

Issue Paper

Health and Human Rights

**prepared by
Birgitta Rubenson**



SWEDISH INTERNATIONAL DEVELOPMENT
COOPERATION AGENCY

Department for Democracy
and Social Development
Health Division

Author: Birgitta Rubenson
Sida Consultant: BR-Konsult, Biskopsgården, 645 30 Strängnäs

Sida Representative: Gunilla Essner

Health Division Document 2002:2A
Commissioned by Sida, Department for Democracy and Social Development,
Health Division

© Sida and the author
Written in 2002
Printed in Stockholm, Sweden, 2002
ISSN 1403-5545
ISBN 91-586-8765-3

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

ICESCR General Comment 14

“The right to health does not mean the right to be healthy, nor does it mean that poor governments must put in place expensive health services for which they have no resources. But it does require governments and public authorities to put in place policies and action plans, which will lead to available and accessible health care for all in the shortest possible time. To ensure that this happens is the challenge for both the human rights community and the public health professionals.”

Mary Robinson, High Commissioner for Human Rights.

“All human rights are universal, indivisible and interdependent and interrelated. The international community must treat human rights globally in a fair and equal manner, on the same footing, and with the same emphasis. While the significance of national and regional particularities and various historical, cultural and religious backgrounds must be borne in mind, it is the duty of the States, regardless of political, economic and cultural system, to promote and protect all human rights and fundamental freedoms.”

Vienna Declaration and Programme of Action,
World Conference on Human Rights.

Contents

1	Introduction	5
2	Linkages between Health and Human Rights	6
3	Main Human Rights Instruments related to Health	7
4	Other International Instruments	10
5	General Comments	12
6	Mechanisms for Implementation and Monitoring	14
7	Important Actors	15
8	A Rights-based Approach	17
9	A Human Rights Perspective on Health Systems	19
10	Conclusion	23
	Reference literature	24

	List of Health Division Documents	25
--	--	-----------

1 Introduction

The Universal Declaration of Human Rights from 1948 articulates the norms and the demarcations of human rights. The basic value underpinning all human rights is that all human beings are born free and equal in dignity and rights.

Respect for the individual and the prohibition of any kind of discrimination are the cornerstones in all human rights work.

Human Rights include civil, cultural, economic, political and social and rights. They are internationally agreed principles protecting individuals and groups against actions that interfere with human dignity and fundamental freedom as well as principles on entitlements to ensure the well being and development of individuals.

Their strength is the common commitment by all ratifying states to respect, protect and fulfil them.

Human Rights are developed in international fora, agreed on in international conventions and voluntarily ratified by states. Conventions are legally binding documents that the parliaments of the state parties have voted to ratify and implement. Their fulfilment is the responsibility of the national governments. The need for international co-operation for the implementation of the rights is underlined, especially in relation to the possibilities for lesser developed countries to fulfil their obligations.

Human Rights Conventions define what the government *can do to us, cannot do to us and should do for us.*

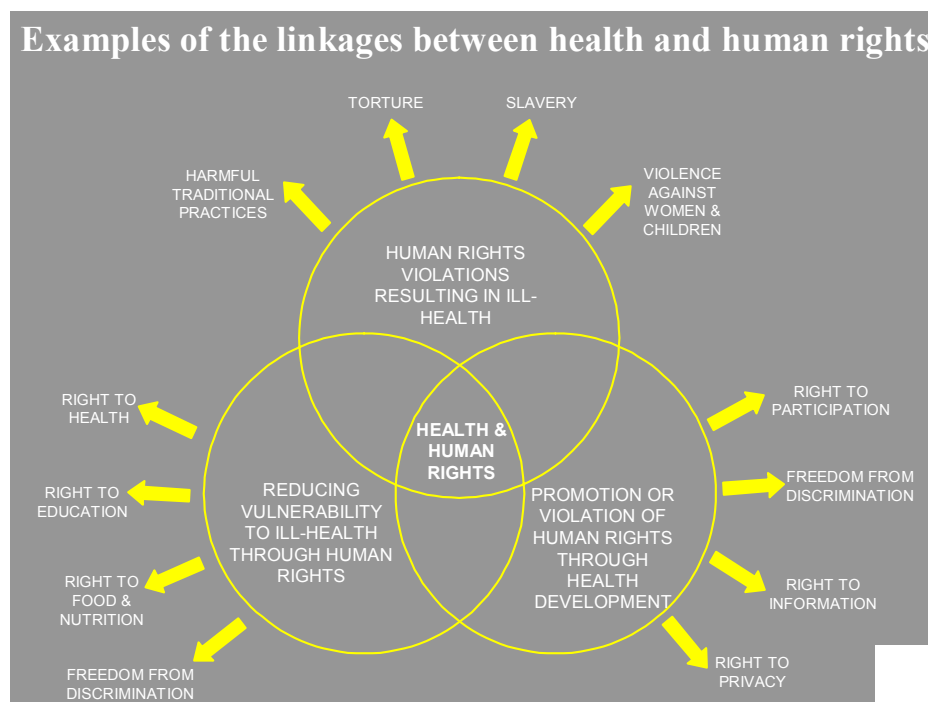
After adopting the declaration on human rights in 1948 it was agreed that also a legally binding document on human rights should be developed. Cold war pressures led to the development of two separate tracks with civil and political rights and social, economic and cultural rights evolving in isolation from each other and sometimes even in conflict with each other. One track emphasised individual freedom and independence, the other underlined the responsibility of the state to cater for its citizens. Two different Covenants were developed (1966) one on civil and political rights and one on social, economic and cultural rights.

The end of the cold war and the global conferences of the 1990s laid the political and normative basis for bridging this unfortunate gap. The Declaration from the World Conference in Vienna in 1993¹ underlines that all rights are *universal, interdependent, indivisible* and *mutually reinforcing*. Respecting, protecting and fulfilling human rights, is striking a balance between them all.

¹ Declaration from Vienna 1993

2 Linkages between Health and Human Rights

There are many and complex linkages between health and human rights, as the model below shows.²



- Violations or lack of attention to human rights can have serious health consequences (inhuman and degrading treatment, abuse and violence, torture, harmful practices, poor living conditions, lack of information, lack of health services);
- Respecting, protecting and fulfilling human rights can reduce the vulnerability to and impact of ill health (health, nutrition, living standard and education, adequate environmental and working conditions).
- The health system can promote or violate human rights in the way it is designed and implemented (accessibility to service, provision of information, respect for integrity and privacy, cultural sensitivity, gender and age sensitivity)

² WHO, Questions and Answers on Health and Human Rights, 2002

3 Main Human Rights Instruments related to Health

The right to the highest attainable standard of health (in short referred to as “*the right to health*”) is affirmed in several human rights instruments.

3.1 The Universal Declaration of Human Rights from 1948, art. 25(1)

states that “everyone has a right to a standard of living adequate for the health of himself and his family, including food, clothing, housing, and medical care and necessary social services.”

3.2 The International Covenant on Economic, Social and Cultural Rights 1966 (CESCR)

Article 12 (1) of the Covenant recognises the right of everyone to the enjoyment of the highest attainable standard of physical and mental health and elaborates in *article 12 (2)* steps that need to be taken by state parties to achieve full realisation:

- (a) The right to maternal, child and reproductive health;
- (b) The right to healthy natural and work environments;
- (c) The right to prevention, treatment and control of diseases;
- (d) The right to health facilities, goods and services.

Other relevant articles are:

article 2 which urges the convention states to use their available resources to the utmost to fulfil all the rights of the convention and when needed within international co-operation.

article 7 which recognises the right of everyone to work under just and favourable working conditions;

article 11 which recognises the right of everyone to an adequate standard of living, including food, clothing and housing;

article 15 which specifies the right of everyone to enjoy the benefits of scientific progress and its applications;

The CESCR has been ratified by 145 states (February 2002), among them all countries with Swedish co-operation in the health field except Mozambique and Laos. In 2000 the committee on the CESCR in collaboration with WHO developed the General Comment 14 on the right to health.³

3.3 The Convention on the Elimination of All Forms of Discrimination Against Women 1979 (CEDAW)

includes several of the rights included in CESCR and underlines especially in *article 12* the abolishment of all discrimination against women in relation to healthcare. The Convention stresses the right of women to adequate care dur-

³ CESCR General Comment 14, The right to highest attainable standard of health

ing pregnancy and childcare. These services should be given free of charge when necessary.

Many of the other articles in the convention, prohibiting discrimination and underlining the right to equal treatment and opportunities have implications for the health and well being of women and girls. Unfortunately the CEDAW has many reservations, which, even if they are not directly linked to the right to health, restrict women's right to decide about their sexual and reproductive health and limit their access to health care.

In 1999 the Committee on the Elimination of Discrimination against Women developed the CEDAW General Comment 24 on Women and Health.⁴

At the international conferences on population (Cairo)⁵ and Women (Beijing) the health rights of women and girls have been interpreted and further developed. The declarations and plans of action from the conferences have become normative in relation to the right to information and services for sexual and reproductive health.

Reproductive health-care programmes should provide the widest range of services without any form of coercion. All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so. (ICPD-Report)

The CEDAW has been ratified by 168 states, (February 2002) among them all countries with Swedish co-operation in the health field

3.4 The Convention on the Rights of the Child 1989 (CRC)

includes the same rights related to health as CESC, but also several articles on protection against abuse and exploitation.

It confirms in *article 24* the right to highest attainable standard of health and to facilities for treatment of illness and rehabilitation of health.

It elaborates what this means in relation to health services, maternal and child health, information, living conditions etc. in subsequent paragraphs.

article 32 the right to protection from economic exploitation and from performing any work that is likely to be hazardous... or to be harmful to the child's health or physical, mental, spiritual, moral or social development;

article 33 the right to protection from the illicit use of narcotic drugs;

article 34 the right protection from all forms of sexual exploitation and abuse;

article 35 the right protections from abduction and trafficking;

article 39 the right to physical and to psychological recovery and social reintegration of child victims.

⁴ CEDAW General recommendation 24 (General Comments), Women and health: 02/02/99.

⁵ A/CONE.171/13: Report of the International Conference on Population and Development (94/10/18)

The CRC has been ratified by all states except the USA and Somalia and is thus the universally most accepted HR-document. It also does not have as many reservations as e.g. CEDAW. It is a common HR-instrument in all countries with Swedish development co-operation.

In addition to the general human rights principles of non-discrimination and participation the CRC requests that “the best interest of the child” should be a guiding principle when deciding matters concerning children. This principle requires that the child’s total situation be taken into consideration when decisions affecting the child are made. Considering the socio-economic and cultural context in which the child is living may lead to a different decision from one taken looking at the child in isolation from surrounding factors.

Example:

Breast-milk from an HIV-positive mother may transmit the virus. Ideally therefore an HIV-positive mother should not breastfeed her child. But when considering the high risk from bottle-feeding in poor communities and the cultural aspects in many African communities, it may be in the best interest of the child to be breastfed and not bottle-fed.

4 Other International Instruments

Besides the legally binding HR-instruments there are several international documents with relevance for the interpretation and understanding of human rights in relation to health. These are declarations, recommendations, plans of action etc., which governments have agreed on (but they are not part of the legal system).

International Conferences and their Follow-up

elaborate on how human rights in relation to specific topics or groups can be understood and implemented. During the nineties several important conferences were organised.

- The World Summit for Children, New York (1990);
- The World Conference on Human Rights, Vienna (1993);
- The International Conference on Population and Development, Cairo (1994);
- The World Summit for Social Development, Copenhagen 1995;
- The Fourth World Conference on Women in Beijing 1995 and Beijing +5 (2000);
- The Sec. UN Conference on Human Settlements (Habitat II) in Istanbul (1996);
- The World Food Summit, Rome (1996);
- The UN General Assembly Special Session (UNGASS) on AIDS (2001);
- The UN General Assembly Special session (UNGASS) on Children (2002).

At all these conferences declarations were adopted and plans of action agreed on. Participating governments undertook to prepare their own national plans of action in an effort to achieve the goals set out in the plans. Following the conferences from the first part of the last decade follow-up conferences have been held for which countries were requested to prepare reports on what had been achieved.

Many of these plans of action interpret and develop the conventions further than all countries are willing to subscribe to. When implementing and monitoring these plans of action it is important to respect the individual and cultural rights, which may not conform to the interpretation of the majority.

United Nations Standard Rules on the Equalisation of Opportunities for Persons with Disabilities 1993

These rules were agreed on to set a standard for countries in their efforts to improve the situation of persons with disability and to strive for more equal opportunities for all. The Convention on the Rights of the Child also includes the basic principles of the standard rules in the convention itself.

The Alma Ata Declaration on Primary Health Care 1978 (WHO and UNICEF)

This declaration has been of profound importance for the understanding of health, its underlying determinants and the development of health services all

around the world. Without explicitly referring to human rights it builds on the human rights principles of respect for the individual, non-discrimination and participation.

The Code on Marketing of Breast-milk Substitutes 1981 (WHO and UNICEF)

This code focuses on a very specific issue with the aim of protecting the infant's right to the best nourishment and the mother's right to true and honest information.

5 General Comments

The human rights conventions special committees are appointed by the UN general assembly to monitor how states parties implement their obligations following ratification of human rights instruments. They also prepare general comments as a guide to the state parties in the interpretation of the conventions. Important comments in relation to “the right to health” are comments 3 and 14 to CESR and comment 24 to CEDAW. During 2002 General Comments on HIV/AIDS and Adolescent Health are being developed by the Committee on the Rights of the Child.

The General Comment No 3 on CESCR article 2(1) on the Nature of State Parties Obligations CESCR, 1990

The CESR, (article 2) underlines the responsibility of the government to “take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum extent of its available resources, with the view to achieving progressively the full realisation of the rights recognised [herein]”.

What this means is elaborated in the General Comment No 3 of the CESCR. Both prioritising between competing areas, such as education, health, sanitation and security and within the different areas is needed. To be able to do this, countries need to analyse their budget processes to follow the flow of funds and to balance the different needs, always keeping the needs of the most vulnerable in mind. Even if full realisation can not be achieved at once the steps must be targeted and concrete towards meeting the obligations. When setting priorities special attention has to be paid to the respect of the overarching norms of freedom of discrimination, respect for the dignity and integrity of the individual and right to information and participation. The comment underlines that “in times of severe resource constraints whether caused by a process of adjustment, of economic recession, or by other factors vulnerable members of society can and must indeed be protected.”

The General Comment No 14 on the Right to Health ICESCR 2001

In this comment the committee in collaboration with the WHO has developed comprehensive guidelines for the interpretation of “the right to health”. It discusses how “health” should be understood, what the obligations of the state are and what the responsibility of the individual should be.

The essential elements necessary for the fulfilment of the “right to health” mentioned are:

- *availability*. This includes not only functioning health care facilities but also underlying determinants for health such as water, sanitation, housing and food;
- *accessibility*. This includes four overlapping dimensions: non-discrimination, physical accessibility, economic accessibility and accessibility to information for all sections of the population;

- *acceptability*. This underlines the need for respect for the individual and the culture, medical ethics, the confidentiality of the individual and for gender and generation sensitivity. It includes the need for ability among health staff and decision makers to speak and understand the language as well as the beliefs around health and disease of the community and need for participation and influence from those concerned;
- *quality*. Health services should provide care, which is scientifically and medically appropriate and of good quality. This requires adequate regulations and control mechanisms and continuous training of staff.

The Committee develops which measures need to be taken for its implementation.

- In the comment they underline the need for sexual and reproductive health services, access to family planning and emergency obstetric care, as well as access to information and to “resources necessary to act on that information”. 12.2(a)
- They also underline the need for preventive measures in respect of occupational accidents and diseases, for adequate supply of potable water and basic sanitation, for food and housing and for discouraging the abuse of alcohol, and the use of tobacco, drugs and other harmful substances. 12.2(b)
- They point out the need for prevention and education programmes for behaviour-related health concerns such as sexually transmitted diseases, in particular HIV/AIDS, and those adversely affecting sexual and reproductive health, and the promotion of social determinants of good health, such as environmental safety, education, economic development and gender equity. 12.2(c)
- Medical services should include provision for equal and timely access to basic preventive, curative, rehabilitative health services and health education, regular screening programmes, appropriate treatment of prevalent diseases, illnesses, injuries and disabilities. An important aspect is also the improvement and furtherance of participation of the population. 12.2(d)

6 Mechanisms for Implementation and Monitoring

The Treaty Monitoring Bodies

The implementation of human rights by the state parties is monitored by UN committees (treaty monitoring bodies) related to the six core conventions (CCPR, CESCR, CERD, CEDAW, CAT, CRC). The committees develop interpretations, set standards, monitor implementation, promote compliance and investigate violations of human rights. They are appointed by and report to the United Nations General Assembly. They consist of independent experts representing different regions and professional backgrounds. All countries that have ratified the conventions have to report regularly to the committees, who review the reports and invite country representatives for a “constructive dialogue” with the committees on how to fulfil the human rights obligations under the conventions. The committees prepare concluding observations at the end of the sessions, presenting their observations and suggestions for how human rights can be enhanced in the respective countries. All reports should be made widely available in the community, to form a basis for a public debate and to encourage participation of the civil society in the process.

Reports and concluding observations as well as other documentation from the treaty bodies can be found on www.unhchr.ch in the treaty bodies database.

The Commission on Human Rights

The Commission with the Sub-commission on the Promotion and Protection of Human Rights has an important role in strengthening the work for human rights. They appoint special rapporteurs, independent experts and working groups to monitor and report on thematic human rights issues (e.g. violence against women, sale of children, effects of conflict on children), or on special regions and countries.

National Human Rights Institutions

Also at the national level there is a need for special institutions for the promotion and protection of human rights as well as for the monitoring of progress. The two main models are the National Human Rights Commissions and the Ombudsman. In a resolution⁶ by the General Assembly from December 1993 the role, composition, status and functions of national human rights institutions were agreed on. These principles (the Paris Principles) underline the importance of competence, a broad mandate, independence and a clear legal mandate, and state the main responsibilities of such an institution.

National and International NGO-community

The citizens and communities also have a role in monitoring the situation and advocating for respect for the individual and his/her rights. Their role has been very important in publicising violations against individuals by the health profession, as well as cruelty by military and paramilitary against health personnel. International and national NGOs prepare shadow reports to supplement the government reports to the different treaty monitoring bodies.

⁶ The Paris principles, Resolution A/RES/48/134 by the General Assembly 1993.

7 Important Actors

States

The states have representatives in the different UN bodies developing conventions, resolutions and declarations and they adopt and ratify UN human rights instruments. They are the main actors with the obligation to realise all the rights they have committed themselves to in the conventions. This they can do through laws, administrative systems/structures, budgeting, service provision, monitoring etc. This responsibility involves all sectors and levels of government and public administration. The governments have, when ratifying, undertaken to report to the UN-system on the implementation of human rights in their countries.

The UN-system

The UN-system represents the states parties as a group. It is responsible for organising the development of human rights instruments, for standard setting, for monitoring and for advocacy. Agencies within the UN-structure shall support countries technically, as well as financially, in their efforts to implement their human rights obligations.

Civil Society Organisations

Civil Society Organisations have an important role in representing the public, the rights-bearers. They advocate for the promotion, protection and fulfilment of human rights. Many act as watchdogs and monitor how governments and business, at home and internationally, protect, promote and fulfil human rights. Many CSOs contribute to improving access to services thereby supporting people's possibilities to have their rights fulfilled (education and health services). CSOs are bearers of norms, attitudes and value-systems that can both promote and violate human rights. People have the right to organise and to promote their ideas and views, but it is the responsibility of the government to regulate and monitor the CSO, so that they do not infringe on the rights of others or harm others.

Private Sector

The private sector is not formally a party to any convention, but they have an ethical/moral responsibility to follow international conventions. Governments have the responsibility to regulate and control the private sector to protect the rights of the citizens. With a more and more globalised business sector national legislation is not sufficient to regulate and control the activities. Working conditions and salary levels, as well as unethical, dishonest marketing are means of competition, and often the rights of workers are abused for the profit of the companies. Almost all industry and production may include processes, ingredients or waste products harmful to the health and well-being. Of special importance are the pharmaceutical and the food market. International co-operation to regulate and control the business sector becomes more and more urgent.

Sponsoring is becoming more common as a means of taking responsibility and showing concern by companies. Many companies institute their own human rights codes and social clauses.

Laos

The Swedish health development co-operation with Laos has focused on the provision of pharmaceuticals. The overall programme has been to contribute to good health, with focus on the poor and vulnerable population in the remote areas. The programme has included five projects:

quality of drugs, rational use of drugs, management of the quality assurance system, health systems research and programme administration.

These projects all have human rights implications. The provision of quality drugs is important for fulfilling the right to health care and protecting people from poor quality drugs and unethical prescribing and marketing.

8 A Rights-based Approach

A human rights approach to health sets the focus on basic principles of human rights, such as non-discrimination, participation, transparency, accountability and interdependence. International human rights documents give a normative long-term framework for analysis and action. Human rights clearly defines every individual in the society as the rights-holder, while the state has the obligation to respect, protect and fulfil the rights of its citizens. The state can use legislation, law enforcement, administrative systems and regulations, services, information and education as means to fulfil their obligations. In planning, programming and monitoring the basic principles of human rights have to be developed and considered.

- every human being has the same right to health *without discrimination*. To ensure this, a rights-based approach means that target-groups have to be analysed and disaggregated to discover their different needs and abilities. Gender, age, socio-economic background and other characteristics need to be considered and respected.
- every human being has the right to decide about his/her own life and to *participate* in public decision-making. For this to be possible access to *information* is crucial, both at an individual level and in society at large. People have the right to information about how to stay healthy and patients have the right to information about their ill health and available treatment. The community needs to be informed and given opportunity to influence how health services are developed, but also how to protect health by affecting underlying health determinants.
- the state parties have the obligation to respect, protect and fulfil the human rights of their citizens. They are *accountable* to their citizens for the way in which they strive to fulfil their obligations. For citizens to be able to follow and understand the process decision-making and activities have to be *transparent*.
- the different rights are *interdependent* and the realisation of one right, for example the right to health depends on the level of realisation of other rights such as education, housing, nutrition or security.

For the three themes in the Swedish health co-operation this would mean:

- for *public health* to focus on underlying determinants affecting health and regulating and restricting negative habits while at the same time respecting the integrity and decisions of the individual. Regulating and monitoring the activities of the private sector (tobacco industry, food industry and work-places) is another important area. Here development of legal systems and their follow-up are important together with information and education to the community.
- for *health systems development* to focus on issues of non-discrimination and on affordable and acceptable accessibility to services of good quality. The transparency and accountability of the providers (public and private) need to be developed as well as the provision of opportunities for dialogue with the community. Development of financing systems that can bear the

growing costs for health care is needed. Care should be taken so that those in need but without resources are not excluded. Training of health personnel to provide good quality care that does not violate the integrity and privacy of the patients is essential.

- for *sexual and reproductive health* to focus on providing adequate information and services to men, women, boys and girls in a manner that respects their different needs and beliefs. This has been an area with many HR-violations (sterilisation campaigns, lack of privacy, disregard for personal integrity of the individual) including poor access to quality service. Training of personnel and development of adequate services open to the needs of different groups such as youth is needed. The area of violence and abuse of women and girls that often has a sexual connotation needs more attention.

9 A Human Rights Perspective on Health Systems

Public Health is concerned with protecting and preserving the health of the community as a collective. It involves curative services, prevention of diseases and promotion of a healthy life. This may include restrictions on behaviour and choices of the individual both for his own and the community's benefit. Human Rights is concerned with protecting the rights and freedoms of the individual, which may at times be contrary to public health goals (smoking being a typical example).

Key rights related to the implementation of the right to health include:

- the right to non-discrimination
- the right to information and participation
- the right to privacy, physical integrity and confidentiality
- the right to education
- the right to a healthy environment and an adequate standard of living
- the right to work and to just and favourable conditions of work
- the right to social security

Human Rights have implications for public health and health services in many ways. They recognise the right of the individual to access to health services and the obligation of the government to fulfil this by making health services available to all. They include underlying determinants for health, as the right to housing, food, water, healthy occupational and environmental conditions etc. They are important in guiding how public health activities are implemented, so as not to violate the rights of the individuals. By offering adequate health services human rights will be protected and promoted in the community and by respecting human rights principles in the health services dignity and well being of the individual can be restored.

HR to Health	HR in Health Systems	HR through Health
Everybody should have access to affordable, adequate health services and to living conditions and information adequate for protecting health and preventing disease.	Everybody should be treated with dignity, without discrimination, irrespective of health problem and possibility for cure. Confidentiality and physical integrity should be respected.	Adequate health systems promote human rights by protecting and promoting good health and by restoring health, dignity and well being.

The “*right to (highest attainable) health*” expresses the right the individual has and the obligation of the state to guarantee this right. Health services should be provided equally to all persons within the jurisdiction of the state and nobody should be denied the right as a result of discriminatory regulations and practices. The Committee on the Rights of the Child underlines that illegal residency

is not an acceptable cause for exclusion. But it is not enough, not to deny anyone access to health services. A human rights approach requires that the government takes active steps to guarantee accessibility (financial, geographical, cultural etc) especially to marginalize and vulnerable groups, who otherwise may have no access. The realisation of “the right to health” requires setting priorities, developing functional and just systems for financing, for balancing the freedom of choice and the responsibility of the individual for her/his health and the need for restrictions and regulations to protect and promote public health.

The Alma Ata declaration from 1978 set the standard for how governments should develop health services for all. The services should be accessible and acceptable to everyone. They should be both curative and preventive and available to all at a cost the country and community could afford. The declaration underlines the importance of community participation and information. The individual has the main responsibility for his/her own health and the right to adequate information to protect and promote health. Communities should be supported in developing and running basic health services and supplied with necessary goods and personnel.

Realising *the right to health* involves both a focus on how the health system is organised and how it is financed. For everyone to have the right to health, the health system (every aspect that aims at improving the health of people) should be accessible to all. Special attention needs to be given to people living in remote areas, people belonging to marginalized groups (ethnic, religious minorities), displaced people and illegal residents (immigrants, refugees, slum-dwellers). The government has a special responsibility to make health available to these groups, whose health status is often poor. In planning and programming for improvement of underlying determinants and services the special needs and wishes of the respective groups need to be investigated and respected. Also the special needs of women, youth and children need attention.

The financing of the health system is a problem for all countries. Health service costs increase constantly as new medication and new treatments are introduced. Financing can be organised in different ways, through taxation, through an individual or employment related insurance system, through user fees or a combination of them. Whichever system is chosen it is the responsibility of the government to monitor the effects for all sections of society, so that everyone has access to affordable services.

Human Rights in the health services refer to how health services are provided and how patients, citizens experience the services. Human rights are often violated in the health services. Patients are dependent and insecure in the situation and know little about their rights. It is easy for health personnel to misuse the position. Withholding information and denying the patient the right to participation in decisions about treatment and care is common. The right to privacy, confidentiality, physical integrity and individual autonomy are also often violated. It is the obligation of the government to institute clear rules and regulations to protect patients and to monitor compliance. These rules should be the same for public and private institutions.

Everybody has the right to be treated with dignity and respect for her/his physical integrity and privacy irrespective of health problem and possible cure, as

Colombia

Colombia adopted a general system of social security in health using the general clauses of its constitution as a basis for legislative regulation. This reform managed to triple the health coverage from 19% in 1992 to 61% in 1996.

Theoretically the rest of the population is covered by the public sector health system, but there is still a large group who lack effective coverage.

(Report from ILO/PAHO meeting in Mexico 1999)

Vietnam

The Vietnamese-Swedish Health Co-operation from 1994–2001 included a special support to develop health services for disadvantaged areas to reduce the inequalities in health status and health services in the country.

In the planning special consideration was given to the cultural aspects of the minority groups and their participation in the process was sought.

well as any other reason for discrimination (i.e. sex, age, ethnic background, religion, diagnosis etc). Everybody has the right to access to information about her/his health status as well as about treatment and other relevant facts. Adequate health services include a requirement for competent staff with ability to communicate and understand the patients' needs and situation.

An area of controversy is when the patient and the medical profession do not agree on the treatment, when the patient refuses to, or is unable to follow prescriptions. Here practice differs between countries depending on where the human rights emphasis is put. In Sweden the rights of the profession and the authorities go further than in e.g. the USA, where the rights of the individual has a stronger stand. (Restrictions for HIV+ persons, rules relating to the treatment of children, DOTS programmes for TB-patients etc). Limitations and derogation clauses exist in all human rights instruments, recognising the need of the state to limit the rights of its citizens at certain times for the protection of the individual and public health. This may mean interference with the freedom of movement and isolation to fight an epidemic (e.g. ebola).

HIV/AIDS

Stigma and discrimination is a major problem in relation to HIV/AIDS, which has contributed to its spread and to the suffering of those affected. Confidentiality has been violated which has caused many to avoid being tested and counselled, which in turn has affected the preventive work. Lack of true and honest information has denied people the knowledge on how to protect themselves and others, and sometimes even exposed people to abuse and violence. Fear and lack of knowledge has left many AIDS-patients without the basic care and help they needed.

Only as a last resort can human rights be interfered with to achieve a public health goal. Such interference can only be justified when all of the narrow defined circumstances set out in human rights law, known as the *Siracusa Principles*⁷, are met. It defines in five principles under which a government may restrict people's movements and actions.

The *Siracusa Principles* define under which conditions a government may restrict people's movements and actions:

- the restriction is provided for and carried out in accordance with the law;

- the restriction is in the interest of a legitimate objective of general interest;
- the restriction is strictly necessary to achieve the objective;
- there are no less intrusive and restrictive means available to reach the same objective;
- the restriction is not drafted or imposed arbitrarily, i.e. in an unreasonable or otherwise discriminatory manner.

Human Rights through Health

In providing adequate living conditions, access to potable water, necessary nutrition and accessible and acceptable health services governments fulfil their human rights obligations and contribute to the dignity and well being of the population.

A healthy population contributes to productivity, development and economic growth. And this in turn increases the possibility to improve living-conditions and underlying determinants for health as well as creating funds for health services. Health and well being are basic to the enjoyment of other human rights such as education, freedom of speech, free movement, work etc.

Access to health services and rehabilitation is especially important for people who without the input of health promoting activities would not be able to enjoy their basic rights in society, such as people with disabilities, people who have been abused and people with chronic disease.

CBR on the West-bank and Gaza

Diakonia is, with support from Sida, running a rehabilitation programme on the Westbank and Gaza. The aim of the programme is to “improve the quality of life for people with disability through more equitable possibilities to participate in society, promotion of the rights of disabled people and through improved care and support”. This shall be done by “contributing to the development and implementation of a coordinated national programme for rehabilitation with a focus on CBR (community based rehabilitation) as the national strategy”. While “the main target group is the local community in its broad sense, special reference is made in all activities to *enhance the rights of women and promote the Convention on the Rights of the Child with the girl child as the special priority*”.

The programme is implemented in collaboration with some 20 local NGOs involved in CBR-activities in their regions, with specialised rehabilitation clinics, universities, the ministries for health, education, sports and organisations of the disabled. The choice of the CBR-method has lead to increased knowledge and insight about disability, about its causes and the possibilities to improve the situation of the disabled and their families. And with knowledge comes attitude change.

The programme has meant new possibilities for disabled. It has given them *access to society and strengthened their ability and possibility to impact their own lives*. It has also enhanced the collaboration between civil society organisations and the Palestinian Authority and their respect for each other's role.

According to the impact assessment from 2001 “the CBR has contributed to *increase awareness, changed attitudes towards people with disabilities in a positive direction, and spread information about causes of disabilities to counter superstition and stigmatisation*. This in turn has contributed to improve the status of individuals with disabilities and their families”.

10 Conclusion

Human Rights are entitlements that states have agreed to grant all their citizens. They are common to all countries that have ratified them and the countries are mutually responsible to each other for respecting, protecting and fulfilling them. Sweden has the main human rights conventions in common with most countries with which Sweden has development co-operation. As a State Party Sweden has an obligation to adhere to the human rights conventions. One important aspect of the conventions is the reference to international co-operation to fulfil the obligations. This is of special importance in relation to the needs of developing countries with a shortage of resources to fulfil the social, economic and cultural rights such as “the right to health”.

Referring to and promoting Human Rights in the health co-operation may open the way for discussions also around other HR-themes.

When overarching principles of human rights programming are used in dialogue and planning for health co-operation it will affect the respect for the dignity and rights of the individual also outside the health field.

Reference literature

1. The International Covenant on Social, Economic and Cultural Rights.

Resolution 2200A (XXI) of 16 December 1966

Entry into force 3 January 1976

2. The Convention on the Elimination of All Forms of Discrimination against Women

Resolution 34/180 of 18 December 1979

Entry into force 3 September 1981

3. The Convention on the Rights of the Child

Resolution 44/25 of 20 November 1989

Entry into force 2 September 1990

4. The right to highest attainable standard of health.

CESCR General Comment 14, E/C.12/2000/4

5. Women and Health

CEDAW General Comment 24, 2 February 1999

6. Questions and Answers on Health and Human Rights

WHO Document from March 2002

7. WHO Strategy on Health and Human rights

WHO Document, Draft September 2000

8. Vienna Declaration and Programme for Action

A/CONF. 157/23

List of Health Division Documents

Strategies/Policies		Issue Papers	
1997:1	Policy for Development Cooperation Health Sector	1998:1	Maternal Health Care, by Staffan Bergström
1997:2	Política para la Cooperación para el Desarrollo Sector Salud	1998:2	Supporting Midwifery, by Jerker Liljestrand
1997:3	Position Paper Population, Development and Cooperation	1998:3	Contraception, by Kajsa Sundström
1997:4	Positionspapper Befolkning, utveckling och samarbete	1998:4	Abortion, by Kajsa Sundström
1997:5	Marco de Referencia para la Cooperación para el Desarrollo Población, Desarrollo y Cooperación	1998:5	Female Genital Mutilation, by Beth Maina-Ahlberg
1997:6	Strategy for Development Cooperation Sexual and Reproductive Health and Rights	1998:6	Adolescent Sexuality Education, Counselling and Services, by Minou Fuglesang
1997:7	Estrategia para la Cooperación para el Desarrollo Salud y Derechos Sexuales y Reproductivos	1998:7	Discrimination and Sexual Abuse Against Girls and Women, by Mary Ellsberg
1997:8	Handbook for mainstreaming A Gender Perspective in the Health Sector	1998:8	Health Care of the Newborn, by Ragnar Thunell
1999	Investing for future generations. Sweden's International Response to HIV/AIDS	1998:9	Men, Sexuality and Reproductive Health, by Beth Maina-Ahlberg, Minou Fuglesang and Annika Johansson
2000:2	Guidelines for Action – Illicit Drugs and Swedish International Development Cooperation	1998:10	Illicit Drugs and Development Cooperation, by Niklas Herrmann – Replaced by 2000:2 –
2001:1	Hälsa & Utveckling, Fattigdom & Ohälsa – ett folkhälsoperspektiv by Göran Paulsson, Ylva Sörman Nath and Björn Ekman	1999:3	Socio-economic Causes and Consequences of HIV/AIDS by Stefan de Vylder
		2000:1	HIV/AIDS in the World Today – a Summary of Trends and Demographic Implications by Bertil Egerö and Mikael Hammar skjöld
		2001:2	Health and Environment by Marianne Kjellén
		2001:3	Improving Access to Essential Pharmaceuticals, by IHCAR
		2001:5	A Development Disaster: HIV/AIDS as a Cause and Consequence of Poverty by Stefan de Vylder
		2001:6	National Health Accounts – Where are we today? by Catharina Hjortsberg
		2001:7	Ideas work better than money in generating reform – but how? by Alf Morten Jerve
		2002:2	Health and Human Rights by Birgitta Rubenson

Continues

Health Division Documents and a complete list of earlier publications may be ordered from:

Infocenter, Sida S-105 25 Stockholm, phone: +46 (0)8 698 55 80, fax: +46 (0)8 698 56 15
www.sida.se, e-mail: info@sida.se

Facts and Figures	
1995/96	Facts & Figures 95/96 Health Sector Cooperation
1997	Facts & Figures 1997 Health Sector
1999:2	Facts & Figures 1998 Health Sector
2000:3	Facts & Figures 1999 Health Sector
2001:4	Facts & Figures 2000 Health Sector
2002:1	Facts & Figures 2001 Health Sector

Country and Regional Health Profiles	
1995	Angola
1995	Bangladesh
1995	El Salvador
1995	Ethiopia
1995	Guatemala
1995	Guinea Bissau
1995	Honduras
1995	India
1995	Kenya
1995	Laos
1995	Nicaragua
1995	Vietnam
1995	West Bank/Gaza
1995	Zambia
1995	Zimbabwe'
2000:4	Uganda
2000:5	West Africa

Fact Sheets	
1997	Hälso och sjukvård
1997	Reformer inom hälsosektorn
1997	Rätten till sexuell och reproduktiv hälsa
1997	Befolkning och utveckling
1997	Ungdomshälsa
1997	Handikappfrågor
1999	Aidsbekämpning i Uganda
1999	Förebyggande insatser mot drogmissbruk
1999	Insatser mot familjevåld i Centralamerika
1999	Bättre mödrahälsovård i Angola
1999	Utbildningssamarbete Kenya-Linköping
2001	Sveriges stöd till Hiv/Aids-insatser – 2001
2002	Fler välutbildade barnmorskor ger tryggare förlossningar
2002	Femina skapar het debatt om sex och hiv
2002	Rent vatten ger bättre hälsa och ökad jämställdhet

Sida Evaluations	
98/14	Expanded Programme on Immunization in Zimbabwe
99/10	Working with Nutrition. A comparative study of the Tanzania Food and Nutrition Centre and the National Nutrition Unit of Zimbabwe
99/11	Apoyo de Asdi al Sector Salud de Nicaragua. Prosilais 1992–1998
99/36	Support to Collaboration between Universities. An evaluation of the collaboration between MOI University, Kenya, and Linköping University, Sweden
01/03	Tackling Turmoil of Transition. An evaluation of lessons from the Vietnam-Sweden health cooperation 1994 to 2000
01/32	Review of PAHO's project. Towards an integrated model of care for family violence in Central America. Final report
02/13	Sida's Support to the Reproductive Health and TANSWED HIV Research Programmes in Tanzania

Continues

Health Division Documents and a complete list of earlier publications may be ordered from:

Infocenter, Sida S-105 25 Stockholm, phone: +46 (0)8 698 55 80, fax: +46 (0)8 698 56 15
www.sida.se, e-mail: info@sida.se

Other documents

- 1999:1 Report on:
World Youth Conferences in Portugal
August 1998, by Wanjiku Kaime-Atterhög
and Anna Runeborg
- 2000:6A Framtid Afrika –
Huvudrapport
- 2000:6B Annex to Framtid Afrika –
Health Support in Africa – Country Reports
- 1998 Gender and Tuberculosis
- 2000 Webs Women Weave
- 2001 Hälsa – en nyckel till utveckling
- 2001 Jord för miljarder
- 2001 Aids: The Challenge of this Century
- 2002 Health Sector Reforms: What about Hospitals?

Health Division Documents and a complete list of earlier publications may be ordered from:

Infocenter, Sida S-105 25 Stockholm, phone: +46 (0)8 698 55 80, fax: +46 (0)8 698 56 15
www.sida.se, e-mail: info@sida.se



SWEDISH INTERNATIONAL DEVELOPMENT COOPERATION AGENCY

Address: S-105 25 Stockholm, Sweden. Office: Sveavägen 20, Stockholm

Telephone: + 46 (0)8-698 50 00. Telefax: + 46 (0)8-20 88 64

www.sida.gov.se e-mail: info@sida.se