



The Federation's Pages

WFPHA: World Federation of Public Health Associations

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Journal of Public Health Policy (2013) **34**, 574–579. doi:10.1057/jphp.2013.38

The right to health is coming of age: Evidence of impact and the importance of leadership

At this year's high-level session of the World Health Assembly, the right to the highest attainable standard of health was mentioned by Ministers of Health more often than at any recent meeting of the Assembly.¹ Nepal's Minister of Health and Population confirmed that his country has adopted a rights-based approach to health. The South African Minister of Health spoke about health care as 'a birth right'. Colombia's Assistant Health Minister called for a 'global effort for the development and effective universalization of the human right to health'.

Germany's Minister of Health emphasized that health is 'a key human right and of vital importance for all human development'. The US Secretary of Health and Human Services quoted the words of President Obama: access to healthcare is 'not some earned privilege – it is a right'. Speakers observed that the right to the highest attainable standard of health is enshrined in the Constitution of the World Health Organization. Multiple references to the right to the highest attainable standard of health (or 'right to health') came from every region of the world.

Some health policymakers will be quick to dismiss these references as rhetorical. After all, these are high-level speeches, not detailed policy prescriptions. Nonetheless, speeches can tell us something. Sometimes they signal important shifts in opinion and direction.

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In our view, the numerous human rights references in Ministers' speeches reflect profound changes in the relationship between health and human rights – changes beginning to be felt in many countries.

Today, it is universally accepted that human rights not only include classic civil and political rights, but also economic, social, and cultural rights, including the right to the highest attainable standard of health. This right is to be realized progressively and subject to the availability of resources. It demands accountability that comes in many forms, for example, by way of community groups, parliamentary committees, suitably designed maternal and peri-natal death audits, independent inspectors, national human rights institutions, and UN treaty-bodies. Accountability is more than monitoring, but it is not blame and punishment. It is about keeping commitments, improving interventions, and making health gains, including for disadvantaged populations, communities, and individuals. All sectors and professions need accountability if they are to gain and retain the public's respect and confidence. The hallmark human rights contributions to health are reasonable, evidence-based standards of behaviour and performance, supported by fair and balanced accountability arrangements. This is the vital insight provided by the Commission on Information and Accountability for Women's and Children's Health² and confirmed by its progeny, the independent Expert Review Group.³

All States have recognised the right to health. The right (in various formulations) is enshrined in over 100 constitutions, as well as in global treaties, some of which have almost universal ratification. Until recently, however, the right was mainly confined to the law books. Thanks to the work of countless organizations and individuals, including human rights pioneers working on HIV/AIDS, the right to health is now reaching beyond the legal texts; it is being applied in practice in numerous State health policies, programmes, and other interventions. Health-related ministries, UN agencies, and civil society organizations are translating human rights law into action. This is not an easy process. It requires both leadership and open-minded, respectful collaboration across disciplines and sectors.

A recent WHO publication confirms that translation of human rights law into health policies and interventions is beginning to bear fruit. *Women's and Children's Health: Evidence of Impact of Human Rights*, prepared by many authors, examines selected aspects of women's and children's health in Nepal, Brazil, Malawi, and Italy.⁴ It explores how human rights have explicitly shaped some of the relevant laws, policies, and interventions in these countries. In Italy, for example, the study tracks the influence of the right to health from Constitution to community. The right to health is protected by Italy's Constitution and the Constitutional Court has decided a handful of important right-to-health cases. Moreover, this human right explicitly shaped the country's national health service (*Servizio Sanitario Nazionale*) and

subsequent national health plans. It also shaped community schemes, such as *Consultori Familiari*, that deliver women's health information, facilities, and services. The right to health also shaped some specific interventions, including cancer screening programmes. The health guidelines for breast, cervical, and colorectal screening remind health professionals that 'access to screening is an application of a right'.

The three other countries demonstrate similar pathways. In Nepal, for example, the Interim Constitution enshrines health-related rights. The Supreme Court has decided some right-to-health cases, the National Human Rights Commission has oversight of health and human rights issues, the National Safe Motherhood and Newborn Health Long-Term Plan is explicitly shaped by human rights, and the footprint of human rights is visible on several implementation interventions, such as the Women's Right to Health and Life Programme.

The study emphasizes that, in all four countries, the practical application of the right to the highest attainable standard of health remains work-in-progress. Examined through the right-to-health 'lens', some of the health policies and interventions in each country have shortcomings. Nonetheless, each Government deserves credit for beginning to translate human rights law into good health practice. Such a complex undertaking is bound to take time.

The authors of this WHO publication then ask a challenging question: what is the evidence that the explicitly human rights-shaped interventions have contributed to improvements in women's and children's health? By way of an initial assessment, they conclude that applying human rights to women's and children's health policies, programmes, and other interventions not only helps governments comply with their binding national and international obligations, but also contributes to improving the health of women and children.

What are some of these health gains? In Italy, women's health status has significantly improved in recent decades. Female life expectancy at birth is now the second highest in Europe. Italy's maternal mortality ratio is one of the lowest in the world. Antenatal examinations and hospital visits, as well as hospital deliveries, are free of charge. Breast cancer mortality decreased between 1989 and 2010, from 38.59 per 100 000 to 23.62 per 100 000. There have been sharp declines in infant and neonatal mortality, from 16.79 and 13.30 per 1000 live births to 3.51 and 2.47 per 1000, respectively, between 1978 and 2009. Italy has made impressive progress in the control and prevention of infectious diseases, for example, since 1991 hepatitis B incidence has decreased by almost 80 per cent.

The study looks at the impact of five Nepali human rights-shaped interventions, including the Women's Right to Health and Life Programme. This programme has several human rights-based elements, including participation of users and providers, outreach to disadvantaged groups, and clinical

protocols to ensure quality. Between 2004 and 2010, observers noted considerable improvements, including a reduction in maternal and under-five mortality rates, a five-fold increase in met need for emergency obstetric care, as well as a significant increase in met need for caesarian sections, and a significant increase in institutional delivery rates.

The authors acknowledge that numerous factors contributed to these health gains. They do not argue that human rights caused the health improvements. Their point is more subtle: human rights were among the factors that contributed to health gains for women and children. Although they find plausible evidence that human rights contributed positively to women's and children's health gains in the selected countries, they emphasize that there remains much room for improvement.

Given multiple social, environmental, and individual determinants of health, attributing gains in health outcomes among these factors is often a considerable challenge. Thus, it is important to identify and assess the various factors that contribute to positive health outcomes. When examining the possible link – or attribution – between human rights-shaped interventions and health gains, there must be no double standards. Attribution between public health interventions and health gains is commonly established. This is also true for attribution between overseas development assistance and impact. Human rights-shaped interventions should not be subject to a stricter test of attribution than is commonly accepted elsewhere in public health or when considering the impact of overseas development assistance.

In addition to finding evidence of the impact of human rights on women's and children's health, two themes emerge from the research. First, a human rights-based approach to women's and children's health is supported by an enabling environment with a number of features, including high-level political leadership and advocacy, and a dynamic civil society. The report identifies steps that governments can take towards such a positive environment, including ratifying key international human rights treaties, endorsing global commitments, recognizing the right to health in the constitution, establishing oversight bodies, and ensuring policy coherence and effective coordination among multiple stakeholders.

The second emerging theme is that there is a scarcity of research on, and evaluation of, the impact of a human rights-based approach on women's and children's health. This paucity of evidence is likely attributable not to a lack of impact, but to several issues, including questions about what constitutes a human rights-based approach. Furthermore, there is a lack of clarity about the methods and tools needed to carry out research and evaluation of this sort. The report suggests that multi-disciplinary and multi-method approaches to research on, and evaluation of, a human rights-based approach to women's

and children's health are critically important as they allow for the use of a broad and diverse range of methods and tools that encompass both quantitative and qualitative, including ethnographic, methods.

The study also addresses a related methodological challenge to which reference has already been made: what level of evidence is sufficient to inform decisions and actions? The scale of evidence strength and attribution ranges from 'adequacy' through 'plausibility' to 'probability'. Public health and social research have traditionally devoted more attention to both ends of the scale ('adequacy' and 'probability') than to the intermediate position ('plausibility'). The study suggests that 'plausibility' will often be the most compelling and feasible level of evidence for researchers and evaluators to use when assessing the impact of a human rights-based approach on women's and children's health, although 'adequacy' and 'probability' may also have a role.

The WHO report calls for the establishment of a multidisciplinary network of policy makers, practitioners, and scholars interested in research on, and evaluation of, impact of a human rights-based approach to women's and children's health. It also identifies a need for global and other arrangements that offer an opportunity for those working in the executive and legislative branches of government to exchange country experiences, discuss ideas, and provide advice, support, and encouragement on the implementation of a human rights-based approach.

Crucially, the study emphasizes that conformity with human rights is required by binding national and international law, and evidence of beneficial impact *supplements* the compelling moral, political, and legal reasons for adopting a human rights-based approach to women's and children's health.

This is not a comprehensive survey of the research; for example, we have not mentioned an instructive chapter that reports on findings from a review of the academic literature on participation, human rights, and women's and children's health.

So, in conclusion, is it wise to dismiss as rhetorical flourishes the numerous references to human rights in high-level speeches at this year's World Health Assembly? We do not think so. The speeches reflect growing recognition that the health community has an indispensable role to play in the implementation of the right to the highest attainable standard of health; they acknowledge that this fundamental human right can help health workers achieve their professional objectives; and they reflect profound changes that are taking place in the relationship between health and human rights. Moreover, all of these insights are confirmed by the WHO report: some Ministries of Health are already explicitly and actively using the right to health in their work, with evidence of beneficial impact. In short, the right to health is coming of age.

If the right to the highest attainable standard of health is to realize its potential to save lives and reduce suffering, much remains to be done by a

wide range of stakeholders. We hope that Ministers, Secretaries of Health, and other leaders of the public health community will chart the way forward in future meetings of the World Health Assembly – and beyond.

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References and Notes

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