

LEADING THE REALIZATION OF HUMAN RIGHTS TO HEALTH AND THROUGH HEALTH



Report of the High-Level Working Group
on the Health and Human Rights
of Women, Children and Adolescents



Leading the realization of human rights to health and through health: report of the High-Level Working Group on the Health and Human Rights of Women, Children and Adolescents

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Report of the High-Level Working Group on the Health
and Human Rights of Women, Children and Adolescents





Foreword

Healthy women, children and adolescents whose rights are protected are the very heart of sustainable development. Their inherent right to the highest attainable standard of health is enshrined in the constitution of the World Health Organization and international human rights law. When their right to health is upheld, their access to all other human rights is also enhanced, triggering a cascade of transformative change. Survive, thrive AND transform: that is the clarion call of the *Global Strategy for Women's, Children's and Adolescents' Health (2016–2030)*. If rights to health and through health are upheld, delivery of the Sustainable Development Goals (SDGs) will indeed leave no one behind.

Recognizing this, one year ago, the World Health Organization and the Office of the High Commissioner for Human Rights announced the formation of a High-Level Working Group on the Health and Human Rights of Women, Children and Adolescents. The Group was tasked with securing political support for the implementation of the human rights-related measures contained in the SDGs and the *Global Strategy*.

The High-Level Working Group, which we are honoured to co-Chair, brings together a diverse group of people from different regions, backgrounds and experiences. We come from civil society, academia, the health community, parliaments and executive government. While we come together via different paths, we are united by two fundamental convictions.

First, you cannot improve health if you fail to uphold rights. Second, you cannot uphold rights without bold, unapologetic leadership at the highest levels.

Our work is inspired by the human rights principles of equality, inclusiveness, non-discrimination, participation and accountability, and stands on a firm foundation of international human rights law. It owes much to the efforts of activists, health professionals, lawyers, politicians, academics and others whose tireless, and at times courageous efforts, have elaborated this mutually dependent field of health and human rights over the past decades. And it includes numerous examples of the evidence of the efficacy of a human rights-based approach to improving health, and how better health can enable women, children and adolescents specifically to realize their other rights.

Still merely a concept for millions of women, children and adolescents, this report calls urgently on leaders to take up the challenge of translating human rights to health and through health into a reality for all. By acting decisively to uphold human rights, leaders—especially at national and local levels—can put an end to preventable and unacceptable suffering, and in so doing, unlock enormous human potential. Only when health and human rights walk hand in hand will women, children and adolescents be able to realize the vision of the *Global Strategy* and the 2030 Agenda for Sustainable Development to survive, thrive, and truly transform our planet.

We have the knowledge, means and the motivation to act. Let's not wait a moment longer.



H.E. Tarja Halonen
Former President, Finland
Working Group Co-Chair



Hina Jilani
The Elders
Working Group Co-Chair

Acronyms, abbreviations and definitions

The “**right to health**” is used throughout this report to refer to the right to the highest attainable standard of physical and mental health as defined by Article 12 of the International Covenant on Economic, Social and Cultural Rights.

The phrase “**rights to health and through health**” is used throughout this report to express the fact that the right to health does not stand alone but is indivisible from other human rights. Good health not only depends on but is also a prerequisite for pursuing other rights. Human rights cannot be fully enjoyed without health; likewise, health cannot be fully enjoyed without the dignity that is upheld by all other human rights.

Agenda 2030

2030 Agenda for Sustainable Development

CEHURD

Centre for Health, Human Rights and Development

CRC

Convention on the Rights of the Child

GDP

gross domestic product

Global Strategy

Global Strategy for Women’s, Children’s and Adolescents’ Health (2016-2030)

High-Level Working Group

High-Level Working Group on Health and Human Rights of Women, Children and Adolescents

HRBA

human rights-based approaches

IAP

Independent Accountability Panel

OECD

Organisation for Economic Co-operation and Development

OHCHR

Office of the United Nations High Commissioner for Human Rights

SDGs

Sustainable Development Goals

UAF

Unified Accountability Framework

UHC

universal health coverage

UN

United Nations

WHO

World Health Organization

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Executive Summary

We all have the right to the highest attainable standard of physical and mental health, without discrimination, wherever we are, and whatever our circumstances. We all have the right to receive good quality health services, with dignity and respect. We all have the right to the essentials for healthy life, including food, water, sanitation, housing, clean air and a safe environment.

States are legally obliged by international law to enable us to realize our right to health, which is a prerequisite for the fulfilment of all other human rights, such as the rights to life, education and information, to participation, and to benefit from scientific progress and its applications. This report refers throughout to rights “to health and through health” to express this fact: the right to health does not stand alone but is indivisible from other human rights. Good health not only depends on but is also a prerequisite for pursuing other rights. Human rights cannot be fully enjoyed without health; likewise, health cannot be fully enjoyed without the dignity that is upheld by all other human rights.

That is why whole-of-government leadership is needed to realize the whole nexus of intersecting, interdependent rights. This term presents no changes to the States’ human rights obligations nor does this report have legally binding status.

The High-Level Working Group on Health and Human Rights of Women, Children and Adolescents was established in May 2016 by the World Health Organization (WHO) and the Office of the United Nations High Commissioner for Human Rights (OHCHR) to secure political support, both nationally and internationally, for the implementation of the human rights-related measures required by the *Global Strategy for Women’s, Children’s and Adolescents’ Health (2016-2030)*.

The *Global Strategy* presents a comprehensive human rights-based roadmap by prioritizing human rights to health and through health for the most marginalized; by recognizing age groups’ distinctive needs and adopting a gender-sensitive life course approach; and by

challenging critical sexual and reproductive health and rights concerns. It offers a path which if implemented will allow women, children and adolescents not only to survive, but to thrive and transform the world. The *Global Strategy*, therefore, is vital for the achievement of the 2030 Agenda for Sustainable Development, whose goals will not be achieved unless and until human rights and dignity are ensured for all individuals, everywhere, leaving no one behind.

Worldwide, the need to realize rights to health and through health has never been more urgent. Discrimination, abuse and violence against women, children and adolescents—the most widespread of human rights violations—erode physical and mental health, stealing the personal destinies of millions, and robbing the world of precious and needed talent, potential and contribution. Meanwhile, unprecedented rates of unplanned urbanization, climate instability, environmental degradation and pollution are introducing new dangers, and intensifying known impediments, to the health of women, children and adolescents, while conflicts are forcing people out of their homes and livelihoods at record levels.

Against a backdrop of rising nationalism, the marginalization of millions of people, including undocumented migrants, refugees, slum dwellers and indigenous peoples, proceeds hand in hand with violations of their rights, escalating individual and public ill-health, and thereby undermining stability for entire societies.

The realization of human rights, particularly sexual and reproductive health and rights, including access to safe abortion, remains seriously uneven or unattainable at the country level, risking the reversal of hard-won advances in preventable maternal and child mortality and undermining the health of adolescent children, in particular.

Given that preventable death, ill-health and impairment are firmly rooted in the failure to protect human rights, this report is designed to

encourage leadership to realize rights to health and through health. In many settings the international community can play an important role, but national and local leadership are vital. Even when resources are restricted, committed leadership can make a huge difference to the lives of women, children and adolescents.

Only through focused leadership by governments, both nationally and locally, can inequities in health outcomes be addressed conclusively, gender-based and other forms of inequality be tackled, and discrimination removed, including within health systems. Only committed leadership with accountability will produce sustained abandonment of harmful practices, inspire others to act in support of human rights to health and through health, guide systematically the needed human rights-based approaches to the design, implementation and evaluation of policies and programmes affecting health, and implement the necessary legal provisions.

The High-Level Working Group is convinced that committed leadership for collective action is urgently needed to safeguard the full exercise of women's, children's and adolescents' human rights for their health and for the health of their communities. This requires that they be enabled to: access comprehensive information, exercise autonomous decision-making in keeping with their age-related abilities, and receive the services necessary for, inter alia, their mental, sexual and reproductive health.

A transformative leadership agenda is vital if women, children and adolescents are to realize their health and well-being and to flourish and prosper. This report describes the key dimensions of this agenda. The Working Group urges the world's leaders to found their efforts in pursuit of this agenda squarely on the human rights principles of equality, inclusiveness, non-discrimination, participation and accountability. Evidence shows that this formula can create the transformation necessary to secure more peaceful, fairer and more inclusive societies, for everyone.

RECOMMENDATIONS

Create an enabling environment



1. Uphold the right to health in national law

All States should strengthen legal recognition of human rights to health and through health, including sexual and reproductive health and rights, in their national constitution and other legal instruments. Remedies for violations of these obligations should be effective. Sufficient financial and human resources should be allocated for designing and implementing legislative and policy measures and social initiatives to ensure the realization of rights to health and through health and to facilitate universal access to health care.



2. Establish a rights-based approach to health financing and universal health coverage

All States should develop national and subnational financing strategies with clear timelines that contribute directly to the realization of the right to health, including universal health coverage. These strategies should apply the human rights principles of equality, inclusiveness, non-discrimination and participation. Redress should be available where these universal standards are not reasonably met. States should take steps to allocate at least 5% of GDP for public health spending, which is the recognized prerequisite for universal health coverage.



3. Address human rights as determinants of health

All States should undertake periodic human rights-based assessments of the determinants of women's, children's and adolescents' health, with particular attention to gender inequality, discrimination, displacement, violence, dehumanizing urbanization, environmental degradation and climate change, and develop rights-based national and subnational strategies to address these determinants.



4. Remove social, gender and cultural norms that prevent the realization of rights

All States should implement legal, policy and other measures to monitor and address social, gender and cultural norms and to remove structural and legal barriers that undermine the human rights of women, children and adolescents. Urgent attention must be given to developing national frameworks that prohibit and adequately punish gender-based violence, end female genital mutilation and child, early and forced marriage, and remove barriers to the enjoyment of sexual and reproductive health and rights.

To achieve greater momentum in this global effort, we call on **the WHO Director-General and the High Commissioner for Human Rights** to:

- establish a joint programme of work to support the implementation of these recommendations, including at regional and country levels

Partner with people



5. Enable people to claim their rights

All States should take concrete measures (for example, through awareness raising campaigns and community outreach) to better enable individuals (particularly women, children and adolescents), communities and civil society to claim their rights, participate in health-related decision-making, and obtain redress for violations of health-related rights.



6. Empower and protect those who advocate for rights

All States should take concrete measures to better enable, support and protect defenders, champions and coalitions advocating for human rights to health and through health.



7. Ensure accountability to the people for the people

All States should ensure that national accountability mechanisms (for example, courts, parliamentary oversight, patients' rights bodies, national human rights institutions, and health sector reviews) are appropriately mandated and resourced to uphold human rights to health and through health. Their findings should be regularly and publicly reported by States. Technical guidance in support of this should be provided by WHO and OHCHR.

Strengthen evidence and public accountability



8. Collect rights-sensitive data

All States should take concrete steps to enhance data concerning human rights to health and through health, particularly with respect to women, children and adolescents, in line with the 2030 Agenda for Sustainable Development and the *Global Strategy for Women's, Children's and Adolescents' Health*. These data should enable disaggregation by all forms of discrimination prohibited under international law, paying particular attention to those who are rendered invisible by current data methodologies.



9. Report systematically on health and human rights

All States should report publicly on progress made towards the implementation of the recommendations of this report at the World Health Assembly, in their Universal Periodic Reviews and as part of their implementation of the 2030 Agenda for Sustainable Development and the *Global Strategy for Women's, Children's and Adolescents' Health*. Technical guidance in support of this should be provided by WHO and OHCHR.

- build institutional capacity and expertise at their headquarters and at regional and country levels to assist States to advance their realization of human rights to health and through health, particularly for women, children and adolescents
- ensure ongoing coordination of, and tracking of progress towards, the realization of human rights to health and through health, particularly for women, children and adolescents, which will enable prompt dissemination of good practices.



PART ONE: An unprecedented opportunity in challenging times

We all have the right to the highest attainable standard of physical and mental health, without discrimination, wherever we are, and whatever our circumstances. We all have the right to receive good quality health services, with dignity and respect. We all have the right to the essentials for healthy life, including food, water, sanitation, housing, education, clean air and a safe environment. States are legally obliged by international law to enable us to realize our right to health,* which is a prerequisite for the fulfilment of all other human rights, such as the rights to information, to participation, and to

benefit from scientific progress and its applications. In sum, the fundamental human right to health is an inseparable and indispensable foundation for the exercise of other human rights.¹

This report refers throughout to rights “to health and through health”. The phrase is intended to express the fact that the right to health does not stand alone but is indivisible from other human rights. Good health not only depends on but is also a prerequisite for pursuing other rights. Human rights cannot be fully enjoyed without health; likewise, health cannot be fully enjoyed

* The shorthand term “right to health” is used throughout this report to refer to the right to the highest attainable standard of physical and mental health as defined by Article 12 of the International Covenant on Economic, Social and Cultural Rights.

without the dignity that is upheld by other human rights. That is why whole-of-government leadership is needed to realize the whole nexus of intersecting, interdependent rights. The term “rights to health and through health” presents no change to the States’ human rights obligations, nor does this report have legally binding status. This term is introduced in order to better communicate the essence of the report’s message that there can be no full enjoyment of rights without health and that enjoyment of rights is the surest pathway to health itself.

Worldwide, the need to realize rights to health and through health has never been more urgent. Discrimination, abuse and violence against women, children and adolescents—the most widespread of human rights violations—erode physical and mental health, stealing the personal destinies of millions, and robbing the world of precious and needed talent, potential and contribution. Meanwhile, unprecedented rates of unplanned urbanization, climate instability, environmental degradation and pollution are introducing new dangers, and intensifying known impediments, to the health of women, children and adolescents, while conflicts are forcing people out of their homes and livelihoods at record levels.

Against a backdrop of rising nationalism, the marginalization of millions of people, including undocumented migrants, refugees, slum dwellers and indigenous peoples, proceeds hand in hand with violations of their rights, escalating individual and public ill-health, and thereby undermining stability for entire societies.

The realization of human rights, particularly sexual and reproductive health and rights, including access to safe abortion, remains seriously uneven or unattainable at the country-level, risking the reversal of hard-won advances in preventable maternal and child mortality and undermining the health of adolescents, in particular.

However, by embracing the current unprecedented opportunity to transform human rights to health and through health, we can change this. The 2030 Agenda for Sustainable Development

(Agenda 2030)² provides that opportunity. It reaffirms that States must “respect, protect and promote human rights, without distinction of any kind as to race, colour, sex, language, religion, political or other opinions, national and social origin, property, birth, disability or other status”. It emphasizes that its Sustainable Development Goals (SDGs) will not be achieved unless and until human rights and dignity are ensured for all individuals, everywhere, leaving no one behind.

How each country embraces this opportunity over the next 15 years will determine whether it fully reaps the benefits of development. By ensuring the engagement, empowerment and dignity of women, children and adolescents a country can maximize those benefits. Realizing the “sustainable development” vision for women, children and today’s 1.8 billion young people³—almost a quarter of the world’s population—will change their lives for the better, bring lasting gains for all communities, and contribute significantly to progress across all the SDGs, securing more equitable social, economic and environmental development, and more just and sustainable peace.

That is why the *Global Strategy for Women’s, Children’s and Adolescents’ Health (2016-2030)*⁴ is so important to Agenda 2030. The *Global Strategy*’s vision is of: “a world in which every woman, child and adolescent in every setting realizes their rights to physical and mental health and well-being, has social and economic opportunities, and is able to participate fully in shaping sustainable and prosperous societies”. By prioritizing human rights to health and through health for the most marginalized; by recognizing age groups’ distinctive needs and adopting a gender-sensitive life course approach; and by challenging critical sexual and reproductive health and rights concerns, the *Global Strategy* offers a comprehensive human rights-based roadmap to health. It offers a path which if implemented will allow women, children and adolescents not only to survive, but to thrive and transform the world.

For health, human rights are imperative. We know what needs doing. We know why we should do it.

We know it also makes financial sense. What we need is more concrete and sustained political commitment and leadership to trigger a human rights chain reaction for health and for more inclusive, sustainable development.

This was recognized by the independent Expert Review Group in its 2014 report, which therefore recommended the establishment of a Global Commission on the Health and Human Rights of Women and Children to propose ways to protect, augment and sustain their health and well-being.⁵ In May 2016, the World Health Organization (WHO) and the Office of the United Nations High Commissioner for Human Rights (OHCHR) established the High-Level Working Group on Health and Human Rights of Women, Children and Adolescents (see Annex A for list of members). The first of its kind, the High-Level Working Group was given a one-year mandate to generate political momentum, both nationally and internationally, for the implementation of the human rights-related measures required by the *Global Strategy*. These measures are listed in Annex B.

About this report

Following the frameworks of the SDGs and the *Global Strategy*, this report builds on international law, guidance issued by OHCHR, WHO and other United Nations (UN) agencies over the last two decades, global agreements and consensuses, international and regional human rights treaties, national laws and public health evidence. The report was informed by expert advice and detailed inputs from a technical advisory group (Annex A). More than 50 stakeholders responded to an online call for inputs. Over 200 individuals and organizations participated in a global consultation, led by WHO and OHCHR, involving dialogues at regional level and with civil society working on global health and human rights. Discussions were held with WHO regional and country offices, professional associations, UN Special Rapporteurs on the right to health, and on violence against women, and members of several UN Human Rights Treaty Monitoring Bodies, among others. Consultations were also

undertaken with the Global Financing Facility's "frontrunner" countries.

Given that preventable death, ill health and impairment are firmly rooted in the failure to protect human rights, this report is designed to encourage leadership to realize rights to health and through health. It is addressed to leaders: heads of State, parliamentarians, ministers of health and all ministries whose policies impact on health (including ministries of social protection, justice, finance, children, gender, education, labour, environment and culture, among others). This report seeks to inspire leaders to act with confidence and conviction. It also urges strong leadership for the realization of rights to health and through health from human rights organizations and defenders and from the media, education and training institutions, health and social services, international agencies, nongovernmental organizations and the private sector.

Although there is an important repository of norms and standards at the global level, action by leaders of national, district and local governments, of civil society organizations, of community groups and the media is essential: without local leadership universal norms will not translate into tangible action, and the lives of the most disadvantaged, vulnerable and marginalized will not improve. It is therefore vital that authority and resources be vested in local bodies to enable them to bring real benefits to communities and particularly to women, children and adolescents.

Part 1 of this report sets out the essence of a human rights-based approach to health, provides a brief situational analysis of the gender- and age-specific issues concerning the health and human rights of women, children and adolescents, and ends with the Working Group's vision for 2030. Part 2 proposes a framework of action to be taken by States, and by a diverse group of stakeholders including individuals, communities and civil society, recognizing the urgent need for a more concerted effort to uphold the rights of women, children and adolescents.

1.1 Realizing human rights to health and through health

In 1946, WHO's Constitution defined health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". It also stated that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition".⁶

The right to health is both dependent on and essential for the attainment of other human rights. The rights to information, education and shelter; the right to physical and mental integrity; the right to live free from violence: each of these also plays a determinative role in the realization of the right to health and thus in building an enabling environment for health.

The right to health includes both freedoms and entitlements. Freedoms include the right to control bodily integrity, including the right to be free from non-consensual medical treatment and experimentation. Entitlements include the right

to a system of health protection that provides equality of opportunity for people to enjoy the highest attainable standard of health, as well as more specific entitlements such as the rights to maternal, child and reproductive health; a healthy workplace and natural environment; the prevention, treatment and control of diseases, including access to essential medicines; and access to safe and potable water.

A human rights-based approach to health is a people-centred approach. It requires that the root causes of ill health and the impediments to enjoyment of health and well-being be remedied, for example by inclusive education, access to information and gender equality. A human rights-based approach requires delivery of health care through systems, and in a manner, compatible with the norms and standards of human rights. It also requires attention to gender- and age-sensitive participation in health decision-making, including at the community level.



Box 1. States' commitments to health and human rights: a historical perspective

In 1948, the UN General Assembly adopted the Universal Declaration of Human Rights,⁷ enshrining the human rights and fundamental freedoms of all individuals which serve as “the foundation of freedom, justice and peace in the world”. Health is included in the right to an adequate standard of living. This was followed by national, regional and international health-related human rights declarations, some of which are listed below.

- The 1948 American Declaration on the Rights and Duties of Man recognized that every person has the right to the preservation of health.
- One of the 10 principles in the 1956 Declaration of the Rights of the Child is: “The right to special protection for the child’s physical, mental and social development”.⁸
- In 1966, the International Covenant of Economic, Social and Cultural Rights confirmed the “right of everyone to the enjoyment of the highest attainable standard of physical and mental health”.⁹ In 1979, the Convention on the Elimination of all Forms of Discrimination against Women was adopted, followed in 1990 by the Convention on the Rights of Child.
- The 1981 the African Charter on Human and People’s Rights stated that “Every individual shall have the right to enjoy the best attainable state of physical and mental health”.¹⁰
- The 1993 Declaration on the Elimination of Violence against Women stated: “Women are entitled to the equal enjoyment and protection of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field”.¹¹
- The 1994 International Conference on Population and Development Programme of Action and the 1995 Beijing Declaration and Platform of Action both recognized the centrality of women’s rights, empowerment and sexual and reproductive health as central to international development and population policies.¹²
- In 1999, the Committee on the Elimination of Discrimination Against Women provided guidance on women’s human rights in relation to health.¹³
- In 2000, the European Charter on Human Rights recognized that: “Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices”.¹⁴
- In 2000, the UN Committee on Economic, Social and Cultural Rights elaborated on the obligations of States Parties concerning the right to the highest attainable standards of health, and, in 2016, it issued a general comment on the right to sexual and reproductive health.¹⁵
- In 2015, the Committee on Rights of the Child provided an authoritative interpretation of the right to health of the child and, in 2016, similarly on the rights of adolescents.¹⁶

In addition to these and other statements of States’ obligations concerning the right to health, operational guidance on a human rights-based approach to health has also been published in recent years.

Box 3. State obligations imposed by the right to health

The obligation to **respect** the right to health requires States, inter alia: to refrain from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and irregular immigrants, to preventive, curative and palliative health services; to abstain from enforcing discriminatory practices as State policy; and to abstain from imposing discriminatory practices relating to people’s health status and needs.

The obligation to **protect** includes, inter alia, the duties of States to adopt legislation or to take other measures ensuring equal access to health care and health-related services provided by third parties. States should also ensure that third parties do not limit people’s access to health-related information and services.

Box 2. Why is a human rights-based approach necessary?

- ✓ Because it helps States meet their obligations under international human rights law.
- ✓ Because it offers a principled basis for universal access to health services, emphasizing that interventions must be non-discriminatory, transparent and participatory, and founded on strong public accountability.
- ✓ Because it requires focus on both the empowerment of rights-holders (all people, including women, children and adolescents) and the responsibilities of duty-bearers (States, policy-makers, health-care providers, etc.)
- ✓ Because it aims to enhance the capacity of duty-bearers at local, district and national levels to carry out their obligations to respect, protect and fulfil human rights in transparent, effective and accountable ways.
- ✓ Because it requires full and informed participation by all those affected by any action or policy.
- ✓ Because it builds true sustainability into health systems and towards improving health outcomes by requiring that the underlying determinants of health be tackled, including through the realization of health-enabling rights.

Seen through a human rights lens, universal health coverage (UHC) becomes also a question of non-discrimination over the life course. International human rights law requires that access to health services must be free from all

forms of discrimination. Concrete steps towards UHC must ensure that throughout the life course no one is left behind.

States' commitments to preserve human dignity were crystallized in 1948, in a Universal Declaration of Human Rights, whose tenets have been reinforced ever since by successive and diverse international instruments. Some of these instruments have specifically highlighted State obligations with respect to health and human rights generally; others relate specifically to women, children and adolescents (Box 1).

Box 2 highlights the value added by a human rights-based approach to health.

As well as being required by international human rights law and standards, the evidence also shows that human rights-based policies, programmes and other interventions are effective to improve women's and children's health. Human rights-based approaches contribute to more equitable health-related outcomes for women and children, as shown by reduced early childhood mortality (Malawi), increased access to emergency obstetric care (Nepal), increased

The obligation to *fulfil* requires States, inter alia, to give sufficient recognition to the right to health in national political and legal systems, preferably by way of legislative implementation, and to adopt a national health policy with a detailed plan for realizing the right to health. This obligation also requires the State to implement positive measures, including allocation of budgets and financial resources, that enable and assist individuals and communities to enjoy the right to health. To ensure *availability* of and *access* to *quality* services without discrimination, a human rights-based approach also requires that the *means* to these ends should be *participatory, inclusive, transparent* and *responsive*.¹⁸

access to modern contraception (Brazil), and increased access to cancer screening and better vaccination coverage (Italy).¹⁷

In a human rights-based approach, individuals must be empowered as “rights-holders”. Health planning, policy and provision must be shaped by the principles of *participation, equality, non-discrimination* and *accountability* as well as by the principles of *availability, accessibility, acceptability* and *quality* of health facilities and services.

The State, however, is the primary duty-bearer for rights. In the context of health, duty-bearers include a State’s policy-makers, health systems managers and health workers. A human rights-based approach aims to strengthen the capacity of duty-bearers, and that of the State as a whole (at local, regional and national levels) so that obligations to respect, protect and fulfil human rights are carried out competently and in transparent and accountable ways. States’ obligations are summarized in Box 3.

Some progress towards human rights-based approaches has been made. Countries have taken action to better respect, protect and fulfil rights to health and through health. However, gaping differences remain between States’ legal obligations, the promises they have made and the actual circumstances of the people to whom they are accountable. Despite international, regional and national commitments to the contrary, gross violations of health and human rights are reported from every region of the world, and disproportionately against the health and well-being of women, children and adolescents.

“Women are not dying of diseases we can’t treat. [...] They are dying because societies have yet to make the decision that their lives are worth saving.”

Mahmoud Fathalla



These gaps are evident, for example, when violence against children is characterized as a “cultural” issue; and when “tradition” is defended more vigorously than women’s and children’s rights to physical and mental integrity. So too when protection of the family is set in opposition to the rights of individual family members; when the health implications of violations of civil and political rights are ignored; when women and children are detained in health facilities for failure to pay for health services; and when States treat the right to health as a right merely to access health services, which is only one component of that right.

Mahmoud Fathalla, former president of the International Federation of Obstetricians and Gynaecologists, said “Women are not dying of diseases we can’t treat. [...] They are dying because societies have yet to make the decision that their lives are worth saving.” The implementation of rights to health and through health requires real political commitment. This requires authorities to allow public scrutiny and to meet their corresponding accountability. In this area are perhaps the largest gaps in health care today.



1.2 Why now?

We have an unprecedented opportunity—thanks to Agenda 2030—to advance all individuals' human rights, to counter forces seeking to undermine these and to achieve the conditions in which rights to health and through health can be realized, leaving no one behind.

There now exists an unique possibility—thanks to the advances in medical science and public health (as set out in the *Global Strategy*)—to achieve significant advances in the health and human rights of women, children and adolescents if proven solutions are invested in appropriately.

There exists an urgent need to do so—thanks to the largest ever population of adolescents and to commitments to gender equality—now that the health and well-being of women, children and adolescents are recognized, not only as essential to human dignity, but also as drivers of sustainable development, peace and security.

When their human rights are violated women, children and adolescents are prevented from achieving their full potential; this in turn prevents their families, communities and societies from

developing sustainably. Investing in their human rights is not only the right thing, but also the smart thing to do. Societies as a whole harness larger dividends when rights are respected, protected and fulfilled. A world without fear, stigma and discrimination drives equality and progress for all.¹⁹

While unique opportunities are within our grasp, challenges remain: without committed leadership, these opportunities will be squandered.

Persistent threats to the fundamental values of human rights undermine inclusive and sustainable policy-making for health and rights. As for people on the move—including refugees, stateless persons and the billion or more living in informal slums—their rights are severely threatened. Women's rights to decision-making about their own bodies must be upheld, in accordance with human rights law, along with the development and implementation of evidence-based policy and programming. This is necessary in order to achieve equitable outcomes from public policy anchored in the rationality that is essential for just and inclusive public policy.

1.3 Why women, children and adolescents?

In support of the *Global Strategy*, the High-Level Working Group advocates a sharper focus on women, children and adolescents because, as population groups, they are simply at greater risk than adult men, not least because they far more rarely participate in policy, planning and programming activities at local, national and international levels.



Millions of women, children and adolescents around the world are denied their inalienable fundamental human rights, leading to preventable deaths, disability, physical and mental illness and other harm.

A substantial uplift in human dignity is urgently needed for those currently most denied it, if we are to fulfil the SDGs' promise to end preventable human suffering and to drive productivity and sustainability more equitably in communities worldwide. Inequality and discrimination are prejudicial to the aims of Agenda 2030 and to inclusive health outcomes. The people who are most frequently discriminated against, being denied personal autonomy in decisions about their health, and facing the greatest barriers in seeking access to health care services, ultimately suffer the worst health outcomes.

However, strategically addressing the interplay between health, gender and age offers great promise for the implementation of Agenda 2030. When discrimination is removed, whole communities benefit. By adopting special measures for those currently subjected to discrimination, individuals' lives can be transformed and their futures made more secure. The results benefit their families, communities and countries. Tackle the intersections between gender, age and other forms of discrimination, especially those based on ethnicity, disability, indigeneity and other minority status, and no one need be left behind.

Women, children and adolescents are by no means homogeneous groups. Each of these populations faces specific challenges. And within each, there is tremendous diversity. There is, however, a common thread: many of the barriers faced by children, adolescents and women—impeding their access to health care and reducing their ability to live healthy lives—are caused by the denial of their human rights.



Upholding children's rights to health and through health

Newborns and younger children are at crucial yet vulnerable stages of human development, and have unique needs. Under human rights law, States bear the obligation to meet those needs and should take specific measures, such as birth registration and provision of vaccines and immunization, to protect their rights, ensuring not only that they survive but that they thrive.²⁰

Respect for the agency of children as rights-holders is a precondition for their full exercise of their rights to health and through health. This is enshrined in international human rights law, which stipulates that children's views and wishes must be given due weight in accordance with their age and maturity.²¹ However, cultural norms about the child's place in the family and society often result in their agency being ignored, or even rejected.²² Harmful social norms and practices are often wrongly believed either to benefit children or to be more important than a child's best interest: a phenomenon from

which girls particularly suffer. Yet, the law is clear: the best interests of the child must prevail. Much work remains to be done to address the harmful consequences of such practices for child health by recognizing and realizing children's rights.²³

Preventable deaths of children under age five have been halved since 1990, but still nearly six million children die every year from largely preventable causes.²⁴ Marginalized groups of children, such as those with disabilities, those in forced and hazardous labour, those affected by HIV/AIDS, migrant children, children in detention and child refugees, are particularly disadvantaged. Yet early childhood development is known to profoundly affect health throughout life. Likewise, poor realization of rights in childhood frequently undermines enjoyment of rights in later life.²⁵ The reverse is also true: protecting, respecting and fulfilling children's rights is one of the surest paths to productive, active rights enjoyment and better health in later adulthood.

Achieving the rights of the children currently left furthest behind will be a game changer in the struggle for health and against discrimination and inequality.

Yet, in many countries children are discriminated against because of their gender. The girl child continues to be denied access to the same levels of education, nutrition and dignity as the boy child. Furthermore, lack of data on the sexuality and reproductive health status of “early adolescents” (aged 10 to 14) is a serious barrier to the provision of comprehensive age- and gender-responsive services.

To satisfy children’s rights to health and through health, attention must be paid to root causes.

These include their rights to adequate water, sanitation and hygiene; food; safe and secure living environments; protection from harmful practices; and their right not to be subjected to discrimination.

Parents and caregivers are profoundly important to the well-being and prospering of children. Children whose mothers are subjected to violence have worse health outcomes over their life course, making protection of women’s rights also key to the rights of the child. Child victims of neglect, maltreatment and abuse also lack the capacity to protect themselves or gain protection from others. Concrete steps by the State are essential to protect them from such human rights abuses.



Upholding adolescents’ rights to health and through health

Paving the way from childhood to adulthood, adolescence is a critical life stage. Behaviours learned and habits formed in adolescence can have a profound impact on health and well-being for years to come. This development period is characterized by rapid physical,

cognitive and social changes, including sexual and reproductive maturation. Adolescence involves the gradual building of capacity to assume adult behaviours and roles, bringing new responsibilities and requiring new knowledge and skills.

Box 4. Adolescent mental health: need for critical action

Worldwide 10-20% of children and adolescents experience mental health conditions. Suicide and accidental death from self-harm were the third cause of adolescent mortality in 2015.³⁰ Half of all mental health conditions begin by the age of 14, and three quarters by the mid-20s. Neuropsychiatric conditions are the leading cause of disability in young people in all regions. If untreated, these conditions severely influence children's development, their educational attainment and their potential to live fulfilling and productive lives. Children with mental health conditions face major challenges of stigma,

isolation and discrimination, as well as lack of access to health care and education facilities, in violation of their fundamental human rights.

Poor mental health can have important effects on the wider health and development of adolescents. It is associated with negative health and social outcomes, such as higher use of alcohol, tobacco and illicit substances, adolescent pregnancy, school drop-out and delinquent behaviour. There is growing consensus that healthy development during childhood and adolescence can prevent mental health problems.³¹

Under international human rights law, most adolescents, defined by the UN as those between the ages of 10 and 19, are still “children”. However, their needs and rights are distinct from those of younger children. Adolescents must also be recognized as agents of change. Millions are positively engaged in health and education campaigns, family support, peer education, community development initiatives, participatory budgeting and creative arts, and are making contributions towards peace,²⁶ environmental sustainability and climate justice. Many are at the cutting edge of communications technology which in turn holds innovative potential for political engagement and monitoring accountability.²⁷

During adolescence violations of human rights can be life-critical, particularly for girls. While health outcomes for boys and girls are more similar in earlier childhood, they change dramatically with the onset of puberty. At this point, negative gender-based social norms divide the developmental pathways of the sexes, to the disadvantage of young women: intensifying threats to their mental health and well-being and their sexual and reproductive health, and closing down opportunities for their participation in public life.²⁸

Despite some progress, girls continue to suffer severe disadvantages in education; only two out of 35 countries in sub-Saharan Africa have reached gender parity in education.²⁹ Girls' school drop-out rates can be addressed by: increasing their access to sanitary products; ensuring school bathrooms have safe water and sanitation; ending child, early and forced marriage and reducing—through services and information—rates of early childbearing. Furthermore, social stress, mental health disorders and psychosocial illnesses remain key challenges confronting adolescent health (see Box 4). The evidence is clear that removing these challenges can be a powerful circuit breaker in cycles of poverty and exclusion.

The sheer number of young people aged between 10 and 24 alive today, 1.8 billion or 24% of the world's population in 2014,³² presents a pivotal opportunity for the world at large. Over the life of the SDGs, if sufficient attention and investments are directed to their human rights to health and through health, adolescents will become tremendous global assets. If countries with young populations educate their young people and protect their health, then sustainable economic growth can be primed. This requires States to take urgent measures to ensure enabling environments that help adolescents make the

transition into adulthood and enter the workforce. As fertility and mortality rates decline, and the proportion of working-age population grows in relation to the number of dependents, countries benefit from the phenomenon known as the demographic dividend.³³

Conversely, persistent failure to fulfil adolescents' rights will undermine health and inclusive development. Evidence from high-, middle- and low-income countries reveals that health services for adolescents are highly fragmented, poorly coordinated and of uneven quality.³⁴ Adolescents' access to health-care services, particularly sexual and reproductive health and mental health services and information, is further hindered by laws and regulations that impose restrictions relating to minimum age, third-party authorization or marital status.

These disempowering policies, along with social norms and stigma, can dissuade adolescents from consulting health services. Some health-care providers fail to respect adolescents, and disregard their privacy and confidentiality. Stigma and discriminatory practices create further barriers that are exacerbated by the moral judgements of some practitioners.³⁵

Globally, there were an estimated 1.2 million adolescent deaths in 2015,³⁶ most of which could have been prevented. Adolescents form the only age group in which deaths due to AIDS increased.³⁷ Preventive approaches, as well as empowerment, are required to ensure that all adolescents—both boys and girls—not only survive and thrive, but also enter adulthood with the attributes they need to help transform their societies.³⁸



Upholding women's rights to health and through health

Despite some global progress towards gender equality, women everywhere continue to be denied their full rights. They still face gender-based discrimination, which no country in the world has yet fully eliminated.

Laws, policies and practices that discriminate against women (and girls) undermine their ability to make decisions about their own health, and limit their access to quality health care and health information. Discrimination against

women (and girls), including gender stereotyping, is at the heart of harmful practices injurious to their health and human rights. Such practices include child, early and forced marriage, gender-based violence, female genital mutilation and infanticide. All these manifestations of harmful social norms, and many others that are less obviously egregious but that also affect women's access to health services, undermine their rights to privacy and confidentiality, which may in turn inhibit them from seeking services in the future. Social restraints on women's mobility (or freedom of movement) in many countries also reduces their ability to access health care independently.

This is most evident in regard to sexual and reproductive health and rights, which have a direct bearing on women's right to life and to make meaningful and autonomous decisions about their lives and health.³⁹ Barriers to information, services and life-saving commodities mean that women still bear a huge burden of unmet need for contraception. Hundreds of thousands of women are the casualties of preventable maternal mortality and morbidity, for which there is simply no excuse.⁴⁰ Ideologically based health policies and practices, such as denial of services based on a practitioner's conscience, deny women the care to which they are entitled. Lack of access to emergency obstetric care and to safe abortion lead to preventable maternal deaths, which violates the right to life, and in some circumstances can amount to torture, or to cruel, inhuman or degrading treatment.⁴¹

Even when health-enabling laws and policies are in place, prevailing social norms can result in the continuation of harmful practices, confining women to the role of mothers and caregivers, and limiting the exercise of their rights to education, paid employment and equal opportunities. No family can fully thrive when women and girls are denied their rights. And no country can afford or should tolerate such waste of talent, participation and contribution.

Improved living standards, access to essential health services and declining fertility have driven rising longevity globally, a demonstrable success



of development efforts. But this also has profound human rights implications.

In context of older women their personal circumstances depend on a range of economic, social, cultural and political factors and are influenced by the extent to which they are discriminated against. Their rights to informed decision-making and consent regarding their own health care are not always respected. Information on sexual health and HIV/AIDS is rarely provided in a form that is acceptable, accessible and appropriate to older women. Postmenopausal, post-reproductive and age-related physical and mental health conditions and diseases tend to be neglected in research, academic studies, public policy and service provision. Social services for older women, including long-term care provision, are often disproportionately reduced when public expenditure is cut. In several countries many older women have no private health insurance or are excluded from State-provided schemes to which they were unable to contribute due to a lifetime spent working in the informal sector, as domestic workers or unpaid carers.⁴²

Yet, the contributions of older women to society in both public and private life, as leaders in their communities, are invaluable: they provide a wide range of experience, knowledge, ability and skills as entrepreneurs, care-givers, advisers and mediators, among their other roles.⁴³

The most important health issues affecting women, children and adolescents are presented in the following infographics.

KEY CHALLENGES

CHILDREN



An estimated 5.9 million children under age 5 died in 2015 of which almost half were newborns⁴⁴



There were an estimated 2.6 million stillbirths in 2015⁴⁵



Almost half of deaths before age 5 are linked to undernutrition⁴⁶



250 million children are at risk of not reaching their full potential due to poverty and stunting⁴⁷



The best interest of the child is often overlooked

ADOLESCENTS



An estimated 1.2 million adolescents died in 2015⁴⁸



Self-harm was the third ranked cause of death for adolescents in 2015⁴⁹



AIDS-related deaths are increasing among adolescents while decreasing in all other age groups⁵⁰



15 million girls under the age of 18 are married each year⁵¹



Laws imposing third-party consent hinder access to health services

WOMEN



An estimated 303 000 women died in pregnancy and childbirth in 2015⁵²



An estimated 225 million women have an unmet need for contraception⁵³



An estimated 22 million unsafe abortions take place worldwide each year⁵⁴



1 in 3 women experience violence in their lifetime⁵⁵



Discriminatory laws and policies perpetuate gender inequality



Addressing intersecting and multiple forms of discrimination

Discrimination works against equitable health outcomes and extends beyond the grounds of age and gender. It interacts with, for example, economic status, education level, sex, sexual orientation and gender identity, place of residence, race, ethnicity, religion, health and disability.⁵⁶ Population groups subjected to discrimination systematically suffer inequities in health outcomes. For example, the stigmatization and marginalization to which people who are lesbian, gay, bisexual, trans, and/or intersex (LGBTI) are subjected drives high rates of sexually transmitted infections, poor mental health outcomes and suicide (especially among adolescents). Interplay between different forms of discrimination (intersectionality) has a major role in determining health outcomes and broader opportunities.⁵⁷

Women bear the brunt of intersectional discrimination in health care. For example, in many communities women from ethnic minorities or indigenous peoples have less access to fewer services, and receive less health

information; consequently, they have higher mortality rates than the general population.⁵⁸ Women with disabilities, especially women and girls with intellectual disabilities, are at higher risk of forced or involuntary sterilization and other medical interventions performed without their free and informed consent.⁵⁹ Refugee and internally displaced women, and those who are stateless, asylum-seekers or migrant workers, often face discrimination, abuse and neglect. They are sometimes denied access to health care because they lack legal status in the country of asylum, lack legal documentation, or are resettled far from health-care facilities. They can also experience cultural and language barriers to accessing services.⁶⁰

Human rights law places on all States a special obligation to prevent all internationally prohibited forms of discrimination in the provision of health care and health services, especially with respect to the core obligations created by the right to health.⁶¹



Location matters: the critical relevance to health of emergency and other crisis settings

Conflict, disaster, climate instability (Box 5) and collapsing States have driven a dramatic rise in the number of displaced people, both within and across national borders. Today 65 million people are displaced either within their own countries or as refugees elsewhere.⁶² The average time spent in displacement has now reached 20 years.⁶³

Women, children and adolescents are disproportionately affected in both sudden and slow-onset emergencies. They suffer multiple human rights violations in situations far beyond their control. The evidence clearly demonstrates the intimate relationship between health, peace and security.⁶⁴ In countries designated by the Organisation for Economic Co-operation and Development (OECD) as fragile states, the estimated lifetime risk of maternal mortality is

1 in 54.⁶⁵ Three quarters of countries with maternal mortality ratios above 300 per 100 000 live births are fragile states.⁶⁶

In these settings, pregnant women face increased medical risks, such as gestational hypertension and anaemia, along with adverse outcomes, including for the newborn, with lower birth weights and higher rates of preterm birth. Crises further increase the risk of pregnancy-related death due to pre-existing nutritional deficiencies, susceptibility to infectious diseases, and lack of access to antenatal care, assisted deliveries and emergency obstetric care. The disruption and lawlessness common during emergencies often results in increased rates of sexual violence, further prejudicing the health and survival of women and girls.⁶⁷

Box 5. Climate change and women's, children's and adolescents' health and human rights

Climate change is one of the greatest environmental and health equity challenges of our time: wealthy, energy-consuming nations contribute most to global warming, yet the world's poorest and often youngest populations bear the brunt. By WHO's most conservative estimates, 250 000 people per year are likely to die as a result of climate change between 2030 and 2050.⁶⁸ It is estimated that the vast majority of these deaths will be among malnourished children, children who contract pneumonia and diarrhoea, and children who are affected by disease whose transmission has increased due to climate change (such as malaria, dengue and leishmaniasis). As rains fail, crops wither and livestock die, the poor—often women and children—will face starvation and diminishing water supplies for drinking and hygiene. Air pollution, associated with higher temperatures and the burning of many of the fuels that themselves exacerbate climate change, triggers pneumonia, one of the world's top killers of children under age five.⁶⁹

Climate change also disproportionately prejudices women's realization of their health and human rights. The impacts of climate change have been shown to widen existing gender disparities and inequities. Natural disasters, such as droughts and floods, kill more women than men, and at a younger age. Notably, these trends are more pronounced in countries where the socioeconomic status of women is particularly low. Other effects of climate change, such as food and water insecurity, extreme weather events and conflict related to resource scarcity, also put women and children at increased risk. In many societies, women and girls collect water; its scarcity means they suffer disproportionate health consequences, including nutritional deficiencies and the burdens (and safety risks) associated with travelling further to collect water.⁷⁰

It is important to remember, however, that while women and children, especially the poor, are vulnerable to climate change, they are also effective actors and agents of change in relation to both mitigation and adaptation. Many women have knowledge and expertise that must be used in climate change mitigation, disaster reduction and adaptation strategies and spurring bold action on climate change.



1.4 Needed changes are feasible, realistic and affordable

Against this backdrop, the human rights-based *Global Strategy* sets out a realistic and affordable pathway to a better future for all, by focusing first and foremost on women, children and adolescents. To ensure that no one is left behind, and for the sake of sustainable inclusive development, the High-Level Working Group believes that it is possible to realize the rights to health and through health of women, children and adolescents. We strongly advocate the realization by 2030 of the following vision of the world.

- All people are fully exercising their right to the enjoyment of the highest attainable standard of physical and mental health, including through non-discriminatory access to essential services and participation in health system planning and priority setting.
- Each nation's legal system recognizes people's right to the highest attainable standard of health as established in international law, including in their constitution where applicable.

- All governments have enacted their legal duties with respect to health and human rights.
- All health service providers respect the rights of those in their care and are protected when defending human rights.
- All health systems are designed and regulated in accordance with human rights principles, norms and standards.

This vision, which is in line with both *Agenda 2030* and the *Global Strategy*, is certainly achievable. A comprehensive set of standards and technical guidance is already available which sets out in detail the core elements of this human rights-based approach. In addition to providing an authoritative account of the linkages between health and human rights, these resources present a wide range of practical advice for action.

1.5 No substitute for local and national leadership

A human-rights based approach to health requires an enabling environment including: favourable laws and policies; proportionate and focused investments; informed, engaged health professionals; and a dynamic civil society inclusive of broad-based coalitions for age- and gender-sensitive health services.

These enabling environments flourish best when sponsored and supported by committed political leadership. In many settings the international community can play an important role, but national and local leadership are vital. Even when resources are restricted, committed leadership can make a huge difference to the lives of women, children and adolescents. For that reason, Part 2 of this report focuses on

why and how such leadership can make an unparalleled difference. It sets out inspirational examples showing what is possible; it presents concrete recommendations and identifies critical actions that can create a new paradigm of health, dignity and well-being for women, children and adolescents, now and for generations to come. The Working Group urges the world's leaders to found their efforts in pursuit of these goals squarely on the human rights principles of equality, inclusiveness, non-discrimination, participation and accountability. Evidence shows that this formula can create the transformation necessary to secure more peaceful, fairer and more inclusive societies, for everyone.



PART TWO: Leading the realization of human rights to health and through health

As driving forces for the sustainable enjoyment of their rights by women, children and adolescents, national and local leadership are simply essential. Nothing can substitute for them.

Only through focused leadership by governments, both nationally and locally, can inequities in health outcomes be addressed conclusively, gender-based and other forms of inequality be tackled, and discrimination removed, including within health systems. Only committed leadership with accountability will produce sustained abandonment of

harmful practices, inspire others to act in support of human rights to health and through health, systematically guide the needed human rights-based approaches to the design, implementation and evaluation of policies and programmes for health, and implement the necessary legal provisions.

A transformative leadership agenda is vital if women, children and adolescents are to realize their health and well-being and to flourish and prosper. The key dimensions of this agenda are described below.

2.1 Create an enabling environment



UPHOLD THE RIGHT TO HEALTH IN NATIONAL LAW

While the right to health allows for progressive realization, in acknowledgement of the limits imposed by resource and other constraints, States also have obligations of immediate effect, such as the guarantee that this right will be exercised without discrimination of any kind and that deliberate, concrete and targeted steps will be taken towards the right's full realization.

However, there is an important gap between the recognition of the right to the highest attainable standard of physical and mental health and its systematic implementation at the country level. This is evidenced by uneven codification of international and regional human rights obligations in national law. Legislators and policy-makers must be convinced of their responsibilities to protect

economic, social and cultural rights in the same way as they are obliged to protect civil and political rights.

Many countries have yet to codify these international and regional human rights obligations in national law. For instance, one analysis found that, as at 2011, most of the 191 UN Member States' national constitutions failed to guarantee rights related to public health (86%), medical care (62%) or overall health (64%). Further, 91% of those constitutions failed to guarantee free medical care; 87% failed to guarantee children's rights to health and medical care; 94% failed to do so for persons with disabilities; and 95% did not do so for either the elderly or the socioeconomically disadvantaged.⁷¹

Many States have also not adopted or amended other laws impacting on the right to health. For example, the Committee on the Rights of the Child has stated that countries are required to introduce

Box 6. Slow progress on legislation concerning marketing of breast-milk substitutes

Breastfeeding is one of the best ways to reduce newborn, infant and under-5 mortality and morbidity. The aggressive marketing of breast-milk substitutes is still a significant barrier to improved breastfeeding rates in many countries. Global sales of breast-milk substitutes are expected to rise from US\$ 44.8 billion in 2015 to US\$ 70.6 billion by 2019.⁷² The International Code of Marketing of Breast-milk Substitutes, adopted by the World Health Assembly in 1981, sets out vital regulation to reduce inappropriate marketing. Furthermore, the Guiding Principles on Business and Human Rights⁷³ stipulates that all business enterprises should operate with respect for human rights. Companies marketing breast-milk substitutes are required to respect human rights. That duty involves exercising due diligence to identify any risk that marketing might adversely impact on human rights, including the right of the child to health, and

taking all necessary steps to prevent or mitigate that risk.

The 2016 report on national implementation of the Code⁷⁴ shows that too few countries have adopted effective legislation to reduce or eliminate the inappropriate marketing of breast-milk substitutes, and that only a handful of countries have enacted legal measures and established operational monitoring and enforcement mechanisms. The report makes direct reference to technical guidance and accompanying recommendations, addressed to countries, to enable them to regulate private actors, such as pharmaceutical companies, commodities and device manufacturers and producers and marketers of breast-milk substitutes, in order to prevent violations of child health-related rights and ensure accountability, including remedy and redress if violations occur.

Box 7. Using litigation when the State fails to fulfil its legal obligations⁷⁵

Advocates in domestic courts have successfully relied on constitutional and human rights law to argue that a State is not fulfilling its legal obligations to prevent maternal mortality and morbidity.

In the 2010 decision of *Laxmi Mandal v Deen Dayal Hari Nager Hospital & Others*, the Delhi High Court recognized a constitutionally protected right to maternal health care and ordered compensation for human rights violations experienced by two impoverished women who died during childbirth.⁷⁶

Similarly, in Nepal a ground-breaking case was decided by the national Supreme Court which held the government liable for failing to ensure the affordability of abortion services, and instructed the government to take steps

to guarantee that no woman is denied an abortion solely on financial grounds.

Litigation has also been successfully invoked at the international level. An example is the case of *Alyne da Silva Pimentel Teixeira*, who died of postpartum haemorrhage following the stillbirth of a 27-week-old foetus on 16 November 2002, in Rio de Janeiro, Brazil. Her death led in 2011 to the first decision by an international treaty body to hold a government accountable for a preventable maternal death. In this first ever decision on maternal mortality, the Committee on the Elimination of Discrimination against Women found Brazil in violation of its human rights obligations and ordered the government to take steps to improve access to maternity services and provide compensation to Alyne's family.⁷⁷

into domestic law and implement and enforce the International Code on Marketing of Breast-milk Substitutes, but few have done so (Box 6).

Leadership to uphold the legal underpinnings of the right to health is key. It is a shared responsibility. National parliaments, judiciaries and independent institutions, for example, should work to ensure that the right to health is legally recognized as a fundamental human right, rather than an aim which need only be fulfilled when their government considers that sufficient resources are available. Once enshrined in national law, health rights cannot be overridden by ruling political parties.

However, in many contexts courts are not empowered to instruct governments to act nor to provide individual redress for violations of the right to health. When they are, a judicial system can be pivotal in helping individuals and groups to hold governments to account (see Box 7 for examples) as well as empowering governments to act with the confidence of the law.

It is also important to consider the structure of a country's health governance and financing system, for example federated health systems with multiple jurisdictions, as this system may offer additional layers of opportunity to engage in upholding the right to health at the country level.

RECOMMENDATION 1

All States should strengthen legal recognition of human rights to health and through health, including sexual and reproductive health and rights, in their national constitution and other legal instruments. Remedies for violations of these obligations should be effective. Sufficient financial and human resources should be allocated for designing and implementing legislative and policy measures and social initiatives to ensure the realization of rights to health and through health and to facilitate universal access to health care.



ESTABLISH A RIGHTS-BASED APPROACH TO HEALTH FINANCING AND UNIVERSAL HEALTH COVERAGE

Large sections of populations, particularly in rural areas, are excluded from access to health services due to, for instance, insufficient numbers of skilled health workers, poor infrastructure, limited social protection and /or high out-of-pocket payments. It is estimated that approximately 90% of all people living in low-income countries have no health insurance coverage, and that about 39% of the global population lack cover.⁷⁸

Among countries that have signed up to the broad principles of universal health coverage (UHC) there is considerable variation in the way in which that commitment is operationalized. Even in high-income countries the financing of good quality health services to ensure UHC remains a challenge, and even in countries where entitlement to health coverage is established in national and local laws, UHC is often inadequate or simply not implemented.

Often the resources allocated do not adequately address the health needs of marginalized and vulnerable groups.

According to WHO, “UHC is, by definition, a practical expression of the concern for health equity and the right to health”.⁷⁹ Perhaps the strongest objective of UHC is to remove financial barriers impeding access to health care,⁸⁰ thus ending the exclusion from health care that is ascribable to poverty.⁸¹ For progress towards UHC, expert analyses recommend that governments take steps to allocate at least 5% of GDP on health.⁸²

SDG 3 (healthy lives) includes a target for UHC: “Achieve UHC, including financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all”.⁸³ The *Global Strategy* emphasizes that UHC,

Box 8. The route to effective coverage through health workers

Evidence clearly shows that the only way to achieve effective coverage is to eliminate the difference between the *theoretical* coverage implied by the availability of the workforce and the *actual* coverage resulting from the quality of the workforce.⁸⁷ The *Global Strategy* emphasizes the critical role of health workers and the need to strengthen their capacity, especially by formalizing the role of community health workers. Further, the *Global Strategy* requires that all countries use proven mechanisms to ensure that health workers are trained in accordance with the latest guidelines, with job-aids and checklists in place at the point of service to support effective delivery of essential interventions. Health workers at all levels should receive sufficient education in human rights to enable them to provide gender- and age-responsive services. Such training has a proven positive effect on the acceptability and quality of services.⁸⁸



including financial risk protection and access to quality essential services, medicines and vaccines, is key to women's, children's and adolescents' health.

The obligation to remove financial barriers to accessing health care is a core element of the right to health. The right to health requires governments to provide health care to all people who need it, without discrimination, including without discrimination on financial grounds.^{84,85} Human rights principles and standards, such as non-discrimination, availability, accessibility, acceptability, quality, accountability and universality, are essential foundations for the fair and equitable application of UHC⁸⁶ and are essential for guaranteeing coverage inclusive of and responsive to women's, children's and adolescents' health needs.

Furthermore, in order to reach every woman, every child and every adolescent everywhere, and to ensure effective coverage, a well-trained health workforce able to provide gender- and age-sensitive health services is vital (Box 8).

Health systems should be enabled, through legislation, resourcing and capacity, to respond to the health as well as the protection needs of women, children and adolescents. Any practices that violate human rights, such as detaining people in health facilities because of their inability to pay for treatment or care, must immediately be banned.

A clearly defined "road map" for equitable financing of the health needs of different population groups should be in place at national and subnational levels, setting out how the State intends to enact UHC and to ensure respect for and protection of the rights of women, children and adolescents in all health-care provision, including that provided by the private sector.⁸⁹ The development and implementation of Global Financing Facility country investment cases provide unique opportunities to forge an integrated human rights-based approach to health. Several frontrunner countries are

Box 9. Children's rights and health-care services

In 2013 and 2014, 11 hospitals in Kyrgyzstan, 10 hospitals in Tajikistan and 21 hospitals in Moldova conducted a rights-based assessment of the quality of care delivered to children and adolescents.⁹⁴ This exercise was part of a larger quality of care assessment supported by the WHO Regional Office for Europe. A set of tools for assessing and improving children's rights in hospitals, based on the Convention on the Rights of the Child (CRC) was used. These translate the rights enshrined in the CRC and related dimensions into concrete measures and activities that health professionals and managers can apply in the delivery of health care for children and adolescents.

The assessment facilitated a multistakeholder process, with active and meaningful participation by children, adolescents and their caregivers, as well as hospital management and staff. This resulted in a properly comprehensive analysis of the care provided, and presented crucial information about the fulfilment of certain rights that would otherwise have been difficult to gather.

This project produced some promising results. However, long-term impact from such approaches can only be achieved with sustained commitment from governments and the international community. This must include: systematic integration of human rights standards into quality of care monitoring and evaluation; human rights capacity building of relevant stakeholders, including legal awareness and literacy; integration of child rights and quality of care in medical curricula and in-service training; sufficient financial resources; and development of the evidence base for applying a human rights-based approach to child health, including through randomized control trials on the use of the assessment tools, and measuring its impact on quality of care and child health outcomes.

taking concrete steps towards integrating a human rights-based approach into their country investment plans and opening up possibilities for operationalizing human rights at the national and subnational levels.

Strategies for embedding human rights-based approaches in health systems have been published by WHO⁹⁰ and a clear framework is set out in the Committee on Economic, Social and Cultural Rights General Comment No. 14 (2000).⁹¹ A set of tools is available for conducting rights-based assessments of quality

of care (see Box 9 for an example). WHO and others have also developed, for example, a matrix for a human rights-based analysis of policies and programmes for the provision of family planning services.⁹² Similar guidance for UHC is needed, with scoring of health systems performance, regardless of context.⁹³ Comparative and analytical case studies also generate tools for identifying system-level gaps in care, recognizing specific needs across the life course and ensuring the responsiveness of health systems to the health and human rights of women, children and adolescents.

RECOMMENDATION 2

All States should develop national and subnational financing strategies with clear timelines that contribute directly to the realization of rights, including universal health coverage. These strategies should apply the human rights principles of equality, inclusiveness, non-discrimination and participation. Redress should be available where these universal standards are not reasonably met. States should take steps to allocate at least 5% of GDP for public health spending, which is the recognized prerequisite for universal health coverage.





ADDRESS HUMAN RIGHTS AS DETERMINANTS OF HEALTH

Human rights determinants exert powerful influence on the health of women, children and adolescents.

Discrimination, inequality, marginalization and unequal access to resources are not only violations of rights but also the main drivers of health inequities within and between countries.⁹⁵ Gender differentials in access to education, nutritious food and health services; child, early and forced marriage; unequal access to labour markets and unequal pay for equal work; gender-based violence; and child abuse and lack of child protection are not only social determinants contributing directly to maternal and child mortality and morbidity; they also violate the human rights of those affected.

Rights-based measures to mitigate these negative factors can help States to improve

health outcomes and reduce disparities. Rights-based action to address health inequalities, equalize power dynamics within health services and engage enabling sectors (such as those providing for nutrition, child welfare/protection, education, water and sanitation, environmental protection, justice and security) can help transform the determinants of health.⁹⁶ The severe consequences for women's, children's and adolescents' health and well-being wrought by crises such as conflict, contagion and climate change should be anticipated through gender- and age-sensitive risk assessments and contingency planning.

One example of the important role played by the health sector is preventing and responding to violence against women, which is a target of SDG 5 on gender equality (Box 10).

Box 10. A global multisectoral plan to address violence against women and girls

In May 2016, at the World Health Assembly, all 194 national ministers of health endorsed a “Global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls and against children”.⁹⁷ The global plan of action was a historic achievement, for the first time recognizing, and committing the health sector to addressing, violence against women and girls as a public health issue in the global health agenda. The plan of action places women’s and girls’ human rights, including those related to sexual and reproductive health and rights and gender equality, at the centre of its guiding principles. Among other actions, the plan urges WHO Member States and partners to:

- publicly challenge the acceptability of violence against women and the discriminatory gender norms that underlie such violence;
- train health-care providers to identify women and girls experiencing violence and to provide comprehensive and appropriate medical care, including sexual and reproductive health services and psychological support;
- implement evidence-based interventions to prevent violence against women and girls, including interventions that promote egalitarian gender norms, empower women and girls and build respectful relationships among children and adolescents through comprehensive sexuality education;
- improve the evidence base by strengthening surveillance and health information systems to collect data on violence against women and girls, and by regularly conducting population-based surveys to collect data on the prevalence of violence against women, including for SDG 5.2 monitoring; and

- invest in research to better understand, prevent and respond to violence against women and girls.

An increasing number of countries are implementing strategies and actions within the global plan of action, adapting them to their national context. For example, countries including Cambodia and Kazakhstan have conducted surveys on national violence against women based on the WHO multi-country study on women’s health and domestic violence. Countries including Afghanistan, Cambodia, Guinea, India, Namibia, Papua New Guinea, Pakistan, the Solomon Islands, Uganda, Uruguay and Viet Nam are updating or have updated their national protocols, guidelines or training curricula for health-service providers to respond to violence against women in line with WHO guidelines and recommendations, and are in the process of scaling up a health system response. Governments are mounting public campaigns against the acceptability of violence towards women and girls. Some countries are also implementing prevention interventions, such as community mobilization, to promote gender equitable norms. For example, Australia has recently launched a new framework on primary prevention of violence against women and their children.⁹⁸ The framework emphasizes that gender equality is both the heart of the problem and its solution, and identifies a set of critical actions for prevention of violence against women and their children.

RECOMMENDATION 3

All States should undertake periodic human rights-based assessments of the determinants of women’s, children’s and adolescents’ health, with particular attention to gender inequality, discrimination, displacement, violence, dehumanizing urbanization, environmental degradation and climate change, and develop rights-based national and subnational strategies to address these determinants.



REMOVE SOCIAL, GENDER AND CULTURAL NORMS THAT PREVENT THE REALIZATION OF RIGHTS

While social and other rights-related determinants of health affect all populations, gender-based social and cultural norms have additional and often devastating consequences for the health, well-being and dignity of women, girls and adolescents. Adolescent girls are denied education about sexual health and well-being; women are denied contraception because their husband has not consented to it; women and girls are subjected to sexual abuse and exploitation: in every region of the world, women and girls in particular are denied their human rights simply because of their gender and the associated societal norms and cultural practices.

The UN Convention on the Elimination of All Forms of Discrimination against Women calls on States to “modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women”.⁹⁹

These patterns take many forms, including: child, early and forced marriage; female genital mutilation; the forcing of girls and women with unintended pregnancies to carry the pregnancy to term;¹⁰⁰ and the denial of girls’ and women’s rights to decide whether, when and with whom to have sex and to marry, and whether, when and at what intervals to bear children.¹⁰¹

Improving the health of women, children and adolescents requires the promotion of egalitarian gender norms in communities and societies, respectful relationships between women and men, and the empowerment of women and girls. Removing harmful gender norms, including masculine norms that promote male privilege and entitlement and the subordination of women, requires the involvement and engagement of men and boys along with the empowerment of women and girls. Although these norms disproportionately affect the health



of women and girls, they also contribute to increased risk taking behaviours among adolescent boys and young men, producing adverse consequences related to the use of alcohol and tobacco and the practice of unsafe sex. Harmful gender norms, including masculine norms, are also key drivers of men’s violence against women. Box 11 sets out some evidence-informed actions to change these harmful norms.

Far from challenging and seeking to eradicate the norms and practices that violate women’s and girls’ human rights, some governments entrench these, compelling conformity to stereotypes and discriminatory norms that erode dignity, particularly in sexual and reproductive life. A key means of addressing harmful norms in sexual and reproductive life (and simultaneously improving health outcomes) is comprehensive sexuality education for all adolescents and young people (Box 12).

Governments have an obligation to “give full attention to meeting the reproductive health service, information and education needs of young people with full respect for their privacy and confidentiality, free of discrimination, and to provide them with evidence based comprehensive education on human sexuality, on sexual and reproductive health, human rights and gender equality, to enable them to deal in a positive and responsible way with their sexuality”.¹⁰⁷

Governments must move urgently to fulfil this commitment and ensure that adolescents and young people have access to comprehensive, evidence-based sexuality education.

Harmful norms are enforced by laws and policies that support third-party consent requirements (parental or spousal), restrict access to services (especially sexual and reproductive health and rights services), or deny individuals’ autonomy, agency and choice. Many national guidelines

give primacy to religious authorities and traditional law over human rights obligations. Furthermore, the religious and moral convictions of some health-care providers have been allowed to prevent the use and sometimes the provision of essential, even life-saving, interventions. Such hierarchies of influence over health policy and practice are harmful to the interests of women and girls and impede their access to health services as autonomous agents with rights to privacy, confidentiality and dignity.¹⁰⁸

Certain groups of women and adolescents are particularly stigmatized, and fearful of negative consequences if they access health information and services. Examples include unmarried women and mothers; migrants; women and girls of minority communities; sex workers; those living with HIV; and LGBTI persons. Some countries impose discriminatory sanctions on stigmatized populations, involving a range of human rights

Box 11. Addressing harmful masculine norms and engaging men and boys

Evidence accumulated from nearly two decades of research on masculinities and programming with men and boys shows that men’s and boys’ attitudes about gender can be changed by programmes that generate critical reflection on how harmful masculine norms affect men’s own health and well-being, the quality of their intimate relationships and the health and well-being of their partners. This evidence also suggests that programmes to transform harmful masculinities and gender norms must work, not only with individual or groups of men and boys, but with entire communities to effect sustained changes in norms and behaviours. Efforts must address institutions that promote a culture of male privilege and entitlement and women’s subordination. Available evidence highlights several other effective responses, a few of which are listed below.

- Investment in programmes to engage men and boys must be accompanied by investment in empowering women and girls.

- Addressing men’s and boys’ own health is an important health issue in its own right, including their histories of trauma and neglect.
- It is important to recognize the roles of class, ethnicity, race and sexual orientation in shaping masculinities of different groups of men and boys.
- Investment is needed to build a more robust evidence base on the most effective strategies to engage men and boys and bring about sustained changes in norms and behaviours in communities and over time.
- Efforts to work with men and boys must be undertaken carefully in order to prevent or minimize any harmful backlash against the autonomy and rights of women and girls.

Men and boys are critical allies, just as the empowerment of women and girls is central to the promotion of gender equality.¹⁰²

violations: denial of health services, denial of freedom of association, harassment and violence against individuals.¹⁰⁹ Specific efforts must be made to remove such provisions in order to make services truly inclusive and effective.¹¹⁰

Legal or statutory provisions that impede access to so-called “sensitive” services, such as sexual and reproductive health services, including comprehensive sexuality education, family planning and safe abortion, must be addressed. Harmful gender, social and cultural norms that restrict access to sexual and reproductive health services are themselves forms of discrimination. Criminalizing and imposing punitive sanctions for consensual same-sex activity or HIV transmission are human rights violations, as well as deterring individuals from accessing the health services to

which they are entitled. Threats to and harassment of those working for sexual and reproductive health and rights have been reported across the globe, yet these people are human rights defenders whose own rights must also be upheld.¹¹¹

The best designed and best resourced health, and health enabling, system will only succeed in improving women’s and girls’ lives if political and legal commitments by governments to ensure gender equality and to remove harmful social and cultural norms are at their heart. For this, committed leadership is essential.

Box 12. Comprehensive sexuality education

The UN Commission on Population and Development has repeatedly confirmed the responsibility of governments to “provide young people with comprehensive education on human sexuality, on sexual and reproductive health, on gender equality and on how to deal positively and responsibly with their sexuality”.¹⁰³ However, programmes that empower women, particularly adolescent girls and young women, by encouraging them to know their bodies and to exercise their rights remain extremely rare.¹⁰⁴ According to UN estimates, the vast majority of adolescents and young people still lack access to the comprehensive sexual and reproductive health



and rights services and education on sexuality that they need for a healthy life.¹⁰⁵ Evidence has shown that providing young people with comprehensive sexuality education—scientifically accurate and rights-based information about sexuality and reproductive health appropriate to their age—is effective in improving their health. The widespread lack of such preparation currently leaves young people vulnerable to coercion, abuse, exploitation, unintended pregnancy and sexually transmitted infections, including HIV.¹⁰⁶

RECOMMENDATION 4

All States should implement legal, policy and other measures to monitor and address social, gender and cultural norms and to remove structural and legal barriers that undermine the human rights of women, children and adolescents. Urgent attention must be given to developing national frameworks that prohibit and adequately punish gender-based violence, end female genital mutilation and child, early and forced marriage, and remove barriers to the enjoyment of sexual and reproductive health and rights.



2.2 Partner with people



ENABLE PEOPLE TO CLAIM THEIR RIGHTS

Under international human rights law, States have the primary obligation to respect, protect and fulfil human rights. National agendas that integrate health and other human rights can inspire political commitment and direct leadership towards the fulfilment of these obligations. Enabling communities and people, specifically women, children and adolescents, to advocate for their rights, can help motivate and inspire authorities to take accountable action: they are an invaluable force for change (see Boxes 13 and 14 for two examples). Ensuring that people are enabled to be aware of and to claim their rights can provide renewable energy for sound policy implementation. But this requires a shift away from older approaches: away from viewing individuals as “patients” or mere passive beneficiaries of health, and towards treating individuals as rights-holders and active agents for health, capable of making significant contributions.

Women, children and adolescents offer resources for positive social change that in many places have been largely untapped. A rights-based approach can enable them to flourish and become powerful and influential actors, helping to enhance health outcomes at local, national, regional and global levels. Empowering and including adolescents and young people in planning and decision-making, as agents of change and future leaders, will not only result in more informed and responsive health programmes but also generate public trust and understanding. However, this talent and potential will only be realized when national and community leaders expand the opportunities for adolescents and young people to enjoy greater social, economic and political participation.

In order to realize the potential of women, children and adolescents as actors for positive and sustainable change, not only in relation to their own health but also in broader community

and societal matters, they must be able to exercise their civil and political rights, for example to accurate, impartial and relevant information and to freedom of association, expression and assembly. This in turn will inform their decision-making about and contribution to health, dignity and social life. Policies and practices that promote misinformation and falsehoods about sexual and reproductive health and rights (often stemming from taboos around sexual intimacy and sexuality, especially adolescent sexuality) and perpetuate gender stereotypes are contrary to human rights obligations and severely detrimental to health outcomes.

Enhancing the capacity of women, children and adolescents to participate effectively must be accompanied by efforts to ensure that their environments are also supportive of their voices. Women and girls are denied a voice when public policy and processes fail to take into account their lived realities, including the disproportionate burdens of care and domestic work carried by many. In places where discrimination against women bars them from public discussion, or otherwise devalues their existence in public life, concrete countermeasures must be taken.

Respect for the agency of children, including of young children, in the context of their families, communities and societies is frequently neglected or even rejected. To ensure active participation by children, who are often denied opportunities to exercise agency in relation to their own health and lives, specific consideration

and procedures are required that give primary consideration to their best interests and due weight to their views and preferences, in accordance with their age and maturity.

Human rights law and the SDGs require that priority attention be given to vulnerable and marginalized groups, including by creating effective mechanisms to ensure their engagement in decisions about health. Governments have a role to play to ensure that this is systematically implemented.

To enable people to demand their rights, their participation must involve more than mere consultation: there must be continuing dialogue between duty-bearers and rights-holders about their concerns and demands. For policies and interventions to be fully responsive to their needs and consistent with their rights, they should be designed and monitored in partnership with the rights-holders.

Sustained engagement with people and their communities is only possible where the freedoms of information, expression, association and peaceful assembly are respected. True participation also requires that practical steps be taken to make authorities accountable for commitments made, including provision for remedies and redress when commitments are not met.

In order to build an environment that supports those defending and championing human rights, closer attention must be paid to the processes of governance that impact upon the health of women,

Box 13. Adolescents at the front line of calls for global change

At the age of 11, and just a year before his untimely death, Nkosi Johnson, born in 1988 to an HIV-positive mother, delivered a powerful speech at the opening ceremony of the 13th International AIDS Conference, in Durban, South Africa. He called for an end to the stigmatization of people living with HIV/AIDS, at a time when those suspected of carrying the virus were often shunned by their families and

chased away by their communities. He urged his government to provide HIV-positive mothers with drugs that reduce the risk of transmission of the virus during childbirth. Nkosi finished his influential Durban speech thus: “Care for us and accept us — we are all human beings. We are normal. We have hands. We have feet. We can walk, we can talk, we have needs just like everyone else — don’t be afraid of us — we are all the same!”¹¹²

Box 14. Children participate at a United Nations event

At the Day of General Discussion of the Committee on the Rights of the Child in 2016,¹¹³ child and youth representatives



from Colombia, India, Samoa and Zambia presented their analysis of the effects of environmental degradation and pollution on the rights of the child, including the rights to life, survival, development and health. They reported their activities in their communities and schools to bring about change, including through peer education, information sharing and awareness raising, participating in the modification of school curricula, etc. They voiced concrete requests to parents, communities, governments and the Committee on the Rights of the Child to realize their rights.

children and adolescents. Human rights-based governance relies on transparency to enable meaningful participation by stakeholders. To support rights-based claims to health and through health, participatory efforts should also engage health-enabling sectors (education, finance, infrastructure, women's and children's affairs, environment etc.) and include representation of diverse interests (beyond technical experts and officials) involving civil society, development partners, the private sector, etc.

When these collaborative elements are in place a more deliberative process is possible that can expand the ways in which problems are identified, deepen analysis, strengthen the setting of priorities and tailor more effective interventions. This presents new opportunities to “reshape the possibility frontier”¹¹⁴ for advancing the health and human rights of women, children and adolescents. Those with experience in establishing multistakeholder engagement report

that such initiatives also forge mutual understanding. The inclusion of diverse voices prompts actors to “look beyond a purely biomedical approach in order to address inequalities and root causes of impediments to sexual, reproductive, maternal and child health”.¹¹⁵ When diverse stakeholders work together solidarity is fostered between them, which is invaluable for reducing gaps between policy intent and policy acceptance.

Cooperative, collaborative effort across domains also reinforces the recognition that that each of us, wherever we are, has a role to play in standing up for human rights to health and through health. Although State ministries of health bear the primary responsibility, health and human rights cannot be left to them alone. Parliamentarians, the judiciary, the media, the private sector, development actors and, importantly, every individual—including women, children and adolescents—should be enabled to play their part.

RECOMMENDATION 5

All States should take concrete measures (for example, through awareness raising campaigns and community outreach) to better enable individuals (particularly women, children and adolescents), communities and civil society to claim their rights, participate in health-related decision-making, and obtain redress for violations of health-related rights.



EMPOWER AND PROTECT THOSE WHO ADVOCATE FOR RIGHTS

Despite their invaluable contributions to health and human rights, many people defending and championing health-related rights suffer reprisals. These human rights defenders may be subjected to intimidation and public attack, renounced by officials, their organizations de-funded; some have even been assassinated. For those working on gender equality, sexuality, sexual health and reproductive health the risks are heightened.

Governments will find that the transformative potential of an integrated health and human rights agenda is squandered unless there are also guarantees of a safe environment for rights to be peacefully advocated, defended and claimed without fear of retaliation.

Governments should recognize, in particular, the crucial roles of health workers in comprehensive

rights-based approaches. Practitioners often have little or no voice in larger health planning processes, despite having the most direct contact with health system users. In consequence, for example, front-line service providers and health service managers cannot send “up the chain” information that is critical to better health service planning, such as client complaints about treatment received, and information about stock-outs of life-saving commodities or unmet community needs.

Health workers also play a critical role in civil registration processes. Birth registration is the foundation of legal personhood, on which the formal exercise of rights depends. The collection, analysis and reporting of cause of death data, including for maternal, newborn and infant deaths, are indispensable to the planning and provision of quality, accountable health services.

While most health workers are human defenders and enablers, some health workers have been actively involved in health and human rights violations. For example, health professionals have been known to exercise discriminatory practices in contravention of human rights standards (e.g. using metal restraints on patients with mental health conditions; performing surgery to “adjust the sex” of intersex children; and derogatory treatment of women in labour).

Box 15. Role of professional associations

The Society of Midwives of South Africa is using OHCHR’s technical guidance on a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal mortality and morbidity.¹¹⁶ This is part of its efforts to build the capacity of midwives to apply a human rights-based approach, and to promote the special role of midwives, as distinct from general nurses, in sexual and reproductive health, including their separate training, registration and management. The Society developed the *Trainers’ handbook on applying human rights-based approaches to midwifery*, which draws on and contextualizes the technical guidance, conducted workshops to empower its executive members and strategic educators to introduce this work in their respective training institutions, and carried out advocacy for midwifery. Thus far, the handbook has been piloted with 30 midwives in courses facilitated by two trained educators. The workshops and training courses also helped to sharpen advocacy efforts and facilitated collaboration with the National Department of Health and the Minister of Health, leading to explicit and independent recognition of midwives in the South African Nursing and Midwifery Act 2015.

Conversely, health-care workers can themselves suffer human rights violations at work (e.g. violence against gynaecologists providing legal abortions; and unsafe and unhygienic working conditions) against which they need and are entitled to protection.

In order to empower health workers as human rights defenders: their training should include information on human rights norms and technical guidance on what this means for health policy and clinical practice; their overall working conditions should be brought into line with human rights standards; and their participation encouraged in initiatives to foster more constructive dialogue between facility-based providers, managers, community providers, referral points and critically, service users.

Examples of how stakeholder groups can advocate for rights to health and through health are listed below.

- Health policy-makers should ensure that health planning is based on a robust situational analysis that identifies the key human rights challenges facing women, children and adolescents in respect of their health and well-being.
- Parliamentarians should review and repeal discriminatory laws and ensure that budgetary allocations are in line with identified human rights and health priorities.
- The judiciary should use the opportunities of cases in which health and human rights are at issue, not only to order individual redress, but also to challenge systemic shortcomings.
- The media should help to raise public awareness of health and human rights, dispel harmful stereotypes and tackle harmful social norms and practices.
- Professional associations should provide better support for and defence of the defenders. They should enforce rights-based professional codes of ethics. Box 15 highlights how the Society of Midwives of South Africa is applying a human rights-based approach in the training and regulation of midwives.

Box 16. Civil society as defenders of the right to health

In Uganda, civil society, led by the Centre for Health, Human Rights and Development (CEHURD),¹¹⁷ has engaged in strategic litigation on maternal health as a human right. For example, in 2012, CEHURD filed a civil suit against Nakaseke District local government for its failure to supervise health facilities, leading to the negligent death of a woman during childbirth. The woman needed a caesarean section but the doctor had absconded from duty. The court asserted that access to emergency obstetric and newborn care is a legal right. Although this provision is not recognized constitutionally, it set an important precedent in Uganda.

CEHURD also works with partners to build capacity among duty-bearers, training health workers and other technical personnel on human rights-based approaches (HRBA) to sexual and reproductive health, with a special emphasis on maternal health. For example, in Naguru hospital training efforts were informed by the findings of a human rights assessment of the hospital's maternal health services. Drawing on lessons learned from Naguru, in April 2017, the Ministry of Health and partners proposed an HRBA taskforce to conduct similar needs assessments of health services in a sample of health centres to inform health workforce training on human rights-based approaches in line with the capacity gaps identified.

- Health workers should report human rights violations at work, and ensure that there are mechanisms in place to respond to complaints when they occur.
- Civil society should monitor the impact of government policies and practices and mobilize public action where violations take place or rights are threatened (see Box 16 for an example from Uganda).



RECOMMENDATION 6

All States should take concrete measures to better enable, support and protect defenders, champions and coalitions advocating for human rights to health and through health.



ENSURE ACCOUNTABILITY TO THE PEOPLE FOR THE PEOPLE

Accountability is a core principle of both the SDGs and the *Global Strategy*. It is also a central pillar of a human rights-based approach to health: without accountability, human rights are no more than window-dressing.

Strengthening accountability as a core pillar of good governance and in fulfilment of duty-bearers' obligations to rights-holders offers important opportunities for the realization of health and human rights. The State is ultimately accountable for realizing the right to health, as a binding legal requirement. From a human rights perspective, this accountability requires multiple forms of oversight, including administrative, social, political and legal review.¹¹⁸

Any person or group whose health-related rights are violated should have access to judicial or other effective remedies at both national and international levels. All such victims should be entitled to adequate reparation, in the form of restitution, compensation, satisfaction or guarantees of non-repetition. National ombudsmen, human rights commissions, consumer forums, patients' rights associations and similar institutions should be involved in these processes.¹¹⁹

Accountability also requires that the consequences of violations perpetrated in the context of health services, such as gender-based violence, be clearly set out. Health-system complicity in violations must be addressed, including the roles of health workers, not only as perpetrators but also as victims of human rights violations.

Recent reviews of efforts to strengthen accountability approaches to women's, children's and adolescents' health¹²⁰ identified national and subnational initiatives in the areas of litigation and human rights mechanisms,¹²¹ in citizen-led and social accountability,¹²² and by way of activities in the health system's internal processes and regulations. Specific progress was achieved where the focus had been on enforcing regulations, norms and practices.

Of particular note is the increasing evidence of the benefits of social accountability, in which citizens actively engage in monitoring service delivery. Social accountability approaches involving community participation in health system monitoring and decision-making have been shown to increase the responsiveness of providers to the communities they serve. They have also enhanced communities' knowledge and awareness of their rights to quality health

care and to respectful treatment at health facilities. Social accountability approaches can build bridges between communities and those making decisions about services, bringing all stakeholders together to jointly address barriers to the provision of services.¹²³

The most promising examples of social accountability within health systems pay attention not only to increasing the voice of patients and communities, but also to bolstering the institutional capacity to respond, which can be challenging in health systems that are already weak and under-resourced. Perversely, inadequately resourced social accountability mechanisms that are narrowly focused and time-limited might solve immediate problems only to create incentives for new forms of corruption or malfeasance (“squeezing the balloon”).¹²⁴ Nonetheless, when appropriately resourced and supported from within the broader system, engaging communities and health workers in accountability processes can build mutual

respect and trust, and promote improvements in the quality of and satisfaction with services.¹²⁵

Overall much more needs to be done to achieve robust accountability. A necessary first step is to incorporate and implement systems for people-centred accountability within health planning and delivery in support of better quality health policy and improved, non-discriminatory and more equitable health outcomes.

The capacity of health workers to incorporate accountability into their own practices must also be increased, for example by including these issues in curricula for their education and in-service training.

An example of enhanced accountability in the interest of better clinical outcomes is the “best practice” of Maternal Death Surveillance Reviews. These inquiries are triggered by notification of a maternal death at a facility, and involve cause of death reviews to identify actions needed to address any system weaknesses.

Figure 1. The *Global Strategy's* Unified Accountability Framework



Box 17. Seeking remedies: country examples¹²⁸

The *Parliamentary Ombudsman in Finland* increasingly deals with right-to-health complaints, in particular with respect to patients' rights and the right to health care (guaranteed under the Constitution). In 2005, the Ombudsman examined several complaints involving the unavailability of adequate health services, lack of access to quality treatment and the manner in which patients were treated. The Ombudsman consulted the National Board of Medico-legal Affairs before reaching decisions in these cases.

The *National Human Rights Commission in Mexico* has been dealing increasingly with right-to-health complaints, in particular the refusal to provide or the inadequate provision of public health services, and medical negligence. In 2004, the Commission issued a general recommendation directed to relevant national and district ministers on the human rights of persons with psychosocial disabilities who had been institutionalized in reclusion centres. The recommendation was based on an inquiry and visits made to such centres throughout the country to examine their compliance with human rights standards.

This example specifies who is answerable, what the standards are and what the recourse mechanisms are.

The *Global Strategy's* Unified Accountability Framework (UAF) is a major asset to accountability for women's, children's and adolescents' health. The UAF is a harmonized, multistakeholder accountability framework spanning local, regional, national and international levels (each accountable to the other) with ultimate accountability to women, children and adolescents.

Efforts to date have focused mainly on the technical details of operationalizing the UAF (for example, agreeing a set of monitoring indicators¹²⁶). Building on this, human rights must now be placed centre stage as focus moves from technocratic issues towards an approach centred on accounting for progress (or its absence) to the people whom it is

designed to serve, especially to those left furthest behind: the most disadvantaged and marginalized.

Although the UAF is firmly rooted in existing mechanisms, the Independent Accountability Panel (IAP) was only established in 2016. It is mandated to independently review, and make recommendations to accelerate, implementation of the *Global Strategy*. In its first report¹²⁷ the IAP made the welcome addition of "remedy" to the UAF's monitor, review and act functions shown in Figure 1.

The High-Level Working Group notes, as did the IAP, that remedies for abuses and violations of health and human rights are important to ensure that preventative and corrective measures are generated at all levels, and to identify critical accountability gaps to be addressed through intensified policies and investments. Box 17 includes two examples of countries that have established national human rights commissions or other independent institutions to deal with right-to-health complaints.

RECOMMENDATION 7

All States should ensure that national accountability mechanisms (for example, courts, parliamentary oversight, patients' rights bodies, national human rights institutions and health sector reviews) are appropriately mandated and resourced to uphold human rights to health and through health. Their findings should be regularly and publicly reported by States. Technical guidance in support of this should be provided by WHO and OHCHR.



2.3 Strengthen evidence and public accountability



COLLECT RIGHTS-SENSITIVE DATA

Reviews highlight the critical importance of collecting and analysing quality data in order to more effectively monitor progress in health and human rights.^{129,130} Throughout the processes of collecting, analysing, disseminating and using such data, human rights must be respected.

The core principles of self-identification, participation and non-discrimination, along with data protection (including protection of privacy and confidentiality) are key to the integrity of statistical measures to monitor rights to health and through health, for which structural, process and outcome indicators are all important.¹³¹

Yet, in many countries, health information systems and associated mechanisms are insufficiently resourced and inadequately

implemented, making it impossible to assess the status of population subgroups, let alone discover the extent to which human rights are being upheld, promoted or violated, and how this is contributing to health and human rights outcomes more widely.¹³²

Investment in *health information systems* that are sensitive to human rights is essential. Even where resources are constrained such investment can pay dividends by fostering effective, efficient and equitable health policy. Such systems require the collection of data beyond those specifically focused on health, including on gender, economic status, education level and place of residence, in order to reveal the broader dimensions of inequality. The systems should enable analysis of the impacts of non-health factors, including budget allocations, discriminatory laws, laws

criminalizing certain services and school curricula that omit comprehensive sexuality education. There should be funding specifically for technical knowledge, analytical skills and good practices to ensure human rights-sensitive data analyses.

Disaggregated data are vital for monitoring the links between health and human rights. The *Global Strategy* underscores this need: “The collection of sex-disaggregated data and gender sensitive indicators is essential to monitoring and evaluating the results of health policies and programmes”.¹³³ Better disaggregated data are urgently needed to understand and address inequities and to promote human rights within and across sex and gender, sexual orientation, gender identity and gender expression, including for people with diverse gender identities and expressions, as well as men, women and transgender individuals.

Comprehensive data on the health status of children are not yet collected. Data on adolescents’ health are fragmented. Little or no data are collected on younger adolescents’ sexual and reproductive health, despite the earlier onset of puberty, particularly in girls, and even though many women report that their first experience of sexual intercourse occurred

before age 15. In Asia, Northern Africa and some francophone countries of sub-Saharan Africa unmarried women are either excluded from fertility and health surveys, or are included but not asked questions about sexual activity, contraceptive use and desired fertility. Yet, studies in these regions show that some young, unmarried women are sexually active and in need of sexual and reproductive health and rights services. National fertility and health surveys, relying on household samples, often miss adolescents who live in vulnerable situations, such as refugees and those living on the street.¹³⁴

Quality disaggregated data are urgently needed to better expose discrimination. Geo-spatial data play a vital role in revealing racial inequalities. Disaggregated data are also needed to obtain more robust baseline data, specifically on the relationship between gender inequality and the health system.¹³⁵

From a human rights perspective, quantitative indicators alone are not enough. *Qualitative data* contribute to a more comprehensive understanding of baselines and the impact of interventions as well as health outcomes. An understanding of qualitative experiences and policy contexts is essential to determine the

extent to which human rights are being enjoyed or denied. Further, purely quantitative indicators can be instrumentalized in favour of policies that undermine human rights. For example, policies aimed at improving contraceptive prevalence rates that disregard the principle of prior and informed consent or deny the autonomy of women and girls to choose between modern forms of contraceptives can result in coercion and other human rights violations, such as forced sterilization.



Human rights-sensitive monitoring and documentation methodologies, particularly community-based documentation and data gathering, together with other forms of meaningful involvement by civil society, are also crucial and complementary tools for enabling a fuller understanding of whether States are meeting their human rights obligations related to health.

There is strong evidence that a human rights-based approach contributes to health improvements for women, children and adolescents. Data are also needed on the impact of human rights interventions on women's, children's and adolescents' health to ensure that evidence-based health programming and policy-making reflect human rights standards.¹³⁶

Urgent action is also needed to increase national capacities, including in civil society organizations, to generate the data necessary for accountability at local, national, regional and global levels. In an era of rapid technological progress, the absence of more comprehensive quality data in support of rights to health and through health is unacceptable. Necessary concrete action includes:¹³⁷

- ensuring respect for the principles of self-identification, participation, non-discrimination and protection of data when collecting, analysing, disseminating or using data;
- establishing governance mechanisms in which all users and potential users of data, including parliamentarians and young men and women, actively participate;
- strategically integrating quantitative, qualitative and policy data to build more comprehensive and inclusive accounts of people's access to and experiences of health systems;
- ensuring comprehensive collection and analysis of data disaggregated by sex, age, disability, race, ethnicity, and economic and other status, as nationally relevant, to better identify women, children and adolescents facing discrimination in their enjoyment of human rights to health and through health;
- investing in implementation research to ensure that good quality data and evidence are available on issues relating to the implementation of interventions; and
- collecting and analysing data on indicators that measure structure, process and outcome to enable evidence-based assessments of progress from commitment, to action, to outcome.



RECOMMENDATION 8

All States should take concrete steps to enhance data concerning human rights to health and through health, particularly with respect to women, children and adolescents, in line with the 2030 Agenda for Sustainable Development and the Global Strategy for Women's, Children's and Adolescents' Health. These data should enable disaggregation by all forms of discrimination prohibited under international law, paying particular attention to those who are rendered invisible by current data methodologies.



REPORT SYSTEMATICALLY ON HEALTH AND HUMAN RIGHTS

States are obliged to submit regular reports on their human rights situation to international

human rights monitoring bodies, including through the universal periodic review of the Human Rights Council, and to monitoring bodies of treaties they have ratified, including regional human rights bodies and UN treaty monitoring bodies. The observations, interpretations and recommendations emanating from these different human rights bodies have enhanced accountability on one hand, while clarifying the nature and extent of States' obligations to guarantee human rights on the other.

States should take concrete action to apply this information on progress made, and on any gaps, which can be utilized by various actors to help improve respect for human rights at the local and national levels. However, the High-Level Working Group notes with concern that States have often overlooked the health and

rights of women, children and adolescents in their reports and recommendations. This should be rectified.

Sound reporting depends on sound monitoring. In this context, monitoring means "providing critical and valid information on what is happening, where and to whom (results) and how much is spent, where, on what and on whom (resources)".¹³⁸ Human rights-based approaches require holistic monitoring of women's, children's and adolescents' health at the national and subnational levels, including monitoring the underlying human rights determinants of ill health, disability and preventable death. As noted above, underlying human rights causes include poverty, gender inequality (manifested in discriminatory laws, policies and practice) and marginalization (based on age, ethnicity, race, caste, national origin, immigration status, disability or other grounds); all of these are human rights violations.

To strengthen the value and utility of monitoring for rights to health and through health, the High-Level Working Group urges that, alongside the indicators to be used for monitoring progress in implementing the *Global Strategy* as agreed in 2016,¹³⁹ additional bespoke reporting to the World Health Assembly and the Universal Periodic Review be introduced. Specifically, we urge reporting by States on the steps they have taken, the policies they have enacted and the resources they have allocated to:

- identify systematically, including through disaggregated data on all prohibited grounds of discrimination, baselines for those who are currently left behind, and build tailored national strategies and action plans to uphold human rights to health and through health;
- reduce gender inequality, eliminate gender-based discrimination in law and practice and address child abuse and gender-based violence;
- identify and address discriminatory policies and practices confronting women, children and adolescents when accessing and using health services;
- build the knowledge, capacity and skills of health workers to respect women's, children's and adolescents' health and human rights;
- enhance awareness among women, children and adolescents of their health and human rights, and invest in their capacity to claim and exercise their rights;
- ensure meaningful participation by women, children and adolescents in health-related data collection, decision-making, implementation and monitoring; and
- facilitate access to justice and remedies by women, children and adolescents in case of violation of their rights relating to health and in the health system context.

The High-Level Working Group also notes that the *Global Strategy's* accountability mandate was further strengthened in May 2016, when the World Health Assembly resolution on the *Global Strategy* called on Member States and others to “strengthen accountability and follow-up at all levels” and requested the WHO Director-General to “report regularly on progress towards women's, children's and adolescents' health”.¹⁴⁰ Member States will start reporting to the World Assembly in 2017.

In addition, based on inputs from Member States and others, the Partnership for Maternal, Newborn & Child Health will lead the production of an annual progress monitoring report. This will analyse commitments, expenditures, outcomes, processes and emerging issues related to the implementation and impact of the *Global Strategy*, and will be used to hold Member States and partners to account for their human rights-related commitments to the *Global Strategy*. It will feed into the IAP's annual report and the High-Level Political Forum for the SDGs, the monitoring mechanisms for the implementation of Agenda 2030.

The High-Level Working Group considers it essential that these reports include systematic reporting on human rights aspects, including steps taken towards implementing the recommendations made in this report.

RECOMMENDATION 9

All States should report publicly on progress made towards the implementation of recommendations of this report at the World Health Assembly, in their Universal Periodic Reviews and as part of their implementation of the 2030 Agenda for Sustainable Development and the Global Strategy for Women's, Children's and Adolescents' Health. Technical guidance in support of this should be provided by WHO and OHCHR.



Building momentum for human rights to health and through health

The issues set out in this report are highly relevant for all countries in all regions of the world, not least because of current threats to earlier advances in respecting and protecting women's, children's and adolescents' rights, including their personal autonomy.

The High-Level Working Group is convinced that committed leadership for collective action is urgently needed to safeguard the full exercise of women's, children's and adolescents' human rights, including their access to comprehensive information, their rights to autonomous decision-making in keeping with their age-related abilities,

and their enjoyment of services necessary for their mental, sexual and reproductive health, including safe abortion services.

As the implementation of Agenda 2030, including the *Global Strategy*, moves forward, the High-Level Working Group urges active engagement by national governments, parliaments, and community and civil society leaders. We urge all leaders to stand up for the health, dignity and human rights of all people, and to champion women's, children's and adolescents' health and rights, through advocacy and activism. We call on the health and human



rights communities at all levels—subnational, national, regional and international—to work together to hasten delivery of positive outcomes for women, children and adolescents. Further, we highlight the urgent need for participatory accountability mechanisms, including for access to effective remedies in cases of violations.

To achieve greater momentum in this global effort, we call on **the WHO Director-General and the High Commissioner for Human Rights to:**

- a) establish a joint programme of work to support the implementation of these recommendations, including at regional and country levels
- b) build institutional capacity and expertise at their headquarters and at regional and country levels to assist States to advance their realization of human rights to health and through health, particularly for women, children and adolescents
- c) ensure ongoing coordination of, and tracking of progress towards, the realization of human rights to health and through health, particularly for women, children and adolescents, which will enable prompt dissemination of good practices.



Annex A.

Members of the High-Level Working Group on the Health and Human Rights of Women, Children and Adolescents and the Technical Advisory Group

Members of the Working Group

- Tarja Halonen, former President, Finland (co-chair)
- Hina Jilani, member of The Elders, Pakistan (co-chair)
- Denis Mukwege, Gynaecologist, Democratic Republic of Congo (rapporteur)
- Aminata Touré, former Prime Minister, Senegal
- Marie-Claude Bibeau, Minister for International Development and La Francophonie, Canada
- Rosy Akbar, Minister for Health and Medical Services, Fiji
- Cristina Lustemberg, Vice-Minister of Health, Uruguay
- Natasha Stott Despoja, former Global Ambassador for Women and Girls, Australia
- Richard Horton, Editor of *The Lancet*, United Kingdom

Members of the Technical Advisory Group

- Pascale Allotey, Professor of Public Health at the Jeffrey Cheah School of Medicine and Health Sciences, Monash University, Australia
- Zulfiqar Bhutta, Co-Director of the SickKids Centre for Global Child Health, Toronto, Canada, and Founding Director of the Center of Excellence in Women and Child Health at the Aga Khan University, Pakistan
- Lynn P Freedman, Professor of Population and Family Health and Director, Averting Maternal Death and Disability Program, Columbia University, USA
- Sofia Gruskin, Director, Program on Global Health & Human Rights, University of Southern California, USA
- Elly Leemhuis, Senior Advisor, Sexual and Reproductive Health and Rights, Ministry of Foreign Affairs, The Netherlands

Co-convenors

- Flavia Bustreo, Assistant Director-General, World Health Organization
- Kate Gilmore, Deputy High Commissioner, Office of the United Nations High Commissioner of Human Rights

Secretariat

The Working Group was supported by a joint WHO and OHCHR secretariat, headed by Rajat Khosla, World Health Organization. Other members of the secretariat included: Lucinda O'Hanlon (OHCHR), Anna Gruending (WHO), Lynn Gentile (OHCHR) and Asako Hattori (OHCHR). Joanne McManus and Anna Rayne provided editorial support.

Annex B.

Human rights-related actions under the *Global Strategy for Women's, Children's and Adolescents' Health*

HUMAN RIGHTS-RELATED ACTIONS UNDER THE *GLOBAL STRATEGY FOR WOMEN'S, CHILDREN'S AND ADOLESCENTS' HEALTH*

ENABLING ENVIRONMENT (SDG TARGETS 10.3, 16.2, 16.9, 16.10 AND 17.18)

Collect comprehensive data, disaggregated by sex, age, disability, race, ethnicity, mobility, economic and other status, as nationally relevant, to identify women, children and adolescents facing discrimination in access to health care and other entitlements and services which affect their health and related human rights. The data should identify groups subject to multiple and intersecting forms of discrimination and disparities in health between the target populations and the general population, as well as within them.

Conduct an assessment of the extent to which existing legal and policy frameworks comply with the human rights norms applicable to health and well-being, as part of a comprehensive analysis, through a participatory, inclusive and transparent process, with stakeholder consultation throughout.

Repeal, rescind or amend laws and policies that create barriers or restrict access to health services (including sexual and reproductive health and rights services) and that discriminate, explicitly or in effect, against women, children or adolescents as such, or on grounds prohibited under human rights law. This includes repealing laws that criminalize specific sexual and reproductive conduct and decisions, such as abortion, same-sex intimacy, sex work and the delivery or receipt of sexual and reproductive health and rights information.

Enact laws and implement policies promoting positive measures to ensure that essential health services, including primary health care, sexual and reproductive health and rights services, maternal health services, mental health services, and neonatal, child and adolescent health services are available, accessible, acceptable and of good quality.

Prohibit harmful practices such as child, early and forced marriage, female genital mutilation, and violence against women, children and adolescents, including gender-based violence.

Promote social mobilization, education, information and awareness-raising programmes and campaigns to challenge discrimination and harmful social norms and to create legal awareness and literacy among health service personnel and beneficiaries, with a focus on women, children and adolescents, including vulnerable and marginalized groups within these populations.

PARTICIPATION (SDG TARGETS 5.5 AND 16.7)

Build the capacity of rights-holders to participate and to claim their rights, through education and awareness-raising, and ensure that transparent and accessible mechanisms for engaging stakeholder participation and facilitating regular communication between rights-holders and health service providers are established and/or strengthened at community, subnational and national levels.

Ensure stakeholder participation in priority-setting, policy and programme design, implementation, monitoring and evaluation, and in accountability mechanisms. This can be achieved by establishing and/or strengthening transparent participation and social dialogue or multistakeholder mechanisms at community, subnational and national levels and ensuring that participation outcomes inform subnational, national and global policies and programmes related to women's, children's and adolescents' health.

EQUALITY AND NON-DISCRIMINATION (SDG TARGETS 3.8, 5.1, 5.2, 5.3 AND 10.2)

Develop and fund a national strategy to address discrimination against women, children and adolescents in access to health services and in health care, taking into account, particularly, gender- and age-based discrimination.

Adopt measures to address the specific barriers faced by women, children and adolescents from marginalized and vulnerable population groups, such as the provision of culturally appropriate health services for indigenous peoples, the provision of health information in formats that are accessible to persons with disabilities, and health coverage for both documented and undocumented migrant populations.

HUMAN RIGHTS-RELATED ACTIONS UNDER THE *GLOBAL STRATEGY FOR WOMEN'S, CHILDREN'S AND ADOLESCENTS' HEALTH*

PLANNING AND BUDGETING (SDG TARGET 16.7)

Formulate comprehensive, rights-based, coordinated, multisectoral strategies and adequately resourced plans of action mandating explicit action to ensure the accessibility, availability, acceptability and quality of facilities, goods and services, without discrimination, and to address barriers to access. Plans of action should include targets and indicators prioritized through a participatory and inclusive process and should focus attention on the health needs of women, children and adolescents.

Establish participatory budget processes with a view to ensuring transparency and promoting the involvement of women, children and adolescents in monitoring the allocation and utilization of resources for their health.

RIGHTS-BASED SERVICES (SDG TARGETS 3.1, 3.7, 3.8 AND 5.6)

Formulate comprehensive strategies, through consultative processes and user participation, to ensure access to high quality and affordable health care for diseases affecting women, children and adolescents, in an environment that guarantees free and informed decision-making, respect for autonomy and agency and respect for the right to privacy. Health information, counselling and education, including comprehensive sexuality education, should be evidence-based, in line with human rights and readily available and accessible to women and adolescents as well as children, in accordance with their level of maturity.

Provide for universal access to health coverage for all women, children and adolescents, including those from marginalized or vulnerable populations and those not employed in the formal sector. Coverage should identify the guaranteed priority interventions and should cover access throughout the life course. Services should be free at the point of access, in particular for persons with limited mobility or without an independent source of income, in order to ensure the protection of the right of adolescents and women to privacy and confidentiality in accessing health services.

Provide comprehensive training on the health rights of women, children and adolescents, including on sexual and reproductive health and rights, the impact of discrimination and the importance of communication and respect for patient dignity in health-care settings, as an integral part of all training for health personnel.

DETERMINANTS OF HEALTH (SDG TARGETS 1.3, 1.4, 1.5, 2.1, 2.2, 3.1–3.7, 4, 5, 6.1, 6.2 AND 8.5)

Identify the structural and other determinants of women's, children's and adolescents' health, such as poverty, inadequate nutrition, poor education and inadequate housing, based on a participatory approach, with a view to developing comprehensive strategies to advance women's, children's and adolescents' health.

Establish effective coordination mechanisms between different ministries and departments, including education, health and finance and develop multisectoral approaches to empowering women, children and adolescents to claim their health and health-related rights.

ACCOUNTABILITY (SDG TARGETS 16.3, 16.6 AND 16.7)

Conduct regular national and subnational reviews, in a fully participatory and inclusive manner, of the performance of health systems, and the identification of vulnerable groups or those experiencing discrimination in access to health care.

Establish and/or strengthen transparent, inclusive and participatory processes and mechanisms, with jurisdiction to recommend remedial action, for independent accountability at the national, regional and global levels within both the health and the justice systems. These include courts and quasi- and non-judicial bodies, complaints mechanisms within the health system, national human rights institutions, ombudspersons and professional standards associations.

Develop a national strategy to promote access to justice mechanisms for women, children and adolescents and allocate sufficient funding to ensure affordability, availability and access for women, children and adolescents. Possible measures include identifying and removing barriers to access, such as cost, through the provision of free legal assistance, the establishment of mobile courts or quasi-judicial redress mechanisms to improve physical access, and ensuring that services are available in languages that are understood by the client communities.

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