dissatisfied with it. Up to 25% of Americans have at some time gone without prescribed medical treatment because of the price of medicine. For those without health insurance, the figure is 49%.

The system also came under severe attack in the report *The U.S. Health Care System: Best in the World or Just the Most Expensive?*[126] wherein it was shown that the price of the system (in terms of expense per person) was the highest in the world. "The United States is the only country in the developed world, with the exception of South Africa,[127] which does not provide medical care to all its

---

[121] Ibid.

[122] *Checkup on Health Insurance Choices*. AHCPR Publication No. 93-0018, December 1992. Agency for Health Care Policy and Research, Rockville, MD, http://www.ahrq.gov/consumer/insuranc.htm .

[123] R. Cohen and M. Martinez, *Health Insurance Coverage: Estimates from the National Health Interview Survey*, Jan.-Sept. 2005, http://www.cdc.gov/nchs/nhis.htm .

[124] Ibid.

[125] G. Langer, *Health Care Pains. Growing Health Care Concerns Fuel Cautious Support for Change,* 9 April 2006, www.abcnews.go.com .

[126] Bureau of Labor Education, University of Maine, Orono, Summer 2001.

[127] It is noteworthy that this country is no longer considered a developed country by the U.N.

citizens", concludes the report (and one can question the classification of South Africa as a "developed" country). The infant mortality rate is one of the highest of the OCED, and the country is at the bottom of the OCED list regarding cost in comparison to the individual's ability to pay.

2. Cuba

The Cuban constitution declares the equality of all citizens, who have each the same rights and duties in society. One of these rights is the right to medical care in all medical establishments (art. 43); article 50 is more detailed, as follows:

> *"Everyone has the right to health protection and care. The state guarantees this right; by providing free medical and hospital care by means of the installations of the rural medical service network, polyclinics, hospitals, preventative and specialized treatment centers; by providing free dental care; by promoting the health publicity campaigns, health education, regular medical examinations, general vaccinations and other measures to prevent the outbreak of disease. All the population cooperates in these activities and plans through the social and mass organizations."*[128]

Since the 1959 revolution, Cuban health policy has been based on five points: 1. access to medical care is everybody's right, and, in order to realize this right, medical care must be free and equipment dispersed throughout the country; 2. public health is the government's responsibility; 3. health care should be comprehensive – information, prevention and treatment of illness should form a whole; 4. the people and their grass roots organizations should be involved in setting up and running the public health system; 5. medical care concerns should always be integrated into socio-economic development.

Over the years, the organizing structures necessary for the realization of these principles have constantly evolved, depending on the greatest and most pressing needs.

The costs to the family includes out-patient medicine, hearing aids, orthopedic prostheses, wheel chairs, canes and crutches etc., eye glasses. Prices are low, subsidized by the government. Persons with low income receive government financial aid and products, including medicines and prostheses.

The public health system[129] comprises preventive medicine and rehabilitation; assistance to the elderly and to the physical and mentally handicapped; hygienic-epidemiological monitoring; training, specialization and continuing education of professionals coupled with an emphasis on the perfection of techniques and technology; medical science research and development; health promotion; non-medical supplies and system maintenance; technological, medical and electro-medical technology; production, distribution and marketing of medicines and medical equipment. Each of the system's units is backed by a corresponding support network.

---

[128] http://www.parlamentocubano.cu/espanol/const.ingles .

[129] Componentes del Sistema Nacional de Salud: www.cubaob.cu .

The high quality of the Cuban health care system is widely acknowledged, and the 11 million Cubans are generally in very good health. This was recognized by the WHO in 1998.[130] With a life expectancy and an infant mortality rate placing it among the developed countries of the world, Cuba has distinguished itself from other poor countries. C. Grégoire put it thus:

> *"It is said that the Cubans live like poor people but die like the rich, for the main causes of death are those that afflict people in developed countries, such as cardio-vascular illness and cancer."*[131]

3. Finland

The right to health is enshrined in article 19 of the Finnish constitution (Right to Social Security):

> *"Those who cannot obtain the means necessary for a life of dignity have the right to receive indispensable subsistence and care. Everyone shall be guaranteed by [legislative] Act the right to basic subsistence in the event of unemployment, illness and disability and during old age as well as at birth of a child or the loss of a provider. The public authorities shall guarantee for everyone, as provided in more detail by [legislative] Act, adequate social, health and medical services and promote the health of the population. Moreover, the public authorities shall support families and others responsible for providing for children so that they have the ability to ensure the well being and personal development of children."*[132]

The public health system is regulated by the Illness Insurance Law.[133] The Institute of Public Health is responsible for implementing and monitoring compliance with this law as well as overseeing the well being of all the permanent inhabitants of Finland. The insurance covers visits to the doctor and to the dentist, prescription medicines and travel expenses for the insured, including required medical care when the insured is out of the country. One compulsory requirement for this is that treatment must be prescribed by an certified doctor or dentist. Ordinarily the cost of visits to the doctor or dentist is reimbursed at 60%, supplementary tests at 75%, travel expenses at 100% (for the lowest priced means of travel), medicine at 50% but up to 100% for certain chronic illnesses. The insurance also covers the loss of income in case of long illness. The law establishes the framework without specifying the details.

Concretely, it is up to the local communities to organize the details of medical services, with the health care system decentralized among 448 municipalities. According to the law, the compulsory services are the following: preventive medical consultations (information and check-ups); medical service and social and professional rehabilitation (public health centers and emergency clinics);

[130] The Cuban president became the only head of state to receive the "Health for All" medal, for having realized in his country, since 1983, all the goals established by the WHO in 1988. See the WHO press release: WHA/5 of 14 May 1998.

[131] C. Grégoire, "La bonne santé des Cubains", *Alternatives*, 25 April 2005: www.alternatives.ca .

[132] Unofficial translation of the Justice Ministry: http://www.finlex.fi/pdf/saadkaan/E9990731.PDF#search=%22http%3A%2F%2Fwww.finlex.fi%2F%20site%3Awww.finlex.fi%20%22 .

[133] Sjukförsäkringslag 21.12.2004/1224.

transportation (ambulances); dental care (information, visits to the dentist and treatment); school health programs (regular medical check-ups for youth between 7 and 18 years of age) and university health programs (for universities and university-level schools, at reduced price); general check-ups for those considered to be at risk; work-related medicine (annual check-ups and prevention); protection of the environment and of health.[134] The law also determines the maximum waiting time for urgent medical care.

The public health system is primarily financed by the public sector. In 1999, 43% of its activities were financed by the municipalities, 18% by the central government, 15% by the FPA (public insurance agency) and 24% by the private sector.[135]

This public system is complemented by private services that are reimbursable at the same rates. The public system and the private system network (specialists, preventive services on the job etc.) are neither coordinated among themselves nor in competition but complement each other in such a way that it is not at all unusual for a person to use both. Many doctors work within both systems. Of all payments made in 2004, only 15.7% were for private services.[136]

However, the Finnish health care system is showing signs of wear, for it has not escaped neo-liberal economic pressures and pressures from the European Union. In fact, it has often been criticized in recent years for its long waiting lines at full hospitals where the personnel are overworked.[137] Some political parties have begun to advocate a privatization of the system, but they have yet to get any substantial support.

C. International obligations of various stake holders

The right to health in and of itself demonstrates to what extent it is indissociable from and interdependent on the other human rights and the necessity of concerted actions being taken by the international community. Although governments are the most concerned players, actions and orientations of the international organizations and institutions as well as those of the private sector play an ever more important role in the health care sector. And it is incumbent on civil society to monitor what these actors contribute to the realization of the right to health.

1. Governments

In spite of their manifest weakening in recent years, governments remain – as subjects of international law – the major actors in the realization of all human

[134] *Lagstadgade tjänster inom hälso- och sjukvården,* Social- och hälsovårdsministeriets broschyrer 2005:7swe, Helsingfors 2005.

[135] *Health Care Systems in Transition: Finland*, European Observatory on Health Care Systems, vol. 4, no. 1, 2002.

[136] *FPA-statistik : Sjukförsäkring 2004*, Kansaneläkelaitos, Tilastoryhmä, Helsinki 2005: www.fpa.fi/statistik .

[137] Holmberg, V., *Myten om privatiseringen,* Löntagaren, Årg. 32, No. 1/2002, www.lontagaren.fi .

rights, including the right to health. As is the case with other human rights, the right to health involves three basic obligations: it must be *respected*, *protected* and *implemented*.[138]

The obligation to *respect* prohibits governments from adopting discriminatory policies or measures, in particular with regard to the most needy and vulnerable. They must not, for example, deprive their populations of their means of subsistence, evict them arbitrarily from their lodgings or impede their access to medical care. In short, they must avoid any action detrimental to human health.

The obligation to *protect* requires that governments prevent a third party from interfering with the right to health, which means adopting appropriate laws guaranteeing the right to health. They must, for example, assure equality of access to medical care and insurance coverage, including those furnished by the private sector.

The obligation to *implement* means that, inter alia, "States must ensure provision of health care, including immunization programs 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."[139] In the same vein: "Further obligations include the provision of a public, private or mixed health insurance system which is affordable for all…"[140]

Lack of resources and international cooperation

In its *General Comment No. 14*, while acknowledging in paragraph 5 "the formidable structural and other obstacles resulting from international and other factors beyond the control of States", the Committee on Economic, Social and Cultural Rights goes on to note in paragraph 47 that "it is important to distinguish the inability from the unwillingness of a State party to comply with its obligations…" Accordingly, the paragraph continues, "If resource constraints render it impossible for a State to comply fully with its Covenant obligations, it has the burden of justifying that every effort has nevertheless been made to use all available resources at its disposal in order to satisfy, as a matter of priority, the obligations outlined above."

As for outside assistance in such cases, paragraph 45 states: "For the avoidance of any doubt, the Committee wishes to emphasize that it is particularly incumbent on States parties and other actors in a position to assist, to provide 'international assistance and cooperation, especially economic and technical' which enable developing countries to fulfill their core and other obligations…"

Collective actions by governments in favor of the right to health and the prohibition of embargos

The Committee, in paragraph 39 of the same *General Comment*, also reminds states parties to the *Covenant* that they must "respect the enjoyment of

[138] Paragraphs 33 to 37 of *General Comment No. 14*. See Annex 1.
[139] Par. 36 of *General Comment No. 14*. See Annex 1.
[140] Ibid.

the right to health in other countries, and to prevent third parties from violating the right in other countries". Further, in the same paragraph, it enjoins them to "facilitate access to essential health facilities, goods and services in other countries, wherever possible and provide the necessary aid when required". In a clarification of this, paragraph 41 states emphatically, "States parties should refrain at all times from imposing embargoes or similar measures restricting the supply of another State with adequate medicines and medical equipment. Restrictions on such goods should never be used as an instrument of political and economic pressure."

Failure by a government to fulfill its duty

The Committee continues the *General Comment* by listing the following elements, inter alia, that constitute a failure by a government to fulfill its duty:

> *"…the denial of access to health facilities, goods and services to particular individuals or groups as a result of de jure or de facto discrimination; … and the failure of the State to take into account its legal obligations regarding the right to health when entering into bilateral or multilateral agreements with other States, international organizations and other entities, such as multinational corporations" [paragraph 50].*
>
> *"… the failure to regulate the activities of individuals, groups or corporations so as to prevent them from violating the right to health of others; …the failure to protect consumers and workers from practices detrimental to health, e.g. by employers and manufacturers of medicines or food; …the failure to protect women against violence or to prosecute perpetrators" [paragraph 51].*
>
> *"…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" [paragraph 52].*

2. International organizations and institutions

As the world's highest instance for the setting international public health policy, the World Health Organization occupies a preponderant place among the international organizations, playing a major role in the promotion and realization of the right to health.

Founded on the ruins of the second World War, its goal is to preserve and promote public health throughout the world through international cooperation. This cooperation, according to the initiators, "is driven by the propagation of epidemic illnesses such as cholera, plague, yellow fever, and related to the extension of international relations and trade that had allowed the development of means of transport and communication".[141] As was the case with other specialized institutions of the United Nations system, a major factor was also the necessity of functional arrangements, ad hoc, of networks among nations, founded on common interests. This cooperation would contribute to the peaceful modification of international relations and the preservation of peace.[142]

[141] *Organisation mondiale de la santé*, Que sais-je ?, Presses universitaires de France, April 1997.
[142] *Ibid.*

Its main objective as stated in its constitution is "the attainment by all peoples of the highest possible level of health".[143] This document also affirms that "the health of all peoples is fundamental to the attainment of peace and security".[144]

Today, all U.N. member states are also WHO members, an asset for international cooperation and coordination. With some 8,000 public health specialists from all over the world, "WHO experts produce health guidelines and standards, and help countries to address public health issues."[145]

Further, the WHO "supports and promotes health research. Through WHO, governments can jointly tackle global health problems and improve people's well-being."[146] The WHO proudly claims, for example, the eradication of small pox in 1979 and the adoption in 2003 of the *Framework Convention for Tobacco Control* (see Illustration 2).

Although these accomplishments and the WHO's preponderant role are undeniable, one must also realize that the WHO "today is profoundly infiltrated by neo-liberal ideology".[147]

Among the other international organizations active in the area of health are UNICEF, working for children's right to health, the United Nations Office of the High Commissioner for Refugees (HCR), the International Federation of Red Cross and Red Crescent Societies and the International Committee for the Red Cross (ICRC). They all play a huge role in dealing with refugees and/or displaced persons in case of armed conflicts or natural disasters regardless of occasional inefficiency owing to a lack of funds or to political considerations.

The influence within the WHO acquired by the pharmaceutical industry since the 1980s and UNICEF's acceptance of partnerships with such transnational corporations as McDonald's and Coca-Cola[148] have undermined these organizations' credibility. They are not alone, however, for the entire U.N. system has been tainted by "partnerships" with transnational corporations, starting with the creation of the *Global Compact*.[149] From this comes the call from the United Nations Research Institute for Social Development to "rethink" the entire idea of "partnerships" between the U.N. and transnational corporations.[150]

The harmful role played by the international financial institutions (World Bank, IMF) in the degradation of public services has already been touched upon. In this regard, the Committee on Economic, Social and Cultural Rights states that:

> *"…States parties which are members of international financial institutions, notably the International Monetary Fund, the World Bank, and regional development banks, should pay greater attention to the protection of the right to*

[143] WHO constitution, art. 1: http://www.yale.edu/lawweb/avalon/decade/decad051.htm .
[144] WHO constitution, preamble: http://www.yale.edu/lawweb/avalon/decade/decad051.htm .
[145] *Working Together for Health*, WHO brochure, May 2006.
[146] Ibid.
[147] Article by Alison Katz in *ONU: droits pour tous ou loi du plus fort?*, éditions CETIM, Jan. 2005.
[148] See *Les obstacles à la santé pour tous*, éditions Centre Tricontinental et Syllepse, Aug. 2004.
[149] See the CETIM brochure on transnational corporations: http://www.cetim.ch/fr/publications_details.php?pid=130 .
[150] Ibid.

health in influencing the lending policies, credit agreements and international measures of these institutions".[151]

3. The private (business) sector

Driven essentially by profit and market solvency, the private/commercial sector currently has a profoundly harmful effect on the development of public health policies, as was noted in previous chapters. For this reason, the Committee on Economic, Social and Cultural Rights has been steadfast in reminding states parties of their duty:

> *"to ensure that privatization of the health sector does not constitute a threat to the availability, accessibility, acceptability and quality of health facilities, goods and services; to control the marketing of medical equipment and medicines by third parties; and to ensure that medical practitioners and other health professionals meet appropriate standards of education, skill and ethical codes of conduct".*[152]

4. Civil society

The horrible situation of health conditions and the many obstacles for getting access to medical care in so many countries have pushed civil society to organize in opposition to governments that are often inert and sometimes complicit in the pursuits of the commercial sector.

And, occasionally, civil society's mobilization has been crowned with success. For example, Salvadorian civil society supported a health workers' strike that lasted nine months (October 2002 to June 2003) in an effort to block a World Bank-inspired privatization of the health sector.[153] This victory is not definitive and requires constant vigilance by Salvadorian civil society as well as by social movements from other countries, for the World Bank is standing its ground on the matter.

It was also following a forceful mobilization of civil society, at both the national and international level, that 39 transnational corporations withdrew the complaint they had filed in Pretoria on 5 March 2001 against a South African law favoring the importing of generic medicines and price controls on them in the fight against HIV/AIDS.

The Uruguayans, incensed by the abusive privatization of their water supply, managed to have inscribed in the national constitution, by a referendum vote of 65%:

> *"Access to drinking water is a basic right the implementation of which cannot be guaranteed by private entities".*[154]

At the international level, many networks are active in the social arena, but the one with the greatest support seems to be the People's Health Movement

---

[151] *General Comment No. 14 (2000)*, paragraph 39, See Annex 1.
[152] *General Comment No. 14 (2000)*, par. 35. See Annex 1.
[153] http://www.agirici.org/HTML/PRESSE/ESPACE_DPRESSE_FICHE.php?IdCampagne=50&numero_fiche=3 .
[154] CETIM Bulletin No. 22 ; http://www.cetim.ch/en/documents/bul22eng.pdf .

(PHM). Based on the idea that "inequality, poverty, exploitation, violence and injustice are at the roots of ill health and the deaths of poor and marginalized people",[155] the PHM launched a campaign (at the end of 2005) for the right to health, challenging the commodification of health care and stressing the inalienable role of governments in public health systems.[156]

[155] Preamble, *People's Charter for Health*: http://www.phmovement.org/files/phm-pch-english.pdf .
[156] See the article by C. Schuftan and A. Shukla, to be included in the next CETIM book, dealing with the economic and political determinants of health.

CONCLUSION

As an interdependent right par excellence, the right to health requires concerted action for its realization, on both the national and the international level. This action should, as a priority, concentrate on the economic and political problems of health.

The right to health is the pillar of the right to development and to life. It is neither normal nor tolerable that a world that has enough resources and means should fail – after sixty years – to assure the "highest possible level of health" to all its inhabitants.

As already mentioned, well-being requires the satisfaction of basic needs, which, in turn, requires a just distribution of wealth. Governments, in keeping with their obligations to their citizens, should guarantee access to the means of satisfying such basic needs as food, water, adequate housing and essential medicines.

Given the many obstacles to the effective realization of the right to health, particularly the neo-liberal ideology that undermines most governments' health policies, it is once again up to civil society to mobilize to force governments to respect the right to health and honor their commitments. All those involved, at all levels, must mobilize for the implementation of the right to health, for, without health, there can be no healthy world and nothing is possible.

IV. ANNEXES

Annex 1

General Comment No. 14 (2000) on the right to health[157]

Adopted on 11 May 2000 by the Committee on Economic, Social and Cultural Rights

1. Health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity. The realization of the right to health may be pursued through numerous, complementary approaches, such as the formulation of health policies, or the implementation of health programmes developed by the World Health Organization (WHO), or the adoption of specific legal instruments. Moreover, the right to health includes certain components which are legally enforceable.

2. The human right to health is recognized in numerous international instruments. Article 25.1 of the Universal Declaration of Human Rights affirms: "Everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services". The International Covenant on Economic, Social and Cultural Rights provides the most comprehensive article on the right to health in international human rights law. In accordance with article 12.1 of the Covenant, States parties recognize "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health", while article 12.2 enumerates, by way of illustration, a number of "steps to be taken by the States parties ... to achieve the full realization of this right". Additionally, the right to health is recognized, inter alia, in article 5 (e) (iv) of the International Convention on the Elimination of All Forms of Racial Discrimination of 1965, in articles 11.1 (f) and 12 of the Convention on the Elimination of All Forms of Discrimination against Women of 1979 and in article 24 of the Convention on the Rights of the Child of 1989. Several regional human rights instruments also recognize the right to health, such as the European Social Charter of 1961 as revised (art. 11), the African Charter on Human and Peoples' Rights of 1981 (art. 16) and the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights of 1988 (art. 10). Similarly, the right to health has been proclaimed by the Commission on Human Rights, as well as in the Vienna Declaration and Programme of Action of 1993 and other international instruments.

3. The right to health is closely related to and dependent upon the realization of other human rights, as contained in the International Bill of Rights, including the rights to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information, and the freedoms of

[157] The full title is "The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights". For the sake of brevity, we have eliminated many of the notes. For the full text:
http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En?OpenDocument .

association, assembly and movement. These and other rights and freedoms address integral components of the right to health.

4. In drafting article 12 of the Covenant, the Third Committee of the United Nations General Assembly did not adopt the definition of health contained in the preamble to the Constitution of WHO, which conceptualizes health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". However, the reference in article 12.1 of the Covenant to "the highest attainable standard of physical and mental health" is not confined to the right to health care. On the contrary, the drafting history and the express wording of article 12.2 acknowledge that the right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment.

5. The Committee is aware that, for millions of people throughout the world, the full enjoyment of the right to health still remains a distant goal. Moreover, in many cases, especially for those living in poverty, this goal is becoming increasingly remote. The Committee recognizes the formidable structural and other obstacles resulting from international and other factors beyond the control of States that impede the full realization of article 12 in many States parties.

6. With a view to assisting States parties' implementation of the Covenant and the fulfilment of their reporting obligations, this general comment focuses on the normative content of article 12 (Part I), States parties' obligations (Part II), violations (Part III) and implementation at the national level (Part IV), while the obligations of actors other than States parties are addressed in Part V. The general comment is based on the Committee's experience in examining States parties' reports over many years.

1. Normative content of article 12

7. Article 12.1 provides a definition of the right to health, while article 12.2 enumerates illustrative, non-exhaustive examples of States parties' obligations.

8. The right to health is not to be understood as a right to be *healthy*. The right to health contains both freedoms and entitlements. The freedoms include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.

9. The notion of "the highest attainable standard of health" in article 12.1 takes into account both the individual's biological and socio-economic preconditions and a State's available resources. There are a number of aspects which cannot be addressed solely within the relationship between States and individuals; in particular, good health cannot be ensured by a State, nor can States provide protection against every possible cause of human ill health. Thus, genetic factors, individual susceptibility to ill health and the adoption of unhealthy or risky lifestyles may play an important role with respect to an individual's health. Consequently, the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health.

10. Since the adoption of the two International Covenants in 1966 the world health situation has changed dramatically and the notion of health has undergone substantial changes and has also widened in scope. More determinants of health are being taken

into consideration, such as resource distribution and gender differences. A wider definition of health also takes into account such socially-related concerns as violence and armed conflict. Moreover, formerly unknown diseases, such as human immunodeficiency virus and acquired immunodeficiency syndrome (HIV/AIDS), and others that have become more widespread, such as cancer, as well as the rapid growth of the world population, have created new obstacles for the realization of the right to health which need to be taken into account when interpreting article 12.

11. The Committee interprets the right to health, as defined in article 12.1, as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health. A further important aspect is the participation of the population in all health-related decision-making at the community, national and international levels.

12. The right to health in all its forms and at all levels contains the following interrelated and essential elements, the precise application of which will depend on the conditions prevailing in a particular State party:

(a) Availability. Functioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party. The precise nature of the facilities, goods and services will vary depending on numerous factors, including the State party's developmental level. They will include, however, the underlying determinants of health, such as safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs, as defined by the WHO Action Programme on Essential Drugs;

(***b) Accessibility.*** Health facilities, goods and serviceshave to be accessible to everyone without discrimination, within the jurisdiction of the State party. Accessibility has four overlapping dimensions:

Non-discrimination: health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds;

Physical accessibility: health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS. Accessibility also implies that medical services and underlying determinants of health, such as safe and potable water and adequate sanitation facilities, are within safe physical reach, including in rural areas. Accessibility further includes adequate access to buildings for persons with disabilities;

Economic accessibility (affordability): health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households;

Information accessibility: accessibility includes the right to seek, receive and impart information and ideas concerning health issues. However, accessibility of information should not impair the right to have personal health data treated with confidentiality;

*(c) **Acceptability.*** All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned;

(d) Quality. As well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires, inter alia, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.

13. The non-exhaustive catalogue of examples in article 12.2 provides guidance in defining the action to be taken by States. It gives specific generic examples of measures arising from the broad definition of the right to health contained in article 12.1, thereby illustrating the content of that right, as exemplified in the following paragraphs.

Article 12.2 (a): The right to maternal, child and reproductive health

14. "The provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child" (art. 12.2 (a)) may be understood as requiring measures to improve child and maternal health, sexual and reproductive health services, including access to family planning, pre- and post-natal care, emergency obstetric services and access to information, as well as to resources necessary to act on that information.[158]

Article 12.2 (b): The right to healthy natural and workplace environments

15. "The improvement of all aspects of environmental and industrial hygiene" (art. 12.2 (b)) comprises, inter alia, preventive measures in respect of occupational accidents and diseases; the requirement to ensure an adequate supply of safe and potable water and basic sanitation; the prevention and reduction of the population's exposure to harmful substances such as radiation and harmful chemicals or other detrimental environmental conditions that directly or indirectly impact upon human health. Furthermore, industrial hygiene refers to the minimization, so far as is reasonably practicable, of the causes of health hazards inherent in the working environment. Article 12.2 (b) also embraces adequate housing and safe and hygienic working conditions, an adequate supply of food and proper nutrition, and discourages the abuse of alcohol, and the use of tobacco, drugs and other harmful substances.

Article 12.2 (c): The right to prevention, treatment and control of diseases

16. "The prevention, treatment and control of epidemic, endemic, occupational and other diseases" (art. 12.2 (c)) requires the establishment of prevention and education programmes for behaviour-related health concerns such as sexually transmitted diseases, in particular HIV/AIDS, and those adversely affecting sexual and reproductive health, and the promotion of social determinants of good health, such as environmental safety, education, economic development and gender equity. The right to treatment includes the creation of a system of urgent medical care in cases of accidents, epidemics and similar health hazards, and the provision of disaster relief and humanitarian assistance in emergency situations. The control of diseases refers to States' individual and

---

[158] Reproductive health means that women and men have the freedom to decide if and when to reproduce and the right to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice as well as the right of access to appropriate health-care services that will, for example, enable women to go safely through pregnancy and childbirth.

joint efforts to, inter alia, make available relevant technologies, using and improving epidemiological surveillance and data collection on a disaggregated basis, the implementation or enhancement of immunization programmes and other strategies of infectious disease control.

Article 12.2 (d): The right to health facilities, goods and services

17. "The creation of conditions which would assure to all medical service and medical attention in the event of sickness" (art. 12.2 (d)), both physical and mental, includes the provision of equal and timely access to basic preventive, curative, rehabilitative health services and health education; regular screening programmes; appropriate treatment of prevalent diseases, illnesses, injuries and disabilities, preferably at community level; the provision of essential drugs; and appropriate mental health treatment and care. A further important aspect is the improvement and furtherance of participation of the population in the provision of preventive and curative health services, such as the organization of the health sector, the insurance system and, in particular, participation in political decisions relating to the right to health taken at both the community and national levels.

Article 12: Special topics of broad application

Non-discrimination and equal treatment

18. By virtue of article 2.2 and article 3, the Covenant proscribes any discrimination in access to health care and underlying determinants of health, as well as to means and entitlements for their procurement, on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health. The Committee stresses that many measures, such as most strategies and programmes designed to eliminate health-related discrimination, can be pursued with minimum resource implications through the adoption, modification or abrogation of legislation or the dissemination of information. The Committee recalls general comment No. 3, paragraph 12, which states that even in times of severe resource constraints, the vulnerable members of society must be protected by the adoption of relatively low-cost targeted programmes.

19. With respect to the right to health, equality of access to health care and health services has to be emphasized. States have a special obligation to provide those who do not have sufficient means with the necessary health insurance and health-care facilities, and to prevent any discrimination on internationally prohibited grounds in the provision of health care and health services, especially with respect to the core obligations of the right to health. Inappropriate health resource allocation can lead to discrimination that may not be overt. For example, investments should not disproportionately favour expensive curative health services which are often accessible only to a small, privileged fraction of the population, rather than primary and preventive health care benefiting a far larger part of the population.

Gender perspective

20. The Committee recommends that States integrate a gender perspective in their health-related policies, planning, programmes and research in order to promote better health for both women and men. A gender-based approach recognizes that biological and sociocultural factors play a significant role in influencing the health of men and women. The disaggregation of health and socio-economic data according to sex is essential for identifying and remedying inequalities in health.

Women and the right to health

21. To eliminate discrimination against women, there is a need to develop and implement a comprehensive national strategy for promoting women's right to health throughout their life span. Such a strategy should include interventions aimed at the prevention and treatment of diseases affecting women, as well as policies to provide access to a full range of high quality and affordable health care, including sexual and reproductive services. A major goal should be reducing women's health risks, particularly lowering rates of maternal mortality and protecting women from domestic violence. The realization of women's right to health requires the removal of all barriers interfering with access to health services, education and information, including in the area of sexual and reproductive health. It is also important to undertake preventive, promotive and remedial action to shield women from the impact of harmful traditional cultural practices and norms that deny them their full reproductive rights.

Children and adolescents

22. Article 12.2 (a) outlines the need to take measures to reduce infant mortality and promote the healthy development of infants and children. Subsequent international human rights instruments recognize that children and adolescents have the right to the enjoyment of the highest standard of health and access to facilities for the treatment of illness. The Convention on the Rights of the Child directs States to ensure access to essential health services for the child and his or her family, including pre- and post-natal care for mothers. The Convention links these goals with ensuring access to child-friendly information about preventive and health-promoting behaviour and support to families and communities in implementing these practices. Implementation of the principle of non-discrimination requires that girls, as well as boys, have equal access to adequate nutrition, safe environments, and physical as well as mental health services. There is a need to adopt effective and appropriate measures to abolish harmful traditional practices affecting the health of children, particularly girls, including early marriage, female genital mutilation, preferential feeding and care of male children. Children with disabilities should be given the opportunity to enjoy a fulfilling and decent life and to participate within their community.

23. States parties should provide a safe and supportive environment for adolescents, that ensures the opportunity to participate in decisions affecting their health, to build life skills, to acquire appropriate information, to receive counselling and to negotiate the health-behaviour choices they make. The realization of the right to health of adolescents is dependent on the development of youth-friendly health care, which respects confidentiality and privacy and includes appropriate sexual and reproductive health services.

24. In all policies and programmes aimed at guaranteeing the right to health of children and adolescents their best interests shall be a primary consideration.

Older persons

25. With regard to the realization of the right to health of older persons, the Committee, in accordance with paragraphs 34 and 35 of general comment No. 6 (1995), reaffirms the importance of an integrated approach, combining elements of preventive, curative and rehabilitative health treatment. Such measures should be based on periodical check-ups for both sexes; physical as well as psychological rehabilitative measures aimed at maintaining the functionality and autonomy of older persons; and attention and care for chronically and terminally ill persons, sparing them avoidable pain and enabling them to die with dignity.

Persons with disabilities

26. The Committee reaffirms paragraph 34 of its general comment No. 5, which addresses the issue of persons with disabilities in the context of the right to physical and mental health. Moreover, the Committee stresses the need to ensure that not only the public health sector but also private providers of health services and facilities comply with the principle of non-discrimination in relation to persons with disabilities.

Indigenous peoples

27. In the light of emerging international law and practice and the recent measures taken by States in relation to indigenous peoples, the Committee deems it useful to identify elements that would help to define indigenous peoples' right to health in order better to enable States with indigenous peoples to implement the provisions contained in article 12 of the Covenant. The Committee considers that indigenous peoples have the right to specific measures to improve their access to health services and care. These health services should be culturally appropriate, taking into account traditional preventive care, healing practices and medicines. States should provide resources for indigenous peoples to design, deliver and control such services so that they may enjoy the highest attainable standard of physical and mental health. The vital medicinal plants, animals and minerals necessary to the full enjoyment of health of indigenous peoples should also be protected. The Committee notes that, in indigenous communities, the health of the individual is often linked to the health of the society as a whole and has a collective dimension. In this respect, the Committee considers that development-related activities that lead to the displacement of indigenous peoples against their will from their traditional territories and environment, denying them their sources of nutrition and breaking their symbiotic relationship with their lands, has a deleterious effect on their health.

Limitations

28. Issues of public health are sometimes used by States as grounds for limiting the exercise of other fundamental rights. The Committee wishes to emphasize that the Covenant's limitation clause, article 4, is primarily intended to protect the rights of individuals rather than to permit the imposition of limitations by States. Consequently a State party which, for example, restricts the movement of, or incarcerates, persons with transmissible diseases such as HIV/AIDS, refuses to allow doctors to treat persons believed to be opposed to a Government, or fails to provide immunization against the community's major infectious diseases, on grounds such as national security or the preservation of public order, has the burden of justifying such serious measures in relation to each of the elements identified in article 4. Such restrictions must be in accordance with the law, including international human rights standards, compatible with the nature of the rights protected by the Covenant, in the interest of legitimate aims pursued, and strictly necessary for the promotion of the general welfare in a democratic society.

29. In line with article 5.1, such limitations must be proportional, i.e. the least restrictive alternative must be adopted where several types of limitations are available. Even where such limitations on grounds of protecting public health are basically permitted, they should be of limited duration and subject to review.

2. States parties' obligations

General legal obligations

30. While the Covenant provides for progressive realization and acknowledges the constraints due to the limits of available resources, it also imposes on States parties various obligations which are of immediate effect. States parties have immediate

obligations in relation to the right to health, such as the guarantee that the right will be exercised without discrimination of any kind (art. 2.2) and the obligation to take steps (art. 2.1) towards the full realization of article 12. Such steps must be deliberate, concrete and targeted towards the full realization of the right to health.

31. The progressive realization of the right to health over a period of time should not be interpreted as depriving States parties' obligations of all meaningful content. Rather, progressive realization means that States parties have a specific and continuing obligation to move as expeditiously and effectively as possible towards the full realization of article 12.

32. As with all other rights in the Covenant, there is a strong presumption that retrogressive measures taken in relation to the right to health are not permissible. If any deliberately retrogressive measures are taken, the State party has the burden of proving that they have been introduced after the most careful consideration of all alternatives and that they are duly justified by reference to the totality of the rights provided for in the Covenant in the context of the full use of the State party's maximum available resources.

33. The right to health, like all human rights, imposes three types or levels of obligations on States parties: the obligations to ***respect*, *protect*** and ***fulfil.*** In turn, the obligation to fulfil contains obligations to facilitate, provide and promote.[159] The obligation to ***respect*** requires States to refrain from interfering directly or indirectly with the enjoyment of the right to health. The obligation to ***protect*** requires States to take measures that prevent third parties from interfering with article 12 guarantees. Finally, the obligation to ***fulfil*** requires States to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health.

Specific legal obligations

34. In particular, States are under the obligation to ***respect*** the right to health by, inter alia, refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum-seekers and illegal immigrants, to preventive, curative and palliative health services; abstaining from enforcing discriminatory practices as a State policy; and abstaining from imposing discriminatory practices relating to women's health status and needs. Furthermore, obligations to respect include a State's obligation to refrain from prohibiting or impeding traditional preventive care, healing practices and medicines, from marketing unsafe drugs and from applying coercive medical treatments, unless on an exceptional basis for the treatment of mental illness or the prevention and control of communicable diseases. Such exceptional cases should be subject to specific and restrictive conditions, respecting best practices and applicable international standards, including the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care. In addition, States should refrain from limiting access to contraceptives and other means of maintaining sexual and reproductive health, from censoring, withholding or intentionally misrepresenting health-related information, including sexual education and information, as well as from preventing people's participation in health-related matters. States should also refrain from unlawfully polluting air, water and soil, e.g. through industrial waste from State-owned facilities, from using or testing nuclear, biological or chemical weapons if

[159] According to general comments Nos. 12 and 13, the obligation to fulfil incorporates an obligation to *facilitate* and an obligation to *provide*. In the present general comment, the obligation to fulfil also incorporates an obligation to *promote* because of the critical importance of health promotion in the work of WHO and elsewhere.

such testing results in the release of substances harmful to human health, and from limiting access to health services as a punitive measure, e.g. during armed conflicts in violation of international humanitarian law.

35. Obligations to ***protect*** include, inter alia, the duties of States to adopt legislation or to take other measures ensuring equal access to health care and health-related services provided by third parties; to ensure that privatization of the health sector does not constitute a threat to the availability, accessibility, acceptability and quality of health facilities, goods and services; to control the marketing of medical equipment and medicines by third parties; and to ensure that medical practitioners and other health professionals meet appropriate standards of education, skill and ethical codes of conduct. States are also obliged to ensure that harmful social or traditional practices do not interfere with access to pre- and post-natal care and family planning; to prevent third parties from coercing women to undergo traditional practices, e.g. female genital mutilation; and to take measures to protect all vulnerable or marginalized groups of society, in particular women, children, adolescents and older persons, in the light of gender-based expressions of violence. States should also ensure that third parties do not limit people's access to health-related information and services.

36. The obligation to ***fulfil*** requires States 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. 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 promotion and support of the establishment of institutions providing counselling and mental health services, with due regard to equitable distribution throughout the country. Further obligations include the provision of a public, private or mixed health insurance system which is affordable for all, the promotion of medical research and health education, as well as information campaigns, in particular with respect to HIV/AIDS, sexual and reproductive health, traditional practices, domestic violence, the abuse of alcohol and the use of cigarettes, drugs and other harmful substances. States are also required to adopt measures against environmental and occupational health hazards and against any other threat as demonstrated by epidemiological data. For this purpose they should formulate and implement national policies aimed at reducing and eliminating pollution of air, water and soil, including pollution by heavy metals such as lead from gasoline. Furthermore, States parties are required to formulate, implement and periodically review a coherent national policy to minimize the risk of occupational accidents and diseases, as well as to provide a coherent national policy on occupational safety and health services.[160]

[160] Elements of such a policy are the identification, determination, authorization and control of dangerous materials, equipment, substances, agents and work processes; the provision of health information to workers and the provision, if needed, of adequate protective clothing and equipment; the enforcement of laws and regulations through adequate inspection; the requirement of notification of occupational accidents and diseases, the conduct of inquiries into serious accidents and diseases, and the production of annual statistics; the protection of workers and

37. The obligation to ***fulfil (facilitate)*** requires States inter alia to take positive measures that enable and assist individuals and communities to enjoy the right to health. States parties are also obliged to ***fulfil (provide)*** a specific right contained in the Covenant when individuals or a group are unable, for reasons beyond their control, to realize that right themselves by the means at their disposal. The obligation to ***fulfil (promote)*** the right to health requires States to undertake actions that create, maintain and restore the health of the population. Such obligations include: (i) fostering recognition of factors favouring positive health results, e.g. research and provision of information; (ii) ensuring that health services are culturally appropriate and that health-care staff are trained to recognize and respond to the specific needs of vulnerable or marginalized groups; (iii) ensuring that the State meets its obligations in the dissemination of appropriate information relating to healthy lifestyles and nutrition, harmful traditional practices and the availability of services; (iv) supporting people in making informed choices about their health.

International obligations

38. In its general comment No. 3, the Committee drew attention to the obligation of all States parties to take steps, individually and through international assistance and cooperation, especially economic and technical, towards the full realization of the rights recognized in the Covenant, such as the right to health. In the spirit of Article 56 of the Charter of the United Nations, the specific provisions of the Covenant (arts. 12, 2.1, 22 and 23) and the Alma-Ata Declaration on primary health care, States parties should recognize the essential role of international cooperation and comply with their commitment to take joint and separate action to achieve the full realization of the right to health. In this regard, States parties are referred to the Alma-Ata Declaration which proclaims that the existing gross inequality in the health status of the people, particularly between developed and developing countries, as well as within countries, is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.

39. To comply with their international obligations in relation to article 12, States parties have to respect the enjoyment of the right to health in other countries, and to prevent third parties from violating the right in other countries, if they are able to influence these third parties by way of legal or political means, in accordance with the Charter of the United Nations and applicable international law. Depending on the availability of resources, States should facilitate access to essential health facilities, goods and services in other countries, wherever possible, and provide the necessary aid when required. States parties should ensure that the right to health is given due attention in international agreements and, to that end, should consider the development of further legal instruments. In relation to the conclusion of other international agreements, States parties should take steps to ensure that these instruments do not adversely impact upon the right to health. Similarly, States parties have an obligation to ensure that their actions as members of international organizations take due account of the right to health. Accordingly, States parties which are members of international financial institutions, notably the International Monetary Fund, the World Bank, and regional development banks, should pay greater attention to the protection of the right to health in influencing the lending policies, credit agreements and international measures of these institutions.

---

their representatives from disciplinary measures for actions properly taken by them in conformity with such a policy; and the provision of occupational health services with essentially preventive functions. See ILO Occupational Safety and Health Convention, 1981 (No. 155) and Occupational Health Services Convention, 1985 (No. 161).

40. States parties have a joint and individual responsibility, in accordance with the Charter of the United Nations and relevant resolutions of the United Nations General Assembly and of the World Health Assembly, to cooperate in providing disaster relief and humanitarian assistance in times of emergency, including assistance to refugees and internally displaced persons. Each State should contribute to this task to the maximum of its capacities. Priority in the provision of international medical aid, distribution and management of resources, such as safe and potable water, food and medical supplies, and financial aid should be given to the most vulnerable or marginalized groups of the population. Moreover, given that some diseases are easily transmissible beyond the frontiers of a State, the international community has a collective responsibility to address this problem. The economically developed States parties have a special responsibility and interest to assist the poorer developing States in this regard.

41. States parties should refrain at all times from imposing embargoes or similar measures restricting the supply of another State with adequate medicines and medical equipment. Restrictions on such goods should never be used as an instrument of political and economic pressure. In this regard, the Committee recalls its position, stated in general comment No. 8, on the relationship between economic sanctions and respect for economic, social and cultural rights.

42. While only States are parties to the Covenant and thus ultimately accountable for compliance with it, all members of society - individuals, including health professionals, families, local communities, intergovernmental and non-governmental organizations, civil society organizations, as well as the private business sector - have responsibilities regarding the realization of the right to health. States parties should therefore provide an environment which facilitates the discharge of these responsibilities.

Core obligations

43. In general comment No. 3, the Committee confirms that 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. Read in conjunction with more contemporary instruments, such as the Programme of Action of the International Conference on Population and Development, the Alma-Ata Declaration provides compelling guidance on the core obligations arising from article 12. Accordingly, in the Committee's view, these core obligations include at least the following obligations:

(a) To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups;

(b) To ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone;

(c) To ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water;

(d) To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs;

(e) To ensure equitable distribution of all health facilities, goods and services;

(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.

44. The Committee also confirms that the following are obligations of comparable priority:

(a) To ensure reproductive, maternal (prenatal as well as post-natal) and child health care;

(b) To provide immunization against the major infectious diseases occurring in the community;

(c) To take measures to prevent, treat and control epidemic and endemic diseases;

(d) To provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them;

(e) To provide appropriate training for health personnel, including education on health and human rights.

45. For the avoidance of any doubt, the Committee wishes to emphasize that it is particularly incumbent on States parties and other actors in a position to assist, to provide "international assistance and cooperation, especially economic and technical" which enable developing countries to fulfil their core and other obligations indicated in paragraphs 43 and 44 above.

3. Violations

46. When the normative content of article 12 (Part I) is applied to the obligations of States parties (Part II), a dynamic process is set in motion which facilitates identification of violations of the right to health. The following paragraphs provide illustrations of violations of article 12.

47. In determining which actions or omissions amount to a violation of the right to health, it is important to distinguish the inability from the unwillingness of a State party to comply with its obligations under article 12. This follows from article 12.1, which speaks of the highest attainable standard of health, as well as from article 2.1 of the Covenant, which obliges each State party to take the necessary steps to the maximum of its available resources. A State which is unwilling to use the maximum of its available resources for the realization of the right to health is in violation of its obligations under article 12. If resource constraints render it impossible for a State to comply fully with its Covenant obligations, it has the burden of justifying that every effort has nevertheless been made to use all available resources at its disposal in order to satisfy, as a matter of priority, the obligations outlined above. It should be stressed, however, that a State party cannot, under any circumstances whatsoever, justify its non-compliance with the core obligations set out in paragraph 43 above, which are non-derogable.

48. Violations of the right to health can occur through the direct action of States or other entities insufficiently regulated by States. The adoption of any retrogressive measures incompatible with the core obligations under the right to health, outlined in paragraph 43 above, constitutes a violation of the right to health. Violations through ***acts of commission*** include the formal repeal or suspension of legislation necessary for the continued enjoyment of the right to health or the adoption of legislation or policies which are manifestly incompatible with pre-existing domestic or international legal obligations in relation to the right to health.

49. Violations of the right to health can also occur through the omission or failure of States to take necessary measures arising from legal obligations. Violations through ***acts of omission*** include the failure to take appropriate steps towards the full realization of everyone's right to the enjoyment of the highest attainable standard of physical and mental health, the failure to have a national policy on occupational safety and health as well as occupational health services, and the failure to enforce relevant laws.

Violations of the obligation to respect

50. Violations of the obligation to respect are those State actions, policies or laws that contravene the standards set out in article 12 of the Covenant and are likely to result in bodily harm, unnecessary morbidity and preventable mortality. Examples include the denial of access to health facilities, goods and services to particular individuals or groups as a result of de jure or de facto discrimination; the deliberate withholding or misrepresentation of information vital to health protection or treatment; the suspension of legislation or the adoption of laws or policies that interfere with the enjoyment of any of the components of the right to health; and the failure of the State to take into account its legal obligations regarding the right to health when entering into bilateral or multilateral agreements with other States, international organizations and other entities, such as multinational corporations.

Violations of the obligation to protect

51. Violations of the obligation to protect follow from the failure of a State to take all necessary measures to safeguard persons within their jurisdiction from infringements of the right to health by third parties. This category includes such omissions as the failure to regulate the activities of individuals, groups or corporations so as to prevent them from violating the right to health of others; the failure to protect consumers and workers from practices detrimental to health, e.g. by employers and manufacturers of medicines or food; the failure to discourage production, marketing and consumption of tobacco, narcotics and other harmful substances; the failure to protect women against violence or to prosecute perpetrators; the failure to discourage the continued observance of harmful traditional medical or cultural practices; and the failure to enact or enforce laws to prevent the pollution of water, air and soil by extractive and manufacturing industries.

Violations of the obligation to fulfil

52. Violations of the obligation to fulfil 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.

4. Implementation at the national level

Framework legislation

53. The most appropriate feasible measures to implement the right to health will vary significantly from one State to another. Every State has a margin of discretion in assessing which measures are most suitable to meet its specific circumstances. The Covenant, however, clearly imposes a duty on each State to take whatever steps are necessary to ensure that everyone has access to health facilities, goods and services so that they can enjoy, as soon as possible, the highest attainable standard of physical and mental health. This requires the adoption of a national strategy to ensure to all the enjoyment of the right to health, based on human rights principles which define the objectives of that strategy, and the formulation of policies and corresponding right to health indicators and benchmarks. The national health strategy should also identify the resources available to attain defined objectives, as well as the most cost-effective way of using those resources.

54. The formulation and implementation of national health strategies and plans of action should respect, inter alia, the principles of non-discrimination and people's participation. In particular, the right of individuals and groups to participate in decision-making processes, which may affect their development, must be an integral component of any policy, programme or strategy developed to discharge governmental obligations under article 12. Promoting health must involve effective community action in setting priorities, making decisions, planning, implementing and evaluating strategies to achieve better health. Effective provision of health services can only be assured if people's participation is secured by States.

55. The national health strategy and plan of action should also be based on the principles of accountability, transparency and independence of the judiciary, since good governance is essential to the effective implementation of all human rights, including the realization of the right to health. In order to create a favourable climate for the realization of the right, States parties should take appropriate steps to ensure that the private business sector and civil society are aware of, and consider the importance of, the right to health in pursuing their activities.

56. States should consider adopting a framework law to operationalize their right to health national strategy. The framework law should establish national mechanisms for monitoring the implementation of national health strategies and plans of action. It should include provisions on the targets to be achieved and the time frame for their achievement; the means by which right to health benchmarks could be achieved; the intended collaboration with civil society, including health experts, the private sector and international organizations; institutional responsibility for the implementation of the right to health national strategy and plan of action; and possible recourse procedures. In monitoring progress towards the realization of the right to health, States parties should identify the factors and difficulties affecting implementation of their obligations.

Right to health indicators and benchmarks

57. National health strategies should identify appropriate right to health indicators and benchmarks. The indicators should be designed to monitor, at the national and international levels, the State party's obligations under article 12. States may obtain guidance on appropriate right to health indicators, which should address different aspects of the right to health, from the ongoing work of WHO and the United Nations Children's Fund (UNICEF) in this field. Right to health indicators require disaggregation on the prohibited grounds of discrimination.

58. Having identified appropriate right to health indicators, States parties are invited to set appropriate national benchmarks in relation to each indicator. During the periodic reporting procedure the Committee will engage in a process of scoping with the State party. Scoping involves the joint consideration by the State party and the Committee of the indicators and national benchmarks which will then provide the targets to be achieved during the next reporting period. In the following five years, the State party will use these national benchmarks to help monitor its implementation of article 12. Thereafter, in the subsequent reporting process, the State party and the Committee will consider whether or not the benchmarks have been achieved, and the reasons for any difficulties that may have been encountered.

Remedies and accountability

59. Any person or group victim of a violation of the right to health should have access to effective judicial or other appropriate remedies at both national and international levels. All victims of such violations should be entitled to adequate reparation, which may take the form of restitution, compensation, satisfaction or guarantees of non-repetition.

National ombudsmen, human rights commissions, consumer forums, patients' rights associations or similar institutions should address violations of the right to health.

60. The incorporation in the domestic legal order of international instruments recognizing the right to health can significantly enhance the scope and effectiveness of remedial measures and should be encouraged in all cases. Incorporation enables courts to adjudicate violations of the right to health, or at least its core obligations, by direct reference to the Covenant.

61. Judges and members of the legal profession should be encouraged by States parties to pay greater attention to violations of the right to health in the exercise of their functions.

62. States parties should respect, protect, facilitate and promote the work of human rights advocates and other members of civil society with a view to assisting vulnerable or marginalized groups in the realization of their right to health.

5. Obligations of actors other than States parties

63. The role of the United Nations agencies and programmes, and in particular the key function assigned to WHO in realizing the right to health at the international, regional and country levels, is of particular importance, as is the function of UNICEF in relation to the right to health of children. When formulating and implementing their right to health national strategies, States parties should avail themselves of technical assistance and cooperation of WHO. Further, when preparing their reports, States parties should utilize the extensive information and advisory services of WHO with regard to data collection, disaggregation, and the development of right to health indicators and benchmarks.

64. Moreover, coordinated efforts for the realization of the right to health should be maintained to enhance the interaction among all the actors concerned, including the various components of civil society. In conformity with articles 22 and 23 of the Covenant, WHO, the International Labour Organization, the United Nations Development Programme, UNICEF, the United Nations Population Fund, the World Bank, regional development banks, the International Monetary Fund, the World Trade Organization and other relevant bodies within the United Nations system, should cooperate effectively with States parties, building on their respective expertise, in relation to the implementation of the right to health at the national level, with due respect to their individual mandates. In particular, the international financial institutions, notably the World Bank and the International Monetary Fund, should pay greater attention to the protection of the right to health in their lending policies, credit agreements and structural adjustment programmes. When examining the reports of States parties and their ability to meet the obligations under article 12, the Committee will consider the effects of the assistance provided by all other actors. The adoption of a human rights-based approach by United Nations specialized agencies, programmes and bodies will greatly facilitate implementation of the right to health. In the course of its examination of States parties' reports, the Committee will also consider the role of health professional associations and other non-governmental organizations in relation to the States' obligations under article 12.

65. The role of WHO, the Office of the United Nations High Commissioner for Refugees, the International Committee of the Red Cross/Red Crescent and UNICEF, as well as non-governmental organizations and national medical associations, is of particular importance in relation to disaster relief and humanitarian assistance in times of emergencies, including assistance to refugees and internally displaced persons. Priority in the provision of international medical aid, distribution and management of resources, such as safe and potable water, food and medical supplies, and financial aid should be given to the most vulnerable or marginalized groups of the population.

Annex 2

Extracts from General Comment No. 17 on the Human Rights and intellectual property[161]

Adopted by Committee on Economic, Social and Cultural Rights, in November 2005

I. Introduction and basic premises

1. The right of everyone to benefit from the protection of the moral and material interests resulting from any scientific, literary or artistic production of which he or she is the author is a human right, which derives from the inherent dignity and worth of all persons. This fact distinguishes article 15, paragraph 1 (c), and other human rights from most legal entitlements recognized in intellectual property systems. Human rights are fundamental, inalienable and universal entitlements belonging to individuals and, under certain circumstances, groups of individuals and communities. Human rights are fundamental as they are inherent to the human person as such, whereas intellectual property rights are first and foremost means by which States seek to provide incentives for inventiveness and creativity, encourage the dissemination of creative and innovative productions, as well as the development of cultural identities, and preserve the integrity of scientific, literary and artistic productions for the benefit of society as a whole.

2. In contrast to human rights, intellectual property rights are generally of a temporary nature, and can be revoked, licensed or assigned to someone else. While under most intellectual property systems, intellectual property rights, often with the exception of moral rights, may be allocated, limited in time and scope, traded, amended and even forfeited, human rights are timeless expressions of fundamental entitlements of the human person. Whereas the human right to benefit from the protection of the moral and material interests resulting from one's scientific, literary and artistic productions safeguards the personal link between authors and their creations and between peoples, communities, or other groups and their collective cultural heritage, as well as their basic material interests which are necessary to enable authors to enjoy an adequate standard of living, intellectual property regimes primarily protect business and corporate interests and investments. Moreover, the scope of protection of the moral and material interests of the author provided for by article 15, paragraph 1 (c), does not necessarily coincide with what is referred to as intellectual property rights under national legislation or international agreements.[162]

---

[161] The full title is: The right of everyone to benefit from the protection of the moral and material interests resulting from any scientific, literary or artistic production of which he or she is the author (article 15, paragraph 1 (c), of the Covenant, E/C.12/GC/17): http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/b664b2b80ab80f77c125710e0034cded?Opendocument .

[162] Relevant international instruments include, inter alia, the Paris Convention for the Protection of Industrial Property, as last revised in 1967; the Berne Convention for the Protection of Literary and Artistic Works, as last revised in 1979; the International Convention for the Protection of Performers, Producers of Phonograms and Broadcasting Organizations (Rome Convention); the WIPO Copyright Treaty; the WIPO Performances and Phonograms Treaty (which, inter alia, provides international protection for performers of "expressions of folklore"), the Convention on Biological Diversity; the Universal Copyright Convention, as last revised in 1971; and the Agreement on Trade related Aspects of Intellectual Property Rights (TRIPS Agreement) of WTO.

3. It is therefore important not to equate intellectual property rights with the human right recognized in article 15, paragraph 1 (c). (…)

4. The right to benefit from the protection of the moral and material interests resulting from one's scientific, literary and artistic productions seeks to encourage the active contribution of creators to the arts and sciences and to the progress of society as a whole. As such, it is intrinsically linked to the other rights recognized in article 15 of the Covenant, i.e. the right to take part in cultural life (art. 15, para. 1 (a)), the right to enjoy the benefits of scientific progress and its applications (art. 15, para. 1 (b)), and the freedom indispensable for scientific research and creative activity (art. 15, para. 3). The relationship between these rights and article 15, paragraph 1 (c), is at the same time mutually reinforcing and reciprocally limitative. The limitations imposed on the right of authors to benefit from the protection of the moral and material interests resulting from their scientific, literary and artistic productions by virtue of these rights will partly be explored in this general comment, partly in separate general comments on article 15, paragraphs 1 (a) and (b) and 3, of the Covenant. As a material safeguard for the freedom of scientific research and creative activity, guaranteed under article 15, paragraph 3 and article 15, paragraph 1 (c), also has an economic dimension and is, therefore, closely linked to the rights to the opportunity to gain one's living by work which one freely chooses (art. 6, para. 1) and to adequate remuneration (art. 7 (a)), and to the human right to an adequate standard of living (art. 11, para. 1). Moreover, the realization of article 15, paragraph 1 (c), is dependent on the enjoyment of other human rights guaranteed in the International Bill of Human Rights and other international and regional instruments, such as the right to own property alone as well as in association with others[163], the freedom of expression including the freedom to seek, receive and impart information and ideas of all kinds, the right to the full development of the human personality, and rights of cultural participation, including cultural rights of specific groups. (…)

II. Normative content of article 15, paragraph 1 (c)

6. Article 15, paragraph 1, enumerates, in three paragraphs, three rights covering different aspects of cultural participation, including the right of everyone to benefit from the protection of the moral and material interests resulting from any scientific, literary or artistic production of which he or she is the author (art. 15, para. 1 (c)), without explicitly defining the content and scope of this right. Therefore, each of the elements of article 15, paragraph 1 (c), requires interpretation.

Elements of article 15, paragraph 1 (c)

"Author"

7. The Committee considers that only the "author", namely the creator, whether man or woman, individual or group of individuals, of scientific, literary or artistic productions, such as, inter alia, writers and artists, can be the beneficiary of the protection of article 15, paragraph 1 (c). This follows from the words "everyone", "he" and "author", which indicate that the drafters of that article seemed to have believed authors of scientific, literary or artistic productions to be natural persons, without at that time realizing that they could also be groups of individuals. Under the existing international

[163] See article 17 of the Universal Declaration of Human Rights; article 5 (d) (v) of the International Convention on the Elimination of All Forms of Racial Discrimination; article 1 of Protocol No. 1 to the Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention on Human Rights); article 21 of the American Convention on Human Rights; and article 4 of the African Charter on Human and Peoples' Rights (Banjul Charter).

treaty protection regimes, legal entities are included among the holders of intellectual property rights. However, as noted above, their entitlements, because of their different nature, are not protected at the level of human rights.

8. Although the wording of article 15, paragraph 1 (c), generally refers to the individual creator ("everyone", "he", "author"), the right to benefit from the protection of the moral and material interests resulting from one's scientific, literary or artistic productions can, under certain circumstances, also be enjoyed by groups of individuals or by communities.

"Any scientific, literary or artistic production"

9. The Committee considers that "any scientific, literary or artistic production", within the meaning of article 15, paragraph 1 (c), refers to creations of the human mind, that is to "scientific productions", such as scientific publications and innovations, including knowledge, innovations and practices of indigenous and local communities, and "literary and artistic productions", such as, inter alia, poems, novels, paintings, sculptures, musical compositions, theatrical and cinematographic works, performances and oral traditions.

"Benefit from the protection"

10. The Committee considers that article 15, paragraph 1 (c), recognizes the right of authors to benefit from some kind of protection of the moral and material interests resulting from their scientific, literary or artistic productions, without specifying the modalities of such protection. In order not to render this provision devoid of any meaning, the protection afforded needs to be effective in securing for authors the moral and material interests resulting from their productions. However, the protection under article 15, paragraph 1 (c), need not necessarily reflect the level and means of protection found in present copyright, patent and other intellectual property regimes, as long as the protection available is suited to secure for authors the moral and material interests resulting from their productions, as defined in paragraphs 12 to 16 below.

11. The Committee observes that, by recognizing the right of everyone to "benefit from the protection" of the moral and material interests resulting from one's scientific, literary or artistic productions, article 15, paragraph 1 (c), by no means prevents States parties from adopting higher protection standards in international treaties on the protection of the moral and material interests of authors or in their domestic laws, provided that these standards do not unjustifiably limit the enjoyment by others of their rights under the Covenant.

"Moral interests"

12. The protection of the "moral interests" of authors was one of the main concerns of the drafters of article 27, paragraph 2, of the Universal Declaration of Human Rights: "Authors of all artistic, literary, scientific works and inventors shall retain, in addition to just remuneration of their labour, a moral right on their work and/or discovery which shall not disappear, even after such a work shall have become the common property of mankind."[164] Their intention was to proclaim the intrinsically personal character of every creation of the human mind and the ensuing durable link between creators and their creations.

13. In line with the drafting history of article 27, paragraph 2, of the Universal Declaration of Human Rights and article 15, paragraph 1 (c), of the Covenant, the Committee considers that "moral interests" in article 15, paragraph 1 (c), include the right of

[164] Commission on Human Rights, second session, Report of the Working Group on the Declaration on Human Rights, E/CN.4/57, 10 December 1947, page 15.

authors to be recognized as the creators of their scientific, literary and artistic productions and to object to any distortion, mutilation or other modification of, or other derogatory action in relation to, such productions, which would be prejudicial to their honour and reputation. (…)

“Material interests”

15. The protection of “material interests” of authors in article 15, paragraph 1 (c), reflects the close linkage of this provision with the right to own property, as recognized in article 17 of the Universal Declaration of Human Rights and in regional human rights instruments, as well as with the right of any worker to adequate remuneration (art. 7 (a)). Unlike other human rights, the material interests of authors are not directly linked to the personality of the creator, but contribute to the enjoyment of the right to an adequate standard of living (art. 11, para. 1).

16. The term of protection of material interests under article 15, paragraph 1 (c), need not extend over the entire lifespan of an author. Rather, the purpose of enabling authors to enjoy an adequate standard of living can also be achieved through one time payments or by vesting an author, for a limited period of time, with the exclusive right to exploit his scientific, literary or artistic production.

“Resulting”

17. The word “resulting” stresses that authors only benefit from the protection of such moral and material interests which are directly generated by their scientific, literary or artistic productions. (…)

III. States Parties obligations

General legal obligations

(…)

28. The right of everyone to benefit from the protection of the moral and material benefits resulting from any scientific, literary or artistic production of which he or she is the author, like all human rights, imposes three types or levels of obligations on States parties: the obligations to respect, protect and fulfil. (…)

Specific legal obligations

30. States parties are under an obligation to respect the human right to benefit from the protection of the moral and material interests of authors by, inter alia, abstaining from infringing the right of authors to be recognized as the creators of their scientific, literary or artistic productions and to object to any distortion, mutilation or other modification of, or other derogatory action in relation to, their productions that would be prejudicial to their honour or reputation. States parties must abstain from unjustifiably interfering with the material interests of authors, which are necessary to enable those authors to enjoy an adequate standard of living.

31. Obligations to protect include the duty of States parties to ensure the effective protection of the moral and material interests of authors against infringement by third parties. In particular, States parties must prevent third parties from infringing the right of authors to claim authorship of their scientific, literary or artistic productions, and from distorting, mutilating or otherwise modifying, or taking any derogatory action in relation to such productions in a manner that would be prejudicial to the author’s honour or reputation. Similarly, States parties are obliged to prevent third parties from infringing the material interests of authors resulting from their productions. To that effect, States parties must prevent the unauthorized use of scientific, literary and artistic productions that are easily accessible or reproducible through modern communication and reproduction technologies, e.g. by establishing systems of collective administration

of authors' rights or by adopting legislation requiring users to inform authors of any use made of their productions and to remunerate them adequately. States parties must ensure that third parties adequately compensate authors for any unreasonable prejudice suffered as a consequence of the unauthorized use of their productions.

32. With regard to the right to benefit from the protection of the moral and material interests resulting from any scientific, literary or artistic production of indigenous peoples, States parties should adopt measures to ensure the effective protection of the interests of indigenous peoples relating to their productions, which are often expressions of their cultural heritage and traditional knowledge. In adopting measures to protect scientific, literary and artistic productions of indigenous peoples, States parties should take into account their preferences. Such protection might include the adoption of measures to recognize, register and protect the individual or collective authorship of indigenous peoples under national intellectual property rights regimes and should prevent the unauthorized use of scientific, literary and artistic productions of indigenous peoples by third parties. In implementing these protection measures, States parties should respect the principle of free, prior and informed consent of the indigenous authors concerned and the oral or other customary forms of transmission of scientific, literary or artistic production; where appropriate, they should provide for the collective administration by indigenous peoples of the benefits derived from their productions.

33. States parties in which ethnic, religious or linguistic minorities exist are under an obligation to protect the moral and material interests of authors belonging to these minorities through special measures to preserve the distinctive character of minority cultures.[165]

34. The obligation to fulfil (provide) requires States parties to provide administrative, judicial or other appropriate remedies in order to enable authors to claim the moral and material interests resulting from their scientific, literary or artistic productions and to seek and obtain effective redress in cases of violation of these interests. States parties are also required to fulfil (facilitate) the right in article 15, paragraph 1 (c), e.g. by taking financial and other positive measures which facilitate the formation of professional and other associations representing the moral and material interests of authors, including disadvantaged and marginalized authors, in line with article 8, paragraph 1 (a), of the Covenant. The obligation to fulfil (promote) requires States parties to ensure the right of authors of scientific, literary and artistic productions to take part in the conduct of public affairs and in any significant decision making processes that have an impact on their rights and legitimate interests, and to consult these individuals or groups or their elected representatives prior to the adoption of any significant decisions affecting their rights under article 15, paragraph 1 (c).

Related obligations

35. The right of authors to benefit from the protection of the moral and material interests resulting from their scientific, literary and artistic productions cannot be isolated from the other rights recognized in the Covenant. States parties are therefore obliged to strike an adequate balance between their obligations under article 15, paragraph 1 (c), on one hand, and under the other provisions of the Covenant, on the other hand, with a view to promoting and protecting the full range of rights guaranteed in the Covenant. In striking this balance, the private interests of authors should not be unduly favoured and

---

[165] See article 15, paragraph 1 (c), of the Covenant, read in conjunction with article 27 of the International Covenant on Civil and Political Rights. See also UNESCO, General Conference, nineteenth session, Recommendation on Participation by the People at Large in Cultural Life and Their Contribution to It, adopted on 26 November 1976, at paragraph I (2) (f).

the public interest in enjoying broad access to their productions should be given due consideration. States parties should therefore ensure that their legal or other regimes for the protection of the moral and material interests resulting from one's scientific, literary or artistic productions constitute no impediment to their ability to comply with their core obligations in relation to the rights to food, health and education, as well as to take part in cultural life and to enjoy the benefits of scientific progress and its applications, or any other right enshrined in the Covenant. Ultimately, intellectual property is a social product and has a social function. States parties thus have a duty to prevent unreasonably high costs for access to essential medicines, plant seeds or other means of food production, or for schoolbooks and learning materials, from undermining the rights of large segments of the population to health, food and education. Moreover, States parties should prevent the use of scientific and technical progress for purposes contrary to human rights and dignity, including the rights to life, health and privacy, e.g. by excluding inventions from patentability whenever their commercialization would jeopardize the full realization of these rights.[166] States parties should, in particular, consider to what extent the patenting of the human body and its parts would affect their obligations under the Covenant or under other relevant international human rights instruments.[167] States parties should also consider undertaking human rights impact assessments prior to the adoption and after a period of implementation of legislation for the protection of the moral and material interests resulting from one's scientific, literary or artistic productions. (…)

VI. Obligations of actors other than States Parties

55. While only States parties to the Covenant are held accountable for compliance with its provisions, they are nevertheless urged to consider regulating the responsibility resting on the private business sector, private research institutions and other non State actors to respect the rights recognized in article 15, paragraph 1 (c), of the Covenant.

56. The Committee notes that, as members of international organizations such as WIPO, UNESCO, the Food and Agriculture Organization of the United Nations (FAO), the World Health Organization (WHO), and the World Trade Organization (WTO), States parties have an obligation to take whatever measures they can to ensure that the policies and decisions of those organizations are in conformity with their obligations under the Covenant, in particular the obligations contained in articles 2, paragraph 1, 15, paragraph 4, 22 and 23 concerning international assistance and cooperation.

57. United Nations organs, as well as specialized agencies, should, within their fields of competence and in accordance with articles 22 and 23 of the Covenant, take international measures likely to contribute to the effective implementation of article 15, paragraph 1 (c). In particular, WIPO, UNESCO, FAO, WHO and other relevant agencies, organs and mechanisms of the United Nations are called upon to intensify their efforts to take into account human rights principles and obligations in their work concerning the protection of the moral and material benefits resulting from one's scientific, literary and artistic productions, in cooperation with the Office of the High Commissioner for Human Rights.

[166] Cf. article 27, paragraph 2, of the WTO TRIPS Agreement.

[167] See article 4 of the UNESCO Universal Declaration on the Human Genome and Human Rights, although this instrument is not as such legally binding.

Annex 3

Declaration of Alma-Ata[168]

Adopted by WTO Member States, 12th September 1978

The International Conference on Primary Health Care, meeting in Alma-Ata this twelfth day of September in the year Nineteen hundred and seventy-eight, expressing the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world, hereby makes the following Declaration**:**

I. The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

II. The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.

III. Economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace.

IV. The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.

V. Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.

VI. Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of selfreliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

VII. Primary health care:

1. reflects and evolves from the economic conditions and sociocultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience;

[168] Cf. http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf .

2. addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;

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

4. involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors;

5. requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate;

6. should be sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need;

7. relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

VIII. All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors. To this end, it will be necessary to exercise political will, to mobilize the country's resources and to use available external resources rationally.

IX. All countries should cooperate in a spirit of partnership and service to ensure primary health care for all people since the attainment of health by people in any one country directly concerns and benefits every other country. In this context the joint WHO/UNICEF report on primary health care constitutes a solid basis for the further development and operation of primary health care throughout the world.

X. An acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of independence, peace, détente and disarmament could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part, should be allotted its proper share. The International Conference on Primary Health Care calls for urgent and effective national and international action to develop and implement primary health care throughout the world and particularly in developing countries in a spirit of technical cooperation and in keeping with a New International Economic Order. It urges governments, WHO and UNICEF, and other international organizations, as well as multilateral and bilateral agencies, nongovernmental organizations, funding agencies, all health workers and the whole world community to support national and international commitment to primary health care and to channel increased technical and financial support to it, particularly in developing countries. The Conference calls on all the aforementioned to collaborate in introducing, developing and maintaining primary health care in accordance with the spirit and content of this Declaration.

Annex 4

Main reference websites and instances to which one may recur

MAIN REFERENCE WEBSITES

World Health Organization: www.who.int
Office of the High Commissionner for Human Rights: www.ohchr.org
Inter-American Commission on Human Rights: www.cidh.oas.org
African Union: www.africa-union.org
African Commission on Human and People's Rights: www.achpr.org
Council of Europe: www.coe.int
European Union: http://europa.eu.int
United Nations Children's Fund (Unicef): www.unicef.org
United Nations Program on HIV/AIDS: www.unaids.org
United Nations Environment Program: www.unep.org
People's Health Movement: www.phmovement.org
International Baby Food Action Network: www.ibfan.org
Corporate Accountability International (formerly "Infact"): www.stopcorporateabuse.org
Medact: www.medact.org
Global Health Watch: www.ghwatch.org
Global Equity Gauge Alliance: www.gega.org.za
Centro de estudios y asesoria en salud: www.ceas.med.ec
Médecins sans frontières (Doctors Without Borders): www.msf.org
Médecins du monde: www.medecinsdumonde.org

INSTANCES TO WHICH ONE MAY RECUR

At the international level

Committee on Economic, Social and Cultural Rights, CESCR (to request information)
Office of the High Commissioner for Human Rights
Mr. Alexandre Tikhonov, Secretary
Avenue de la Paix 8-14, CH-1211 Geneva 10, Switzerland
Tel.: + 41 (0)22 917-93-21 Fax: +41 (0)22 917-90-46/22
E-mail: atikhonov@ohchr.org

Committee on the Elimination of Discrimination Against Women, CEDAW (to file complaints and request information)
United Nations
2 UN Plaza, DC2-12th Floor, New York, NY, 10017, USA
Fax: + 1 212 963-3463
E-mail: daw@un.org Web: http://www.un.org/womenwatch/daw

Committee on the Elimination of Racial Discrimination, CERD (to file complaints and request information)
Office of the High Commissioner for Human Rights
avenue de la Paix 8-14, CH-1211 Geneva 10, Switzerland
Fax: + 41 (0)22 917-90-22
E-mail: nprouvez@ohchr.org

Committee on the Rights of the Child, CRC (to request information)
Office of the High Commissioner for Human Rights
avenue de la Paix 8-14, CH-1211 Geneva 10, Switzerland
Fax: + 41 (0)22 917-90-22. E-mail: pdavid@ohchr.org

Committee on Migrant Workers, CMW (to request information at the moment)
Office of the High Commissioner for Human Rights
avenue de la Paix 8-14, CH-1211 Geneva 10, Switzerland
Fax : + 41 (0)22 917-90-22
E-mail : cedelenbos@ohchr.org

Human Rights Committee, HRC (to file complaints and request information)
Office of the High Commissioner for Human Rights
avenue de la Paix 8-14, CH-1211 Geneva 10, Switzerland
Fax: + 41 (0)22 917-90-22
Mr. Paul Hunt, Special Rapporteur of the Human Rights Council on the right to health (to file complaints and request information)
Office of the High Commissioner for Human Rights
avenue de la Paix 8-14, CH-1211 Geneva 10, Switzerland
Fax: + 41 (0)22 917-90-06
E-mail: urgent-action@ohchr.org

At the regional level
Secretariat of the African Commission on Human and People's Rights (to file complaints and request information)
avenue Kairaba, P.O. Box 673, Banjul, Gambia
Tel.: + 220 439-2962 Fax: + 220 439-0764
E-mail: achpr@achpr.org

Inter-American Commission on Human Rights (to file complaints and request information)
Organization of American States
1889 F Street, N.W., Washington, D.C. 20006, USA
Fax: + 1 202 458-3992
E-mail: cidhoea@oas.org

European Committee of Social Rights (to file collective complaints and request information)
Secretariat of the European Social Charter
Directorate General of Human Rights – DGII
F-67075 Strasbourg Cedex, France
Tel.: + 33 (0)3-88-41-32-58 Fax: + 33 (0)3-88-41-37-00
E-mail: social.charter@coe.int Web: http://www.coe.int/

PHM PRESENTATION

The People´s Health Movement (PHM) has its roots deep in the grassroots people's movement and owes its genesis to many health networks and activists who have been concerned by the growing inequities in health over the last 25 years. The PHM calls for a revitalisation of the principles of the Alma-Ata Declaration which promised Health for All by the year 2000 and complete revision of international and domestic policy that has shown to impact negatively on health status and systems.

People's Health Movement can be contacted through the global secretariat.

Mailing address:
People's Health Movement Secretariat (Global)
C/O AHED, # 17, Beirut St. Apt. 3/501
Heliopolis, Cairo, Egypt
More on the website : http://www.phmovement.org