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Table 3 Approaches to health and disease

<i>Causal model</i>	<i>Components</i>	<i>Emphasis</i>	<i>Protection</i>	<i>Actors</i>
Ecological triad	Agent, Host, Environment	Health services organization	Disease prevention	Health professionals
Health field	Human biology, Environment, Lifestyle, Organization of health care	Intersectorality, Empowerment	Health promotion	Individuals, Social movements, Governments
Risk	Statistical association between exposure and disease	Risk management	Disease prevention	Individuals, Health professionals and managers
Vulnerability	Individual, social and health-program aspects	Empowerment	Health promotion	Individuals, Social movements

See also: Health Promotion; WHO Definition of Health, Rethinking the.

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Health and Human Rights: Overview

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Introduction

What role do human rights have in public health work? Since the early stages of the women's health, reproductive health, and indigenous health movements it has been asserted that public health policies and programs must be cognizant and respectful of human rights norms and standards. It has also been stated that lack of respect for human rights hampers the effectiveness of public health policies and

programs. For the last decade or so, an interdisciplinary 'health and human rights' movement has been generating scholarship and inspiring programming intended to realize "the highest attainable standard of health" (UN International Covenant on Economic, Social, and Cultural Rights, 1966; Gruskin and Tarantola, 2001) with a particular focus on the most underserved and marginalized populations and human rights language has been integrated into numerous national and international public health strategies, such as

those embraced by [UNAIDS \(2005, 2006\)](#). Yet moving beyond the rhetoric, there is still diversity of opinion as to what this means in practice.

Given that many public health practitioners are interested in the application of human rights to their work even as they are unsure what besides having a good heart this means for their efforts, as a first step an understanding of some aspects of human rights is necessary. In the present article we attempt to set out what application of these concepts has meant to date in practice, discuss 'rights-based' approaches to health, and suggest questions and concerns for the future.

Although this article will not seek to incorporate bioethical frameworks into the discussion, it is important to recognize the long-standing relationship of those working in bioethics and those working in human rights in relation to health (see, e.g., [UNESCO, 2005](#)). The two fields are distinct, but they do overlap particularly in relation to instituting international guidelines for research via professional norm-setting modes. Human rights and ethics in health are closely linked, both conceptually and operationally ([Mann, 1999](#); [Gruskin and Dickens, 2006](#)). Each provides unique, valuable, and concrete guidance for the actions of national and international organizations focused on health and development. Public health workers should appreciate their distinct value, but also the differences in the paradigms they represent in particular with respect to means of observance, action, and enforcement. The similarities and differences between bioethics and human rights frameworks for strengthening protections in relation to health are beginning to be explored but are outside the scope of the present article.

In the work of public health we have learned that explicit attention to human rights shows us not only who is disadvantaged and who is not, but also whether a given disparity in health outcomes results from an injustice. Human rights are now understood to offer a framework for action and for programming, as well as providing a compelling argument for government responsibility – not only to provide health services but also to alter the conditions that create, exacerbate, and perpetuate poverty, deprivation, marginalization, and discrimination ([Gruskin and Braveman, 2005](#)). A diverse array of actors are increasingly finding innovative ways to relate human rights principles to health-related work, thereby demonstrating how a human rights perspective can yield new insights and more effective ways of addressing health needs within country settings as well as in the policy and programmatic guidance offered at the global level.

Approaches to Bringing Human Rights into Health Work

Over time it has become clear that people tend to work in a variety of ways to further work on health and human

rights, and that while some take health as an entry point, others take human rights and no one approach has primacy as the only way to make these connections. Despite this diversity, the frameworks within which they operate can be generally assigned to four broad categories: advocacy, legal, policy, and programs. We summarize each framework briefly as follows.

Advocacy Frameworks

Advocacy is a key component of many organizations' work in health and human rights. Work in the advocacy category can be described as using the language of rights to draw attention to an issue, mobilize public opinion and advocate for change in the actions of governments and other institutions of power. Advocacy efforts may call for the implementation of rights even if they are not yet in fact established by law, and in so doing serve to move governmental and inter-governmental bodies closer to legitimizing these issues as legally enforceable human rights claims. This means also linking of activists working on issues related to health (such as groups focused on violence against women, poverty and global trade issues), reaching out to policy makers and other influential groups, translating international human rights norms to the work and concerns of local communities, and supporting the organizing capabilities of affected communities to push for change in legal and political structures. An example of an advocacy approach is the People's Health Movement (PHM), a civil society initiative created in 2000, bringing together individuals and organizations committed to the implementation of the Alma Ata Declaration on Primary Health Care ([Declaration of Alma Ata, 1978](#); [The People's Health Charter, 2005](#)). In 2006, The PHM launched a campaign "To promote the Health for All goal through an equitable, participatory and inter-sectoral movement and as a rights issue" ([Right to Health and Health Care Campaign, 2006](#)).

Legal Frameworks

This approach prioritizes the role of human rights law at international and national levels in producing norms, standards, and accountability in health-related efforts. This includes engaging with law in the formal sense, including building on the consonance between national law and international human rights norms, for example, to promote and protect the rights of people living with HIV/AIDS through litigation and other means. Pursuing legal accountability through national law and international treaty obligations often takes the form of analyzing what a government is or is not doing in relation to health and how this might constitute a violation of rights, seeking remedies in national and international courts and tribunals and focusing on transparency, accountability, and

functioning norms and systems to promote and protect health-related rights. Examples of a legal approach include recent court cases in Latin America and in South Africa focused on access to antiretroviral therapy by people living with HIV, invoking in particular the right to life and the right to health (Carrasco, 2000; Nattrass, 2006). There, constitutional provisions and international human rights treaties were used to challenge the inaction or opposition of governments to the procurement and availability of drugs alleged to be beyond the economic means of the state or, in the case of South Africa, lacking scientific evidence of their safety and efficacy (Elliott, 2002; PAHO, 2006).

Policy Frameworks

This approach looks to instituting human rights norms and standards mostly through global and national policy-making bodies from health, economic, and development perspectives. These include human rights norms or language as it appears in the documents and strategies that emanate from these bodies as well as the approach taken to operationalize human rights work within an organization's individual programs and departments. In addition to the inclusion of human rights norms within recent global consensus documents such as the UN General Assembly Special Session on AIDS (UN, 2006), a large and growing number of national and international entities have formulated rights-based approaches to health in the context of their own efforts. Among these are several official development assistance organizations and agencies, funds, and programs of the United Nations System. (These agencies include UNAIDS, UNICEF, UNDP, UNFPA, DFID, as well as Canadian CIDA and Swedish SIDA.)

Programmatic Frameworks

This approach is concerned with the implementation of rights in health programming. This includes the design, implementation, monitoring, and evaluation of health programs, including what issues are prioritized and why, at different stages of the work. Often these efforts are carried out by large international organizations, including both inter-governmental and non-governmental entities. In general, work in this category refers to inclusion of key human rights components within programmatic initiatives and in daily practice such as ensuring attention to the participation of affected communities, nondiscrimination in how policies and programs are carried out, attention to the legal and policy context within which the program is taking place, transparency in how priorities were set and decisions were made, and accountability for the results. Examples with respect to this category are discussed in more detail below.

As the health and human rights field has become more strongly rooted in robust human rights principles and

sound public health, it is appropriate that such different interpretations and applications to practice are coming forward. This has, however, unfortunately, in many ways fuelled the lack of clarity as to what added-value human rights offer to public health work. Despite significant differences, work which falls under these different rubrics is often amalgamated under what is called a 'rights-based approach' to health, and these are in themselves 'all over the map,' whether encompassing legal, advocacy, or programmatic efforts. One can say that it is a great accomplishment of all those who have fostered the dialogue around 'rights-based approaches to health' that this term is now being used to characterize such a wide range of activities. A great challenge is that the term is used in very different ways by different institutions and individuals. At worst, the inconsistencies in how 'rights-based approaches to health' are conceptualized threaten to undo major accomplishments. At best, the diversity in interpretation of what is meant by 'rights-based approaches to health' means the field is alive and well.

The Elusive Rights-Based Approach to Health

Ultimately much of the work to bring human rights into public health is looking at synergies and trade-offs between health and human rights and working, within a framework of transparency and accountability, toward achieving the highest attainable standard of health. Central in all settings are the principles of nondiscrimination, equality, and to the extent possible the genuine participation of affected communities. This does not mean a one-size-fits-all approach. In addition to differences in frameworks, the rights issues and the appropriateness of policies and programs relevant to one setting with one population might not be so in a different setting to another.

Initially conceptualized in the mid-1990s as a 'human rights based approach to development programming' by the United Nations Development Programme (UNDP, 1998), rights-based approaches have been applied to specific populations (e.g., children, women, migrants, refugees, and indigenous populations), basic needs (e.g., food, water, security, education, and justice), health issues (e.g., sexual and reproductive health, HIV, access to medicines), sources of livelihood (e.g., land tenure, pastoral development, and fisheries), and the work of diverse actors engaged in development activities (e.g., UN system, governments, NGOs, corporate sector). Even as health cuts across all of these areas and is regarded both as a prerequisite for and an important outcome of development, the understanding of what a rights-based approach actually means for public health efforts varies across sectors, disciplines, and organizations.

In order to define the core principles of rights-based approaches (RBAs) applicable across all sectors of development, including health, a “Common Understanding” was elaborated by the UN system in 2003 (UN, 2003). In short, it suggests that the following points are critical for identifying a rights-based approach: all programs should intentionally further international human rights; all development efforts, at all levels of programming, must be guided by human rights standards and principles founded in international human rights law; and all development efforts must build the capacity of “duty bearers” to meet obligations and/or “rights holders” to claim rights (UN, 2003 May).

UN Statement of Common Understanding of the Human Rights-Based Approach to Development

1. All programmes of development co-operation, policies and technical assistance should further the realisation of human rights as laid down in the Universal Declaration of Human Rights and other international human rights instruments.
2. Human rights standards contained in, and principles derived from the Universal Declaration of Human Rights and other international human rights instruments guide all development cooperation and programming in all sectors and in all phases of the programming process.
3. Development cooperation contributes to the development of the capacities of ‘duty-bearers’ to meet their obligations and/or of ‘rights-holders’ to claim their rights.

This common understanding has clear implications for the implementation of health policies and programs because it offers a common way of thinking although, even within the health domain, the interpretation of what these programs actually mean in practice remains far from universal. A review of public health programs termed ‘rights based’ by a range of UN system actors and their partners points to several areas relevant to what implementation of a rights-based approach to health might look like (Annotated Bibliography, n.d.). A rights-based approach to health makes explicit reference to human rights from the outset, does not invent the content of rights, and does not name the relevance of rights in retrospect; it emphasizes building capacity and does not use human rights norms as a way to name violations after they occur but as a way to prevent violations from occurring in the first place; and it is based on implementation of one or several core rights concepts, including nondiscrimination, participation, accountability, and transparency.

Anchoring public health strategies in human rights can enrich the concepts and methods used to attain health objectives by drawing attention to the legal and policy context within which health interventions occur, as well as bringing in rights principles such as nondiscrimination

and the participation of affected communities in the design, implementation, monitoring, and evaluation of health systems, programs, and other interventions. In addition, it allows for governments and intergovernmental agencies to be held publicly accountable for their actions and inactions. The introduction of human rights into public health work is about approaches and processes and their application toward maximum public health gains. It does not mean how the work is done or what its ultimate outcome will be is preordained to be a certain way. For example, using human rights standards with a focus on health systems requires attention to their availability, accessibility, acceptability, quality, and outcomes among different population groups (see Annex 1 at the end of the article) (General Comment no. 14, 2000). These terms have concrete implications:

- Availability demands that public health and health-care facilities, goods, and services, as well as programs be offered to the maximum availability of resources available to governments. These resources may originate from public funding sources or international aid.
- Accessibility requires that health facilities, goods, and services be attainable by everyone without discrimination, including gender and other recognized forms of discrimination as well as socioeconomic status, the community to which they belong, and the distance they live from an urban area.
- Acceptability calls for health facilities, goods, and services to be culturally and otherwise appropriate for the intended populations.
- Finally, health facilities, goods, and services must be scientifically and medically appropriate and of the optimal quality.

Although none of the above should be unfamiliar to those working in public health, the added value of a human rights approach to health is in systematizing attention to these issues, requiring that benchmarks and targets be set to guarantee that any targets set are realized progressively, and ensuring transparency and accountability for what decisions are made and their ultimate outcomes.

Rights-Based Approaches to Health in Practice

Bringing health and human rights together provides a framework within which the progress, success, or failure of a policy or program can be developed and evaluated against both public health and human rights benchmarks. In practice, the assessment, design, implementation, monitoring, and evaluation of any health policy, strategy, and program or intervention should incorporate the key components of a rights-based approach.

Public health and human rights practitioners are increasingly working to transform a commitment to health and rights into an agenda for action with respect to the development, design, implementation, monitoring, and evaluation of policies, programs, and interventions. **Table 1** is given as an example of how the connections between sound public health and human rights norms and standards can be explicitly established and strengthened. It represents an attempt to outline a process whereby points of convergence and possible tensions between health and rights practices may emerge. It schematically divides the field into five elements, including policy and legal context; situation assessment and analysis; policy, program, or intervention design; implementation; and monitoring and evaluation. It proposes questions that would allow each of these elements to be examined from the perspective of key components of a rights-based approach selected for their relevance to both public health and human rights: participation, attention to the most vulnerable populations, nondiscrimination, and accountability. This table is merely intended to help systematize and present examples of the questions that a rights-based approach to health would ask at each stage of engagement. It is in no way intended to be exhaustive, and if used in practice would require adaptation with respect to the specific health or disability issue considered.

A rights-based approach to health therefore can guide choices about what should be done and how it should be done, for example when applied locally to an institutional or community setting. As with other approaches applied to public health programming efforts, it aims to achieve congruence in responding to individual and collective health needs but also seeks to advance the promotion and protection of human rights. Applying a rights-based approach is only one tool in doing effective public health work. It does not, in and of itself, establish priorities among programs competing for resources, each of which arguably would improve health and the satisfaction of relevant rights, nor does it determine the best way to intervene once a particular intervention has been agreed upon. A rights-based approach will be strongest when used in conjunction with empirical assessment of the complex epidemiological, economic, management, and other information relevant to deciding how resources can most effectively be used and what kinds of improvements in population health should be emphasized.

Conclusion

Considerable progress has been achieved in the last decade in understanding and promoting rights-based approaches to health. The last few years, however, have seen a worrisome trend where, in some quarters, the inadequate success

of public health strategies in areas ranging from HIV/AIDS to child survival is blamed on “unnecessary attention to human rights” (De Cock *et al.*, 2002). Although those arguments may be vague, unfocused, and often based on misinterpretations of how human rights and health actually operate, the skepticism driving such arguments will need to be addressed in the coming years. Greater clarity about the central paradigms of health and human rights is essential to make this work more effective, as well as to enable the framing of counter-arguments that will not only be persuasive to the skeptics but useful to the public health community at large. A benefit then of considering different ways of conceptualizing and pursuing rights-based approaches to health alongside one another is that when considering different initiatives that claim to be ‘rights-based’ it is possible to get a clearer sense of what work is being done but also what work is needed to move the field of health and human rights in the direction of greater clarity. The idea is not to impose one definition of rights-based approaches to health over another, but rather to encourage a discussion about how efforts among different actors working in health and human rights can be better aligned. A preliminary step is to examine these differences rather than to obscure them.

Of critical importance is documentation of the effectiveness of rights-based approaches to health; that is, presentation of solid evidence of how human rights approaches to public health initiatives have actually strengthened those initiatives and informed sound public health practice rather than acting as deterrents. The rights-based approaches to health currently under way in a number of institutions should be examined and validated to ensure clarity in what are understood to be the strengths and limitations of the ways they bring human rights into governmental, nongovernmental, and international health work. Efforts are needed to collect and analyze data to demonstrate how human rights have been relevant to every aspect of public health programming ranging from the analysis of the health and health needs of a population to the ways health systems performance assessments are done. Research is then needed not only to expand the evidence already available that infringements on human rights negatively affect health, but that the enjoyment of human rights – all human rights – has beneficial impacts on health and well-being.

It is through such efforts that the ability to generate the evidence of the effectiveness of rights-based approaches to health will occur. The challenge is now to harness the power of human rights to improve the work of public health in all domains. This will require marshalling the skills and commitment of the entire public health community. While embracing the differences in how rights-based approaches are operationalized, the task is now to ensure that public health and human rights continue to come together in strong, powerful, and practical ways.

Table 1 Applying a rights-based approach to public health: Examples of questions to be addressed to ensure maximum congruence between public health and human rights

<i>Human rights elements</i> <i>Public health elements</i>	<i>Participation</i>	<i>Attention to most vulnerable populations</i>	<i>Non discrimination</i>	<i>Accountability</i>
1. Policy and legal context	<p>Is participation of communities and interest groups supported by law and policy?</p> <p>Have communities been exposed to or disproportionately affected by the health issue in question, been invited to contribute to the drafting of policies concerning them?</p>	<p>Do policies refer to specific vulnerable populations with regards to health, disability, and social and economic determinants?</p> <p>Have the structures, processes and needed resources been made available to translate these policies and laws into practice?</p>	<p>Are policies and laws discriminatory with regards to ill health and its recognized social and economic determinants, practices, and impacts?</p> <p>Are there policies and laws that specifically oppose discrimination on the grounds of health or disability status and their recognized social determinants, practices, and impacts?</p> <p>Are there monitoring, claims, and redress mechanisms in place?</p>	<p>Have policies and laws been debated through political processes and in public fora?</p> <p>Are policies, programs, and interventions consistent with the law and human rights norms and standards?</p> <p>Have policies and laws been translated into decrees or other instruments to make them effective?</p> <p>Is a reporting mechanism in place to address claims of violations of policies and laws?</p> <p>Is a functioning judicial process in place to handle these claims?</p> <p>Have efforts been made to alert people about policies and laws specifically relevant to them?</p>
2. Analysis of the health situation of a particular population or of a specific public health problem	<p>Have members of concerned governmental sectors, private sector, and civil society organizations participated in the design of the study?</p> <p>Has attention been devoted to ensure that populations affected by ill health or their representatives have participated in the design of situation assessments?</p>	<p>Has the situation assessment recognized populations most vulnerable to ill health or disability and focused on assessing their situation, needs and capacity?</p> <p>Have factors leading to increased vulnerability to ill-health and disability been appropriately mapped out and incorporated in the design of the situation analysis?</p>	<p>Is the situation assessment in any way discriminatory in its aim, design, conduct, and analysis?</p>	<p>How and by whom will the results of the analysis be disseminated among political leaders, professional groups, communities, and the media?</p> <p>Will the situation assessment be carried out by competent and trustworthy entities?</p> <p>Has the existing body of evidence informed the situation assessment design?</p> <p>Is the presentation of results sensitive to the risk of aggravating discrimination?</p> <p>If so, what mechanism has been put in place to minimize this risk?</p>

<p>3. Process of devising a public policy, program, or intervention</p>	<p>Has public information and consultation been included in the steps taken to devise the policy, program, or intervention? Have divergent views been taken into consideration before a final decision was reached?</p>	<p>Have communities particularly concerned with the health or disability issue participated in policy, program, or intervention design? What benefits and risks from the policy, program, or interventions could accrue to communities particularly vulnerable to or affected by the health or disability issue? Are sufficient attention and resources devoted to the meet the needs of vulnerable populations?</p>	<p>Is the design of the policy, program, or intervention, in any way discriminatory? Are there legitimate restrictions of rights being considered as part of the policy, program, or intervention? If so, what process has been put in place to legitimize such restrictions?</p>	<p>Is the development of policy, program, or intervention openly discussed with vulnerable communities or their representatives? If restrictions of rights have been pronounced in the interest of public health, has there been a clear presentation of the reasons for and process applied to such decisions? Have the authorities responsible for designing the policy, program, or intervention been made known to the public? Does the policy, program, or intervention meet the criteria of availability, accessibility, acceptability, and quality in the way it responds to the needs of the population? Does the design of the policy, program, or intervention include targets and benchmarks to measure progress in relation to availability, accessibility, acceptability, and quality of services?</p>
<p>4. Implementation of policy, program, or intervention on health and disability</p>	<p>Are public information, education and participation effectively included in policy, program, or intervention implementation? Have actors in health systems and other relevant sectors been educated, trained, and equipped to implement the policy, program, or intervention in a health and human rights sensitive fashion?</p>	<p>Are particularly vulnerable or affected communities engaged in implementing the policy, program, or intervention? Is implementation of the policy, program, or intervention striving towards greater availability, accessibility, acceptability, and quality of services among these populations?</p>	<p>Is implementation of the policy, program, or intervention discriminatory in its application? In what forms is such discrimination perpetrated? In what setting and by what actors? How can discrimination in implementation of the policy, program, or intervention be combated? What plans have been made and resources allocated to combat active discrimination?</p>	<p>Does the implementation of the policy, program, or intervention meet the criteria of availability, accessibility, acceptability, and quality in the way it responds to the needs of the population?</p>

Continued

Table 1 Continued

<i>Human rights elements</i> <i>Public health elements</i>	<i>Participation</i>	<i>Attention to most vulnerable populations</i>	<i>Non discrimination</i>	<i>Accountability</i>
5. A framework within which the success or failure of a policy or program can be evaluated, against both public health and human rights benchmarks	Have targets been set and success and failure been defined with public participation?	<p>Have targets been set and success and failure been defined with the participation of vulnerable or affected communities or their representatives?</p> <p>Is implementation meeting the needs of these populations to the maximum of available resources?</p> <p>Are monitoring and evaluation systems efficiently monitoring and evaluating availability, accessibility, acceptability, and quality of services among these populations?</p>	<p>Is the monitoring and evaluation system designed to detect causes, practices, and impacts of discriminatory actions?</p> <p>Are claims on grounds of discrimination heard and taken into account in the monitoring and evaluation process?</p>	<p>Is there a mechanism to monitor and evaluate the implementation and impacts of the policy, program, or intervention according to set criteria of availability, accessibility, acceptability, and quality?</p> <p>Have processes been planned and resourced to measure the impact of the policy, program, or intervention put in place?</p> <p>Are these findings made public?</p> <p>Are the impacts on health of any potential violations of human rights researched and documented?</p> <p>Has the policy, program, or intervention contributed to the promotion of human rights, including the right to health?</p> <p>Has the policy, program, or intervention contributed to progress in the realization of other human rights?</p> <p>Are these findings used to inform needed changes or adjustments in policy, program, or interventions both within and outside the health sector?</p>

Annex I

The Right to the Highest Attainable Standard of Health : 11/08/2000

E/C.12/2000/4. (General Comments)

Committee on Economic, Social and Cultural Rights, Twenty-second session, Geneva, 25 April–12 May 2000, Agenda item 3.

Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social, and Cultural Rights.

General Comment No. 14 (2000)

The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social, and Cultural Rights).

Excerpts

11. The Committee interprets the right to health, as defined in article 12.1, as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health. A further important aspect is the participation of the population in all health-related decision-making at the community, national and international levels.
12. The right to health in all its forms and at all levels contains the following interrelated and essential elements, the precise application of which will depend on the conditions prevailing in a particular State party:
 - (a) **Availability.** Functioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party. The precise nature of the facilities, goods and services will vary depending on numerous factors, including the State party's developmental level. They will include, however, the underlying determinants of health, such as safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs, as defined by the WHO Action Programme on Essential Drugs.
 - (b) **Accessibility.** Health facilities, goods and services have to be accessible to everyone without discrimination, within the jurisdiction of the State party. Accessibility has four overlapping dimensions:
 - Non-discrimination: health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds.
 - Physical accessibility: health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS. Accessibility also implies that medical services and underlying determinants of health, such as safe and potable water and adequate sanitation facilities, are within safe physical reach, including in rural areas.
 - Accessibility further includes adequate access to buildings for persons with disabilities.
 - Economic accessibility (affordability): health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.
 - Information accessibility: accessibility includes the right to seek, receive and impart information and ideas concerning health issues. However, accessibility of information should not impair the right to have personal health data treated with confidentiality.
 - (c) **Acceptability.** All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.
 - (d) **Quality.** As well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires, *inter alia*, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.

See also: Agenda Setting in Public Health Policy; Evidence-Based Public Health Policy; Global Health Initiatives and Public Health Policy; Human Rights, Approach to Public Health Policy; International Law, and Public Health Policy; Law, and Public Health Policy.

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Health Behavior and Risk Factors

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Why Health Behavior Is Important

Health-related behavior is one of the most vital elements to the public's health and well-being. Its importance has grown during the past century, as sanitation has improved and medicine has advanced so that once deadly or incurable diseases can be prevented or successfully treated. Thus, health-related behavior is an increasing focus of attention in public health and improving health-related behavior is central to public health activities.

The major causes of death in the United States and other developed countries are chronic diseases such as heart disease, cancer, and stroke. The causes of each of these diseases include health risk behaviors. Behavioral factors are thought to contribute to almost half of the deaths in the United States. The most common behavioral contributors to mortality, or death, in 2000 were tobacco, poor diet and physical inactivity, and alcohol use; other significant causes of death include firearms, sexual behavior, motor vehicle crashes, and illicit use of drugs. These behaviors were