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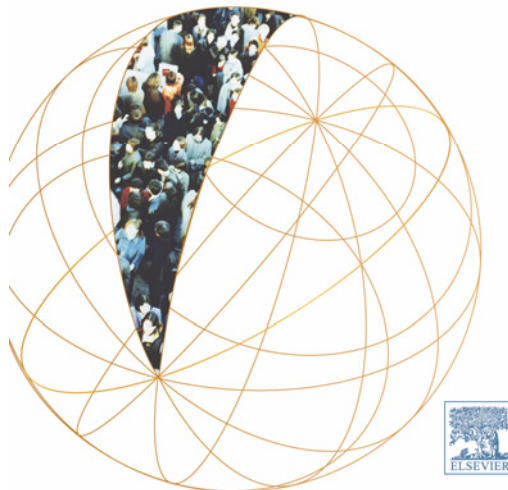
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## PUBLIC HEALTH

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## Human Rights Approach to Public Health Policy

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### Introduction

The origin and justification for human rights, whether anchored in natural law, positive law, or other theories and approaches laid out by various authors, as well as their cultural specificity and actual value as international legal commitments, remains subject to ongoing lively debate. Theoretical and rhetorical discourses continue to challenge and enrich current understanding of the relevance of human rights for policy and governance. Nonetheless, human rights have found their way into public health and play today an increasing role in the shaping of health policies, programs, and practice.

Health and human rights are not distinct but intertwined aspirations. Viewed as a universal aspiration, the notion of health as the attainment of physical, mental, and social well-being implies its dependency on and contribution to the realization of all human rights. From the same perspective, the enjoyment by everyone of the highest attainable standard of physical and mental health is in itself a recognized human right. From a global normative perspective, health and human rights are closely intertwined in many international treaties and declarations supported by mechanisms of monitoring and accountability (even as their effectiveness can be questioned) that draw from both fields.

With respect to health specifically, it is arguably viewed as an important prerequisite for and desirable outcome of human development and progress. Health is

...directly constitutive of the person's wellbeing and it enables a person to function as an agent – that is, to pursue the various goals and projects in life that she has reason to value. (Anand, 2004: 17–18)

Health is also the most extensively measured component of well-being; it benefits from dedicated services and is commonly seen as a *sine-qua-non* for the fulfillment of all

other aspirations. It may also be... “a marker, a way of keeping score of how well the society is doing in delivering well-being” (Marmot, 2004: 37).

Health and human rights individually occupy privileged places in the public discourse, political debates, public policy, and the media, and both are at the top of human aspirations. There is hardly a proposed political agenda that does not refer to health in its own right, as well as justice, security, housing, education, and employment opportunities – all with relevance to health. These aspirations are often not framed as human rights but the fact that they are contained in human rights treaties and often translated into national constitutions and legislations provides legal support for efforts in these areas.

Incorporating human rights in public health policy therefore responds to the demands of people, policy makers, and political leaders for outcomes that meet public aspirations. It also creates opportunities for helping decipher how all human rights and other determinants of well-being and social progress interact. It allows progress toward these goals to be measured and shapes policy directions and agendas for action.

This article highlights the evolution that has brought human rights and health together in mutually reinforcing ways. It draws from the experience gained in the global response to HIV/AIDS, summarizes key dimensions of public health and of human rights and suggests a manner in which these dimensions intersect that may be used as a framework for health policy analysis, development, and evaluation.

### Human Rights as Governmental Obligations

Human rights constitute a set of normative principles and standards which, as a philosophical concept can be

traced back to antiquity, with mounting interest among intellectuals and political leaders since the seventeenth century (Tomushat, 2003). The atrocities perpetrated during World War II gave rise, in 1948, to the Universal Declaration of Human Rights (United Nations, 1948) and later to a series of treaties and conventions that extended the aspirational nature of the UDHR into instruments that would be binding on states under international human rights law. Among these are the International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social, and Cultural Rights (ICESCR), both of which came into force in 1976.

Human rights are legal claims that persons have on governments simply on the basis of their being human. They are “what governments can do to you, cannot do to you and should do for you” (Gruskin, 2004). Even though people hold their human rights throughout their lives, they are nonetheless often constrained in their ability to fully realize them. Those who are most vulnerable to violations or neglect of their rights are also often those who lack sufficient power to claim the impact of the lack of enjoyment of their rights on their well-being, including their state of personal health. Human rights are intended to be inalienable (individuals cannot lose these rights any more than they can cease being human beings); they are indivisible (individuals cannot be denied a right because it is deemed less important or nonessential); they are interdependent (all human rights are part of a complementary framework, one right impacting on and being impacted by all others) (United Nations, 1993). They bring into focus the relationship between the State – the first-line provider and protector of human rights – and individuals who hold their human rights simply for being human. In this regard, governments have three sets of obligations toward their people (Eide, 1995):

- They have the obligation to respect human rights, which requires governments to refrain from interfering directly or indirectly with the enjoyment of human rights. In practice, no health policy, practice, program, or legal measure should violate human rights. Policies should ensure the provision of health services to all population groups on the basis of equality and freedom from discrimination, paying particular attention to vulnerable and marginalized groups.
- They have the obligation to protect human rights, which requires governments to take measures that prevent non-state actors from interfering with human rights, and to provide legal means of redress that people know about and can access. This relates to such important non-state actors as private health-care providers, pharmaceutical companies, health insurance companies and, more generally, the health-related industry, but also national and multinational enterprises whose

actions can impact significantly on lifestyle, labor, and the environment such as oil and other energy-producing companies, car manufacturers, agriculture, food industry, and labor-intensive garment factories.

- They have the obligation to fulfill human rights, which requires States to adopt appropriate legislative, administrative, budgetary, judicial, promotional, and other measures toward the full realization of human rights, including putting into place appropriate health and health-related policies that ensure human rights promotion and protection. In practice, governments should be supported in their efforts to develop and apply these measures and monitor their impact, with an immediate focus on vulnerable and marginalized groups.

Government responsibility for health exists in several ways. The right to the highest attainable standard of health appears in one form or another in most international and regional human rights documents, and equally importantly, nearly every article of every document can be understood to have clear implications for health.

### The Right to Health

The right to the highest attainable standard of health builds on, but is by no means limited to, Article 12 of the ICESCR (Table 1). Rights relating to autonomy, information, education, food and nutrition, association, equality, participation, and nondiscrimination are integral and indivisible parts of the achievement of the highest attainable standard of health, just as the enjoyment of the right to health is inseparable from all other rights,

**Table 1** The right to highest attainable standard of health, Article 12 of the International Covenant on Economic, Social and Cultural Rights

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
  - a. The provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child
  - b. The improvement of all aspects of environmental and industrial hygiene
  - c. The prevention, treatment, and control of epidemic, endemic, occupational and other diseases
  - d. The creation of conditions which would assure to all medical service and medical attention in the event of sickness

From United Nations (1966a) *Article 2, International Covenant on Economic, Social and Cultural Rights*. United Nations General Assembly Resolution 2200A [XXI], 16/12/1966, entered into force 03/01/1976 in accordance with Art 17. New York: United Nations.

whether they are categorized as civil and political, economic, social, or cultural. This recognition is based on empirical observation and on a growing body of evidence that establishes the impact that lack of fulfillment of any and all of these rights has on people's health status: Education, nondiscrimination, food and nutrition epitomizing this relationship (Gruskin and Tarantola, 2001). Conversely, ill-health constrains the fulfillment of all rights as the capacity of individuals to claim and enjoy all their human rights depends on their physical, mental, and social well-being.

The right to health does not mean the right to be healthy as such, but the obligation on the part of the government to create the conditions necessary for individuals to achieve their optimal health status. In addition to the ICESCR, the right to health is further elaborated in CERD (Convention on the Elimination of all forms of Racial Discrimination, 1965); in CEDAW (Convention on the Elimination of all forms of Discrimination against Women, 1979), and CRC (Convention on the Rights of the Child art 24 1989) and in a range of regional human rights documents.

In May 2000, the United Nations Committee on Economic, Social, and Cultural Rights adopted a General Comment further clarifying the substance of government obligations relating to the right to health (UN Committee on Economic, Social and Cultural Rights, 2000). In addition to clarifying governmental responsibility for policies, programs and practices impacting the underlying conditions necessary for health, it sets out requirements related to the delivery of health services including their availability, acceptability, accessibility, and quality. It lays out directions for the practical application of Article 12 and proposes a monitoring framework. Reflecting the mounting interest in determining international policy focused on the right to health, the UN Commission on Human Rights appointed in 2002 a Special Rapporteur whose mandate concerns the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. The Special Rapporteur's role is to undertake country visits, transmit communications to states on alleged violations of the right to health, and submit annual reports to the Commission and the UN General Assembly. Accordingly, through publication review and country visits, the Special Rapporteur has explored policies and programs related to such issues as maternal mortality, neglected medicines, and reproductive health as they connect to human rights (Hunt, 2007).

All international human rights treaties and conventions contain provisions relevant to health as defined in the preamble of the Constitution of the World Health Organization (WHO), repeated in many subsequent documents and currently adopted by the 191 WHO Member States: Health is a "state of complete physical, mental, and social

well-being, and not merely the absence of disease or infirmity." The Constitution further stipulates that "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, political belief, economic or social condition." The Constitution was adopted by the International Health Conference held in New York from 19 June to 22 July 1946, signed on 22 July 1946 by the representatives of 61 States (World Health Organization, 1946), and entered into force on 7 April 1948. Amendments adopted by the Twenty-sixth, Twenty-ninth, Thirty-ninth and Fifty-first World Health Assemblies (resolutions WHA26.37, WHA29.38, WHA39.6 and WHA51.23) came into force on 3 February 1977, 20 January 1984, 11 July 1994 and 15 September 2005, respectively, and are incorporated in the present text.

## The Emergence of a New Public Health

The focus of public health from its inception in the eighteenth century through the mid-1970s remained on combating disease and some of its most blatant social, environmental, and occupational causes. The state acted as a benevolent provider of services and the source of policies, laws, regulations, and practices generally based on the disease prevention and control model emphasizing risk- and impact-reduction strategies through immunization, case finding, treatment, and changes in domestic, environmental, and occupational hygiene.

In 1978, the Alma Ata conference solidified a new international health agenda (Litsios, 2002). The aim of achieving Health for All by the Year 2000 was put forward, and this was to be achieved through a Primary Health Care (PHC) approach. Invoking the human right to the highest attainable standard of health, the Declaration of Alma Ata called on nations to ensure the availability of the essentials of primary health care, including education concerning health conditions and the methods for preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common disease and injuries; and provision of essential drugs (Declaration of Alma Ata, 1978).

The 1980s also witnessed the recognition that health was not merely determined by social and economic status but was dependent on dynamic social and economic determinants that could be acted upon through policy and structural changes. In 1986, the Ottawa Charter on Health Promotion helped sharpen the vision of the relationships between individual and collective health and its social, economic, and other determinants (Ottawa

Charter for Health Promotion, 1986). The Charter spelled out the fundamental conditions and resources for health as peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice, and equity. All of these prerequisites could have been framed as human rights. Probably to stay clear from political controversy that could have been divisive and best been addressed in a United Nations forum, however, the Charter did not explicitly bring human rights or state obligations into play.

The late 1980s and the 1990s saw growing attention being directed in the policy discourse to human rights and to their particular implications for health, and this resulted from several factors. First, the ICCPR and IESCR entered into force in 1976, and in the 1980s the UN Committees responsible for the monitoring of their implementation had begun to decipher their actual meaning and core contents, making the obligations of governments explicit and measurable. Second, the decay of the world geopolitical block ideologies of the late 1980s and the advent of economic neoliberalism created a space for alternate paradigms to help shape public policy and international relations. Human rights entered the scene of geopolitical reconstruction and became common parlance after the Glasnost and the fall of the Berlin Wall, in 1989, regardless of whether in reality they were used or abused by new political leaders. Third, the connection between human rights and health was increasingly being shaped around focal causes in various social and political movements. This resulted in the creation of NGOs, some of which engaged in human rights work (responding to torture in particular), others in advocacy around reproductive health and rights issues, while others provided health assistance in armed conflicts and natural disasters, all with the intent of positively impacting on policy and practice. Fourth, and particularly important for the ways this contributed to the integration of human rights concepts into health policy, the emergence of AIDS in 1981, and the recognition of HIV as a global pandemic, resulted in a variety of human rights violations by those seeking to address this mounting public health problem. As traditional disease control policies that had marked the earlier history of public health were put in place by state authorities, with a few exceptions, community-based and advocacy organizations, supported by academic groups, voiced the necessity for policies that afforded greater protections for the rights of people living with or vulnerable to HIV.

Until this time, the focus of public health had generally been to promote the collective physical, mental, and social well-being of people, even if in order to achieve public health goals, policies had to be implemented that sacrificed individual choice, behavior, and action for the common good. This was, and continues to be, exemplified by the principles and practices that guide the control of such communicable diseases as tuberculosis, typhoid, or

sexually transmitted infections, where quarantine or other restrictions of rights are imposed on affected individuals. In a number of instances, in particular where health policy addressed communicable diseases and mental illness, restrictions of such rights as privacy, free movement, autonomy, or bodily integrity have been imposed by public health authorities with the commendable intention to protect public health even without valid evidence of their intended public health benefit. The current resurgence of this issue in the context of systematic testing for HIV in health facilities or within entire populations, advocated by some in order to enhance the early access to care and treatment by people found infected, illustrates that disease control methods blind to human rights have by no means vanished. Insufficient attention has been devoted to assessing and monitoring the impact of such policies on the life of people whose rights were being restricted or denied, and to the negative consequences such impositions can have on their willingness to participate supportively in public health efforts that concern them. Public health abuses have also been exemplified by policies which result in the excessive institutionalization of people with physical or mental impairments where alternate care and support approaches have not been adequately considered. In the fields of disability and in mental health, in a number of countries national policies have been found to be discriminatory and, in the case of mental health, at times when carried out in practice to amount to inhuman and degrading treatment. And far from uncommon was – and remains – something often invisible to policy but invidious if not adequately addressed, discrimination in the health-care setting on the basis of health status, gender, race, color, language, religion, or social origin, or any other attribute that can influence the quality of services provided to individuals by or on behalf of the State.

### **HIV and Genesis of the Integration of Human Rights into Health Practice**

Cognizant of the need to engage HIV-affected communities in the response to the fast-spreading epidemics in order to achieve their public health goals, human rights were understood as valuable by policy makers not for their moral or legal value but to open access to prevention and care for those who needed these services most, away from fear, discrimination and other forms of human rights violations, and as a way to ensure communities that needed to be reached did not go underground. The deprivation of such entitlements as access to health and social services, employment, or housing imposed on people living with HIV was understood to constrain their capacity to become active subjects rather than the objects of HIV programs, and this was recognized as unsound from a public health perspective.

The evolution of thinking about HIV/AIDS moved from the initial recognition of negative effects of human rights violations among people living with HIV to principles that guided the formulation of a global strategy on HIV/AIDS and, beyond, to the application of these principles to other health issues. In the decade that followed the emergence of AIDS, tremendous efforts were made to induce behavior change through policies that supported intensified, targeted prevention efforts. Everywhere, the initial approaches to HIV had been focused on the reduction of risk of acquiring HIV infection through policies that supported the creation of protective barriers: The use of condoms, early diagnosis and treatment of sexually transmitted infections, and reduction in the number of sexual partners. Some of these efforts were successful on a small scale, in particular where communities were educated and cohesive, as was the case for communities of gay men on the East and West Coasts of the United States, Western Europe, and Australia. Less immediately successful were interventions in communities under immediate social or economic stress and those hampered in their ability to confront HIV/AIDS as a result of strong cultural and other barriers. In sub-Saharan African countries, for example, early interventions related to condoms and other prevention methods, even when supported by national-level policy, were confronted with denial and rejection. Gender-related discrimination was often at the core of resistance to change. Stigma and discrimination directed toward people living with HIV or people whose behaviors were associated with a risk of acquiring and transmitting infection (sex workers, injecting drug users, as well as people defined by their racial or ethnic characteristics) also created obstacles to reaching those who, even perhaps more than others, needed open access to prevention and care. For these reasons, the protection of human rights and combating discrimination became important underlying principles of the first Global Strategy on HIV/AIDS formulated by WHO in 1987 (World Health Organization, 1987).

The risk-reduction strategies of the late 1980s confronted several obstacles in implementation. One was the practical difficulty of scaling up successful approaches to national or international levels. Another was the poor results achieved from applying models proven successful in some settings to different social and cultural environments: Clearly, one size did not fit all. Empirical evidence showed that even as the capacity of individuals to minimize or modulate their risk of exposure to HIV was closely related to specific behaviors or situations, these were in turn influenced by a variety of other factors. In 1992, a risk-vulnerability analysis and reduction model was put forward, positing that in order to successfully impact on risk-taking behaviors, it was necessary to recognize and act on factors that determined the likelihood of individuals engaging in such behaviors

(Mann and Tarantola, 1992). A broader perspective suggesting the need for an expanded response to HIV began to emerge, bridging risk, as measured by the occurrence of HIV infection, to risk-taking behaviors, and to their vulnerability determinants. Vulnerability factors could be categorized for simpler analysis as individual (linked to personal history and status, agency, knowledge, or skills); societal (linked to social, economic, and cultural characteristics of the community within which people lived or had lived, including the policy and legal environment); and program-related (dependent on the capacity and approach of programs – health and social in particular) and the extent to which they responded appropriately to people's needs and expectations and assured their participation (Mann and Tarantola, 1996).

While the linkages between health outcomes and health determinants was already very present in the public health discourse, the mounting HIV epidemic made clear the need for policy to simultaneously address a wide and complex assembly of health outcome and determinants touching many facets of society. Simply listing these determinants born out of the established and empirical evidence was overwhelming. There was a need to categorize these determinants in a logical fashion and in a way that would allow them to be taken up by different sectors engaged in human development. The human rights framework was very well suited to this purpose in that it allowed vulnerability factors to be categorized as civil, political, social, economic, or cultural, and each of these factors, recognized through research or empirical evidence, could be easily linked to one or more specific human rights. This expanded approach helped clarify the related responsibilities of different sectors, thereby expanding the scope of public policy change and possible interventions. Importantly, these interventions could build on commitments already expressed, and obligations subscribed to, by governments under international human rights law. From an initial focus on nondiscrimination toward people known or assumed to live with HIV/AIDS, human rights was now helping guide the analysis of the roots, manifestations, and impacts of the HIV epidemics. Stemming from an instrumental approach rather than moral or legal principles, the response to HIV had exposed the congruence between sound public health policy and the upholding of human rights norms and standards (Mann *et al.*, 1994).

The analytical and action-oriented risk and vulnerability framework that linked HIV to the neglect or violations of human rights and the call for needed structural and societal changes grounded in solid policy were important features of the 1994 Paris Summit Declaration on HIV/AIDS (UNAIDS, 1999) and later served as one of the founding principles of the 1996 UNAIDS global strategy and its subsequent revisions (UNAIDS, 1996). These

ideas are also apparent in the Declaration of Commitment which emerged from the 2001 United Nations General Assembly.

International activism and a series of international political conferences that took place in this period facilitated similar changes in the approach taken to a wide range of diseases and health conditions, in particular with respect to reproductive and sexual health issues (Freedman, 1997). The 1994 Cairo International Conference on Population and Development was a watershed in recognizing the responsibility of governments worldwide to translate their international-level commitments into national laws, policies, programs, and practices that promote and do not hinder sexual and reproductive health among their populations. National laws and policies were thus open to scrutiny to determine both the positive and negative influences they could have on sexual and reproductive health programming, information, services, and choices. Human rights concerns, including legal, policy, and practice barriers that impact on the delivery and use of sexual and reproductive health services thereafter became a valid target for international attention.

### Human Rights and Health Policy in the New Millennium: Key Concepts

As, from a theoretical perspective, the interaction between health and human rights was drawing increased attention from policy makers in an expanding array of health-related domains, two issues were and continue to be cited as creating obstacles to the translation of theory into practice. The first is that the realization of the right to health cannot be made real in view of the structures, services, and resources it requires. The second, often cited by those concerned with communicable disease control, is that the protection of human rights should not be the prime concern of policy makers when and where such public health threats as emerging epidemics call for the restriction of certain individual rights. As these two obstacles are often used and misused to question the validity of the health and human rights framework, they are discussed briefly below.

### Progressive Realization of Health-Related Human Rights

In all countries, resource and other constraints can make it impossible for a government to fulfill all rights immediately and completely. The principle of progressive realization is fundamental to the achievement of human rights as they apply to health (United Nations, 1966a), and applies equally to resource-poor countries as to wealthier countries whose responsibilities extend not only to what

they do within their own borders, but also their engagement in international assistance and cooperation (United Nations, 1966b).

Given that progress in health necessitates infrastructure and human and financial resources that may not match existing or future needs in any country, the principle of progressive realization takes into account the inability of governments to meet their obligations overnight. Yet, it creates an obligation on governments to set their own benchmarks, within the maximum of the resources available to them, and to show how and to what extent, through their policies and practices, they are achieving progress toward the health goals they have agreed to in international forums such as the World Health Assembly, as well as those they have set for themselves. In theory, States account for progress in health (or lack thereof) through a variety of mechanisms that include global monitoring mechanisms, as well as national State of the Health of the Nation reports or similar forms of domestic public reporting.

### Human Rights Limitations in the Interest of Public Health

There remains a deeply rooted concern of many in the health community that application of a health and human rights approach to health policy will deprive the State from applying such measures as isolation or quarantine or travel restrictions when public health is at stake. Public health and care practitioners alike, acting on behalf of the State, are used to applying restrictions to individual freedom in cases where the enjoyment of these rights creates a real or perceived threat to the population at large. Recently, the SARS and Avian flu epidemics have demonstrated that such restrictions can also be applied globally under the revised International Health Regulations (IHR), the only binding agreement thus far under the auspices of WHO (World Health Organization, 2005). They stipulate that WHO can make recommendations on an *ad hoc*, time-limited, risk-specific basis, as a result of a public health emergency of international concern, and that implementation of these Regulations “shall be with full respect for the dignity, human rights and fundamental freedoms of persons.” The human rights framework recognizes that these are situations where there can be legitimate and valid restriction of rights, and this under several circumstances relevant to the creation of health policies: Public emergencies and public health imperatives. Public emergencies stipulate that in time of a public emergency that threatens the life of the nation and the existence of which is officially proclaimed, the States Parties to the present Covenant may take measures derogating from their obligations under the present Covenant to the extent strictly required by the exigencies of the situation, provided that such measures are not inconsistent with their other obligations under international law and do not

involve discrimination solely on the ground of race, color, sex, language, religion, or social origin (Art 49, ICCPR). Public health imperatives give governments the right to take the steps they deem necessary for the prevention, treatment, and control of epidemic, endemic, occupational, and other diseases (Art 16, ICCPR).

Public health may therefore justify the limitation of certain rights under certain circumstances. Policies that interfere with freedom of movement when instituting quarantine or isolation for a serious communicable disease – for example, Ebola fever, syphilis, typhoid, or untreated tuberculosis, more recently SARS and pandemic influenza – are examples of limitation of rights that may be necessary for the public good and therefore may be considered legitimate under international human rights law. Yet arbitrary restrictive measures taken or planned by public health authorities that fail to consider other valid alternatives may be found to be both abusive of human rights principles and in contradiction with public health best practice. The limitation of most rights in the interest of public health remains an option under both international human rights law and public health laws, but the decision to impose such limitations must be achieved through a structured and accountable process. Increasingly, such consultative processes are put in place by national authorities to debate over the approach taken to public health issues as they arise, such as in the case of immunization, disability, mental health, HIV, smoking, and more recently pandemic influenza preparedness.

Limitations on rights are considered a serious issue under international human rights law – as noted in specific provisions within international human treaties – regardless of the apparent importance of the public good involved. When a government limits the exercise or enjoyment of a right, this action must be taken only as a last resort and will only be considered legitimate if the following criteria are met:

1. The restriction is provided for and carried out in accordance with the law.
2. The restriction is in the interest of a legitimate objective of general interest.
3. The restriction is strictly necessary in a democratic society to achieve the objective.
4. There are no less intrusive and restrictive means available to reach the same goal.
5. The restriction is not imposed arbitrarily, i.e., in an unreasonable or otherwise discriminatory manner (United Nations, 1984).

The restriction of rights, if legitimate, is therefore consistent with human rights principles. Both principles of progressive realization and legitimate limitations of rights are directly relevant to public health policy as they can inform decisions on how to achieve the optimal

balance between protecting the rights of the individual and the best interest of the community. Examples of the impact of human rights violations and protection on public health are set out below. Discrimination – a frequent, severe, and persistent issue confronted both in society and in the health-care setting – has been chosen to illustrate how public health can be hampered by the neglect of human rights and enhanced by their incorporation in public health policy.

## Public Health Policy and Nondiscrimination

Discrimination can impact directly on the ways that morbidity, mortality, and disability – the burden of disease – are both measured and acted upon. In fact, the burden of disease itself discriminates: Disease, disability, and death are not distributed randomly or equally within populations, nor are their devastating effects within communities. Tuberculosis, for example, is exploding in disenfranchised communities, in particular among prison inmates and people already affected by HIV and subjected to dual discrimination both in their communities and in the health-care setting.

Far from uncommon, discrimination in health systems, including health centers, hospitals, or mental institutions, may further contribute to exacerbating disparities in health. A few examples of myriads that could be cited are named here. Undocumented migrant workers receive poor or no treatment for fear of having to justify their civil status. Documented migrant workers, refugees, and asylum seekers and their families may not avail themselves of services that have not been designed to suit their culture and respond to their specific needs. People with hemophilia have been given unsafe blood products on the premise that this adds only a marginal risk to their lives. People with physical or mental disabilities receive substandard care; they are unable to complain or if they do, they fare poorly in legal action (Moss *et al.*, 2007). Discrimination in health systems concerns not only diseases that are already stigmatized, such as AIDS, hepatitis B and C, tuberculosis, and cancer, but also others, such as diabetes and cardiovascular diseases, which could be alleviated if equal treatment within societies and within health-care settings became the norm. A health and human rights approach to policy development concerning health systems requires that state authorities refrain from enacting discriminatory policies and provide information, education, training, and support to their staff toward eliminating discrimination in public health practice and within the workforce.

Discrimination can also be at the root of unsound human development policies and programs that may impact directly or indirectly on health. For example, an infrastructure development project may require the

displacement of entire populations and fail to pay sufficient attention to the new environment to which these populations will have to adjust. In the developing world, when the health impact of large-scale development programs at the local level is considered, it is often from the perspective of the possible further spread of such infectious diseases as malaria and other waterborne diseases. The psychological capacity of displaced communities to relocate and rebuild new lives or the long-term physical and social consequences of such displacement are seldom factored into the equation.

The ongoing international movement toward poverty alleviation has emphasized the critical importance of health in the fight against poverty. The eight Millennium Development Goals (MDGs) – which set targets for 2015 to halve extreme poverty, halt the spread of HIV/AIDS, and improve health and education – have been agreed to by all the world's countries and all the world's leading development institutions (United Nations, 2005). Arguably, all MDGs have a linkage to health either by their direct bearing on health outcomes and the needed services (e.g., through efforts to reduce child and maternal mortality, HIV, malaria, and other diseases) or by underscoring principles central to public health policy (e.g., gender equality) or else by calling for the creation of policies addressing the underlying conditions for progress in health (e.g., education, environmental sustainability, and global partnerships).

### **Public Health Policy and the Value of Health and Human Rights**

Human rights and public health policy intersect in a number of ways, which, for practical purposes, can be regrouped into three broad categories: The national and international context within which policy is developed; the outcome of public policy; and the process through which it is developed, applied, and monitored.

#### **Context**

A distinction exists between public policy affecting health (most of them do) and public health policy (often emerging from public health governmental authorities or on their initiative). Policies affecting health – for example, those related to gender, trade, intellectual property, the environment, migration, education, housing, or labor – are contingent upon national laws and international treaties or agreements which often overlook – by omission or commission – their potential health consequences. As the Health Impact Assessment of development and social policies gained credence in the 1990s, the development of a human rights assessment for the formulation and evaluation of public health policies emerged (Gostin

and Mann, 1999). Health Impact Assessment (HIA), applying different methods, has become more frequently practiced to guide policy options both nationally and internationally. While the aim of such exercises is to forecast the health impact of a single or alternative policies or programs (including those related to infrastructure, financing, service delivery, transportation, or production and many others), the impact of such policies and programs on both health and human rights remains to be adequately tested. Much work is currently ongoing toward the development of a Health and Human Rights Impact Assessment for which assessment methods and health and human rights indicators are required.

An example where such an impact assessment might have been useful was when a number of countries – industrialized and developing alike – applied for membership of the World Trade Organization when such a membership implied for the signatory country to become party to the Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS). The constraints imposed by TRIPS on developing countries with regards to intellectual protection of pharmaceuticals in particular only became evident in the late 1990s as new, proven therapies for HIV/AIDS were reaching the international market. Civil society movements and some international organizations embarked on an active campaign to overcome the constraints set by TRIPS to the production or importation of generic medicines by developing countries needing them most. It was not until 2002, however, that WHO and WTO jointly produced a document on WTO agreements and public health (World Health Organization and World Trade Organization, 2002). In most developing countries, Ministries of Health had not been consulted, been equipped to assess, or had underestimated, the possible health impacts of the new trade and intellectual property agreement they were signing on to as new members of the WTO. This was and continues to be a painful reminder of the oversight or deliberate neglect of the possible health consequences of public policy guided by other agendas, international trade in this case.

Public health policy should seek the optimal synergy between health and human rights, building on the premise that the optimal quality of a public health policy is attained when the highest possible health outcome and the fullest realization of human rights are both attained. This requires a close interaction between public health professionals, human rights practitioners and representatives of affected communities. The response to HIV has been shaped by such an interaction with significant positive impact – at least in the short term – in such countries as Australia, Sweden, Thailand, Brazil, or Uganda. Where misconceptions about either sound public health or human rights have distorted HIV policies and programs,

the epidemic has continued to thrive, as illustrated by the situation in South Africa or China.

As it is generally formulated and monitored by the State, public health policy should operate in the context of the obligations the State has subscribed to under international human rights treaties and national law. Central to these obligations are those to respect, protect, and fulfill all human rights, including the rights to participate in public affairs and policy making, equality, nondiscrimination, and dignity.

### Outcome and Impact

Both public health policy and human rights emphasize the importance of outcome and impact, crudely measured in public health terms by the reduction of mortality, morbidity and disability, and the improvement of quality of life, along with economic measurement enabling an assessment of the value for money of particular policies or programs that can guide priority setting. The extent to which outcome includes the fulfillment of human rights is seldom factored in. For example, one would like to see the value of policies that promote sex education in school measured not only in terms of reduction of teenage pregnancy or the incidence of sexually transmitted diseases, but how the right of the child to information is fulfilled in this way and how it impacts on further demands for other health-related, life-saving information. Likewise, when assessing the outcome and impact of policies that prioritize childhood immunization programs, one would want to know not only how immunization makes people healthier, both early and later in their childhood, but also how such public health policies will advance the right of the child to growth and development and her right to education by improving her attendance to and performance at school.

Measuring the outcome and impact of health and health-related policies from a combined health and human rights perspective implies measurement indicators that are neither fully developed nor tested. One of the constraints is that measuring health and human rights on the national, aggregate level is not sensitive to disparities that may exist within the nation, for example as a result of discrimination.

### Process

The human rights to information, assembly, and participation in public affairs – including policy making – imply, among other practical steps, the engagement of communities in decisions affecting their health. As highlighted earlier, the history of health and human rights has amply established that community representation in decision-making bodies increases the quality and impact of public health measures. An important issue is to

determine who can legitimately speak on behalf of concerned communities. In the last two decades, stimulated by the response to HIV in particular, nongovernmental organizations, and more broadly civil society, have played key roles in drawing attention to policies that were or could be detrimental to health (e.g., restrictions in access to medicines, denial of sex education of young people, access to harm reduction methods among substance users, promotion of tobacco products in young people, marginalized communities and low-income countries, environmental degradation, marketing of unhealthy foods). While state machineries are increasingly cognizant of the growing need for transparency in policy development, civil society is likely to sustain its contribution to such a process, and this through active monitoring by national-level NGOs and such international groups as Amnesty International, Human Rights Watch, or Physicians for Social Responsibility.

### In Conclusion

This article has attempted to lay out the principles underlying the application of health and human rights principles to public health policy, and it has done so by recalling the historical emergence of these concepts and the opportunities they provide for new approaches to policy development.

Health and human rights, together and independently from each other, have achieved today a degree of prominence in the political and public discourse never witnessed before. The fields of health and rights are illuminated today by their commonalities, no longer by their differences. Both are obligations of governments toward their people; and each supports and requires the fulfillment of the other.

Overall, health and human rights provide a framework for all aspects of policy and program development. In practice, human rights considerations are often built into public health policy through the application of what are today called rights-based approaches. The practical application of these principles is a subject of active and rich debates. Rights-based approaches to health are but some of the attempts currently being made to offer practical guidance to health policy makers and other stakeholders in health and human rights toward translating these principles into health policies, programs, and interventions. Through further reflection, practice and research, public health and human rights practitioners can further establish how and to what extent the promotion and protection of health and human rights interact. In the search for a world where the attainment of the highest standard of physical, mental, and social well-being necessitates, and reinforces, the dignity, autonomy, and progress of every human being, the broad goals of health and human rights

are universal and eternal. They give us direction for our understanding of humanity and practical tools for use in our daily work.

See also: Global Health Initiatives and Public Health Policy; Health Policy: Overview; Law, and Public Health Policy; The State in Public Health, The Role of.

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