RIGHT TO HEALTH AS A HUMAN RIGHT UNDER INTERNATIONAL LAW

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CERTIFICATE

This is to certify that **Prachi Jain** has completed her dissertation titled **"Right to Health as a Human Right under International Law"** under my supervision for the award of degree of Master of Laws (One Year Degree LL.M. Programme). To the best of my knowledge this dissertation is the result of her own learning and research.

I wish her all success in her future endeavours.

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DECLARATION

I, **Prachi Jain,** pursing Master of Laws, from National law University and Judicial Academy, Assam do hereby declare that the Dissertation titled "**Right to Health as a Human Right under International Law**" is an original work of research and has not been submitted either in part or full anywhere else for any purpose Academic or otherwise to the best of my knowledge.

Date 17 August, 2019 **Prachi Jain**

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ABBREVIATIONS

AIDS – Acquired immune deficiency syndrome

CAT – Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

CEDAW – Convention on the Elimination of All Forms of Discrimination Against Women

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

ICESCR – Committee on Economic Social and Cultural Rights

CRC – Convention on the Rights of the Child

ECOSOC – Economic and Social Council

ESC – Economic, Social and Cultural Rights

EU – European Union

FCGH – Framework Convention on Global Health

FGM – Female Genital Mutilation

HIV – Human Immunodeficiency Virus

IACHR – Inter-American Commission on Human Rights

ICCPR – International Covenant on Civil and Political Rights

ICESCR – International Covenant on Economic, Social and Cultural Rights

ILO – International Labour Organization

LGBTI – Lesbian, Gay, Bisexual, Transgender & Intersex

MDG – Minimum Development Goals

NCD – Non-Communicable Disease

NGO – Non Governmental Organization

OHCHR – United Nations Office of the High Commissioner for Human Rights

PHC – Primary Health Care

PMTCT – Prevention of mother-to-child transmission

TB – Tuberculosis

UDHR – Universal Declaration of Human Rights

UN – United Nations

UNDP – United Nations Development Programme

UNICEF – United Nations Children's Fund

WCHR – World Conference on Human Rights

WHA – World Health Assembly

WHO – World Health Organization

CHAPTER I

INTRODUCTION

The WHO Constitution (1946) envisages "…the highest attainable standard of health as a fundamental right of every human being."[1] The Preamble further states that "The enjoyment of the highest acceptable quality of health is one of every human being's fundamental rights, irrespective of race, ethnicity, and political ideology, economic or social status."[2]

As people, our wellbeing and those we care for are a problem which is of regular concern. No matter our age, class, socio-economic and ethnic history, we consider our most fundamental and important asset, health. On the other hand, ill health can prevent us from moving from school to work, from taking care of our family responsibilities or from participating fully in our community activities. In the same way, we are willing to make several sacrifices if that alone will guarantee us a happier and safer life for our families. In short, when we are thinking about well-being, what we often have in mind is health. The 1948 Universal Declaration of Human Rights[3] also mentioned health as part of the right to an adequate standard of living. The right to health was again recognized as a human right in the 1966 International Covenant on Economic, Social and Cultural Rights.

Many international human rights treaties have since then recognized the right to health, or aspects thereof, such as the right to medical care. The right to health extends to all States: every State has at least one international human rights treaty ratified which recognizes the right to Health. States have also committed to protecting this by international declarations, domestic laws and policies, and at conferences around the world.

Instances of human suffering are heard regularly, and the health problem is one of these. Apart from death, ill health is another serious form of suffering which have adverse

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[1] Constitution of the World Health Organization, American Journal of Public Health 36, no. 11 (November 1, 1946)

[2] Ibid

[3] UN General Assembly. (1948). *Universal declaration of human rights* (217 [III] A). Paris.

effects on those who still live. And in today's economic times Health is one of the most prominent challenges facing the international community commonwealth.

There are different terminologies used such as ‘right to health’, ‘right to health care’ and ‘right to health protection’. The European Social Charter[4] under Article 11 mentions the ‘right to protection of health’. The right to health protection is linked to many other human rights such as the right to food, shelter, a healthy environment and access to health information.

Currently definition of health has been expanded to include a “socially and economically productive life”. Health treatment is thus an essential condition for an individual's well-being as it gives him the freedom to carry out certain tasks. This may also be expressed as offering facilities available to treat illnesses and promote health.

Health rights are a fundamental part of our human rights and are important for leading a dignified life. It implies all have the right to the greatest achievable physical and mental health requirements which also include the access to all medical facilities, sufficient food, accommodation, sanitization, health care, working conditions and clean surrounding.

RESEARCH FRAMEWORK

1. AIMS AND OBJECTIVES -

This Dissertation aims to shed light on the right to health in international human rights law as it currently stands, amidst the plethora of initiatives and proposals as to what the right to health may or should be. The dissertation also aims to provide more transparency to right to health of individuals and the nature of obligations of States to realize the right to health .

2. RESEARCH PROBLEM -

The human right of Right to health was first recognised in the 1946 World Health Organization (WHO) constitution preamble. Since then it has been enshrined in many key international and regional human rights treaties. Consequently, this places an duty on State parties to take every effort to use the resources available to support, defend, fulfill and promote their citizens' right to health. Also after so many years,

[4] Council of Europe, European Social Charter (Revised), 3 May 1996, ETS 163, available at: https://www.refworld.org/docid/3ae6b3678.html (Accessed on 17 May, 2020)

understanding of the nature of States' rights and responsibilities in enforcing the right to health remains difficult.

3. RESEARCH QUESTIONS -

(i) What is the extent and scope of the right to health under international human rights law framework?

(ii) What is the role of WHO in the promotion and enforcement of the right to health?

(iii) What is the nature and scope of obligations of the State?

(iv) What are the current issues and challenges to the realization of the right to health and to address them?

4. HYPOTHESIS

The lack of legislations at both international and national level is one of the main factors for the difficulty in comprehending the scope of rights of individuals and obligations of the States in implementing the right to health.

5. METHODOLOGY

The researcher has adopted a doctrinal and analytical research methodology.

6. CHAPTER SUMMARY

The dissertation comprises of six chapters.

Chapter I. Introduction

The first chapter deals with the background to the issue. This accounts for the significance and reach of the right to health. under international law

Chapter II. Right To Health Under International And Regional Human Rights Intruments

The second chapter notes the instruments of international and regional human rights by which the right to health has been recognised as a human right.

Chapter III. International Covenant on the Economic, Social and Cultural Rights (ICESCR) and the Right to Health

The third chapter analyzes the ICESCR regulations relating to the Right to health. It explains UN ICESCR's role in providing guidance to the right to health, and in particular the substance of the General Statement 14.

Chapter IV. Role of WHO in the Promotion and Enforcement of the Right to Health

The fourth chapter deals with WHO's role in supporting and upholding the right to health. It addresses the Alma Ata Declaration, the Ottawa Health Promotion Charter and the Millennium Development Goals (MDGs).

Chapter V. Nature and Scope of State Obligations to the Right to Health

In the light of the findings found in ICESCR General Comment 14, the fifth chapter further elaborates on the fundamental components of State commitments to the realization of the right to health.

Chapter VI. Issues and Challenges to the Realization of the Right to Health

The sixth chapter discusses the current problems and obstacles related to understanding the right to health around the world. It analyzes the ICESCR Optional Protocol, underlining its significance for the recognition of the right to health.

Chapter VII. Conclusion

7. MODE OF CITATION

The researcher has used a uniform mode of citation.

CHAPTER II
RIGHT TO HEALTH UNDER INTERNATIONAL AND REGIONAL HUMAN RIGHTS INSTRUMENTS

INTERNATIONAL INSTRUMENTS

1. Universal Declaration of Human Rights(1948)

The declaration puts forth a framework on how to recognize the right to good health. Article 25 states that, "*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.*"

The following documents support the idea of Article 25. These documents recognize especially vulnerable communities when it comes to the right to good health. Therefore, the documents express the wishes of all people around the world.

2. International Convention on the Elimination of All Forms of Racial Discrimination(1966)

The Convention affirmed the fundamental right to good health, and prohibited race-based deprivation of the right.

Article 5 states that, in the enjoyment of the right to good health , medical care, social security and social services, States parties shall prohibit and abolish racial discrimination in all its forms.

3. International Covenant on Economic, Social and Cultural Rights (1966)

The Convention guarantees all employees the right to health careand safety, as well as security of jobs during maternity leave. Article 7 recognizes everyone's

right to enjoy fair and favourable working conditions which guarantee safe and healthy working conditions. Article 10 specifies that mothers should be given special care for a fair time before and after childbirth. This also notes the need to shield children and young people from economic and social abuse.

The ICESCR provides the most detailed clause under Article 12 on the right to health under international human rights law. This respects everyone's right to enjoy the highest attainable physical and mental health levels. Article 12(b) sets out four steps which the State will take to promote the conditions in which people can lead a safe life. Accordingly, Article 12 acknowledges that the right to health requires a wide variety of socio-economic factors that underlie health determinants, such as food, housing, potable water, safe and stable working conditions, and a stable climate.

4. Declaration on the Rights of Mentally Retarded Persons (1971)

This Convention directs that the mentally retarded persons be given proper care. It also stipulates that mentally disabled people should get assistance that would allow them to reach their full human potential. The Declaration stipulates, “The mentally retarded person has a right to proper medical care and physical therapy and to such education, training, rehabilitation and guidance as will enable him to develop his ability and maximum potential.

5. **Universal Declaration on the Eradication of Hunger and Malnutrition (1974)**

This declaration states that all men have the right to nutrition and sustenance to ensure their well-being. Everyone have the inalienable right to be free from hunger and malnutrition to fully grow and sustain their physical and mental capacity. This also notes that governments have a fundamental duty to work together for higher food production and a fairer and more effective distribution of food between countries and within countries. A greater concerted assault on chronic malnutrition and deficiency diseases among poor and lower income groups should be launched by governments immediately. All States should aim to readjust their agricultural policies to give priority to food production, where possible, realizing in this connection the interrelationship between the world food issue and international trade.

6. **Declaration on the Rights of Disabled Persons (1975)**

This declaration stipulates that people with disabilities have the right to medical , psychological and practical care, including prothetic and orthotic devices, medical and social rehabilitation, education,vocational training and rehabilitation, support, counselling, placement services and other resources that will allow them to improve their skills and abilities to the fullest and to the fullest. This provides for the right of disabled people to seek the treatment that they need.

7. **Convention on the Elimination of All Forms of Discrimination against Women(1979)**

Article 10 of the Convention specifies that States Parties shall take effective steps to eradicate discrimination against women by providing access to relevant educational information to help ensure family health and well-being, including family planning information and advice.

Article 11 stipulates that women shall have the right to health care and safety in working environments, including the safeguarding of the reproductive system. It also states that during pregnancy, State parties shall provide special protection to women in the types of work that have proven harmful to them.

Article 12 adds relevant material to the right to health in order to avoid discrimination against women in the “field of healthcare” not only by ensuring access to healthcare services in general but also explicitly by recognizing that healthcare services for family planning are included in the word “healthcare services”. The Article’s second paragraph makes it clear that parties undertake to “ensure to women appropriate services in connection with pregnancy, confinement and post-natal period, granting free services when necessary, as well as adequate nutrition during pregnancy and lactation”.

Article 14 deals with women's unique issues in rural areas and again ensures that women have the right to access appropriate health care facilities, including information, counseling and family planning services. As part of the right to "adequate living conditions" the clause also provides for sanitation and water supply.

8. Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1987)

This Convention obliges the States Parties to take all steps available to avoid torture or other barbaric, inhuman or degrading treatment or punishment. Article 2 specifies that legislative, administrative or judicial steps such as these may be necessary.

9. Convention on the Rights of the Child (1989)

The Convention acknowledges that each child has the right to an intrinsic right to life, and that State parties must ensure the child's survival and growth to the full extent possible.[5] It further states that the child should be shielded from all types of physical or mental harm, injury or disease, negligence or inadequate treatment, harassment or exploitation, including sexual abuse, while being cared for by the parent(s), legal guardian(s) or any other person who is caring for the child.[6]

Article 24(1) includes legislation concerning the right to health. It states that State parties accept the child's right to enjoy the highest achievable health level and services for the treatment of illness and health recovery. The parties shall therefore seek to ensure that no child benefits from their right to access these healthcare facilities.

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

This declaration ensures that mental health services should be subsumed into the overall health and welfare framework, and that all individuals have the right to the best mental health care available, which will be part of the health and social care system.

RIGHT TO HEALTH UNDER REGIONAL INSTRUMENTS

1. The Inter-American System

Article XI of the American Declaration on the Rights and Duties of Man sets out the right to health protection by sanitary and social measures (food , clothes, housing, and medical care), while focusing its enforcement on the availability of public and community services.

[5] Article 6
[6] Article 19

Article 34 of the Charter of the Organization of American States provides for access to knowledge of modern medical science and appropriate urban conditions, as among the objectives of contributing to the integral development of the individual.

The American Convention on Human Rights implicitly refers to the right to health by referring in Article 26 to the obligation of States Parties to take steps to ensure "the full realization of the rights implicit in the economic, social, educational, scientific, and cultural standards set forth in the Charter."

The Additional Protocol of San Salvador in Article 10 sets out clearly the "right to health" for all persons. It lists six steps which States parties should take to guarantee this right, including the establishment of universal primary care networks. However, Article 11 provides for the right to a safe atmosphere. The Protocol does, however, rule out the possibility of sending individual requests to the Inter-American system's supervisory bodies regarding the right to health.

2. European System

Article 11 of the European Social Charter applies to the right to health security, for which it provides for initiatives to promote wellbeing, awareness and prevention of diseases. First Portion Paragraph 13 provides those without sufficient support access to social and medical assistance. Similarly, Article 3 of the Human Rights and Biomedicine Convention enshrines fair access to healthcare.

3. African System

Article 16 of the African Charter on Human and Peoples' Rights enshrines the right to the highest possible standard of health, with the goal of “necessary measures” thus providing medical care in the event of disease. The African Charter on the Child's Rights and Welfare also includes recognition of the right to health.

CHAPTER III

INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS AND THE RIGHT TO HEALTH

In 1960s, the United Nations supported the establishment of two international covenants that expressed accepted human rights within the UDHR. The International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR) are also covenants.

In terms of right to safety, the ICESCR, the so-called Economic Covenant, is the most important. Article 12 of the Covenant states that the right to health shall require 'the enjoyment of the highest physical and mental health levels attainable.'

Article 12 says as follows:

(1) The State Parties to this Treaty recognize right of all to enjoy the highest attainable level of physical and mental health.

(2) The steps to be taken by the States Parties to the present Agreement to ensure that this right is fully exercised shall include those required for:

(a) Provision for raising the mortality rate and infant mortality and safe child development.
(b) Improvement of both environmental and industrial hygienic aspects.
(c) Epidemic, chronic, occupational and other diseases are avoided, treated and controlled.
(d) The development of conditions which in case of sickness will guarantee all medical service and medical attention.

Article 12 of the ICESCR calls for a policy compatible with the WHO constitution. This article is wider than Article 25 of the UDHR, previously adopted, that integrates a right to health in a wider clause on a right to an acceptable standard of living. One topic that has been heavily discussed during the drafting process of Article 12 ICESCR was whether a definition of health should be included in the clause. Several drafters objected to the inclusion of a health definition on the grounds of the statement that such a term

is not suitable for a legal instrument.[7] Therefore the final text of ICESCR does not include a safety description. What has not been abandoned is the large wellness approach, the idea that wellness is not just the 'absence of disease.'[8] Given the omission of the definition of 'social well-being,' the measures listed in the article reflect the understanding of health as a broad term, often referring to environmental hygiene, preventive health care and occupational disease.

The United Nations Committee on Economic, Social and Cultural Rights (ICESCR) is responsible for fostering, implementing and enforcing this Agreement. The ICESCR has given to ICESCR a General Comment 14 which articulates the scope of the right to health. The General Comment is the most definitive declaration on the scope of the right to health. This General Comment is broad and fairly precise and intended to refer to nations that have ratified the ICESCR. It discusses the substance of the right to health, and the right to health being applied and enforced. This also provides redress for particular parties denied the universal right to health.

GENERAL COMMENT NO. 14: THE RIGHT TO THE ATTAINABLE HEALTH STANDARD

In the General Comment, the Committee interprets the right to health as specified in Article 12.1 as an inclusive right extending not only to adequate healthcare in due time but also to the fundamental determinants of health, such as access to clean drinking water and adequate sanitation, adequate provision of nutritious food, nutrition and housing, sound working and environmental conditions, and access to health education and knowledge, including sexual and reproductive health. Another significant factor is public engagement at Individual, regional and international level in health-related decision-making.

The scope of the right to health applies to two important aspects: first, it is a right to access timely and sufficient healthcare; and second, the right to health includes a wide

[7] David P Forsythe, 'Encyclopedia of Human Rights', (Oxford University Press, 2009).
[8] Id at 367

variety of socio-economic factors fostering circumstances under which people can leave a healthier life and expanding to the 'underlying determinant of health.'

A. The Right to Healthcare

The first aspect of the right to health issues individual rights to 'healthcare' services including preventive and curative healthcare.[10] The right to health care ensures the right of an patient to access the necessary facilities and resources for the diagnosis , treatment, care and prevention of diseases during his or her lifecycle. It entitles individuals and communities to a health care program that ensures a level playing field for people to achieve the highest attainable health level.[11] According to Article 12(2)(d), States are therefore required to take the appropriate measures to 'establish conditions that would ensure adequate medical facilities and emergency treatment in the event of sickness.' States are especially obliged to 'ensure sufficient pre-natal and post-natal treatment for mothers.'[12] The definition of pre- and postnatal healthcare involves the prevention and management of low birth weight and premature birth risk factors; ensuring a healthy birth environment; maintaining thermal stability and respiratory support; and promoting breastfeeding shortly after birth.[13]

This clause means a strong duty of conduct ('to take steps') against the purpose of ensuring treatment for everyone in case of illness. "This needs the State, in the Committee's opinion, to: ensure equitable and timely access to basic preventive, curative, rehabilitative health care and health education; routine screening programs; sufficient treatment of prevalent illnesses, diseases, injuries and disabilities, ideally at community level; the provision of appropriate

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[9] B. Toebes, 'The Right to Health as a Human Right in International Law', 245 (Antwerp Interersentia, 1999).

[10] Charter of Fundamental Rights of the European Union (EU Social Charter), Art 35. "Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices A high level of human health protection shall he ensured in the definition and implementation of all Union policies and activities."

[11] ICESCR, General Comment 14, para 8.

[12] CRC, Art 24(d); ICESCR, Art 10(2); UDHR, Art 25(2); African Charter on the Rights and Welfare of the Child, Art 14(2)(c). Prenatal healthcare denotes the care existing or occurring before birth, while postnatal denotes care after birth. ICESCR, General Comment 14.

[13] G Van Bueren, *The International Law on the Rights of the Child* (The Hague, Martians Nijhott, 1998). 305.

drugs; and sufficient mental health treatment and care. This obliges the state to ensure that there are working public health facilities (including hospitals , clinics and other health-related buildings), qualified medical and technical staff earning domestically competitive wages, and essential drugs, as described in the WHO Essential Drugs Action Plan.

Prevention, diagnosis, and illness and injury prevention are central to ensuring the right to health. Recognizing this, ICESCR Article 12(2)(c) allows States to take the appropriate steps to 'prevent, manage and control epidemic, infectious, occupational and other diseases.' It includes setting up preventive and awareness services to tackle mental health issues.[15] These include sexually transmitted diseases, especially HIV / AIDS) and those adversely affecting sexual and reproductive health, and promoting good health social determinants, such as environmental protection , education (including compulsory sex education in schools), and economic growth and gender equality.[16] States are also expected to show what steps have been taken to 'provide information on prevalent health issues and preventive and control measures.'[17] This should extend to strengthening legislative and non-legislative initiatives, including awareness-raising campaigns to counter cultural practices that damage children's health[18], particularly those affecting girls, including adolescent pregnancy[19], 'early (and

[14] The *WHO Model Lists of Essential Medicines* has been updated every two years since 1977. *WHO Model List of Essential Medicines*, 19th edn (April 2015, rev June 2015), available at http://www.who.int/medicines/publications/essentialmedicines/en/.

[15] CRC, Art 24(2)(e) obliges states: "To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breast-feeding, hygiene and environmental sanitation and the prevention of accidents."

[16] ICESCR, General Comment 14, para 54.

[17] Compilation of Guidelines, para 54

[18] CRC, Art 24(3); CRC Committee, Concluding Observations: Malawi, UN Doc CRC/C/15/Add.174 para 50.

[19] CEDAW Committee, Concluding Observations: Uganda, UN Doc A/57/38 (23 August 2002) paras 147-8.

forced) marriage, female genital mutilation [FGM], preferential feeding and male child care.'[20]

The right to treatment requires the establishment of an emergency medical care system in case of incidents, epidemics and related health threats, and the provision of immediate disaster relief and humanitarian assistance in emergency situations.[21] Control of diseases refers to individual and joint efforts by states to, inter alia, make appropriate technologies accessible, utilizing and improving disaggregated epidemiological monitoring and data collection, and introducing or enhancing immunization programs and other infectious disease prevention strategies.[22] States are expected to 'describe the steps taken to prevent, treat and control infectious, chronic, occupational and other diseases'[23] in the reporting guidelines.

B. Underlying determinants of health

The second dimension of the right to health includes a broad variety of socio-economic factors supporting conditions under which people can lead a healthier life and applies to the fundamental determinants of health, such as adequate provision of nutritious food, education and housing, access to clean and drinking water and adequate sanitation,[24] secure and sound working or working environments[25] and a safe atmosphere and access to knowledge and information

[20] ICESCR, General Comment 14, para 22; World Health Assembly Resolution, *Maternal and Child Health and Family Planning: Traditional Practices Harmful to the Health of Women and Children* (1994), WHA47.10; UN Doc E/CN.4Sub.2/1989/42.

[21] ICESCR General Comment 14, para 16. On 8 August 2014, WHO Director-General Margaret Chan declared the Ebola Virus Disease (EVD, or Ebola) outbreak in West Africa a 'public health emergency of international concern'.

[22] ICESCR General Comment 14, para 16

[23] Compilation of Guidelines, para 51(g).

[24] E Guisse, 'Relationship between the Enjoyment of ESC Rights and the Promotion of the Realisation of the Right to Drinking Water Supply and Sanitation', UN Doc E/CN.4/Sub.2/2002/10 (25 June 2002) para 43 notes: "The quality of water and sanitation is crucial for health. Water related diseases continue to be one of the major health problems of the world's population, particularly in developing countries, where it is estimated that some 80 per cent of illnesses and more than one third of death are caused by drinking contaminated water."

[25] K Cook, 'Environmental Right as Human Rights' (2002) 2EHRLR 196; D Shelton, 'Environmental Rights' in P Altson (ed), *Peoples' Rights* (Oxford, Oxford University Press, 2011) 189.

relating to health, including sexual and reproductive health.[26] Many of those elements form an integral relationship with human rights already developed. The right to health must therefore be understood as a 'right to enjoy a range of facilities, products , services and conditions required to achieve the highest possible health level.'

The African Commission held that the right to health guaranteed under Article 16 of the African Charter imposes an obligation on states to provide essential services such as clean drinking water and electricity, in addition to the more obvious provision of sufficient medicine supply.[28] Accordingly, the failure of a state to provide basic services required for adequate health requirements, such as clean drinking water, and drug shortages arising from the documented mismanagement of the resources of a state, have been considered to constitute a violation of the right to health.

Likewise, ICESCR Article 12(2)(b) allows states to 'improve all environmental and industrial hygiene aspects.' It includes multiple steps, including:

> *"preventive measures for workplace accidents and diseases; obligation to ensure adequate availability of clean and healthy drinking water and basic sanitation; prevention and reduction of exposure of the population to hazardous substances such as radiation and toxic chemicals or other adverse environmental factors that directly or indirectly affect human health."*[30]

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[26] ICESCR, General Comment 14, paras 4 and 11.
[27] *Ibid*, para 9.
[28] *Free Legal Assistance Group and Others v. Zaire.*

[29] *Ibid*.

[30] According to the WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation, billion people still remain without improved sanitation facilities and around 900 million people still rely on unimproved drinking-water supplies. *UN Global Annual Assessment of Sanitation and Drinking-water (GLAAS)* (Geneva, WHO, 2008). In 2000, the WHO estimated that 1.1 billion people did not have access to an improved water supply (80 per cent of them rural dwellers) able to provide at least 20 litres of safe water per person a day; 2.4 billion people were estimated to be without sanitation. WHO, *The Global Water Supply and Sanitation Assessment 2000* (Geneva, WHO and UNICEF 2000).

This also includes adequate accommodation and safe and hygienic working conditions, sufficient food supply and proper nutrition.[31] In addition, enhancing industrial hygiene requires states to mitigate the causes of health hazards inherent in the work environment to the degree that is realistically feasible.[32] It is worthy of noting that the poor and oppressed are disproportionately suffering from environmental disruption.[33] States must also prevent 'toxic racism' by dumping toxic waste, or by ignoring pollution in areas populated by vulnerable groups, i.e. the poor, racial and ethnic minorities, people with disabilities, and those with mental and physical disabilities.[34]

In this regard, the right to health overlaps, is strongly interrelated and relies on the realization of other human rights, including food, housing, employment and education rights.[35] In reality, improved nutrition, good hygiene, better education and a clean environment increase the awareness of the right to health.[36]

The significant factor is the involvement of the community at Local , regional and international level in all health-related decision making.[37] Individuals should be encouraged to encourage, protect, and eventually determine their own health status in order to participate effectively.[38] The reporting guidelines also call for states to state 'what steps have been taken to enhance community engagement in primary health care planning , organization, service and control.'[39] Education has an significant role in this regard in encouraging individuals and groups to recognize the right to health.

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[31] ICESCR, General Comment 15.

[32] *Social and Economic Rights Action Center (SERAC) and the Center for Economic and Social Rights (CESR) v. Nigeria*, (2001) AHRLR 60.

[33] *Lopez Ostra v. Spain*, App no 16798/90 (1995) 2 EHRR 277.

[34] Shelton, *supra* note 34.

[35] V Leary, 'The Right to Complain: the Right to Health' in F Coomans *et al, The Right to Complain about Economic, Social and Cultural Rights* (Utrecht, SIM, 1995) 87, 88.

[36] ICESCR, General Comment 14, para 3.

[37] *Szijjarto v. Hungary.*

[38] Lawson, Edward, ed. Encyclopedia of Human Rights. Washington, DC: Taylor & Francis, 1991. 1907 pp.

[39] Turk, D (1992). The Realization of Economic, Social and Cultural Rights: Final Report (Geneva: United Nations).

Obligations

The right to health for civil rights places 3 duties on governments. First, states must honor them, ensuring states cannot actively or implicitly interfere with the enjoyment of the right to health . Second, states must defend them; steps must be taken to prohibit private individuals and companies from interfering with the right to health. Eventually, they must be met by governments, i.e. supported and encouraged by governments. Fulfilling the right requires states to take proactive steps, including regulatory, financial, and promotional initiatives, to allow and assist individuals and populations to enjoy the right to health. The General Comment defines "essential responsibilities" which ensure minimum service rates. The total service volume is comprised of:

(1) Non-discriminatory access to health services, in particular where they belong to poor or disadvantaged groups;
(2) Provided nutritionally sufficient and nutritious food.
(3) Core home, sanitation, and clean and drinking water; and
(4) Essential Medicines.

To truly recognize the right to health, States must enact and enforce, on the basis of epidemiological data, a national public health policy and action plan that discusses the health issues of the entire population. Also, the ICESCR provides preference to the following services: parental and reproductive and immunization, prevention of infectious diseases and knowledge about health.[40]

Violations

When deciding which acts or omissions breach the right to safety, it is necessary to differentiate between the incapacity of the state to comply (because of lack of resources) and its inability to comply. Violations by omission may entail failing to take appropriate action to recognize the right of all to possess the highest attainable level of physical and

[40] Forman, Lisa, et al. "Conceptualising Minimum Core Obligations under the Right to Health.: How Should We Define and Implement the ›Morality of the Depths‹?" *Healthcare as a Human Rights Issue: Normative Profile, Conflicts and Implementation*, edited by Sabine Klotz et al., Transcript Verlag, Bielefeld, 2017, pp. 95–122. *JSTOR*, www.jstor.org/stable/j.ctv1fxf7w.6.

mental health. Actions breaches include state laws that contravene the requirements set out in the General Comment that are likely to result in harm, sickness or premature mortality. Such actions include, for example, denial of access to health care, or the intentional withholding of health-critical information.

Implementation

The General Comment provides clear guidelines for upholding the “right to health”. Those requirements will allow States:

(1) Adopt structure legislation setting out a national strategy and action plan, and allocating appropriate resources to execute the program;
(2) Identify relevant health metrics and benchmarks right; and
(3) Suitable solutions and transparency – for example, access to courts, ombudsmen or human rights commissions.

The international law of human rights makes a distinction between civil and political rights and economic, social, and cultural rights. All sets of rights are considered interdependent and equally important. Nevertheless, many countries see civil and political rights as inviolable, especially in the Northern and Western Hemispheres, but see financial, economic, and cultural rights as general directives. The right to health is seen as ambiguous and unjusticiable. Governments also fear the financial commitment needed to safeguard the right to health.

Promoting the right to health definitely includes government investment to ensure health care, sanitation, nutritious food and drinking water, as well as other underlying public health problems. The United States is likely to violate the right to health not because it spends too little on health care and public health, but because it inequitably distributes its money. Americans want to believe we have the best health system in the world, but statistics show that we are performing fairly badly in the main population health indicators, because the ICESCR has not been adopted, even if it did, there will be a long way to go to ensuring equal access to health care and fair distribution of public health services in order to meet international human rights standards.

CHAPTER IV

ROLE OF WHO IN THE PROMOTION AND ENFORCEMENT OF THE RIGHT TO HEALTH

The era 1968–75 saw drastic shifts in the goals affecting WHO's work programme. The global drive to eliminate malaria has been WHO's leading initiative for more than a decade. This was introduced in the mid-1950s, and was a purely vertical system focused on DDT's insecticide capacity. When it became clear that eradication of malaria would not be accomplished, the provision of basic health services was given greater importance. In the years that followed, several steps have been taken to concentrate attention on the quality of health programs and how they should be improved.

In 1975 the WHO Executive Board was established with the primary health care strategy. In May 1973, the 26th World Health Assembly adopted Resolution WHA26.35, entitled 'Organizational Analysis of Methods for Promoting Basic Health Services Growth.' Among other items, this resolution affirmed the high priority to be provided to developing health services that were both available and appropriate to the general population, adapted to their needs, to the country's socio-economic circumstances, and at the level of health technology deemed necessary to meet the country's problems at a given time.[42] In 1975, the search for new approaches led to two important publications by the WHO :

(1) Specific strategies in developed countries to address critical health needs
(2) People's well-being

(A) Primary health care: WHO's modern approach to the development of health

[41] Heyer, Kate, et al. "Assessing the Role of State and Local Public Health in Outreach and Enrollment for Expanded Coverage: A Case Study on Boston and Massachusetts." *Assessing the Role of State and Local Public Health in Outreach and Enrollment for Expanded Coverage: A Case Study on Boston and Massachusetts*, RAND Corporation, 2016, pp. 1–12. *JSTOR*, www.jstor.org/stable/10.7249/j.ctt1d9np17.1.

[42] *Ibid.*

The World Health Assembly (WHA) in 1974 called on the WHO to report in January 1975 to the 55th Executive Board on the measures taken by the WHO to assist governments towards their global health goals, with priority being given to the rapid and efficient development of the health care system. The paper submitted to the board stated that there was a need to put the resources available to the community into balance with the resources available to health services. To do this, a revolutionary break from the traditional approach to health services is needed, one that creates new facilities out of a set of peripheral systems tailored for the context they are to serve, including the reorientation of existing health services to create a cohesive approach to primary healthcare.

The Declaration of Alma-Ata, 1978

Newell formally created the Primary Health Care program area in January 1975, the members of which included those who had drafted the report to the executive committee. While there was a mixed reaction within the WHO to this new priority, a wide range of NGOs joined forces in what soon became the NGO Committee on Primary Health Care, working closely with the PHC group of the WHO. This group of organizations trained separately for the International Conference on Primary Health Care which was held in Alma-Ata in September 1978, thereby helping to keep WHO on track.

At the end of the three-day cycle, almost all countries around the world had signed on to an ambitious commitment. The meeting itself, Alma-Ata 's final declaration and its recommendations, mobilized countries around the globe to embark on a process of slow but steady progress towards Health for All's social and political goal. Alma-Ata and Primary Health Care were inseparable concepts ever since. The 1970s saw awareness among large segments of the world's population of rising inequality. This appreciation provided the impetus for the dedication to Health for All in the Year 2000 during the 28th and 29th World Health Assemblies in 1975–76.

It was at the 28th World Health Assembly in 1975 that we first acknowledged the urgent need for new approaches to health care for everyone and for all. Thus came

the notion of primary health care, and it was a triumph for the developing world. The proposal was officially adopted at the World Health Assembly four months later, and the conference was scheduled to take place in 1978 in Alma-Ata, Kazakhstan, USSR. The conference was co-hosted and coordinated jointly with UNICEF as the result of many years of contact.

The Alma-Ata Declaration accepted the values of:

(1) Health is a basic human right, and that reaching the highest possible level of health is one of the most significant social goals worldwide.
(2) The existing gross inequality in people's health status , particularly between developed and developing countries, is inacceptable politically, socially and economically.
(3) Government has a responsibility for their people's welfare which can only be fulfilled by providing sufficient social and health care; initiatives.
(4) People have the right and the responsibility to engage in the preparation and delivery of their health care, individually and collectively.
(5) All countries will work together in a spirit of cooperation and support to ensure that people have PHC.
(6) Centered on a new international economic order, economic and social growth is of essential importance for the utmost attainment of safety for all.
(7) In year 2000 an optimal standard of wellbeing for all the world's population will be reached by more and greater use of the world's capital.
(8) All countries will work together in cooperation and support to ensure that people have PHC.

A) Characteristics of Primary Health Care

Primary health care is basic health care that is made freely available by means appropriate to people and families within the society, by their complete involvement and at a rate that the community and country can afford. It is an integral part of both the health system of the nation of which it is the center, and of the community 's overall social and economic growth. Public health care addresses the community 's key health concerns and offers encouraging, prevention, curative, and rehabilitative programs accordingly. As these programs represent and develop

from the economic conditions and social values of the nation and its populations, they may differ by country and society but at least include supporting proper nutrition and clean water supply; basic sanitation; maternal and childcare, including family planning; immunization against major infectious diseases; locally prevalent disease prevention and control; awareness on predominant health issues and means of avoiding and combating them; and adequate care for chronic diseases and injuries.

Full society and citizen self-reliance for health growth is necessary to make primary health care widely available within the population as soon as possible. Achieving such self-reliance needs full community involvement in primary health care planning, managing and organizing. This engagement is better organized by proper schooling that helps people to address their actual health issues in the most effective ways. We would be in a stronger position to make informed choices on primary health services and to ensure the other tiers of the national health system have the best kind of assistance. These other levels need to be organized and reinforced to support primary health care with technical knowledge , training, guidance and supervision, logistical support, supplies, information, financing and referral facilities, including institutions that can be referred to as unresolved issues and individual patients.

Primary health care is likely to be most efficient if it employs means that the community understands and accepts and is applied by community health workers at a cost that the community and the country can afford. Such community health staff, including mainstream practitioners where appropriate, can perform well if they stay in the neighborhood they represent and are properly professionally educated and to respond professionally to the health needs articulated therein. Because primary health care is an important part of both the country's health system and overall economic and social development, without which it is expected to fail, it needs to be integrated centrally with other levels of the health system, as well as with the other sectors that lead to the overall growth strategy of a country.

(B) Ottawa Health Promotion Map

Health promotion theory isn't new. Until germ theory emerged in the "bacteriological age" of public health, the dominant approaches and principles of environmental health in the 19th century included many of the political and ecological characteristics of contemporary health promotion. The emergence in health promotion as a separate, coordinated area of public policy and practice can be dated back to 1974. At the time, Marc, Lalonde, the Canadian Minister of Health and Welfare, published a monograph entitled 'A New Canadian Health Perspective.' It is generally called the "Lalonde Paper" and is valued.

Globally, the Lalonde Study represented the first time a national government policy paper described health promotion as a core approach for a population's health change. This paper stimulated international interest for health promotion as a policy strategy that could theoretically be helpful to states, organisations, societies, and people, but it appeared to be used more frequently in favor of a health promotion emphasis on lifestyles. The Lalonde Study (1974) was a Western democracy's first effort to say that the approach to health was flawed, calling for perhaps a fundamentally different approach to solving the problems of a rich country's 'lifestyle.' He started to believe that health was not only the responsibility of the public service, but that a wider solution was required, first to curb human suffering caused by illness, but also to reduce the escalating health care costs. It concentrated more emphasis than historically on the position of the environmental sector and lifestyle, thereby calling for a change to prevention. Many of this insight later made its way into the Ottawa Charter, and since then, Canada has been a hub with thoughts on health promotion.

Among other nations, including the United States (U.S. Department of Agriculture, Employment and Welfare, 1979) and Australia (Commonwealth Ministry of Health, Housing and Social Services, 1993), the Lalonde Report provided inspiration for community promotion programs. In 1986, the First International Conference on Health Promotion, which published the Ottawa Charter for Health Promotion, caught and welcomed the increase in enthusiasm in health promotion. The Charter defines health promotion as "the process whereby people can increase control over their health and improve it." It is seen as the official beginning of the campaign for Modern Public Safety. The goal was to

increase the importance of the primary health care strategy to minority countries which had previously ignored the Alma-Ata Declaration.

The Ottawa Charter defines a range of basic health prerequisites and specifically framed health promotion as more inclusive than health care and lifestyles. Those preconditions are:

(1) Education
(2) Food
(3) Peace
(4) Shelter
(5) A stable ecosystem
(6) Income
(7) Social justice and equity.
(8) Sustainable implies

Improving wellbeing requires a stable base for these basic preconditions.

The value of the Ottawa Charter rests in its combining both broad and inclusive Primary Health Care viewpoints. Furthermore, the Charter 's five fields of practice, which are used together within any community and in any environment, have a much greater chance of encouraging wellbeing than when used singularly. The Ottawa Health Promotion Charter stresses the role of institutions, processes, and societies, as well as human attitudes and capacities. The Charter 's five fields of practice aim to encourage health by:

(1) Creating sound public policies - Health policy alone is not what affects health: all public policies will be analyzed for their effect on wellbeing, and if policies have a negative impact on health, we need to work to improve them. Of example, if a city council had a strategy to approve industrial developments near residential neighborhoods, that would need to change if it has an adverse effect on the health of the residents. The Charter made a bold argument, 'Health promotion goes beyond health care,' to say that health care is just a small part of health development. It called for all policy makers to recognize the health implications of their policies and made the argument that many government

sectors constitute the key to health development – in particular jobs, trade and business, schooling, transportation , housing, etc. A good public policy needs concerted effort, which is a framework for solving health's social determinants.

(2) Building conditions that encourage a healthy lifestyle- It addresses specifically the value of natural environment and habitat preservation, calling for a socio-ecological approach to health. Protecting both the natural and the built environment is critical to health. We need living, working and recreation conditions in the urban world arranged in ways that don't generate or lead to bad health. They ought to provide affordable childcare for working adults, for example. We also need to safeguard the healthy natural environment. It will come from good public policy making.

(3) Reinforcing Collective engagement- Strong neighborhoods form the third main pillar of the health promotion system. Communities themselves are their own community's experts and will decide what their needs are, and how best to fulfill them. Therefore, with the citizens themselves, more influence and authority prevail, rather than with the 'experts' entirely. The growth of the Society is one way of doing this.

Farrant underlines:

At the very least, to endorse this principle implies:

(a) Challenging workplace safety promotion control;

(b) Validating and promoting urban health programs aimed at improving power delivery, possession, and management; and

(c) Recognizing political inequalities, possession and regulation and vested interests in the preservation of inequality.

(4) Create customized skills. The fourth sector is about helping individuals improve leadership skills, and is focused on promoting professional growth, delivering health awareness and knowledge, and improving life skills. We will need to learn more skills if they want to be more in charge of their life and have more influence over decisions that concern them. It may involve providing the

information, preparation or other tools required to enable individuals to take steps to improve or protect their wellbeing. Those who work in health must strive to allow people to develop the expertise and skills required for educated decision making.

(5) To reorient healthcare- Health facilities need to be reoriented, 'embrace an extended mission' and step past their curative orientation, but they do need to be more receptive to the interests of people and populations, while accommodating diverse cultural needs. Health promotion is the responsibility of everyone, and the secret to intersectoral partnership. There needs to be a balance between health promotion and curative care within the health system. One prerequisite for this reorientation is a significant change in the way health workers are being educated.

The implementation of the Ottawa Charter has resulted in substantial convergence of health promotion practices as a basic feature of public health of countries such as the United Kingdom and Canada, where health promotion is seen as a central aspect of public health along with other characteristics such as prevention, security and oversight. The Charter of Ottawa has developed structures and frameworks for government, society and person level action to help them. The adoption of the Health Evaluation System, for example, has reinforced the need to include equality in healthcare. Establishing regional community organisations helps build a positive environmental climate with the Healthier Neighborhoods, or Safe Communities in the Americas, is one example. Following the Ottawa Charter, initiatives were conducted to encourage awareness of health promotion services to tackle concerns such as obesity, diet, drug consumption, alcohol, etc., which were moving toward public policy through personal skills promotion. Hence it can be claimed that in a variety of nations, four of the five intervention approaches outlined in the Ottawa Charter have been successfully adopted and implemented.

(C) The Millenium Development Goals

The Millennium Development Goals (MDGs) of the United Nations are the eight targets established in September 2000 by the 189 UN member states, and agreed to be reached by 2015. The Millennium Declaration was signed at the September Global Summit held at the United Nations Headquarters in New York and attended by the 149 world leaders committed to combating illness, hunger, injustice, analphabetism, sexism against women and environmental harm. This Declaration extracted the MDGs, and added unique metrics and goals to them.

The Eight Millennium Development Goals are as follows:

(1) To attain free primary education;
(2) Reducing child mortality;
(3) For treating tuberculosis, HIV / AIDS and other diseases;
(4) To create a universal development partnership;
(5) Promoting sustainable environment;
(6) Promoting motherhood;
(7) To eradicate hunger and extreme poverty; and
(8) Empowering women and promoting gender equality.

Implementation of these eight Millennium Declaration chapters was decided to begin on 1 January 2001, and the United Nations consented to hold the summits in every five years to evaluate its progress in achieving the MDGs. At the World Summit in 2005 the first follow-up to the Millennium Summit was held.

One of the most remarkable aspects of the MDGs is their importance to safety. Among the eight MDGs, four are specifically related to health: goal 4 (reduction among infant mortality); goal 5 (improvement of maternal health); goal 6 (combating HIV / AIDS , malaria and other diseases); and goal 7 (sustainability of the environment, including halving the proportion of people without adequate access to healthy drinking water). Two other MDGs are closely connected to health: Mission 1 (to eliminate extreme poverty and hunger); and Goal 8 (to create a sustainable development partnership). Both of the remaining objectives (attaining universal primary education and empowering women — Goals 2 and 3) have a direct health effect. It's well documented that educated girls and women provide themselves and their children with better care and nutrition.

Health is central to the MDGs, because poverty reduction and development are central to it. Better health is not simply the product of poverty reduction and development: it is a way to achieve them. Yet more than that, too. International law — and numerous national constitutions — as we have seen, recognize the human right to the highest achievable standard of physical and mental health.

CHAPTER V

NATURE AND SCOPE FOR THE RIGHT TO HEALTH OBLIGATIONS

States are obligated to render affordable, usable, appropriate and of high standard healthcare and exposure to the fundamental health determinants.[43] Below are certain components of the right to safety.

(A) Availability:

The capacity represents two separate duties on the state. First, ensuring that 'functioning public health and community care infrastructure, supplies and resources, as well as systems' are accessible to the whole populace in adequate amounts throughout the society.[44] Second, it requires that a state guarantee that ample amounts of the fundamental determinants of safety, such as healthy and potable drinking water and proper sanitation facilities, are available. Accessibility also requires sufficient public support for health given that public health services are the only form of health service that the vulnerable will actually have access to. In Mariela Viceconte v. Ministry of Health and Social Services, Mariela Viceconte and the National Ombudsman urged the court to compel Argentina's government to take preventive action against hemorrhage fever, which affected 3.5 million people.[45] More precisely, they also requested the court to require the government to develop a WHO approved vaccine (Candid-1) for hemorrhagic fever in Argentina. According to the ruling, it was the Government's duty to make healthcare accessible in a case when the current healthcare network, particularly the private sector, was not protecting individuals' health. Having respect to the adoption of international treaties upholding the right to health by the Constitution, the court found that the government had not fulfilled its responsibility to make the Candid-1 vaccine

[43] ICESCR, General Comment 14, para 12; CRC, General Comment 4: Adolescent Health and Development Context of the Convention on the Rights of the Child. UN Doc CRC/GC/2003/4 (July 2003), para 34.

[44] ICESCR, General Comment 14, para 12.

[45] Case No 31.777/96 (1998).

safe. Since the private sector regarded vaccine production as unprofitable, the court required that the state manufacture Candid-I.

(B) Accessibility:

Accessibility has four common levels in regard to health institutions, equipment and resources. Facilities, products and services must be: (i) available without discrimination; (ii) available physically; (iii) economically accessible (i.e. affordable); and (iv) open to patient records according to the protection of personal patient details.

(i) *Equality and Non-discrimination:*

In the field of wellness, the two universal human rights values of equity and non-discrimination mean that outreach and other services must be in place to ensure that vulnerable people and communities have the same coverage, both in legislation and in action, as those with more benefit. The UN Commission on Human Rights reaffirmed that health-related non-discrimination would extend to all individuals and in all circumstances.[46] States are obligated, on all of the globally forbidden grounds, to eradicate de jure and de facto inequality in access to healthcare and to fundamental health determinants, as well as mechanisms and entitlements for their acquisition.[47] It is designed to provide access to all citizens, including vulnerable populations such as women[48], disabled persons[49], the aged[50], prisoners[51], racial and ethnic minorities[52], asylum seekers an illegal

[46] Resolution 1989/11, Non-discrimination in the Field of Health, 2 March 1989.

[47] ICESCR, General Comment 14, para 18; ICESCR, Concluding Observations: Trinidad and Tobago (17 May 2002), para 14; United Kingdom, UN Doc E/C.12/1/Add.79 (5 June 2002), para 14; Ireland, UN Doc EWA 2/1/Add.77 (17 May 2002), paras 15, 22 and 35.

[48] CEDAW Committee, General Recommendation 24: Women and Health (Article 12).

[49] ICESCR, General Comment 5: Persons with Disabilities, UN Doc E/C.1211994/13 (1994).

[50] ICESCR, General Comment 6: The Economic. Social and Cultural Rights of Older Persons 113th Session, 1995), UN Doc E/C.1211995/16/Rev.I (1995). paras 34 and 35.

[51] UN Standard Minimum Rules for the Treatment of Prisoners UN ECOSOC Res 663 C (XXIV), 31 July 1957, amended by UN ESOSOC Res 2076 (LXII), 13 May 1977; African Commission Guidelines and Measures for the Prohibition and Prevention of Torture, Crue,. Inhuman or Degrading Treatment or Punishment in Africa, (October 2002). para 33.

[52] WHO, *Health and Freedom front Discrimination: WHO's Contribution to the World Conference against Racism* (Geneva, WHO, 2001).

immigrants[53], and people living with HIV / AIDS[54]. States will support and promote civil rights 'in accordance with the values of non-discrimination and fair access to health facilities and resources' in the National Health Strategy. [55]

(ii) Physical Accessibility:

It needs all parts of the population, including remote areas, to provide community facilities and basic determinants of health within healthy physical scope[56]. This has to be the case especially for disadvantaged or marginalized communities.[57] Physical accessibility also requires sufficient access for persons with disabilities to the houses.[58]

(iii) Economically accessible (i.e. affordable):

Economic mobility (affordability) requires charging for healthcare facilities, as well as facilities linked to the basic determinants of wellbeing, to be based on the concept of equality, meaning that all programs are essentially available for everyone, whether privately or publicly funded.[59] Equity allows disadvantaged families not to be unfairly burdened by health-care costs relative to wealthier households.[60] The South African Constitutional Court, in Minister of Health v. Care Action Program, decided, inter alia, whether Nevirapine was available or not.[61] With just two testing and training sites per province, the State received Nevirapine, an antiretroviral medication used to cure HIV. The medication can also be purchased from private health care providers. As a result, there was no

[53] ICESCR, General Comment 14, para 34.

[54] Fighting HIV-related Intolerance: Exposing the Links Between Racism, Stigma and Discrimination. Paper prepared by WHO and UNAIDS in consultation with OHCHR. August 2001.

[55] ICESCR, General Comment 14, para 54

[56] ICESCR, General Comment 14. para 12(b)(ii).

[57] R Duggal, 'Operationalising Right to Healthcare in India', paper presented at the 10th Canadian Conference on International Health, Ottawa, Canada, 26-9 October 2003. available at httrewww.cchat.org/rtheirthpaper.htm4Jrol.

[58] ICESCR, General Comment 14, para 12(b)(iii).

[59] *Ibid*, para 12(b)(iii).

[60] CCT 8/02,[2002] ZACC 15; 2002(5) SA 721; 2002 (10) BCLR 1033 (5 July 2002).

[61] UDHR, Art 19; ICCPR, Art 19(2); American Convention on Human Rights, Art 13(1). Reports of the UN Special Rapporteur, Promotion and Protection of the Right to Freedom of Opinion and Expression. UN Doc E/CN.411995131 (14 December 1995), para 35.

access to Nevirapine for mothers and their babies who had no access to the testing and educational sites and who could not afford access to private healthcare. The Government contended that

> *until the best programme has been formulated and the necessary funds and infrastructure provided ... the drug must be withheld from mothers and children who do not have access to the research and training sites.*

The Court, however, ruled that the minimal supply of Nevirapine by the state was unfair. It directed the government to act without delay and include the medication as scientifically necessary in public hospitals and clinics.

(iv) Informational accessibility:

The UN General Assembly adopted Resolution 59(1) at its very first session in 1946 which stated: 'Freedom of information is a basic human right and the touchstone of all the freedoms to which the UN is committed.' It includes the right to try, obtain and transmit knowledge and ideas[62] on, inter alia, health issues.[63] The Inter-American Court of Human Rights recognized in a 1985 Advisory Opinion that freedom of information is a basic human right and is as essential to a free society as freedom of expression.[64] In three main cases, the ECtHR held that Article 10 of the European Convention for the Protection of Human Rights and Fundamental Freedoms, which protects freedom of speech, 'basically forbids a government from preventing a individual from accessing information that others want or may want to relay.'[65] In the most recent case, Guerra, the Court ruled that the Italian Government was under a duty to supply citizens of a 'at-risk' region with such environmental information, even though it had not yet obtained the information.[66] States will expand access to health

[62] ICESCR, General Comment 14, para 12(b)(iv).

[63] Compulsory *Membership in an Association Prescribed by Law for the Practice of Journalism* Opinion OC-5/85 (13 November 1985) paras 30, 32 and 70.

[64] *Leander v. Sweden*. judgment of 26 March 1987, 9 EHRR 433, para 74.

[65] *Guerra and Ors v. Italy*, ibid. 165 [1997] 3 SCR 624, full judgment available at http://www.canlii.org/en/ca/sce/dod1997/1997canlii327/ 1997canlii327.html

[66] CEDAW, General Recommendation 24, para 31(e), ICESCR, General Comment 14, para 12(b)(iv).

services for all, including elderly people.[67] A community of deaf plaintiffs protested the lack of sign-language interpreters in the federally supported healthcare program in the Canadian case of Eldridge v. British Columbia (Attorney General). The Supreme Court ruled that, under the Canadian Charter of Rights and Freedoms, municipal governments had a substantive duty to meet the interests of vulnerable persons, such as people with disabilities. The Court ruled that the applicants were entitled to publicly supported sign-language representation of healthcare services and that the inability of the authorities to insure that the applicants benefited equally from the regional healthcare system was discriminatory. Accessibility of information (as with all other health services) must, however, be compatible with other human rights, including privacy protection, personal health data security, informed consent and preference.[68]

(C) Acceptability and Quality:

Acceptability allows for a assured continuity of patient care and basic environmental determinants. Health services must also be 'good quality and technically and medically acceptable.'[69] In the North, drugs denied because they are past their expiry date and dangerous should not be exported to the South.[70] Acceptability also requires basic health and safety guidelines, including qualified health staff specifications that must be set, controlled and implemented by the government, medically accepted and unexpired medications and medical supplies, clean and drinking water, and proper sanitation.[71] In this respect, States are obliged to

issue safety and health regulations; allow for implementation of these regulations by supervisory measures;[and] encourage the inclusive

[67] ICESCR, General Comment 14, para 12(d). Dr *Mohiuddin Farooque v. Bangladesh* 48 DLR (1996) HCD 438 (The Supreme Court of Bangladesh).

[68] ICESCR, General Comment 14, para 12(d). Dr *Mohiuddin Farooque v. Bangladesh* 48 DLR (1996) HCD 438 (The Supreme Court of Bangladesh).

[69] ICESCR, General Comment 14, para 12(d).

[70] Revised ESC Art 3 (2-4).

[71] ICESCR, General Comment 14, 12(c).

provision of workplace health programs for both effectively preventive and advisory employees.[72]

Acceptability equally includes that:

all healthcare facilities, products and services shall uphold medical ethics and be culturally relevant, uphold the community of individuals , groups, peoples and societies, be responsive to gender and lifecycle criteria, and be built to protect confidentiality and enhance the health status of the persons involved.[73]

Patients' informed consent to health care or treatment must be respected; and where a particular act of care, such as non-therapeutic sterilization (a vasectomy), is contemplated for an adult lacking the capacity to consent to the procedure, it is vital to take into account the best interests of a person who does not have the mental capacity to consent after all circumstances.[74] As long as the right of women to health is concerned, appropriate health systems must ensure that 'a patient gives her full informed consent, values her privacy, maintains confidentiality and is responsive to her wishes and viewpoints.'[75] A Hungarian woman of roman descent in Andrea Szijjarto v. Hungary[76] alleged she had been coercively sterilized. She had gone to work and had been admitted to the hospital. It was discovered, upon examination, that the foetus had died and a Caesarean operation was urgently needed. She was asked to sign a consent statement for the Caesarean section on the operating table, as well as a 'nearly legible note,' signed by the doctor, allowing sterilization. The reference to 'sterilization' happened in a language she did not understand. She argued in her appeal to the CEDAW Committee that this conduct represented a breach of her right to adequate healthcare facilities, as well as her right to independently and reasonably agree on the number and spacing of her babies. The Committee concluded that Hungary had refused to offer sufficient information and

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[72] *Supra* note 78.

[73] *Supra* note 79.
[74] A NHS Trust v. DE and Others [2013] EWHC 2562
[75] CEDAW Committee, General Recommendation 24, para 22
[76] General Comment 14, E/C.12/2000/4, 4 July 2000, available at <www.unhchr.ch/ tbs/doc.nsf/>.

guidance on family planning to Szijjarto, and to ensure that she had given her full informed consent to the procedure, and recommended that the Government pay reasonable compensation to the claimant.[77]

(D) Implementing the right to safety by legislation and other practical steps:

Human rights-based approaches to ESC rights, including health, rely on the implementation of basic concepts of human rights such as non-discrimination, responsibility, engagement, openness, equality, security and international assistance,[78] as well as criteria and commitments relating to unique human rights applicable to a particular policy or system:

> *A human rights-based approach recognizes rights-holders and their entitlements and related duty-holders and their responsibilities, and encourages all rights-holders' capacity to make their claims and duty-holders uphold their obligations.*

Such an strategy can also concentrate on defining clear, realistic institutional steps needed by human rights laws and values in order for states to satisfy their responsibilities to protect human rights. As for family planning, for example, the following steps are required:

(a) Wide and sub-national strategies for awareness, information and resources in sexual and reproductive health and family planning:

Develop proposals to include equal access (not only for married people, but also for unmarried individuals, youth, those excluded by employment, profession or other factors) through a participatory process; to include all related public, private, regional and foreign actors; and to include other elements, such as goals and how to achieve them.

(b) Commodities:

[77] N. Daniels, B. Kennedy, and I. Kawachi, "Justice is Good for Our Health," Boston Re- view, February/March 2000: 6-15.

[78] S.D. Jama, "The International Human Right to Health," Southern University Law Re- view 22 (1994): 1-68.

Making the fullest practicable variety of safe and reliable modern contraceptives available, including emergency contraception, as enumerated in a WHO-based national list of critical medicines. System Collection and supplied via all applicable public and private networks.

(c) Health services:

Offer health facilities that are safe, offer seating and anonymity for user-provider contact, are properly staffed and fitted, adhere to published hours of operation, and remind patients of their rights.

(d) Monitoring and accountability:

Establish frameworks that provide accurate, open, transparent, and continuous analysis of service quality; measure progress towards fair access and other goals; and ensure that all stakeholder obligations are fulfilled.

(e) Ability to capital:

Offer federal grants and mutual benefit plans to provide coverage to those who simply would not be able to provide care.

(f) Setting down legislative and administrative hurdles:

Remove obstacles that hinder access to education, information, and resources in sexual and reproductive health, including family planning, particularly for vulnerable groups.

(g) Education services in the communities and in hospitals:

Train appropriate numbers of health workers who are qualified and trained to deliver high-quality sexual and reproductive health care, provide complete and reliable contraceptive knowledge and conventional contraception, use local language, and practice respect for anonymity, security, fairness, and other basic principles of ethics and human rights.[79]

[79] J Cottingham, A. Germain, and P. Hunt, 'Use of Human Rights to Meet the Unmet Need for Family Planning' (2012) 380 (9837).

LEVELS OF OBLIGATIONS

The primary control for the protection of human rights lies with the States from an international law perspective. The States are obligated to protect, support and uphold the civil rights of people within their control pursuant to universal human rights treaties. Human rights are binding on all political authorities, bodies, and institutions, irrespective of whether they are at federal, national, or local level, or are super-ordinate or sub-ordinate. States' duty therefore applies to those private persons who have been charged with the execution of public duties or who act on behalf of, on order or under State supervision. Human rights are now developing responsibilities to uphold, protect and execute as a result of more recent changes in dogmatic international law.

(a) Obligation to Respect the Right to Health:

Obligations to equality form the center of a radical philosophy of human rights that defends the independence of people from state interference and places the protective value of human rights at the forefront of doing so. They require states not to obstruct people in the pursuit of their human rights, either overtly or implicitly – and where they do so to address these actions. This above all concerns omission duties.[80]

Respecting the commitments requires States to refrain from violating the right to safety themselves. Therefore, States should not take any action that runs counter to the right to health and that may result in physical harm, excessive morbidity and preventable mortality. What might be that kind of action? So far as healthcare is concerned, this typically includes any state acts that hinder the provision, affordability or adequacy and efficiency of healthcare to the degree that people's wellbeing is compromised or damaged.

In its General Report, the UN Committee presents the rejection of medical attention as a primary example and thereby insists on a non-discriminatory, universal access to health care. If rules, legislation or even the culture of public health facilities restrict or impede equal access to particular demographic

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[80] B.C.A. Toebes, "Towards an Improved Understanding of the International Human Right to Health," Human Rights Quarterly 21 (1999): 661-79.

populations or persons needs to be discussed here. That may be persons with disabilities, the mentally disabled or children, but also foreign immigrants, refugees, illegal migrants or prisoners, for example minority groups or national minorities. The organisation of healthcare for lesbians, homosexuals, bi-, trans- and intersexual (LGBTI persons) is often often troublesome particularly when they have to face criminal penalties, as is the case in many countries.

However, the manner in which patients are served in state-run health care facilities is often important in terms of the responsibilities to be fulfilled. Not only refused, but inappropriate or harmful care can also lead to infringements of human rights. We are concerned with the appropriateness and consistency of healthcare here in this regard. Of starters, it must be checked if the treatment options available are being explored, and if the established guidelines are being adhered to. That is not necessarily the case, after least. Around the same time, there are several historical and current examples of individual acts which are detrimental to health in state health care facilities: this range from experimental experimentation on people who did not agree to illegal institutionalization of individuals with mental disorders in psychiatric institutions (or, as is the case in China , for example, misuse of psychiatric facilities as a place of detention for political dissidents) to compulsory sterilization of persons with disabilities or women. In Peru, for example, during the term of office of Alberto Fujimoris (1990–2000), about 300,000 women and about 22,000 men – mostly indigenous and farmers – were subjected to forced sterilization as part of the birth control without their permission and without justification. There have not been any criminal prosecutions as demanded by those involved up to now.

Specifically, several issues emerge from the State's responsibilities to equality of healthcare, the above stated topic of segregation to give only one example. Apart from the fact that medical care has to be tailored to the particular patients, the question arises as to what health facilities the right to fair treatment without prejudice applies to as civil rights.

Also in the face of the state's valid regulatory priorities, the de jure and de facto unfair treatment of citizens in the health sector, based on their ethnicity or residency status, should be viewed objectively from the point of view of human

rights, especially where the resultant healthcare service becomes evidently inadequate and even emergency care becomes hindered by bureaucratic hurdles. This also holds true when it comes to illegal migrants in the world. Such citizens are in fact allowed to access healthcare facilities. For all the regional peculiarities and sporadic positive cases, however, Heinz-Jochen Zenker has stated that there are individuals without papers at the edge of access to proper medical treatment everywhere, and that this is incompatible with the human rights treaties and the European Universal Charter. Moreover, the practice of monitoring, recording and detaining people also actively discourages other unidentified persons from accessing healthcare facilities.

Acts of governments that are detrimental and hazardous to health can also impact certain factors that control the health of individuals outside of the health care system. The UN Committee for ESC Rights specifically specifies access to clean and drinking water, proper sanitation, nutritious food and housing, sustainable working and environmental environments and health-related statistics, as stated earlier. Against this context it is important to determine the degree to which environmental threats and harm to environmental emerge from state interventions in the different policy areas (economy, energy, defence, etc.) – for example in the form of human rights impact evaluations. State-run companies or public maintenance initiatives may also infringe the right to safety if environmental security is ignored at work or if the air is polluted. Joint liability can also emerge from partnerships with private companies. The African Charter on Human Rights passed a historic ruling on this issue against the former military government in Nigeria. This had done significant harm to the climate and health in the Niger Delta along with a major oil company in the process of national oil production. The Commission concluded that infringed the rights to safety and to an acceptable – here: clean – atmosphere guaranteed by the Banjul Charter.

The misuse or misstate of health-related records may also amount to an violation of the duties of the state to protect it. The state does not hold back or falsify critical or essential health records related to illness or disease or environmental catastrophe prevention. For example, from the right to health viewpoint, it was criticized that the Zimbabwean government ignored the outbreak of the cholera

epidemic in 2008 for a long time, and announced it to be over too early. Justified criticism of human rights was even aimed at the South African government under Thabo Mbeki (1999–2008), which trivialized the possibility of HIV transmission and also dismissed a connection between HIV and AIDS for a while. By comparison, steps to prevent epidemics such as forced quarantine in the case of Ebola victims in Sierra Leone, Guinea and Liberia in 2014 may contribute to interference in the rights of those affected of democracy and involvement. To the extent such actions are justified, it can be addressed, for example, by the Siracusa Principles concerned with restrictions or the derogation of civil and political rights in the event of such national emergencies.

(b) Obligation to Protect the Right to Health

Obligations to protect consist of the state duty to protect persons from real or future human rights abuses by third parties , usually private actors. Security duties are not restrictions of action but conditions of practice. Nevertheless, state decision-makers have a broad margin of choice and independence when it comes to the nature of these initiatives. Therefore it is not always straightforward to assess potential violations of State responsibilities to defend. For eg, the can emerge through the absence of a state to act where:

(i) Public officials are aware of an actual or potential danger or may have done so if they had taken the appropriate care;
(ii) Given the awareness, they struggle to take appropriate security steps within the means available to them; and
(iii) Around the same time it should have been possible to introduce countermeasures in line with civil rights.

Those infringements may occur in healthcare, for example, where the state permits private healthcare facilities to violate safety regulations or neglect to do enough to discourage the dissemination of dangerous or defective drugs (as is the case in a variety of countries). So far as the responsibilities to protect are concerned, the state must properly monitor and track private healthcare institutions, programs and goods and ensure that patients are genuinely receiving medical help so ensuring their safety is not affected. In general, the same flaws that occur here as in the case of state-run health care facilities, the

distinction is that here the damage arises from private actors. The State duty to protect is especially clear as preventable deaths occur in private healthcare facilities and at the same time the state has refused to meet its supervision and management responsibilities. There is a collection of specific rulings in this respect, for instance by the Inter-American Court of Human Rights or through the CEDAW appeals process.

The issue of whether free access to private healthcare facilities needs to be is of considerable significance in terms of human rights. This is generally undisputed that private healthcare providers cannot refuse anyone medical treatment, but access to private services that extend beyond that is not typically available or accessible to all. It is particularly a concern where there is no robust public healthcare system at the same time or where that is of low quality. In this situation, the state must ensure that a qualitatively sufficient healthcare service is available to all, either by means of private providers' respective legislation or by widening the public healthcare system, which also applies to fulfillment commitments.

Unlike the responsibilities to uphold, the duties to protect are not limited in the narrow sense to the delivery of healthcare, but rather to working and living environments that can dictate the health of people. Here, the responsibilities to protect apply, on the one hand, to proper supervision and monitoring of health safety in the workplace, and, on the other hand, to the preservation of an stable and safe community from private (economic) intervention, which is vital to the health of persons. Private companies have reported unhealthy working practices and instances of environmental contamination around the world, be it natural resource depletion, in agriculture or in the manufacturing sector. Harmful working conditions in South Asia's textile industry which attracted media attention following the collapse of fires and factories in Bangladesh and Pakistan come to mind here. In developed countries and emerging markets the issue is especially apparent. To make matters worse, there remain mainly informal job ties.

State responsibilities to guard against injuries and diseases at work and contamination of the atmosphere can be found not only in Article 12, para 2(b)

ICESCR but also in International Labor Organization (ILO) conferences. An argument based on a violation of the European Social Charter can also be made within the framework of the Council of Europe. For example, in the case of joint grievances against Greece, the European Social Committee concluded that the right to health has been infringed because – despite the space for flexibility and intervention permitted – the national authorities have done very little to shield people from private industries from water and air pollution. A specific issue is waste management, which is mostly privatized.

Furthermore, public safety security is important. The State would prohibit the sale of heavily contaminated or health-damaging consumer products. Around the same time, smoking bans and calls for steps to reduce alcohol and opioid use have been justified with the right to safety in the last few years. Demands for body weight safety or for a Regional Agreement for the Protection and Promotion of Balanced Diets go even further. The latter of these requests was made by Olivier de Schutter, the then Special Rapporteur for the right to food, and explained on the grounds that unhealthy diets pose an even greater health danger than cigarettes. Hitherto, the right to health as regards dietary habits and balanced diets has scarcely extracted from state responsibilities. There will definitely be a need for an in-depth debate as to what and to what degree it is necessary and appropriate to participate in people's rights and areas of duty above and above the responsibilities of knowledge and education.

In the case with actual acts of aggression the situation is different. The UN Committee on ESC Rights here obliges states – on the grounds of the right to safety – to combat private abuse, particularly domestic violence, and to prosecute criminals as well. The Committee frequently stresses the duty to shield women and girls from sexual or other abuse in many different contexts of risk, and also makes use of other human rights: on the road to school or work or in the workplace, in the hunt for water or sanitation facilities, or in emergency shelters and refugee camps. Moreover, the state is obliged to prevent dangerous cultural practices to health , especially female genital mutilation (FGM). Both the UN Committee on ESC Rights and the CEDAW Committee have described female genital mutilation as a breach of human rights, although not necessarily focused on the right to safety.

(c) Obligations to Fulfill the Right to Health

Compliance obligations are purely constructive entitlements. We force the States to allow the most robust exercise of human rights by strong state intervention possible. This is about providing the prerequisites for the fulfillment of the right to health in the form of income, products or services by the respective laws, establishments and procedures as well as by way of state provisions.

The respective conventions on civil rights now allow for a number of measures to recognize the right to wellbeing. The duties to meet in the wellbeing sector are thus complex. Originally, these require the development and maintenance of medical and health-relevant facilities, whereby states need to ensure that appropriate medical establishments, clinics and initiatives with well-trained personnel are available, open to everyone, and that people have access to sufficient food and nutrition, housing, sanitation, drinking water and critical medicines. Additionally, the human rights treaties call for concrete measures to be taken by states to strengthen the health status of the general public and that of persons , especially poor or disadvantaged groups, such as infants, mothers, the elderly or disabled. For this respect, it is not usually necessary merely to guarantee access to medical services. Sometimes it is important to change the socio-economic and socio-cultural factors which co-determine the state of health, e.g. deprivation or social marginalization and exclusion.

The type of healthcare programs, whether public and/or private, as well as particular policy initiatives relating to health, fall largely within the jurisdiction of the respective states, at least as long as they follow certain standards of human rights (such as openness, engagement, non-discrimination) and ensure the general affordability, efficiency, acceptability and consistency of healthcare provision. However, privatized or contractually outsourced healthcare facilities do not rid the governments of their duty to ensure that. Of example, policymakers must avoid qualitatively sufficient healthcare coverage being made available exclusively to those people who can afford it. According to the WHO, however, every year 100 million people are forced into poverty as they have to pay for health care facilities themselves (out-of-pocket payments). It not

only points to a close connection between the right to health and the right to social security, but also also to the question of the abominable delivery of universal health services. Of this cause, as reported from India, for instance, many poor people often opt for fee-based private healthcare facilities rather than free treatment in state-run hospitals, while running up big debts at the same time.

Like in the case of the right to health the execution of the commitments is related to rising prices, the recognition has several countries hitting the limits. Many developed countries, in fact, have considerable problems in maintaining adequate healthcare delivery and in addressing the partially severe healthcare sector shortcomings. Let alone, they can afford such an comprehensive and expensive healthcare program as the developing countries. This does not, however, exempt developed countries from their duty to increasingly take steps to recognize the right to health on the basis of their limited wealth.

The duty to gradually realize the right as provided for by the ICESCR (Article 2, paragraph 1) takes into account the fact that the basic human rights cannot be realized immediately in the face of social challenges that are difficult to resolve and finite resources, particularly those components of the right that require robust state protections and long-term measures for their realization. As for the right to wellbeing (and other ESC rights), this applies in turn to the duties to be met.

The duty to follow a incremental understanding cannot, however, serve as an justification for failure to behave at all. On the opposite, the state has the constitutional duty to formulate clear and appropriate legislation and to take steps which will result in the aim of recognizing the right to health. As such, states are obligated to establish a coherent national health policy in a participatory and open mechanism without delay in order to resolve the current (and identifiable) health-care challenges in the region.

In fact, some key commitments must be understood promptly, as far as possible. That requires at least access to public facilities and primary services without prejudice, as well as access to a reasonable amount of adequate education, housing, hygiene and clean drinking water, and the availability of

basic drugs, according to the UN Commission for ESC Welfare. Therefore, there is a equal allocation of hospital services and medical treatment, with the attention here being on the unique issue of rural deficits. The Committee finds the following issues to be of equal priority: healthcare in regards to reproductive wellbeing, motherhood and infants, vaccines against infectious diseases, prevention, diagnosis and battle against chronic and emerging diseases, awareness and information on important population health services and appropriate preparation of healthcare staff.

Based from this, steps must be taken to constantly and comprehensively recognize the right to wellbeing. The obligation of gradual realization – at the time enshrined with a considerable amount of progress-oriented optimism – is not in accordance with an absolute prohibition of regression, but inevitable setbacks need to be explained. Therefore, it is vitally necessary for the state to actively use its money – and therefore a sufficient proportion of the shares of the state and potential foreign assistance – to recognize the right to health. The opinion of the UN ESC Rights Committee is that a state that is not able to do so violates its commitments under Article 12 ICESCR.

Of course what constitutes sufficient resources must always be defined. The ICESCR's wording which obliges the respective state to expend the full amount of its available resources is not especially useful. It is obvious that, however significant they might be, a state cannot use all of its tools to achieve individual human rights. The duty to expend all capital operates on the basis that the state is left with ample means to carry out its various duties (and to carry out certain human rights as well). Accordingly we are concerned here with the weighting of goals as well as the allocation and usage of resources available.

In reality, it soon becomes clear that human rights changes are desperately needed in the political setting of goals and the budget policies of many States. Or put it lightly, as we look at what the states are wasting money on and at the same time millions of people are dying of illnesses that can be stopped and treated, it is not impossible to see that certain services are being misused, misused and definitely not expended from a human rights point of view. There is a lot of room for skepticism in the call to make use of the best possible

resources because it pushes the states to mobilize more money to realise universal human rights in the face of ongoing social problems. Significantly, the UN Committee on ESC Rights periodically urges states to make more money available for health care delivery within the framework of the ICESCR monitoring procedures. By regional budgeting for human rights and systemic country comparisons, these debates will be made more realistic, even if the use of substantial means alone does not ensure adequate fulfillment of the human right to health.

The UN Committee on ESC Rights will not give a definitive response to the issue at what point the full recognition of the human right to health was made. The desire for the 'best attainable quality standard' leaves several unanswered questions. Because a person's health depends on a number of contingents and therefore variables that can be affected, the circumstances for a stable life should, in theory, also be further enhanced. Therefore, pragmatically, the implementation of the human right to health must be regarded as a continual cycle dependent on the respective health and medical criteria which are defined and further implemented at national or international level. However, it is clear that the universal right to health is not limited to the basic treatment levels. Therefore, the right of each person to attain the best possible quality of health acts as a vital correction, ensuring that adequate medical services and safe working and living standards are not reserved for other communities within society.

MINIMUM CORE OBLIGATIONS OF THE RIGHT TO HEALTH

States have a central responsibility to ensure that the minimum basic standards of any of the rights specified in the ICESCR, including critical primary health services and the fundamental determinants of health, are fulfilled, at the very least, in order to meet the requirements of the Convention. In the health sense, Chapman ha referred to the central minimum requirements as a 'scale' to which health issues and programs would not be permitted to slip.[81] This happens at all times irrespective of resource scarcity or other conditions and difficulties. As for the minimum core quality of the right to health, the

[81] V. Leary, The Right to Health in International Human Rights Law," Health and Human Rights 1 (1994):24-56.

WHO's Health For All and Primary Health Care policies specify that 'there is a health benchmark [core welfare obligations] beyond which no persons can be in every region.'[82] Which are those main responsibilities, more precisely? In the ICESCR's opinion, these main safety responsibilities require at least the following duties (of conduct):

(a) Ensuring access to the nutritionally sufficient and healthy minimum basic food and ensuring the freedom from hunger;
(b) Providing important medicines, as established from time to time under the WHO Essential Drugs Action Programme;
(c) Ensuring the right of non-discriminatory access to health facilities, goods and services, in particular for vulnerable or marginalized groups;
(d) Ensuring a fair distribution of all health care facilities, goods and services;
(e) Ensuring access to basic food , healthcare and sanitation, and adequate clean and potable water supply;
(f) To enact and enforce, on the basis of epidemiological data, a national public health policy and action plan addressing the health problems of the whole population; the policy and action plan shall be developed and regularly reviewed using a participatory and open process; they shall contain measures such as the right to health metrics and milestones to track success closely; the mechanism by which the policy and action plan are created. All disadvantaged or oppressed people should be given special consideration as well as their substance.

The emphasis on the fundamental rights of the right to health is, on the one hand , based on access to, and equal delivery of, non-discriminatory health services, the availability of prescription medicines and the introduction of a regional public health agenda and action plan. At the other side, it emphasizes at access to basic minimum food, clean and drinking water, and accommodation. Therefore it incorporates both treatment and the basic environmental determinants. The ICESCR has stated that the following are 'comparable

[82] K. Tomasevski, "Health Rights," in Eco- nomic, Social and Cultural Rights A Textbook, eds. A. Eide, C. Krause, and A. Rosas (Dordrecht: Nijhoff, 1995):125-142.

[83] R. Cook, "Human Rights and Reproductive Self Determination," The American University Law Review 44 (1995):975-1016 (identifying clusters of rights that comprise women's reproductive rights

priority' obligations, which means that states are obliged to meet these obligations until they have met the minimum core obligations:

(a) Take prevention, diagnosis and management of infectious and emerging diseases;
(b) Providing appropriate health personnel training including health and human rights education;
(c) Providing immunization against the main public infectious diseases;
(d) Ensuring reproductive, maternal (pre-natal and post-natal) and infant health care;
(e) Providing awareness and access to information, including ways of avoiding and managing the key health issues in the community.

The above list of elements that represent central and 'comparable' safety commitments is broad but omits significantly the protection of liberty from significant environmental health risks such as emissions. It is argued that this would be an additional dimension of the right to health's core content. The language used by the ICESCR when it comes to core health rights obligations is to 'assure' or 'provide.' It needs more constructive contributions. However, given the limited funding available and high debt burdens[84], along with insufficient facilities and a shortage of trained health personnel, it is unlikely that this center will be completely enforced or accomplished immediately in developing countries (particularly the least developed ones) without substantial targeted international assistance and cooperation. It is important to note that other states and other players in a position to assist will play a vital role in helping developed countries meet core human rights obligations.[85] These foreign aid will be aimed carefully at minimum core commitments to strengthen the understanding of the right to health.

This is important to note that there is a commitment to take meaningful action for the inclusive implementation of the remainder of the right following recognition of the cornerstone of the right to safety. Similarly, 'retrogressive steps taken in relation to the

[84] V. Leary, see note 1, p. 46; P. Alston and G. Quinn, "The Nature and Scope of States Parties' Obligations under the International Covenant on Economic, Social and Cultural Rights," Human Rights Quarterly 9 (1987): 156-229, 177-81.

[85] *Ibid.*

right to safety are not acceptable'[86] until they are completely explained, with the most rigorous examination of all options, through referring to the entirety of the freedoms provided for in the Covenant and in the light of the best usage of the fullest means accessible.'

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[86] Minimum core obligations include duties of immediate effect and justiciable duties. The categories of obligations of immediate effect and justiciable obligations are broader than the category of minimum core du-ties, however.

[87] Committee on Economic, Social and Cultural Rights, General Comment 3, The nature of States parties obligations (art. 2, para. 1 of the Covenant)

CHAPTER – VI

ISSUES AND CHALLENGES IN THE REALISATION OF THE RIGHT TO HEALTH

The inability to understand the right to safety, except in a gradually progressive way manner, raises questions about the State officials' political commitment t public health, social structural justice to ensure social welfare and about the values of individuals and the public which form decision making processes.

The main issues and challenges around the right to health are:

1. Access to healthcare, medical products and technologies

It is critical to have access to robust, affordable health care services. Promotion and conservation of hygiene, disease prevention and control, reduction of unnecessary disability and premature death, and ensuring equality in wellbeing for all. The WHO is predicting the one third of the world's population lacks secure access to necessary and new drugs and that expand access to existing interventions in such areas as the provision of medicines for respiratory, maternal and child welfare, and non-communicable diseases.[88] More Studies[89] show that the pain relief needs are significantly unmet and care of an estimated 1.2–1.4 million people in the WHO African Region Moderate to severe pain is experienced annually during the final stages of AIDS and cancer in the end, without any diagnosis.

The main impediments to access include prohibitive costs, weak public health infrastructure, geographical access to health centres, adequate availability healthcare skills, insufficient recognition of gender-responsive healthcare needs and inefficient referral structures. The most frequent costs included common barriers to access to medical products and technologies (Payments out of pocket), price, counterfeit and under-standard pharmaceutical products; insufficient Drugs R&D reward systems and disease vaccines which have a disproportionate impact on the least developed countries, and barriers relating to trade.

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88 "The World Health Organization on the Global Tobacco Epidemic." *Population and Development Review*, vol. 34, no. 1, 2008, pp. 188–194.

89 Van Herten, Loes M., and Harry P. A. Van de Water. "New Global Health for All Targets." *BMJ: British Medical Journal*, vol. 319, no. 7211, 1999, pp. 700–703.

Insufficient health financing in poor countries is a problem affecting the making of right to health a reality. There are currently only 11 Member States of the European Union WHO African Region (Benin, Ivory Coast, Gabon, Ghana, Malawi and Mali), that articulated Namibia, Rwanda, Sierra Leone, South Africa and Tog Single Coverage Policies. In fact, about half of the overall safety in the region, spending relates to private health spending, much of which is out-of-pocket household expenses that can expose people to the possibility of catastrophic and poverty-stricken costs.

For certain classes and cultures marginalization, stigma and prejudice are a problem which hampers the realization of the right to health in many countries. Many of the disadvantaged classes include minors, street kids, the elderly, migrants, refugees, internally displaced persons (IDPs), people with disabilities disabilities, sex workers, drug users, homosexuals, inmates and indigenous people communities and HIV / AIDS-patients. Persons with disabilities and diseases including leprosy, tuberculosis, heart disease, buruli ulcer, fistula, mental and society shuns physical disabilities and refuses them. Were forced to shy we are therefore refused access to vaccinations, aside from finding aid because of discrimination access providing support and complete engagement in society. However, these populations are sub-groups are likely to suffer from poor health and poor living standards because of their specific health care demands are ignored, with the consequence that hospitals are underfunded and services which are targeted at them.

2. Gender inequities and abuses

This has been identified as a problem which hinders the realization of the health right of women, and their infants. Societal prejudice based on age, marginalizes and disadvantages women, when combined with minimal connection to education and other economic opportunities is a key factor for a safe woman. High maternal and infant mortality due to inadequate living conditions sexual and reproductive care, including abortion and family access; planning programs, female genital mutilation and the lack

[90] Ruger, J P. "THEORY AND METHODS: Ethics and Governance of Global Health Inequalities." *Journal of Epidemiology and Community Health (1979-)*, vol. 60, no. 11, 2006, pp. 998–1003

of mother-to - child prevention transmission of HIV services (PMTCT) has also been described as gender related inequities.[91]

3. Being mindful of the right to health

In many developing countries, human rights debates are usually held and, in fact, the right to health appears to be very professional and is the most common maintaining legal expertise. This led to a lack of awareness amongst the people, even health workers, have a right to health and health working conditions, thus restricting their capacity to take steps to improve such rights.[92] Health workers are most often lacking in training on this topic, thus creating a situation in which human rights are insufficiently incorporated into the programmes and policies, and sometimes violations of patient rights, and unethical policies behave.

4. Frameworks of law and of strategy

With all the Member States being signatories of at least one human being the rights treaty which enshrines the right to health and which makes 85 per cent a major challenge is recognition of the right to health in their national constitutions is the inability to properly implement certain commitments at country level. That's it.This is especially the case when countries do not give sufficient recognition to the right to health through legislation and policies and the institutionalization of mechanisms which promote the realization of this right. Even if countries do have this applies to various types of legislation covering aspects of the right to health should not put into practice policies or plans for mainstreaming human rights in medical care. Most countries have institutions which generally tackle human rights. The scope of such bodies ranged from commissions on human rights to ministries of Justice and the Offices of State Ombudsmen. And none of them have Right to Health reporting mechanisms. These

[91] Singer, Peter A., and Solomon R. Benatar. "Beyond Helsinki: A Vision For Global Health Ethics: Improving Ethical Behaviour Depends On Strengthening Capacity." *BMJ: British Medical Journal*, vol. 322, no. 7289, 2001, pp. 747–748.

[92] Nixon, Stephanie A. "Critical Public Health Ethics and Canada's Role in Global Health." *Canadian Journal of Public Health / Revue Canadienne De Sante'e Publique*, vol. 97, no. 1, 2006, pp. 32–34.

[93] Winskell, Kate, et al. "INCORPORATING GLOBAL HEALTH COMPETENCIES INTO THE PUBLIC HEALTH CURRICULUM." *Public Health Reports (1974-)*, vol. 129, no. 2, 2014, pp. 203–208. *JSTOR*, JSTOR, www.jstor.org/stable/43775353.

processes differ from those of provision of regional reports by state, ministerial commissions/Parliamentary studies and processes for monitoring the UN.

5. The global burden of diseases which are not communicable

Non-communicable diseases (NCDs), also called chronic diseases, tend to develop be of long period and are the product of genetic, physiological combinations, factors of the environment and of behaviors. The principal types of NCDs are cardiovascular diseases (such as heart attacks and strokes), cancers, and chronic diseases Respiratory illnesses (such as chronic pulmonary obstructive disease and asthma) diabetes and. NCDs disproportionately affect low- and low-income people medium-revenue countries with more than three quarters of global NCD deaths occur (32million). NCDs affect people of every age group, region, and country. Those are older age groups are frequently correlated with the conditions, but evidence suggests that around 30 and 69 years, 15 million of all deaths due to NCDs occur years. Years of such "premature" deaths, it is predicted that more than 85 per cent will occur in low and middle income countries. Kids, adults and senior citizens are all vulnerable risk factors which contribute to NCDs, whether from unhealthy, physical diets inactivity, tobacco smoke exposure, and harmful alcohol use.

Such diseases are powered by forces involving quick unplanned urbanization, globalizing unhealthy habits and aging populations. Nourished diets and in humans, a lack of physical activity may appear as increased blood pressure, blood glucose increased, blood lipid increased and obesity increased. Their titles are the leading NCD, the metabolic risk factors that may lead to cardiovascular disease as for premature deaths.

Concentrating on reducing risk factors is an effective way to monitor NCDs related to these illnesses. There are low-cost solutions for the governments and to reduce common modifiable risk factors, other stakeholders must. Surveillance progress and developments in NCDs and their risk are crucial to policy guidance and Goals. A holistic way to reduce the effect of NCDs on individuals and society It takes an approach that requires all sectors, including health , finance, transport, Training, forestry, preparing and others, to work together to reduce risks associate with NCDs, and promote prevention and control interventions.

It is crucial to invest in better management of the NCDs. Managing NCDs includes the detection, screening and treatment of and access to these diseases to provide palliative care for the needy. Key high impact NCD interventions could be achieved by early reinforcement of primary health care approach screening and timely treatment. Proof indicates this kind of action is excellent economic investments, because they can reduce patients if provided early need more costly treatment.

ADDRESSING HUMAN RIGHTS AS KEY TO THE COVID-19 RESPONSE

The latest remarks by the Director-General of the World Health Organization (WHO) on COVID-19 emphasized that "all countries must strike a fine balance between protecting health, mitigating economic and social damage and upholding human rights".[94] The human rights frameworks provide a crucial structure that can reinforce the effectiveness of global pandemic response efforts.

The current COVID-19 outbreak has been described as a pandemic. The global and national responses to COVID-19 have posed specific and rapidly changing obstacles to the promotion and protection of human rights and wellbeing of people around the world. As countries find ways to tackle COVID-19, incorporating safeguards and guarantees of human rights into our common responses is not just a moral necessity, it is necessary to resolve public health issues effectively. The 'enjoyment of the highest attainable standard of health' is at the heart of the World Health Organization 1948 Constitution. The COVID-19 pandemic is causing cause cataclysmic suffering worldwide, with sweeping global health ramifications for human rights. While a study of human rights has started to evaluate the wide-ranging human rights abuses in the midst of this unparalleled pandemic response, it will also be important to consider the consequences of this response for the recognition of the human right to enjoy the highest possible quality of physical and mental wellbeing (right to wellbeing). Under international law, the right to health has evolved to provide a foundation for prevention of public health, health care services, social distancing measures and global health solidarity in COVID-19 response.

[94] WHO Director General's Opening Remarks at the edia briefing on 11 March, 2020. Available at https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020

A fundamental right under international law

The right to health, elaborated seminally under the International Covenant on Economic, Social and Cultural Rights (ICESCR), requires States to take steps for the "prevention, treatment and control of epidemic, endemic, occupational and other diseases" and create conditions to assure "medical service and medical attention in the event of sickness. Framing health equity, the right to health goes beyond medical treatment, encompassing socio-economic health determinants such as safe and stable working environments, food and nutrition, housing and water , sanitation and hygiene. The UN Committee on Economic, Social and Cultural Rights (ICESCR) has outlined essential attributes to guide implementation of the right to health, finding that health services, goods, and facilities should be:

- available in adequate numbers;
- accessible – physically, economically, and on the basis of non-discrimination, as well as accessible health information;
- acceptable to all and respectful of medical ethics; and
- of good quality.

Disease prevention through public health

Under the right to health, States must take urgent and proactive measures to avoid the danger of COVID-19 to public health. Even as States consider the appropriate limits on individual freedoms to address a public health emergency — ensuring that such limitations are reasonable, proportionate, non-discriminatory, and law-based — it is also crucial to consider the collective rights underpinning public health, addressing population-level interests in the prevention of infectious diseases. Instead of taking proven public health measures to prevent disease, States initially responded to COVID-19 through reactive and ineffective travel bans, neglecting the policies required to implement social distancing initiatives, increasing medical testing and monitoring the contacts of infected people. The ICESCR acknowledged these State failures to "take steps to avoid or at least minimize" the effects of the pandemic, proposing interventions based on "the best scientific evidence available to protect public health," as expressed in World Health Organization (WHO) guidance.

Health-related rights amidst social distancing -

While COVID-19 is a public health concern that has inflicted steep barriers to the realization of the right to health, the pandemic response also poses a serious challenge to the full range of human rights underlying physical and mental health and social well-being. Highlighting the indivisibility and inter - dependence of human rights in the response to the pandemic, global distancing initiatives have already revealed gaps in the realization of social and economic rights, including housing , food, water and sanitation. Social distancing policies have a disproportionate effect on the rights of vulnerable and oppressed populations — particularly those living in poverty, employed in the informal sector or without secure housing — threatening continued access to critical health determinants. In the absence of social security safeguards, "stay at home" directives are impoverishing families, prohibiting people from buying essential needs, shutting down vital community programs and expanding health inequities among populations without jobs.

The interrelated nature of human rights related to health requires a comprehensive response to social distancing with the right to health at the forefront, recognizing the impact of underlying public health determinants. It will be necessary to fulfill minimum core obligations in the midst of this period of social distance to realize social determinants of health by securing the livelihoods of vulnerable populations engaging in social distancing. It will be crucial to adjust these workplaces to minimize the risk of infection in their work for those needed to remain employed outside the home , particularly those working in industries that are not amenable to physical distancing. States must take such steps to minimize the effects of the pandemic through economic and social rights that inequitably affect vulnerable communities, evaluate these actions through human rights impact assessments and promote transparency for state efforts to realize health determinants during an extended pandemic response.

International obligations to realize global solidarity

COVID-19 is a global public health crisis calling for global solidarity and coordinated action, yet States have largely responded to this common threat with nationalist approaches that ignore the need for collective action. While many high-income

countries continue to experience high mortality as well as catastrophic inequality, the global trends are changing as the pandemic hits low- and middle-income countries, causing widespread death, hunger, and misery. Where health systems are weak — with overcrowded living conditions, fragile sanitation infrastructures, and limited resources for health care — COVID-19 is an imminent health disaster. Despite repeated calls from the WHO for global unity in this global response, high-income countries have failed to provide sufficient international assistance and cooperation to countries in need, undermining global health stability, opening the door to complex humanitarian crises and undermining the health and human rights of the world's most vulnerable.

In the context of severe international inequalities the pandemic's global health challenge requires a dramatic shift towards global solidarity and shared responsibility. The ICESCR, along with other human rights treaties, agrees that all States in a position to assist are obligated to provide foreign assistance and cooperation. This responsibility is fundamental to global efforts to manage infectious diseases and includes exchanging research, medical supplies, and best practices to combat COVID-19. With WHO playing a vital governance role in coordinating the pandemic response, State support for WHO remains essential-through assessed contributions, voluntary contributions, and adherence to WHO guidelines. Based on WHO help, these international commitments include help for the UN 's Global Humanitarian Response Plan COVID-19; restrictions on economic sanctions, debt obligations, and intellectual property structures that obstruct access to the services needed; and cooperation with the UN Human Rights Framework to promote transparency for human rights in global health.

Realizing health through unprecedented times

This unprecedented pandemic imposes an imperative to reaffirm the universal commitment to the right to health, with the right to health providing a framework for nation-wide prevention, treatment and response to this threat. Looking beyond the immediate response, nations must recognize their health rights obligations by framing evolving responsibilities for this rapidly changing world. As politicians increasingly realize that this pandemic can only fully end with the creation of an effective vaccine, human rights obligations – at the intersection of the right to health and the right to benefit from scientific advancement – will be essential to the eventual realization of

universal access to the required benefits of this medical advance, bringing the world together to ensure the highest attainable standard health for all.

CHAPTER VII

CONCLUSION

Despite the right to health being recognized under various instruments of international law, regional law and national constitutions, there is huge disparity in the health outcomes both globally and domestically. This suggests that the right to health does not exist in practice. The relatively low international importance attached to public health further promotes the gross health inequities existing around the world. The goal to achieve global health with justice is not possible without robust global governance. Therefore, the adoption of a legally binding global health treaty would extensively strengthen the global right to health. Such a treaty would strengthen the right to health on a national basis, and provide legal space for States to challenge acts and international regimes negatively impacting that right. It would create obligations on States to take the social determinants of health into account in decision-making and may provide an overarching sense of direction in global health governance.

A Framework Convention on Global Health (FCGH)

The concept of an FCGH was first proposed by Lawrence O. Gostin in the year 2008. Recently on September 6, 2017, The World Federation of Public Health Associations, along with other Organizations, NGOs and professionals involved in Global Public health, signed a joint letter that was Submitted to the Director General of the World Health Organization Dr. Tedros Adhanom Ghebreyesus, urging him to endorse and establish a WHO process to implement a Framework Convention on Global Health (FCGH).

At present, the understanding of the right to health is shrouded in vagueness. This hinders accountability to international human rights obligations. While existing treaties establish a legal right to health, the FCGH would create a regime that actors could draw on, legally and politically, to strengthen their challenge to acts and frameworks impacting this right. Ideational factors and potential dispute resolution mechanisms would underpin this strengthened capability. In addition, the right to become more salient among actors over time through greater awareness, acknowledgement, and acceptance of the values, obligations and processes embodied in the FCGH. The FCGH might also assist the right to health become an established norm A further important

aspect of the FCGH is that it would help decouple an individual's effective right to health from their economic circumstances, a key aim of health justice, and strengthen the political legitimacy of universal health systems. It would do this by setting general benchmarks for global health (e.g. clean water and adequate sanitation), creating responsibilities to fund universal health systems, and establishing those systems' international and domestic financing frameworks. These provisions may enhance the right to health on a national basis by encouraging states to establish justiciable obligations to fund their health systems. In addition, they would provide ideological assistance to actors to resist neo-liberal policies negatively impacting universal health systems.

While a FCGH would assist in strengthening national health systems, it would likely be less effective in establishing and fully funding their international financing frameworks. Wealthier states have shown a "deep resistance" to transfer wealth to poorer states, and have historically been unwilling to make large, increasing, and untied payments for horizontal health programs. The latter is evidenced by the essentially static assessed contributions to WHO over recent decades: US$856 million in 2002-2003, rising to US$929 million in each of 2012-2013, 2014-2015 and 2016-17. In addition, global development assistance for health (DAH) sector support and sector-wide approaches in 2015 was only US$2.7 billion, a small fraction of the total US$36.4 billion DAH.

Nonetheless, a FCGH might lead to wealthier states marginally increasing their funding of poorer states' health systems, if only for reputational reasons. A FCGH would also strengthen states' acknowledgement of the importance of social determinants of health. It would oblige them to take such factors into account in decision-making, possibly through use of the *Health in All Policies* approach.109 This would be a move to addressing systemic factors impacting health, noting that the FCGH would not address structural elements such as power, gender, and economic inequity.

The FCGH may also provide a stronger overarching policy focus for actors in the chaotic global health governance arena. While the FCGH would not govern the actions of non-state actors, its greater ideational focus on the social determinants of health may influence their policies and funding. Furthermore, while it is not clear which body would administer the FCGH, providing this responsibility to WHO would enhance the organization's status and leadership role, and broaden its focus from technical to

political matters. With a strong Director General, WHO's responsibility for carriage of the FCGH may also strengthen global health governance.

Need for Human Rights Empowerment

If human rights are to have an effect, they have to be actively claimed. For this reason, human rights empowerment is necessary. This denotes a process, in the course of which the right holders acquire the capacity to claim and assert human rights for themselves and others effectively. The main recipient of human rights claims are the respective states which are the primary duty bearers. Their readiness and ability to realize the human rights must be claimed and enhanced. However, also non-state actors such as commercial enterprises are noticeably being made accountable for human rights. Those concerned and their support groups generally have a wide range of possibilities to act available to them when it comes to asserting their human rights claims in the face of resistance.

From a legal point of view the right is especially characterized by the fact that it can be asserted through the courts. With an increasing recognition of the for a long time contested justiciability of social human rights, in the past few years an increasing number of possibilities to claim have become available. The amount of case law on social human rights in general and in particular on the right to health has grown considerably. By now there are numerous judgments and decisions which either directly or indirectly concern the right to health.

Interestingly, these refer not only to obvious discrimination situations and the infringement of obligations to respect and protect, but sometimes also to the benefits entitlements of those concerned. Empirically it must also be examined who actually takes re-course to the courts, how the courts decide and whether the corresponding judgments are acted on appropriately and result in sustainable effects.

It is almost as important that the human right to health is claimed and asserted by way of political means, for example through protests and campaigns or through lobbying and advocacy work. Without underestimating the significance of influential landmark judgments, fundamental, structural reforms with the goal of achieving a better and more comprehensive respect, protection and guarantee for the social human rights such as the right to health are primarily secured politically, and here it is mostly about conflicts of power and distribution.

Ideally the (quasi-) judicial and the political enforceability of the right to health should complement each other. On the one hand, political demands to realize human rights gain in legitimacy and force as a result of the legal entitlements being positively enshrined in law and possibly subject to claims in the courts.

For this, as a rule, an active civil society is of great significance. To what extent the possibilities of demanding and claiming the right to health are used depends first of all on the organizational potential and capacity to act of civic groups and social movements, however, also constitutional structures and civic freedoms are necessary. Many governments restrict the scope of activity of the civil society and attempt to suppress human rights entitlements.

The spectrum here ranges from complete repression to co-optation. Between these there are open and subtle forms of obstruction, for example legal and administrative restrictions on the freedom of assembly, association and opinion or also the targeted defamation, stigmatization or criminalization of persons and groups who promote human rights (human rights defenders).

As such it is all the more important to organize and support civic commitment and human rights empowerment with solidarity, which is why great significance is attached to transnational human rights networks which provide a link between the local and global levels. With regard to the right to health, for example the *People's Health Movement* is one such global network. It is not, however, about exporting supposed western human rights into foreign countries. The starting point and point of reference for solidary support is always the struggles of the people locally and protest against injustice, oppression, exploitation and hardship they have suffered, and who – implicitly or explicitly – point to their right to live a humane, liberal and autonomous life in community with others.

The human right to health is most certainly a part of this.

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